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State of California

Little Hoover Commission

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UNSAFE IN THEIR OWN HOMES:

STATE PROGRAMS FAIL TO PROTECT ELDERLY FROM INDIGNITY, ABUSE AND NEGLECT

NOVEMBER 1991

cover

Commission on California State Government Organization & Economy

LITTLE HOOVER COMMISSION

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November 6, 1991

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The Honorable Pete Wilson
Governor of California

The Honorable David Roberti
President Pro Tempore of the Senate
and Members of the Senate

The Honorable Kenneth L. Maddy
Senate Minority Floor Leader

The Honorable Willie L. Brown Jr.
Speaker of the Assembly
and Members of the Assembly

The Honorable Bill Jones
Assembly Minority Floor Leader

Dear Governor and Members of the Legislature:

A man's home is his castle. But if the man or woman is an elderly Californian who needs assistance with the activities of daily living, that home may well turn into a trap of indignity, abuse and neglect. The Little Hoover Commission is dismayed to report that the State's efforts to help this vulnerable population may instead leave the frail elderly at the mercy of untrained, unreliable and even abusive care givers who are largely unmonitored by either the State or the counties.

In the past, the Little Hoover Commission has focused its energies on elderly citizens who, through ill health and unfortunate circumstances, have been forced to enter institutions to receive care and protection. In turning its attention to the frail elderly who are able to remain in their own homes despite disabilities, the Commission has found a flawed system that fails to meet the needs of too many senior citizens who have turned to the State for protection and care.

In one example brought to the attention of the Commission, a woman was hired to provide in-home services. No one reviewed her history of assault and battery, drunken driving, manic-depressive illness and frequent incarceration. The end result was a state prison sentence for a murder attempt on the elderly man she was supposed to be taking care of.

While not the norm, this kind of example unfortunately was not unique. Cases reviewed by the Commission frequently showed a lack of quality control and safeguards; these cases signal a program that leaves the elderly in distressful situations too often to be tolerated.

The flaws of a single state program, however, are not the Commission's only concerns. In addition, the Commission has found that the vast array of services that are supposed to provide a continuum of care for the elderly are not well-integrated and may be difficult to access since they are scattered among a variety of state departments. Finally, because of changes in the way the State handles budgeting for elder care programs, the Commission is concerned about the prospects for maintaining or improving senior services in the future.

Background

A little more than a year ago, the Commission began a series of studies on the elderly in California. Revisiting past topics of concern to review progress and pinpoint ongoing gaps in services, the Commission issued a report on residential care facilities in January 1991 and a report on skilled nursing facilities in March 1991. Rounding out the trilogy, the Commission chose to examine Elder Care At Home, an early step in the different levels of care that are available to the elderly.

In its August 1990 hearing, the Commission focused on In-Home Supportive Services, a program designed for those who are poor and in need of some level of assistance in order to continue living at home. Not only is such home care supposed to be more psychologically beneficial for the elderly, who thus can remain in familiar surroundings, but it is also supposed to provide a less costly level of care than if the person had to be institutionalized prematurely.

As the study progressed, the Commission became aware that other programs designed to help this same population, such as Adult Protective Services and the Area Agencies on Aging, were fragmented among various departments and limited in how many people could be served. Thus, in March 1991, the Commission held a second hearing devoted to the network of state programs for the elderly and the potential for better integrating these services. (Please see Appendix A for a complete list of witnesses at each hearing.)

As this report neared completion, the State's budget crisis led to a shift in funding for the programs under study and opened the door to changes in eligibility and service levels in the future. The Commission's concerns about this new approach to IHSS have been folded into the study.

On the basis of its examination, the Commission has reached four conclusions and formulated five recommendations, detailed in this letter report.

Findings

FINDING # 1: In-Home Supportive Services Has Inherent Structure And Funding Limitations That Prevent The Program From Working Well. The Result Is That Frail Elderly People Are Left At The Mercy Of Untrained Care Givers, May Be Preyed Upon By Criminals In Their Own Homes And May Be Subject To Abuse, Neglect And Indignity.

In-Home Supportive Services, commonly called IHSS, is the largest state program involving in-home care for the elderly.[a] Using a combination of State and federal funds, the program pays various types of care providers to meet the needs of those who can no longer live independently in their homes but who do not have complex enough problems to require institutionalization. Because of the way the program is structured and funded, however, it often fails to deliver appropriate care. Key concerns with the program are:

* The fragmentation of responsibility.
* The method of managing care.
* The quality of care delivered.
* The differences in modes of delivering care.

The end result of this mixture of problems is that many elderly may face abuse and fear in their own homes, or may fail to receive the help they need and are entitled to.

In the 1991-92 fiscal year, IHSS will serve about 170,000 persons who are aged, blind or disabled at a cost for direct services of about $731 million.[1] Roughly 65 percent of the recipients are 65 or older.[2] (Although the program also serves the blind and disabled, the Commission's study involved elder care only. Nonetheless, many of the program issues identified by the Commission that affect the elderly are also concerns for those with disabilities.)

Overseen by the California Department of Social Services (Department) and locally administered by county social services or welfare departments, the program is open to anyone whose income is low enough to qualify for the Supplemental Security Income/State Supplemental Program (roughly under $600 a month income for a single person) and who cannot live safely in their own home without assistance.[b]

The Department has described the IHSS program as having the nation's broadest range of services for the widest range of recipients with the most latitude for service providers (spouses and other relatives may be paid under the program). IHSS is an entitlement program, which means that anyone who fits the eligibility criteria has the right to services regardless of how much money has been allocated for the program. In past years, the program has overrun its budget and the Legislature has made additional allocations.[3]

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a Other programs that provide services to the elderly at home include: the Department of Aging's In-Home Services program and the Multiple Senior Services Program; the Department of Health Services' Medi-Cal programs for in-home care; and the Department of Rehabilitation's Independent Living Rehabilitation program.

b Approximately 11,500 persons who have excess income but who otherwise would qualify for IHSS participate in the program under a share-of-cost basis that allows them to "spend down" their resources until they are below the income limits.

So far, the State has approached cost containment by setting a limit on the number of hours of service that can be granted. When further cost containment has been proposed requiring recipients to be more disabled to qualify and/or eliminating many recipients whose spouses and other relatives are paid by the State as providers of care, the Legislature has refused to enact the restrictions.

The program may provide domestic services (housecleaning), heavy cleaning, non-medical personal services (meal preparation, feeding, bathing, etc.), essential transportation, yard hazard abatement, protective supervision, teaching of skills, and paramedical services.

Once an individual applies for IHSS, the program begins with an assessment by county social workers of the individual's capabilities and the degree of assistance that is needed for the person to remain safely at home. For instance, a person who can no longer cook or who has repeatedly started fires in the kitchen may be judged to need assistance with meals. On the other hand, someone who merely shows poor judgment by only eating junk food or allowing garbage and dishes to stack up may be found to not need assistance.

Since individual social workers in each of the State's 58 counties are in charge of assessing eligibility and level of need, the program is susceptible to being administered differently in different areas of the State. However, at the direction of the Legislature in 1987, the Department instituted a "Uniformity System," accompanied by intensive training, in an effort to ensure that recipients are treated the same if they have the same level of disability, regardless of where they live in the State.

The system, which seeks to make assessments objective rather than subjective, is based on rating the individual's abilities in 11 categories using a scale of values from one to six. Examples of the categories include housework, laundry, shopping, meal preparation, bathing and grooming, dressing, and bladder and bowel care. Possible scores range from a one (no help needed) to five (cannot perform at all without human help) and six (needs paramedical services).[4]

The Department believes the system has made a substantial difference in assessment equality. As will be discussed in more detail later, others maintain that assessments are influenced by factors that have little to do with an individual's needs. For instance, those who qualify for only a few hours of assistance may have more difficulty finding a care giver than someone who has been granted more hours. Conversely, fewer hours may be granted to someone using more expensive types of care givers.

Following assessment, the social worker uses a formula to compute how much assistance is needed for specific daily activities. The recipient is then authorized a certain number of hours per month of care. Those who are found to be "severely impaired" (needing more than 20 hours a week of personal care) can be allocated up to 283 hours a month (about nine and one-half hours a day), while the "non-severely impaired" are limited to 195 hours (about six and one-half hours a day).[5]

The State tracks information about those receiving IHSS services. The table on the next page details some selected characteristics.

