

Direct Care Forums

Finding Solutions:

A report created by a diverse group of participants at a series of four forums on direct care issues that impact the quality of care in Iowa.

February 2001

Convened by:

**Iowa CareGivers Association
and
the Alzheimer's Association**

Introduction

It has never been more important to find solutions to the problems that face us in direct care than right now. The health care needs of Iowans cannot be met without a quality stable pool of direct care workers such as certified nurse assistants (CNAs), home care aides (HCAs), and other front line caregivers who deliver the most basic and fundamental care of all. They work in nursing homes, hospitals, residential care facilities, group homes, Veteran's hospitals, adult day care, assisted living, and home and hospice care settings. Recipients of their care are the frail elderly, children with special needs, the disabled and the ill.

A tight labor market is making it difficult for providers to find workers, but that is only a part of the problem. CNAs are leaving the field at alarming rates. As many as 800 CNAs are registered within the state of Iowa each month, but at least that many leave the field each month. This revolving door costs taxpayers and providers millions of dollars each year, not to mention the costs in quality and consistency in care. The obvious answer is that we must find ways to retain and recruit these important workers. Based upon the CNA Needs Assessment completed as a part of the CNA Recruitment and Retention Project, we know that CNAs are leaving the field for the following reasons: short staffing, poor wages/benefits, inadequate training and orientation, and lack of respect from their supervisors and the general public.

It is time to come together and develop solutions. That is why the Iowa CareGivers Association in cooperation with the Alzheimer's Association planned the first ever Direct Care Forum, the goal being to bring people of various backgrounds together to develop solutions and action steps.

The first forum was successful and it was recommended to continue the efforts begun in the first Direct Care Forum. Iowa CareGivers Association and the Alzheimer's Association responded by conducting a set of forums focused on individual issues. The forum topics were directly taken from the statewide CNA Needs Assessment and were held in the order of importance expressed by those CNAs surveyed. The four forums were: Forum 1: Examining the Issues, Forum 2: Staffing, Forum 3: Wages and Benefits, Forum 4: Educational Standards.

The following pages outline the key discussion points and ideas of the forums. As you read through each of the forums, you will notice a slightly different format was used to present the information. This is due to the fact that as the forums progressed changes in the group discussions evolved.

For more information, contact:



1211 Vine Street, Suite 1120
West Des Moines, IA 50265
Phone: (515) 223-2805
Fax: (515) 226-3214
information@iowacaregivers.org
www.iowacaregivers.org



700 East University Avenue, Level B
Des Moines, IA 50316
515-263-2464
515-263-2466 (fax)
www.alz.org

Direct Care Forum 1: Examining the Issues

September 18, 2000

***The Problem:** The care needs of Iowans cannot be met because Certified Nurse Assistants (CNAs), Home Care Aides (HCAs), and other direct care workers cannot be recruited or retained. Tight labor markets are making it difficult to fill these positions, the number of which are on the rise due to our increasing aging population and the expansion of home and community-based services.*

The following chart outlines the key discussion points and ideas that arose from the group discussions at the first Direct Care Forum. In the first forum, the afternoon discussions revolved around six key issues, each assigned to a small group. Comments and suggestions for action steps from the groups were combined under each of the issues. If some specific ideas were omitted, it was due to duplication or the inability to read the recorded description.

Direct Care Issues

What actions need to be taken?

<p>Issue 1: Certified Nurse Assistants (CNAs) and other direct care workers leave the field because they lack respect from their supervisors and are undervalued by society.</p>	<p>Maintain and expand the CNA Recruitment and Retention Project to develop data and programming that can support funding and management issues. Increase education and professional development for CNAs to improve new CNAs expectations about what the job includes. Integrate conceptual training of all health professional roles in care delivery. Take steps to improve the prestige and respect for CNAs both within the industry and society as a whole. Need a societal change that supports needs of the elderly and provides care appropriate to social and medical needs. Talk to service groups within the community about the value of the CNA. Include CNAs in the decision making process within facilities, creating an “ownership”. Emphasize best practices. Emphasize responsibility and accountability at all levels.</p>
<p>Issue 2: Certified Nurse Assistants (CNAs) and other direct care workers leave the field because they don’t receive enough training and continuing education, and their job orientations are inadequate.</p>	<p>Job preview—let the potential candidate see firsthand what is expected of them. Longer orientation period. Update and standardize curriculum. Do in-house, hands-on training. Break down job responsibilities into units. Establish a mentor program (with mentoring to occur the first year and beyond). Offer an apprenticeship or internship for caregiving positions. Resident specific training. Set up caregiver support groups. Increase the number of continuing education hours that are required in a year. Require the 120 hours for long term care. Pay staff to attend training and continuing education. Get individual caregivers involved in the care plans. Offer career ladders. CNA involvement in support and training offerings. Promote professionalism of the workforce.</p>
<p>Issue 3: Wages and benefits- Certified Nurse Assistants (CNAs), Home Care Aides (HCAs) and other direct care workers earn an average of \$7.97 per hour and many have no benefits.</p>	<p>Increase the Medicaid reimbursement, then make sure that it is spent on direct care wages/provide accountability. Parity among states for reimbursements. Insurance reimbursement program. Self-contained staffing within facilities. CNAs need to lobby for higher wages. Need to educate legislature on needs of direct care workforce. Buy insurance through an outside company and pool caregivers to make a large group seeking benefits. Offer a cafeteria plan for benefits. Encourage Older Iowans Legislature to make this a priority issue. Look at self-sufficiency standards. Create a coalition of interested parties to focus effort and inform legislature and public of the issues.</p>

