Envisioning a

"Quality Care / Quality Jobs" Registry

for Los Angeles County's

In-Home Supportive Services Program

Presented to the

Personal Assistance Services Council
of Los Angeles County

by the

Paraprofessional Healthcare Institute

with the assistance of the

Los Angeles Homecare Workers Union
(SEIU Local 434-B)

and the
Service Employees International Union

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Preface

In the fall of 1998, the Paraprofessional Healthcare Institute (PHI)—at the request of the Los Angeles Homecare Workers Union (HWU) and the Service Employees International Union (SEIU)—conducted a brief study of possible designs for a county-wide registry system for Los Angeles County's *In-Home Supportive Services (IHSS)* program.

That study had several objectives:

- An assessment of the goals of various stakeholders—including consumers, workers and public agencies—relative to the creation of an IHSS registry system for all of Los Angeles County;

- A review of various types of registry infrastructures developed both within and outside California to support the delivery of consumer-directed home care services;

- A consideration of operational modifications of existing registry infrastructures that might enhance both *care quality* for consumers and *job quality* for caregivers, as well as deal effectively with the challenges of scale posed by LA County's IHSS system; and

- Some preliminary projections about the expertise, staff, information systems, physical plant and resources that would be required to develop and run such a registry system.

An additional objective of the study's initial phase was to help the HWU identify what it could best offer to the design and implementation of an IHSS registry in collaboration with Los Angeles' new Personal Assistance Services Council (PASC). This report includes the union's feedback to that initial phase of the study.

PHI presents this report to the PASC not as an exhaustive, "final word" study of home care registries, but rather as an initial frame for what we anticipate will be a productive discussion between consumer advocates, worker advocates and public officials about creating the best registry possible for LA County's IHSS system. We appreciate the opportunity to participate in these important deliberations, and we welcome the PASC's feedback to this report.

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We would like to thank all those whose expertise and experience helped to shape both the original conception of this study and the contents of its final report.

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Executive Summary

The creation of Los Angeles County's *Personal Assistance Services Council (PASC)* is the culmination of years of effort by allied consumers and home care workers to improve the ***quality of care*** offered by the county's In-Home Supportive Services (IHSS) program. And a key theme of that campaign has been the recognition that a stable and experienced caregiving workforce—an essential factor in ensuring long-term care quality—will only be achieved with an improvement in the ***quality of jobs*** enjoyed by the county's IHSS providers.

The creation of a countywide IHSS registry offers one means whereby the PASC can begin to pursue its quality care / quality job objectives. But the sheer enormity of LA's IHSS program, and the range of consumer and provider needs currently unmet within that system, seem to demand that the PASC consider innovations on existing registry models if it is to achieve its overall goals.

This paper presents a variety of options for the PASC to consider as it begins to plan its registry's development. Of those options, we recommend the PASC look toward the creation of what we call a **full-service, shared registry system**. This new model aims to combine effective practices found at existing public authority and community-based IHSS registries located both inside and outside Los Angeles County. The model is

- ***"Full-Service"*** because of the wide range of activities that comprise its operation, including: provider referrals and assessment; countywide data management; consumer support and education; provider recruitment, training and retention activities; and systemic Quality Assessment. And it is

- ***"Shared"*** in the way it organizes the delivery of those activities: some of them implemented through a centralized operation run by the public authority, and others of them delivered on decentralized, district-by-district basis by field staff in collaboration with existing consumer and provider organizations.

Registry Goals

Los Angeles' IHSS consumers have been especially anxious for the PASC's development of a countywide registry in order to improve:

- The continuity of their care;
- The qualifications and skills of referred caregivers;
- Consumer access to information about the IHSS program; and
- Consumer support that is otherwise lacking in the IHSS system.

At the same time, caregivers employed under the IHSS system (and the consumers with whom they work) have been looking to such a registry to enhance:

- Their opportunities to maintain or upgrade their caregiving skills;
- Their chances for achieving full-time work and a decent income; and
- Provider support that is otherwise lacking in the IHSS system, thereby contributing to workforce turnover.

The PASC must decide which of these inter-connected outcomes it wishes to pursue through the operation of its registry.

Registry Activities

Once it determines its registry's goals, the PASC can assess the proper range of operations that should be planned into its registry. To aid this process, we suggest that the PASC think of "the registry" not as a single, indivisible entity, but as a *system of activities* directed toward:

- Ensuring a supply of qualified providers, through the *recruitment*, *screening*, and *training* of prospective caregivers;

- Referring providers to consumers, including *data management*, *basic referral* of providers, and pre- and post-*referral assessment*;

- Offering *additional supports requested by consumers and providers* in the course of providing referral services; and

- Implementing *Quality Assurance* systems to make sure the registry achieves its prescribed service goals.

Based on our analysis of how different home care registries select from this range of activities, we suggest that the PASC choose from among three possible levels of service outcome: *Minimal*, *Expanded* and *Full-Service*.

	Minimal	**Expanded**	**Full-Service**
Provider Recruitment			**X**
Provider Screening	(x)	**X**	**X**
Provider Training			**X**
Data Management	**X**	**X**	**X**
Basic Referral	**X**	**X**	**X**
Referral Assessment		(x)	**X**
Consumer Supports		(x)	**X**
Provider Supports			**X**
Quality Assurance		(x)	**X**

Given the range of services that are already requested from existing IHSS registries in Los Angeles County, and the PASC's presumed commitment to a quality care / quality jobs strategy for improving the county's IHSS program, we identify the ***full-service registry*** as the logical choice to be pursued by the PASC.

Registry Structures

Whatever level of service the PASC eventually chooses for its registry, the Council will also have to grapple with the operational challenges posed by the unprecedented scale of service area and client population that its registry will have to cover across the expanse of Los Angeles County. It is in this context that the issue of registry *structure*—and who will take what role(s) within that structure—becomes particularly important.

There are two main types of countywide registry structures found among California's other IHSS public authorities:

- *Centralized Structure*—in which all of the county's registry activities are housed under one operation, run either by the public authority or by another agency under contract with the authority; and

- *Decentralized Structure*—in which the public authority contracts with a number of community-based organizations to create several mini-registries, which are dispersed throughout the county to serve specific geographic areas or client populations.

Each of these arrangements has its respective strengths and weaknesses relative to the different activities that comprise a full-service registry. Neither seems a particularly good match for Los Angeles County, however, especially given the immensity and diversity of the county's IHSS client population, and the variety of distinct geographic areas into which the registry will deploy its services.

However, thinking again of the registry not as an indivisible entity, but as a system of activities—each deliverable by different actors, according to their expertise and bases of operation—we recommend the PASC also consider a third option. We propose a ***"Shared" registry structure***, which draws on the relative strengths of both the centralized and decentralized models in a manner that maximizes the potential service outcomes of the PASC's registry, while at the same time dealing effectively with the challenges of scale posed by LA County's IHSS system.

	Centralized Structure	**Decentralized Structure**	**"Shared" Structure**	
			Central Registry	Decentralized Services
Provider Recruitment		(x)		**X**
Provider Screening	**X**	**X**	(x)	**X**
Provider Training				**X**
Data Management	**X**	*	**X**	*
Basic Referral	**X**	**X**	**X**	
Referral Assessment		**X**		**X**
Consumer Supports		**X**		**X**
Provider Supports		(x)		**X**
Quality Assurance			**X**	

The report closes with an analysis of the range of actors that could participate in the implementation of a ***full-service, shared registry system*** on behalf of the PASC, along with some preliminary projections of the resources that might be necessary to develop and operate such a system.

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What goals does the PASC have for its registry?

The creation of Los Angeles County's Personal Assistance Services Council (PASC) is the culmination of years of effort by allied consumers and home care workers to improve the ***quality of care*** offered by the county's In-Home Supportive Services (IHSS) program. A key theme of that campaign has been the recognition that a stable and experienced caregiving workforce—an essential factor in ensuring long-term care quality—will only be achieved with an improvement in the ***quality of jobs*** enjoyed by the county's IHSS providers.

