

Meeting Notes
Thursday, October 13, 2011
10:00 a.m. – 3:00 p.m.



Urbandale Public Library
3520 86th Street
Urbandale, IA 50322

Council Members

Greg DeMoss
Erin Drinnin
Di Findley
Diane Frerichs
Vicky Garske
Terry Hornbuckle
Melanie Kempf
Norma Nelson
Susan O'Dell
Ann Riley
Suzanne Russell

Lin Salasberry
Anita Stineman
Teresa Tekolste
Pat Thieben
Lisa Uhlenkamp
Anthony Wells

Guest

Steve Garrison, Olmstead Task Force

Staff

Stacie Bendixen
Jennifer Furler

Welcome and Overview of Agenda

Jennifer Furler welcomed members and gave an overview of the day.

Pat Thieben announced that Health Occupation Students of America will hold a conference on March 25-27, 2012 in Des Moines where students will compete in skills and events, and judges are needed. She handed out information.

Ann Riley gave an update on the state's Mental Health Redesign, noting there seems to be commitment to quality of care and tracking direct care workers. Riley offered thoughts on credentialing direct care workers during the public comment period of a meeting on Mental Health Redesign.

Pilot Update and Upcoming Activities

Erin Drinnin provided updates. The grant team has partnered with Northeast Iowa Community College on a U.S. Department of Labor Trade Adjustment Assistance Community College and Career Training Grant. NICC will be assisting in developing the final module, Health Monitoring and Maintenance, and piloting the Health Support Professional credential (this fills in a gap in the current pilot grant). This will bring the pilot across the continuum of programs and settings.

Two live webinars for direct care professionals (DCPs) will be held to explain the Direct Care Workforce Initiative in November. Flyers were passed around and will be emailed to the group. Members were asked to share and post this for their DCPs. DCPs involved in the project will help present the webinars. The webinars will be recorded for on-demand access online afterwards.

The first in-person meeting with all pilot sites was yesterday. The mentoring toolkit was launched, developed by the Iowa CareGivers Association (ICA) and the Upper Midwest Public Health Training Consortium (UMPHTC), and titled "A Call to Mentoring." It is on the ICA website, www.iowacaregivers.org. It was developed as part of the pilot grant but is available to anyone, and has tools,

resources and guidance for starting a mentor program for DCPs. Di Findley said ICA is proud of the product because they have never had an online tool before, and lessons learned from previous experiences were incorporated. Care was taken to use inclusive language for all settings, and feedback is welcome. Many providers participated in revising and reviewing the toolkit. Inquires sent through the "Contact Us" link go to ICA staff. This summer ICA will do two mentor training programs for DCPs in the pilot; there may be components of that training that could be adapted to an online guide. A blog was suggested as a place for DCPs to interact. Pilot sites are to have mentor programs developed by May 2012. Leadership trainings will be held in May 2012 and ICA mentor trainings will be in June 2012.

Anita Stineman gave an update on curriculum development. The Direct Care Professional Educational Review Committee reviewed the Core and part of the Personal Support module this week, and Stineman will share some of the changes with the curriculum committee today. One major change was that, to the definition of a direct care professional that is given in the Core, the review committee wanted to add something about the direct care profession being a partnership in care with the person served, because the person served must have a trusting relationship with the DCP in order to effectively be assisted. An additional bullet point with this expansion of the definition could be added with language such as, "A DCP partners with a person experiencing disability or illness who needs services and care...and the DCP is compensated for providing such care." The code of ethics in the Core includes language about a partnership. The DCP educational review committee was happy with the Core and had no other major comments. In the documentation section, they had minor suggestions and expressed a need to further address electronic communication. The first meeting of the Personal Activities of Daily Living work group was in September. The first item of discussion for that group was what skills are expected of someone who says they have been trained in PADL. The committee generated ideas, then broke them down into units and defined competencies. The group has a diverse representation of settings; they felt that workers who take this module need to be able to have a large range of skills, so many skills were shifted to PADL from Health Monitoring and Maintenance. This will modify the Health Monitoring and Maintenance module, but it will still have enough contents. Furler noted that pilot sites wanted their DCPs to be able to take the grandfathering assessment that would align them with the career pathways, and that will be discussed in the curriculum committee. They felt it would help determine where staff training needs are. Stineman clarified that in each content section, there will be a section on documentation and reporting. The PADL work group meets again later this month; they have developed eight units. The Home and Community Living module is almost complete; the final comments from the resource committee need to go back to that work group. DCP comments on Personal Support are forthcoming. Drinnin noted that Connie Brennan had great things to say about how well this very diverse committee works together; all share a passion for what they do. The Council should know that the model they put together for the Board of Direct Care Professionals with diverse representation is working well.