SUMMARY OF IHSS RECIPIENT CHARACTERISTICS*
January through March 1991

Gender:

Male	50,625	30.2%
Female	117,170	69.8%
Total	167,795	100.0%

Age:

0-6	1,097	.7%
7-18	3,037	1.8%
19-44	21,010	12.5%
45-64	33,239	19.8%
65-79	63,252	37.7%
80 plus	46,179	27.5%
Total	167,814	100.0 %

Level of Impairment:

Non-Severe	132,902	79.9%
Severe	33,525	20.1%
Total	166,427	100.0%

Spouse/Parent Aid:**

None	131,917	79.2%
Spouse Able/Available	5,997	3.6%
Spouse Able/Part Avail	890	.5%
Spouse Able/Not Avail	249	.1%
Spouse Not Able/Avail	2,825	1.7%
Spouse IHSS Recipient	20,733	12.4%
Parent--All Services	2,380	1.4%
Parent--Some Services	997	.6%
Parent--No Services	130	.1%
Parent--IHSS Recipient	349	.2%
Total	166,467	100.0%

Care delivery mode:

Independent Provider	152,593	90.9%
Contract Care	14,021	8.4%
County Homemaker	766	.4%
Mixed	442	.3%
Total	167,822	100.0%

Source: "In-Home Supportive Services in California: Quarterly Statistical Report, January-March 1991," California Department of Social Services

* The California Department of Social Services indicates that the total for each characteristic category is not the same because of missing data elements in individual cases that are tracked at the county level. This is why, for instance, the total number of cases by gender (167,795) is not the same as the total number of cases by age (167,814). In addition, percentage totals may not add up to 100 percent because of rounding off.

** This category indicates what resources (either a spouse or parent) other than IHSS are available to provide help to the recipient in his or her own home and is broken down to indicate how much help is available.

As the table indicates, the program serves far more women than men (117,170 vs. 50,625), and those who are elderly make up the bulk of recipients (109,431 or 65.2 percent are age 65 or older). The breakdown of elderly and disabled recipients by available household help shows that 131,917 had neither parents nor spouse to attend their needs, while another 21,082 had either a spouse or parent that was also an IHSS recipient. This indicates that almost 92 percent of the recipients simply have no close relative in their own home who can attend to their needs.

In addition, the table indicates that the bulk of people on the program do not have a need for extensive services. Only about 20 percent (33,525) are severely impaired and therefore eligible for a greater number of hours. Moreover, other information from the Department of Social Services shows that only 3,674 were allocated the full monthly maximum hours of services.

The Department's statistical report also shows the most heavily provided services during January through March 1991:[6] 92 percent of the cases received domestic help (housecleaning, which is capped at 6 hours per month), 89 percent were helped with laundry and mending, 83 percent had their shopping done, 81 percent could send workers on errands, and 77 percent had their meals prepared. Of the more personal services offered under IHSS, 69 percent of the cases were helped with bathing, 52 percent with dressing, 34 percent with walking and 32 percent with bowel and bladder functions.

Of course, statistical reports may only tell what is occurring on the surface of a program. A more human face is brought into the picture when recipients tell of their experiences. One woman wrote to the Commission:

> *My husband and I are both disabled and dependent on in-home care. We are in our 70s. He has cancer and vertigo and shakes a lot and falls from dizzy spells. I am in the late stages of a rare form of muscular dystrophy. I'm dependent on someone 24 hours a day: I can't bathe myself, I need a bedpan or diaper, and I'm too weak to do any cooking...*
>
> *The in-home care workers are just off the street. They have no training to care for the frail or disabled, or to handle bed-baths, bedpans or other personal problems we might have. They don't even know first aid.*
>
> *Because they are just off the street and they aren't screened good enough, some steal from you. We've lost money and a $50 camera. Most are uncaring, lazy and careless. One drank on the job. They sleep on the job. Some have mental problems that you don't find out about until they are in your home. All are clock watchers. They are just putting in hours.*
>
> *In two years, we have never found one that did a good job...*
>
> *Right now, I'm looking for a new worker, and I'm scared of who will show up and want to share my home and time. Will she be a drinker, on drugs, or maybe a mental case? Or have a boyfriend on drugs who knows everything you own, knows you are old, frail and alone? How safe would you feel looking for a new worker to share your home?*
>
> *I'm grateful for all the help I have gotten in the past. We couldn't have made it at home without it. But now I'd like to find just one caring, reliable, honest in-home care worker -- one who would take good care of me because she cared, not just for the money.*[7]

Another woman told the Commission that in-home care workers neglected to change her sheets and failed to adequately clean up after meals, instead putting dirty dishes away on shelves.[8] Others say they put up with being cheated on the hours they are supposed to receive for fear they will end up with no care provider at all if they refuse to sign fraudulent time cards.

State officials believe such problems are not widespread and they point to surveys that indicate recipient satisfaction. Others charge that such surveys are flawed because people are afraid their hours will be cut back if they complain. Although it is difficult to accurately assess how many IHSS recipients are plagued with problems, no one involved with the program denies that there are flaws with IHSS that could and should be avoided.

Fragmentation of responsibility: The program's problems begin with the fragmentation of responsibility and authority. The State funds, sets standards and oversees, in a general sense, the operation of IHSS. The counties administer the program, screening people for eligibility, providing ongoing assessments and, to varying degrees, acting as case managers. The recipient is responsible for employing and supervising the care providers.

The fragmentation allows the State to deny responsibility for problems that occur when care providers are unreliable or abusive. Counties, in turn, maintain that the responsibility is not theirs and that the State neither provides enough funds nor requires counties to provide adequate oversight. If IHSS recipients have problems with their care providers, they may receive little or no help from their county social worker. If their problem is with an assessment or ruling at the county level, they face a State administrative law judge appeal process that is hardly "user friendly." One woman wrote to the Commission about her frustration:

> *Written information, such as brochures or pamphlets that generally describe the IHSS program's policies and procedures, should be provided to each recipient and care provider at the time of program enrollment. If such information is available, I have never seen nor received it in our five years of enrollment. I have requested both general and specific written explanations of IHSS regulations and county decisions from my county social worker and other IHSS administrators.*
>
> *When I filed for a State hearing on the IHSS hourly allotment, I obtained a copy of regulations through the office of my county supervisor. This is the only written data about the IHSS program I have been able to acquire, and it took me five years and a hearing to get it. This reflects the absence of a solid organizational structure for the IHSS program....*
>
> *Since written program information either does not exist or is not made available to IHSS recipients, greater reliance is placed upon county social service workers to obtain answers to questions about the program. Based upon my experience and the experiences of other IHSS participants as described to me, the county personnel typically do not follow up on telephone messages nor on direct requests for information....The county personnel whom I have encountered can be described as: incompetent, disorganized, unaware, vague, contradictory, insensitive, non-compassionate, non-disclosing and out of touch with their clients' needs....*
>
> *Instructions for requesting a State hearing are printed on the back of the Notice of Action form. This is the only written information about the hearing process offered to recipients by the county or State....As a result of my research and communication skills, I was able to develop our case and present it at our hearings. However, few care providers are likely to possess these abilities, nor should they need to if the process were defined clearly and assistance provided easily and readily to them.*
>
> *During this process, the authoritative attitude I encountered from county and State IHSS personnel probably would intimidate most persons, discouraging them from continuing with their hearing requests. This further hinders the equitable distribution of IHSS resources by keeping silent those who are in need.*
>
> *The waste of tax dollars as a result of administrative inefficiency and program mismanagement must not be discounted in a study of IHSS. Thousands of dollars were squandered needlessly in our IHSS case.*[9]

The State may believe it is fulfilling its responsibilities and the counties may feel they are doing their share. But from the recipients' perspective, because there is little centralized accountability and leadership, the program often appears uncoordinated, unresponsive and unreliable.

Management of care: For the preponderance of IHSS cases, it is the recipients themselves who actually manage the services they receive. The irony of this cannot be overemphasized. Individuals who have been assessed and found to need assistance just to get by with their daily living activities are, nonetheless, expected to recruit, interview, hire, supervise, train and, if necessary, fire the workers who provide care to them.

