



Iowa Department of Public Health

# Direct Care Workforce Initiative Summit Report

Division of Health Promotion and Chronic Disease Prevention

December, 2016

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## **Introduction**

The Iowa Department of Public Health (IDPH) convened the first Direct Care Workforce Summit on October 6, 2016. The intent and purpose of the meeting was to provide key stakeholders a venue for positive interaction, discussion, understanding, idea sharing, and an opportunity to take a renewed look at the direct care workforce and associated initiatives. The summit provided a foundation for friendly discourse on the current status of and issues pertaining to the direct care workforce. This report is a summary of the presentations and group discussion. The agenda and the list of attendees can be found in Appendix A and Appendix B, respectively.

## **Problem Statement and Challenge**

Direct care professionals (DCPs) are individuals who provide supportive services and care to and for people experiencing illness or disability. They are the front line of Iowa's health care workforce, providing hands-on care and support to individuals of all ages and abilities. Care settings include services in the home, community-based opportunities, acute care in hospitals, and many other settings. DCP is the umbrella name for the workforce commonly referred to as direct support professionals, direct care workers, supported community living workers, home health aides, certified nursing assistants, etc. For the purpose of this event and report, Direct Care Worker (DCW) will be used to refer to this workforce.

IDPH has managed the State of Iowa's Direct Care Workforce Initiative since the passage of legislation (2005 Iowa Act, Chapter 88) that established the Direct Care Workforce Advisory Council. Legislation passed in 2007 (2008 Iowa Acts, Chapter 1188, section 69) further stipulated that IDPH provide support to the mission of the Direct Care Workforce Advisory Council in its development of recommendations for improving workforce efforts. These recommendations were presented to the Governor and Iowa General Assembly in 2012. The Direct Care Workforce Advisory Council continues to meet and discuss the development of and enhancements to training programs, recruitment and retention initiatives, and related efforts.

In 2010, IDPH was awarded a three-year Federal Personal and Home Care Aide State Training (PHCAST) grant that provided a total of \$2.25 million dollars in annual increments. The purpose of the grant was to develop a model to improve recruitment and retention of the direct care workforce through standardized training and certification. Through funding from the PHCAST grant, the *Prepare to Care* curriculum was developed. *Prepare to Care* is a comprehensive,

competency-based training that prepares individuals to serve the needs of lowans regardless of the care or service setting. *Prepare to Care* provides training portability across health settings.

Based on recommendations from the Direct Care Workforce Advisory Council and with the opportunity provided by the PHCAST grant, IDPH developed AMANDA, a direct care workforce portal within a professional licensure computer system. The AMANDA system collects applications for licensure from various health professions. Using both state funding and a portion of the federal PHCAST grant, IDPH invested \$400,000 for the direct care workforce portal component of the AMANDA system. The AMANDA system is currently used by several health profession licensing boards; however, the direct care workforce portal within this system remains inactive.

Data generated by the Direct Care Workforce Initiative suggests these workers are the single largest group of health care workers in Iowa. Data from the University of Iowa survey of direct care worker employers indicate that annual turnover may be as high as 30 percent. This high turnover rate could be a result of difficult working conditions, a need for additional training opportunities, or stagnant wages.

The Direct Care Workforce Initiative has focused on the development of training programs and competencies to increase worker skills, employment longevity, and wages to benefit lowans receiving care through home health organizations, in nursing homes, and other facilities.

The Iowa Legislature allocates \$500,000 annually for the Direct Care Workforce Initiative; however, deficiencies in training program infrastructure, the number of workers, and quality of care continue to exist. While the original direction of the program pointed toward licensure of direct care workers in Iowa, the Legislature has not acted on the creation of licensing requirements. There has been a lack of progress in advancing the policy agenda as outlined in the Iowa Direct Care Worker Advisory Council Final Report (March 2012) and questions exist regarding the best next steps for this program to ensure continued positive progress. This summit provided an opportunity to review the initiative to determine where resources and focus would best benefit future efforts.

The 2016 Older Iowans Legislature (OIL) conducted its second annual 'bottom-up' priority bill writing session September 26-27, 2016. OIL debated and amended three issues to be written as the Older Iowans Legislature Priority Bills of 2016: 1) easing the direct care workforce shortage/challenges; 2) fully funding Lifelong Links; and 3) providing funding for facilities to house aging sexual predators.

The documents provided to summit attendees are listed below and can be found in the Appendix.

- Iowa Workforce Survey 2016: Direct Care, Supports & Service Workers. Produced by Iowa CareGivers with data analysis by Iowa Workforce Development (Appendix C).
- Suggested Approaches for Strengthening and Stabilizing the Medicaid Home Care Workforce. CMS Informational Bulletin, August 3, 2016 (Appendix D).
- Direct Care Workforce 2020: Solutions to Direct Care Workforce Issues, 2016. IowaCareGivers (Appendix E).
- Direct Care, Supports and Service Workers Survey (summary of 2016 survey). IowaCareGivers (Appendix F).

### **Presentations**

Eight individuals were invited to provide 15-minute presentations to share their perspectives, concerns, and recommendations related to the direct care workforce. The following is a summary of each presentation.

#### **Perspective: Workforce**

**Courtney Maxwell-Greene**

**Communications Director, Iowa Workforce Development**

Maxwell-Greene provided a summary of the 2016 workforce survey, including employment, wages and projected need for nursing assistants, home health aides, and personal care aides (see Appendix C for report). She identified the top hiring issues as low wages and lack of applicants for open positions, and the top retention issues as low wages and compensation.

Key recommendations from the presentation are as follows:

- Listen to business leaders and stakeholders.
- Grow registered apprenticeships.
- Participate in or align with Future Ready Iowa Initiatives with the goal of 70 percent of Iowans obtaining a post-secondary education.
- Explore opportunities under the Workforce Innovation and Opportunity Act (WIOA), with the goal of supporting Iowans entering and leaving the job market to obtain new workforce skills to improve re-entrance.

Discussion points which followed the presentation included:

- There needs to be a focus on wages, particularly when a consumer pays out-of-pocket for in-home services. Based on the experiences of those in attendance, it appears that the hourly rate is closer to \$22 - \$24, rather than the hourly wages stated in the report summary. Maxwell-Greene noted that this discrepancy is likely due to the addition of the staffing agency's overhead costs.
- Some employers in care facilities also contract with staffing agencies to provide temporary employees to fill vacancies for CNAs, and pay \$20- \$22 an hour. These temporary employees do not receive benefits or paid time off. This wage gap creates tension in the workplace, since permanent facility employees earn less.

**Perspective: Research**

**Brad Richardson**

**National Resource Center In-Homes Project Evaluator, Research Director at the National Resource Center for Family Centered Practice, and Adjunct Associate Professor for the University School of Social Work, University of Iowa**

Richardson shared information about the workforce based on his research and review of the literature. He noted that the model of client care relying on DCWs has not changed since the late 1960s, nor has there been any significant change in the research findings since then.

Key information from the presentation:

- Iowa has a large elderly population and it continues to increase, much like the rest of the country. There is an imbalance between the number of older lowans and the number of younger-aged DCWs.
- DCWs are 90 percent female, with an average age of 39 years. The average wage is \$11/hour with limited benefits. Approximately 23 percent of DCWs are eligible for Medicaid.
- Turnover rates of 100 percent in a year are not unusual.
- DCWs are an essential part of delivering long-term care. The work is difficult and there is risk of work-related personal injury.
- Based on a national survey, 40 percent of DCWs are looking for another job at any given time.
- To stay in the field, DCWs need to experience job satisfaction. The indicators for 'intent to stay' include job satisfaction, training, the potential for wage increases, and having fewer people to care for.
- Job turnover leads to inconsistent care that is stressful for DCWs and the recipients of their care.
- Inconsistent care and even decreased quality of care occur when DCWs are frequently assigned new clients, rather than having consistent client assignments.
- Recruitment and pay go together.

