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Training Standards for Personal Care Aides: Spotlight on Iowa

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In Iowa, training requirements for personal care aides (PCAs) are uniform—but minimal compared to training requirements for home health aides and nursing assistants. Since 2006, Iowa's long-term care leaders have been striving to create a competency-based training and certification system that spans all direct care workers and ensures high-quality care across populations and settings. While their efforts have achieved promising results, actual training requirements have not been adopted by the state. This report is part of a three-part series focusing on states that have led the way in developing PCA training standards. Specifically, we ask: what was the need for improved PCA training standards in Iowa? How did long-term care leaders address that need? And how did the broader long-term care community react to proposed training standards?

EXECUTIVE SUMMARY

As the population of older adults in Iowa continues to rapidly grow, so does the demand for well-prepared direct care workers—personal care aides (PCAs), home health aides, and nursing assistants. Yet attracting and retaining enough workers to meet demand is difficult, in part due to a fragmented training system for direct care workers. Workforce advocates in Iowa believe a more streamlined training system would improve professionalism and career mobility among direct care workers, which would improve recruitment and retention as well as care outcomes.

In 2006, Iowa's state legislature began addressing this fragmented training system by creating a Direct Care Worker Task Force and subsequent Direct Care Worker Advisory Council to develop a statewide system for training and certifying direct care workers across care settings. The proposed system would require direct care workers to certify as "direct care associates." It would also offer additional training modules leading to advanced certifications (as "community living professional," "personal support professional," and "health support professional"). When the new "Prepare to Care" training curriculum was developed and pilot-tested, evaluation data showed that it was well-received by trainees and associated with lower turnover on the job.

The new training and certification system was proposed to Iowa's state senate in 2012, but died in committee due to concerns about the additional costs of establishing a Board of Direct Care Professionals, the potential limitations on the ability of self-directed consumers to train their own workers, the potential recruitment challenges that may arise from increased training requirements, and the added burden on employers to track employee certifications. Subsequent versions of the bill have been introduced but not enacted. However, the advisory council continues to disseminate the Prepare to Care curriculum to community colleges and long-term care providers statewide. As of September 2017, 267 instructors had been trained to provide the curriculum to PCAs, home health aides, and nursing assistants.

FIGURE 1: PCA TRAINING STANDARDS IN THE UNITED STATES

- Without federal standards, states have implemented an assortment of training requirements. Even within a given state, there is typically little uniformity across programs.
- **23 states** have at least one personal assistance services program with no training requirements (excluding consumer-directed PCA services).
- While **19 states** have uniform training requirements for PCAs across programs, only **7 states** specify detailed skills or offer a state-sponsored curriculum.
- **7 states** require PCAs to complete home health aide or certified nurse aide training.

Source: PHI. 2016. "Personal Care Aide Training Requirements." https://phinational.org/policy/issues/training-credentialing/training-requirements-state/personal-care-aide-training

THE NEED FOR WELL-TRAINED PERSONAL CARE AIDES

In Iowa, older adults and people with disabilities can access state-funded, paid assistance with daily activities such as eating, bathing, and dressing through six Medicaid waiver programs.[1] Training requirements for PCAs (who provide that assistance) are nearly uniform across these Medicaid programs, which is not common; Iowa is among only 19 U.S. states with uniform training requirements for PCAs (see Figure 1). Agency-employed aides must complete a 13-hour training, which covers several state-designated topics (see Figure 2).[2] Following training, aides must pass an agency-developed competency test and complete 12 hours of continuing education each year. Workers employed directly by consumers are exempt from training requirements. A 2003 survey by AARP and Iowa CareGivers (a nonprofit organization that works to ensure a stable direct care workforce) found that these training requirements did not align with the general public's preferences; most AARP members (88 percent) in Iowa believed PCAs should be tested and certified, and 54 percent believed they should have at least 75 hours of training.[3]

FIGURE 2: AGENCY-EMPLOYED PCAS ARE REQUIRED TO COMPLETE A 13-HOUR TRAINING.

