Collaborating to Improve In-Home Supportive Services:

Stakeholder Perspectives on Implementing California's Public Authorities

By Janet Heinritz-Canterbury

PHI Quality Care THROUGH Quality Jobs

Project Sponsors

The **Paraprofessional Healthcare Institute** (PHI) is a national nonprofit organization that focuses on direct-care workforce issues within long-term care. A recent publication authored by PHI, *Direct Care Health Workers: The Unnecessary Crisis in Long Term Care* (Aspen Institute, 2001), documents the critical staffing crisis in long-term care, makes several recommendations to address the crisis, and specifically encourages experimentation — such as California's home care public authorities — by long-term care's key stakeholders. PHI manages the *National Clearinghouse on the Direct Care Workforce* (www.directcareclearinghouse.org) and also staffs a national coalition, the *Direct Care Alliance*, made up of consumers, workers, and provider agencies working together to create quality jobs and quality care while maximizing consumer direction.

Mission: Paraprofessional Healthcare Institute
- To create decent jobs in long-term care for low-income individuals, with an emphasis on women who are unemployed or transitioning from welfare to work; and
- To provide high-quality care to consumers who are elderly, chronically ill, or living with disabilities.

The **California Wellness Foundation** is a major health funder in California and defines health as a state of physical, mental, and social well-being, not merely absence of illness. Its commitment to capacity building and public policy work brings its interest and funding to examine the issue of the In-Home Supportive Services (IHSS) public authorities and their on-going effectiveness.

Mission: California Wellness Foundation
To improve the health of the people of California by making grants for health promotion, wellness education, and disease prevention.

Project Development, Oversight, and Review

To assist in the planning and implementation of this project, PHI convened a *Project Strategy Group* of people from stakeholder organizations in existing public authority counties, as well as from counties that are in the process of developing public authorities (see below).

Project Strategy Group

- **Jo Black**, Director, Independent Living Resource Center of San Luis Obispo, Santa Barbara, and Ventura Counties
- **Luis Calderon**, Project Coordinator, San Francisco IHSS Public Authority
- **Eldon Luce**, Executive Director, Contra Costa IHSS Public Authority
- **Bernadette Lynch**, Executive Director, Sacramento IHSS Public Authority
- **Betty Perry**, Public Policy Director, Older Women's League – CA
- **Loretta Stevens**, Western Regional Homecare Coordinator, SEIU
- **Mariko Yamada**, District Director for Yolo County Supervisor Dave Rosenberg

Project Staff

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Cover photography courtesy of the Service Employees International Union AFL-CIO, CLC. Local 616.

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We could not have written this report without candid contributions from individuals in every IHSS stakeholder group. Using the same collaborative process described in this report, we sought and received generous help, advice, and support at every stage of the project. More than any other factor, the willingness of IHSS stakeholders to look beyond their self-interests and focus on common goals will make it possible to realize improvements in consumer-directed in-home care for both the consumers who receive assistance and the workers who provide it.

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Preface

Dear Friend:

We have developed this report on California's first eight In-Home Supportive Services (IHSS) public authorities, hoping to assist stakeholders — consumers, workers, county IHSS administrative agencies, and county boards of supervisors — who are now grappling with the task of establishing public authorities in their counties.

With the goals of maintaining consumer-direction in IHSS and improving quality of care for consumers and quality of jobs for workers, stakeholders in these eight counties described to us the process of developing their public authorities. All agreed that the process required collaboration of all stakeholders — establishing trust, developing patience with each other, and having a willingness to look beyond one's self-interest to the larger interest of all.

We hope the experiences, issues, and lessons of stakeholders cited in this report will be of value to the overall effort to improve IHSS and in-home long-term care in California.

Jo Black, Director, Independent Living Resource Center of San Luis Obispo, Santa Barbara, and Ventura Counties

Luis Calderon, Project Coordinator, San Francisco IHSS Public Authority

Eldon Luce, Executive Director, Contra Costa IHSS Public Authority

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Mariko Yamada, District Director for Yolo County Supervisor Dave Rosenberg

Executive Summary

California's **In-Home Supportive Services** (IHSS) program, created in 1973, provides housecleaning, meal preparation, laundry, grocery shopping, and personal care services to more than 270,000 low-income consumers who are elderly, blind, or living with disabilities and who are unable to live safely at home without assistance. IHSS currently employs more than 200,000 home care workers across California.