County social workers who testified at a Commission hearing indicated they assist the recipients as much as their case loads allow them to. But social workers, who estimate that 15 to 20 percent of the cases need some kind of ongoing management, feel there is little they can do. A Southern California social worker said:

> *We try to help them understand their role as an employer, that the care providers work for them and that they have the right to hire and fire. Some of us get more involved then we can afford to, talking to doctors, family members and others. But caseloads are doubling and more. It's a lot of stress for the social worker because he knows he can't really help the client and that he isn't really servicing the client adequately.*[10]

The crunch of cases for social workers is partially related to growth in the IHSS program, which has seen recipients increase more than 50 percent in the past decade. But the more critical element has been the static amount of funding coming from the State to counties for administration of the program.

The funding picture is complicated. Historically, IHSS services have been funded 50 percent by the federal government, 49 percent by the State and 1 percent by counties. (As will be discussed in Finding 3, this formula was changed substantially when the 1991-92 budget was adopted; the counties share of service costs will now be 35 percent.) Because the federal funding that goes into IHSS has been capped, any additional expenditures--whether for higher pay for care providers or more services to more seniors--would have to come out of the State's General Fund. The State's overall, annual fiscal problems have applied steady pressure on administrators and policy makers to place limitations on IHSS to keep costs from eating into the General Fund any further.

IHSS funds are broken down into two pools of money. The first, about $731 million in 1991-92, directly supplies the services. The second pool of money, about $93 million in 1991-92, is a block grant that is supposed to cover the administration of all adult services: Adult Protective Services, In-Home Supportive Services and Information and Referral Programs.[11] The State allocates money to counties and requires matching funds from the counties based on the number of projected cases and the resulting number of caseworkers that are needed to handle that many cases.

A problem, however, lies in the reimbursement rate for the cost of the social workers. Since fiscal year 1984-85, the State has kept the figure it uses to calculate the cost of IHSS social workers steady at $49,400 (this so-called "fully loaded" figure includes salary, benefits, administration and overhead for one caseworker). Counties argue that had the figure been adjusted for inflation and rising costs each year, it would be closer to $75,000 by now, a figure that is comparable to that used by the State for a "fully loaded" children's services caseworker.[12]

Thus, counties feel that each year's budget has granted them less and less money, after adjusting for inflation, to provide adult services.

With the freedom to divide the block grant in any way they wish among the adult services programs, counties have chosen a variety of methods to make ends meet. Some have subsidized the administration of adult services with local funds. In 1986-87, the statewide block grant was about $100 million, with counties adding an additional $19 million.[13]

Other counties have forced social workers to handle increasingly larger caseloads for the In-Home Supportive Services program. For instance, while the state standards call for a caseworker to handle 126 new and ongoing cases, Los Angeles County has workers handling between 350 and 400 cases, Nevada County has 352 cases per social worker and Kings County's sole worker handles 690 cases. In Alameda County, the caseload is kept at 140 cases, according to social workers, by having 3,000 cases that "float" with no worker assigned to them except when an emergency arises.[14]

The concept that each case will be reviewed whenever conditions change and that the social worker will be available to help the IHSS participant who is having problems becomes little more than a pretense when the caseload mounts to these levels.

Such high caseloads leave management of the services to the recipient. The frail recipients are told how many hours of care they are eligible for but are left to advertise for, screen, hire, train, supervise and/or fire their own workers.

In some counties, registries of workers are offered to IHSS recipients. Unfortunately, in many cases the lists are not current, showing people no longer available, or do not reflect the status of workers who already have full schedules. But there are worse problems with some registries. A February 3, 1991 *Sacramento Bee* article revealed that of 630 people on Sacramento County's list of potential chore workers, 16 had prior convictions for petty theft, 10 for possession of drugs for sale, seven for possession of drugs, five for burglary, three for assault with a deadly weapon and three for robbery. One woman on the list is actually in prison serving a four-year term. In sentencing another on the list, a judge said the woman was "an incorrigible thief. What I see is someone who has stolen from innocent people. Time and time again, she has stolen from innocent people."[15]

Although counties warn recipients that they do not screen the lists, program participants understandably may feel there is some implied "approval" of registry workers. But those who have problems with their workers may expect little help from the same county bureaucracy that gave them the worker to start with. A Sacramento County official told the Bee, "I feel horrible that people with those kinds of backgrounds are providing service to vulnerable, frail elderly and disabled people. But one of the positive things about the program is that clients are allowed to hire whomever they want. We don't have the right to do it and we don't have the money."[16]

Unfortunately, the task of managing an employee is beyond the capabilities of some recipients and is a drain on energy and health for many others. In addition, it may be difficult for the recipient to get rid of those who provide inadequate care, particularly if the recipient is fearful and feels powerless. Testifying to the Commission, a representative for Southern California Presbyterian Homes told how that organization tries to bridge the management gap:

> *He/she may not be able to find a worker; may not know how to deal with the system; and he/she must do his or her own monitoring. By the time everything is finally in place, the resident is desperate and discouraged....*

Many of our residents have not had in-home help before. They are not always sure what to tell a worker to do. Sometimes the resident even has some fear of the worker because of difficulty in communication. My staff often sits with the resident and worker to go over what needs to be done so that the worker knows we will be checking.

Even when there are problems, the resident will hesitate to resolve them, also hesitates to call for help in resolution, because of fear that he or she will end up without any help.[17]

The lack of rational, professional day-to-day management of the care provided to recipients is a key flaw in the IHSS program that allows many of the problems that are discussed in the next section to occur.

Quality of care: One of the major concerns expressed by many IHSS recipients is that the quality of service is poor. Workers are neither trained nor educated to handle the needs of a geriatric population. Recipients also complain that many workers are lazy, unreliable or dishonest. Some say the workers do not know first aid, while others say even simple chores, like sweeping a floor or washing dishes, need to be explained. Such complaints lead to the question of whether the State is getting its money's worth in terms of care that IHSS is supposed to provide.

Those connected with the program believe most of the quality problems stem from the unattractive nature of the care provider jobs. The pay offered is low and benefits non-existent, leading to low incentive and high turnover. Individual care providers are paid $4.25 an hour. (The cost to the State, which pays the Social Security contribution and unemployment insurance costs normally paid by an employer, brings the total hourly amount to $4.79.)[18]

This low wage compares unfavorably with the "careers" enjoyed by the average hamburger flipper at a fast-food restaurant ($5/hour) or a housekeeper working for a service ($6/hour), jobs that typically include some level of benefits and hold at least a hint of possible upward mobility. State officials have indicated, however, that because of the size of the IHSS program, each raise of the hourly rate by one penny would cost the State an additional $1 million. Increasing the pay of workers could come only at the expense of paring back the hours granted to IHSS recipients or foreclosing the program entirely to some group of recipients, officials say.[19]

But critics of the program believe the State does more than underpay the workers. They believe that federal requirements for minimum worker conditions are routinely skirted because the workers are employed neither by the State nor the counties. One person told the Commission during its August 30, 1990, hearing that other states, including Washington and Wisconsin, are moving away from such systems because of federal labor law problems.

In California, while the State processes the paychecks for care providers and covers costs normally contributed by an employer, the State has carefully distanced itself from being the employer of record. Unions that would like to deal directly with the State to bargain for higher wages, vacations, and other benefits have argued that the State is sidestepping its responsibility so that it need not pay for travel time between jobs, overtime and other items that the unions believe are federally mandated. The representative of one union wrote the following to the Commission:

We're paying low income, largely minority women barely minimum wages with no benefits and no job protection. Because of the legal charade maintained about each client/recipient being the employer, instead of the government, the workers are denied the opportunity to be represented by a collective bargaining agent, which would provide them the chance to advance economically. There is no training, supervision or screening of employees, no substitutes provided when a worker doesn't show up, and complaints of worker and client abuse proliferate.

(These workers) cannot even make a simple home appliance purchase on credit because when they list the county as their employer, the county denies it and refers the creditor to the frail, elderly, sick client for the employment/credit reference. This is absolutely ridiculous and completely humiliating.[20]

Even if low pay and lack of benefits were not enough to discourage a quality pool of workers, other system failures also work against the provision of quality care. No criminal background checks of potential workers are required or conducted. This can lead to abusive situations. Wrote one IHSS participant:

Care providers simply cannot be found for the minimum wage (with no benefits). When care providers are hired for less than the prevailing private sector wage, the disabled recipient is often the helpless victim of theft and abuse.[21]

Statistics noted by the *Sacramento Bee* about the Sacramento County registry of workers are detailed in the previous section, but they are not isolated. When Santa Clara County was given funding for a pilot program in 1988 and 1989, 10.7 percent of the 294 people fingerprinted were found to have criminal records.[22]

In a letter to the Commission, the Inyo-Mono Ombudsman/Advocacy Services wrote:

In this area, when in-home services are suggested, many elderly will do without rather than use this service because of the stories they have heard from friends who have been victimized by in-home services help or their own fear of the unknown....The frail senior is easily intimidated due to their frail condition and are afraid to confront anyone if there is a chance of retaliation.