TOPIC	TRAINING HOURS
The Role of the Home Care Aide*	4 hours
Communication	2 hours
Understanding Basic Human Needs	2 hours
Maintaining a Healthy Environment	2 hours
Infection Control	2 hours
Emergency Procedures	1 hours
Total	**13 hours**

* In Iowa, PCAs employed in home care industries are often referred to as "home care aides."

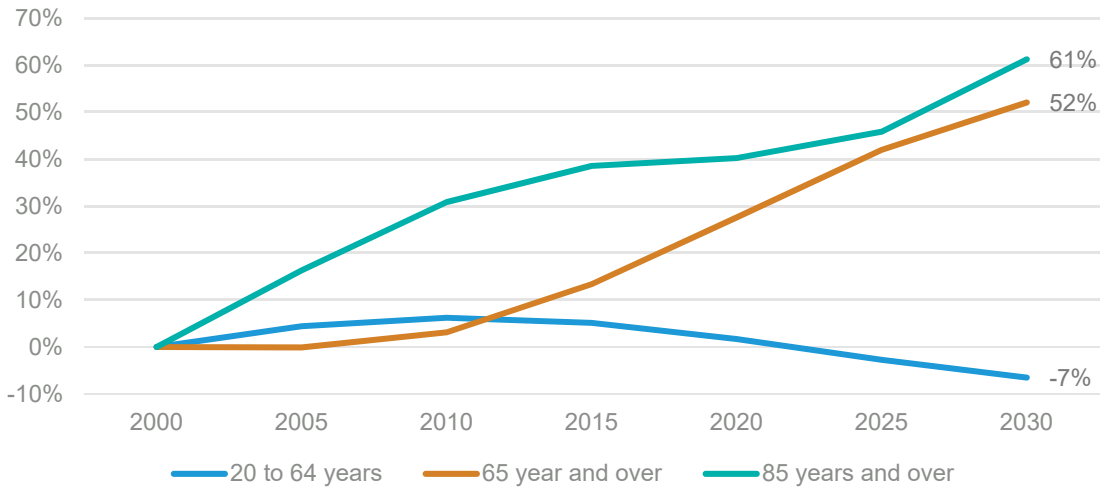
Source: Public Health Services. 2015. Home Health Aide Services. 641 § 80.3(6).

In the coming years, two factors will increase demand for PCAs: the general preference by long-term care consumers for home care and the population growth of older adults. A 2002 AARP member survey revealed high demand for home and community-based personal care services in Iowa: 95 percent of respondents reported it was "important" or "very important" to receive long-term services and supports at home, for as long as possible, and PCAs provide the bulk of in-home assistance.[4] In addition, from 2000 to 2030, Iowa's population of adults aged 65 and older is projected to grow by more than 50 percent, from 436,000 to 663,000—and many of these older adults will require long-term care (see Figure 3). During the same time, the population of working age adults (aged 20 to 64)—the primary labor pool for PCAs—will remain static.

In 2006, workforce advocates in Iowa recognized that these trends would drive demand for direct care workers, notably those providing home and community-based care.[5] However, turnover was around 80 percent across this workforce.[6] Rising demand, high turnover, and stagnant population growth among working-age adults together indicated a looming workforce shortage. Iowa's training system, described above, complicated efforts to recruit new workers. PCA training was not transferable to the 75-hour training requirements for home health aides and nursing assistants, despite the similar nature of their on-the-job responsibilities. Advocates believed a streamlined

training system could increase professionalism and career mobility, which would improve recruitment and retention for all direct care workers.

FIGURE 3: IN IOWA, THE POPULATION OF OLDER ADULTS IS PROJECTED TO GROW BY HALF FROM 2000 TO 2030.



Source: State Data Center of Iowa. 2005. *Iowa Census Data Tables: Projections*. http://www.iowadatacenter.org/browse/projections.html; analysis by PHI (August 24, 2017).