It is within that context that the PASC—like the other California IHSS "public authorities" that have preceded it—now begins to plan for the development of a county-wide IHSS registry that will ensure that IHSS consumers have timely access to a pool of qualified care providers who can ably assist them with their essential tasks of daily living.

As it embarks on this endeavor, the PASC can and should learn from the experiences of the state's other public authority registries. But the PASC will also face challenges beyond those encountered in other counties. For one, the PASC's registry must meet the demands of an IHSS system comprised of some 80,000 consumers—and a comparable number of caregivers—spread out over 4,000 square miles of service area. As such, the PASC's registry will not only be California's biggest; it will most likely be the largest long-term care registry operation in the *entire country*.

At the same time, Los Angeles IHSS consumers have waited years for the creation of a public authority and a registry that might, in a very real way, *improve the day-to-day quality and continuity of IHSS services* received across a county otherwise under-served by its IHSS program. These local expectations, coupled with the attention that the Los Angeles IHSS program has recently received from across the United States, have raised the bar that the PASC will be expected to clear as it plans and rolls out its registry program.

Can a registry improve care quality for consumers?

Clearly, there are limits to the impact that the PASC-sponsored registry might have on the level and quality of services offered to IHSS consumers. For example, there are core characteristics of the IHSS program over which the PASC registry will have no control, including the insufficient public funds devoted to the program overall, the sometimes unpredictable processes whereby service hours are allocated to individual consumers, and the high attrition rate among IHSS caregivers that mirrors the turnover rates found in any poorly paid entry-

level occupation. These are challenges that the PASC and its allies will likely engage, but not through the structure or operation of its registry *per se*.

Likewise, because IHSS is a consumer-directed program in which client independence is valued and traditional social service models are suspect, there will be limits placed on the PASC registry's authority to regulate, structure or otherwise supervise the day-to-day interactions between individual IHSS providers and their clients—that is, the intimate environment where care quality is ultimately determined. The registry can work to create an overall IHSS environment in which quality care is encouraged and supported, but it ultimately cannot dictate *how* care is delivered to individual consumers.

However, a number of important areas remain in which a properly structured registry could have a positive effect on the quality of care enjoyed by IHSS consumers. They include:

Continuity of Care

- Quick referral of providers with the necessary skills and attributes to meet individual clients' needs.
- Emergency referrals of replacement / substitute providers when a consumer's regular caregiver is suddenly unavailable.
- A common foundation of basic skills demonstrated by all providers referred to an individual client.
- More consistent consumer satisfaction with registry-referred providers.

Qualified Caregivers

- Registry providers with a clear understanding of the practices and philosophy of consumer-directed care, and with the "soft skills" (communication, problem-solving, conflict resolution) necessary to implement client directions in the delivery of services.
- Providers with experience—or access to training—in specific clinical skills for particular client conditions (if that is desired by a client).
- Exclusion of "bad actors" from the registry's provider pool.

Access to Information

- Single-call access to up-to-date information about all IHSS providers currently available for referral, based on a range of variables (e.g., current schedule, skills, experience, geographic district of preferred operation).

- Clear and comprehensive information about the IHSS program, its expectations of consumers and providers, and the respective roles of the PASC registry and other county agencies.

Improved Consumer Support

- Immediate assistance available from the registry for consumers who encounter difficulties in finding a provider or managing IHSS services.
- Linkages to consumer-oriented support organizations for clients in need of deeper assistance.

The connection between *quality care* and *quality jobs*

Consumers of home- and community-based care consistently cite the care, support and companionship offered by home care paraprofessionals as the prime determinants of their day-to-day quality of life. Unfortunately, because home care employment—both in California and throughout the United States—typically offers low pay, no benefits, little training, and no support for caregivers working in isolation from each other out in the field, attrition rates among home care workers are inordinately high (40-60% / year). Such workforce turnover limits the number of home care providers with a significant base of experience working with clients, and subjects individual consumers to an endless parade of new providers coming into their homes—some of them good, some of them not, and all of them needing to be oriented to a client's particular needs and preferences.

Anything the PASC registry can do to enhance the stability of this caregiving workforce will therefore reap significant dividends for LA County's IHSS consumer community. As with care quality, however, there are bottom-line determinants of job quality (or lack thereof) within today's IHSS system—like the insufficient resources available to allow low-income caregivers to earn a living wage—that a registry cannot touch. But a well-structured PASC registry could improve other elements of an IHSS provider's job, and thereby increase the retention, skills and experience levels of IHSS caregivers overall. Those elements include:

Opportunities to Maintain / Upgrade Skills

- Full orientation to the principles of consumer-directed care, and the proper role of and boundaries for providers therein.
- Availability of formal training in soft skills (communication, problem-solving skills, team-building) as they relate to consumer-directed care.

- Options for clinical training related to particular diagnoses / conditions, so as to improve providers' employability across a range of consumers.

Opportunities to Earn a Stable Income

- Referral protocols (e.g., geographic clustering) that reduce provider travel time and increase options for full-time work (for those who desire it).
- Efficient blending of long-term hires and "on-call" assignments, in order to boost provider hours.
- Prompt and accurate payment to referred providers for services delivered.
- Protection of providers from abusive or otherwise untenable situations—without loss of hours / income due to removal from a case.

Individual Provider Support

- On-call support for individual providers working in the field.
- Opportunities for isolated caregivers to meet and share with their peers.
- Linkages to support services (outside registry) to help providers maintain their employment and make ends meet.

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These are among the goals the PASC might envision for its registry—one committed to improving both care quality and job quality throughout the county's IHSS system.

How those ends might be pursued by the PASC is the focus of the balance of this report, both in terms of:

- the range of *activities* that the registry will engage in pursuit of these ends; and

- the organizational *structures* that the PASC will use to deliver its registry services countywide.

What registry activities are warranted?

How should the PASC organize its registry in pursuit of these interconnected quality care / quality jobs goals? To assess the options, we have found it useful to picture the registry not as a single, indivisible entity, but as a *system of activities*—all of which contribute to the registry's central function of bringing together compatible caregivers and clients, and supporting those relationships in a manner that ensures consistent, quality service to IHSS consumers.

What range of services will *consumers* expect from the PASC registry?

The answers to this question vary from consumer to consumer, and even from day to day within the same consumer's lifetime. Some IHSS consumers have relatively modest expectations about what they'll need from a PASC registry. For example, most IHSS consumers have in the past found their providers not through registries, but through referrals gleaned from their own personal networks: family, friends, neighbors or other IHSS clients whom they trust. Some of these consumers will continue to rely exclusively on such networks even after the PASC registry is created, and as such may never seek direct services from the Council.

A smaller number of consumers have developed a relationship with a local consumer organization (e.g., an independent living center or senior center) that, as part of its client services, runs a small, in-house registry offering highly personalized caregiver referrals to a relatively limited number of consumers. Many of these centers consider their registries to be a central element of their IHSS consumer services, and as such will maintain their operation even after the PASC's registry is up and running.

From these consumers, one might anticipate a relatively limited demand for services from the PASC registry. IHSS consumers will, presumably, continue to use existing relationships—with family, friends and consumer advocates—as their primary source of support and provider referrals. Such consumers might only contact the PASC registry on those occasions when their standing referral networks have left them temporarily without a provider (e.g., an aide unexpectedly calls in sick, or a family caregiver needs a break). Such a perspective has prompted some to predict that only 10 percent of Los Angeles' IHSS client population will ever make significant use of a PASC registry. [1]

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[1] RTZ Associates, "Bold Action for A Challenging Problem…" report to the Los Angeles County Auditor- Controller and County Board of Supervisors, November 1996.