<p>Issue 4: Certified Nurse Assistants (CNAs) report their number one reason for leaving the field is short-staffing. Many are trying to care for 20, 30, and even 40 residents. They feel they can't give the kind of care their residents need and deserve.</p>	<p>Hire a full-time mentor. Identify "best practices" to reinforce training and encourage provider. Increase opportunities for nurses to be positive role models. Make sure that orientation is not provided by temp staff. Increase family participation. Require mentor to have specific training in mentoring/orientating. Provide consistent training curriculum for all mentors. Train the trainer program development.</p>
<p>Issue 5: The state and employers are turning to mature Iowans, those with disabilities, immigrants, and welfare recipients to recruit workers due to tight labor markets. While tight labor markets are a major problem, the other big problem is the retention of workers.</p>	<p>Enhance support of current and new workforce through mentoring/coaching incentives. Coaching/mentoring needs to be two track—top down and bottom up. Flexibility in training and testing of "nontraditional" workforce. Have a core group of workers who can reach out to target populations. Need to rethink how we address training. Administrators and supervisors attend a leadership training course which addresses the issue of coaching staff in a motivational/positive manner. Implement a CNA career ladder. Develop a mentor curriculum.</p>
<p>Issue 6: It is estimated 50-70% of all nursing home residents have dementia. Care for a person with dementia is more labor intensive. Impaired communication, personality changes, and intensity of needs impact the resident/provider relationship and job satisfaction.</p>	<p>Increase awareness of existence of Alzheimer's Association. Provide education on dementia for family members, and workers in all long term care settings. Increase education requirements in dementia for direct care, professional and administrative staff. Respond to safety needs of persons with dementia. Incorporate recent dementia care learning to create supportive care environments. Broaden competency requirements to include skills in communication, behavioral interventions. Identify outcome standards to measure provider performance. Assure delivery system develops a range of care settings including adult day care, assisted living, and nursing facilities. Increase staff ratios in facilities serving dementia patients. Quality care outcome measures to be utilized in determining provider performance.</p>

Following are the resources and involvement needed to accomplish some of the above suggested action steps in regards to the issues.

Resources

Involvement

<p>Leadership, funds for training and increase in wages, etc., ongoing evaluation, investment from providers, continued meetings, standardized curriculum, mentor training, train the trainer program</p>	<p>State agencies, professional trade associations, administrators, CNAs and other caregivers, community colleges, state certification board, legislators, facilities, agencies, Dept. of Human Services, Iowa CareGivers Association, Community College Consortium, Dept. of Education, Senior Living Coordinating Unit, Dept. of Inspections and Appeals, Dept. of Elder Affairs, Dept. of Public Health, Alzheimer's Association, Iowa Medical Society, American Nursing Association, Iowa Hospital Association, Law enforcement</p>
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Direct Care Forum 2: Staffing

November 6, 2000

Certified Nurse Assistants (CNAs) report their number one reason for leaving the field is "short-staffing." Many are trying to care for 20, 30, and even 40 residents. They feel they can't give the kind of care their residents need and deserve.

The following chart outlines the key discussion points and ideas that arose from the group discussions at Forum 2 on Staffing. The number located behind the main issues indicates the number of groups that responded to this as a main concern. There were a total of 10 groups of 8 - 10 people participating in the discussions. Comments and suggestions for action steps from all groups were combined under each of the concerns. If some specific ideas were omitted, it was due to duplication or the inability to read the recorded description.

What issues concern you most about staffing?

What actions must be taken?

Finding qualified staff (5)	Give staff a reason to be qualified, offer them incentives. Provide a good benefit package. The incentives should be related to being a professional. Enforce policies and procedures (e.g. attendance rules) for all employees making treatment equitable. Need to increase the support services for the caregivers (e.g. offering daycare, transportation, health insurance, career options).
Training and education (6)	Create a more professional image for caregivers by increasing their opportunities for continuing education. Another aspect that should be addressed is educating the public about the caregiving profession. Include mentorship of staff and allow time for proper orientations. Require the CNAs to have 75 hours of training before being employed. Offer tuition reimbursement. Provide accountability through testing. Make courses more user-friendly.
Quality of care being provided when staffing issues exist (1)	Have back up staff readily available, calling a temp service if necessary. Take action before staffing becomes a hindrance to quality of care, by providing incentives and education and other opportunities for professional growth.
Safety of staff (2)	More specific training on safety measures in the workplace. Make sure that staff uses proper lifting techniques. When working short-staffed, do not put staff or residents at risk of injury. Include more specific training on dementia and abuse issues. Make sure that the resident needs are posted in an easily accessible place.
Retention (4)	Develop and use a better screening process for hiring employees. Offer a better incentive and benefits program. Providing more opportunities for CNAs to contribute input, especially involvement in care plans. Adjust the staff ratio to the acuity level of patients, easing the heavy workload. Include sources of support for personal issues for the staff. Make the work environment one where they feel a part of the team. Care facilities need to look at alternative approaches to retention (look outside the box).