## **Perspective: Education**

**Gene Leutzinger**

**Dean, School of Inter-Professional and Health and Safety Services, Hawkeye Community College**

Leutzinger described how Hawkeye Community College has addressed the acute shortage of CNAs in their 10-county region. Market analysis found that most of their students do not intend to be a CNA for a significant period of time. Approximately 25 percent of students take CNA coursework as a prerequisite for nursing programs. For those who do plan to work as CNAs, one CNA is equivalent to about 0.6 FTE because many want to work part-time due to family obligations or to retain other benefits. The CNA exam pass rate on the first attempt has been approximately 70 percent.

Key information from the presentation:

- Based on this information, Hawkeye Community College increased its capacity from 550 to 930 students per year; however, 200 seats were canceled due to lack of enrollment.
- Two care centers in the area are using *Prepare to Care* to train staff to ‘challenge’ (take the test without completing the requisite coursework) the state CNA test. Testing analysis determined these students were not performing well primarily because they were not familiar with the model of bed used at the test site. The community college now allows students to visit the exam room and use the equipment prior to taking the test. Hawkeye Community College also increased the frequency of testing to twice per month in order to decrease the time gap between the end of training and the exam.
- In order to increase diversity in this workforce, Hawkeye Community College developed a four week pre-CNA course to teach medical terminology to students identified as English Language Learners.

Challenges and issues facing community colleges include the following:

- It is a struggle to find qualified faculty. Some highly qualified professionals cannot teach the CNA coursework because they lack the required long-term care experience.
- Iowa is the only state that allows people to ‘challenge’ the CNA test.

Discussion points which followed the presentation included:

- Questions about the availability and access to CNA coursework at the high school level. Leutzinger noted such coursework is available in the Waterloo and Grundy Center areas.
- There is a need for programs designed to allow high school students to obtain college credit for CNA coursework.

**Perspective: Employer**

**Joyce McDanel**

**Vice President of Human Resources and Education, Unity Point Health Systems (UPHS)**

UPHS employs 500 DCWs in its hospital system in positions known as Patient Care Techs (PCTs). These individuals must complete the advanced CNA course. Approximately 190 DCWs are hired each year due to a 40 percent turnover rate. This compares to the organization's overall turnover rate of 14 percent. Approximately 15 percent of the DCWs are in nursing school and view a PCT position as transitional. UPHS is pleased to retain those DCWs who go on to obtain nursing degrees, because the health system has even more unfilled nursing positions than DCW vacancies. UPHS has invested significantly in its employee safety program, particularly with the purchase of equipment to reduce the risk of personal injury while completing client care tasks.

Key information from the presentation:

- UPHS estimates the cost for every PCT that leaves employment is between \$45,000 - \$50,000 due to training, advertising, substitution of other workers to fill in, etc. They often must use contract PCTs at much higher rates of pay to fill shifts due to vacancies.
- UPHS has been exploring strategies to build more career paths using grant funding to support the effort. One example of these strategies is exploring the feasibility of having a position between the PCT and RN in terms of scope of work and responsibilities. It has been difficult to persuade nursing leadership to consider this option. The recent nursing shortage, however, has created more urgency to address the situation.
- Younger employees are looking for positions with leadership development, career coaching, and opportunities for advancement.

Discussion followed about the feasibility of avoiding or limiting the high costs of turnover by focusing on retention strategies, including higher salaries.

**Perspective: Family Caregiver**

**Michael Wolnerman**

Wolnerman shared his story of care and services for his elderly parents, and his efforts to provide an enjoyable quality of life by keeping them in their home. The family welcomed DCWs into their home and included them in family events and meals. The family was frequently asked for assistance to pay for gas, tires or car repair; or provide food and clothing for the DCWs children. The family worked with three companies to obtain services, and approximately 50 different DCWs provided care over the course of a single year. Wolnerman reflected that some DCWs provided quality care, but many did not. Wolnerman stated it was confusing for new DCWs to become familiar with his parents' care needs because of paperwork and multiple medications.

Key recommendations from the presentation:

- It is critical to build on recruitment, retention, and training. All companies claim to ‘give you the best employees, with the most training, and the best employee wages/benefits’. That was not his family’s experience.
- It is critical to find people with heart and passion to do this work.
- Some DCWs left employment because their agency made it difficult to stay. For example, DCWs had limited or no sick leave and no opportunities for improvement or career advancement.
- There is consumer confusion about the titles, roles and responsibilities of DCWs. For example, Wolnerman assumed all caregivers were nurses; they were not.
- A strategy is needed to track credentials and clearly communicate with families what these credentials mean.

**Perspective: Direct Care Worker**  
**Fran Mancl, CNA**

Mancl has worked for many years as a CNA in a long-term care setting. His presentation was based on his own knowledge and insight as a direct care worker and was not reflective of his place of employment.

Key information from the presentation:

- Direct care work needs to be viewed as a profession and credible career, not just an entry level job in skilled care settings. A culture of respect is needed for DCWs.
- Compensation and benefits must be addressed. Many DCWs live paycheck to paycheck, and often have second jobs to make ends meet. Benefits and insurance will help attract people to the field and reduce high turnover rates.
- Recruitment and retention strategies are needed.
- Turnover is very high, the resource pool is limited, and it is hard to fill vacancies. Vacancies often increase the number of clients assigned to a DCW, impacting the continuity and quality of care.
- Maintaining adequate staffing is difficult for several reasons. For example, many part-time DCWs are students in other professional programs. When school starts, they decrease their scheduled work hours.
- Facilities need stable and full-time employees to provide consistent and quality care. This helps ensure that care plans are up-to-date and staff understand each client’s likes and needs. It also reduces stress for clients and families concerned about who is providing care each day.

- Training and scheduling of new employees is critical. Mancl recommended a mentoring program; however, he noted that in some settings there are not enough experienced employees to train new ones. He has observed employees with six weeks of experience being designated as the trainer for new employees.
- DCWs need reasonable work hours to allow a balance between work and personal life. Turnover and vacancies in a facility often lead to 12-hour shifts or working nine days in a row. These staffing patterns contribute further to injury, burnout, and turnover.
- Education and training needs to be portable. Mr. Mancl shared that he is very interested in providing hospice care, but risks losing his CNA credential if he does.

**Perspective: Consumer**

**Michele Meadors**

**Ms. Wheelchair Iowa 2014**

Meadors shared her experiences as a recipient of care. Due to an accident, she is limited in mobility and the ability to care for her daily needs. She needs care and services twice each day: in the morning to get ready for the day, and in the evening to get ready for bed. She needs consistency in care from quality DCWs within the home care setting. She emphasized the additional needs of those with disabilities who depend upon care to go about their daily lives.

Key information from the presentation:

- Services need to be available more than once a day. To her knowledge, there is only one company in the state that provides services twice per day (morning and night). Most provide hourly services and either morning or evening services.
- Recruitment and retention is a concern. On average, she has had 100 DCWs per year in her home providing services.
- Each time another worker enters into her home, she must repeat directions and provide the same information given to previous workers. This constant repetition impacts the length of time it takes to receive the care needed. In her experience, most DCWs work three-hour shifts, meaning she only has three hours to both explain and receive the care she needs.
- Some employees have walked out and some did not show up or call to say they were not coming.
- There is a need to teach the younger generation that this is an honorable job. They must be given sufficient wages and more professional or empowering titles to eliminate or decrease some of the 'less than' attitude towards the direct care profession.
- Consumers, caregivers, employers, teachers, constituents, etc., need to move towards more action and solutions. There has been a lot of talk about this issue and now it is time to move into action and solutions.