NEW TRAINING STANDARDS FOR DIRECT CARE WORKERS

In 2006, the state legislature responded to the research from AARP and Iowa CareGivers and convened the Direct Care Worker Task Force. Charged with identifying current training requirements, the task force compiled the competencies required for more than 40 different direct care occupational titles, which revealed numerous commonalities in job responsibilities across settings and populations.[7] The task force recommended a streamlined system—to be overseen by a state governance body—where all direct care workers would receive training in the same core competencies, rather than setting-specific skills. To realize this recommendation, the state legislature extended the duration of the task force in 2008 and provided limited funding for an ongoing Direct Care Worker Advisory Council in 2010.[8] Task force and advisory council members included state officials, workforce advocates, and providers (see Appendix A); four members represented people with intellectual and developmental disabilities and older adults. Organizations representing people with physical disabilities offered input informally.[9]

Designing the Training and Certification Framework

The task force developed the framework for training requirements, which was later refined by the advisory council. The task force initially grouped the various direct care competencies into six, broadly-defined training modules (see Appendix B).[10] They recommended that all direct care workers should be required to complete a core module to become certified as a "direct care

associate." Workers could then choose to complete advanced modules that certified them as a "community living professional," "personal support professional," and/or "health support professional" (see Figure 4). In addition to completing training, the advisory council recommended that workers obtain at least 70 percent on a standardized exam to achieve each certification.[11] The advisory council also recommended the development of additional modules on topics such as behavioral health and Alzheimer's disease, described as "specialty endorsements," which workers could complete to satisfy continuing education requirements as well as demonstrate advanced skills to employers and consumers.

Another recommendation was that the community living and personal support professional certifications provide PCAs with optional advancement opportunities uniformly recognized by employers across the state. For these two certifications, training providers would be encouraged to develop (and submit for approval) their own curricula, based on the agreed set of competencies. The health support professional certification would be required for home health aides and nursing assistants, who perform clinical tasks under the supervision of a licensed medical professional. To achieve certification, these workers would be required to complete the core and advanced modules on personal activities of daily living and health monitoring and maintenance; these standardized modules align with state and federal training requirements for nursing assistants and home health aides employed by Medicare- and Medicaid-certified providers.

To ensure training would be delivered by qualified individuals, the task force and advisory council proposed a three-tiered hierarchy of training roles.[12] "Trainers" would facilitate trainings for home health aides and nursing assistants seeking the health support professional certification. To meet federal regulations, these trainers would need to be registered nurses with two years of nursing experience, including one year of experience in a long-term care facility. In addition to training health support professionals, trainers would also prepare "instructors" to deliver the other training modules. Both trainers and instructors would need to maintain direct care associate certification. This network of trainers and instructors would be overseen by a "training coordinator," who would provide instruction on adult learner-centered teaching methods and solicit feedback from trainers and instructors about the curricula.

Finally, the advisory council recommended a Board of Direct Care Professionals to oversee the system.[13] Similar to other licensing boards, such as the Iowa Board of Nursing, the proposed board would develop regulations for the new training system, approve curricula (including the Prepare to Care curriculum), and maintain an online registry of direct care workers. Its membership would primarily be comprised of direct care workers, but would also include consumers, trainers, and long-term care providers.

FIGURE 4: IOWA'S PROPOSED TRAINING SYSTEM WOULD BE CHARACTERIZED BY FOUR DIRECT CARE WORKER CERTIFICATIONS, EACH WITH DIFFERENT CURRICULAR REQUIREMENTS.