But the experiences of current Los Angeles IHSS registries seem to indicate that *significantly more* than 8,000 IHSS consumers (10 percent of 80,000) will make regular use of a PASC registry, and that a sizeable portion of these consumers will be looking to such a registry—as they do to existing IHSS registries—for a *broader range of services* than simple provider referrals. These consumers will likely include the many IHSS clients who do not have a relationship with an independent living center or senior center, and who have given up on seeking personal support or guidance from their IHSS social workers at the county's Department of Public Social Services. These are consumers who will see the PASC registry as the primary institution within the IHSS system to which they will appeal for help across a variety of issues, including, but not but not exclusive to, finding a qualified IHSS provider.

Requests regularly fielded by the Homecare Workers Union IHSS registry—the only countywide registry in Los Angeles, and one of the larger IHSS registries in the state—illustrate this consumer demand for a range of registry services, including requests for:

- Help in understanding the IHSS program in general;
- Assistance in contacting an IHSS social worker to determine the cause of a sudden reduction in a consumer's service hours allocation;
- Guidance in setting up workers' schedules, given a client's IHSS hours allocation and "share of cost" requirements, as well as her care preferences;
- Assistance in filling out paperwork (e.g., a blind client who cannot fill out a written release form without assistance);
- Support for processing of time sheets and keeping employer records;
- Requests for intervention from the registry to help a consumer with a "problem" provider;
- Requests for referrals to social service agencies for food assistance, anti-eviction services, etc.; or
- Emotional support for clients who are just looking for a familiar voice to call and who therefore will find reasons to repeatedly call the registry even when they are not in need of a new IHSS provider.

While many such requests are technically outside the purview of an IHSS registry, these calls for help nevertheless come to registry operators on a regular basis from consumers who do not feel able to deal with these issues on their own, and who otherwise have few ready alternatives for assistance in these matters.

What range of services will *providers* seek from the PASC registry?

Consumers are not the only people looking for help from IHSS registries. Home care providers—typically working in isolation with little support or training, and with few resources of their own to draw upon in times of crisis—also will appeal to registries with which they have developed long-term relationships for occasional assistance or support. So, too, do individual consumers seek, on behalf of their home care worker, provider-related services from an IHSS registry, in the hope that such assistance might help a valued but struggling provider maintain her employ as that client's caregiver.

For example, the HWU registry often receives requests from providers for:

- Guidance in how to effectively apply to a consumer for hire;
- Advice on how to deal professionally with a client;
- Additional IHSS work when a provider's hours are down;
- Support in tracking down at DPSS "lost" or delayed time sheets that are holding up a provider's payment for services delivered;
- Help in resolving late or insufficient payment for hours worked; or
- Linkages to other social services (e.g., food assistance, medical assistance) to help these low-income workers make ends meet.

Again, while such assistance may seem to lie outside the technical definition of a registry operation, it is nevertheless often necessary for a registry to provide such support—or to find someone who can—in order to retain a registry's quality providers and to support the development of positive, long-term relationships between caregivers and clients.

Such examples of "other-than-referral" services sought from registries are presented here primarily to underscore that running a quality registry—with a commitment to responding to client needs, and improving the care and quality of life enjoyed by IHSS consumers—is not as simple as creating a database, staffing the phones, fielding inquiries and generating names of providers looking for work. As IHSS registries in Los Angeles County and elsewhere in California have already demonstrated, there are deeper dimensions to operating a quality registry that require a range of activities beyond those typically associated with running a simple referral agency.

Possible PASC registry activities

As the PASC becomes *the* identifiable Los Angeles institution to which IHSS consumers and providers will appeal not only for referrals, but quite possibly for a range of services, the Council will have to decide what breadth of activities it wants to undertake to fill out its registry operation. For example:

- What activities will be required to ensure the effectiveness of the PASC's core operation—the bringing together of compatible caregivers and clients?

- What related activities might the PASC pursue—not simply to refer provider names, but also to improve the quality of the providers it refers, the consistency of the services delivered by those providers, and the potential for the development of long-term relationships between clients and caregivers?

We have identified four main areas of activity that the PASC might incorporate into its registry system:

1. Ensuring a Supply of Qualified Providers

- *Provider Recruitment:* This task is an often overlooked aspect of what will be required to maintain a large enough and diverse enough labor supply for a countywide registry—especially one committed to serving all client populations and geographic districts within Los Angeles' IHSS system. Current labor shortages within paraprofessional healthcare in general, and home care in particular, will make this an even more essential activity to counteract attrition and increasing frictions in bringing new providers into home care occupations. Recruitment activities could include both at large advertising and community-based, ward-by-ward outreach to identify potential providers in all sections of the county.

- *Provider Screening:* The PASC will likely wish to set some *negative* standards (e.g., criminal background, record of client abuse) to determine who may *not* be listed as a provider on the IHSS registry. To facilitate matching of caregivers to clients, a full-service registry would also want to assess and document each newly registered provider's skills, experience, prior client references, etc., so that data could be forwarded to consumers as part of the registry's referrals.

- *Provider Training:* To ensure a pool of qualified providers with a sufficient range of skills to serve consumers with varied needs and conditions, the

registry system should be prepared to offer training to providers—but as an *option*, not as a requirement for participation in the registry. [2] Trainings could range from developing providers' basic understanding of consumer-directed care, to enhancing providers' soft skill development (communication, problem-solving, etc.), to clinical training in particular transfer techniques or client conditions, to basic English language skills that would broaden the range of clients an individual provider could serve.

2. Referring Providers to Consumers

- *Data Management:* A primary reason for establishing a county-wide registry system is to have in *one database* an active and accurate record of the county's available IHSS providers, as well as information on file about the needs and preferences of consumers who regularly use the registry. The registry should also attempt to maintain up-to-date records of all placements made through the registry, and their outcomes. This will be essential to ensure the currency of the registry's information about provider availability, as well as to assess the overall effectiveness of the registry's referral services. [3]

- *Basic Referral:* This is the heart of any registry operation: the "matching" function of fielding calls from consumers and then referring the names of potential providers according the particular variables specified by the consumer. Depending upon the level of information kept on each provider, these referrals can be structured with a certain amount of "pre-matching" for general characteristics (e.g., district of residence, language, past experience with different types of clients, documented skills or training, and current and projected availability).

- *Pre- and Post-Referral Assessment:* To serve consumers who want more assistance (beyond the simple referral of names) in identifying the "right"

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[2] Conventional training methods for home care workers have often been rejected as inappropriate for consumer-directed programs like IHSS because it is the *individual client*—not an instructor in a classroom—who should tell a caregiver the "right way" to provide assistance. But some consumer-directed advocates have recently acknowledged the promise of alternative training curricula—such as those under development within PHI's *Cooperative Healthcare Network*—that attempt to develop caregivers' skills in communicating and collaborating with a client so she might fully understand his desired plan of care, and then implement that plan within the context of basic clinical "principles" (vs. rigid clinical "techniques"). The PASC registry could consider developing similar curricula for the baseline training of IHSS providers.

[3] It should be noted that documentation of placements is not always easy within some consumer-directed home care programs like IHSS, since it is the client—not the registry—who decides when providers are hired or dismissed, without any formal expectation that those decisions be reported to the registry. Attempts by the Homecare Workers Union registry to encourage voluntary consumer reporting of hires have yielded uneven results, thereby limiting the registry's ability to assess which of the referred providers are available for hire on any given day. The PASC registry might consider developing alternative feedback mechanisms—perhaps with DPSS, which knows through its payroll function which providers have been hired—that allow the registry to track placements and provider availability.

provider, some registries offer: more in-depth discussions with clients about their specific needs (which in some cases even include an in-home assessment) [4]; talking through the short list of referred providers to help the consumer pinpoint some of the better matches; and post-referral follow-up with clients to make sure the provider is working out, or to assist the consumer with the initial structuring of service hours and payment.

3. Offering Additional Supports

- *Supports to Consumers:* As mentioned earlier, these could include: general consumer education about the IHSS program; helping consumers who are having difficulty supervising their providers, arranging schedules or processing time sheets and employer records; assisting consumers in their efforts to track DPSS changes in their service allotment; and supporting the resolution of conflicts with a provider.