Drinnin and Furler provided an update on instructor training, which will be held in February and will include the principles of adult learning and an overview of the curriculum itself. There will be discussion about how instructors will be trained; most pilot providers said instructors would be trained in groups. They decided on two different groups: one encompassing everything but PADL, and the other for PADL because those instructors have to be nurses. Another training will likely take place before the end of the grant year (September 2012). Pilot sites are very different-sized organizations; some said they would have about two instructors, while others said around five.

Evaluation preparation has been working through the timeline. Sites were trained yesterday on data collection and they practices; they learned what types of things they will be asked to track, and the pilot sites said it will be doable. They tested the baseline survey and provided feedback. The process for the baseline survey will be finalized over the next few months and will go to all DCPs at the pilot sites around January. The baseline includes attitudes about their jobs and the profession; the curriculum will

have pre- and post-tests on the curriculum content. A member asked how turnover is factored in; DCPs will be tracked on a monthly basis starting in February or March, so if a DCP leaves it will be noted. DCPs who leave will remain in the spreadsheet, so it will be noted if they come back. Longevity and retention will be tracked. Evaluators will interview people who leave to find out why they left. DCPs will be tracked by social security numbers, so they can be tracked from employer to employer. The baseline survey asks DCPs how long they have been in the profession and with their current employer. Drinnin will share the baseline survey with members.

Control group sites will be recruited soon among sites that are similar in services and size to the pilot sites; the pilot sites will be asked who is comparable to them. Regional factors like population and demographics will also be considered.

Drinnin presented a proposed change from IDPH in how specialty endorsements would be handled, with the goal of being as efficient as possible, avoiding administrative burdens, and aligning with what other boards do: Specialties: recent change to propose to council: If the Board of Direct Care Professionals approves specialty competencies or training, DCPs will receive the specialty endorsement upon successful completion. There would be no continuing education requirements for specialties; a specialty would be automatically renewed when the base credential is renewed; there would be an initial fee but no renewal fee. (There are continuing education requirements for advanced credentials.) There were questions and concerns on how this model would function with existing certifications awarded by other organizations and other states. The Council was reminded that employers said they want the Board to be the central provider of specialty endorsements, and the Council has discussed an approach to reciprocity that is similar to grandfathering. Employers are responsible for making sure people are qualified to do the work that they are hired for. The Council has said the honor system is acceptable for the base credential, so it is assumed to be acceptable for specialties too. DCPs will be randomly audited for documentation of completing their requirements. There is enthusiasm about specialties being available. In the interim Council report, the governance committee recommended criteria for competencies for specialties.

IDPH made a proposal on instructors and trainers: "Instructor" is the base credential; "trainer" (of instructors) is a specialty endorsement; instructors and trainers are approved to teach specific modules (a letter stating what modules a person is approved to teach will be provided); the trainer credential is automatically renewed when the instructor credential is renewed; there will be an initial fee for the trainer endorsement but no renewal fee (there is just a renewal fee for the instructor credential). Instructors in the pilot will provide feedback on this model.

Board of Direct Care Professionals Legislative Language and Preliminary Budget

Based on feedback from the curriculum committee and the assistant attorney general, the language on "core services" and practice and title protection was revised. The language now defines and protects the practices of a direct care professional but keeps the advanced training credential voluntary. In the code, the definition of "direct care services" includes the areas of the advanced training modules – so someone providing direct care services is working in one of those areas. It then says that a person performing any of those services must be credentialed as a Direct Care Associate, but they do not need to have the corresponding advanced credential (because those are voluntary). This lays out that a person providing direct care or representing themselves as a DCP must have the Direct Care Associate credential (they must have completed the Core). Advanced credentials are title-protected (a person cannot call themselves a "personal support professional," for example, unless they are credentialed as one) but not practice-protected (a person can practice personal support services, for example, without the advanced credential).

