



***IN-HOME SUPPORTIVE SERVICES:  
PAST, PRESENT, AND FUTURE***

*January 2003*

***County Welfare Directors Association of California***

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## ***ABOUT THE COUNTY WELFARE DIRECTORS ASSOCIATION***

The County Welfare Directors Association of California (CWDA) is a non-profit association representing the human service directors from each of California's 58 counties. The Association's mission is to promote a human services system that encourages self-sufficiency of families and communities, and protects vulnerable children and adults from abuse and neglect.

To accomplish this mission, the Association:

- Advocates for policies that will further the mission of the organization;
- Educates state and federal policy-makers and the public regarding the impact of human services policies on individuals, communities, and county social services operations;
- Collaborates with governmental and community-based organizations to ensure efficient and effective service delivery; and
- Facilitates effective communication between and among county social service agencies, and state and federal administrative agencies, including the exchange of knowledge and best and promising practices.

## ***ABOUT THE AUTHORS***

This report is the culmination of many months of planning, discussion, writing, and editing by members of the Long Term Care Operations Subcommittee of the CWDA Adult Services Committee. The report was compiled by Mari Rodin and edited by Susan Era and Janice Lindsay.

## ***PURPOSE OF THE PAPER***

The purpose of this paper is to:

1. Inventory and summarize the many studies and papers that have been produced on the subject of In-Home Supportive Services in the **past**.
2. Describe the **present** state of In-Home Supportive Services *from the point of view of* County Social Services Departments and identify the challenges facing IHSS, with recommendations for addressing them.
3. Initiate discussion with State, County, and Community Partners and Stakeholders about the **future** of the IHSS program and the interests we have in common.

# ***CONTENTS***

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<b>EXECUTIVE SUMMARY</b> .....	<b>4</b>
PROGRAM DESCRIPTION .....	4
ADMINISTRATION AND FUNDING .....	4
CHALLENGES FACING IHSS .....	4
POLICY AND PROGRAM RECOMMENDATIONS .....	5
<b>I. INTRODUCTION</b> .....	<b>7</b>
<b>II. DESCRIPTION OF IHSS</b> .....	<b>7</b>
IHSS IN THE CONTEXT OF CALIFORNIA'S LONG TERM CARE (LTC) SYSTEM ...	7
PHILOSOPHY OF IHSS .....	8
IHSS HISTORY AND CURRENT STRUCTURE .....	8
ADMINISTRATION AND FUNDING OF IHSS .....	10
<b>III. IHSS CONSUMERS</b> .....	<b>13</b>
IHSS SERVES A UNIVERSAL POPULATION .....	13
IHSS CONSUMER DEMOGRAPHICS .....	13
<b>IV. IHSS STAKEHOLDERS</b> .....	<b>13</b>
IHSS CONSUMERS .....	14
IHSS CAREGIVERS .....	14
CALIFORNIA DEPARTMENT OF HEALTH SERVICES .....	14
REGIONAL CENTERS .....	14
PUBLIC AUTHORITIES .....	15
IHSS ADVISORY COMMITTEES .....	15
CALIFORNIA ASSOCIATION OF AREA AGENCIES ON AGING (C4A) .....	15
CALIFORNIA FOUNDATION FOR INDEPENDENT LIVING CENTERS (CFLIC) .....	15
<b>V. CATALYSTS FOR CHANGE IN IHSS</b> .....	<b>16</b>
OLMSTEAD DECISION .....	16
IHSS IN THE WORKPLACE .....	17
EMPLOYER OF RECORD .....	17
PERSONAL CARE SERVICES PROGRAM .....	19
<b>VI. A SYNTHESIS OF IHSS STUDIES AND REPORTS</b> .....	<b>20</b>
IHSS IN THE LONG TERM CARE SYSTEM .....	20
IMPLEMENTATION OF EMPLOYER OF RECORD .....	21
QUALITY OF CARE .....	22
<b>VII. KEY ELEMENTS FOR IMPROVING THE QUALITY OF CARE IN IHSS</b> .....	<b>24</b>
<b>VIII. SPECIFIC POLICY AND PROGRAM RECOMMENDATIONS</b> .....	<b>28</b>



## ***EXECUTIVE SUMMARY***

The In-Home Supportive Services (IHSS) program is, and will continue to be, California's largest and most important in-home care program.<sup>i</sup> **The goal of this report is to describe the IHSS program and its history and lay out a vision for enhancing the program that is supported by both research and the experiences of County Social Services Departments in California. The County Welfare Directors Association (CWDA) hopeful that the report, or sections from it, can be used as a springboard for improving IHSS through avenues such as cooperation and coordination among stakeholders and legislative advocacy.**

### ***PROGRAM DESCRIPTION***

The In-Home Supportive Services (IHSS) program provides personal care and domestic services to aged, blind or disabled individuals in their own homes. The purpose of the program is to allow these individuals to live safely at home rather than in costly and less desirable out-of-home placement facilities.

IHSS is an entitlement program. This means that federal and state laws mandate the program's existence. Any interested individual who meets the eligibility criteria must be served. There is no cap on the growth of the program.

While IHSS regulations determine the range of services, it is the consumer who drives the program. The consumer decides how, when, and in what manner IHSS services will be provided. In addition to being consumer-driven, IHSS is unique among programs in California's long-term care system in the types of services it provides. This is because IHSS employs a social model rather than a medical model. Services are determined by a social worker assessment rather than medical criteria. The social model focuses on activities of daily living and the IHSS consumer's ability to function in his or her own home. The medical model assesses clients based on medical deficits.

### ***ADMINISTRATION AND FUNDING***

The California State Department of Social Services (CDSS) and the counties share administrative responsibilities for the IHSS program. CDSS oversees the IHSS data and payroll system (Case Management, Information and Payrolling System [CMIPS]), serves as the payroll agent for the IHSS providers, and writes the IHSS regulations. Counties are responsible for the day-to-day administration of the IHSS program. County staff determines consumers' program eligibility and the number of hours and type of services each consumer needs.

IHSS is supported through a complex array of federal, state, and county funding sources. In addition to the significant growth in the size of the program over the last several years, important new laws and court decisions have served to increase the costs of the IHSS program. This increase has put serious pressure on public coffers.

### ***CHALLENGES FACING IHSS***

The challenges facing IHSS are best viewed in the context of California's changing demographics. Currently, the State has 3.5 million people over the age of 65 - the largest older adult population in the nation. This figure is projected to increase by 172% over the next 40

years, with most of the growth occurring in the next 20 years. As the population ages and individuals become less able to care for themselves, there will be an increasing demand for personal assistance services.

Against California's demographic backdrop are the multiple challenges that are expected to result from the Olmstead Decision and the passage of Assembly Bill (AB) 1682, both of which occurred in 1999. These two events have the potential to increase the number of IHSS consumers statewide, with an associated increase in program operating costs. In addition, further caseload growth is expected with the aging population. For these reasons and the currently bleak State budget, the need for cost control has been raised. It is essential that any cost control measures to be explored preserve the philosophy and purpose of the IHSS program, to provide services that are essential for enabling aged, blind and disabled individuals to remain safely in their own homes.

As the IHSS program has changed over the years, the number of stakeholders—agencies that affect, or are affected by, IHSS—has increased. Now, more than ever before, IHSS staff is required to act as a member of a multi-disciplinary team of stakeholders in coordinating services for IHSS consumers. In planning for the future of IHSS, it is critical that decision-makers incorporate the breadth of experiences and insights of stakeholders into the most effective and efficient service delivery system possible.

### ***POLICY AND PROGRAM RECOMMENDATIONS***

The ultimate goal of this report is to set forth a vision for managing and enhancing the IHSS program. To this end, the report—using research, stakeholders' contributions, and the hands-on experiences of IHSS administrators—provides a rationale for specific IHSS policy and program recommendations as follows.

#### Funding

- It is imperative that CDSS work with CWDA in the immediate future to reevaluate the IHSS administrative funding formula. *(Page 12)*
- It is essential that CDSS and CWDA develop strategies to address cost control that preserve the IHSS philosophy and protect the needs of consumers at risk of losing their independence. *(Page 17)*
- State financial participation levels must be consistent regardless of a county's employer of record structure. *(Page 17)*
- It is critical that CDSS provide written instructions and training to counties to increase MediCal reimbursement for appropriate activities including the processing of income-eligible PCSP cases. *(Page 11)*
- CWDA and IHSS stakeholders must pursue legislation to revise Medicaid eligibility to include IHSS spouse and parent providers in PCSP. *(Page 11)*

#### Quality of Care/Program Integrity

- CDSS should create a training program for IHSS social workers to standardize use of the IHSS assessment tool. *(Page 22)*.