Discussion followed about the individualized and varied needs of consumers and the delivery of services to meet their needs. This discussion underscored the importance of adequate and ongoing training.

**Perspective: Advocacy**

**Di Findley**

**Executive Director, IowaCareGivers**

Findley briefly described the work of the organization and added her support and appreciation for the information, recommendations and issues identified by the other speakers.

Key information from the presentation:

- The direct care workforce impacts more than just older adults; the thousands of children with special health care needs were not addressed at the summit.
- The direct care workforce is fragmented and needs a perspective that will focus on this workforce as a whole. There is a need for consistency and standards within the workforce. Less fragmentation will better serve employees and consumers.
- In Iowa, there have been many events and activities about this subject, but we need to move past this and into action.
- We need to do more analysis of the data and seek consistency in how the data is being extrapolated.
- Inconsistencies in retention need to be examined. Some facilities experience a 400 percent turnover rate, but others may have a rate of only 10 percent. What is making one more successful at retention than another?

**SWOT Analysis**

In preparation for the SWOT (Strengths, Weaknesses, Opportunities, and Threats) analysis, Director Clabaugh shared the following list of common themes or key words he noted from the preceding discussion.

- |                                |                        |
|--------------------------------|------------------------|
| Diversity                      | Pipeline               |
| Turnover                       | Training/credentialing |
| Work ethic                     | Testing                |
| Work conditions                | Competence             |
| Best practice                  | Compensation           |
| Qualified faculty              | Care quality           |
| Public education and awareness | Outcomes               |
| Career ladder                  |                        |

Attendees participated in discussion to identify strengths, weaknesses and opportunities that exist and may impact forward movement in addressing Iowa's direct care workforce initiative. Due to time limitations, the group did not identify threats.

The list of identified strengths and weaknesses appear in the following tables.

Strengths	Weaknesses
<ul style="list-style-type: none"> <li>• Legislative investment</li> <li>• <i>Prepare to Care</i></li> <li>• Motivated people/resources</li> <li>• Organizational culture</li> <li>• Existing body of work</li> <li>• Public education/awareness</li> <li>• High school and community college pipeline</li> <li>• Good governmental infrastructure and accountability</li> <li>• Expert participation</li> <li>• Access to trainings, DCW specialized trainings</li> <li>• Workforce demand</li> <li>• Data rich</li> <li>• Person-centered</li> <li>• Rich history</li> <li>• Collaborative efforts to create change</li> <li>• DCW at table, buy-in</li> <li>• Longevity/aging workforce</li> <li>• High employer awareness</li> <li>• Legislative resources</li> <li>• Pathways</li> <li>• Strong partnerships</li> <li>• Employer best practices</li> <li>• Pilot projects</li> <li>• Challenge the CNA test</li> <li>• Public/private partnerships</li> <li>• Future Ready Iowa</li> <li>• Healthiest State Initiative</li> <li>• Partners gathered</li> <li>• Good quality care</li> </ul>	<ul style="list-style-type: none"> <li>• Wages/overall compensation</li> <li>• Lack of moving forward</li> <li>• Eight-hour rule/turnover</li> <li>• Lack of public priority</li> <li>• Restrictions for instructors</li> <li>• Lack of legislative commitment</li> <li>• Lack of portability/trainings</li> <li>• Over-regulation at agency level</li> <li>• Lack of positive public perception</li> <li>• Lack of public awareness</li> <li>• Workers carry elder care stigma</li> <li>• Other disciplines within health care look down on DCWs</li> <li>• DCW stigma/looked down upon</li> <li>• Employer driven credentialing</li> <li>• Lack of legislative priority</li> <li>• Safety around issues of aging sexual Predators</li> <li>• Gaps in critical services</li> <li>• Aging workforce/losing expertise</li> <li>• Accountability for professional behavior</li> <li>• Career counseling for middle schools</li> <li>• Career counseling for high schools</li> <li>• Inconsistency in Iowa Administrative Code</li> <li>• Low unemployment</li> <li>• Low wage/low recruitment efforts</li> <li>• Federal training opportunity not available because of low wages</li> <li>• Information poor</li> <li>• Challenge the CNA test</li> </ul>

## Opportunities

- Policy and communication alignment
- Science, Technology, Engineering and Mathematics (STEM) as model – incorporate health
- Quality of care initiatives
- Loan forgiveness
- Understand how state regulations are impacting eight-hour rule and instructor restrictions/look at other state models
- Expand long term care insurance and other payment mechanisms
- Reallocate money/funding to keep people
- Further assessment/analysis of data
- Lobby with uniform message
- Collective impact
- Pipelines
- Career and Technical Education (CTE) redesign
- Sector partnerships/career pathways
- Change language/remove stigma (ladder vs. spectrum) compensation
- Not equal to entry level
- “Master” practitioner within DCW
- Health within STEM – high demand jobs
- Compensation
- Speak positive
- Creative education – online, English as a Second Language (ESL)
- Communication plan
- Creativity with money/funding – technology, benefits
- Collaborate to create opportunities
- Continue outreach to DCW – engage workforce
- Marketing DCW ‘Be Like Fran’
- Regulatory barriers to entry – analyze
- Continue engaging stakeholders
- Involve providers/employers groups in wage discussion
- Get best practices
- DCW appreciation week
- Look at what’s worked – best practices discussion

Participants were asked to cast up to two votes on the top weaknesses to be addressed. Each topic receiving at least one vote is listed below with the number of votes appearing in parentheses following the topic.

- Wages/overall compensation (15 votes)
- Lack of moving forward (7 votes)
- Eight-hour rule/turnover (6 votes)
- Lack of public priority (5 votes)
- Restrictions for instructors (4 votes)
- Legislative commitment (4 votes)
- Lack of portability/trainings (3 votes)
- Over-regulation at agency level (2 votes)
- Lack of positive public perception of DCW (2 votes)
- Lack of public awareness (1 vote)
- Workers carry elder care stigma (1 vote)
- Health care sector looking down on DCW/stigma (1 vote)
- Inconsistency in regulation/enforcement (1 vote)

### **Conclusion**

The summit provided a venue for reviewing the data, identifying issues and challenges, and sharing perspectives and opportunities related to the direct care workforce. Discussion included the current DCW initiative and how it might better address training, recruiting and retaining an adequate direct care workforce in the state. The draft report was shared with all panelists and participants and feedback was incorporated to accurately reflect the presentations and discussion. The final report will be reviewed by Director Clabaugh and department staff in consideration of next steps.

## Appendix A

**October 6, 2016**

### **Summit Agenda**

<b>10:00 – 10:15</b>	<b>Welcome and Introduction</b>
	Gerd Clabaugh, Director, IDPH
	Janice Edmunds-Wells, Executive Officer, Division of Oral and Health Delivery Systems, IDPH
<b>10:15 – 10:45</b>	<b>Introductory Presentation: Articulation of Problem Statement and Challenge</b>
	Janice Edmunds-Wells
<b>10:45 – 12:15</b>	<b>Panel Presentation</b>
	Iowa Workforce Development      Courtney Maxwell Greene
	University of Iowa      Brad Richardson
	Hawkeye Community College      Gene Leutzinger
	Hospital Employer      Joyce McDanel
	Family Caregiver      Michael Wolnerman
	Employee      Fran Mancl
	Consumer      Michele Meadors
	IowaCareGivers      Di Findley
<b>12:15 – 12:45</b>	<b>Lunch</b>
<b>12:45 – 2:30</b>	<b>SWOT Analysis and Discussion</b>
<b>2:30 – 3:00</b>	<b>Wrap up and next steps</b>