In speaking with two adult probation officers in Inyo County, I was told the following information: Of the 30 or so people on a list given out by the Inyo County Social Services Department to do in-home services, five or six of these people are on probation for substance abuse. Other people on the list may be on probation for theft, forgery, child abuse, spousal abuse or other reasons....

Another example from the probation department was a female who presented as a quiet, docile person. She was hired to do in-home services. This person had a history of assault/battery on a child, drunk driving and a Mental Health Department determination of manic-depressive. This person had served a lot of jail time for assaultive behavior. The end result of this was a state prison sentence for a murder attempt on an elderly man she was providing care for.

In another case, an In-Home Supportive Services worker was hired. The senior was asked if the [worker's] grandchildren could come along when the worker was doing work. The senior thought it would be good to have children around and agreed. Other family members started to come also and would stay the day, taking

over the senior's home. The worker would then feed all of the family members at the senior's home, would place the senior in bed so the senior would not bother the family members when watching TV or other activities. The senior finally, with the assistance of friends and neighbors, had this person removed from their home, but was so fearful of a repeat of this scene that they went to a board and care facility.

For the career criminal, it is common knowledge that the elderly "rat-hole" money and valuables as security for rainy days. There are in-home service workers that prey on this situation and the elderly are not inclined to report for fear that this will affect their Medicare or Medi-Cal status....There certainly are some very responsible and wonderful in-home workers, but an effort must be made to either have a more effective screening process for seniors to follow when hiring or to allow more cross-reporting of agencies to protect this frail segment of our society.[23]

In a less anecdotal vein, a 1987 Auditor General report found that almost 7 percent (709) of the care givers in three counties had previous criminal convictions.[24] Concluding that the health, safety and welfare of the elderly may have been endangered, the Auditor General said that it would cost the State $1.2 million initially to screen IHSS care providers and $200,000 annually thereafter. In recent years, legislation to provide such screening has been vetoed because of the State's fiscal problems.

Finally, quality of care is undermined by the lack of training programs or standards. Workers need know nothing more to become care providers than how to find their way to the recipient's house and how to fill out a time card. The State has refused to set such standards, citing higher costs; the counties have clearly indicated it is not their responsibility. The recipient, the manager of last resort, often is so desperate to get "someone, anyone" that training becomes a nicety that falls by the wayside.

Thus, when it comes to the question of quality of care, IHSS does not appear to provide Cadillac care or even Volkswagen care. For many recipients, the program sputters along like an antiquated junker that may not make it to the next service station.

Mode of care: A pivotal issue in the IHSS program is the difference between the two primary methods of delivering care to recipients: Independent Providers and Contract Care agencies. On the surface, one mode appears to be cheaper--thereby allowing limited dollars to provide more services to more people--and allows for greater personal choice and flexibility in who provides care. The other appears to be more expensive but holds greater promise for accountability and quality control.

Under IHSS, care can come from Individual Providers (IPs), who make less than $5 an hour, Contract Care agencies, which charge around $9 an hour, or county employees under county "Homemaker" programs, where costs run between $30 and $40 an hour. (This last category is used almost entirely in emergency situations and is never a long-term arrangement. Thus, it is not considered a primary mode of care.) Services to about 91 percent of the recipients are delivered by IPs found and hired directly by the recipient. Since 40 percent of all recipients use relatives as care providers, a large component of IP service is family care givers.[25]

All of the problems detailed in the sections above--forcing frail recipients to act as employers and problems with accountability, training and reliability--are hallmarks of the Individual Provider mode as it functions in IHSS today because there is no centralized authority in charge of the workers and no responsible party to complain to when problems occur. Advocates for the elderly and disabled and state officials connected with IHSS feel, however, that the Individual

Provider mode is a vital element of the IHSS program, providing recipients with the maximum freedom of choice in who will take care of their personal needs. They particularly point to the ability of recipients to choose their own relatives as care givers.

The fact that IHSS will pay relatives to care for family members draws criticisms from some. Their question: For recipients who need only a few hours a week for chores or grocery shopping to allow them to remain home, should it be society's role to subsidize relatives who perform services that many other committed families do routinely and without government intervention?

Conversely, for severely disabled recipients whose family members give up their own lives to provide care, supporters of family care providers argue it is a proper role for society to support these people with a stipend. One woman told Commission staff that her grown, disabled son would be a far more costly burden to the State if she had not quit her job and stayed home with him 24 hours a day. The IHSS check allows her to meet mortgage payments and put food on the table. Another wrote:

> *To provide care for one recipient in a home, an IHSS care provider does the work of 20 institutional employees at a maximum annual salary of $14,000....IHSS parent care providers are not legally allowed to have Social Security withheld from our pay, nor do we receive any insurance or pension benefits. What if: We become ill? Our children die, which concludes our jobs as care givers? We outlive our children but we have no way of supporting ourselves?*
>
> *The posture of the IHSS regulations and administrators toward parents, spouses or family members as IHSS care providers is that we should volunteer to be care providers, that we should be willing to sacrifice our health, well-being and lives to be care providers, and that we should be grateful for any dime our government generously hands out to us to do this care providing.*
>
> *The facts are: We have tried to hold down a full-time job and care for our disabled family member, and it is an impossible life for any length of time; even with full 283-hour a month reimbursement, we are volunteering the rest of those hours; our purpose is to sustain the lives of our family members through a healthy, happy, loving home life.*
>
> *The facts are: If we get ill, we have no health insurance; and when we get old, we will have no pension or Social Security to draw upon after all our years of dedicated work.*[26]

In the case of relatives of severely impaired IHSS recipients, it is difficult to conclude that anyone is getting rich off this government program. These relatives may quit their jobs and stay home to provide round-the-clock care while receiving only a minimum wage for a small portion of the hours they actually put in.

But not all relatives who work for IHSS recipients are in this same selfless, sacrificing category. Statewide statistics reflect the fact that elder abuse is typically committed by family members rather than outsiders. And many believe that IHSS recipients are even less likely to complain to officials about shorted hours, poor quality of care and other problems when the provider is a relative. Thus, the problems outlined in previous sections--accountability, training and reliability of workers--may remain a problem even when the care provider is a family member.

While there is widespread agreement that there is little quality control in IHSS today, there is no such agreement over changes to address the problems in the program.

One option is to make broader use of Contract Care agencies. These agencies tout their ability to deliver the accountability, training and reliability that is missing in the Independent Provider mode of care. They point out that they handle the recruiting, screening, training and supervision of workers. And while they may pay little more than the same minimum wage offered to IP workers, benefits such as vacations and sick time, as well as standard pay for mileage and travel time, are usually included in their contracts with workers. In addition, the agencies represent a focal point for responsibility and liability when problems arise.[27]

Only 16 of the 58 counties in the State use a "mixed mode" model for IHSS, offering both IP and contract agency services. Contract services are usually authorized for low-hour-need cases that might otherwise have difficulty finding a willing care provider. (Individual providers would, in general, rather work full-time for one person than splitting their hours among many clients and locations, since travel and mileage are not reimbursed.)

Since the cost of contract services is roughly twice that of independent provider service, one would expect counties to shy away from these services. But the agencies and a union representing agency workers say that the State's own surveys have shown that their services are actually less costly for low-hour cases. A 1988 statistical analysis by the Department of Social Services showed that the average monthly cost per non-severely impaired case was $234.89 in counties that offered mixed modes and $241.35 in IP-only counties. In a case-by-case comparison for non-severely impaired recipients, when contract care was compared directly with IP care, the savings was $28.87 a month per case.

The underlying reason for the cost savings, according to contentions by the contract agencies and a union that represents contract workers, is that counties tend to give more hours to recipients when assessing their needs for the IP mode of care. They contend that only by granting more hours can the county make the small jobs attractive enough for the recipients to find an IP. Others point out, however, that the expensive cost of contract services causes case workers to limit the number of hours that are granted even if the workers believe more are needed.

