Meeting Summary
Thursday, January 17, 2013
9:30 a.m. – 12:00 p.m.

IOWA DIRECT CARE ADVISORY COUNCIL

Link Associates – Board Room
1452 29th Street
West Des Moines, Iowa

Council and Committee Members
Don Chensvold, Iowa Health Care Association
Greg DeMoss, Iowa Department of Inspections and Appeals
Erin Drinnin, Iowa Department of Public Health
Di Findley, Iowa CareGivers
Linda Matkovich, H.O.P.E.
Kelly Meyers, Iowa Health Care Association
Susan Odell, Iowa Department of Inspections and Appeals
Ann Riley, Center for Disabilities and Development, U of Iowa
Suzanne Russell, Home Caring Services, Inc.
Lin Salasberry, CNA
Marilyn Stille, Northwest Iowa Community College
Anita Stineman, College of Nursing, U of Iowa
Amy Wallman Madden, H.O.P.E.
Anthony Wells, CNA

Ambassadors and Pilot Participants
Leda Burton, Woodward Resource Center
Elizabeth Fishler, Direct Care Professional
Kellee McCrory, University of Iowa
Jan Munson, Woodward Resource Center
Emily Noel, American Institute of Caring
Cindy Ramer, Direct Care Professional
Lori Reams Parrish, Woodward Resource Center
Amy Stevens, Easter Seals Iowa
Annie Strawn, Iowa Home Care
Carol Warren, Progress Industries
Michelle Webb, Link Associates
Jeff Weinstock, Direct Care Professional
Jamie Wheelock, DMACC
Pam Williams, Monroe County Professional Management

Guests
Pam Conder, Direct Care Professional
John Hale, Iowa CareGivers
Leslie Hayenga Adams, Direct Care Professional
Julie Kennedy, Direct Care Professional
Jennifer Schumann, Iowa Health Care Association
Ashley Small, University of Iowa
Mary Ann Young, Iowa CareGivers Association

SPPG Staff
Jennifer Anderson
Stacie Bendixen
Indira Blazevic
Arlinda McKeen

Welcome and Introductions
Arlinda McKeen, SPPG facilitator, welcomed attendees and gave an overview of the meeting agenda. Michelle Webb of Link Associates made remarks about the new Link building where the meeting was being held. Council members, Ambassadors, pilot site representatives, and guests introduced themselves. McKeen reviewed the legislative charge for the Iowa Department of Public Health to continue the work of the Direct Care Worker Advisory Council and implement the Council's recommendations from its March 2012 final report.

Program Updates

Outreach

McKeen provided a summary of outreach activities conducted to engage stakeholders over the last several months. Nine community forums were held around the state over the summer and fall. Meetings have been held with stakeholder organizations to provide information, and Initiative staff has supported partners in providing information to stakeholders. Organizational meetings have included the Iowa Health Care Association, Olmstead Consumer Task Force, Iowa Association of Community Providers, and others, to explain the issue and ensure all have the facts. Staff and partners have made presentations and staffed exhibit booths at conferences with interested audiences. The Council and its recommendations for direct care professional training and credentialing were represented at a health care forum convened in December by Senate Democrats; statements from Linda Matkovich of H.O.P.E. and Matthew Clevenger, a DCP, were read. E-Updates are sent regularly; partners are encouraged to share them with others who are interested.

McKeen went over several new outreach materials developed through ongoing efforts to address questions about the Initiative. These include a new piece on the composition of the workforce, an updated one-pager for elected officials, updated cost of turnover report, and clarified and elaborated career pathways (to clarify which piece is required and which are voluntary, and provide detailed breakdowns of the advanced credentials). These can be made available electronically for those who would like to share them.

McKeen asked what questions members are hearing about the Initiative. Ann Riley said she is often asked about why DCPs would have to register in addition to taking Core training; to which she answers that another reason for this initiative is to track the workforce and understand its size and makeup. She suggests adding to informational materials that DCPs must both take the training and receive a credential that puts them on a registry, giving the state a way to track and learn about the workforce.

Anthony Wells said in northwest Iowa there are a lot of older DCPs concerned about grandfathering; he has tried to explain that it will be seamless for existing workers. They struggle with thinking it will be a long, drawn-out process that will leave people who are not computer-savvy in a lurch. Wells said he explains that community partners like community colleges will be there to help. Erin Drinnin, IDPH project manager, spoke to how the department has worked to address these issues and recognizes that resources will need to be dedicated to hands-on support for these workers. It appears that states have an opportunity to apply for another multi-year PHCAST grant, which could support a launch of the grandfathering process. Di Findley mentioned that she often gets questions about continuing education.