A member commented that a lot of public education will be required to make sure everyone understands that all people providing direct care services are required to take the Core and get the base credential. There was concern that direct care workers who have already taken training might have a problem with being required to pay a credentialing fee. It was noted that hopefully some employers will pay for the credential, and that training should be seen as a positive in this system. A member commented that for DCPs to have ownership and be seen as professionals, they must step up and invest in their credentialing, as other professionals such as nurses do. It is possible that someone could choose to only take the Core initially and get the Direct Care Associate DCA credential, and later decide to add an advanced credential, rather than paying for both at once; that would be up to the Board, and this system is meant to be flexible and broad. The grandfathering window is two years; a person starting new can obtain the Direct Care Associate credential and then work toward an advanced credential. Concern was raised about the potential perception of burden among employers for DCP credentialing fees and ensuring certifications are maintained; it was stressed that the new system should involve dialogue and communication between DCPs and employers. The turnover report was done to show how much the current system costs employers; the idea is that they will want to invest in this system because it will save money in the long run.

Formulation of the "Scope of Chapter" section of the legislation was summarized and discussed. Discussion notes follow:

- The definition of a DCP was revised to note that a DCP is compensated for providing services, so this section states that this legislation does not apply to people who are not paid for the services.
- A line about people caring for family members was removed because it was seen as unnecessary, since they are included in unpaid caregivers.
 - There was discussion on the need to retain the family member exception to the credentialing requirement, because family members serve as Consumer Choice Option caregivers and are reimbursed by Medicaid, so they may be seen as paid caregivers. There were concerns about the implications of family caregivers potentially being required to earn a credential.
 - Others felt it would benefit family members to take the six hours of education in the Core to prevent injury and diseases; it was noted that CDAC providers have expressed desire for more education. A common sentiment is that family members who are reimbursed with public funds to care for a relative should be willing to take a minimum level of training. Project managers have received many questions about why family members are exempted from the credentialing requirement.
 - It was decided to add "paid family members under Consumer Choice Options" (not under CDAC) as exempted from the credential requirement.
 - "Family" and "compensated" will both have to be defined at some point, but may be defined by Iowa Medicaid Enterprise.
- The last part of the section exempts from the credential requirement people otherwise licensed by a licensing board who are operating within the scope of that license and do not represent themselves to the public as a direct care professional. "License" is broadly defined to include credentials, etc.

Budget

The budget assumptions – estimated numbers of DCPs who will be grandfathered, newly credentialed, and renewed, and the numbers of instructors and trainers credentialed in the first, second, and ongoing years of the new system – were approved by the Council previously. The following clarifications were made:

- Everyone's renewal date will be different (their birth month), so the year they have to renew their credential could be adjusted based on what time of year they receive their credential.

- To encourage DCPs to have multiple specialties, there is only one flat fee no matter how many specialties a DCP has – it does not cost more to have more than one.

Proposed fees were drafted based on current budgets for other boards and what it takes to run them. Unique factors in this case include the use of an IT system (AMANDA) that will create many of efficiencies, the consideration of what it will take to manage this profession, and the consideration of the Board of DCPs as a stand-alone board (other boards have shared activities and resources, and the IDPH bureau has an administration infrastructure that supports them all). This board will have to operate on a very slim margin, as one of the goals is to have low fees and avoid burdening DCPs. Many other boards have a one-time fee with the initial credential for a background check; that one-time fee was previously incorporated in the DCP fee but has now been separated out.

Proposed fees and notes from the related discussion follow:

- There is a one-time \$15 background check fee.
 - The Council previously decided to require a background check for the credential because of the weight a state credential carries.
 - A background check is required when grandfathering.
 - If someone applying to be grandfathered has a hit on their background check, the Board will handle it by either working with DHS or using DHS's method for handling. There was concern about the time and cost involved in investigating hits and potential hits on background checks; Drinnin will research and learn about this process from DHS.
 - The board could put in place a process where someone could submit documentation that their conviction has already been checked out and they have been cleared to work, to save time and money of the board initiating an investigation again.
- A new Direct Care Associate credential is \$20 every two years.
- A new advanced credential has a \$30 total fee (which includes the Core/Direct Care Associate credential).
 - If someone receives the DCA credential (for \$20) and later gets an advanced credential within their two-year period before renewing, there is a \$10 advancement fee.
- Specialty \$15 (no matter the number of specialties)
- New instructor: \$60
- Trainer: additional \$15
- Early grandfathering Direct Care Associate credential : \$15 (plus one-time background check fee of \$15)
- Early grandfathered advanced credential: \$20 (plus one-time background check fee of \$15)
- DCA renewal every two years: \$25
- Advanced credential renewal every two years: \$35
- Instructor renewal: \$60
 - This will probably often be paid by the employer, because they want their staff to have access to the training the instructor can provide.
- There is no specialty renewal fee planned, but this still needs to be discussed.
- Late renewal fee: \$50. There is a 60-day grace period; reminders will be sent before the renewal date and if renewal is late.
 - It was asked how late a renewal can be and still cost \$50; a suggestion was that people pay more the later the renewal? Previous Council discussions will be referred to.