- *Supports to Providers:* As noted above, these can include: guidance to new providers in how to apply effectively to be hired by a consumer; supporting a provider's relationship with her client; helping providers identify ways to enhance their availability for on-call assignments (e.g., the use of pagers); promoting the timely processing of time sheets by consumers and DPSS; resolving late or insufficient payment for hours worked; offering home care workers opportunities for peer support in what otherwise is a solitary and isolating occupation; and putting providers in contact with public or private programs that can supplement the resources of low-wage workers (e.g., food programs and Medicaid). Finally, while it is not a "service" per se, any registry efforts to promote full-time work—in how it schedules and clusters cases, to the extent this is achievable under a consumer-directed system—would also be a form of support that helps providers stay within the IHSS system.

[4] One of the gaps that some registry operators have identified between DPSS and IHSS registries is that no portion of a social worker's assessment of an IHSS client's needs—i.e., the basis of the agency's allocation of service hours—is made available to the registry after it has been contacted by the consumer for assistance. As a result, registry operators and consumers must attempt to walk through another sometimes lengthy assessment—usually over the phone—in order to determine which providers would potentially meet his / her needs. While there are clear issues at stake regarding confidentiality and the desire by clients to describe their own needs to a registry, the PASC might consider at least examining this disconnect in information-sharing within the IHSS system as it sets up its own registry.

4. Quality Assurance

A series of activities comprising a Quality Assurance system will be essential to monitor the registry's effectiveness at all points during its development, and to ensure its consistency with the PASC's goals.

- *Ongoing benchmark assessments:* The PASC could work with the registry staff to establish measurable benchmarks of performance, based on the overall "Quality Care / Quality Jobs" goals set for the registry—such as those proposed earlier in this paper. Use of standard Quality Assurance (QA) systems (e.g., balanced scorecards) are also an option.

- *Surveys of participants:* Periodic surveys of all consumers and providers, to assess whether the registry is having a positive, on-the-ground effect on care delivery.

- *Individualized follow-up and monitoring:* Given the limits of surveys in gathering in-depth feedback from clients and their providers, the registry could also institute scattered home visits and interviews with participants to assess if IHSS services are actually improving client care.

Possible levels of service outcome

Of course, registries can vary greatly in their aspirations to incorporate all or only a few of the above-listed activities. From the preceding menu of activities, we can construct three possible levels of service outcome that the PASC might consider for its registry system (summarized in Table 1):

- A ***minimal*** service version, in which the registry's activities are limited exclusively to the simple referral of provider names to consumers, with only the mandated negative pre-screening of providers. Such a registry would not offer any additional services to consumers or providers, and it would not attempt to assess how IHSS services are being delivered—presuming individual consumers will assess and ensure their own care quality. Ensuring an adequate supply of providers and monitoring overall Quality Assurance would not be components of this model.

- An ***expanded*** service option, which would put additional emphasis on assessing the backgrounds (positive and negative) of potential providers, while providing some additional services to consumers beyond simple provider referrals. This type of registry would also implement some limited Quality Assurance monitoring to assess the outcomes of its efforts.

However, this model would not address any of the identified issues related to labor supply, competency or retention.

- The ***full-service*** option, in which the PASC registry system engages in the broader range of listed activities, attempting to maximize both *care quality* for consumers and, correlatively, *job quality* for providers. This registry would offer a range of support services to consumers to ensure the success of provider referrals, and would attend to issues related to labor supply, competency and retention. Such a registry system would also establish benchmarks and QA systems in order to assess its own performance and stakeholder satisfaction (consumers, workers, and public payers).

Table 1: Registry Activities and Service Outcomes

	Minimal	**Expanded**	**Full-Service**
Recruitment			**X**
Pre-Screening	(x)	**X**	**X**
Training			**X**
Data Management	**X**	**X**	**X**
Basic Referral	**X**	**X**	**X**
Referral Support		(x)	**X**
Services to consumers		(x)	**X**
Services to providers			**X**
Quality Assurance		(x)	**X**

X = Core element (x) = Secondary element

Given the range of day-to-day consumer needs currently unmet by the existing IHSS program, and the PASC's desire to create for Los Angeles County a registry that might have some tangible effect on the care quality enjoyed by IHSS consumers, **we would encourage the PASC to pursue, over time, the development of a <u>full-service registry system</u>**. While this is clearly not the easiest of registry systems to develop, its goals for service improvement seem the most consistent with the overall expectations that some consumers have associated with the creation of a PASC registry. Most importantly, we believe a full-service registry is *achievable*—if the PASC considers some innovations in how it organizes and structures its services.

Possible PASC registry structures

The organizational structure that the PASC ultimately chooses for its registry will turn on two main considerations:

- The level of service outcome desired; and

- An assessment of how the PASC might deal with the unprecedented scale posed by Los Angeles County's IHSS program.

While there are several existing countywide IHSS registries to which the PASC can look for ideas about how to structure its own registry, the sheer size of LA's IHSS client community—more than 10 times that of any other California county—makes it unlikely that simple replication of registry infrastructures found elsewhere will work well for the PASC. With that said, however, an overview of existing public authority registries can offer some lessons about how some of these existing structural models—if modified for LA—may or may not serve the PASC's service outcome goals.

There are two main types of registry structure found in today's IHSS public authority counties:

- **Centralized Structures** (e.g., San Francisco, San Mateo, Sacramento)

  In this scenario, all of the county's registry activities are housed under one operation—run either by the public authority or another single agency under contract with the authority. All calls from the county's consumers come into to that single office, which maintains the central database of providers and makes all referrals. Countywide caregiver recruitment and screening, and any services or supports offered to providers, are also administered by that central registry operator.

  - and –

- **Decentralized Structures** (e.g., Alameda)

  The public authority contracts with a number of community-based organizations to create several mini-registries, each with its own intake center, which are dispersed throughout the county. Some of these mini-registries can be designated to serve a particular segment of the county's IHSS population (e.g, seniors, people living with disabilities, an ethnic or language group) or a particular geographic area. Regardless of their specific consumer niches, however, all mini-registries are expected to

provide the *same menu of services* in accordance with the protocols and standards set by the public authority. The decentralized system requires each mini-registry to maintain its own distinct database of providers (compiled in accordance with common screening standards), and to recruit providers as needed to maintain its labor supply.

Relative Strengths and Weaknesses

Picturing "the registry" not as a single entity, but as a coordinated system of activities, allows us to assess the relative strengths and weaknesses of centralized vs. decentralized systems in the delivery of each of our previously identified registry components. (See Table 2)

Centralized

The strengths of a centralized registry system rest primarily within activities related to the *referral process*. Since it is the sole repository and access point for information about a county's IHSS providers, the centralized registry has clear advantages over the typical decentralized system in which consumers might have to bounce between multiple and incomplete provider listings until they locate a quality referral. Having a large and diverse central pool of providers also increases a consumer's chances for finding an available provider, especially if he or she needs a replacement provider on short notice or she otherwise presents difficult-to-serve clinical or scheduling needs.

However, while the centralized registry can offer the largest pool of potential providers, such a registry—especially since it would sit within the large and populous Los Angeles County—may not be the best system to maintain the supply of labor necessary to keep such a pool filled. At-large recruitment of IHSS providers—as opposed to ward-to-ward outreach and screening—will most likely generate an uneven number of applicants from community to community, thereby putting consumers living within certain wards at greater risk of not finding a local caregiver from the central registry pool.

Another potential weakness of the centralized system is its inability to provide the type of personalized services that some consumers seek from an IHSS registry. A centralized registry system does not offer local or center-based intake services or support. It is limited in the depth of relationship it can develop with one consumer (or provider, for that matter). Nor is it well-equipped to track its own care quality or job quality performance outcomes, due to its inherent limits in tracking individual clients and providers.

In all, the centralized system seems best suited to pursue the "minimal" service model outlined in Table 1. This is not to say that a large centralized registry cannot aspire to provide services beyond simple provider referrals. For example, the Homecare Workers Union registry has served over the past five years more consumers (close to 10,000) than any of the other the state's other Public Authority central registries—and yet has made considerable strides toward developing something that, over time, might have become a full-service registry.