Ambassadors

Indira Blazevic of SPPG, who manages the Direct Care Workforce Initiative Ambassador program, gave an update on the activities of this network of DCPs and employers who serve as local resources and advocates for the Initiative. Recent activities include monthly Ambassador webinars, an orientation for two new Ambassadors, and individual Ambassadors' activities. Ambassadors in attendance were asked to share their recent activities. Cindy Ramer spoke about contacting legislators in her area. Elizabeth Fishler spoke about reaching out to different care centers about the project, and she demonstrated safety techniques for a video for the online Core curriculum. Jeff Weinstock served as the local host for the Ottumwa outreach forum, and has been talking to coworkers about the initiative. Carol Warren of Progress Industries facilitated a meeting between project partners and the Iowa Association of Community Providers to provide that organization with updated and accurate information. Suzanne Russell, Home Care Services, talks to people in her community and organizations she interacts with

about the initiative. Amy Stevens mentioned that Jamie Bargman from Easter Seals participates in Ambassador webinars. Blazevic thanked Ambassadors for their work in making sure the Initiative has a presence across the state. Drinnin reiterated that all Council members, Ambassadors and pilot participants are key parts of a network in connecting partners with those who need information. Wells said the E-Updates have been very helpful in disseminating information – his administrator reads and asks him questions about things in the E-Update. E-Updates are also the main avenue for recruiting help with curriculum development and other aspects of the project.

Pilot Sites and PHCAST Grant

Drinnin gave an update on the pilot sites' hard work and recognized that the process of rolling out the curriculum has gone somewhat slower than expected. The advantage to that has been a high level of involvement in curriculum review, which has been very valuable so the curriculum is in good shape by the time it gets to the pilot sites. The sites are getting into routines for delivering training. Drinnin reviewed who the participating pilot sites are. Job Corps in Ottumwa has expressed interest in participating; they train home health aides and CNAs there and are interested in using DCWI curriculum. Northeast Iowa Community College has a separate U.S. Department of Labor grant for a program they call Bridges to Health Care, and are developing the Health Monitoring and Maintenance module and piloting training for the Health Support Professional advanced credential.

Drinnin gave an overview of PHCAST grant activities. IT system development continues in preparation for a board being established. There are three components to this effort to using online tools to make this process simpler, more efficient and more cost-effective:

1. Course completion and testing system. The ability to upload advanced credential exams is being explored. Course completion tracking will ensure DCPs are eligible to take certain exams and will keep records of each DCP's education throughout their career. This will simply include pass/fail information for each course a DCP completes.
2. Online application and Board website and functions. The most challenging parts of this have been tackled. The DCP software system is being developed after many other boards', so their processes are largely being replicated. This will include both the user interfaces for DCPs to apply for credentials and for the public to look up information, and the "back office" functions that administrative staff will use. A lot of automation is being built in to minimize the amount of staff time that will be needed and keep costs low. A group of DCPs will be providing feedback on system.
3. Appraisal of Work Experience (grandfathering). This will consist of checklists for current DCPs to indicate tasks they have experience doing, which will allow the computer to automatically determine which credential(s) the DCP is eligible for.

This IT system will collect a lot of data, such as how long a worker has been in the workforce, what their career plans are, whether they work part time or full time, and other items the Council has advised should be collected. It will be easy to generate reports – for example, to show trends in renewal and new workers entering the profession. Staff will easily be able to add and change the questions the computer asks DCPs. This system will automatically cross-compare with other systems and databases.

A pilot participant asked about the credential renewal process and estimated fees, and Drinnin summarized the Council's recommendations for renewal requirements and how it would work in the online system. Drinnin noted that some of these answers will be determined by the legislation and the rules the Board of Direct Care Professionals will eventually set. The legislation will give the Board authority to write rules about many specific items.

Drinnin noted that the other PHCAST components (curriculum development, training, and exams, mentoring, and evaluation) would be discussed later on the agenda.

Curriculum, Testing, and Online Core

An update on the curriculum was provided by Anita Stineman, PHCAST Curriculum Director. The term "grandfathering" has been changed to a term that the Education Review Committee came up with: "appraisal of work experience."

The Committee has taken each of the modules and looked at them extensively in order to identify the most significant elements that an individual taking that class ought to be able to do. In an attempt to recognize the work experience that individuals bring, the Committee decided that recognition would be given on a modular basis. In order to receive credit for a module, the Direct Care Professional would rank experience on a rating scale, which has two levels.