	Personal Care Aides			Home Health Aides/Nursing Assistants
Training Requirement	**Direct Care Associate**	**Community Living Professional**	**Personal Support Professional**	**Health Support Professional**
Core Training (6 Hours)	●	●	●	●
Personal Support (9 Hours)		●	●	
Instrumental Activities of Daily Living (11 Hours)		●	●	
Home and Community Living (13 Hours)		●		
Health Monitoring and Maintenance (27 Hours)				●
Personal Activities of Daily Living (48 Hours)			●	●
Total Training Duration	**6 Hours**	**39 Hours**	**74 Hours**	**81 Hours**
Continuing Education Requirements	**6 Hours/ 2 Years**	**18 Hours/ 2 Years**	**18 Hours/ 2 Years**	**18 Hours/ 2 Years**

Source: Prepare to Care. 2015. *Direct Care Professional Career Pathways.* Des Moines, IA: Prepare to Care. http://www.iowapreparetocare.com/file/view/DC%20Curriculum%20Career%20Pathways%20%26%20Training%20Modules%20Description%202015%205%201%20hng.pdf/556896571/DC%20Curriculum%20Career%20Pathways%20%26%20Training%20Modules%20Description%202015%205%201%20hng.pdf.

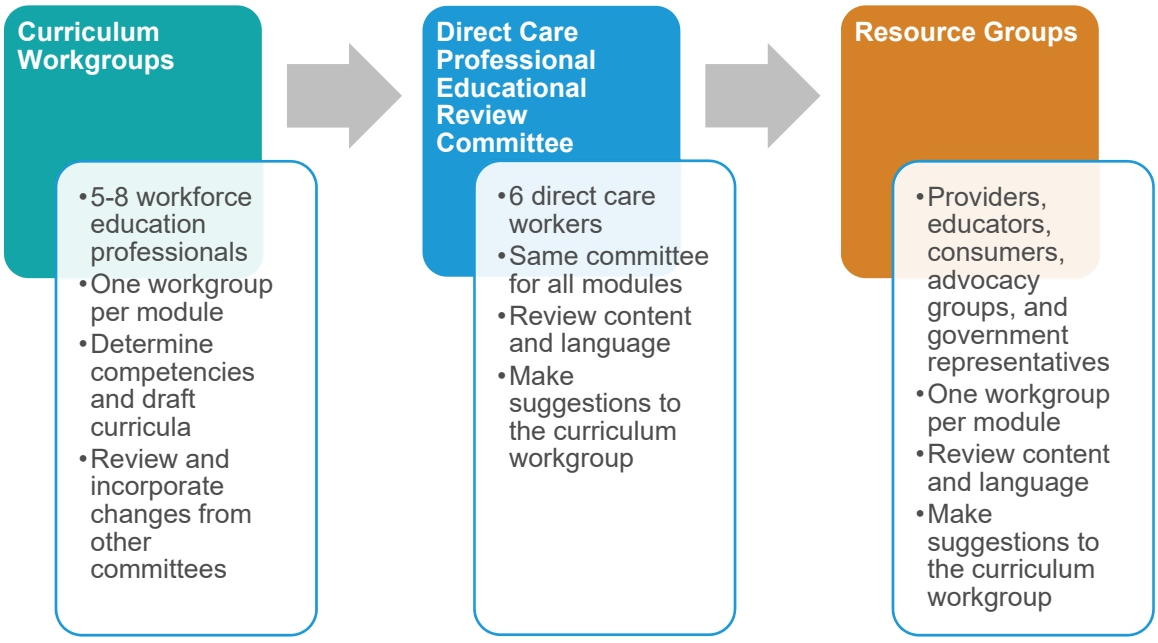
Developing and Testing the Training Curriculum

After the training and certification framework was established by the task force, the advisory council developed the core training curriculum, drawing from existing curricula offered by entities such as the National Alliance for Direct Support Professionals, the College of Direct Support, and the Hospice and Palliative Care Nurses Association.[14] Stakeholders note that discussions about the core curriculum were at times contentious because providers that focused on older adults tended to emphasize different skills and concepts in their trainings compared to providers who provided services for people with disabilities of all ages. After extensive deliberations, the advisory council agreed that knowledge and skills related to health monitoring and maintenance would benefit workers who served all people with disabilities as well as those specifically serving older adults, since younger consumers might develop chronic conditions over time. They also agreed that independence and autonomy—foundational principles within the independent living community—should be incorporated into all proposed curricula.