But the ability of the HWU, the PASC or any other central registry operator to deliver adequately on each of the "full-service" activity areas across the enormity of LA's IHSS population will inevitably be strained beyond its capacity. Indeed, every registry "expert" consulted for this study—including those who run centralized IHSS registries in other California counties—could not conceive of how the PASC could run a single, service-oriented registry for a client population as large and diverse as Los Angeles County's.

Decentralized

Alternately, the decentralized system finds its greatest potential advantage in the very *outreach and support services* that would overtax a centralized registry. Because a system of mini-registries could break LA's immense client population into smaller, more manageable pieces, it could allow registry staff at each site to develop a more in-depth knowledge of individual consumers and of the communities in which their registry's providers are deployed. Local registries can develop community-based recruitment and screening networks in order to compile a group of providers who live in the same neighborhoods as their IHSS clients. And because they focus on making referrals in a particular geographic area, decentralized registries can use more creative means of organizing provider deployment—such as the geographic clustering of referrals or the creation of district-wide teams of on-call providers—to boost individual workers' hours while improving clients' care continuity.

Localized registry staff can also develop working relationships with a district's consumer organizations (independent living centers, senior centers, etc.) that are running in-house IHSS registries even after the PASC registry system has been established. Such connections between PASC-sponsored staff and these centers would improve the coordination of replacement caregivers when called upon to fill-in on those occasions when center-based registries cannot meet a client's short-term needs. It could also allow local PASC-sponsored registries to develop referral networks for isolated consumers who are in need of more intensive services or supports but who lack a relationship with any local consumer organization.

Finally, a decentralized registry system within Los Angeles County could create local venues for communication between local registry staff and IHSS case managers within each of the district offices of the Department of Public Social Services. Existing Los Angeles IHSS registries often complain about the difficulty of extracting even basic information—often at the request of consumers themselves—from the sizeable DPSS bureaucracy. Confirmation of a client 's condition or needs assessment, explanations for dramatic changes in a consumer's service allocation, the name of the provider whom the consumer has hired, the status of a provider's overdue payment: such is the information that could be made more available by DPSS to the PASC registry. **We recommend that this gap between the DPSS and IHSS registry systems be narrrowed—** regardless of whether the PASC adopts a centralized or decentralized registry model.

We propose, however, that such information flow might best be facilitated *at the district level*, where local registry staff could talk regularly to DPSS case management staff also working in the same district. A decentralized system, then, could support the building of heretofore missing bridges between the IHSS program's primary service allocation agency (DPSS) and what will now become its primary public service delivery entity (the PASC).

Where all of the promise of a decentralized system fades, however, is in the potential for unevenness in the delivery of any particular service across the system's several mini-registries. A diligent public authority may try to make sure that all of its district registries are performing up to standard in all phases of their operations, but there will inevitably be inconsistencies from site to site. If existing community organizations are used to deliver registry services on behalf of the PASC, it is likely that each will offer these services in a manner consistent with its particular mission and philosophy— thereby creating potential for unevenness.

A related weakness of the decentralized system is the potential inability of any one mini-registry to deliver to its clients a large and diverse enough pool of providers to meet all consumers' needs, especially on an on-call basis. Such challenges already face Los Angeles' existing collection of center-based mini-registries—which is precisely why those centers have looked forward to the PASC's creation of a centralized pool of providers with enough on-call providers, for example, to fill in gaps left by their smaller-scale operations. While a decentralized registry system may be in a better position to do localized recruiting of providers in each of its service areas, it is not in a good position—relative to the centralized system—to maintain on its own a sufficiently large referral pool to meet all local consumers' needs.

One way this problem of access to a central provider pool, however, might be addressed within a decentralized system is with the help of current information and telecommunications technologies. In this day of seamless dial-up networking and Intranet connections linking computers across the world, the costs and difficulties of developing a countywide computer registry network—in which "field" computers can access a large database sitting on a central network server—have been greatly reduced. Each mini-registry would just need a computer, a modem and a phone line to have access to an up-to-the-minute list of all the county's available providers meeting specific selection criteria—so long as there was a central administrator for that database that maintained its integrity and accuracy of content. [5]

Finally, a decentralized system fails to capture the budgetary economies of scale offered by a single, centralized registry. By setting up or subsidizing the operation of several mini-registries—each with its own space, equipment, administration and base personnel costs—the countywide system multiplies its expenses significantly over what would be required to set up one central registry office with a larger staff. As an alternative, it might be possible to mitigate some of these start-up costs by initially establishing field staff (as opposed to field offices) who are deployed from the central registry, but who are assigned to a particular service district in the county. District activities that require a local physical space could be delivered in conjunction with an existing organization within that district that could lend its space to the PASC for those local efforts.

A Third Way? The "Shared" Registry Structure

Does a structure exist that offers the strengths of the centralized system—specifically, its economies of scale in data management and referral—without sacrificing the recruitment and service advantages offered by a decentralized network? We propose that the PASC consider developing a hybrid—*or "shared"—registry structure* that draws on the relative strengths of both the centralized and decentralized models, thereby maximizing the potential service outcomes of the PASC's registry, while at the same time dealing effectively with the challenges of scale posed by LA County's IHSS population.

Such a shared system—as illustrated in the final column of Table 2—would house the database and basic referral activities within one central office, administered either by the PASC or its contractor. At the same time, the PASC would gradually build (or incorporate) a network of community-based r*egistry service centers*—or, alternately, *registry field staff* working in collaboration with

[5] While such a dial-up network does not exist (to our knowledge) at any current IHSS registry, PHI personnel have in the past played a role in the development of similarly structured information systems connecting multiple offices across a several county area to assist with the coordination of home- and community-based long-term care services.

existing community-based organizations—dispersed geographically throughout Los Angeles County. These local operations would resemble in some ways the "mini-registries" found in the typical decentralized system—except that these decentralized operations offices would *not* be responsible for *every activity* delivered by the overall registry system. Rather, they would be working in coordination with the central office, which would be primarily responsible for the system's call intake, database management and basic referral activities.

That is, the division of labor envisioned within a shared system is an effort to divide up registry activities—as opposed to registry districts, the demarcation within the typical decentralized system—between different organizations, according to their expertise and experience. In turn, some of those activities (e.g., core referral operations) will be housed centrally, while others of them (e.g., provider recruitment or support for consumers) will be delivered on-the-ground through field operations rather than from telephone operators sitting in a downtown office.

In addition, if there were a specific IHSS constituency for whom neither the

Table 2: Registry Structures—Relative capacities for identified activities

	Single Centralized Registry	**Coordinated System of Decentralized Registries**	**"Shared" system**	
			Central Registry	Decentr. Services
Recruitment		(x)		**X**
Pre-Screening	**X**	**X**	(x)	**X**
Training				**X**
Data Management	**X**	*	**X**	*
Basic Referral	**X**	**X**	**X**	
Referral Support		**X**		**X**
Services to consumers		**X**		**X**
Services to providers		(x)		**X**
Quality Assurance			**X**	

X = Core element (x) = Secondary element

* Achievable with a countywide network connecting all field offices to central database.

central registry nor a local service center possessed the necessary expertise—such as, members of a language group that comprise a very small percentage of the IHSS population—the PASC would have the flexibility within a shared system to contract out some of its registry activities to a community organization structured to serve that population, in order to ensure those consumers' full integration into the PASC registry system.

On the provider side, an organization like the Homecare Workers Union could agree to work with the PASC to assist with a shared system's recruitment, training and support of caregivers—thereby drawing on the union's expertise and relationships with a significant segment of the Los Angeles provider community. One existing model for such a collaboration between a public authority registry and a local union is found in San Francisco, where the county's IHSS Public Authority has entered into a partnership with the Health Care Workers Union (SEIU Local 250) to develop a foundation-funded "Workers Center" that delivers some of the provider orientation, training and support activities described above. Here in Los Angeles, the Homecare Workers Union (SEIU Local 434-B) could work with the PASC to establish such programs for the county's IHSS providers as well as assist in the countywide recruitment of providers to maintain the PASC registry's rolls.