<p>Short staffing (6)</p>	<p>Be creative and flexible in your scheduling. Try a shift flex. Recruit nursing students to serve as CNAs. Include more positions that are single task, for instance, responsible for just assisting in feeding. Assist in finding ways to help with child care needs. Scholarships for nurse assistant classes. Recruit young people into direct care through a work-study program. Explore options for other workforces, e.g. retired CNAs recruited to assist with feeding only. Set up training programs for immigrant workers, where they can learn the language (ESL), earn certificate, and become employed before earning their green card. Reward facilities for improving their staff to resident ratios. Need to expand labor pool, the industry is competing against itself. Include a pre-screening process and job shadowing before hire.</p>
<p>Need for more compassion and respect (5)</p>	<p>Teaching/coaching fellow staff. Administrative staff needs to be more supportive and seek input from all levels of staff. (Need to include CNAs in the care plans.) Recognize importance of keeping lines of communication open with CNA staff. There needs to be a mutually earned respect from top down and from bottom up. Need to have supervisor and administrative sensitivity. Encourage ICA membership. Encourage professional certifications.</p>
<p>Wages (6)</p>	<p>Include educational opportunities such as mentor and orientation training, then compensate for that extra education. Raise the wages. Include benefits. Make wages comparable to temp agencies. Lobby efforts for a living wage. Efforts to increase the Medicaid reimbursement. Offer a cafeteria plan for benefits package. ICA could help with insurance (educate on options or possibly become a group provider).</p>
<p>Talking Point: top 10 measurable direct care service indicators (1)</p>	<p>Flex schedule options, pay minimum of \$10 and benefits, education paid for by employer, CQI environment, clean facility, happy well-groomed residents, staffing ratios, staff satisfaction with low turnover rate, family satisfaction and involvement, ICA membership for CNAs (advocacy)</p>
<p>How do we make caregiving an accepted profession? (3)</p>	<p>Take responsibility for changing the terminology that is used to describe caregiving positions. Refer to them as professionals. Promote individual caregiving stories that represent caregiving as a career. Encourage participation in ICA. Support groups, mentoring, etc. Employee recognition opportunities.</p>
<p>Concern that there are several options for service oriented jobs (restaurants, etc.) that can take staff away from the caregiving profession (1)</p>	<p>Need to offer incentives, sign on bonuses, tuition assistance, opportunities for continuing education, higher wages, benefits, supportive work environments. The career and profession of caregiving needs to be actively promoted and marketed. Find out why CNAs stay on the job and promote those positive aspects.</p>
<p>Concern about unrealistic work schedules for staff (overtime) (2)</p>	<p>Expand the labor pool. Temps may not show, can't depend on them, need permanent staff.</p>

<p>Inconsistent management (2)</p>	<p>Need to define expectations, policies, procedures, protocols, and reporting channels. Increase the accountability of management especially in regards to financial program.</p>
<p>Misconception about the nurse assistant career by the public (4)</p>	<p>Need to develop public “telespots” or marketing campaigns geared toward enhancing the nurse assistant profession and the public’s concepts of the ill and aged in our population. Talk to high school and junior high about caregiving as a profession. Job fair at the mall. Newspaper articles about positive caregiving. Intergenerational programs for employees/children.</p>

Following are the resources and involvement needed to accomplish some of the above suggested action steps in regards to staffing.

Resources

Higher reimbursements, money saved on turnover costs could go toward tuition reimbursements, CNAs should be required to be more responsible for their own continuing education requirements, sharing staff throughout the industry, grants, CMP fund, state, older workers, immigrants, younger workers, welfare recipients, volunteers, more time, more education, knowledge of the residents needs, proper equipment to perform job, accreditation program

Involvement

Community colleges, legislators, government, public, media (positive coverage), schools, administration in facilities, Iowa CareGivers Association, state agencies and departments, corporations and boards of directors, Health Care Financing Administration (HCFA), Dept. of Inspections and Appeals, Ombudsmen, Disease specific organizations, Alzheimer’s Association, regulatory agencies, CNAs, nurses, insurance industry, community agencies, AARP, churches, service clubs, Resident Advocate Committees, medical industry

Direct Care Forum 3: Wages and Benefits

January 5, 2001

Wages and benefits—Certified Nurse Assistants (CNAs), Home Care Aides (HCA), and other direct care workers earn an average of \$7.97 per hour and many have no benefits.

The following chart outlines the key discussion points and ideas that arose from the group discussions at Forum 3 on Wages and Benefits. The number located behind the main issues indicates the number of groups that responded to this as a main concern. There were a total of 8 groups participating in the discussions. Comments and suggestions for action steps from all groups were combined under each of the concerns. If some specific ideas were omitted, it was due to duplication or the inability to read the recorded description.

What issues concern you most about direct care wages?

What actions must be taken?

Who should be responsible for an adequate wage for direct care workers?(1)	Let representatives know that this is an important issue. Send out a list of representatives so that supporters are aware of how to contact their representative. Create a database of legislators and how to contact.
Where are the funds to come from to pay for increase in wages?(1)	Possibly state and federal funding. Suggest alternatives for tax cuts. Position papers. Check into Americorps.
Make the wage for caregivers “livable”. (2)	Look at living wage standards and definitions. Collect data on comparable wages/jobs.
Addition of benefits for direct care workers (6)	Provide information about wages vs. benefits (how do you decide what is most beneficial for you and your family?) Do a presentation or a workshop focused on different options within benefits packages, etc. Establish group benefits (creating pools from different entities). Ask the association to inquire and to be involved in the process. Or even use the association to administer the benefits. Include EE feedback. Consider the portability of the benefits. Legislative support for caregivers to be insured. Provide options and understandable equitable wage and benefits.
Concern about the fragmentation of efforts in addressing the problem of wages and staffing within health care. (1)	Form a coalition of all parties involved (join forces and become a stronger voice to affect change). Have monthly meetings to ensure progress. Begin training on how to lobby effectively.
Staff scheduling must be looked at to see how to utilize staff more productively (1)	Have more staff available during feeding times/bathing times and less staff at other slower times. Offer flexibility in schedule. Staffing should be adjusted according to patient need. At-risk patients need more staffing and higher levels of care.
Concern about the pay scale. (4)	Unionize. Government regulations. Publish wage scales. Include more in the policy and procedure manuals. Must be a basic minimum wage established (must be above poverty level). Use incentives/advocacy.