In 1992, in order to strengthen the IHSS program, the California legislature passed Senate Bill 485, which authorized the creation of county-level "home care public authorities" to oversee and manage IHSS delivery issues in the counties. The 1992 legislation was an unprecedented achievement for both workers and consumers in California, because the public authority provided workers with a vehicle to secure improved wages and benefits, gave consumers a policy-level voice in IHSS, and retained the consumer's right to hire, train, and terminate their in-home care worker. Each county that chose to establish a public authority agreed to create:

- A **consumer-majority board** or committee to oversee;
- An **employer of record** for IHSS workers;
- A **registry** to help consumers and workers find each other; and
- **Access to training** for consumers and workers.

The 1992 legislation offered a large-scale opportunity to demonstrate that the consumer-directed, or "independent provider," mode of delivery could be a viable, cost-effective, noninvasive way to provide in-home care. Along with the subsequent infusion of millions of new federal dollars, through the Personal Care Services Program (PCSP)[1] created in 1993, the public authority became the impetus in several counties for intense discussions among four major IHSS stakeholder groups:

- **Consumers** and advocates;
- **Workers** and organized labor;
- The county **IHSS administrative agencies;** and
- The county **boards of supervisors** and county departments.

From 1993 through 1999, seven counties chose to establish public authorities, including Alameda, Contra Costa, Los Angeles, Monterey, San Francisco, San Mateo, and Santa Clara counties. Then, in 1999, the seven initial public authorities and IHSS activists from around the state successfully advocated for additional legislation that permanently changed California's IHSS program. The stunning two-fold victory included:

- Dedicating new state monies to fund substantial wage and benefit increases for IHSS workers over five years; and

[1] The PCSP provides personal care services as an optional Medi-Cal benefit within the IHSS system.

- Mandating a framework that will result in the proliferation of the public authority model of IHSS delivery.

Following this guarantee of state funding for public authorities, Sacramento County enacted a public authority in September 2000, making it California's eighth public authority.

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This paper explores the perspectives of the four key stakeholders within the first eight public authorities.[2] In order to help stakeholders in counties that are now working to comply with the legislative mandate by the target date of January 2003, we have attempted to identify common concerns and to describe the successful collaborative process that arose during the development of the eight pioneer authorities.

Guided by a seven-person Project Strategy Group (see inside cover), made up of leaders from the four stakeholder groups, the author interviewed persons from all four stakeholder groups, as well as others who helped lead the development of the first eight public authorities.

Despite quite differing perspectives among the stakeholders, the more than two-dozen interviews revealed a startling amount of shared understanding and agreement. All four stakeholder groups focused on the degree to which the public authorities were achieving:

1) Consumer/worker matching, worker screening and training, and follow-up monitoring of the public authority's overall performance;
2) Workers' wage and benefit increases, improved morale, job satisfaction, and empowerment;
3) Consumer access to services and ability to design and develop those services ("Nothing about us without us"); and
4) Access to federal and state funding and technical assistance.

In addition, interviewees from all four stakeholder groups reflected similar "lessons learned" about the collaborative process that proved necessary in designing and implementing the initial public authorities:

1) Stakeholders shared an awareness of serious problems in IHSS, and developed a shared excitement about the potential of the public authority to address the problems;
2) The collaborative vision to improve the IHSS program was effective in galvanizing support because it incorporated goals from each of the stakeholder groups;

[2] Over the past 18 months, several additional counties, including Marin, San Diego, Sonoma, and Yolo, have voted to establish public authorities. However, these public authorities are just starting up and, thus, were too new to be included in this analysis.

3) Through the collaborative process, stakeholders developed trust, the ability to communicate, and a shared recognition of the strategic value of cooperation; and
4) All groups are affected by the quality of the consumer advisory committees or boards, and therefore, people who serve on them must be carefully selected and provided greater support and training.