The advisory council began developing and pilot-testing the core and advanced modules in 2011, drawing on two funding sources: a Personal and Home Care Aide State Training (PHCAST) grant from the U.S. Department of Health and Human Services and a Bridges2Healthcare grant from the U.S. Department of Labor.[15]

The first version of the advanced modules was developed through a rigorous drafting and vetting process coordinated by faculty from the University of Iowa College of Nursing (see Figure 5). As noted above, the core module and advanced modules were collectively titled Prepare to Care.

FIGURE 5: ADVANCED MODULES WERE DEVELOPED BY TRAINING PROFESSIONALS, DIRECT CARE WORKERS, AND OTHER STAKEHOLDERS.



Source: Iowa Direct Care Worker Advisory Council. 2012. *Final Report*. Des Moines, IA: Iowa Department of Public Health (IDPH).
https://idph.iowa.gov/Portals/1/Files/DirectCare/DCW%20March%202012%20Report%202012%202%2028%20hng.pdf

To start the process, curriculum workgroups comprising five to eight workforce education professionals convened to draft every module, building on the competencies identified by the task force and advisory council. The draft modules were then reviewed by the direct care professional educational review committee, which comprised six direct care workers from different long-term care settings. The review committee suggested specific changes to make the content more accessible to trainees—for example, substituting "germ" for "pathogen" in a section on infection prevention, and proposing a complete revision of content on "positive behavior supports" due to concerns that trainees would find the language and concepts too complex. After the curriculum workgroups incorporated changes suggested by the review committee, the curriculum was reviewed by module-specific resource review committees, which included providers, educators, consumers, advocacy groups, and government representatives.

As part of the pilot-testing, the advisory council contracted with a Montana-based testing company to develop standardized certification exams. Direct care workers, educators, providers, and community organizations were involved in developing the exam questions, which were then reviewed and edited by the testing company and advisory council for consistency with the curriculum.

Once the pilot phase began, rural providers struggled to offer the Prepare to Care core training module, as they hired only a few new workers each month. In response, the advisory council partnered with the University of Iowa to create an online, interactive version of that module. Online training developers attended live training sessions to study how the courses were taught, which helped them replicate the highly participatory nature of instruction.

After the Prepare to Care curriculum was pilot-tested, evaluations yielded promising results. They showed that nine in ten Prepare to Care students were satisfied with their training.[16] Many of the trainees pursued multiple training sessions, which demonstrated their desire and need for further skill development. The new training system also appeared to reduce turnover at participating home care providers by 13 to 59 percent.[17]

The new competency-based approach to training also proved more efficient than the previous setting-specific and population-specific approach, as providers voluntarily formed partnerships across settings and populations to implement training programs. For instance, Easter Seals (a provider for individuals with disabilities) and Home Instead (a provider for older adults) pooled their trainees, rather than continuing to hold smaller trainings simultaneously.

The new training system also appeared to reduce turnover at participating home care providers by 13 to 59 percent.

After the pilot projects concluded, Iowa CareGivers secured funding to develop the first specialty curriculum on oral health, "Mouth Care Matters,"[18] abiding by the curriculum development process described earlier. Ninety-five percent of trainees were satisfied with this new course, and nursing homes where staff had been trained reported increased attention to oral care.[19]

EFFORTS TO IMPLEMENT THE NEW TRAINING STANDARDS

With promising outcomes in hand, the advisory council compiled their recommendations and worked with state lawmakers to introduce a 2012 legislative bill (SF232). The bill included the training and certification recommendations made by the advisory council in its 2012 final report. The cost of implementing this system was projected to be $250,000 in 2013 and around $200,000 in 2014.[20] Thereafter, the system was designed to become fiscally self-sufficient by collecting license fees from direct care workers at an estimated rate of $20 for direct care associate certifications and $35 for advanced credentials.

