



Workforce Needs in California's Homecare System

Eileen Boris, Gawon Chung, Linda Delp, Ruth Matthias, and Carol Zabin

In-Home Supportive Services (IHSS) enables more than 300,000 low-income elderly and younger disabled recipients to stay in their homes rather than live in more expensive institutional settings. This innovative, cost-effective, consumer-directed program has become a national model that other states are examining, and is a vital component of California's continuum of services for those who need long-term care.

IHSS is key to California's compliance with the Olmstead decision, which requires that states provide services that allow people with disabilities to live in community settings rather than institutions. Proposed budget cuts in wages, benefits, and services will slow the growth and increase turnover of the workforce, make it more difficult to match consumers with competent providers, and severely undermine the effectiveness and integrity of IHSS, the state's largest in-home care program. They may ultimately lead to greater state expenditures by forcing some consumers into higher-cost care and by increasing the use of costly emergency services as the continuity and quality of IHSS care are diminished.

This paper, funded by the California Policy Research Center, was written by a multidisciplinary team of UC researchers from the California Homecare Research Working Group, who analyzed current studies that evaluate long-term care workforce needs in order to improve service delivery, with a particular emphasis on IHSS. Based on current research, we analyze the implications of the proposed cuts on the capacity of IHSS to provide quality care.

SUMMARY OF RESEARCH FINDINGS

IHSS is the backbone of California's long-term care system, and provides the state a cost-effective alternative to institutional care

- ▶ In 1998, 92% of long-term care recipients lived in their own homes or in a community setting, while the remaining 8% were in institutions such as nursing homes or developmental centers (Harrington et al., 2001).
- ▶ California allocated 82% of Medi-Cal long-term care expenditures to institutional care and 18% to homecare in 1999 (Nawrocki and Gregory, 2000).
- ▶ From 1996 to 2001 the percentage of residents in California nursing facilities decreased from 67.3% to 51.3%, while the percentage of residents utilizing home- and community-based services increased from 17.3% to 40.4%.
- ▶ The cost effectiveness of home- and community-based services relative to nursing homes is complex and depends on such factors as the level or care consumers need, which makes it difficult to give an overall assessment of relative costs.

However, current homecare recipients who lose services and need to be placed in a nursing home will cost the Medi-Cal program \$43,000 per person each year, vs. \$8,820 per person for homecare services for the IHSS residual program. If only one of every eight homecare recipients who will lose services enters a nursing home, the state will see absolutely no savings from cuts to homecare (Harrington and Newcomer, 2004).

The quality and integrity of the IHSS system are dependent on attracting and retaining a qualified workforce, which in turn is dependent on adequate wages and benefits

- ▶ Staff turnover affects the quality of care for long-term care recipients. In a survey of IHSS recipients in San Francisco, Reif (2002) found that consumer satisfaction was positively related to lower turnover. This has been corroborated in other studies. For people with developmental disabilities, the length of the match between the consumer and the caregiver is a key variable in contributing to positive outcomes for consumers (Lakin, and Bruininks, 1981; Larson and Lakin, 1999).
- ▶ Turnover has been reduced where wages have risen. San Francisco data from the state's Case Management Information and Payrolling System between 1996 and 2002, when IHSS wages rose from the minimum rate to \$10/hr, show that the supply of homecare workers doubled for both family and nonfamily providers. Regression analysis showed that 55% of the growth could be attributed to the growth in wages and another 25% to the addition of benefits. (Howes 2003) Turnover decreased by 24%, and the wage increase may have contributed to as much as a 15% decrease in the number of people living below the poverty line (Howes, 2004, 2002).
- ▶ Turnover has been reduced when health benefits are provided. Workers who enroll in the IHSS health benefits program are far more likely to remain in the workforce in month 12 than are unenrolled workers. Health plan enrollees who leave the workforce during the 12-month period are much more likely to return to the workforce within those 12 months than are nonenrollees (Zawadski and Radosevich, 2003). Howes (2004) also found that the addition of health insurance increased the probability of a new worker remaining in the workforce for a year by a factor of four.
- ▶ The relationship between turnover and wages and benefits has been corroborated in numerous other studies in the human services field (for a review, see Zabin, 2003).

The value of the public authority, the employer of record, and consumer advisory committees

- ▶ The current IHSS structure—public authorities, consumer advisory committees, and unions—is the result of a historic collaboration between stakeholders to advocate for a consumer and worker voice in order to improve the independent provider model of homecare (Heinritz-Canterbury, 2002; Delp and Quan, 2002).
- ▶ Public authorities have five main roles in addition to serving as official employers-of-record: (1) to establish a provider registry to help IHSS recipients find a caregiver; (2) to investigate the qualifications and backgrounds of potential caretakers; (3) to provide access to training for caretakers and recipients; (4) to perform any other functions related to delivering in-home supportive services; and (5) to ensure that the requirements of the personal care services program are met.