## Appendix B

### Summit Participant List

Amy Wallman Madden, HOPE Agency  
Angie Doyle-Scar, Iowa Department of Public Health  
Arlinda McKeen, State Public Policy Group  
Brad Richardson, University of Iowa  
Brandon Geib, Alzheimer's Association, Greater Iowa Chapter  
Brenda Dobson, Iowa Department of Public Health  
Courtney Greene, Iowa Workforce Development  
Dawn Fisk, Iowa Department of Inspections and Appeals  
Deborah Thompson, Iowa Department of Public Health  
Di Findley, Iowa CareGivers  
Dr. Bob Russell, Iowa Department of Public Health  
Emily Schuldt, Unity Point Health -Allen College Nursing  
Erin Helleso, United Healthcare Managed Care Organization (MCO)  
Fran Mancl, Direct Care Worker  
Gerd Clabaugh, Iowa Department of Public Health  
Gene Leutzinger, Hawkeye Community College  
Janice Edmunds-Wells, Iowa Department of Public Health  
Joel Wulf, Iowa Department on Aging  
John Hale, the Hale Group  
John McCalley, Amerigroup Managed Care Organization (MCO)  
Joyce McDanel, Unity Point Health Systems  
Julie Adair, Iowa Health Care Association  
Julie McMahan, IowaCareGivers  
Kelsey Feller, Iowa Department of Public Health  
Matt Blake, Leading Age Iowa  
Melanie Kempf, Iowa Department on Aging  
Michael Wolnerman, Caregiver  
Michele Meadors, Consumer  
Natalie Koerber, Amerigroup Managed Care Organization (MCO)  
Pat Thieben, Iowa Department of Education  
Suzanne Heckenlaible, Delta Dental of Iowa  
Rayna Halvorson, United Healthcare (Student)  
Zoe Thornton, Iowa Department of Education

IOWA  
WORKFORCE SURVEY 2016:  
DIRECT CARE, SUPPORTS &  
SERVICE WORKERS  
Released 2016

Produced by:  
IOWA CareGivers  
Data Analysis by:  
IOWA WORKFORCE DEVELOPMENT

*Made possible by funding through the Iowa Department of Public Health (CONTRACT #5886NW02) - Direct Care Worker Recruitment & Retention Project*

# DIRECT CARE, SUPPORTS & SERVICE WORKERS SURVEY

## METHODOLOGY & BACKGROUND

Iowa CareGivers partnered with Iowa Workforce Development to learn more about the workforce in Iowa that provides direct care, supports & services. Contributing to the Report was Steve Ovel (Legislative Consultant for the Iowa Association of Community College Trustees), Arlinda McKeen (State Public Policy Group), Erin Drinnin and Renee Miller (United Way of Central Iowa), Greg DeMoss (Department of Inspection and Appeals/Health Care Facilities).

Healthcare providers were invited to participate in the survey, which was conducted from April 18, 2016 to May 6, 2016 and was designed to help identify the following:

- Number of individuals working in direct care, supports & service occupations
- Current vacancies/job openings for direct care, supports & service occupations
- Employer obstacles retaining direct care, supports & service workers
- Future demand for the direct care, supports & service workers

The results of this study will help educators, workforce professionals and policy makers understand the needs of employers pertaining to these vital occupations and the critical support/services they provide.

Employers across Iowa assign more than 30 different job titles to direct care, supports & service occupations. For reporting consistency, we asked employers to categorize positions into the following occupational titles as defined by the **U.S. Department of Labor, Bureau of Labor Statistics**:

- **Home Health Aides** - Provide routine individualized healthcare, such as, changing bandages and dressing wounds and applying topical medications to the elderly, convalescents or persons with disabilities at the patient's home or in a care facility. Monitor or report changes in health status. May also provide personal care such as bathing, dressing and grooming of patient.
- **Nursing Assistants** - Provide basic patient care under direction of nursing staff. Perform duties such as feed, bathe, dress, groom, move patients or change linens. May transfer or transport patients. Includes nursing care attendants, nursing aides and nursing attendants.
- **Personal Care Aides** - Assist the elderly, convalescents or persons with disabilities with daily living activities at the person's home or in a care facility. Duties performed at a place of residence may include keeping house (making beds, doing laundry and washing dishes) and preparing meals. May provide assistance at non-residential care facilities. May advise families, the elderly, convalescents and persons with disabilities regarding such things as nutrition, cleanliness, and household activities.

## OVERVIEW

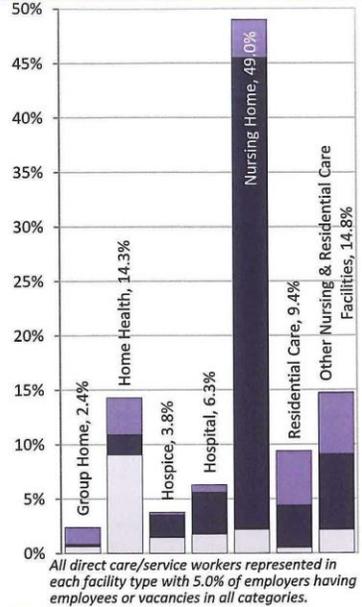


### PERCENTAGE OF RESPONDENTS THAT EMPLOY OR HAVE VACANCIES FOR DIRECT CARE/SERVICE WORKERS, REPORTED EMPLOYMENT & VACANCIES PER DIRECT CARE, SUPPORTS & SERVICE WORKER TYPE



# OVERVIEW (CONTINUED)

## RESPONDENT FACILITY TYPE AND DIRECT CARE, SUPPORTS & SERVICE WORKERS THEY EMPLOY OR HAVE VACANCIES FOR



## BENEFITS OFFERED BY EMPLOYERS (AS REPORTED)

	BOTH FULL & PART TIME EMPLOYEES	FULL-TIME EMPLOYEES ONLY
<b>INSURANCE COVERAGE</b>		
Life Insurance	57.7%	29.6%
Dental Coverage	52.9%	37.1%
Long-Term Disability	51.5%	25.0%
Health Insurance	49.3%	43.7%
Accidental Death & Dismemberment Coverage (AD&D)	48.6%	30.0%
Prescription Drug Coverage (included with medical plan)	48.6%	41.4%
Short-Term Disability	47.8%	27.5%
Vision Coverage	45.7%	32.9%
Prescription Drug Coverage (stand alone policy)	14.5%	6.5%
<b>PAID LEAVE</b>		
Paid-Time-Off (PTO)	65.7%	17.1%
Bereavement/Funeral Leave	62.0%	28.2%
Vacation	55.1%	20.3%
Maternity/Paternity Leave	54.4%	25.0%
Holiday Leave	52.9%	27.1%
Sick Leave	47.8%	22.4%
Personal Days/Floating Holidays	44.1%	19.1%
Training Leave	38.2%	13.2%
<b>ADDITIONAL BENEFITS</b>		
Company Vehicle/Mileage Reimbursement	81.2%	8.7%
Employee Assistance Program	61.4%	4.3%
Flex Spending Account/Cafeteria Plan	59.4%	18.8%
Shift Differential Pay (2nd/3rd shift, or Weekend)	55.7%	7.1%
Retirement Package	53.7%	16.4%
Wellness Program	51.4%	11.4%
Tuition Assistance/Educational Reimbursements	47.1%	8.8%
Bonuses (annual, hiring, holiday, productivity, etc.)	39.1%	7.2%
Clothing/Uniform Allowance/Reimbursement	17.9%	4.5%
Profit Sharing/Stock Options	9.0%	3.0%
Childcare Assistance (reimbursements, on-site, etc.)	7.5%	3.0%
Relocation/Moving Expense	1.5%	0.0%