Staff are not shown appreciation and have no empowerment to make decisions. (1)	Structure an advancement policy through education. Advancement through specialty training.
Reimbursement (3)	Reimbursement should be based upon outcomes, it needs to be tied to the quality of care that is delivered. Needs to be a better understanding of the reimbursement system. There needs to be more oversight on the distribution of money. Monitor the cost reports more often and increase the sanctions. More accountability of administration costs.
Some new hires are being hired at higher wages than veteran employees. (Question of pay equity). (3)	Government regulations. Publish wage scales. Include more in the policy and procedure manuals. Develop grade scales. Establish best practice standards. Incentives through governmental actions. Inservice for administrators.
Quality mentor and training programs (1)	Find ways to provide mentor training. Ask associations involvement.
Cultural attitude does not value the paid caregivers.(3)	Increase the requirements of education for the caregiver. Publicity and marketing of the positive aspects of caregiving. Resources, and support to organize and unite to educate the community and legislature about the role of caregivers within our society. Increase visibility of the caregiving profession. Need for positive press.
Wages reflect society's value of women, predominantly female group wages have not been raised accordingly (2)	Women need to take stronger position on advocating for pay equity.
Younger workforce is not interested in the caregiving professions.(1)	Increase public awareness/publicity. Increase funding to ICA and similar organizations so they can provide mentoring of younger workers, career laddering and empowerment programs. Need to recognize the different value systems of different generations. Explore alternative methods to the delivery of care. Link education, community colleges, high schools with providers and caregivers.
Create career ladders (3)	Include education level and pay ranges for consideration in promotions and different levels. Promote the caregiving profession as a career and not a "pass-through" job.
CNA classes are not completed for various reasons (1)	Need to provide services that allow completion and attendance at class and work (transportation, child care, etc.)
Overtime is necessary to meet expenses. (1)	Consider flexibility within schedules.
Dwindling workforce (1)	Look at other pools of people. How can we do the same job differently, explore other alternatives.
Employee Recognition (1)	

Resources

IAHSA database, ICA newsletter, ICA conference, national Alzheimer's Association public policy, develop a state LTC insurance program, government oversight, newsletters, newspapers, commitment to time from facility, state and federal funds for ICA, tap experiences of other successful groups, develop more partnerships between existing organizations and combining resources, increasing recognition of employees which lowers turnover and increases savings to use on employee advancement and benefits, town meetings, fact sheets, forums, HCBC, technology, job sharing, time, money, expertise

Involvement

Iowa CareGivers Association, Area Agencies on Aging, Iowa Association of Homes and Services for the Aging, SEIU and AFSCME, Workforce Development, Dept. of Human Rights, government, business/industry, legislators, EE, Community colleges, trade associations, facilities, caregivers, CNAs, insurance companies, high school educators, Dept. of Human Services, Department of Education, students in health occupations, Department of Economic Development, Department of Labor, Alzheimer's Association, Commission on the Status of Women, community involvement, Fiscal Bureau, facility management, NHA, Association of Counties, City Council, community leaders

In addition to listing their issues and concerns, each group was given this set of five questions to which to respond. Not all groups were able to provide answers to all of the questions due to time limitations at the forum. Listed are the questions, followed by the groups' responses.

1. How would you define a livable wage? Can you put a dollar amount on it?

- It must be appropriate for the community. It must be pegged to another established wage in the community. We are unable to pick a dollar amount because of the rural/urban factor, however, possibly \$25,000 per year, adjusted for skills, experience, and education level.
- \$15.00 per hour (many variables need to be considered)
- You must be able to pay your living expenses with some left over. Suggestion: \$10 per hour minimum plus benefits (quality/affordable insurance). You have to consider that the basic needs are being met, food, health care, day care, transportation, etc. Also take into consideration the cost of living.
- Defined by how you can live and pay the bills. Depends on urban and rural areas. What it can take to get off of welfare. Caregiver wage needs to be compared to other similar jobs wages. Not less than \$10, \$12, \$15 if providing the direct care.
- \$12.57, must include benefits.

2. A. Should wage ranges for direct care workers be based upon years of experience and education? B. How does the demand for direct care workers impact the wage levels?

- A. Yes, wage ranges should be based upon experience and education, given acceptable performance. B. Should increase money paid. Other incentives should emerge for employees who have longevity.

- A. Yes. B. It forces it up.
- A. Yes, proficiency of work would be an additional criteria. B. It's becoming more of an issue. More competition among the work force. There is a need to promote the direct care profession in a positive way. Marketing is important.
- A. Yes B. Demand does affect wages. Long term care providers no longer compete with hospitals, but with other care providers, home care, respite care, other LTC, and adult day care. Need to be specific as to what percentage of funds is going for care specifically.
- A. Yes, include merit and performance. B. Currently, very little.

3. A. If worker wages are attached to provider reimbursements, should wage levels be legislated? B. Should wages become a quality assurance incentive or measure for providers?

- A. Not realistic to expect legislature to set wages. Legislature might set a minimum for CNAs. B. How can this be monitored and controlled? Yes, but lots of questions on how to do it without unintended results.
- A. Nobody really wants to see it mandated, but there is concern if we don't, nothing will happen. B. No, care indicators should be the quality assurance measure.
- A. No B. It could make a difference but no guarantee.
- A. No, this would be too rigid. B. Yes, wages should become a quality assurance indicator.
- A. Minimums should be legislated. B. Yes.

4. A. Should the state subsidize health insurance benefits for direct care workers? B. Are there already programs that might address this problem?