The registry enables public authorities to know who is providing homecare, whether a worker is good or not, whether they have current information on the provider, and what kind of background checks have been done. As one county service director said: “One of my biggest concerns before the public authority was the lack of background checks. The registry has meant a significant change. Not refer-

ring people who shouldn't have been referred in the first place means less turnover." A consumer advisory committee member noted the success of training: "... it has been a great safety issue because now they learn CPR and how to safely lift and transfer people without hurting their clients or themselves."

California's aging and disabled population is generating increased demand for long-term care

- ▶ The population age 65 and older is expected to double to roughly 7.2 million between 2000 and 2025 and triple to roughly 10.8 million by 2050 (Lee et al., 2003).
- ▶ The population age 85 years and older is projected to grow by 200% between 2000 and 2040 (Scharlach, Torres-Gil, and Kaskie, 2001).
- ▶ This growth is due in part to increased life expectancy. By 2050, Californians' life expectancy is expected to increase from the current 78.8 years to 84.2 years (Lee et al., 2003).
- ▶ The percentage of the elderly population reporting inability to perform daily tasks is predicted to drop in the next 30 years from 17% to 12%, but since the overall numbers of those age 65 and older will increase, the disabled elderly will constitute a greater proportion of the state's population after 2030 than they do today (Lee et al., 2003).
- ▶ Among the 21 million Californians from 16 to 64 years of age, 5.8 % have physical disabilities that substantially limit their ability to perform basic physical activities, such as walking, climbing stairs, reaching, lifting, or carrying; 7.8% of them have difficulty leaving home alone to shop or visit a doctor's office; and 1.7% of them have difficulty dressing, bathing, or getting around inside the home (U.S. Census Bureau, 2000).

The supply of care providers will not meet the demand for care due to changing population demographics and competing job options

- ▶ By 2010, more than 780,000 additional aides will be needed nationwide to fill long-term care direct staff positions, an increase of 39% over the year 2000. During the same 10-year period, the "traditional" source of new long-term care workers (women 25–44 years of age in the civilian workforce) is projected to grow by only 1.25%, an increase of 400,000 workers (Hecker, U.S. Bureau of Labor Statistics, 2001, quoted in Dawson, 2003).
- ▶ The National Center for Health Workforce Analyses projects that California will need 47.4% more personal care and home health aides in 2008 than existed in 1998 (HRSA, 2004).
- ▶ The California Department of Social Services projects a widening gap between providers and recipients in the In-Home Supportive Services program. In 2000 the ratio of recipients to providers was roughly 1.2:1. This ratio could increase to 1.4:1 by 2020 and to 1.8:1 by 2040.
- ▶ The current wage structure is not conducive to attracting new entrants into this field. Workers in caregiver aide occupations earn less (in the 35th to 45th percentile) and have fewer benefits than other occupations requiring similar skills, education, and experience (EDD, 2001).
- ▶ The report found average entry-level wages statewide of \$7.23/hr for nurse's aides, \$7.15/hr for home health aides, and \$6.61/hr. for homecare workers, not including IHSS. Average wages for all levels (entry and experienced) were \$8.78 for nurse's aides, \$9.73 for home health aides, and \$8.23 for personal and home care aides (EDD, 2001).

At these wages, all three occupational categories fell under the Lower Living Standard Income Level (LLSIL) established by the U.S. Department of Labor as the minimum earning level for self-sufficiency (\$14.18 for a family of four in California). Personal and homecare aides were at federal poverty guidelines of \$8.20/hr for a family of four. At these wages, personal and homecare aides were 16th lowest among 22 comparable California occupations (EDD, 2001).

The Costs and Benefits of Family Providers

- ▶ In 2000, 43% of IHSS providers were relatives of the recipient. Adult children made up 19.7% of IHSS providers, minor children 0.2%, parent of an adult child 4.5%, parent of a minor child 2.7%, spouse 2.9%, and other relatives 12.8%. Providers who are either a spouse or a parent of a recipient tend to be older than the average IHSS provider (median ages between 51–60 years and 41–50 years, respectively) (CDSS, 2001).
- ▶ Results of a random sample of 1,095 clients and 618 workers in California compared family and non-family providers and demonstrated that clients who hired a family member as caregiver reported a greater sense of security, interpersonal closeness, and satisfaction. (Benjamin et al., 1999).
- ▶ In Illinois, the benefits of paying family caregivers outweighed negative consequences. Hiring family members eased worker shortages in difficult-to-serve areas and facilitated recruitment of workers for hard-to-serve clients. It resulted in improved quality of care, improved consumer satisfaction, and economic benefits for consumers and families. Negative side-effects resulted from blurred boundaries between business and family relationships and the potential interference of family conflicts on the quality of caregiving (Linsk et al., 1986).