- CDSS in conjunction with CWDA and IHSS stakeholders, must complete revision of the IHSS regulations. In addition, CDSS should train IHSS staff in the revised regulations. *(Page 23)*
- CDSS should modify IHSS regulations to allow IHSS staff to conduct more in-home monitoring of quality of care. This could be accomplished by, adding two additional components to the social worker assessment: 1) frequency of home visits; and 2) use of IHSS support staff. *(Page 26)*
- CDSS should expand IHSS service activities that address quality of life issues raised by the IHSS consumer population. *(Page 24)*
- CDSS and CWDA in conjunction with the IHSS employers of record should create a best practice model for IHSS caregiver training. *(Page 27)*
- CDSS should support incentives and/or stipends for IHSS caregivers to attend training. *(Page 27)*
- CDSS should create an IHSS fraud investigation unit and improve security measures within the payrolling system. *(Page 10)*

#### Coordination of Services

- The California Departments of Social Services, Health Services, Developmental Services, and Aging should coordinate responsibilities and oversight vis-à-vis client overlap and codify them in a memorandum of understanding. *(Page 20)*
- CDSS should develop a formal structure for including IHSS stakeholders in the ongoing planning for the future of the IHSS program. *(Page 13)*

#### Data Collection

- CDSS must provide financial and programmatic support for CMIPS at a level equal to that provided to similar state systems (CMS and SAWS) and should ensure that enhanced case management capability is included in any CMIPS upgrades. *(Page 10)*
- CDSS should fully fund CMIPS II implementation including infrastructure, hardware, and training to ensure statewide accessibility. *(Page 10)*

The authors of this report are hopeful that these policy and procedural recommendations lay the groundwork for improving the IHSS program in the 21<sup>st</sup> century.

# ***IN-HOME SUPPORTIVE SERVICES: PAST, PRESENT, AND FUTURE***

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*County Welfare Directors Association, Adult Services Committee*

## ***I. INTRODUCTION***

California's current older adult population of 3.5 million persons is expected to increase by 172% over the next 40 years.<sup>ii</sup> As the population ages and individuals become less able to care for themselves, there will be increasing demand for personal care services. The In-Home Supportive Services (IHSS) program is, and will continue to be, the largest and most important state program providing personal care services to people with disabilities who live in their own home.<sup>iii</sup> As such, it is a key element in California's system of Long Term Care (LTC) for older adults. Although Court rulings and legislation over the past ten years have affected the program in different ways, IHSS is still an effective and efficient program.

Policy makers and researchers interested in the future of the LTC system in California have studied many facets of the IHSS program. While research findings are key to improving IHSS, the CWDA Adult Services Committee recognized that, in addition, there is a need for policy makers to understand the program from the perspective of IHSS program administrators who directly observe and experience the mechanics of the program on a daily basis.

**The goal of this report is to describe the IHSS program and its history and lay out a vision for enhancing the program that is supported by both research and the experiences of its authors. The authors are hopeful that the report, or sections from it, can be used as a springboard for improving IHSS through avenues such as legislative advocacy.**

## ***II. DESCRIPTION OF IHSS***

### ***IHSS IN THE CONTEXT OF CALIFORNIA'S LONG TERM CARE (LTC) SYSTEM***

LTC refers to a set of health, personal care, and social services that help people with functional or cognitive limitations carry out activities of daily living and other activities over a sustained period.<sup>iv</sup> LTC services span a range of programs serving the most independent (e.g., employment assistance and training, information and referral services, housing assistance, and socialization opportunities) to the most dependent (e.g., in-home assistance, money management, case management, institutionalization, and public guardian/public administrator services). Three state agencies administer and support most of California's LTC programs—Health Services (CDHS), Social Services (CDSS), and the Department of Aging (CDA). The majority of older adults who receive public LTC services are living in their homes and communities although the majority of California's public LTC funds are being spent on institutional services for a relatively small number of individuals.<sup>v</sup> IHSS, which operates under CDSS and is financed primarily by MediCal, is the largest personal assistance services program in the United States. It is the core of California's LTC system.

## ***PHILOSOPHY OF IHSS***

IHSS by its very nature is a consumer-driven program. The goal of IHSS is to maintain consumers' quality of life by providing assistance that enables them to remain safely in their own homes. Consumers receive a variety of basic services, including: domestic assistance such as housecleaning, meal preparation, laundry, and shopping; personal care, such as feeding and bathing; transportation; protective supervision; and certain paramedical services ordered by a physician. Services are provided without cost to Supplemental Security Income and or State Supplemental Payment (SSI/SSP) consumers. Those with higher incomes are eligible for the program by paying a share of the cost of the services.

IHSS social workers meet directly with the consumer and evaluate what the consumer can and cannot do for him/herself. While the scope of services is determined by program regulations, it is the consumer who decides how, when, and in what manner those services will be provided. If IHSS consumers request assistance finding caregivers, IHSS staff will, in some counties, locate potential candidates from the IHSS registry. The consumer offers input and provides updates on his/her condition to the social worker. Should the consumer have a disagreement with the services authorized by the social worker, he/she may pursue a fair hearing, where an administrative law judge will determine the services for which the IHSS consumer may be eligible.

It is important to stress that the IHSS program is based on a social model - one that relies on social worker assessment rather than assessment based on medical criteria. This makes IHSS unique in the LTC system, where programs such as Home Health and Adult Day Health, which employ a medical model, are the norm. This distinction is important for two critical reasons. First, a social model functions with caregivers who are non-medical personnel. As a result, consumers are able to hire and fire their own caregivers rather than be presented with whatever caregiver a medical agency might send out. The importance of this feature to consumers' sense of independence and control, particularly among the disabled community, cannot be under-estimated. Secondly, the social model focuses on activities of daily living and the ability of IHSS consumers to function in their own homes. The medical model assesses consumers based on medical deficits rather than their daily functioning.

***Guiding Principle:***  
**The IHSS program is based on a social model—one that relies on social worker assessment rather than assessment based on medical criteria.**

## ***IHSS HISTORY AND CURRENT STRUCTURE***

Beginning in the 1950s, the federal government addressed the needs of older adult blind and disabled individuals through the Old Age Assistance, Aid to the Blind, and Aid to the Totally Disabled programs. In the early 1950s, California established the Attendant Care program. Funded by both the State and federal government, the Attendant Care program allowed for a cash grant to be distributed directly to eligible consumers for use in contracting with individual caregivers. In the early 1970s, the Homemaker program was added to the Attendant Care program. The Homemaker program allowed recipients who could not hire or supervise their own individual providers the opportunity to receive services. Counties employed the caregivers in the Homemaker program.

In April 1979, the California legislature acted to eliminate the distinction between the county homemaker and attendant care service provision modes. This new program was the precursor of today's IHSS program. The legislature identified the consumer as the employer, yet maintained the responsibility for IHSS provider payments and fiscal issues with the State. Today, the IHSS program offers counties three distinct modes of service delivery. They are:

- 1) the **contract mode**, wherein the county contracts with a public or private entity that employs the IHSS caregivers;
- 2) the **individual provider mode**, wherein the consumer directly employs the IHSS caregiver and is in charge of hiring, firing, and supervising the caregiver; and
- 3) the **homemaker mode**, wherein the county employs the IHSS caregivers.

While counties have the option to deliver IHSS services through their own employees (homemaker mode) or a contractor's employees (contract mode), the individual provider mode has proven to be the least costly and is overwhelmingly favored by counties and consumers. In fact, 95% of all IHSS consumers receive services through the individual provider mode. In the individual provider mode, the consumer reviews and authorizes the number of hours paid to his/her caregiver and has sole authority to determine whether the quality of care provided meets his/her needs. Most counties provide assistance to consumers in finding caregivers. In many cases, consumers hire family members or friends to provide services for them.

In addition, IHSS is flexible - meeting consumers' unique language, financial, and personal needs. Like innovative "cash and counseling" programs in other states, IHSS - through the advance pay option - can provide services to consumers who need access to funds immediately to pay caregivers. Further flexibility in the IHSS Program is evidenced through the use of the Inter-County Transfer procedures, which allows consumers to continue receiving IHSS when they move anywhere in California.

IHSS is a state mandated and regulated program that is operated at the county level in accordance with the California Welfare and Institutions Code. Both federal and state laws serve, effectively, to make IHSS an entitlement program. Interested individuals have a right to apply for IHSS services and are guaranteed services if they meet the financial and functional eligibility criteria described above.

Consistent with all public entitlement programs, IHSS provides applicants certain rights - timely decision of eligibility, timely notice of change in eligibility or service, and an appeals process to dispute eligibility decisions. California Welfare and Institutions Code Section 12302 states, "Each county is obligated to ensure that services are provided to all eligible consumers during each month of the year in accordance with the county plan . . ." While the state no longer requires counties to submit an annual plan, the obligations remain.