The Committee has done a litmus test across various work settings. When the piloting begins, the following two questions will be addressed: Are the behaviors identified appropriate, and are the people who ought to be receiving the credit, receiving it. All of the modules are complete, up through Personal Activities of Daily Living (PADL). The Committee will be meeting in March to complete the Health Monitoring and Maintenance (HMM) curricula.

Don Chensvold inquired whether or not the rating scale is a self-assessment and how it would be taken and evaluated. Stineman confirmed it is a self-assessment and stated that the individual would take the assessment and the computer would perform the validation. The individual would need to carefully read through the list to identify the appropriate modules. Erin Drinnin added that, in terms of validation, random auditing will also be done. Grandfathered DCPs will also be required to enter their work history for the last five years. When auditing, both the information entered and the employment history would be examined. Chensvold asked whether any testing of the testing would be performed, in order to make sure that the questions asked are understandable. Stineman explained that the terminology used is very particular to the work that individuals do, so they would be able to understand the specific language; the use of the terminology is purposeful. The pilot testing will validate the questions. Jan Munson, Woodward Resource Center, asked about individuals with English as a second language. Stineman said they would be included in the pilots. In an attempt to be as inclusive as possible, that was the recommendation that the group came up with.

Stineman continued by stating that the Committee had a conversation about the process for CNAs. The rating scale would ask a CNA if s/he is active on the registry. If not, or if uncertain, a couple of other questions would also be asked. For example, it would be asked if the DCP can provide a copy of the certificate of completion, or a written and skills state competency test for a CNA was completed. If they can provide validation of either, then they would meet the criteria for the Health Support Professional (HSP) Credential. If someone qualifies for all of the modules that make up the Health Support Credential, s/he would not automatically also obtain a CNA credential, because the two credentials are overseen by two different groups. However, if an individual is already a CNA, and s/he can validate the training and work experience, s/he would also qualify as a HSP.

Chensvold asked whether the current Nurse Aide designation meets the criteria for a HSP Credential and whether this would be true for new Nurse Aides or if they will fall into the new system. Stineman responded that the hope is that as the curriculum is implemented, the individual seeking the HSP credential would take the core, PADL and HMM, and a written exam, and then apply for the credential. The process would be the same for a CNA. They would take the core training, and receive the Direct Care Associate (DCA) Credential. Then, if they wanted to go the CNA route, they would then take PADL

and HMM training, and then they would have to complete a clinical portion in a long-term care setting, (which is one of the current requirements for a CNA). Then, they would be eligible to take the same written exam as a HSP. However, they would also take a skills test, in order to be eligible on the CNA registry.

Anthony Wells noted that DCPs in the room need to have a correct understanding of how this (the credentialing) will work, because other DCPs will ask them, and it is important that this information is being distributed properly. An attendee from the Woodward Resource Center asked how they can support their staff, who would like to have a CNA designation, in doing the clinical, if they are not a long-term facility. Stineman replied that the CNA designation has federal guidelines, and because of those federal guidelines that speak directly to long-term care, the facility would have to be a designated long-term care facility. If the instructor is a nurse, and has that required prior work experience in a long-term care facility, then perhaps Woodward could work with her to identify an appropriate clinical site. A follow up question was asked as far as making the clinical training more widely available. Jamie Wheelock, DMACC, stated that community colleges might be able to be a part of the solution in making this available to people. Stineman added that the groups that worked on the curriculum envisioned it this way, as well, that the community colleges would be offering that stand-alone clinical experience. If it has been a while since the individual has taken the modules, they would probably do a lab experience first to verify the experience before they do the clinical setting. This speaks to the choice that the Initiative provides to both individuals and employers.

Marilyn Stille added that most community colleges would be very willing to work that in, so that individuals could take that clinical portion. Wells added that by that point, the hope is that there would be additional community partners, in addition to community colleges, that would provide the same service. Greg DeMoss stated that they (at the Iowa Department of Inspections and Appeals) get a lot of phone calls from CNAs who work at Woodward. He also stated that as far as the federal regulations go, the CNA regulations are always based on employment. This additional training, recommended through the Initiative, does not keep CNAs active on the registry, even though some CNAs think it does. The advancement is fine for the purposes of the Board, but it still does not change the federal requirements for CNAs. Drinnin added that an advantage to this curriculum is that it promotes so much flexibility. She offered that the individual from Woodward could offer an HSP to the individual, and they would just have to add on the clinical and the test. In this way, they would be offered an advanced credential and some movement on the pathway. Stineman added that the employer also benefits from the added skills.