Whatever the reason, the differences do exist. In a small but random sample of 18 cases that had been switched from contract to IP care, the total hours allotted for all cases went from 310 to 761 per month, or by average case from 17 hours to 42 hours per month.[c]

The Commission was unable to locate any studies that quantitatively assess the case-by-case care given by contract agencies versus that given by independent providers. It is human nature to want more hours of service. But if better training, supervision and efficiency provide the same service packed into fewer hours, is the recipient not actually better off?

One sign that this may be the case is the direction that other states are moving. Contacts with some of the larger states showed that Illinois, Massachusetts, New York, Virginia, New Jersey and South Carolina do not allow independent providers. Washington and Wisconsin, which have been involved in federal lawsuits over the issue of who is the employer, are both moving away from the IP mode, while Florida and Maine run only small IP programs.

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c Taken from a random sample of 125 cases that were terminated from contract care (National Homecare Systems) in a two-year period. Of those cases, 18 were switched to Independent Provider mode.

California officials defend the heavy reliance on IPs because it gives the recipients freedom of choice in who serves them. Advocates for the elderly and the disabled also have argued strenuously against legislation in past years that would have automatically placed non-severely impaired recipients with Contract Care agencies. They say that not only is freedom of choice critical to allowing IHSS participants to retain their dignity but they also argue that past performances by contract agencies have not been good. Some have treated workers poorly, others have abruptly quit providing service in counties and others have not been any more successful in finding adequate numbers of care providers than those struggling to obtain service in the Individual Provider mode.

The Commission is hard put to ignore the similarities between these arguments and those advanced by advocates for Medi-Cal recipients who fight against managed care systems. In an earlier study on Medi-Cal, the Commission noted that freedom of choice is illusory if the choice is limited to doctors who refuse to provide service. Similarly, the right of the elderly to choose anyone they want as a care giver is a phantom right if they can only find inadequate workers who are poorly screened, trained and supervised.

The Commission also observed that poor performance by managed health care systems in earlier decades of the Medi-Cal program did not continue as a persistent problem in this mode of health care delivery once contracts were adequately written and enforced so that quality control was a key element.

Contract Care agencies, then, offer one remedy, although a controversial one, to the problems in the IHSS program.

Another option that would focus on bolstering the Independent Provider mode has been experimented with by some counties. Ventura County has hired "recipient aides" to help IHSS participants with securing a provider and dealing with any problems that arise. The county says this approach has benefitted both the participants and the care providers and takes up the slack in services that overloaded social workers cannot be expected to provide.[28]

However, this so-called Supported IP mode, when proposed in state regulations, was criticized for requiring a new layer of bureaucracy and, because it was coupled with funding restrictions to counties, was seen as an attempt to shut out contract agencies. (The regulations were rejected by the State Office of Administrative Law on April 11, 1990.) It has also been suggested that this option moves both the county and the State that much closer to being the actual employers of care providers, thus raising the issue of costly federal labor standards again.[29]

Another plan to bring accountability and responsibility to the Independent Provider mode is backed by advocates for the elderly and disabled. Under this plan, non-profit groups already in existence or created solely for this purpose would set up regulated and screened registries of workers, offer training and provide other services on a county-by-county basis.

While adding an unknown cost to the IHSS program, this option is believed by its backers to be a more practical approach than hiring more case workers to provide a higher level of case management for each IHSS participant, yet another option. Because of the non-profit status of these groups, overhead and management costs should be less than those of Contract Care agencies, and because the case managers would be functioning at a level lower than full-fledged county social workers, the cost should also be less than it would be to expand the current county system, according to advocates.

Each of these options would require some infusion of new resources (except for expanding the Contract Care mode, if its advocates are correct in their contention that better service can be provided in fewer hours). If taken out of the existing allocation for IHSS, the program would be forced to cut back on the numbers of people served or the hours of service provided. An alternative would be to find a new, richer source of funding. As will be discussed under Finding #2, many believe that a more aggressive effort by the State to integrate programs between departments and bring in more federal funding might yield the needed resources.

While those most closely connected with IHSS on an official basis are willing to concede the program is riddled with problems, little progress has been made on the structural flaws that produce those problems. As detailed above, those flaws include:

* A purposeful fragmentation of responsibility to avoid increased program costs.

* A management method that leaves the least capable element in the IHSS equation (the recipient) in charge of workers.

* Poor quality of care stemming from low worker wages, lack of training and inadequate screening of workers.

* Disagreements over how services should be delivered.

The program may be fulfilling its bottom-line intention: keeping people out of institutionalized care for as long as possible. But there are no signs that it is doing so with the maximum degree of effectiveness and efficiency.

FINDING 2: The State Has Failed To Put Uniform Mechanisms In Place That Would Allow It To Fully Implement The Goals Of The California State Plan on Aging; The Elderly In Need Of Assistance Thus Are Left To Navigate A Fragmented System Of Programs Run By A Diversity Of State And County Entities.

In a perfect world, as the elderly move from complete independence to needing constant attention, they would find easy access to all options along a continuum of care. In California, the blueprint for such a world has been drawn up, but bureaucratic barriers, lack of funds and a failure of leadership have kept it from being implemented.

Under the federal Older Americans Act (OAA), each state must have a plan to deal with senior citizens that is updated every two to four years. California's current State Plan on Aging, issued by the Department of Aging, covers 1989 to 1993. If one were only to read the State Plan on Aging, one could imagine all is well with California's seniors, for the plan incorporates everything that could be on a senior advocate's wish list. The plan:

1. Emphasizes the need to develop a comprehensive and coordinated community-based system of services for older persons.

2. Professes that one of its key elements is ensuring that older persons can easily access the services.

3. Envisions the elderly moving through a continuum of care based on changing need. They begin as completely independent, then are in need of some assistance so they can remain in their homes, eventually may be in need of limited out-of-home care at a residential facility, and finally may need full-time care in a skilled nursing institution.

4. Draws together program descriptions and goals from agencies and departments throughout state government that are designed to serve the elderly.

5. Defines the Department of Aging as the lead state agency for services to seniors and designates 33 Area Agencies on Aging around the State as the primary mechanism for ensuring that services are coordinated.

The State Plan on Aging, then, is a model for coordination of services and cooperation among the state agencies that house a variety of programs to serve the elderly. Under the plan, any senior citizen should be able to contact one of the 33 Area Agencies on Aging and receive information and referral to services suited to his or her needs. Armed with the correct information, the senior citizen would be able to pick and choose among the appropriate programs to receive a wide variety of help.

In some cases, reality does match the State Plan on Aging. Structurally, the plan envisions a well-coordinated network of programs that will meet the changing needs of the State's elderly. And in some counties, such as Monterey, disparate agencies have pulled together at the local level to accomplish just such coordination.[30] In Los Angeles County, an integration of services has begun with the movement of the county's Adult Protective Services program from the county's Department of Public Social Services to the Department of Community and Senior Citizens Services in November of 1990. A Los Angeles official says the transfer already has led to closer coordination with the Area Agency on Aging and that it has allowed a much higher priority to be placed on services that could easily be lost in the large bureaucracy of the county's welfare system. The official further recommends structural changes "beyond mere coordination of services," including the creation of an Adult Services Department at both the state and county levels.[31]

But such examples of close coordination are the exception rather than the rule. At the state level, the coordinating entity--the state Department of Aging with a budget of about $134 million--is a small tail attempting to wag a rather large dog. Just one program alone, the Department of Social Services' IHSS, has administrative costs of about $93 million and direct service costs of about $731 million. The Department of Health Services is another large provider of care to the elderly through various Medi-Cal services, spending $2 billion alone on nursing home care.

While the Area Agencies on Aging are meant to be the place where an elderly person would have one point of contact and one assessment, eligibility and screening process for a wide variety of services as his or her needs change, in many areas of the State they fall short of that goal. Officials from the Department of Social Services and county government say seniors are much more apt to come into the network of programs through the assistance of the local social services or welfare department.[32] Advocates for seniors go one step farther and argue that too many seniors fail to make connections at all--either through Area Agencies on Aging or through county offices--with programs that they desperately need.

In addition to finding diffused points of contact for programs, the elderly also quickly run into the limitations of programs because of a lack of federal and state funds. One such program is Adult Protective Services. This state-funded, county-run operation is intended to investigate allegations of abuse involving the elderly and determine follow-up actions that will ensure the safety of the senior citizen. But in many counties, Adult Protective Services has faced a progressive squeeze on funding that has resulted from a rising caseload demand on all adult services, static state funding and the inability of counties to make up the difference.