Who are the potential players in a Shared Registry system?

A key factor in a shared system's success will be the particular constellation of actors that the PASC brings together to implement the system's various components. Who are those potential participants?

Two primary options exist for the delivery of the ***centralized*** portion of the shared system's services:

- *PASC*: The Council could decide to expand its own staff and physical plant in order to run the registry's call intake, basic referral and MIS activities, as well as coordinate and monitor Quality Assurance throughout the system.

- *Contractor*: The PASC could contract those activities out to another agency, with specific guidelines for operations and with set performance benchmarks in order to better ensure that the contractor is in compliance with the PASC's desired service outcomes.

Given the importance of this central position within the countywide system, the PASC would have to be fully assured that, if it chooses to turn this central role over to another organization, the selected agency must be thoroughly in

agreement with the mission and goals of the PASC, and—beyond whatever contractual conditions the PASC sets in place—must be accountable more generally to the consumers and providers within LA County's IHSS program. For example, a large, for-profit MIS or technical systems corporation—while it may be able to manage the data in / data out aspects of the central registry—would likely not be in tune with, nor feel particularly accountable to, the issues of care quality and job quality that have defined the ten-year grassroots effort in Los Angeles to establish an IHSS public authority. Nor would such an entity be able to fully adopt the service perspective that informs the consumer community's expectations for the PASC registry.

A more suitable central registry operator would seem to be an organization that has been a part of, or has strong connections to, those constituencies that have worked very hard to create the PASC. Even in that circumstance, however, the level of stakeholder collaboration and broad-based accountability that characterizes the PASC itself must also be required of the selected operating organization—be it consumer-based or provider-based—that takes over the PASC's role as the registry system's functional hub.

For the ***decentralized*** portion of the shared system, three options also exist for who might perform those activities:

- *Existing Organizations*: Under this strategy, the PASC would contract out all decentralized services—including the maintenance of district registry offices—with community-based organizations that are already providing services to a local area's IHSS consumers.

- *Satellite Offices*: In this scenario, the PASC hires its own field staff and establishes its own satellite outlets in order to provide the necessary community outreach, client contact, provider recruitment and local inter-organizational relationship building.

- *Field Staff*: Instead of creating eight new field offices, the PASC could hire field staff and assign them to specific districts in the county, but still house and deploy them from the central registry office. For those field activities that require a physical location in a district (e.g., informational meetings about becoming an IHSS provider, meetings with local consumer advocates about the PASC registry's performance, etc.) field staff would establish a standing arrangement with existing community-based organizations (ILCs, Senior Centers etc.) to use their offices on an *ad hoc* basis to hold such meetings, meet with local clients and providers, etc.

Each of these options has clear pros and cons. *Contracting with existing organizations* allows the PASC to take advantage of their already established IHSS

expertise and connections with local consumers, as well as existing spaces and support staff that could be developed quickly and provided in-kind or at reduced cost. On the other hand, since these organizations already have their own clients, philosophies, priorities and in some cases in-house IHSS registries, there is significant potential for inconsistency from site to site within the PASC's network. Given the level of integration that will be required between the shared registry system's centralized and decentralized components—in how local providers are recruited, screened and forwarded to the central registry pool; in how referrals are made and serviced; in the assessments of local performance that will determine the PASC registry's overall "quality" rating—such unevenness between local sites could put the entire system at risk. Efforts to assert such consistency could, in turn, put the PASC in the uncomfortable position of forcing consumer organizations to alter strongly held practices.

Under the *satellite office* option, the PASC would stand a better chance of assuring consistency in service and philosophy from site to site, and in having the flexibility to quickly implement any needed changes throughout its network. Performance measures could be assessed from site to site without putting a PASC consumer ally at risk for potential public embarrassment. However, the related risk is how much time or resources would be required to build up such a network from scratch. Creating ten new offices would probably demand more of the PASC's resources than would contracting out with ten existing organizations.[6] The requisite start-up time required to find new space, hire staff and establish systems at each of the local sites would likewise take longer than would using existing groups.

A viable middle road could be the *field staff* option, which would not require the start-up time or resources associated with outfitting satellite offices, but would assure a level of consistency across decentralized operations that a contracting-out model might not. Further, if the PASC were adept at developing partnerships with community organizations willing to share their neighborhood offices on an ad hoc basis, the central registry would likewise benefit from the already established relationships and reputations of these existing organizations within these local districts.

[6] If the PASC were to establish eight satellite offices, however, the number of clients served by each would be greater than the consumer base served by any of the state's other public authority registries. As such, even with the cost of setting up ten offices in addition to the central registry operation, it is possible that the per-client cost of such a system would be comparable to the resources expended on IHSS registries elsewhere in California.

Conclusion

The proposed "shared registry system" seems to have the best potential—especially within the context of Los Angeles County—to achieve an appropriate "full-service" outcome for the PASC's registry efforts. While some may have valid concerns about the risks associated with developing a new and unprecedented registry structure, the reality is that the challenges facing the PASC are themselves unprecedented among the state's IHSS public authorities. However, the shared system is in many ways simply a *novel combination* of what are otherwise already tested centralized and decentralized IHSS registry systems from which the PASC can continue to learn as it builds its own registry infrastructure. Further, if the PASC decides to incorporate the recommended Quality Assurance activities in the early stages of its registry development, those systems will then serve as a valuable check on the effectiveness of the shared infrastructure, and give early warning of any necessary changes or adjustments to ensure the system's effectiveness in improving care quality and job quality within LA's IHSS program.

Of course, because the shared system multiplies the number of entities to be managed by the PASC, it would pose a significant administrative and coordination challenge when compared to a standard, centralized registry model. Since multiple actors and slightly more complicated MIS systems will be required, potential exists for the shared system to take an extended period of time to build across the entire county. Furthermore, the shared system would require a larger budget than if the PASC opted instead for a simple centralized registry—though, given the size of LA's IHSS client population, it is conceivable that even with the creation of a central referral registry and a series of eight or more local service centers, the shared system's per client expenses could be comparable to those of California's other public authority registries.

These are all formidable challenges, yet it is our assessment that such innovations are worthwhile, given the PASC's mission and the potential well-being that such a system could offer to the IHSS consumers of Los Angles County.

Appendix

Resource and Implementation Issues
(Preliminary)

Resource and Implementation Issues

It is beyond the scope of this report to present a detailed business plan and implementation schedule for any particular registry structure. However, given the PASC's obvious interest in the potential costs of different registry models, we present the following thumbnail sketch of what might be required to build and operate a version of the "full-service, shared registry system."

Prior DPSS Cost Estimates

In 1997, the Los Angeles County Board of Supervisors asked DPSS to provide budget estimates for different types of public authority registries. We briefly review them here to establish a baseline comparison for the full-service, shared model.

Proposed range of activities

In its report, DPSS analyzes several different registry models, ranging from

- A *"Bare Bones" Registry*—the least form of centralized registry allowed by the PASC's enabling statute, comparable to the "minimal" service model described in our report ; to

- A *"Comprehensive" Registry*—a centralized registry with the addition of the consumer services (at reduced scale) and "negative" provider screening activities that resemble a version of our mid-range "expanded" service model.

As such, the most comprehensive of the DPSS registries, while an improvement over a "minimal" service model, does not aspire to deliver the range of activities prescribed by our full-service registry. It does not propose a comparable range of consumer support services, nor does it organize activities related to provider outreach, recruitment, training, or ongoing support and retention.

Further, the DPSS model intends delivery of all of its services via a centralized structure, without the supplemental field operations or network of community-based service partners found under the "shared" registry structure defined in this report. As such, the DPSS model makes no focused effort to ensure a sufficient number of qualified providers in each of the county's local districts.