- A. yes B. Title XIX
- No, there are already state programs. Need to develop group rates for the nursing home industry.
- A. This is not really the correct fix, only a stopgap measure. B. There are already programs, but they need to initiate group-purchasing.

5. How can we ensure quality care by quality workers through quality jobs?

- Incorporating the recommendations from the forums. Raise the status of the elderly in our society. Take part of the millions of dollars paid to baseball players and distribute that money to where it is really needed.
- Ensuring that the workforce is properly trained, that there is respect for the profession, and that there are measurable outcomes to determine quality care.
- Using recommendations from the forums. "What you talk about becomes reality."

Direct Care Forum 4: Educational Standards

January 22, 2001

Certified Nurse Assistants (CNAs) and other direct care workers leave the field because they don't receive enough training and continuing education, and their job orientations are inadequate.

The following chart outlines the key discussion points and ideas based upon the pre-set questions that arose from the group discussions at Forum 4 on Educational Standards. Comments and suggestions for action steps from all groups were combined under each of the concerns. Multiple answers will be noted by numbers in parentheses. There were a total of 8 tables with 10 – 12 participants. If some specific ideas were omitted, it was due to duplication or the inability to read the recorded description.

Educational Standards ?'s	What actions must be taken?
1. Should training for all direct care workers be mandatory and why or why not?	<p>Yes. (5) Should move to at least 80 hours of training with 5 hours of training related to dementia. Also include inservices as yearly updates. These training topics might be considered: communication, stress, abuse reporting, dementia, sexual harassment, safety training, conflict resolution, advocacy, and working with other cultures. Not comfortable with the testing out exceptions. There needs to be standardized training. Mandatory training will provide consistency. Elevates the position of caregivers. Education allows for more efficient delivery of care. Class provides for better mentors, orientation and ability to assess coworkers competency.</p> <p>No. (1) Mandatory training would involve more regulation.</p>
2. Are the number of hours now required adequate? Why or why not?	<p>No. (6) CNAs need more hours up front in clinical training with a nurse and also more continuing education hours. Challenge testing needs to be done away with, except for maybe equivalent education like nursing. Administrators should have the basic level of training. Even nurses may need training to work as a CNA because of the different scope of work. Recommend mentor program for new CNAs as they are in the course or in the first several months at work. Suggested increase to at least 80 hours. Survey the states surrounding Iowa to see what the requirements are and what their retention rates are. Iowa is low for the number of hours required. Suggested increase to at least 90 hours. Include psychology as another component. Struggle to get all of the information in 75 hour class. Need lifelong education, including specialties.</p>
3. Should there be standardized specialized training opportunities for direct care workers? Why or why not?	<p>Yes. (6) CNAs need more than the 6 hours of dementia specific training that are offered. Specialized training needs to be required as continuing education for workers in those settings where the workers are caring for specialized populations. Train the trainer. Development of standard training. Topics that might be included are: diabetes management, stroke, AIDS, disease processes, pain control, depression, skin care, end of life care, discrimination, employee rights. Current standards do not reflect what current needs are. Either add more specifics to the core requirements or</p>

	<p>add specialty training. The specialized training should be “out of facility training,” improved learning environment. Might help reduce the turnover rate due to better prepared staff. Specialized training should yield financial rewards.</p>
<p>4. Should there be a certifying board for direct care workers? Why or why not? If so, describe what the ideal structure would look like.</p>	<p>No. (3) Not necessary. It would not accomplish what we want to at the local level.</p> <p>Maybe. (2) Need to create a task force to examine the feasibility/affect of creating a certifying board for direct care workers.</p> <p>Yes. (3) Board control, by peers. It should represent direct care workers (as an advocate) and have more input on what training occurs. Agree that it would provide more efficiency, right now the oversight is so fragmented, it is difficult. Recognize caregivers as professional. Would give CNAs empowerment. State standards would certify/validate that the individuals met them. Disciplinary power. More of a check and balance system. If you have well-trained and supported staff, costs go down.</p>
<p>5. What should the continuing education requirements be for direct care workers?</p>	<p>Maybe not expand on the 12 hrs., but be more specific about what needs to be part of that 12 hours. 12 hours should be the minimum. The responsibility for continuing education requirements should be put back on the CNAs. Quality assurance system should drive this continuing education.</p>
<p>6. Should immigrant workers be required to speak and understand the English language in order to work in the health care field? Why or why not?</p>	<p>Yes (6) There should be state monies available to support ESL programs if trying to promote more immigrants to work in this field. The biggest barrier with nonEnglish speaking caregivers is being able to meet the residents needs. Establish a mentoring program in the nursing facility before the immigrant worker starts. They need to understand English to pass the competency test. A local sponsor for the immigrant worker would be helpful (e.g. church). First, put the immigrant worker in other areas of service before caregiving so that the language can be attained. Need a certain level of comprehension</p>
<p>7. Should all health care environments where direct care workers are employed have the same educational standards? Explain.</p>	<p>Yes (1) It is beneficial to have consistent training and consistent trainers.</p>
<p>8. Should direct care worker levels of training, education, and competency be tied to quality assurance measures? Why or why not?</p>	<p>Yes (4) Use quality assurance to drive training/education in areas you see need improvement. Use quality assurance elements as part of structure of the training and education calendar. Competencies in evaluations of providers and competency in compensation regardless of health care setting.</p>

Resources

<p>Standard curriculum, training manual, videos, incorporating facility philosophy into educational opportunities, job shadowing, best practices models, ESL classes, tuition assistance, policy/evaluations</p>	<p>Involvement</p> <p>Department of Inspections and Appeals, facilities, associations, legislature, Alzheimer’s Association, Iowa CareGivers Association, Department of Elder Affairs, Legislative Service Bureau, Department of Labor, Department of Human Rights, Department of Public Health, Department of Human Services, Department of Education, community organizations, educational institutions, facility owners, nursing students, community colleges, human resources, direct caregivers</p>
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Summary