As described above, the current structure of IHSS preserves the right of consumers as employer—to hire, fire, and supervise their own caregivers. For the majority of consumers this structure works extremely well. However, there are a small percentage of consumers who have impaired judgment and are therefore more vulnerable to being victims of provider fraud (see Section XII for more detail on this population of consumers). Fraud may manifest as phony time sheets or consumers approving hours for caregivers that were not provided

due to intimidation and/or fear of losing the caregiver on whom the consumer depends. Another sensitive fraud related area focuses on a small percentage of mentally competent consumers who commit fraud in concert with the caregivers. This fraud manifests in the form of consumers knowingly approving phony/incorrect timesheets. Additionally, some consumers do not pay the share-of-cost requirement to the caregiver. Since the consumer's share-of-cost liability is automatically deducted from the caregivers' warrant by the State payrolling system; the consumer must pay the share-of-cost directly to the caregiver. Caregivers that are not paid the required share-of-cost benefit eventually terminate employment. This can manifest itself in a high turnover rate of caregivers. Special attention should be given to consumers that consistently have a high turnover rate of caregivers. An assessment by the social worker or fraud investigator may be warranted to ensure program integrity. The IHSS social work assessment could be expanded to include determination of a need for intensive in-home monitoring. Although administrators know that fraud is present within the IHSS program, the present structure, which places the consumer in control, is one that must be preserved. The issue of fraud, however, cannot be ignored. CDSS and CWDA accountability measures need to be developed that minimize fraud. CWDA recommends that: 1) CDSS create an IHSS fraud investigation unit and improve security measures within the payrolling system; and 2) reduce the social worker to consumer ratio so that social workers can better monitor the home environment and assess cases with high caregiver turnover rates to determine whether they should be referred to a fraud investigation unit.

***CWDA Recommendation:*** CDSS should create an IHSS fraud investigation unit and improve security measures within the payrolling system and reduce the social worker to consumer ratio to ensure program integrity.

***ADMINISTRATION AND FUNDING OF IHSS***

CDSS and the State's counties share administrative responsibility for the IHSS program. In relation to funding, CDSS's primary function is to oversee, Electronic Data Systems, the contractor that operates the Case Management Information and Payroll System (CMIPS). CMIPS is the data system that tracks information about IHSS consumers and their caregivers and processes the payroll for the caregivers. However, it is increasingly clear that the State needs to develop a state-of-the-art information management system for IHSS. The program's data system must meet the future challenges associated with program growth, interaction with employers of record and labor organizations, case management, and increasing payroll responsibilities. To meet this challenge, CWDA recommends that CDSS provide financial and programmatic support for CMIPS at a level equal to that provided to similar state systems such as CMS and SAWS. CDSS should fully fund CMIPS II implementation including, infrastructure, hardware, and training to ensure statewide accessibility.

***CWDA Recommendation:*** CDSS must provide financial and programmatic support for CMIPS at a level equal to that provided to similar state systems (CMS and SAWS).

***CWDA Recommendation:*** CDSS should fully fund CMIPS II implementation including infrastructure, hardware, and training to ensure statewide accessibility.

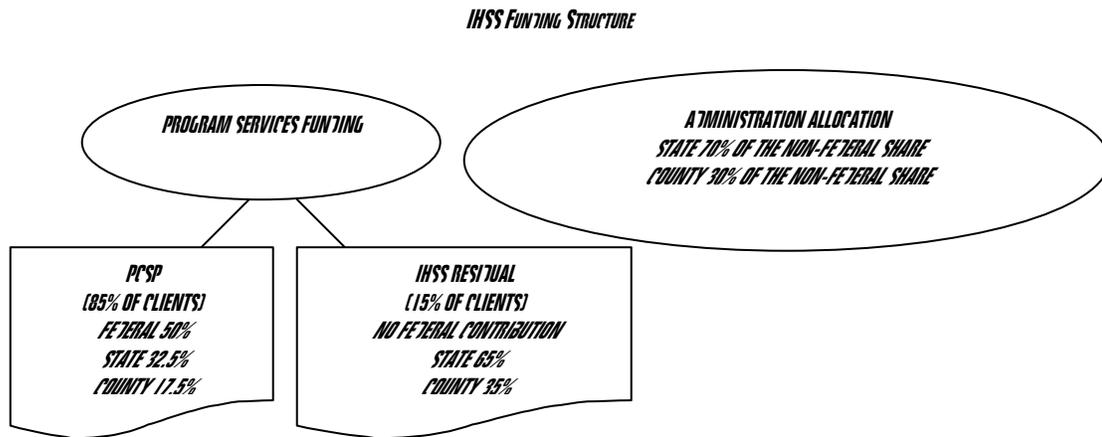
The State also is responsible for paying unemployment

insurance and workers' compensation insurance on behalf of IHSS consumers. The State collects reimbursements from the counties for costs the State incurs on their behalf. CDSS also writes regulations for the IHSS program.

Counties are responsible for the day-to-day administration of the IHSS program. They determine an individual's eligibility for IHSS as well as the amount and type of services each recipient needs. Using CDSS guidelines, county social workers determine how many hours of service per month consumers are qualified to receive.

The passage in California of AB 1682 in 1999, which mandates the establishment of employers of record for IHSS caregivers for the purpose of collective bargaining for wages and benefits, is an important variable in the funding formulas described above because this law is significantly raising the costs of the IHSS program. AB 1682 is described in more detail in Section V, Catalysts for Change.

Federal, state, and county money support two different funding streams for IHSS. The first type of funding stream is for program services. This funding pays for direct services to the consumers. These services include caregiver payroll (wages, unemployment and disability insurance, and employer taxes) and benefits, one-time cleaning fees and public authority administration. The funding for the program services allocation in fiscal year 01-02 totaled \$2,036,288,344.



The Personal Services Care Program and the IHSS Residual Program comprise the program services funding. The Personal Care Services Program (PCSP) is supported by Federal (Title XIX of the Social Security Act) Medicaid Act Regulations for Federal SSI program, State (General Funds) and county funds. In August 2002, 242,477 of the 286,953<sup>vi</sup> IHSS consumers (85%) were PCSP eligible. The federal contribution for PCSP is 50%. The State contribution is 35%. Each county picks up the remaining 15%. Many counties are unaware that they can, and should be, time-studying and charging expenses associated with the PCSP program to

***CWDA Recommendation:***  
It is critical that CDSS provide written instructions and training to counties to increase MediCal reimbursement for appropriate activities including the processing of income-eligible PCSP cases.

MediCal. To educate counties on this issue, CDSS should provide written instructions and training to counties to increase MediCal reimbursement for appropriate activities including processing of income-eligible PCSP cases.

**CWDA Recommendation:**  
CWDA and IHSS stakeholders must pursue legislation to revise Medicaid eligibility to include IHSS spouse and parent providers in PCSP.

Another barrier to full and fair reimbursement for counties is the federal Medicaid regulation that excludes certain specified relatives (of the most vulnerable consumer populations, including minor consumers), from being eligible as paid caregivers under PCSP within the IHSS program. CWDA and IHSS stakeholders must pursue legislation to revise Medicaid eligibility to include IHSS spouse and parent providers in PCSP.

The In-Home Supportive Services Residual Program (IHSS Residual) is funded by State and county money only. It receives funds from the State general fund and Title XX of the Social Security Act through the Social Services Block Grant. The non-federal ratio for State and county is 65% and 35% respectively.

The second funding stream is the IHSS administration allocation. This funding pays counties for the cost of administering the IHSS program. This includes all IHSS program staff, including social workers, as well as other costs related to program administration. The administration allocation is funded by federal, State, and county funds. In fiscal year (FY) 01-02, the administration allocation totaled \$194,644,429. The State contribution is 70% of the non-federal share. The county contribution is 30% of the non-federal share<sup>vii</sup>.

In April 1993, when PCSP was first created, the IHSS administrative allocation formula was reevaluated as a result of Proposition 13 and the Senate Bill (SB) 90 requirement that all new State mandates be fully funded by non-county funds. To meet the added costs to counties of implementing PCSP, a new administrative cost calculation was developed using the “wedding cake” formula<sup>1</sup>. Specifically, the base allocation for IHSS administration did not change. However, the added costs for performing the new functions required by PCSP were estimated on a per-case basis based upon “current” (at that time) dollars. Three funding components were added to the base casework and supervisory costs of IHSS cases that addressed costs of caseworkers, supervisors, and nurses (reference). However, dramatic changes in IHSS demographics have put unjust and unreasonable fiscal pressure on counties and IHSS administrative costs have not had a true Cost of Living Adjustment in close to 30 years, when Title XX was implemented. Adequate administrative funding of the IHSS program is critical. In light of the dramatic growth in caseload, it is imperative that adequate administrative funding be obtained which supports staff necessary to service IHSS consumers and ensures proper program operations. It is imperative that the State work with CWDA in the immediate

**CWDA Recommendation:**  
It is imperative that the California Department of Social Services work with CWDA in the immediate future to re-evaluate the IHSS administrative funding formula.

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<sup>1</sup> This name is used to describe the cost calculation because the formula was depicted in a wedding cake graphic by CDSS.

future to reevaluate the IHSS administrative funding formula.

### **III. IHSS CONSUMERS**

#### ***IHSS SERVES A UNIVERSAL POPULATION***

IHSS serves older adults and persons of any age who are physically disabled, developmentally disabled, mentally ill, or have severe cognitive difficulties such as dementia and Alzheimer's disease. The program does not carve out any subsection of the disabled population—any individual who is on SSI or meets income requirements can qualify for IHSS as long as they have a distinct need for services. This is in contrast to many other public programs, which serve only a select subsection of those served by IHSS. The fact that IHSS serves a universal population is significant because it means that the program serves an extremely diverse population with wide-ranging needs. Associated with the diverse IHSS consumer population is the myriad of agencies, or stakeholders, that must interact with the IHSS program to establish eligibility, coordinate care, etc. All of this has significantly increased the complexity of serving consumers.