Presumed consumer utilization levels

DPSS adopts what we consider to be the RTZ study's overly conservative projection that consumer utilization of a countywide registry will not exceed 10% of Los Angeles' IHSS population. In making its cost estimates for years 1 and 2 of the registry's operation, the agency also does not seem to presume any year-to-year change in the overall size of the countywide IHSS population. Hence, a flat utilization number of approximately 8,000 consumers is in effect across all DPSS cost estimates.

Attention to provider attrition

The DPSS estimates also do not include any projections for possible growth in the provider recruitment or retention activities necessary to meet fluctuations or concentrations of consumer demand in each area within LA county.

Staff and budget estimates

Given these utilization levels and the mid-range activity set proposed by its "comprehensive" model, DPSS estimated a necessary registry staff of 11 people. This compares, for example, to a seven-person registry operation under the San Francisco IHSS public authority, which serves a client population one-tenth the size of that in Los Angeles.

First-year operating costs for the PASC are pegged at $4.34 million, with **$1.66 million earmarked for the comprehensive registry's start-up** expenses. Ongoing annual costs for the PASC are set at $2.49 million, with the costs of **running a comprehensive registry slated for $1.12 million per year**. Assuming 8,000 consumers using the registry, per-capita costs would average to **$140 per consumer-user per annum**.

Full-Service, Shared Registry System

Our cost estimates for a full-service, shared registry reach beyond those made by DPSS, both in terms of the range of activities prescribed, and in the expected numbers of consumers who might avail themselves of such a "quality care / quality jobs" registry within an expanding IHSS program.

Proposed range of activities

When compared to the DPSS model, a full-service, shared registry aims to

- Extend the range of activities in order to better support consumers and providers in their development of long-term partnerships; and

- Deliver each of these activities in a manner that maximizes their effectiveness—by *centralizing* the registry's data management and referral functions, and *decentralizing* the delivery of consumer support and provider recruitment, screening, training and retention activities on a district-by-district basis.

As noted in the preceding report, this shared structure allows the PASC to use, in addition to its own registry staff, existing IHSS consumer and provider organizations from throughout the country to assist with the registry's field operations.

Various combinations of actors could participate within such a structure. For the purposes of the following budget projections, we are presuming that the PASC will itself run the centralized data and referral functions, and that it will hire and deploy from its central office its own field staff (versus establishing separate satellite offices) assigned to each of eight different service districts.[7] We are also assuming that if the PASC did decide to contract out any of these field activities (e.g., if it asked the Homecare Workers Union to use its existing community-based networks for the purposes of provider recruitment, training and support), the overall costs to the PASC would be the same as if the authority implemented those activities in-house.

Presumed consumer utilization levels

The preceding report proposes that a countywide registry launched and promoted by the PASC—especially with the quality care / quality job innovations we've recommended—will be sought out by more than 10% of the consumer population. In our projections, we present a scenario in which the PASC registry starts with a 10% utilization level (i.e., something comparable to the transfer of clients from the Homecare Workers Union's countywide registry to the PASC), and then grows at 5% a year as registry operations extend into each community district, efficiencies in on-call and replacement referrals increase, and the reputation of the PASC registry grows.

[7] As such, we assume—much as did the DPSS estimates—that the registry will make use of the PASC infrastructure for its executive leadership and administrative functions. Therefore, no costs have been included in our estimate for general administrative support staff or for senior management positions such as an Executive Director, Chief Financial Officer or Human Resource Director. PHI also assumes that space, furniture and office equipment will be provided by the PASC. If the registry is contracted to an outside provider, additional overhead costs would be incurred beyond those included in the following estimates.

Further, we assume the consistent growth of the IHSS consumer population witnessed over the past seven years will continue at 5% per year for the next several years. This, too, will contribute to the projected growth of the PASC registry operation.

Attention to provider attrition

Just as more investigation is needed to establish real projections about consumer utilization, additional research is needed to assess provider turnover and attrition within LA County's IHSS system.

In the attached projections, we assume that in any one year, half of the PASC registry's consumer users will seek referrals for a new provider. That is, we are presuming a per-employer worker turnover of 50% per year, which corresponds to homecare worker turnover of 40-60% nationally. Of course, some consumers will use the registry more frequently and call volume may be significantly higher if the registry becomes known for emergency or temporary replacement referrals.

Further, we also assume that the industry turnover rate—i.e., the number of providers who do not just leave a client, but who leave IHSS home care employment altogether—will be about 40% a year. The portion of those lost qualified providers that appears on the PASC registry's list will have to be replaced—through recruitment and screening efforts—if the authority is to maintain its ability to meet consumer demand for referrals.

Staff and budget estimates

To implement the range of activities defined by a full-service registry, the PASC will need to make a commitment to fully staffing both its central referral operation, as well as field-directed consumer and provider outreach and support services. We estimate that, after two years of phased-in development, **the PASC's full-service, shared registry would be comprised of 30 dedicated staff** working across the following positions:

- *Registry Director/Manager* – Responsible for overall program administration and direction. Works closely with Executive Staff and Registry Advisory Board.

- *MIS Manager* – Responsible for maintenance, development and updating of registry database and ensuring smooth functioning of computer systems.

- *Registry Supervisor* –Oversees customer service and provider intake clerks.

- *Customer Service Clerks* – Respond to requests for assistance from consumers seeking providers. Conduct phone assessments of consumer needs; provides matched list of possible providers; offer assistance requested by consumers in identifying appropriate providers; and follow-up with consumers to verify whether a registered provider was hired. At full capacity, we estimate that five Customer Service Clerks will be required.

- *Provider Intake Clerks* – Process provider applications, background checks, etc. (depending on the screens mandated by the PASC). Adds new providers to database and regularly update provider profiles. Five Provider Intake Clerks will be required at full scale.

- *Field Supervisor* – Oversees work of Consumer Outreach Staff. Coordinates field work with central office staff. In a shared system, manages any contracted field services.

- *Consumer Outreach Staff*– Responsible for developing relationships at neighborhood / district level with DPSS staff and with consumer and workforce development organizations; coordinate consumer training sessions; provide basic assistance to consumers who seek additional help finding or retaining providers; develop local referral networks for consumers in need of additional or ongoing support. Within a shared system, these functions may be provided in collaboration with (or in some cases, contracted with) established consumer organizations. At full scale, we recommend nine Consumer Outreach staff persons – slightly more than one per local district.

- *Recruitment and Training Coordinator* – Develops curricula; plans and coordinates training sessions; collaborates with community partners and union to deliver training; identifies additional training resources as needed.

- *Recruiters* – Recruit providers for registry through interface with workforce development organizations; conduct informational sessions with prospective providers about IHSS system and opportunities. Given the contemplated size of the registry and the significant turnover problem in the industry, we estimate that nine full-time recruiters will be necessary at full capacity.

- *Instructional Staff* – Conducts "in-service" training for active registry providers. Specific training sessions to be determined by consumer and /or provider requests, with an emphasis on developing caregivers' skills in communicating and collaborating with a client to ensure that appropriate consumer-directed care is provided. In a shared system,

some of these services could be contracted out to the union or other workforce development organizations.

We estimate that implementation of such a full-service shared registry will require **$1.0 million in start-up funding**, to be expended over a pre-operation period of six months. The registry's ongoing operation budget would

- Start at **$1.6 million in year 1**;

- Increase to **$2.1 million in year 2** as field staff are incrementally deployed to all eight service districts and activities for provider training and support are fully implemented; and

- Continue to grow thereafter to **$3.4 million in year 5**, assuming 5% annual growth in the Los Angeles' IHSS program, and 30% consumer utilization of the PASC registry.

Per-capita costs would average to **$140 per consumer-user per annum** after all proposed registry operations are in place (after Year 2), and decrease thereafter to **$111 per consumer-user per annum** in Year 5 of its operation.

Statistical Details

The following pages detail our:

- *Utilization and Productivity Assumptions*—which form the basis for projecting the scale of registry operation needed to serve a growing IHSS consumer population;

- *Budget Estimates*—projected for pre-operation start-up phase (six months), a build-up operation phase (Years 1 and 2), and a full operation phase (Years 3 to 5); and

- *Personnel Detail*—the number of people required at each staff position, along with estimated salary levels.