Elizabeth Fishler, DCP, asked if someone who works in a hospital setting is still eligible to remain on the (CNA) registry. DeMoss stated that hospitals require all of their direct workers to be active on the registry, because that is their facility policy, and there is no choice because the federal requirements need to be followed. Drinnin clarified by reflecting on why the HSP was developed in the first place. Since the federal regulations for CNAs were first established, much has changed. Things were a lot different about thirty years ago. The services and the needs were different and have changed drastically since that time. Due to those changes, there was significant discussion regarding the need for HSP skills for people who are not working in nursing homes. The benefit is that they can hold and maintain that credential. They could lose their status but not the certification. This is meant to provide another option on the pathway for individuals who need that experience. Therefore, the HSP credential would not be lost, even if registry status was lost. Wheelock suggested finding a sister organization where the individual would be able to work eight hours in a long-term care facility every two years. But that the HSP credential is a good alternative. Drinnin stated that expertise on this issue exists in the room, so if anyone needs more information, they could be consulted after the meeting. Drinnin mentioned that the training and whether or not the individual is on the (CAN) registry would all be tracked on the new information technology (IT) system.

Stineman added that the HMM curriculum is in its final draft stages. Some training is being completed in Northeast Iowa, which will be piloting PADL and HMM curriculum in February. None of the curriculum or the modules is completely done yet, because it is being piloted and questions are being answered. The HMM curriculum was the last one to be developed, so it will be rolled out in February. It is scheduled to be piloted in some courses in early April. Training for instructors will take place on February 13 and 14, 2013.

Stineman also provided updates on the online Core module. Progress is continuing. In early January, some of the skill segments were videotaped. An individual with a disability, from the Cedar Rapids area, participated. The Iowa CareGivers also completed a video on gait belt training and that video will be sent to Stineman.

Mentoring and Leadership

Findley and Mary Ann Young of the Iowa CareGivers provided an update on the mentoring and leadership programs for DCPs associated with the PHCAST grant. Young is new to Iowa CareGivers and will be managing and teaching the mentor program. Young explained that Iowa CareGivers is expanding its existing peer mentoring program to offer it to DCPs working for organizations participating in the PHCAST pilot. The program includes the Mentor Manager Toolkit for employers, available online, which is intended to help employers create a culture of mentoring and a supportive environment. The second component is the "Call to Mentoring" two-day training for DCPs. Communication and building relationships are emphasized in this program. This is a workplace-based program, so individuals leave with a toolkit with tools they can use to become an effective mentor in their workplace. Drinnin noted that pilot sites that have begun the mentoring program so far have had very positive feedback.

Evaluation Overview

Kellee McCrory of the University of Iowa, the PHCAST project evaluator, provided an update on what is being learned from the evaluation. All the DCPs involved have taken a baseline assessment. The curriculum team has been interviewed, and many participants were very happy with the cross-disciplinary nature of the curriculum development groups. Consumer interviews will be conducted by fellow consumers. Several "Penny for Your Thoughts" sessions were held for DCPs and employers to share their thoughts. Evaluation data was shared with the American Public Health Association.

Evaluation is focusing on four areas: Project implementation, training, workforce changes (compared to a control group), and collaboration with the national cross-site evaluation. There is a rural and an urban group (Des Moines and Ottumwa areas) each for the experimental and control groups. An enormous amount of data comes into the data repository to be analyzed. McCrory discussed procedures for working with human subjects for research to ensure confidentiality, including aggregating data, obtaining informed consent and ability to opt out, and data protection. The evaluation project is approved by an institutional review board (IRB).

McCrory then summarized key findings of evaluation so far. When participating DCPs leave their jobs they do an exit interview about why they are leaving; the answers have mostly been about personal factors and not about the work itself. In the experimental group, 323 people have been trained, 163 have taken the Core post-test and five to six people have taken each of the advanced credential post-tests available. McCrory reviewed the demographic characteristics of participating direct care professionals (gender, race, age, and education level). Eventually the data can be correlated with data from the Northeast Iowa Community College pilot with DCPs working in long-term health care. Most participants have computer access and use computers. Chensvold advocated for including true rural areas; the diverse range of types of areas involved in the project was clarified, and challenges with

recruiting organizations to participate were pointed out. McCrory summarized DCP survey responses to questions about opportunities for promotion, retention, direct care as a career choice, the direct care field itself, individuals' knowledge before training, knowledge gained through training, and training satisfaction. She summarized scores on Core tests (pre- and post-tests) and the changes between these. Evaluation should be finished this summer. McCrory will share how this turns out. Additional funding for further evaluation may be available. This data will be shared with various national audiences in the coming year, and McCrory is interested in studying this system as an examination of the effectiveness of Medicaid and Medicare spending.