## HOW PREMIUMS ARE PAID<sup>1</sup>

100% EMPLOYER PAID  
**8.7%**

100% EMPLOYEE PAID  
**17.4%**

SHARED COST  
**69.6%**

OTHER ARRANGEMENTS  
**4.3%**

## OTHER INFORMATION<sup>1</sup>

FEMALE MALE  
**86.7% 13.3%**

AVERAGE AGE  
**44**

AVERAGE COMMUTE  
**7 miles**

WILLING TO CHANGE/ACCEPT EMPLOYMENT  
**43.2%**

# NURSING ASSISTANTS

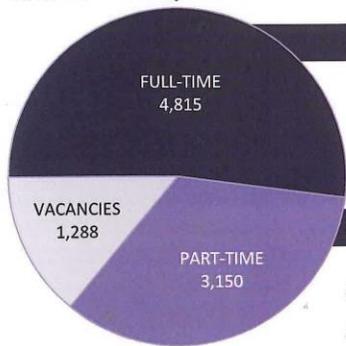


ENTRY LEVEL WAGE<sup>3</sup>  
**\$10.00/HR**

MEDIAN WAGE<sup>3</sup>  
**\$11.53/HR**

EXPERIENCED WAGE<sup>3</sup>  
**\$13.22/HR**

## EMPLOYMENT, FUTURE PLANS & VACANCIES (AS REPORTED)



## TOP SKILLS NEEDED BY NURSING ASSISTANTS (LISTED IN ORDER OF IMPORTANCE)<sup>2</sup>

Service Orientation	Actively looking for ways to help people.
Active Listening	Giving full attention to what other people are saying, taking time to understand the points being made, asking questions as appropriate and not interrupting at inappropriate times.
Social Perceptiveness	Being aware of others' reactions and understanding why they react as they do.
Coordination	Adjusting actions in relation to others' actions.
Monitoring	Monitoring/assessing performance of yourself, other individuals or organizations to make improvements or take corrective action.
Speaking	Talking to others to convey information effectively.

## FUTURE WORKFORCE PLANS BY PERCENTAGE OF RESPONDENTS & POSITIONS AFFECTED

EXPAND	REDUCE	MAINTAIN
42.4% FULL-TIME (393)	0.5% FULL-TIME (8)	57.1% FULL-TIME
48.1% PART-TIME (411)	1.3% PART-TIME (11)	50.6% PART-TIME

## HIRING ISSUES (LISTED IN ORDER OF IMPORTANCE AS REPORTED)

- Lack of applicants
- Low wages/compensation
- Scheduling issue
- Work ethic
- Competition
- Facility issues
- Lack of certified applicants

## RETENTION ISSUES (LISTED IN ORDER OF IMPORTANCE AS REPORTED)

- Low wages/compensation
- Work ethic
- Workload
- Employees/students furthering their education/career
- Competition
- Scheduling issues
- Lack of benefits

<sup>1</sup>Iowa Workforce Development, Labor Market Information Division, State of Iowa Laborshed Study 2015  
<sup>2</sup>Iowa Workforce Development, Labor Market Information Division, Occupational Projections program. Employment Projections by Occupation, 2014 and Projected 2024  
<sup>3</sup>Iowa Workforce Development, Labor Market Information Division, 2015 Iowa Wage Survey

# HOME HEALTH AIDES

10,036

Estimated 2014 Employment<sup>2</sup>

13,264

Projected 2024 Employment<sup>2</sup>

## EMPLOYMENT, FUTURE PLANS & VACANCIES (AS REPORTED)

ENTRY LEVEL WAGE<sup>3</sup>  
\$9.23/HR  
MEDIAN WAGE<sup>3</sup>  
\$10.77/HR  
EXPERIENCED WAGE<sup>3</sup>  
\$11.74/HR

### TOP SKILLS NEEDED BY HOME HEALTH AIDES (LISTED IN ORDER OF IMPORTANCE)<sup>2</sup>

Active Listening	Giving full attention to what other people are saying, taking time to understand the points being made, asking questions as appropriate and not interrupting at inappropriate times.
Service Orientation	Actively looking for ways to help people.
Social Perceptiveness	Being aware of others' reactions and understanding why they react as they do.
Critical Thinking	Using logic and reasoning to identify the strengths and weaknesses of alternate solutions, conclusions or approaches to problems.
Monitoring	Monitoring/assessing performance of yourself, other individuals or organizations to make improvements or take corrective action.
Reading Comprehension	Understanding written sentences and paragraphs in work related documents



### FUTURE WORKFORCE PLANS BY PERCENTAGE OF RESPONDENTS & POSITIONS AFFECTED

EXPAND	REDUCE	MAINTAIN
37.1% FULL-TIME (63)	1.6% FULL-TIME (3)	61.6% FULL-TIME
50.0% PART-TIME (61)	1.9% PART-TIME (10)	48.1% PART-TIME

### HIRING ISSUES (LISTED IN ORDER OF IMPORTANCE AS REPORTED)

- Lack of applicants
- Low wages/compensation
- Scheduling issue
- Lack of certified applicants
- Workload/job duties
- Work ethic
- Lack of experienced applicants

### RETENTION ISSUES (LISTED IN ORDER OF IMPORTANCE AS REPORTED)

- Low wages/compensation
- Scheduling issues
- Workload
- Lack of benefits
- Employees/students furthering their education/career
- Work ethic
- Competition

# PERSONAL CARE AIDES

6,978

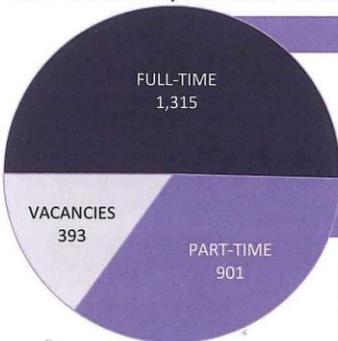
Estimated 2014 Employment<sup>2</sup>

8,802

Projected 2024 Employment<sup>2</sup>

## EMPLOYMENT, FUTURE PLANS & VACANCIES (AS REPORTED)

ENTRY LEVEL WAGE<sup>3</sup>  
\$9.01/HR  
MEDIAN WAGE<sup>3</sup>  
\$10.61/HR  
EXPERIENCED WAGE<sup>3</sup>  
\$11.63/HR



### TOP SKILLS NEEDED BY PERSONAL CARE AIDES (LISTED IN ORDER OF IMPORTANCE)<sup>2</sup>

Service Orientation	Actively looking for ways to help people.
Social Perceptiveness	Being aware of others' reactions and understanding why they react as they do.
Active Listening	Giving full attention to what other people are saying, taking time to understand the points being made, asking questions as appropriate and not interrupting at inappropriate times.
Speaking	Talking to others to convey information effectively.
Monitoring	Monitoring/assessing performance of yourself, other individuals or organizations to make improvements or take corrective action.

### FUTURE WORKFORCE PLANS BY PERCENTAGE OF RESPONDENTS & POSITIONS AFFECTED

EXPAND	REDUCE	MAINTAIN
31.8% FULL-TIME (147)	3.0% FULL-TIME (2)	65.2% FULL-TIME
50.0% PART-TIME (133)	0.0% PART-TIME	50.0% PART-TIME

### HIRING ISSUES (LISTED IN ORDER OF IMPORTANCE AS REPORTED)

- Lack of applicants
- Low wages/compensation
- Lack of skilled applicants
- Work ethic
- Scheduling issue
- Lack of benefits
- Lack of experienced applicants

### RETENTION ISSUES (LISTED IN ORDER OF IMPORTANCE AS REPORTED)

- Low wages/compensation
- Workload
- Scheduling issues
- Lack of benefits
- Employees/students furthering their education/career
- Work ethic
- Competition

<sup>2</sup>Iowa Workforce Development, Labor Market Information Division, Occupational Projections program. Employment Projections by Occupation, 2014 and Projected 2024  
<sup>3</sup>Iowa Workforce Development, Labor Market Information Division, 2015 Iowa Wage Survey

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
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Baltimore, MD 21244-1850



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## ***CMCS Informational Bulletin***

**DATE:** August 3, 2016

**FROM:** Vikki Wachino, Director  
Center for Medicaid and CHIP Services

**SUBJECT:** **Suggested Approaches for Strengthening and Stabilizing the Medicaid Home Care Workforce**

### **Introduction**

This informational bulletin highlights steps available to states, providers, and others to strengthen the home care workforce, the term used in this document to encompass individuals furnishing HCBS, consistent with advancing goals of beneficiary autonomy and self-direction of needed services.