As described in the previous section on IHSS, counties receive a block grant from the State to spend on all adult services. Because there are no State standards and no State-mandated requirements for minimum levels of service, the level of Adult Protective Services activities varies throughout the State. A legislatively authorized pilot program in five counties led to 50 recommendations by the Department of Social Services that would standardize service and ensure greater protection for the elderly. Among those recommendations were 24-hour access to service by use of a crisis phone line, coordination with existing community agencies and services that would include, at a minimum, crisis intervention, needs assessment and investigation of abuse reports. But with an annual price tag estimated at $76 million, no headway has been made on the proposal.[33]

The importance of this type of watchdog program for the elderly can be seen in just one example from Sacramento County. Barbara T., as she was called by the media, was a mentally incompetent woman who was abused by her care provider in Sacramento County early in 1990. Adult Protective Services was asked to investigate her living circumstances three times, once by a taxi driver and twice by neighbors. Each time, county workers found nothing wrong and took no action.

Only when the local ombudsman program became aware of the case was the woman removed from the care provider. She had lost 30 pounds, was bruised, had cigarette burns on her breasts, had open sores and was tied to a bed. The woman was incapable of caring for her own needs; she lived with another woman who was to provide care in exchange for her Supplemental Security Income check. In essence, the care provider was running an unlicensed single-bed residential care facility.

The Barbara T. case represents what can go wrong for an individual human being when the system breaks down. But the Commission also was given examples by a social worker of how effective Adult Protective Services can be when it works well:

> *I've been working on a case of an 84-year-old woman. She was living alone and she fell in her home. She was hospitalized and then one week later she went home. She had her daughter move in with her because there was no one else to take care of her. I advised against this because she had a lot of trouble with her daughter before and I questioned the daughter's motives. I visited the client after the daughter moved in; the client said everything was fine.*
>
> *One month later, I received a call from police. They were with the client at her bank. The daughter had been signing her mother's name to checks totalling over $10,000. The client had no idea that this was happening, unfortunately. The police had contacted the daughter so the client was afraid to go home at this time. She told me that the daughter had slapped her and spit in her face one week before.*
>
> *I took her to a board and care, which was hard to find because we don't have any emergency board and care [facilities in our county]. I called around until I found one. I got a temporary restraining order against the daughter to get her out of the house and to keep her away from the client. I helped the client find a private conservator to handle her money. I insisted that the bank give her all the money the bank had illegally paid out of her account, which they eventually did.*
>
> *Another case example is a 67-year-old man who had two strokes after his wife died. The hospital referred him to us. His children had brought a recreational*

vehicle salesman to the hospital and forced him to sign papers to buy an RV that he could not afford. When I interviewed him at the hospital he said his family had been taking his money. I offered to set up a representative payee for him; he agreed to this. When I took the representative payee to his home after he got out of the hospital, the family became very upset because they didn't want the representative payee to have charge of his money. He then refused the service and I knew that he was being intimidated by his family, who all are on drugs.

I made several more visits to the home and talked to him about the fiduciary abuse and neglect that was going on because we had further reports from visiting nurses. I talked to the family about the abuse and neglect. Nothing took place at this time and he still refused services.

Finally, one day he called me and he said that he was not being cared for at all. There was no one to get him out of bed or to help him get to the bathroom or to fix his meals. He said he would willingly go to any care facility I could arrange for him. I found one and got him moved in. When I went out to get him, the children all arrived at the house and protested him leaving and said they would take care of him, there was no need for him to leave. I told them no, he had made up his mind and we were going on with it. I helped him get a private conservator and if we could have found a good provider for him and kept the children out of the home, he could have stayed in his home. But unfortunately, he couldn't.

Both of these cases are very typical; we deal with this every day. Frail, elderly clients dependent on their abusing relatives.[34]

Those familiar with Adult Protective Services are in firm agreement that the program is overloaded, underfunded and not standardized. But it is only one example of a program that cannot meet the demands placed on it by the State's aging population. For instance, state officials estimate IHSS now serves about 20 percent of the people on Supplemental Security Income and that approximately 50 percent may be eligible for the services. Since IHSS is an entitlement program--one must be given the services if one fits program eligibility requirements--more widespread knowledge about IHSS might result in an explosion of service demands.[35]

Since state and county resources have not grown to meet the needs of the elderly, some have urged that creative solutions be set forth that will bring more federal funds into the State for elder care. The federal Medicaid program (known as Medi-Cal in California), which is generally funded 50-50 by the state and federal governments, has waiver and optional programs available that allow states to provide a variety of services, including case management and personal care. If existing state funding could be used for the State's 50 percent share of cost, taking advantage of Medicaid options would bring new federal funds and new services into the State without adding to the State's fiscal burden.

California does make limited use of some specialized Medicaid programs already. The Multipurpose Senior Services Program serves only eight sites in California, but provides an integrated array of services: case management, adult social day care, housing assistance, IHSS, respite care, transportation, meal services, protective services and special communications. A separate Medi-Cal program provides home health care, but only in limited cases in which recipients have been recently hospitalized. Finally, a very limited program that allows the level of care provided in a skilled nursing facility to be provided at home and which grants 80 percent of the funds that would be needed for institutionalization, allows about a dozen recipients with heavy medical needs to remain in their homes.[36]

Other uses of Medicaid funding could be made if the State applied for program approval. In September 1990, a committee of the California Welfare Directors Association recommended that the State's Medicaid plan be amended to fund an Adult Protective Services emergency response service. Such a program would bring in more than $31 million to the State to either improve services or to free up comparable state funds for other uses. The committee said it had been told by the Department of Health Services that the option was not being pursued because of lack of staff time.[37]

In testimony submitted to the Commission, the National Health Law Program pointed out that a new Medicaid program, which became available on July 1, 1991, allows home- and community-based care for the "frail elderly." The testimony also pointed out that while California has not made extensive use of Medicaid waivers and optional programs to relieve pressures on other state programs, other states have been more creative.

A summary of the National Health Law Program assessment:[38]

* New York provides a "nursing home without walls" program to its elderly Medicaid recipients who might otherwise be placed in nursing homes. Using Medicaid's personal care option and a home and community-based services waiver, the program provides home health attendants to meet a variety of medical and personal care needs. A companion state-funded program pays family members who become care givers. Through the extensive use of case management and a per-patient cap of 75 percent of the cost of residing in a skilled nursing facility, the program has proven that it saves dollars and improves care.

* Colorado runs a similar intensively case-managed program, pairing a Medicaid waiver with a state program called the Home-Care Allowance. The state program pays family members to provide supervision, exercise, assistance with personal hygiene, and aid with the activities of daily living. Once again, a cap is placed on funding so that costs do not exceed that of a nursing home stay.

* New Jersey makes extensive use of all Medicaid options, with its program covering personal care services and home- and community-based waiver services. Short-term skilled nursing care is provided under the Medicaid home health services program. Once again, state funds are used to reimburse family members who provide care. The total program cap is set at 70 percent of the funding that would be required for nursing home placement, but the average expenditure is far less.

* Oregon operates a Medicaid demonstration project, in conjunction with other Medicaid options, that rehabilitates housing and, in some cases, nursing facilities and turns them into "assisted living units." The cost is capped at 80 percent of the average nursing facility rate.

Most of the successful programs in other states, then, have relied on a combination approach--both to the services provided and to the sources of funding. In California, such cross-breeding of programs is encouraged in the State Plan on Aging but has yet to yield much in the way of results. One reason is that different departments have different priorities based on budgeting and staffing constraints. If the Department of Health Services were to vigorously pursue Medicaid programs that would care for the elderly at home, it would need a pool of state matching funds; its own budget of state matching funds is already allocated to other priorities. But if those funds were to come from the Department of Social Services' IHSS program, then the question arises over where ultimate control of the program will be lodged.

Such procedural and bureaucratic barriers are perceived as the main reason for California's failure to follow the lead of other states. The follow-through required to move funding and authority from one state department to another and create integrated programs has been missing. Similarly, the commitment to integrating services so they are easily accessed by the elderly has been fragmented and left without a dedicated source of funding that would ensure success.

FINDING #3: The Effect Of "County Realignment" Remains Uncertain; While It May Pose Risks For The Future Of Elder Care Programs, It Also Presents Opportunities For Improvements.