The bill did not pass for several reasons, according to various stakeholders in Iowa. First, several state representatives expressed concern about the upfront costs of establishing the Board of Direct Care Professionals, and were reluctant to create a new certification system. In addition, the bill was not well-received by long-term care membership associations and other stakeholders. For example, some consumers who directed their own services opposed the bill because they preferred to conduct their own training. They were also concerned that additional training requirements might create a barrier to entry into the workforce, which would undermine their ability to recruit workers.[21] Home care agencies and assisted living facilities were also concerned about the burden that might be placed on employers to track each employee's certification status.[22] The nursing home industry also opposed the proposed certification requirements—which would have extended training for nursing assistants by six hours—due to concerns that the additional training hours might exacerbate recruitment challenges for nursing homes, which they argued were due to limited training resources and an inefficient background check system.[23]

After the first bill failed to become law, in subsequent legislative sessions the advisory council worked with state lawmakers to reintroduce legislation that would implement a statewide direct care worker training system. (The revised bills exempted consumer-directed workers and delayed implementation of the new training requirements for nursing assistants.) However, these efforts were unsuccessful as well.

Disseminating the Curriculum Statewide

While the state did not implement advisory council recommendations or mandate new statewide training requirements, it continued to annually appropriate funds for the advisory council through 2016. With this funding, the Advisory Council advertised the Prepare to Care curriculum, encouraged voluntary adoption, and conducted train-the-trainer sessions.

As of September 2017, 267 instructors were trained to provide the Prepare to Care training across Iowa. Many instructors provide Prepare to Care through the state's community college system, and most community colleges currently offer the curriculum.[24] The remainder of instructors are largely employed by long-term care agencies. While the legislature eliminated funding for the advisory council in 2017, efforts to disseminate the Prepare to Care curriculum are ongoing, as of today.

CONCLUSION

The effort to develop a new direct care worker training and certification system in Iowa spans more than 10 years. The proposed system is unique among state-level training approaches in that it prepares direct care workers to serve every population, regardless of care setting. The incremental process for developing this system ensured participation and buy-in from all relevant stakeholders, and the success of this approach was reflected in the positive outcomes of two successful pilot projects in 2012. However, a confluence of factors prevents the full implementation of a statewide direct care professional credentialing system, including funding concerns and opposition from various industry associations and consumers. Despite legislative challenges, advocates in long-term care continue to build momentum for a standardized, competency-based certification system for Iowa's direct care workers, notably by encouraging community colleges, long-term care agencies, and others to voluntarily adopt the Prepare to Care training curriculum.

Stephen Campbell is PHI's Policy Research Associate.

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APPENDIX A: DIRECT CARE WORKFORCE TASK FORCE AND ADVISORY COUNCIL PARTICIPANTS BY YEAR

NAME	ORGANIZATION	2006	2008	2012
Kealy Anderson	Iowa CareGivers		●	
Ann Aulwes Allison	Iowa Board of Nursing		●	●
Cindy Baddeloo	Iowa Center for Assisted Living		●	
J. Bennett	Iowa Department of Inspections and Appeals (DIA)	●		
Beth Bloom	Iowa CareGivers			
Pam Bradley	Iowa Community College Association		●	
Anthony Brenneman	University of Iowa Physician Assistant Program			
Robert Campbell	Skiff Medical Center	●		
Don Chensvold	Iowa Health Care Association (IHCA)			
Lin Christensen	Iowa Department of Human Services (DHS)	●	●	
Matthew Clevenger	Iowa CareGivers			●
Greg DeMoss	Iowa Department of Inspections and Appeals (DIA)			●
Erin Drinnin	Iowa Department of Public Health (IDPH)			●
Marcia Driscoll	Kirkwood Community College			●
Meredith Field	Iowa University Center for Excellence on Developmental Disabilities (UCEDD)			●
Di Findley	Iowa CareGivers	●	●	●
Diane Frerichs	Good Samaritan Society of Estherville	●	●	●
Vicky Garske	Iowa CareGivers		●	●

APPENDIX A: DIRECT CARE WORKFORCE TASK FORCE AND ADVISORY COUNCIL PARTICIPANTS BY YEAR (CONT.)