CMS and states are taking important steps to support increased access to high-quality home and community based care. These steps are helping to remedy a longstanding imbalance between institutional and home and community-based care: data for fiscal year 2014 showed that 53 percent of total Medicaid long-term services and supports (LTSS) expenditures were spent on home and community-based services (HCBS), a marked change from 2009 when only 45 percent of LTSS expenditures were on HCBS<sup>1</sup>. To continue this progress, CMS and states have moved forward with implementing recent regulations requiring greater community integration, adopting key improvements to managed LTSS, and soliciting public comment on how best to measure access to HCBS. A stable workforce, engaged in the delivery of services and supports that address the needs and preferences of beneficiaries, is a critical element to achieving continued progress.

### ***Workforce Identity***

Home care workers may be employed by an agency, such as a home health agency or personal care agency, or may be employed directly by a beneficiary under self-directed service models. Because home care workers often deliver care on site in the homes of beneficiaries receiving services, and travel from home to home independently, home care workers may interact with their professional peers infrequently, which can promote isolation and disengagement, and make professional development challenging.

Establishing an open registry of workers for public use can help strengthen the identity of the workforce and improve beneficiary awareness of available, qualified home care workers. To be most effective, the registry should include individuals who have attained any required educational or training standards (discussed more below), but states can use registries in different

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<sup>1</sup> Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2014. April 15, 2016.  
<https://www.medicare.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/long-term-services-and-supports.html>

ways, including offering it as an option but not requiring beneficiaries to select home care workers from it. Medicaid beneficiaries should be able to access these registries not only to identify workers but to also add workers, including those who are available for service provision under self-directed service models. Self-direction is an important component of the provision of HCBS, and actions taken to promote workforce stability should also support the ability of beneficiaries to exercise autonomy in determining how service provision can best meet their needs. Registry exclusions should align with state law and policy with respect to criminal history. They should also balance safety concerns with respect for the beneficiaries' right to choose a trusted family member or friend. This is particularly relevant in evaluating what training will address the individual needs of the beneficiary, and whether existing state laws regarding previous criminal history may prevent a beneficiary from choosing a trusted family member or friend. Medicaid administrative match is available to states to help fund the development and maintenance of the registry. Guidance on administrative claiming for these functions can be found at <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/financing-and-reimbursement/downloads/qa-training-registry-costs-071015.pdf>

Professional associations or unions can also help support home care worker training and development. For example, they can offer orientation programs for new home care workers on state requirements regarding qualifications, documentation, and billing; training in new requirements or best practices for the current workforce; professional support and career ladder opportunities; peer support; and an organized way to engage in design of the state's home care system. State Medicaid Agencies may, with the consent of the individual practitioner, make a payment on behalf of the practitioner to a third party that provides benefits to the workforce such as health insurance, skills training, and other benefits customary for employees (42 CFR 447.10(g)(4)).

#### *Provider Qualifications and Basic Training*

HCBS differs from medical-focused services, a fact that has long been recognized by CMS, states, and other stakeholders. Recognizing the importance of balancing program integrity and self-direction, states frequently establish broad provider qualifications for HCBS provision, although the qualifications can vary depending on the specific service being provided. For services provided primarily in the home, such as personal care services, qualifications can include possession of a valid driver's license, a minimum age threshold, and the receipt of any training required by the state. Some states require basic competency-based training content such as first aid and CPR certification, etc. But such minimum qualification requirements should not restrict the ability of beneficiaries to require individualized training on the specific ways to provide care based on their own needs and preferences. Training can be provided by professional home care associations, training organizations, public Workforce Investment Act programs, or trade unions. In many consumer directed personal care programs, much of the training can also be provided directly by the beneficiary.

#### *Wage Analyses*

Access to services is critical to ensuring that individuals get the care they need to live in the community, and wage thresholds help to attract dedicated and engaged workers. CMS has issued several guidance documents articulating how access is to be monitored in both fee for service (in the November 2, 2015 final regulation entitled "Methods for Assuring Access to Covered

Medicaid Services”) and in managed care (in the May 6, 2016 final regulation entitled “Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability”). In response to a Request for Information issued on November 2, 2015, CMS is considering how to develop measures to monitor access to services, including home care, on an ongoing basis. CMS encourages states and providers to be mindful of the relationship between wage sufficiency, workforce health, and access to care. Wages paid to individual workers are often slow to be adjusted in response to inflation and economic growth, and can lag behind wage increases in other health and service sectors. Analyses of how the home care industry relates to the larger marketplace within a state are encouraged when states establish rate-setting methodologies to providers, and when providers determine the wage structure for their employees. This includes taking into account geographic differences in wages within a state. CMS notes that joint-employer relationships addressed in the Department of Labor’s final rule, Application of the Fair Labor Standards Act to Domestic Service, 78 Fed.Reg. 60453 (Oct. 1, 2013), should be kept in mind as states determine what actions to take in the context of wage adequacy.

When developing payment rates for home care services, states should also consider business costs incurred by a provider – whether a home care agency or an individually employed worker – associated with the recruitment, skills training, and retention of qualified workers. Aside from setting appropriate rates generally for this provider group, states have the option to develop tiered rate structures that provide enhanced reimbursement for services rendered by workers who are able to serve beneficiaries with more complex needs or have other advanced skills. For example, the state of Washington used tiered reimbursement rates for personal attendant services authorized under Community First Choice based on the acuity level of the beneficiary receiving services. Similarly, a state may build into its payment rates the provider’s cost of maintaining status as a qualified Medicaid provider, attending Medicaid-specific pre-service orientations or trainings, and post-enrollment training. A provider’s costs for other benefits offered to workers, such as tuition assistance, performance-based bonus payments or higher wages for shiftwork, can also be built into the rate the state pays the provider for the service rendered. For additional information on which costs may be included in developing service rates, states may refer to 45 CFR Part 75 “Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards.”

#### Related Prior Guidance

Previous guidance on programs for home care workers has been issued as part of efforts of the National Direct Service Workforce Resource Center, created by CMS in 2006. Additional information on this topic, and others such as core competencies, can be found at the following website: <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/workforce/workforce-initiative.html>. In August 2013, CMS issued a Toolkit for State Medicaid Agencies titled “Coverage of Direct Service Workforce Continuing Education and Training within Medicaid Policy and Rate Setting”. Aside from providing information on training options, the Toolkit also includes a discussion of how special features of self-directed delivery systems should be taken into account. A goal of the toolkit is to provide a foundation for recognizing and addressing the sometimes disparate needs of beneficiaries, home care workers, provider agencies, professional associations, and others. Training curricula that is developed in partnership with beneficiaries directing their own services instills an understanding of the basic values and skills needed to support these individuals.

As states increasingly turn to managed care to deliver Medicaid-funded HCBS, CMS strengthened approaches to managed long-term services and supports (MLTSS) programs and resulting beneficiary protections in the Medicaid managed care final rule. For example, specific provisions require stakeholder engagement in the design, implementation and oversight of MLTSS programs. The regulation also sets standards to evaluate the adequacy of the network for MLTSS programs and the accessibility of providers to meet the needs of MLTSS enrollees. In addition, states are reminded of their obligations under *Olmstead v. L.C.*, 527 U.S. 581 (1999) and the Americans with Disabilities Act.