**Guiding Principle:**  
IHSS serves a universal population. This is in contrast to many other public programs, which serve only a select subsection of those served by IHSS.

#### ***IHSS CONSUMER DEMOGRAPHICS***

IHSS serves 286,953 consumers throughout California's 58 counties—from Alpine County with only eight consumers to Los Angeles County with 121,569 consumers. Statewide data from August 2002 indicate that:

- 66% of the individuals receiving IHSS are female;
- 57% are ethnic minorities;
- 44% have a primary language other than English; and
- 85% receive personal care services and 86% receive SSI benefits.

Although originally designed as a program to serve blind or disabled aged (65+) individuals, the percentage of aged consumers has been consistently dropping over the last 15 years as increasing numbers of individuals under age 65 have joined the program. Forty percent (40%) of the consumers who now receive IHSS are under the age of 65 - an increase of 25% since 1987. This demographic change in the IHSS population reflects the impact of the Olmstead Decision wherein significant numbers of disabled individuals moved from institutions into community-based programs and became eligible for IHSS. (The Olmstead Decision is discussed in Section V.)

A comparison of statewide consumer data from August 2002 with the prior 18 months reveals that consumers' needs are increasing. In February 2001, records indicate that 81% of IHSS consumers required personal care services compared to 85% in August 2002. The average number of hours spent by IHSS caregivers per consumer per month increased from 83 hours in 2001 to 85 hours in 2002.

### **IV. IHSS STAKEHOLDERS**

As the IHSS program has changed over the years, the number of stakeholders - agencies that affect, or are affected by, IHSS - has increased. Now more than ever before, IHSS program

administrators are required to act as members of a multi-disciplinary team. Although representatives from the stakeholder groups have worked together on some issues, coordination at the State level should be mandatory to ensure services are efficient and high quality. CWDA recommends that CDSS develop a formal structure for including IHSS stakeholders in ongoing planning for the future of the IHSS program.

***CWDA Recommendation:***  
CDSS should develop a formal structure for including IHSS stakeholders in ongoing planning for the future of the IHSS program.

Several of the current key stakeholders are identified below and some of the salient issues that have arisen between them and the IHSS program, such as conflicting regulations and mandates, are briefly touched upon. CDSS is perhaps the most obvious stakeholder because it has primary responsibility for IHSS administration statewide and for developing IHSS policies and regulations. CDSS works in cooperation with CWDA, the association of directors of all county welfare departments throughout California. Other IHSS stakeholders are described below.

### ***IHSS CONSUMERS***

Consumers are the core of the IHSS program and may therefore be considered the IHSS program's primary stakeholder. Consumers have always played an active role as stakeholders in IHSS insofar as they select, hire, train, and supervise their caregivers. Since the advent of IHSS Advisory Committees (first in 1992 and then as a required part of implementing the employer of record mandate of AB 1682), consumers have had an additional avenue to express their needs and influence the IHSS program locally.

### ***IHSS CAREGIVERS***

IHSS caregivers—and their union representatives—are perhaps the second most significant stakeholders in the IHSS program because the success of the program depends upon their participation. Recent legislative developments, such as the establishment of public authorities and employers of record, have focused attention on the wages, benefits, working conditions, and other needs of IHSS caregivers.

### ***CALIFORNIA DEPARTMENT OF HEALTH SERVICES***

The California Department of Health Services (CDHS) is responsible for administering the MediCal program, which both funds a large share of IHSS and provides the medical coverage for all IHSS consumers. The increasing numbers of persons eligible for MediCal programs, as well as changes in federal poverty levels, have resulted in an increase in share-of-cost applications for IHSS. The increase in share-of-cost applications requires counties to carefully and accurately assess IHSS eligibility - a complex and difficult task. There is a great need to increase communication and coordination between CDHS and CDSS to streamline this process. Working relationships that engender open communication and prompt response to issues and concerns are of utmost importance to county personnel.

### ***REGIONAL CENTERS***

The significance of State's Regional Centers, which are responsible for coordinating and providing services for developmentally disabled individuals, has increased since passage of the Olmstead Decision in 1999, which mandated that people with disabilities reside in the

least restrictive setting possible. As a result of this federal court decision, many regional center consumers moved out of institutions into community settings and enrolled in the IHSS program. The resulting increase in IHSS consumers, the associated increase in program costs at the county level, and confusion about eligibility determinations and assessments make it imperative that the California Department of Developmental Services (CDDS) and CDSS administrative staff work together to facilitate interaction between agencies.

### ***PUBLIC AUTHORITIES***

IHSS Public Authorities—independent entities, established by county ordinance, to improve the delivery of IHSS—were first authorized by legislation passed in 1992 although at that time only six counties utilized this option. The passage of AB 1682 in 1999, which required each county to designate an employer of record for IHSS caregivers, identified the establishment of public authorities as one option for counties to meet the employer of record mandate. Public authorities have proven to be the most common way for counties to meet their AB 1682 obligations. The public authority is responsible for maintaining caregiver registries, providing IHSS consumers with caregiver referrals, and providing for consumer and caregiver training. In addition to these services, public authorities are stakeholders that foster collective bargaining for the IHSS caregivers. (AB 1682 and its impact on IHSS are discussed in more detail in Section V, below.)

### ***IHSS ADVISORY COMMITTEES***

IHSS Advisory Committees were established originally in 1992 to act as advisory bodies for public authorities. However, the passage of AB 1682, expanded both their role and responsibilities. By mandate, each county must now have an IHSS Advisory Committee. The majority of the Advisory Committee's members must be past or present consumers of in-home assistance. The IHSS Advisory Committees allow consumers and caregivers to have a direct voice in the administration and delivery of IHSS.

### ***CALIFORNIA ASSOCIATION OF AREA AGENCIES ON AGING (C4A)***

C4A is a statewide group representing 33 statewide Area Agencies on Aging. All of C4A's many programs serve older individuals. Moreover, C4A programs share similar goals that center around assisting consumers to remain active community members for as long as possible. Because 60% of IHSS consumers are also older adults, the two entities have many consumers in common. As such, C4A is a major stakeholder in the IHSS program and has been invited to participate in discussions about the future of IHSS.

### ***CALIFORNIA FOUNDATION FOR INDEPENDENT LIVING CENTERS (CFILC)***

CFILC is a statewide group representing 28 independent living centers (ILC). Independent Living Centers are locally based, non-profit civil rights organizations that work to promote access and integration of persons with all disabilities. ILC programs are strong advocates for the needs of persons with disabilities, and for the programs serving them, such as IHSS. CFILC represents a significant constituency of IHSS and is an important stakeholder in the IHSS program. CFILC is interested in working to build an IHSS system that truly meets the needs of persons with disabilities and is funded at a level to do so.

## ***V. CATALYSTS FOR CHANGE IN IHSS***

The IHSS program has consistently been affected by the decades-old trend to deinstitutionalize the disabled. Milestones in this trend include: the closure of mental facilities as a result of the Lanterman-Petris-Short Act of the late 1960s; transitioning the developmentally disabled into the community pursuant to the California State Superior Court *Caufield* Decision; and, most recently, the mandates from the federal Olmstead Decision that directs a broad range of the disabled into community living. These and other influences on the IHSS program are discussed below.

### ***OLMSTEAD DECISION***

On June 22, 1999, the Supreme Court of the United States upheld the right of individuals with disabilities to live in their community. This ruling is known as the Olmstead Decision. Prior to this Decision, many people with disabilities who could have lived independently in the community with supportive services were institutionalized instead. The Olmstead Decision requires public agencies to provide services “in the most integrated setting appropriate to the needs of qualified individuals with disabilities.” The Court suggested that a state would be in compliance with Title II of the American with Disabilities Act (ADA) if it demonstrated that it has:

- A comprehensive, effective plan for placing qualified persons with disabilities in less restrictive settings, and
- A waiting list that moves at a reasonable pace not controlled by a state’s endeavors to keep its institutions fully populated.

The IHSS program is potentially key to California’s compliance with the Olmstead Decision because it is consistent with the key principles the US Department of Health and Human Services asked states to consider in developing plans for Olmstead compliance:

- Provide an opportunity for interested individuals, including individuals with disabilities and their representatives, to be integral participants in plan development and follow-up.
- Take steps to prevent or correct current and future unjustified institutionalization of individuals with disabilities.
- Ensure the availability of community-integrated services.
- Afford individuals with disabilities and their families the opportunity to make informed choices regarding how their needs can best be met in the community or institutional settings.

Over the past several years the IHSS caseload has changed significantly. First, there has been a significant increase in the number of new IHSS cases as people with disabilities have left institutions and moved into the community. Between 1996 and 1999, the IHSS disabled caseload grew by 21.1%.

Prior to enrolling in the IHSS program, many of the new IHSS consumers had been receiving services from State agencies other than CDSS, such as the Departments of Health Services, Aging, and Developmental Services. The result of multiple agency involvement with

consumers is a duplication of oversight responsibilities at the state level. Such duplication of effort and responsibilities hampers the counties' ability to locally integrate programs serving the same target populations and complicates State implementation of the Olmstead Decision.