NAME	ORGANIZATION	2006	2008	2012
Eileen Gloor	Iowa Department of Public Health (IDPH)		●	
Judy Haberman	Buena Vista County Health and Home Care	●		
Mark Haverland	Iowa Department of Elder Affairs	●		
Larry Hertel	Health Facility Consultants	●		
Joseph Hogue	Iowa Department of Workforce Development			●
Michelle Holst	Iowa Department of Public Health (IDPH)		●	
Terry Hornbuckle	Iowa Department On Aging		●	●
Karen Hyatt	Iowa Department of Human Services (DHS)		●	
Cynthia Kail	Greene County Medical Center	●		
Melanie Kempf	Iowa Department on Aging, Office of the State Long-Term Care Ombudsman			●
Mary Kirschling	Kirkwood Community College, Health Education and Continuing Education Division	●	●	
Ivan Lyddon	Consumer Advocate	●	●	
Linda Matkovich	Honoring Opportunities for Personal Empowerment (HOPE)			●
Julie McMahon	Iowa Department of Public Health (IDPH)	●	●	
Kelly Meyers	Iowa Health Care Association and Iowa Center for Assisted Living (IHCA/ICAL)			
Mary Mincer-Hansen	Iowa Department of Public Health (IDPH)	●		
Tom Newton	Iowa Department of Public Health (IDPH)		●	
Bill Nutty	LeadingAge Iowa			●

APPENDIX A: DIRECT CARE WORKFORCE TASK FORCE AND ADVISORY COUNCIL PARTICIPANTS BY YEAR (CONT.)

NAME	ORGANIZATION	2006	2008	2012
Susan Odell	Iowa Department of Inspections and Appeals (DIA)		●	●
Anne Peters	Home Instead Senior Care			●
Ann Riley	Iowa University Center for Excellence on Developmental Disabilities (UCEDD)			●
Suzanne Russell	Home Caring Services	●	●	●
Lin Salasberry	Iowa CareGivers		●	●
Susan Seehase	Exceptional Persons, Inc.		●	
Marilyn Stille	Northwest Iowa Community College		●	●
Anita Stineman	University of Iowa College of Nursing		●	●
Teresa Tekolste	Mosaic			●
Pat Thieben	Iowa Department of Education			●
Mike Van Sickle	Bethany Lutheran Home		●	●
Catherine Vance	Iowa Department of Education		●	
Amy Wallman-Madden	Honoring Opportunities for Personal Empowerment (HOPE)			●
Anthony Wells	Community Memorial Health Center	●		●
Ben Woodworth	Iowa Department of Public Health (IDPH), Brain Injury Services Program		●	
Jeanne Yordi	Iowa Department on Aging, Office of the State Long-Term Care Ombudsman	●	●	
Steve Young	Iowa Department of Inspections and Appeals (DIA)	●		
Beverly Zylstra	Iowa Department of Inspections and Appeals (DIA)		●	●

Source: Iowa Department of Public Health. 2014. *Direct Care Workforce Initiative, Advisory Council*. Retrieved from https://web.archive.org/web/20150908120357/http://www.idph.state.ia.us/directcare/Council.aspx; Direct Care Worker Task Force. 2008. *Recommendations for Establishing a Credentialing System for Iowa's Direct Care Workforce*. Des Moines, IA: Iowa Department of Public Health (IDPH).