Drinnin acknowledged that pilot sites are encountering challenges incorporating advanced training, such as finding time for DCPs to go through training when they need to work and may have more than one job. Amy Wallman Madden discussed H.O.P.E.'s challenge in finding times for their part-time workers to complete training together and not disrupt services to clients or lose a lot of income.

Online delivery of the Core curriculum is being developed. Most of the advanced credentials are designed as competency-based modules, meaning that any curriculum submitted that meets the approved competencies can be approved by the Board, so the state is currently not developing online delivery for these.

IDPH Preparation for the Legislative Session

It is anticipated that legislation will be introduced again this year asking to establish a Board of Direct Care Professionals. A lot of upfront work has been done this year in terms of providing research to the legislative services staff that is assumed will eventually be requested. The fiscal note is being drafted, as far as the cost numbers, and other estimates. The legislation was introduced last year one way, and then amended another way, as far as the functioning of the Board is concerned. There are two different possibilities for the Board. For example, within IDPH, there is a Bureau of Professional Licensure. On the other hand, a "big board" also exists under IDPH that does not fall under the Bureau, referred to as a stand-alone or independent board, because it has been exempted from some of the rules and regulations under which other boards fall. Things function differently under the different types of boards. Some of the differences are in the administrative/support staff, executive director function, and the hiring of investigators. The independent boards all have an executive director the board are required to hire their own investigators. Independent boards are also able to put forward their own policy recommendations, whereas in bureaus, it all needs to go through the departments. Examples of boards that are not independent are social work, physical therapy, physician assistants, massage therapy, barbers, and respiratory therapists. Findley noted that this definition of an independent board is different than what some people thought earlier.

Expectations for Legislative Session

McKeen provided an update regarding the expectations for the legislative session. The role of the Board would be to implement the recommendations of the council from the Council's March 2012 report. One of the key components of the recommendations is information and education. This includes providing information to policy makers at all levels. However, there is a differentiation between providing information and lobbying. No state department lobbies. On the contrary, they educate on the recommendations related to the proposal, and the research that has been conducted along the way. They also respond to requests for information and offer information.

The responsibility of stakeholders is to be prepared and know what information regarding the Initiative is current and accurate. If stakeholders are unsure, they can contact either Erin Drinnin or the Initiative staff at State Public Policy Group. The packet that was handed out at the Council meeting reflects the current data. It is important for stakeholders to share experiences and examples because that kind of

information resonates with and helps people understand. It is a complex initiative, and those examples and real-life applications are important to those messages.

Additionally, information regarding the Direct Care Workforce Initiative Coalition was shared with the Council during the meeting. This piece of information reflects the individuals and organizations that support the Initiative and the establishment of a board. Currently, there are about twenty supporters who have indicated their support in writing. Nobody is placed on the list until written communication indicating support is received.

Recent activities include a webinar with legislators completed by Drinnin and SPPG staff on January 10, 2013. Three to four legislators were present on the webinar, and a number of legislative staff. The webinar recording and Power Point from this webinar are posted on the IDPH website. Staff from the Initiative will also take part in AARP's legislative breakfast on February 27, 2013.

Ambassadors were encouraged to keep doing outreach activities, both formally and informally. Initiative staff will reach out to the ambassadors for help when potential invitations to present to legislative committees are presented.

Public Comment Period

The public comment period included one additional remark. John Hale commented on the federal rule established in the late 1980s that requires CNAs to work in a nursing facility in order to maintain their status on the registry. There is a letter in its final draft stages that will be transmitted soon to the Governor, Senator Harkin, and various other legislators, seeking a change in that rule. The letter will ask for an exception to the federal rules, to allow Iowa to pilot that exception in the context of the PHCAST program. It will also ask for a longer-term legislative fix, which would give states the option. If anyone would like more information about this letter, or would like to send a letter in support, they may e-mail hale_johnd@msn.com. The letter is being authored by various individuals, not a particular organization. It is time to elevate the issue to generate some action.

No other public comments were made.

Closing Comments

Drinnin thanked all for their participation and closed the meeting.