State efforts to develop the required Olmstead Plan are proceeding, but have met with public concern regarding the length of time and the extent of outreach. It is unclear what impact Olmstead implementation will have in California. Increased residential options for individuals could potentially create an increased draw on IHSS as a resource for community-based care.

### ***IHSS IN THE WORKPLACE***

AB 925 (Aroner) is historic legislation that makes it possible for people to utilize their existing authorized hours of IHSS in the workplace. Previously, people with disabilities had to choose between personal care and a job. They were restricted to home if they needed any significant amount of personal assistance. This is important legislation for people with disabilities, who now have the opportunity for increased independence and self-support, and it represents an evolutionary development in the IHSS program. Implementation will address the new flexibility in the location of service provision.

### ***EMPLOYER OF RECORD***

On July 12, 1999, the Governor of California signed into law AB 1682 and SB 710, which added Section 12302.25 to the Welfare and Institutions Code (WIC). These laws require each county to establish, on or before January 1, 2003, an employer of record for IHSS care providers for the sole purpose of collective bargaining. Although the counties are able to retain the same service mode options, individual IHSS caregivers will have through representation by unions, the opportunity to negotiate for wages and benefits. WIC Section 12302.25 authorizes these five options for employer of record:

- Public authority/non-profit consortium;
- IHSS contract;
- County administration of individual providers;
- County civil service personnel; and
- A combination of the above.

Within the public authority option, there are two models available to counties—county and stand-alone. In the county model, the board of supervisors acts as the governing body of the public authority with an advisory committee comprised of a majority of IHSS consumers. The stand-alone model is an independent entity with a consumer majority governing board appointed by the county board of supervisors.

The county board of supervisors has the responsibility to select the employer of record option best suited to their county. However, by mandate, each board of supervisors must consider the advice and recommendations of their county's IHSS Advisory Committee. The financial impact on counties' from implementing the employer of record mandate depends on

both the option a county chooses for employer of record and the results of negotiations reached through the collective bargaining process.

While quality of care is expected to improve with better pay and benefits for care providers, there have already been significant increases in both the administrative and services costs of IHSS. A study conducted on the impact of unionization of IHSS workers in San Francisco<sup>viii</sup> found that quality of care had improved based, in part, on the improved ethnic match between consumer and caregiver. The study also found that there was “extraordinary constancy in measures of workforce stability, including turnover and the length of match between consumer and provider,” which may also have positively affected quality of care. However, the San Francisco study also confirmed projections of increased costs for IHSS. The study found that the cost of the total compensation package for San Francisco IHSS workers nearly doubled over the three-year period (1997-2000) examined in the study. Associated with this increase in costs, the study found a 39% increase in the number of IHSS workers and a 34% increase in the number of consumers during the same time frame. Combined with the ongoing growth in the IHSS caseload, there will continue to be significant impact on the cost of the IHSS program.

The financial impacts to counties resulting from the employer of record mandate have been, and will continue to be, substantial. In addition, the aging population together with the impacts from the Olmstead Decision will continue to place financial pressures on the IHSS program. It is essential that CDSS and CWDA develop strategies to address cost control that preserve the IHSS philosophy and protect the needs of consumers at risk of losing their independence.

***CWDA Recommendation:***  
It is essential that CDSS and CWDA develop strategies to address cost control that preserve the IHSS philosophy and protect the needs of consumers at risk of losing their independence.

Counties are discouraged from selecting an employer of record structure other than a public authority primarily because the public authority option is the only one for which county reimbursement is available.<sup>2</sup> CWDA recommends that state financial participation levels in implementing the employer of record mandate are consistent regardless of a county’s employer of record structure.

***CWDA Recommendation:***  
State financial participation levels in implementing the employer of record mandate must be consistent regardless of a county’s employer of record structure.

This administrative funding strategy for employer of record was established in the Medicaid Plan Amendment as part of the initial 1992 Public Authority enabling legislation when public authority was a new option to counties. Now,

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<sup>2</sup> The operating cost of a public authority is provided through reimbursement from the IHSS program services funding rather than through the IHSS administration allocation. Counties submit a quarterly claim to the State for reimbursement of public authority-associated expenses, after having received State approval for a reimbursement rate. Generally speaking, the counties’ share of cost is higher under IHSS services funding than it would be under the administration allocation. Counties can claim the start-up costs for an authority through the County Administrative Expense Claim, but once the authority has been fully formed and the rate has been approved, reimbursements must come via the authority’s claim itself.

however, access to maximum State financial participation is *only* available through the public authority option. The State has not yet developed a mechanism for counties to draw down administrative dollars for other employer of record options.

### ***PERSONAL CARE SERVICES PROGRAM***

In March of 1993, CDSS issued an All County Letter (ACL93-21) regarding the implementation of a new program within the In Home Supportive Services Program. This new program—the Personal Care Services Program (PCSP)—significantly changed IHSS. Prior to April 1993, IHSS was funded by the State and counties with no federal participation. The PCSP program brought federal funds to IHSS through Medicaid, lowering state and county costs for the program. PCSP also has had significant programmatic impacts, adding a greater IHSS link to the medical community, requiring additional forms and steps to be taken for eligibility, and removing the 195-hour cap for services of the non severely impaired, to name a few. Initially the PCSP program required counties to collect information to determine consumer and caregiver eligibility. They included:

- The SOC 425, a “prescription” for personal care, to be completed by consumer’s personal physician; and
- The SOC 426, which was used to “vendor” the Individual provider, making it possible to use federal dollars to pay for the personal care services authorized.

In addition, counties were encouraged to utilize nurses to assist the social workers in the assessments and reassessments of the IHSS consumers. Many counties found this to be a welcome addition to the IHSS assessment process and either hired or contracted for registered nurses or public health nurses.

The following IHSS consumers were determined ineligible for the Personal Care Service Program:

- Minor children whose caregiver was their parent,
- Consumers whose spouse was their provider,
- Consumers receiving Advance Pay option for IHSS,
- Consumers who were Income Eligible,
- Consumers who only needed protective supervision services.

In May 1993, the CDSS issued another All County Letter (ACL93-30). It explained that AB 5 had been signed into law by Governor Wilson and resulted in the following three substantive changes to the PCSP program:

- 1) It gave the CDHS the authority to limit the amount, scope and duration of PCSP to assure cost neutrality to the State;
- 2) It eliminated protective supervision as a covered PCSP service; and
- 3) It created a sunset provision effective July 1, 1996 of PCSP as a MediCal benefit. (This provision was later removed.).

AB 5 also more clearly defined the PCSP program and separated it from the IHSS residual program, which included all consumers listed above who had been excluded from PCSP, as well as all consumers who only needed “ancillary services”. Ancillary services were defined as “domestic, laundry, shopping and errands, meal preparation and clean up, accompaniment to medical appointments and alternative resources sites, heavy cleaning, yard hazard abatement and snow removal.” These cases would not be included in PCSP.

Consumers who needed protective supervision and personal care services would have their cases split for funding purposes. Personal care, paramedical services, and ancillary services would be paid for with PCSP funds. Protective supervision services would be funded with IHSS residual program funds.

As the PCSP program has grown, it has become increasingly aligned with MediCal (Medicaid) rules, which are governed by CDHS. At the same time, CDSS has been developing policy in other areas of the PCSP program. The net effect of two state agencies promulgating regulations for a single program is confusion among county administrators of PCSP and inconsistency in how PCSP is implemented by the counties. Increased communication between CDSS and DHS will be key to improving implementation of PCSP.

Additional changes have been made to the PCSP program since its creation in 1993 such as the requirement for nurses and medical forms has been lifted. In addition, many income eligible consumers were made PCSP eligible in April 1998. In January 2001, the IHSS program was adapted to include the Aged and Disabled, Federal Poverty Level program. This effectively lowered the share of cost that a participant must pay by raising the level to the A&D FPL.

## ***VI. A SYNTHESIS OF IHSS STUDIES AND REPORTS***

Numerous reports have been written in the last 25 years on various aspects of the IHSS program. Some are research studies and others are policy papers, but all of the reports have implications for the IHSS program. The authors of this report reviewed many reports on IHSS and synthesized the most significant findings and recommendations into several topical areas as presented below.

### ***IHSS IN THE LONG TERM CARE SYSTEM***

The LTC system in California is comprised of a myriad of agencies and organizations that provide services, in many cases, to the same consumers as described above. With IHSS as the core of the LTC system, there are an increasing number of stakeholders with an interest in its organization and administration. Because the changes in the LTC system have occurred in the absence of an overarching plan, IHSS administrative staff is experiencing the burdening effects of multiple layers of state and agency regulations. The authors of this report are in agreement with several reports that have suggested that successful coordination and/or consolidation of services in California’s LTC are necessary,<sup>ix,x</sup> and will result in:

- Cost-effectiveness and savings;
- Improved access and service match for consumers;
- More flexible, appropriate, and tailored services;

- Improved health outcomes for consumers;
- Improved consumer tracking; and
- Improved information on characteristics and outcomes of users.