APPENDIX B: SUMMARY OF PROPOSED CURRICULAR MODULES

TITLE	DURATION	DESCRIPTION AND COMPETENCIES
Core	6 Hours	Basic foundational knowledge and introduction to profession. • Person-centered approach • Professionalism • Communication & interpersonal skills • Infection control • Documentation • Mobility assistance & worker safety
Personal Support	9 Hours	Support to individuals as they perform personal activities of daily living. • Person-centered support, maximizing independence • Community integration, developing partners • Communication • Principles of teaching and learning • Behavioral support, crisis prevention & intervention • Individualized support plans, outcome-based philosophy, documentation
Instrumental Activities of Daily Living	11 Hours	Services to assist an individual with daily living tasks to function independently in a home or community setting. • Infection control • Laundry support • Light housekeeping • Home safety • Nutritional support • Financial management support • Emergency preparedness
Home and Community Living	13 Hours	Enhancing or maintaining independence, accessing community supports and services, and achieving personal goals. • Home & community-based living principles & services • Building & maintaining friendships & relationships • Cultural competence • Development & disabilities across the lifespan • Behavioral support, crisis prevention & intervention • Individualized support plans, outcome-based philosophy, documentation

APPENDIX B: SUMMARY OF PROPOSED CURRICULAR MODULES (CONT.)

TITLE	HOURS	DESCRIPTION AND COMPETENCIES
Health Monitoring and Maintenance	27 Hours	Medically oriented services that assist an individual in maintaining their health. • Aging process • Support for persons with: sensory, musculoskeletal, gastrointestinal, cardiovascular, respiratory, skin, urinary & reproductive conditions • Diabetes mellitus • Neurologic & nervous disorders • Mental illness & substance abuse disorders • Pain • Cancer • Intellectual & developmental disabilities • End of life
Personal Activities of Daily Living	48 Hours	Services to assist an individual in meeting their basic needs. • Professionalism, reporting & documentation, legal & regulatory guidelines • Person-centered approach, cultural considerations, special populations • Safety, infection control • Personal hygiene support • Functional support, safe patient handling, mobility assistance, vital signs • Nutritional support • Elimination support
Specialty Endorsements	N/A	Specialty Endorsements will be developed by experts in those subject or professional areas and approved by the proposed Iowa Board of Direct Care Professionals.

Source: Prepare to Care. 2015. *Direct Care Professional Career Pathways.* Des Moines, IA: Prepare to Care. http://www.iowapreparetocare.com/file/view/DC%20Curriculum%20Career%20Pathways%20%26%20Training%20Modules%20Description%202015%205%201%20hng.pdf/556896571/DC%20Curriculum%20Career%20Pathways%20%26%20Training%20Modules%20Description%202015%205%201%20hng.pdf

Notes

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[9] Iowa Department of Public Health (IDPH). 2014. *Direct Care Workforce Initiative, Advisory Council*. Retrieved from https://web.archive.org/web/20150908120357/http://www.idph.state.ia.us/directcare/Council.aspx. In 2015 and 2016, PHI conducted interviews with Direct Care Worker Advisory Council members, state officials, and advocacy groups to supplement information gathered through meeting minutes and to gauge acceptance of training standards by long-term care leaders.
[10] Prepare to Care. *Direct Care Professional Career Pathways*. Des Moines, IA: Prepare to Care. http://www.iowapreparetocare.com/file/view/DC%20Curriculum%20Career%20Pathways%20%26%20Training%20Modules%20Description%202015%205%201%20hng.pdf/556896571/DC%20Curriculum%20Career%20Pathways%20%26%20Training%20Modules%20Description%202015%205%201%20hng.pdf
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About PHI

PHI works to transform eldercare and disability services. We foster dignity, respect, and independence for all who receive care, and all who provide it. As the nation's leading authority on the direct care workforce, PHI promotes quality direct care jobs as the foundation for quality care.

Drawing on 25 years of experience working side-by-side with direct care workers and their clients in cities, suburbs, and small towns across America, PHI offers all the tools necessary to create quality jobs and provide quality care. PHI's trainers, researchers, and policy experts work together to:

- Learn what works and what doesn't in meeting the needs of direct care workers and their clients, in a variety of long-term care settings;
- Implement best practices through hands-on coaching, training, and consulting, to help long-term care providers deliver high-quality care;
- Support policymakers and advocates in crafting evidence-based policies to advance quality care

For more information, visit our website at www.PHInational.org or 60CaregiverIssues.org