One proposal to meet the State's daunting fiscal need to close a $14 billion gap in the 1991-92 budget was that certain health and social service programs, including IHSS, be turned over to counties along with new sources of revenue. Known as "county realignment," this process was eventually pared down in the case of IHSS from a complete abdication of state control, interest and participation in IHSS to making counties responsible for a larger share of IHSS costs. But because there is no certainty that the new, added revenue sources for counties will keep pace with program costs, counties in the future may suspend IHSS services to some recipients. On the positive side, the realignment legislative package directed that new approaches to long-term care for the elderly be studied.

Under realignment, the county share of costs for IHSS increased from 3.3 percent to about 35 percent, for a savings to the State of $235 million. The County Services Block Grant, which provides funds for IHSS administration and Adult Protective Services, will now require 30 percent county participation, up from 16 percent, for a total state savings of $13 million. New county revenues, which are expected to cover the costs of a wide array of programs besides IHSS, will derive from one-half cent of the recently increased sales tax and a special increase in the vehicle license fee.[39]

On its face, realignment should neither increase nor decrease the current level of funding for IHSS and Adult Protective Services. The amount cut out of the State's budget is supposed to be placed back into the programs by the new county funding. But the prospects in future years are less clear. If the new funding mechanisms allow revenues to grow at a faster rate than demand for services grow, programs for the elderly may have the resources to be improved. But if the revenues only keep pace with growth in demand or, worse yet, are outstripped by the need for social programs, IHSS will continue to suffer the same inadequacies. This latter possibility is real, given that revenues are tied to the sales tax and the economy currently is slumping.

Recognizing the unpredictability of the future, the Legislature protected the State and the counties--but not necessarily the program recipients. Under realignment, the entitlement to IHSS is suspended for 1992-93 and 1993-94. This means that even if an elderly person meets the eligibility requirements, they will not automatically receive IHSS services if state and county funds are insufficient to cover all demand for the program. The realignment legislation attempts to protect the most frail by requiring counties to only reduce services on a case-by-case basis and then only if the recipient would not be institutionalized as a result of the cuts.

This restriction actually may serve to focus attention on the underlying premise of IHSS and permit some assessment of whether the program works to meet its intent. Under the California Welfare and Institutions Code (Section 12300), the intent of the IHSS program is to provide supportive services to the aged, blind and disabled who are unable to perform the services themselves and who could not otherwise remain safely in their homes. The program meets two of five federal goals: preventing or remedying abuse and neglect, and preventing or reducing

inappropriate institutional care by providing community-based care, home-based care or other forms of less intensive care.[40]

A two-fold motive frequently is cited for providing in-home care: It is psychologically better for someone to remain at home and it is cheaper to provide services at home than to pay for placement in long-term care facilities. But the concept that most state-run, at-home care programs are cheaper is thoroughly disputed by experts who have written an article entitled "The Past and Future of Home- and Community-Based Long-Term Care."[41] After thoroughly examining data and conclusions from 27 studies, the authors of this article concluded that at-home care is only a cost-savings when programs are rigorously and narrowly targeted to those people who are in imminent danger of being placed in a long-term care facility.

Most programs, including IHSS in California, do not practice such targeting. The State's program by statute specifically provides service if a person would be unsafe to remain at home with no help--not the same standard as being in imminent danger of being placed in a long-term care facility. And the program is not always a cost savings for the State. The Department of Social Services says that IHSS recipients at the high end of hours usage cost $1,200 or $1,300 for IHSS and another $600 for their SSI/SSP grant.[42] Placement in a long-term care facility costs about $1,600. At the low end of usage, some critics contend that recipients may be getting services (at a cost to the State) that they would manage without or that someone else would provide to them (at no cost to the State) if IHSS were not available.

If IHSS were rigorously targeted and assessments were aimed at only giving services to those in danger of institutionalization, then counties would have great difficulty in reducing services in the next two fiscal years without violating the legislative strictures that are intended to protect anyone from being forced into skilled nursing facilities. Conversely, if counties easily find recipients who can stay at home without services, either because someone else will pitch in and provide them or because the person will simply get by without help, then the goals of IHSS may need to be re-examined.

Under the realignment legislation, two requirements make such an examination likely and hold out the prospect for future state innovations. The legislation requires the Health and Welfare Agency to establish a task force to recommend the proper role of IHSS in the long-term care continuum and develop methods of coordinating and improving the delivery of long-term care services. A report to the Legislature is required by January 31, 1992. The legislation also requires the Secretary of the Health and Welfare Agency to investigate the feasibility of maximizing federal funds for IHSS under Medicaid waivers and optional programs.

Thus, while realignment may pose short-term problems for IHSS recipients if funding sources fail to grow at a rapid pace, the seeds for eventual program improvement are also part of the package. Re-examining the continuum of care to ensure that it flows smoothly and is accessible to the elderly may lead to dramatic improvements in how the State deliver services. In addition, the emphasis on maximizing the use of federal programs and dollars may cause California to follow the lead of other states that have successfully tried innovative approaches.

Recommendations

The Little Hoover Commission urges the State to take immediate actions to improve the In-Home Supportive Services program, to move more aggressively to integrate the array of services offered to the elderly and to monitor closely the effects of realignment.

Recommendation #1: The Governor and the Legislature should enact legislation to require each county to adopt one of several approaches that will provide accountability, worker training and reliability in the Individual Provider mode of care.

The universal agreement that the Individual Provider mode of care is largely unregulated and unmonitored has not translated, unfortunately, into any statewide moves for improvement. Instead, frail elderly individuals continue to be burdened with the responsibilities of acting as an employer. Changing this system, however, does not have to mean choosing only one answer to the problems on a statewide basis. Under the philosophy of county realignment, which gave counties more fiscal responsibility for programs like IHSS, the State has pledged to allow counties more latitude in methods used to reach general standards and goals. In line with this, it seems appropriate to allow counties to pursue a higher quality of care using whatever option best fits their needs.

Those options should include, but not necessarily be limited to:

* The creation of non-profit entities to run controlled registries of screened and available workers, provide training and offer dispute resolution services.

* Greater allocation of resources for hiring county IHSS case workers and reducing work loads to allow ample time for case management.

* The county creation of an "Assisted Independent Provider" mode that would provide lower level employees to screen care givers and track problems.

* Counties' hiring of care givers directly and providing the supervision normally expected of an employer.

Increased costs deriving from these options may well be offset by the reduction of fraud and waste in provided services. In addition, increased costs may be met by fulfilling Recommendation #4 below, which addresses the desirability of forming programs that bring California more federal funds.

Recommendation #2: The Governor and the Legislature should enact legislation to encourage counties to place new non-severely impaired, low-hour cases into the Contract Care mode of service.

For low-hour cases, the contract care agencies appear to provide a higher quality service for a lower cost, in addition to holding out the promise of accountability that is sorely lacking in the present Independent Provider system. But advocates for the elderly and disabled have legitimate concerns about freedom of choice and holding agencies to high performance standards. Therefore, legislation should include safeguards, such as requiring contract agencies to offer training and employment to relatives who want to become care providers.

In addition, the State should provide counties with model contracts that contain adequate performance-based standards and contract enforcement mechanisms for handling recipient complaints, monitoring the quality of care, dealing with worker concerns and accepting responsibility for any actions taken by employees that adversely affect the recipient.

Recommendation #3: The Governor and the Legislature should enact legislation to institute other IHSS improvements and set standards that will allow the program to work more smoothly and responsively.

Procedurally, the IHSS program is not user-friendly. The Department of Social Services and county welfare departments should be directed to provide full information to recipients and their care providers, including:

* Brochures describing program limitations, restrictions and rules.

* Reasonable resources to provide answers for those with more detailed questions or unique problems.

* Assistance for those who wish to appeal decisions or file complaints.

Care providers also should be notified whenever the recipient's hours are reduced or other changes in status are made to avoid situations where the worker, unaware of any change, continues to work longer hours than the State will pay for. Training standards should be set for workers. Finally, adequate numbers of well-trained social workers should be involved in IHSS to conduct timely assessments and respond to problems immediately.

Recommendation #4: The Secretary of the Health and Welfare Agency should move aggressively, across departmental lines, to implement the integration of services outlined in the California State Plan on Aging and, in the process, maximize federal funding of programs.

Bureaucratic barriers have been successfully breached in other states where programs that meet the varied needs of the elderly at home have been put together using a variety of funding mechanisms. Yet in California, program restrictions and departmental turf appear to disrupt what should be a continuum of care for the elderly.