Such coordination and/or consolidation with IHSS stakeholders will require CDSS to revise the IHSS regulations to ensure that they are compatible with current law and are as efficient and effective as possible (see page 24). A report from the California Center for Long Term Care suggests that the State should promote sharing of service authorization privileges among state agencies and develop a universal release of personal/case information form. CWDA recommends that CDSS, DHS, and CDA should coordinate responsibilities and oversight vis-à-vis client overlap.

***CWDA Recommendation:***  
**The California Departments of Social Services, Health Services, Developmental Services, and Aging should coordinate responsibilities and oversight vis-à-vis client overlap.**

The Center’s report also states that, in order to reach the goal of an integrated, effective LTC system, CDSS must develop performance targets and standards to guide expectations. Lack of coordination at the state level is also evidenced by California’s dearth of preventive care for people in the LTC system, as evidenced by under-funding of IHSS and APS.<sup>xi</sup>

The California Health and Human Services Agency’s Long Term Care Council workgroup has developed recommendations that support and expand the concept of collaboration among agencies in the LTC system. One of their recommendations is that by agencies explore creating a shared client information database to expedite referrals for clients and reduce needless duplication of effort.

***IMPLEMENTATION OF EMPLOYER OF RECORD***

A report from the State Auditor in 1999 expressed concerns around the lack of regulatory guidance from the State in implementing AB 1682 (described in Section V above), which has resulted in inconsistencies across counties. For example the study found differences in the way counties conduct criminal background checks and in how much training they provide to IHSS caregivers.<sup>xiii</sup> The Auditor’s report recommends that the State take a more active role in monitoring and evaluating the implementation of AB 1682. Specifically:

- The State should work with local entities to develop performance standards;
- The State should implement a system to gather and evaluate data that measures the performance of public authorities and other employers of records and caregivers;
- The State should better define IHSS program functions to improve their consistency and effectiveness;
- The State should be required to report to the Legislature on the operational and fiscal impact of recently enacted legislation to see if it has improved the IHSS program;
- Local entities should develop and implement procedures to ensure accurate recording of performance data; and

- The Legislature should further clarify W&I Code 12305.25 to provide counties with the guidance needed to ensure compliance with the legislation.

Since the Auditors' report was written, the State has begun implementing many of the recommendations. However, the CDSS Adult Programs Branch reported to the Legislature that as of June 2000, only eight of 58 counties had established public authorities and only seven of these had met the statutory requirements to operate a registry.<sup>xiii</sup> Seven of the eight were either providing or in the process of providing benefits to caregivers. Despite some of the difficulties with implementation, this report noted that the public authorities have been able to supply services above and beyond what counties have traditionally offered IHSS caregivers and consumers including:

- Improved and expanded caregiver registry and referral system;
- Caregiver and consumer training;
- Active caregiver recruitment; and
- Detailed screening process for new caregivers.

The study of the effects of unionization among IHSS workers in San Francisco County also found positive impacts for both consumers and caregivers.<sup>xiv</sup> Moreover, the CDSS report to the Legislature reported that public authorities have been able to track and improve the quality of care to consumers by prioritizing high-risk consumers, tracking abuse by caregivers, tracking consumer complaints and resolution, and providing medical and dental benefits for caregivers. However, CDSS acknowledged that more monitoring of implementation of AB 1682 is needed and will explore ways in which the CMIPS system might be expanded to accommodate the operational needs of public authorities.

### ***QUALITY OF CARE***

A number of factors affect the quality of care received by IHSS consumers including the mode of service provision (e.g., independent caregiver mode, contractor mode, or homemaker mode), the IHSS caregiver's qualifications and job satisfaction, and how accurately the social worker's assessment of the consumer's need comports with the consumer's actual supportive service needs.

A study conducted by researchers at the School of Public Policy and Social Research at UCLA compared the effect of the "Client Directed Mode" (CDM), which is akin to the individual provider mode, to the "Professional Agency Model" (PAM), which is akin to the contractor/homemaker modes of service provision (where consumers must select caregivers from a given pool) and found that consumers are satisfied with both models but prefer the client-directed model.<sup>xv</sup> The study also concluded that CDM consumers depended on non-program resources, specifically family and friends, to fill in the gaps in program services. The authors noted that, with the exception of counties offering supportive services through programs such as the Supported Independent Provider (SIP) program<sup>3</sup>, IHSS offers little to no

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<sup>3</sup> The SIP program funded IHSS service enhancements such as direct emergency services, preliminary employment screening, conflict resolution, and training to caregivers.

help to CDM consumers. The report concluded that public resources should be made available to assist and support CDM consumers who must arrange and direct their own services or contract with organizations that provide services to fill-in the gaps. This last finding is corroborated by a study from the Little Hoover Commission, which found that quality of care is affected by IHSS relying on disabled consumers to manage their own care.<sup>xvi</sup>

It is interesting to note that counties that employ the homemaker mode of service delivery have the lowest rates of consumer participation in the IHSS program. Counties that employ the individual provider and contract modes of service delivery have roughly equivalent rates of consumer participation in the IHSS program. Rates of participation in the IHSS program are the highest in counties that utilize the individual provider mode of service delivery with the Supported Independent Provider (SIP) model.<sup>xvii</sup>

Consumers appear to value family members more as paid caregivers and feel a heightened sense of security, choice, and interpersonal comfort, while caregivers who are family members have a more mixed experience. Approximately one-third of IHSS caregivers that are family members have a second job and often make emotional as well as career sacrifices. Caregivers in each model find different advantages, with independent caregivers identifying more opportunities for personal satisfaction in their work and relationships with consumers, while agency-employed workers noted feeling insulated from the pressures of their IHSS work.

The Little Hoover Commission study referenced above also found that quality of care is affected by IHSS caregivers' low wages, the transient nature of IHSS caregivers, and lack of standards and training for IHSS caregivers. The Commission's report expressed enthusiasm for the goal of organizing IHSS caregivers for the purpose of collective bargaining (AB 1682 had not yet passed) as a way to remedy these problems but cautioned that benefits to consumers would be negatively affected if the State did not provide enough funding to fully implement the law, a current concern of CWDA.

The Commission's review of the program in 1991 also concluded that limited funding and inherent structural flaws prevented IHSS from providing effective services. The key problems noted in 1991 included: the fragmentation of responsibility, with all levels of government trying to escape the burden of being the employer of caregivers; the prevalence of relying on the disabled consumer to manage his/her own care; and the low quality of care stemming from many factors, including the lack of standards and training for workers, who are often low paid and transient. The Commission subsequently noted in 1996 that none of these problems were resolved.

Quality of care can also be affected by how consistently IHSS social workers assess consumer supportive service needs. A study by the Institute for Social Research at California State University Sacramento addressed the question of reliability, validity, and variability in California's IHSS assessment and authorization practices. The study compared variation in IHSS functional assessments and authorized hours and the reliability and validity of the state's uniform assessment tool, which is used to establish the level of need for IHSS.<sup>xviii</sup> The findings suggest the state needs to promote greater consistency in the

**CWDA Recommendation:**  
CDSS create a training program for IHSS social workers to standardize use of the IHSS assessment tool.

application of what was found to be a very good instrument. CWDA recommends that CDSS create a training program for IHSS social workers to standardize use of the IHSS assessment tool.

CWDA also recognizes that CDSS' lack of updated regulations in the wake of years of program changes has contributed to inconsistent use of the assessment tool, as well as other problems. Quality of care is not the only casualty of inconsistent application of a fundamentally good assessment tool. The integrity of the IHSS program is also jeopardized when social workers do not clearly understand how to apply the findings of their assessment to, for example, consumer eligibility criteria that allow IHSS services *only* for consumers whose health and safety would be threatened without services. The misappropriation by social workers of service hours to consumers who are in actuality able to care for themselves (but may *choose* not to) is a waste of scarce program resources. To address this problem, CWDA recommends that CDSS, in conjunction with CWDA and IHSS stakeholders, should complete revision of the IHSS regulations. In addition, CDSS should train IHSS staff in the revised regulations.

**CWDA Recommendation:**  
CDSS, in conjunction with CWDA and IHSS stakeholders, must complete revision of the IHSS regulations. In addition, CDSS should provide training to IHSS staff in the revised regulations.

A demonstration project in Tulare County looked at the effects of a managed care model of IHSS administration on consumer quality of care. An evaluation of this demonstration project concluded that in-home supportive services provided in a private, managed care environment resulted in less efficient service provision, services being provided to the least needy consumers, and a dramatically higher cost per case and per hour of service. At the same time, there was no improvement in the quality of care provided in comparison to other counties without a managed care administrative structure.<sup>xix</sup>

## **VII. KEY ELEMENTS FOR IMPROVING THE QUALITY OF CARE IN IHSS**

Over the past three decades of operation, IHSS has successfully met the needs of its varied consumers effectively and efficiently. Beginning with basic domestic assistance for frail elderly consumers, IHSS now serves an ever-growing number of younger disabled adults, and older adults with physical impairments.