Based upon a key word summary presented by Joel Olah, Executive Director, Aging Resources, forum facilitator

- **Pay:** Adequate compensation, a living wage for caregiving. It was suggested that a study of wage standards, with other related professions, be conducted to determine what a living wage is for caregivers. Benefits are also part of the compensation package, such benefits should be comprehensive, inclusive of health and fringes, along with educational opportunities for career development.
- **Parity:** Wage and compensation parity with consideration for gender, comparable occupations in similar fields, and adjustments for the rural/urban disparity.
- **Protection:** Protection from physical injury and stress on the job. Protection is also needed from structural abuse such as extended overtime hours, double shifts, and working on holidays and weekends.
- **Praise:** Caregivers need recognition beyond kind words and respect. Incentives are also required, rewarding good performance with fair compensation.
- **Promotion:** The profession of caregiving needs to be promoted and enhanced. Caregiving should be seen as a social value for the welfare of society.
- **Policy:** A comprehensive public policy for caregiving is needed as soon as possible. Such a policy should be visionary with a practical strategy to bring about social change for caregivers.
- **Priority:** Top priority should be given to policy changes for caregivers, not only should federal and state priority be established, but also a social priority within families.

- **Partnerships:** New alliances and exchanges need to take place among the public and private sectors, provider and consumer groups, and a variety of agencies and organizations to advance the profession of caregiving in order to share knowledge and expertise.
- **Passion:** Caregivers need to maintain a passion for the quality of care that they provide to the most vulnerable members of society. This passion needs to be instilled in future generations via mentoring opportunities, such that a living legacy of caring becomes part of the culture.
- **Patient-centered:** Society needs to be ever mindful that caregiving needs to remain patient-centered, never failing to hear the pleas of clients and their families for the dignity they deserve. The dignity of each person and of human life must always be valued and respected, especially our elder members.

The situation in direct care is reaching crisis proportions and it is time we take action. These forums are a good step in the process, however it must not stop here. Iowa CareGivers Association in cooperation with the Alzheimer's Association is taking the initiative to set up a mini-think tank of people to sift through the information provided in this report and come up with some main priorities. Those priorities will then be used to begin discussions and action within a coalition. Those of you who filled out the cards showing interest in the coalition will be contacted soon. If you are interested in participating in the coalition, but did not fill out a card, you may contact the Iowa CareGivers Association, 515-241-8697.

We'd like to thank everyone who was involved in these Direct Care Forums and hope that you will continue your interest in these important issues that affect us all.

On the following pages, you will see a list of the speakers, panelists, facilitators, and participants of all four forums. If your name has been left off of the list, we apologize, and please let us know.

This report is available from the Iowa CareGivers Association office. Please call 241-8697 if you did not receive a copy and would like one. We have the capabilities of emailing you the report or can send you a hard copy by mail.

Thanks again to all who participated.

A Special Thanks to:

Honored Guest at Forum 1: Lt. Governor Sally Pederson

Forum Panelists:

- Steve Ackerson, Iowa Health Care Association
- Heidee Barrett, R.N., Iowa Lakes Community College
- Beverly Brown, Bureau Chief, Nurse Aide Registry
- Jeannine Bunge, Administrator, Community Memorial Health Center, Hartley
- Jan Corderman, President, AFSCME-Iowa
- Neita Derrough, Alzheimer's Family Caregiver
- Nickie Gould, Advocacy Network for Aging Iowans
- Representative Dave Heaton, Mt. Pleasant
- Jeanne Lantz, Family Caregiver
- Ruth Laughlin, RN
- Betty Lord, DON, AASE-Haugen Homes, Inc.
- Connie Lucas, Alzheimer's Association
- Mary McGeough, Health Occupations Coordinator, Hawkeye Community College
- Julie McMahon, Bureau Chief, Community Service Bureau, Iowa Department of Public Health
- Rick Meyer, Administrator, Wesley Acres
- Jenifor Nelson, R.N., M.S.N., Executive Director, Emergency Trauma, Iowa Methodist & Iowa Lutheran Hospitals
- Barbara Newhouse, Director, Alzheimer's Association—Big Sioux Chapter
- Linda Salasberry, CNA, President, Iowa CareGivers Association
- Lori SchraderBachar, Iowa Commission on the Status of Women
- Frank Severino, Iowa Association of Homes and Services for the Aging
- Connie Smith, CNA Mentor
- Gerald Stocker, Executive Officer, Iowa Workforce Development
- John Tapscott, Advocate for Nursing Home Residents
- Deborah Thomson, Alzheimer's Association, Massachusetts
- Dr. Marvin Tooman, Administrator, Division of Health Facilities, Iowa Department of Inspections and Appeals
- Mary Vold, RN, BSN, Regional Health Education Center, Mason City
- Dr. Mary Ann Wilner, Public Policy Analyst, Paraprofessional Health Care Institute, New York
- Jeanne Yordi, Office of the Long Term Care Ombudsman

Forum Facilitators: Greg Anliker, Heidee Barrett, Deanna Clingan-Fisher, Pat Conn, Becky Groff, Kristin Hipwell, Phyllis Huber, Sandi Koll, Joel Olah, Terry Penniman, Wendy Ringgenberg, Chuck Safris, Craig Showalter, Steve Siglin, Linda Simonton, Shirley Sorenson, Anita Stineman, Betty Stone, Marv Tooman, Jenny Van Gundy, Bev Zenor