Recently enacted realignment legislation requires a task force to explore the potential for delivering better long-term care and to examine creative ways of bringing more federal funding into the State to cope with the problems of the elderly, including the use of Medicaid waivers and optional programs. The task force should begin its study with a thorough review of the goals set forth in the State Plan on Aging and should look at examples of coordinated programs in other states.

Recommendation #5: The Governor and the Legislature should closely monitor the effect of county realignment on IHSS and other programs that protect the frail elderly.

Although realignment holds the potential for program improvements, it also may prove to be an avenue for reducing services that are vitally needed by a vulnerable elderly population. The State should be prepared to implement a safety net program if realignment threatens the well-being of those who rely on IHSS.

Conclusion

The Little Hoover Commission believes the State has a high degree of responsibility for the welfare of its citizens that does not diminish just because someone is near the end of life. Just as children should be protected by any caring society, the elderly should not be cast aside and left to suffer indignities, neglect or abuse.

Unfortunately, that is the fate of many elderly citizens who never make connection with existing programs or who receive inadequate service because of program flaws. The Commission has examined programs designed to protect this vulnerable population and found that in many cases they are not working adequately. Therefore, the Commission urges the State to take immediate action on recommendations contained in this report that are designed to improve the level of care and restore dignity and safety to the elderly.

Sincerely,

Nathan Shapell, Chairman

Appendix A

WITNESSES AT COMMISSION HEARINGS ON ELDER CARE AT HOME

August 30, 1990 - Elder Care

Westside Center for Independent Living

Stan Greenberg, Executive Director

California Association of Homes for Aging

Darrell Kelch, Vice President of Public Policy

Southern California Presbyterian Homes

Marc Herrera, Director of Home Administration

California Association for Health Services at Home

Joe Hafkenschiel, President

Visiting Nurse Association

Lynn M. Campbell, P.H.N., M.S.N., Executive Director

Department of Social Services

Loren Suter, Deputy Director, Adult and Family Services

Gerald Rose, Program Manager, In-Home Supportive Services

Service Employees International, Local 535

Sharlene Dane, Sandra Gerbing, Liam Smith

United Domestic Workers of America

Fahari Jeffers

Other Participant

David Valdez

March 20, 1991 - Elder Care

Senior Legislature

Ted Ruhig

Council of Sacramento Senior Organizations

Frank McPeak

San Diego County Department of Social Services

William Bruner

Nevada County Department of Social Services

John Crane

Service Employees International, Local 535

Sharlene Dane, Sandy Einbinder, Barbara Murphin

Department of Aging

Chris Arnold, Director

Department of Social Services

Robert A. Barton, Chief

National Health Law Program

Michelle Melden, Staff Attorney

Protection and Advocacy Program

Marilyn Holle, Staff Attorney

California Dental Hygiene Association

Sharon Ranier

Endnotes

1. *California Department of Social Services, Fiscal Unit Manager for IHSS.*

2. *"In-Home Supportive Services in California: Quarterly Statistical Report, January - March 1991," California Department of Social Services.*

3. *California Department of Social Services, IHSS Program Manager.*

4. *"Report to the Legislature: IHSS Uniformity," California Department of Social Services, July 1, 1989.*

5. *California Department of Social Services, Fiscal Unit Manager, IHSS Regulations*

6. *"In-Home Supportive Services in California: Quarterly Statistical Report, January-March 1991," California Department of Social Services.*

7. *Letter received by the Little Hoover Commission on July 30, 1990, from a San Pablo woman.*

8. *Testimony received by the Little Hoover Commission during a May 17, 1990 hearing on health care issues.*

9. *Letter received by the Little Hoover Commission from a Fullerton resident.*

10. *Interview with social workers from Los Angeles and San Diego Counties, October 31, 1990.*

11. *California Department of Social Services, Fiscal Unit Manager for IHSS.*

12. *Interviews with California Department of Social Services and representatives of social workers.*

13. *California Department of Social Services, deputy director, Adult and Family Services Division.*

14. *Interview with Service Employees International Union, social workers from Los Angeles and San Diego counties, and a representative of the statewide County Welfare Directors Association.*

15. *"Use of Convicts to Care for Elderly, Disabled Under Fire," Sacramento Bee, February 3, 1991.*

16. *Ibid.*

17. *Testimony to Little Hoover Commission, August 30, 1990, by the Director of Home Administration for Southern California Presbyterian Homes.*

18. *California Department of Social Services, Fiscal Unit Manager for IHSS.*

19. *California Department of Social Services, IHSS Program Manager.*

20. *Letter to Little Hoover Commission on September 18, 1990, from Secretary/Treasurer, United Domestic Workers of America.*

21. *Letter to Little Hoover Commission on August 24, 1990 from a Bolinas resident.*

22. *"Use of Convicts to Care for Elderly, Disabled Under Fire," Sacramento Bee, February 3, 1991.*

23. *Letter to Little Hoover Commission on September 14, 1990 from the Coordinator for Ombudsman Advocacy Services of Inyo-Mono.*

24. *"The Department of Social Services Could Reduce Costs and Improve Compliance with Regulations of the In-Home Supportive Services Program," Auditor General of California, March 1987.*

25. *California Department of Social Services, IHSS Program Manager.*

26. *Letter to Little Hoover Commission on October 25, 1990 from Fullerton resident.*

27. *Testimony to the Little Hoover Commission, August 30, 1990, Vice President, National Homecare Systems.*

28. *Letter to Little Hoover Commission on September 4, 1990 from the Director of Public Social Services for Ventura County.*

29. *Documents provided to the Little Hoover Commission by the United Domestic Workers of America, including correspondence from legislators to the Department of Social Services, testimony from United Domestic Workers of America during hearings on the proposed regulations and the Notice of Decision of Disapproval from the Office of Administrative Law.*

30. *Testimony to the Little Hoover Commission, March 20, 1991, Director of Public Social Services, Nevada County.*

31. *Letter to Little Hoover Commission on April 19, 1991 from the Assistant Director of the Los Angeles County Department of Community and Senior Citizens Services.*

32. *Meeting with social service department directors, an IHSS official and a Contract Care agency representative, October 19, 1990.*

33. *"Update to the Legislative Report for the Evaluation of the Adult Protective Services Demonstration Projects," December, 14, 1990, California Department of Social Services.*

34. *Testimony to the Little Hoover Commission on March 20, 1991 by a Contra Costa County Adult Protective Services social worker.*

35. *California Department of Social Services, IHSS Program Manager.*

36. *California Department of Health Services, Medi-Cal Operations Division.*

37. *"Summary of Preliminary Findings and Recommendations," Alternate Funding Subcommittee memorandum to the County Welfare Directors Association Adult Services Committee, September 12, 1990.*

38. *"Follow-Up Report to the Little Hoover Commission," prepared by a staff attorney for National Health Law Program Inc., June 21, 1991.*

39. *"California's Fiscal Crisis: Balancing the Budget 1991-92," Senate Office of Research, July 17, 1991, and the text of 1991's AB 948 (Bronzan).*

40. *"In-Home Supportive Services in California: Quarterly Statistical Report, January-March 1991," California Department of Social Services.*

41. *"The Past and Future of Home- and Community-Based Long-Term Care," William G. Weissert, Cynthia Matthews Cready, and James E. Pawelak, Milbank Quarterly, Vol. 66, No. 2, 1988.*

42. *California Department of Social Services, IHSS Program Manager.*

LITTLE HOOVER COMMISSION FACT SHEET

The Little Hoover Commission, formally known as the Commission on California State Government Organization and Economy, is an independent state watchdog agency that was created in 1962. The Commission's mission is to investigate state government operations and through reports and recommendations, promote efficiency economy and improved service.

By statute, the Commission is a balanced bipartisan board composed of five citizen members appointed by the Governor, four citizen members appointed by the Legislature, two Senators and two Assembly members.

The Commission holds hearings once a month on topics that come to its attention from citizens, legislators and other sources. But the hearings are only a small part of a long and thorough process:

* Two or three months of preliminary investigations and preparations come before a hearing is conducted.

* Hearings are constructed in such a way to explore identified issues and raise new areas for investigation.

* Two to six months of intensive fieldwork is undertaken before a report, including findings and recommendations, is written, adopted and released.

* Legislation to implement recommendations is sponsored and lobbied through the legislative system.

* New hearings are held and progress reports issued in the years following the initial report until the Commission's recommendations have been assimilated.