The central operating goal of IHSS has been to provide the support necessary to enable individuals to remain in their own homes and avoid, or delay, institutionalization. At the core of the program is a philosophy that recognizes the dignity of the consumer by acknowledging their right to self-determination (wherever possible), as evidenced in the Individual provider mode whereby the consumer can hire, supervise, and fire the caregiver of their choice. Throughout its' program history, IHSS has strived to be responsive to evolving consumer needs through service expansion.

As a universal program, IHSS serves a broad consumer base with differing needs in a myriad of situations. Consumer demographics show wide variations in authorized hours, functional index rankings, and alternative resources available. When considering future enhancements it is essential to identify those components that can be successfully incorporated into the existing scope of services, are not duplicative of other resources in the long-term care delivery system, and would benefit the largest number of consumers.

The current IHSS program continuum includes domestic and related services, personal care services, accompaniment to medical appointments and alternative resources, protective supervision, teaching and demonstration, and paramedical services. Prior to AB 1682, counties that implemented service enhancements such as providing direct emergency services, preliminary employment screening, conflict resolution, monitoring, training to caregivers, and development of a caregiver registry did so with funding through the Supported Independent Provider (SIP) program. According to a draft White Paper by the CWDA Adult Services Committee in 1998, the 23 counties that utilized the SIP program noted benefits for the consumer, caregiver, and social worker. These benefits included enabling the consumer to be independent while having support services as needed, improved employee relationships between caregiver and consumer, and a better understanding of the IHSS program and payroll process. SIP allowed social workers to more efficiently use their time to complete eligibility determinations and needs assessments.

The paper also found that SIP, in conjunction with the individual provider mode, could be more cost effective than a contract mode depending on the range of services offered. Although some counties have availed themselves of the opportunities provided through SIP, there are still many counties wishing to provide these additional support services to consumers but lack the dedicated state funding to do so. CWDA recommends that CDSS expand IHSS services that address quality of life issues raised by the IHSS consumer population such as those listed below:

***CWDA Recommendation:***  
**CDSS should Expand IHSS services that address quality of life issues raised by the IHSS consumer population.**

- Readers for the blind and interpreters for the deaf would provide consumers the ability to access information, either communicated in written or audio forms, that is inaccessible to these two groups. Such information may range from program brochures, applications, and forms, to materials that support participation on public committees.
- Money management assistance, by appropriately trained caregivers, would help in paying regular monthly bills, thus ensuring that rent and basic utilities are paid.
- Extra time should be allowed for consumer accompaniment on errands and general shopping because it offers consumers an opportunity to make their own basic consumer choices, and interact with others in the wider world.
- Transportation costs for out-of-county medical appointments should be added, especially for consumers in rural areas where the nearest urban center is often several counties away.
- Transportation costs for consumer errands should be added. Many consumers, who do not have private transportation, rely on their caregivers to absorb the transportation costs involved in running errands and shopping.
- Help with hiring and firing a caregiver should be available to all consumers, but especially the frail elderly, and individuals with impaired judgment and memory. Many IHSS consumers have never before been in the position of employer, and do not feel comfortable with the interview or dismissal process.
- Problem solving between consumers and caregivers is another way to support the consumer in their employer role. Problems can range from communication

issues, as simple as how to give directions regarding mopping the floor, to more serious matters such as theft.

- Limited emergency backup for caregivers can cover situations such as a caregiver not reporting for duty or an imminent discharge from the hospital. The most important aspect of this service is the peace of mind it can provide consumers.

Help with hiring and firing a caregiver, problem solving between consumer and caregiver, and limited emergency backup for caregivers have been implemented in some counties through SIP. These supports have proven to fit well within the scope of the IHSS program and have complemented implementation of the public authorities. Statewide utilization of these additional components would fill long-standing gaps in the service delivery system.

A small, but significant, portion of the IHSS consumer population has diagnoses of dementia or other mental impairments that make them more vulnerable to abuse and exploitation. Typically, but not exclusively, these are the frail elderly. In order for IHSS services to be effective with this population, additional in-home monitoring and hands-on assistance in problem solving is essential. Over the last ten years various reports and analyses of the IHSS program have recommended enhanced case management and greater utilization of the SIP model to provide such services.<sup>xx</sup>

One of the primary criticisms of the IHSS Program is the supposed inability, due to dementia or mental impairment, of some IHSS consumers to hire, supervise, and fire their caregivers. As reviewed earlier in this report, the IHSS consumer population has changed dramatically over the past ten years with a much higher percentage of younger disabled and older adults with physical impairments being served by the program. Consumer advocates vigorously assert, and protect, the consumer’s right to hire, supervise, and fire their caregivers. This concept should be strongly supported for those IHSS consumers who have the capacity to perform these functions; conversely, other measures should be undertaken on behalf of consumers who have mental limitations and need assistance.

A review of the statewide statistics on Functional Index Codes for Memory and Judgment shows the percentage of the IHSS population with these limitations is small. Case management activities can provide direct assistance to those consumers who need help in any of the employer-related activities of hiring, supervising, and firing caregivers.

Statewide Statistics for Memory and Judgment Functional Codes as of 4/30/2002		
Memory		
Value	Statewide Count	Percentage
1	187597	67.63%
2	76641	27.63%
5	13134	4.74%
<b>Total</b>	<b>277372</b>	<b>100.00%</b>
Judgment		
Value	Statewide Count	Percentage
1	212689	76.68%
2	49140	17.72%

5	15543	5.60%
<b>Total</b>	<b>277372</b>	<b>100.00%</b>

For these functional codes, consumers are only ranked as 1, 2, or 5. The values for these ranks are:

**Rank 1:** Independent. Able to perform function without human assistance though consumer may have difficulty. However, completion of the task with or without a device poses no risk to his/her safety.

**Rank 2:** Able to perform but needs verbal assistance such as reminding, guidance or encouragement.

**Rank 5:** Cannot perform function at all without human help.

Statewide Statistics for Protective Supervision as of 2/28/2002		
Protective Supervision		
	Statewide Count	Percentage
	12,104	4.22%
<b>Total</b>	<b>286,995</b>	<b>100%</b>

The program's most vulnerable consumers require frequent home visits and intensive monitoring of the care provided. CWDA strongly believes that regulatory flexibility is essential to address these special cases. CDSS should modify IHSS regulations to allow IHSS staff to conduct more in-home monitoring of quality of care. This could be accomplished, for example, by adding to the social worker assessment, frequency of home visits and need for IHSS support staff. Appropriate and adequate administrative funding would be required to meet the increased caseload, and insure the success of this concept. SIP programs, such as in San Bernardino and Mendocino counties, have been successful in adding trained support staff that assist social workers in providing the additional in-home monitoring, focusing on consumer safety and quality of care. The IHSS social work assessment could be expanded to include determination of a need for intensive in-home monitoring. This task could be provided by the social worker, nurse, or appropriately trained support staff. SIP programs also provide support on basic issues, such as clarification regarding tasks and hours, problem solving with consumers, and explaining IHSS regulations.

**CWDA Recommendation:**  
CDSS should modify IHSS regulations to allow IHSS staff to conduct more in-home monitoring of quality of care.

Program enhancements that support the development of a quality workforce within the IHSS program are necessary. Enhancements should include caregiver support groups, respite, and specific training. Caregiver support groups offer an opportunity to share experiences and solutions to common problems, while respite care services allow the caregiver time off for vacation or illness. Future enhancements could include the opportunity for caregivers to accrue paid vacation and sick leave.

To be effective, trainings need to go beyond simply providing a generic orientation to the IHSS program that explains time sheet procedures.<sup>xxi</sup> CDSS and CWDA in conjunction with the IHSS employers of record should create a best practice model for IHSS caregiver training. Trainings should be supported through incentives and/or stipends to IHSS caregivers. Training topics could include specific-disease care, meeting special dietary needs, how to care for minor children, and how to care for individuals with mental impairments. Other training topics are CPR, First Aid, lifting basics, transfer skills, personal care, nutrition, stress management, domestic services, universal precautions, and mandated reporter requirements. Future caregiver enhancements could include stipends to attend trainings, and variable salary levels that reflect the amount of training completed.

***CWDA Recommendation:***  
CDSS and CWDA in conjunction with the IHSS employers of record should create a best practice model for IHSS caregiver training. Trainings should be supported through incentives and/or stipends to IHSS caregivers.

The development of referral registries has been a great support to both caregivers and consumers. Registries provide employment assistance to caregivers and serve as an invaluable resource to consumers who do not have a relative or friend to provide the care they need. Because caregivers referred from a registry are generally unknown to the potential consumer, all due diligence should be given to determining the good character and health of a caregiver before placement. This can be accomplished through checking past work history supplied on an application, a criminal background check, checking at least three references (work and personal), drug screening, and tuberculosis clearance. Some counties also recommend the administration of a written test (grade six level) comprising of basic math computation and English comprehension. Future registry enhancements could include the development of a statewide database to track individuals with convictions of elder or dependent adult abuse or neglect, IHSS fraud, violent crimes against persons, and substantiated Adult Protective Services (APS) allegations. Another database could be developed to allow inter-county transfers of caregiver information at the same time of the consumer's transfer.