Co-Sponsors:

AARP

Alzheimer's Association--Big Sioux Chapter

Alzheimer's Association—Mid-Iowa Chapter

Alzheimer's Association—Omaha Chapter

CNA Recruitment and Retention Project

Iowa Department of Inspections and Appeals

Iowa Department of Elder Affairs

Iowa Workforce Development

Luther Care Services

Office of the Long Term Care Ombudsman

State Public Policy Group

National Alzheimer's Association

List of Direct Care Forum Participants:

Steve Ackerson, Iowa Health Care Association
Jean Allsteadt, Aging Resources
Greg Anliker, Iowa Department of Elder Affairs
Representative Dwayne Alons, State Legislature
Carolyn Armstrong, Homemaker Home Care Aide Agency
Steph Babinat, Cedar Falls Lutheran Home
Linda Bailey, Registered Nurse
Joyce Barg, Certified Nurse Assistant
Mary Barnabas, caregiver
Heidee Barrett, Iowa Lakes Community College
Mary Ann Bates, Iowa Western Community College
Patricia Bauer, Certified Nurse Assistant, Skiff Medical Center
Sarai Beck, Ecumenical Ministries of Iowa
Nancy Beerbower, Luther Park
Renee Bernier, Certified Nurse Assistant
Pam Biklen, Iowa CareGivers Association
Pastor Mike Biklen, Wilton United Methodist Church
Dottie Blackwell, Certified Nurse Assistant
Chris Blair, Iowa Health System
James Block, ManorCare Health
Terry Bonnet, Iowa Workforce Development
Andrea Bosiljevac, Certified Nurse Assistant
Pam Bradley, Southeastern Community College
Jim Brees
Bev Brown, Iowa Dept. Inspections and Appeals
Donna Buckley, consumer advocate
Jeannine Bunge, Community Memorial Health Center
Peg Buscher, IMMC, ILH and Blank
Ann Cahill, Care Initiatives
Barb Carroll, consumer
Tim Christy, Longhouse Northshire, Ltd.
Deanna Clingan-Fisher, Iowa Department of Elder Affairs
Ruth Cogdill, Certified Nurse Assistant, Lakeside Lutheran Home
Margit Coltvet, Cedar Falls Lutheran Home
Dr. Judy Conlin, Iowa Department of Elder Affairs
Pat Conn, Friendship Manor
Colleen Conrad, Certified Nurse Assistant, Longhouse Northshire, Ltd.
Marlys Cook, Windsor Care Center
Rod Coppel, Green Hills
Jan Corderman, AFSCME
Melinda Cree-Anthony, Broadlawn Medical Center
Toni Crouch, Children's Habilitation Center
LyAnn Culmore, Alzheimer's Association
Irene Davidson, Certified Nurse Assistant
Amy DeLaniot, Friendship Haven
Neita Derrough, interested party
Loretta Dillon, Southwestern Community College
Representative Bill Dix, State Legislature
Judy Dunning, Certified Nurse Assistant
Stacy Edsall, interested party
Darci Elliot, Certified Nurse Assistant
Julie Ernst, Certified Nurse Assistant
Carol Feelhaver, Alzheimer's Association
Glenda Ferguson, Southeastern Community College
Di Findley, Iowa CareGivers Association
Debbie Fisher, 3801 Grand
Betty Fitkin, Resident Advocate
Gretchen Fosket, consumer advocate
Peg Gaar, consumer advocate
Pat Gill, Alzheimer's Association
Jill Gleason, Alzheimer's Association
Linda Goeldner, Iowa Nurses Association
Nancy Gorshe, Certified Nurse Assistant
Nicola Gould, Advocacy Network for Aging Iowans
Betty Grandquist, AARP
Robyn Greenfield, Luther Park
Mary Gregory, Certified Nurse Assistant
Becky Groff, Alzheimer's Association
Robert Halkum, CNA, Heritage Rehabilitation and Health Care Center
Margo Hansen, Link Associates
Lori Harrison, Heritage Nursing & Rehab
Representative Jack Hatch, Iowa Legislature
Shelleen Hatch, Cedar Falls Lutheran Home
Cindy Haverkamp, Iowa Department of Elder Affairs
Representative Dave Heaton, Iowa Legislature
Kristin Hipwell, Iowa CareGivers Association board
Phyllis Huber, Iowa Department of Elder Affairs
Caroline Hurst, Heartland Adult Day Service
Kristy Jackson, Opportunity Living
Launa Jamison, Luther Park
Debbie Johnson, Iowa Department of Human Services
Marlene Kessler, Certified Nurse Assistant, Heritage Rehabilitation and Health Care Center
Francis Kirkpatrick, Older Iowans Legislature
Ginny Kirschling, Kirkwood Community College
Sally Kling, InTrust
Jenny Knust, Iowa Health Care Association
Sandi Koll, Iowa Department of Human Services
Don Koroch, AARP
Lynette Krambeer, Luther Park
Mary Krueger, Jennie Edmundson Hospital
Connie Kudlacek, Alzheimer's Association
Becky Lane, Congressman Boswell's Office
Bob Lantz, family caregiver
Jami Lantz, family caregiver
Jeanne Lantz, family caregiver
Debbie Larsen, Certified Nurse Assistant, Jennie Edmundson Hospital
Mary Ann Larsen, 3801 Grand
Stephanie Laudner, Iowa Department of Elder Affairs
Ruth Laughlin, Registered Nurse
Jean Lemonds, Registered Nurse and consumer
Donald Loots, Friendship Haven
Betty Lord, AASE-Haugen Homes, Inc.
Sheri Lowe, Nelson Nursing Home
Connie Lucas, Alzheimer's Association
Charleen Ludwig, caregiver
Senator Gene Maddox, Iowa Legislature
Minnie Mallard, Iowa Department of Elder Affairs
Harvey Martens, Older Iowans Legislature
Barb McCune, Iowa Veterans Home
Mary McGeough, Hawkeye Community College