Year 3 is considered a normal year in the budget assumptions, so the assumptions for year 3 can be thought of as assumptions for the annual budget. Funding will be needed for two fiscal years before revenue from fees will start to come in.

The projected budget for board staff (personnel) was summarized and discussed. Projected positions include a board executive, clerk specialists DIA investigators a secretary, an outreach and compliance educator, an education director and board members (who would receive a per diem). The staff would be employees of IDPH and support the functions of the board. Drinnin discussed the staff roles and scenarios in which they would function. Clerk specialists would receive and process applications to check for required information and make sure requirements are met, initiate background checks and follow up as needed, and send difficult applications to the board executive, who could make a decision or send to the board for decision on nonstandard situations. It was clarified that staff perform day-to-day functions, and board members are not staff; they have other paid jobs in the profession and are appointed by the governor to serve on the board. The board only reviews situations that are unusual, different, new, or not spelled out in policies already set out, and meets about quarterly. Thousands of regular applications will be processed by staff. Temporary staff could be added to help manage the initial flood of applications with grandfathering, and as needed as the flow of applications changes. The board will elect its own officers.

Great care has been taken to make the proposed budget and fees reflect what is needed to run the profession while not burdening direct care professionals. The board is sustainable based on these fees and this staffing configuration, and the Council agreed that the fees seem reasonable.

Next Steps: Advocacy

Because the Council said at the last meeting that it wanted to forward the board legislation the Legislature, a letter to the governor, lieutenant governor, IDPH and the Legislature expressing support for establishing board was drafted. It is presumed that Council members will sign onto the letter unless being a state employee or agency prevents them. If an agency cannot sign on, members can sign on as individual supporters. Members who need to check with their organizations about signing on should do so now.

This letter reflects the work and recommendations of the Council, so it is important for Council members to stand up for their recommendations by showing support before state policymakers. Passing the legislation establishing the board is the first step for all of the other recommendations to be implemented, and participation is needed from Council members in informing policymakers and stakeholders and advocating for its passage. Furler has presented this letter and asked several associations to sign on. The Iowa Alliance in Home Care is signing on, and is willing to ask individual members to sign on. The Iowa Association of Homes and Services for the Aging has chosen not to support this legislation; however, the effort to educate on what this entails is ongoing – for example, some did not know this involved voluntary credentials. More information will be presented to Association members.

Council members were each asked to secure at least two people or organizations to sign the letter, and members agreed this was reasonable. Assistance in presenting information to stakeholder groups can be provided; tell Furler if assistance is needed. State employees can facilitate connections to stakeholders that can sign on. Members with connections to groups can approach them and bring Furler or Drinnin along to answer questions. The Iowa CareGivers Association will post the letter on their website and ask members to sign on. Members will be asked to help meet with key legislators.

Outreach Activities

Webinars for DCPs statewide on the Direct Care Workforce Initiative are scheduled to cover what DCPs need to know about the Initiative. Organizations were asked to promote them to their DCPs, and DCPs were asked to promote to their peers. DCPs to be co-presenters were sought to show other DCPs that their peers are leading this work. A link to the recorded webinars will be distributed.

Applications for the Ambassador program as coming in, about a third from employers and rest from DCPs. The pilot sites (employers and DCPs) are expected to be Ambassadors. Council and DCP Education Review Committee members can be ambassadors, and expectations will be tailored based on their other responsibilities (just tell Furler if interested). The application deadline was publicized as October 17, but applications will continue to be accepted on a rolling basis, with the first cohort of Ambassadors starting soon.

Council Final Report Outline

The Council's final report is due March 1, 2012. SPPG will bring a draft in December for the Council to review (it will be emailed before the meeting), and final feedback and revisions will occur by email. This will be a final culmination of all of the Council's work; it will be streamlined and concise, and will include the visual diagrams (like the career pathways) already developed and concise narrative to tie them together. Furler walked through the outline. The report will have an executive summary to serve as the quick take-away piece, and the whole report will be about 15 pages. Two sections will cover DCW Initiative recommendations and DCW Initiative status. The Council had no major comments and thought the outline was a good start.

Members met in committees for the remainder of the time.

Public Comment Period

No comments were made.

Upcoming Meetings: Second Thursday of the month. All meetings will be scheduled from 10am to 3pm, unless otherwise noted.

Thursday, December 8, 2011

Thursday, March 8, 2012

Thursday, June 14, 2012