The diverse counties that make up California enjoy different resources and are challenged by different needs. IHSS services continue to vary from county to county, with some public authority and SIP programs initiating training programs and registries. Local control and county flexibility must be protected as the IHSS program continues to evolve. The enhanced services described above, through local direction, could be available to all consumers and caregivers in a statewide IHSS continuum of care.

### ***VIII. SPECIFIC POLICY AND PROGRAM RECOMMENDATIONS***

To address the complex issues challenging the IHSS program, the CWDA Adult Services Committee developed the following recommendations. They are derived from a thorough review of the literature on IHSS and from committee members' direct experience working in the IHSS program. The recommendations are categorized by topical area.

#### ***FUNDING***

The IHSS program is an entitlement program that mandates services to consumers of all ages. To meet this mandate, the IHSS program must be funded at a level equivalent to Child Welfare Services and other entitlement programs. Adequate funding for IHSS administration

in particular, which includes all costs associated with social worker staffing, must be addressed to ensure client access to services. Dramatic changes in demographics have put unjust and unreasonable fiscal pressure on counties and IHSS administrative costs have not had a true Cost of Living Adjustment in close to 30 years, when Title XX was implemented. To address this issue the authors of this report recommend the following:

- It is imperative CDSS work with CWDA in the immediate future to reevaluate the IHSS administrative funding formula. *(Page 12)*

County flexibility should be respected in regard to the implementation of AB 1682. Counties should not experience any negative impacts due to the employer of record structure they select. However, state inaction regarding financial assistance to counties in implementing the different employer of record options in AB 1682 has resulted in hardship to counties that do not select the public authority option. To address this issue, the authors of this report recommend:

- State financial participation levels in implementing the employer of record mandate must be consistent regardless of a county's employer of record structure. *(Page 17)*

The financial impacts to counties resulting from the employer of record mandate have been, and will continue to be, substantial. In addition, the aging population together with the impacts from the Olmstead Decision will continue to place financial pressures on the IHSS program. The authors of this report recommend the following:

- It is essential that CDSS and CWDA develop strategies to address cost controls that preserve the IHSS philosophy and protect the needs of consumers at risk of losing their independence. *(Page 17)*

All efforts must be made to maximize access to federal dollars within the IHSS program. There are a number of avenues to promote these efforts. For instance, many counties are unaware that they can, and should be, time-studying and charging expenses associated with the income-eligible PCSP program to MediCal. In addition, vulnerable consumer populations within the IHSS program do not have access to the maximum level of services available because federal Medicaid regulations exclude relatives from being paid caregivers through the PCSP program. To address these issues, the authors of this report make the following recommendations:

- It is critical that CDSS provide written instructions and training to counties to increase MediCal reimbursement for appropriate activities including the processing of income-eligible PCSP cases. *(Page 11)*
- CWDA and IHSS stakeholders must pursue legislation to revise Medicaid eligibility to include IHSS spouse and parent providers in PCSP. *(Page 11)*

### ***QUALITY OF CARE/PROGRAM INTEGRITY***

IHSS is a complex program to administer and has undergone substantial change over the past ten years, as described in this paper. Mechanisms must be put in place to address improving the quality of care to consumers through, for example, social work training and the

development of a more comprehensive social work assessment that incorporates more in-home monitoring of services. Enhancements in the scope of services available in the IHSS program that address consumers' unmet needs must also be addressed, but not until IHSS regulations for current services have been fully revised to address overlapping and duplicative mandates. To address these issues, the authors of this report make the following recommendation:

- CDSS in conjunction with CWDA and IHSS stakeholders, must complete revision of the IHSS regulations. In addition, CDSS should train IHSS staff in the revised regulations. *(Page 23)*

The current IHSS assessment tool is known to be effective. However, consistent application of the assessment tool is critical for program integrity. Currently there is no statewide training available to county staff in the application of the IHSS assessment tool. To address these issues, the committee makes the following recommendations:

- CDSS should create a training program for IHSS social workers to standardize use of the IHSS assessment tool. *(Page 22)*
- CDSS should modify IHSS regulations to allow IHSS staff to conduct more in-home monitoring of quality of care. This could be accomplished by, for example, adding to the social worker assessment frequency of home visits and use of IHSS support staff. *(Page 26)*
- CDSS should expand IHSS service activities that address quality of life issues raised by the IHSS consumer population. *(Page 24)*

Caregivers play an integral role in ensuring a high quality of care for IHSS consumers. Caregiver training is an integral part of the employer of record legislation. It has been proven that specific training that addresses the diversity and health care issues of consumers improves the quality of care for consumers. To address this issue, the authors make the following recommendations:

- CDSS and CWDA in conjunction with the IHSS employers of record should create a best practice model for IHSS caregiver training. *(Page 27)*
- CDSS should support incentives and/or stipends for IHSS caregivers to attend training. *(Page 27)*

Although the structure of IHSS program—which gives consumers control over the hiring, firing, and supervising of caregivers—is one of the program's unique strengths, this structure is also an area vulnerable to fraud, particularly in regard to the accounting of caregiver hours worked. To address this issue, the authors make the following recommendation:

- CDSS should create an IHSS fraud investigation unit and improve security measures within the payrolling system and reduce the social worker to consumer ratio to ensure program integrity. *(Page 10)*

### ***COORDINATION OF SERVICES***

At the state level there are multiple departments providing oversight to programs serving seniors and the disabled. This hampers counties' ability to locally integrate programs serving the same target populations and to fully implement the Olmstead Decision. To address this issue, the authors make the following recommendations:

- The California Departments of Social Services, Health Services, Developmental Services, and Aging should coordinate responsibilities and oversight vis-à-vis client overlap and codify them in a memorandum of understanding. *(Page 20)*
- CDSS should develop a formal structure for including IHSS stakeholders in the ongoing planning for the future of the IHSS program. *(Page 13)*

### ***CMIPS***

For the State and counties to meet the future challenges associated with program growth, such as interaction with employers of record and labor unions and increasing payroll responsibilities, it is imperative that the State develop a state-of-the-art information management system for IHSS. To address this issue, the committee makes the following recommendations:

- CDSS must provide financial and programmatic support for CMIPS at a level equal to that provided to similar state systems (CMS and SAWS) and should ensure that enhanced case management capability is included in any CMIPS upgrades. *(Page 10)*
- CDSS should fully fund CMIPS II implementation including infrastructure, hardware, and training to ensure statewide accessibility. *(Page 10)*

## ***ENDNOTES***

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<sup>i</sup> Strategic Planning Framework for an Aging Population. Andrew Scharlach, Fernando Torres-Gil, and Brian Kaskie, California Policy Research Center, 2001.

<sup>ii</sup> Ibid.

<sup>iii</sup> Ibid.

<sup>iv</sup> Ibid.

<sup>v</sup> *ibid.*

<sup>vi</sup> Sept 2001 and Oct 2001 Disability and Adult Programs Division IHSS Statewide Summary Report.

<sup>vii</sup> W & I Code 12306 (c)

<sup>viii</sup> The Impact of Unionization and the Living Wage Ordinance on IHSS Home Care Workers in San Francisco County. Candace Howes, Connecticut College, February 2001.

<sup>ix</sup> (History of Program, Service and System Development in California: Themes, Thoughts and Lessons Learned. California Center for Long Term Care Integration. A collaboration of University of Southern California and University of California, Los Angeles.

<sup>x</sup> Lack of a Planned, Integrated System of Services for the Elderly. California Auditor General, 1977.

<sup>xi</sup> Long Term Care: Providing Compassion Without Confusion. Little Hoover Commission, December 1996.

<sup>xii</sup> California State Audit Report, by the State Auditor/Controller, September 1999.

<sup>xiii</sup> Implementing Public Authorities and Non-Profit Consortia to Deliver In-Home Supportive Services. Summary of CCDSS Adult Programs Branch Report to the Legislature. July, 2001.

<sup>xiv</sup> The Impact of Unionization and the Living Wage Ordinance on the IHSS Home Care Workers in San Francisco County. Candace Howes, Connecticut College, February 2001.

<sup>xv</sup> Comparing Client-directed and Agency Models for Providing Supportive Services at Home. Benjamin, A.E. and Matthias, R.E. September 30, 1998.

<sup>xvi</sup> Long Term Care: Providing Compassion without Confusion. Little Hoover Commission, December 1996

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<sup>xvii</sup> California's IHSS Assessment and Authorization Practices: Their Reliability, Validity and Variability. Barnes, Carol Wolff, Institute for Social Research, California State University, Sacramento, 1994.

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<sup>xix</sup> Tulare County IHSS Demonstration Project: An Evaluation of Managed Care. Barnes, Carole, Institute for Social Research, California State University, Sacramento. August, 1995.

<sup>xx</sup> *The Little Hoover Commission Report 1991*

<sup>xxi</sup> *Context of Care, Provider Characteristics and Quality of Care in the IHSS Program: Implications for Provider Standards* Institute for Social Research, Carole Barnes and Sandie Sutherland. California State University, Sacramento. 1995.