Mary McLaughlin, interested party
Julie McMahon, Iowa Department of Public Health
Pat McPherson, Meth-Wick Community
Freddy Mejbon, Certified Nurse Assistant
Tamara Menke, Children's Habilitation Center
Nancy Metcalf, Alzheimer's Association
Gail Meyer, Iowa Hospital Association
Rick Meyer, Wesley Acres
Debi Meyers, Iowa Department of Elder Affairs
Fran Micklewright, Eastern Iowa Community College
Becky Miles-Polka, Center for Healthy Communities
Kim Miller, Service Employees International Union
Debra Moore, Iowa Attorney General's Office
Marlene Moorman, Certified Nurse Assistant
Pat Moreland, Iowa CareGivers Association board
Diana Morman, Wesley Retirement Services
Ruth Mosher, Department of Human Services Council
Peter Nathan, caregiver
Charlotte Nelson, Iowa Commission on the Status of Women
Jenifor Nelson, Registered Nurse, IMMC and ILH
Barbara Newhouse, Alzheimer's Association
Tam Nguyen, Institute for Well-being of Refugees
Joel Olah, Aging Resources of Central Iowa
Jodi Oleson, Link Associates
Mary Oliver, Iowa Department of Inspections and Appeals
Hattie Orwig, caregiver
Hap Palmer, Iowa Department of Human Services
Mike Pelzer, Heather Manor
Robister Penias, caregiver
Terry Penniman, Methodist Manor
Dana Petrowsky, Iowa Association of Homes and Services for the Aging
Carla Pope, Iowa Health Care Association
Susan Powers, Certified Nurse Assistant
Jan Price, Good Shepherd Health Center
Gerry Prine, Iowa Department of Human Services
Cindy Ramer, Certified Nurse Assistant
Bob Renaud, Senator Grassley's Office
Robert Reuter, Resident Advocate
Kit Ricardo, interested party
Dr. Brad Richardson, University of Iowa
Nancy Richter, Iowa CareGivers Association
Bill Rieckoff, consumer advocate
Wendy Ringgenberg, DMACC
Maddy Rouse, Certified Nurse Assistant
Sherran Russell, Certified Nurse Assistant
Chuck Sfris, consumer
Lin Salasberry, CNA, Metropolitan Medical Center
Jane Schadle, Wellmark Blue Cross and Blue Shield
Betty Lou Schamber, Certified Nurse Assistant
Lori SchraderBachar, Iowa Commission on the Status of Women
Betty Lou Schamber, Certified Nurse Assistant, Mayflower Home
Meryuane Sersi, caregiver
Frank Severino, Iowa Association Homes and Services for the Aging
Carolyn Sexton, Friendship Haven
Representative Mike Sexton, State Legislature
Patsy Shors, Iowa CareGivers Foundation board

Craig Showalter, Lakeview Center for Senior Health
Steve Siglin, consultant
Brooke Simmons, Alzheimer's Association
Linda Simonton, Iowa CareGivers Association board
Maribel Slinde, Generations
Shelly Smith, Heather Manor
Connie Smith, Certified Nurse Assistant, Cedar Falls Lutheran Home
Theresa Smith, Mercy College of Health Sciences
Delores Sorem, Bethany Manor
Shirley Sorenson, DMACC
Doreen Spoo, Certified Nurse Assistant
Sharon Starkey, caregiver
Dan Steen, Calvin Community
Susan Steinick, Congressman Ganske's Office
Barb Stephens, Southwestern Community College
Marilyn Stille, Northwest Iowa Community College
Anita Stineman, University of Iowa
Gerald Stocker, Iowa Workforce Development
Betty Stone, Generations
Paul Storbeck, Home Instead Senior Care
Tina Stroud, Alzheimer's Association
Margaret Swanson, Iowa CareGivers Foundation board
Jenni Szalat, Health Education Center, Fort Dodge
John Tapscott, consumer advocate
Linda Thate, Registered Nurse
Deborah Thomson, Alzheimer's Association
Senator Maggie Tinsman, State Legislature
Tom Tobin, consumer
Marvin Tooman, Iowa Department of Inspections and Appeals
Casma Torres, caregiver
Rihselina Torres, caregiver
Tammy Torstenson, Heather Manor
Patricia Triska, Ecumenical Ministries
Catherine Vance, Iowa Department of Education
Jennie Van Gundy, Iowa Foundation for Medical Care
Amy Vernon, Alzheimer's Association
Mary Ann Vedder, Bureau of Refugee Services
Tony Villhauer, Service Employees International Union
Maxine Visner, Opportunity Living
Mary Vold, Regional Health Education Center, Mason City
Sonya Wendell, Senator Harkin's Office
Sue Whalen, Heritage Rehabilitation and Health Care Center
Liz Williams-Chaffin, Iowa Health Care Association
Dr. Mary Ann Wilner, Paraprofessional Health Care Institute
Mary Jo Wilson, interested party
Joel Wolff, Iowa Department of Elder Affairs
Gloria Woods, Certified Nurse Assistant
Mary Ann Young, Iowa Department of Elder Affairs
Karen Zaabel, Iowa Department of Inspections and Appeals
Cathy Zarifis, Black Hawk County Public Health
Bev Zenor, Alzheimer's Association

Report prepared by: Pam Biklen, Program Director, Iowa CareGivers Association