States interested in learning more on these topics and to request technical assistance may contact Melissa Harris, Senior Policy Advisor in the Disabled and Elderly Health Programs Group, at [melissa.harris@cms.hhs.gov](mailto:melissa.harris@cms.hhs.gov).

# DIRECT CARE WORKFORCE | 2020



## SOLUTIONS TO DIRECT CARE WORKFORCE ISSUES

**Collaboration and partnerships between multiple stakeholders are required to implement SOLUTIONS to assure all Iowans have access to high quality care and support through a stable health and long-term care workforce inclusive of direct care workers and family caregivers.**

### COLLECTIVE IMPACT

- Identify an entity to provide the “backbone” for addressing the direct care workforce challenges through a common agenda of assuring that all Iowans receive services when and where they need them. The effort will also focus on the importance of the family caregiver network, as well as the overall economic impact of the issues.
- Collect data and identify emerging trends relating to the direct care workforce in all settings, i.e.: disability, nursing homes and home/community based; identify at a minimum, the current number of direct care workers in Iowa, diversity in the workforce, their employment settings, their current wages and benefits, and the types of services provided.
- Inform public policy about the current and future health and long-term care delivery system in Iowa, workforce barriers and challenges, and models of policies or initiatives that are working in Iowa and other states.

### RECRUITMENT and RETENTION

- Distribute and provide technical support for “The Toughest Job You’ll Ever Love” tool-kit, and other resources, for use by educators, career counselors, workforce development staff, and others that encourage direct care as a worthy profession and career choice.
- Identify, highlight and replicate “best practices” used by health and long-term care providers to recruit and retain staff such as: assuring a positive workplace environment; making sure direct care workers are valued team members; providing high quality orientation and training programs; addressing diversity in the workforce; providing livable wages and family sustaining benefits and workplace balance (adequate levels of staff; flexible work schedules).
- Expand financial support for programs and services that have been proven to help keep good people in the direct care workforce; e.g. mentoring and recognition programs; education and training; leadership development programs; early retention intervention activities; linking workers to physical and financial wellness programs; and outreach efforts focused on expanding health care coverage for workers.
- Invest in an infrastructure that will assure access to Prepare to Care, track utilization of the curriculum, and ensure that direct care workers, employers, and consumers have access to information related to a direct care worker’s training and credentials or certifications.

### PUBLIC EDUCATION and AWARENESS

- Create a public education and recognition campaign informing Iowans about who direct care workers are, what they do, their value to family caregivers, their impact on business and the economy, and why it’s important for all Iowans to care about recruiting and retaining a high quality direct care workforce.

### EDUCATION and TRAINING

- Implement consistent educational and continuing education standards
  - Increase awareness of the state’s Prepare to Care training, including core, other modules, and specialty endorsements such as oral health/ Mouth Care Matters.
  - Create opportunities to specialize in oral care, end of life care, dementia care, mental health, multicultural health, children with special needs, and other areas.
  - Create career choices and training to prepare individuals to work in nursing homes, hospitals, hospices, in the homes of Iowans, or other community-based settings.
  - Embrace portability by eliminating barriers to workers moving from one care or support setting or work environment to another.

### COMPENSATION - Wages and Benefits

- Ensure that direct care jobs become “good jobs”
  - Determine current compensation ranges, including benefits, for direct care workers across all work settings.
  - Establish guidelines for health and long-term care employers.
  - Create incentives such as tax credits for direct care workers and family caregivers, establish a direct care training fund, and investigate incentive models used in other states that attract individuals interested in entering and staying in the direct care field.

*(The use of “direct care workforce” includes those working in what is also often referred to as long-term service and support (LTSS) workforce.)*

See Reverse Side



IOWA CareGivers



# DIRECT CARE WORKFORCE



## SOLUTIONS TO DIRECT CARE WORKFORCE ISSUES

As part of the Direct Care Workforce Initiative, Iowa CareGivers hosted eight (8) Direct Care Workforce 2020 Regional Listening Sessions across the state of Iowa during 2015 and 2016. One hundred ten (110) entities who employ direct care workers, community colleges and others participated in these sessions. They included nursing homes, home care and other community-based providers, hospitals, hospices, residential care facilities; and community colleges and their faculty who educate those in direct care. All the participants actively engaged in the Listening Sessions for the purpose of **Shaping Solutions for the Future: Direct Care Workforce Recruitment and Retention.**

There was consensus by all attending the Listening Sessions that the current system does not adequately support the needs of those routinely providing extensive help with daily activities, delivering complex medically-related services, and coordinating health care and long-term care. While there are some policy efforts and initiatives aimed at addressing the needs of caregivers and the ones they provide care for, there is a great deal of work yet to be done.

Participants shared "best practices" and strategies used to recruit and retain direct care workers. The "best practices" target many of the issues both employers and the direct care workforce identify as hiring and retention issues:

Compensation and Benefits	Thorough Orientation	Training – Access to Continuing Education/ Training (specialized) and Portability of Training/ Credentials Across All Settings
Workplace Environment	Mentoring and Role Modeling	Empowerment
Leadership Development	Employee Recognition	Advancement Opportunities/ Career Ladder
Scheduling – Reasonable Hours, Stability and Flexibility to Allow for Life Balance	Incentives	External Promotion; Public Education and Awareness of the Importance of Position

**For more information contact Iowa CareGivers:**

1231 8th Street #236 • West Des Moines, Iowa 50265 • Phone: (515) 223-2805  
[information@iowacaregivers.org](mailto:information@iowacaregivers.org) • [www.iowacaregivers.org](http://www.iowacaregivers.org)

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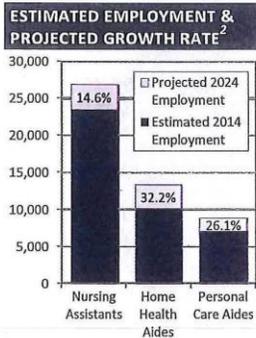
# DIRECT CARE, SUPPORTS & SERVICE WORKERS SURVEY

Iowa CareGivers partnered with Iowa Workforce Development to learn more about the workforce in Iowa that provides direct care, supports & services.

Employers across Iowa assign more than 30 different job titles to direct care, supports & service occupations. For reporting consistency, we asked employers to categorize positions into the following occupational titles as defined by the U.S. Department of Labor, Bureau of Labor Statistics:

- Home Health Aides** - Provide routine individualized healthcare, such as, changing bandages and dressing wounds and applying topical medications to the elderly, convalescents or persons with disabilities at the patient's home or in a care facility. Monitor or report changes in health status. May also provide personal care such as bathing, dressing and grooming of patient.
- Nursing Assistants** - Provide basic patient care under direction of nursing staff. Perform duties such as feed, bathe, dress, groom, move patients or change linens. May transfer or transport patients. Includes nursing care attendants, nursing aides and nursing attendants.
- Personal Care Aides** - Assist the elderly, convalescents or persons with disabilities with daily living activities at the person's home or in a care facility. Duties performed at a place of residence may include keeping house (making beds, doing laundry and washing dishes) and preparing meals. May provide assistance at non-residential care facilities. May advise families, the elderly, convalescents and persons with disabilities regarding such things as nutrition, cleanliness, and household activities.