Table A-1: Utilization and Productivity Assumptions

	6 month Start-up	Year 1	Year 2	Year 3	Year 4	Year 5
Scale/Utilization						
# of consumers		85,000	89,250	93,713	98,398	103,318
% of consumers using registry		10%	15%	20%	25%	30%
# of consumers using registry		8,500	13,388	18,743	24,600	30,995
# of providers needed	5,000	8,500	13,388	18,743	24,600	30,995
Provider attrition from registry		40%	40%	40%	40%	40%
Recruitment Goal	5,000	6,900	10,243	12,852	15,697	18,794
Productivity						
Annual case turnover rate		50%	50%	50%	50%	50%
Consumer calls per month		354	558	781	1,025	1291
Calls per year		4,250	6,694	9,371	12,300	15,498
Calls per CS worker per month		130	130	130	130	130
FTE CS Workers required		2.7	4.3	6.0	7.9	9.9
Recruits per month	833	575	854	1,071	1,308	1,566
Recruits per intake worker/month	200	200	200	200	200	200
FTE Intake workers required	4.2	2.9	4.3	5.4	6.5	7.8
Productivity goal per recruiter/month		100	100	100	100	100
Recruiters required	4.0	5.8	8.5	10.7	13.1	15.7
Consumer Education session:	8	16	24	24	24	24

Assumptions:

1) Growth rate for IHSS Recipients continues at 5% annual increase (average growth rate from 1992 - 1998).
2) Growth rate for percentage of consumers using registry also grows at 5% per year.
3) Provider attrition and annual case turnover rates comes from RTZ extimate and are consistent with homecare industry trends and standards.
4) Productivity for Customer Service workers is based on actual experience of HWU registry.

Table A-2: Budget Estimate for *Full-Serivce, Shared Registry* Start-up and Operation

	6 Months Start-up	Year 1	Year 2	Year 3	Year 4	Year 5
Central Office Staff						
Personnel						
Administration	0	0	0	0	0	0
Core Registry Staff	298,958	577,212	740,838	898,183	1,070,086	1,257,608
Subtotal: Personnel	298,958	577,212	740,838	898,183	1,070,086	1,257,608
Computers, MIS						
Hardware	21,833	2,865	5,918	5,607	-	-
DB design & Development	25,000	5,000	3,000	3,000	3,000	3,000
Subtotal: Computers, MIS	46,833	7,865	8,918	8,607	3,000	3,000
Other Direct Costs						
Intake & Screening	250,000	345,000	512,125	642,600	784,842	939,702
Registry Promotion & Marketing	20,000	15,000	15,000	15,000	15,000	15,000
Registry Staff training & Development	20,000	5,000	3,000	3,000	3,000	3,000
Subtotal: Other Direct Costs	290,000	365,000	530,125	660,600	802,842	957,702
Central Office OTPS (20%)	127,158	190,015	255,976	313,478	375,186	443,662
Subtotal: Central Office Costs	472,950	775,093	1,005,732	1,220,268	1,448,271	1,704,270
Consumer Field Operations:						
Personnel: Salary & Benefits	225,000	360,000	500,000	640,000	640,000	710,000
Computer Costs	10,000	-	4,000	4,000	-	2,000
Consumer Education & Materials	1,600	3,200	4,800	4,800	4,800	4,800
OTPS	47,320	72,640	101,760	129,760	128,960	143,360
Subtotal: Consumer Field Operations	283,920	435,840	610,560	778,560	773,760	860,160
Provider Field Operations						
Personnel: Salary & Benefits	210,000	317,500	428,917	515,900	610,728	713,968
Computer Costs	5,500	-	3,500	-	-	-
Training materials	1,600	4,600	5,300	5,300	5,300	5,300
OTPS	43,420	64,420	87,543	104,240	123,206	143,854
Subtotal: Provider Field Operations	260,520	386,520	525,260	625,440	739,234	863,122
Total Annual Budget	**1,017,390**	**1,597,453**	**2,141,553**	**2,624,269**	**2,961,265**	**3,427,552**
* cost per consumer-user		$ 188	$ 160	$ 140	$ 120	$ 111

Table A-3: *Full-Service, Shared Registry* Personnel Detail

Position	Annual Salary	Start-up		Year 1		Year 2		Year 3		Year 4		Year 5	
		#	Cost	#	Cost	#	Cost	#	Cost	#	Cost	#	Cost
PASC Executive Director													
PASC CFO													
PASC HR Director													
Admin Assistant				-	-	-	-	-	-	-	-	-	-
Subtotal: Administration		-	-	-	-	-	-	-	-	-	-	-	-
Registry Director/Mgr	55,000	1	55,000	1	55,000	1	55,000	1	55,000	1	55,000	1	55,000
MIS Manager	40,000	1	40,000	1	40,000	1	40,000	1	40,000	1	40,000	1	40,000
Registry Supervisor	40,000	1	40,000	1	40,000	1	40,000	1	40,000	1	40,000	1	40,000
Customer Service clerks	30,000	-	-	3	81,731	4	128,726	6	180,216	8	236,534	10	298,033
Provider Intake Clerks	25,000	4	104,167	3	71,875	4	106,693	5	133,875	7	163,509	8	195,771
Subtotal: Ctr Office		7	239,167	9	288,606	12	370,419	14	449,091	17	535,043	21	628,804
Field Supervisor (consumer)	40,000	1	40,000	1	40,000	1	40,000	1	40,000	1	40,000	1	40,000
Consumer Outreach Staff	35,000	4	140,000	4	140,000	6	210,000	8	280,000	8	280,000	9	315,000
Subtotal: Field staff		5	180,000	5	180,000	7	250,000	9	320,000	9	320,000	10	355,000
Rec & Training Coordinator	40,000	1	40,000	1	40,000	1	40,000	1	40,000	1	40,000	1	40,000
Instructional staff	30,000	-	-	1	30,000	1	30,000	1	30,000	1	30,000	1	30,000
Recruiters	32,000	4	128,000	6	184,000	9	273,133	11	342,720	13	418,583	16	501,174
Subtotal: worker center		5	168,000	8	254,000	11	343,133	13	412,720	15	488,583	18	571,174
Subtotal Salaries:			587,167		722,606		963,552		1,181,811		1,343,625		1,554,979
Taxes & benefits @ 25%			146,792		180,651		240,888		295,453		335,906		388,745
Total: Salary & benefits			733,958		903,257		1,204,440		1,477,264		1,679,532		1,943,723
Total Employees:		17		21		29		36		42		48	

Paraprofessional Healthcare Institute

The *Paraprofessional Healthcare Institute (PHI)* is a national non-profit development and policy organization based in the South Bronx in New York City, with affiliates in seven states.

PHI's mission is twofold:

- **To create decent jobs for low-income individuals**, with a special emphasis on women who are unemployed or transitioning from welfare to work, and
- **To provide high-quality healthcare to clients** who are elderly, chronically ill or living with disabilities.

From within the healthcare industry, PHI has linked this twofold mission through a **"Quality Jobs / Quality Care" school of thought**: We believe that creating quality jobs for low-income individuals—who comprise the majority of paraprofessional health care workers—is not only consistent with, but necessary to, the provision of high-quality, cost-effective services to long-term care consumers.

We serve this mission through:

- **Enterprise creation and support:** Creating and supporting the development of profitable, worker-owned healthcare enterprises built around the needs of both the front-line caregiver and the healthcare client.
- **Training and placement:** Supporting employer-based, participant-centered training and placement programs within the healthcare sector.
- **Mutual aid and assistance:** Fostering a network among these enterprises and training/placement programs so they might assist and challenge one another toward excellence and innovation.
- **Policy development:** Offering a voice—on behalf of front-line workers and long-term care consumers—to promote fundamental change in both public policy and health care industry practice.

For more information about this report or other PHI efforts, please contact

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