Hidden Costs of Reducing Wages

- ▶ The worker pool is already too small, and would be reduced severely by cuts in wages and benefits. At a wage of \$6.75 with no benefits, 98% of new providers in San Francisco would be expected to leave the program within a year. In contrast, at a wage of \$10/hr. with health insurance, only 4% would leave (Howes, 2004).
- ▶ Workers in focus groups (Delp et al., 2004) discussed the proposed wage and benefit cuts. Many would look for another job, and some of those would be forced to institutionalize family members; others would need to care for more clients from whom they would be unable to provide quality care. The rest would face extreme financial hardship, as shown in the following quotes:
 - “I might be forced to put my parents in a retirement home [so I could get another job that pays enough]. I don’t want to do that; sending them there would be like the death sentence.” (4/10/04, LA County worker)
 - “If there were no health benefits, I’d quit.” (3/17/04, SF County worker)
 - “If wages were reduced to \$6.75, I would not be able to stay financially. My heart and passion is here, but I cannot do that for IHSS . . . ” (4/16/04, Yolo County worker)
 - “What are we going to sacrifice? Paying the electricity? Buying food? Paying the rent? Seeing the doctor? All this is going to affect us; it will be like going back to the past.” (4/8/04, LA County worker)
- ▶ By paying workers less and not paying family care providers, we can anticipate an increase in nursing home admissions (Harrington and Newcomer, 2004) and an increase in homecare nurse visits, since

nonfamily caregivers cannot legally provide paramedical care.

- ▶ Other hidden costs will be increased unemployment insurance payments to workers, and increased welfare use. One in four workers were on welfare at one time before they became IHSS workers.
- ▶ High job-vacancy rates and turnover can cause problems for consumers. Prior qualitative studies indicate that problems with recruiting and retaining workers can result in poorer quality of care, unsafe care, and disruptions in continuity of care (Wunderlich, Sloan, and Davis, 1996).
- ▶ Eliminating funds for public authorities will effectively dismantle the IHSS structure that has evolved to provide quality care for consumers and quality jobs for workers.

KEY UNANSWERED POLICY QUESTIONS

- ▶ Homecare expenditures have increased rapidly over the past several years, but insufficient research has been conducted to definitively explain or project expenditure growth. Factors that have been suggested include growth in the eligible recipient population, wage increases, pent-up demand, fraud, etc., but the relative weight of each factor cannot be delineated.
- ▶ Analysis of the relative cost of home care vs. institutional care is incomplete and inadequate for assessing the effect of decreasing access to home care on the costs of institutional care.
- ▶ The relationship between worker well-being, including wages, satisfaction and turnover measures, and client quality of care needs to be analyzed. To what extent does worker training include client safety? What is the impact of the worker shortage on quality of care?

CONCLUSIONS

IHSS has earned a national reputation as an innovative home- and community-based program that enables both consumers and workers to have a voice in the services with which they are intimately involved, balancing consumers' needs for independent living and quality care, and workers' need for quality jobs. The proposed budget cuts would decrease the supply of workers, increase turnover, compromise the quality of home care, and undermine the very framework that enables IHSS to provide in-home care to thousands of Californians with disabilities.

Historically, California has been a leader in innovative homecare solutions. Many other states are now following our lead, turning to client-directed home care, providing funding to pay family providers, and initiating public authority models. Efforts to weaken or dismantle this model and reduce provider wages contradict the widely acknowledged link between meeting the growing demand for homecare workers and improving their working conditions. This link underlies a national effort to improve the quality of long-term care by improving the quality of long-term jobs (USHHS/DOL, 2003).

Current research funded by the Robert Wood Johnson Foundation's national Better Jobs, Better Care initiative will further expand our understanding of the IHSS program and providers. If the state is truly concerned about improving the quality of care for California's disabled and aged populations, it needs more studies that shed light on the workforce components needed to provide quality care for California's elderly and disabled populations. Those who make decisions about long-term care policy need reliable data to make informed decisions.

Eileen Boris, PhD, is professor and Hull chair of the Women's Studies Program, and director of the Center for Research on Women and Social Justice, University of California, Santa Barbara. Gawon Chung is a PhD candidate in the Department of Social Welfare, School of Public Policy and Social Research, UC Los Angeles. Linda Delp is project director at the UCLA Center for Labor Research and Education and a PhD candidate in the UCLA School of Public Health. Ruth Matthias, PhD, is an associate researcher at the Lewis Center for Regional and Policy Studies, School of Public Policy and Social Research, UCLA. Carol Zabin, PhD, is associate chair of the UC Berkeley Center for Labor Research and Education.

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