## SUMMARY



**ENTRY TO EXPERIENCED LEVEL WAGES<sup>3</sup>**

**NURSING ASSISTANTS**  
\$10.00-\$13.22/HR

**HOME HEALTH AIDES**  
\$9.23-\$11.74/HR

**PERSONAL CARE AIDES**  
\$9.01-11.63/HR

**REPORTED EMPLOYMENT**  
(FOR ALL CATEGORIES)

**FULL-TIME**  
6,620 (59.6%)

**PART-TIME**  
4,480 (40.4%)

**TOP RETENTION ISSUE**  
(FOR ALL CATEGORIES)

Low wages/compensation

**539 EMPLOYEES PLAN TO RETIRE WITHIN THE NEXT YEAR ACROSS ALL CATEGORIES**

**A TOTAL OF 1,826 VACANCIES WERE REPORTED FOR ALL CATEGORIES**

**TOP HIRING ISSUES**  
(FOR ALL CATEGORIES)

Lack of applicants  
Low wages/compensation

**PLANNED EXPANSION IN THE WORKFORCE IN ALL CATEGORIES**

**603 FULL-TIME POSITIONS**  
**605 PART-TIME POSITIONS**

## OVERVIEW

**319** Total Responses **287** Employ or have Current Job Vacancies for Direct Care, Supports & Service Workers

**REPORTED EMPLOYED** 11,100  
**TOTAL REPORTED VACANCIES** 1,826  
**MEDIAN COST OF TURNOVER PER EMPLOYEE** \$2,000  
**WILLING TO CHANGE/ACCEPT EMPLOYMENT** 43.2%

**BENEFITS OFFERED BY EMPLOYERS TO BOTH FULL & PART-TIME EMPLOYEES (AS REPORTED)**

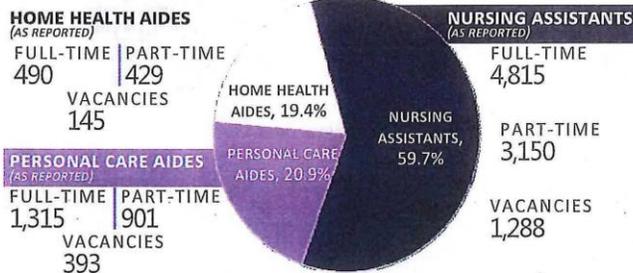
INSURANCE COVERAGE	
Life Insurance	57.7%
Dental Coverage	52.9%
Long-Term Disability	51.5%
Health Insurance	49.3%
Accidental Death & Dismemberment Coverage	48.6%
Prescription Drug Coverage (Included with medical)	48.6%
Short-Term Disability	47.8%
Vision Coverage	45.7%
Prescription Drug Coverage (stand alone policy)	14.5%

**HOW PREMIUMS ARE PAID**

**100% EMPLOYER PAID** 8.7%  
**100% EMPLOYEE PAID** 17.4%  
**SHARED COST** 69.6%

**OTHER ARRANGEMENTS** 4.3%

**PERCENTAGE OF RESPONDENTS THAT EMPLOY OR HAVE VACANCIES FOR DIRECT CARE/SERVICE WORKERS, REPORTED EMPLOYMENT & VACANCIES PER DIRECT CARE, SUPPORTS & SERVICE WORKER TYPE**



**HOME HEALTH AIDES (AS REPORTED)**  
FULL-TIME 490  
PART-TIME 429  
VACANCIES 145

**NURSING ASSISTANTS (AS REPORTED)**  
FULL-TIME 4,815  
PART-TIME 3,150  
VACANCIES 1,288

**PERSONAL CARE AIDES (AS REPORTED)**  
FULL-TIME 1,315  
PART-TIME 901  
VACANCIES 393

PAID LEAVE	
Paid-Time-Off (PTO)	65.7%
Bereavement/Funeral Leave	62.0%
Vacation	55.1%
Maternity/Paternity Leave	54.4%
Holiday Leave	52.9%
Sick Leave	47.8%
Personal Days/Floating	44.1%
Holidays	44.1%
Training Leave	38.2%

**OTHER INFORMATION**  
FEMALE 86.7%  
MALE 13.3%

**AVERAGE AGE** 44  
**AVERAGE COMMUTE** 7 miles

<sup>1</sup>Iowa Workforce Development, Labor Market Information Division, State of Iowa Laborshed Study 2015.  
<sup>2</sup>Iowa Workforce Development, Labor Market Information Division, Occupational Projections program. Employment Projections by Occupation, 2014 and Projected 2024  
<sup>3</sup>Iowa Workforce Development, Labor Market Information Division, 2015 Iowa Wage Survey

# NURSING ASSISTANTS

23,367

Estimated 2014 Employment<sup>2</sup>

26,790

Projected 2024 Employment<sup>2</sup>

## EMPLOYMENT & VACANCIES (AS REPORTED)

### FUTURE WORKFORCE PLANS BY PERCENTAGE OF RESPONDENTS

EXPAND	MAINTAIN
42.4% FULL-TIME (393 JOBS)	57.1% FULL-TIME
48.1% PART-TIME (411 JOBS)	50.6% PART-TIME

### HIRING ISSUES (LISTED IN ORDER OF IMPORTANCE AS REPORTED)

Lack of applicants  
Low wages/compensation

### RETENTION ISSUES (LISTED IN ORDER OF IMPORTANCE AS REPORTED)

Low wages/compensation

ENTRY LEVEL WAGE<sup>3</sup>

\$10.00/HR

MEDIAN WAGE<sup>3</sup>

\$11.53/HR

EXPERIENCED WAGE<sup>3</sup>

\$13.22/HR



# HOME HEALTH AIDES

10,036

Estimated 2014 Employment<sup>2</sup>

13,264

Projected 2024 Employment<sup>2</sup>

## EMPLOYMENT & VACANCIES (AS REPORTED)

### FUTURE WORKFORCE PLANS BY PERCENTAGE OF RESPONDENTS

EXPAND	MAINTAIN
37.1% FULL-TIME (63 JOBS)	61.6% FULL-TIME
50.0% PART-TIME (61 JOBS)	48.1% PART-TIME

### HIRING ISSUES (LISTED IN ORDER OF IMPORTANCE AS REPORTED)

Lack of applicants  
Low wages/compensation

### RETENTION ISSUES (LISTED IN ORDER OF IMPORTANCE AS REPORTED)

Low wages/compensation

ENTRY LEVEL WAGE<sup>3</sup>

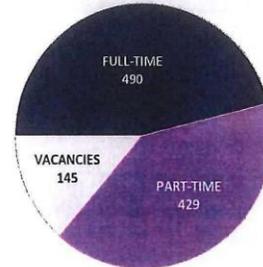
\$9.23/HR

MEDIAN WAGE<sup>3</sup>

\$10.77/HR

EXPERIENCED WAGE<sup>3</sup>

\$11.74/HR



# PERSONAL CARE AIDES

6,978

Estimated 2014 Employment<sup>2</sup>

8,802

Projected 2024 Employment<sup>2</sup>

## EMPLOYMENT & VACANCIES (AS REPORTED)

### FUTURE WORKFORCE PLANS BY PERCENTAGE OF RESPONDENTS

EXPAND	MAINTAIN
31.8% FULL-TIME (147 JOBS)	65.2% FULL-TIME
50.0% PART-TIME (133 JOBS)	50.0% PART-TIME

### HIRING ISSUES (LISTED IN ORDER OF IMPORTANCE AS REPORTED)

Lack of applicants  
Low wages/compensation

### RETENTION ISSUES (LISTED IN ORDER OF IMPORTANCE AS REPORTED)

Low wages/compensation

ENTRY LEVEL WAGE<sup>3</sup>

\$9.01/HR

MEDIAN WAGE<sup>3</sup>

\$10.61/HR

EXPERIENCED WAGE<sup>3</sup>

\$11.63/HR



<sup>1</sup>Iowa Workforce Development, Labor Market Information Division, State of Iowa Laborshed Study 2015

<sup>2</sup>Iowa Workforce Development, Labor Market Information Division, Occupational Projections program. Employment Projections by Occupation, 2014 and Projected 2024

<sup>3</sup>Iowa Workforce Development, Labor Market Information Division, 2015 Iowa Wage Survey

Produced by Iowa CareGivers

Data Analysis by Iowa Workforce Development

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