Admittedly, all stakeholders expressed understanding and patience, but also suspicions, toward the other stakeholders. Many acknowledged problems not only between stakeholders, but within their own groups as well. Yet the collaborative process that eventually emerged, however imperfect, provided an invaluable framework that helped stakeholders see beyond their own interests — helping many appreciate the value of education, training, and mutual support on both the content and the process of creating a public authority.

For the newly emerging public authorities in the remaining counties, an essential first step is securing, at the very beginning, a conscious and explicit commitment to collaborate — learning how to perceive an issue from the point of view of multiple stakeholders. Of equal importance, stakeholders must be prepared, in advance, to agree to return to collaborative discussions after they are, inevitably, divided on a particular issue. In short, they must learn ways to "agree to disagree" in order to work together in the future on those issues that no one stakeholder can resolve alone.

The story of the creation of the first eight public authorities is, despite many subplots of tensions and disagreements, a remarkable one in which true benefits have been secured for both workers and consumers. Much is still left to be achieved, not only within these eight counties, but also in the remaining counties now facing the challenge to create their own home care public authorities. We therefore hope this analysis will prove of value to all stakeholders who are committed to improving both the quality of care and the quality of jobs within California's In-Home Supportive Services Program.

I. Introduction

Along with the rest of the country, California is experiencing an unprecedented expansion of long-term care needs. Through technological, medical, and pharmaceutical advances, more people are living longer — the number of Californians over age 65 is expected to double between 2000 and 2030. Studies also show the overall rate of people under 65 who are living with one or more disabilities is increasing rapidly.[3] Furthermore, the "Baby Boom" generation is protective of its independence and is likely to demand home care over institutional care to a far greater degree than their parents. Within this context, the importance of improving California's **In-Home Supportive Services** (IHSS) program — currently providing services to more than 270,000 Californian consumers — cannot be overstated.

Established in 1973, IHSS allows consumers to direct the worker who provides their care. In this "consumer-directed" model, consumers retain the right to hire, train, and terminate the direct-care worker who provides assistance and support in the consumer's home. By the early 1990s, minimum wage pay and no access to health insurance for IHSS workers, among many other problems affecting both consumers and workers, became a serious threat to the viability of the IHSS program.

In response to aggressive advocacy, the California legislature enacted a series of measures throughout the 1990s to re-organize IHSS and increase state financing while maintaining the program's hallmark consumer direction, also called the "independent provider mode of delivery." In particular, legislation passed in 1992 allowed, but did not mandate, counties to establish a "home care public authority" to give consumers a policy-level voice in IHSS delivery issues, provide an employer of record for workers, and still ensure that each consumer could select, direct, and terminate his or her home care worker.

Between 1994 and 2000, eight counties established public authorities, including: Alameda, Contra Costa, Los Angeles, Monterey, Sacramento, San Francisco, San Mateo, and Santa Clara counties.

Creating the first eight public authorities was an extremely challenging task — both technically and politically. Although the "story" of organizing a public authority was different in each of the eight counties, none could have been created without communication and collaboration among four major stakeholder groups:

- **Consumers** and advocates;
- **Workers** and organized labor;
- The county **IHSS administrative agencies;** and
- The county **boards of supervisors** and county departments.

[3] See H. Stephen Kaye, *Disability Watch: The Status of People with Disabilities in the United States* (Disability Rights Advocates, 1997).

The primary intent of this paper is to explore the collaborative efforts among these four key stakeholders. We believe this is particularly important because, in 1999, the California legislature enacted AB 1682, requiring that all California counties act as or establish an employer for IHSS workers and establish a consumer-majority advisory committee. As a result, many counties will choose to establish public authorities. Several counties, including Marin, San Diego, Sonoma, and Yolo, have recently created public authorities, and the remaining counties are working to comply with the legislation by January 2003.

Therefore, for stakeholders in counties across the state currently engaged in designing and implementing public authorities, we offer this analysis — not as a technical prescription, but rather as a framework for understanding the various stakeholder forces that shaped the first eight initiatives.

In researching this paper, we talked directly to stakeholders to determine what worked, what didn't work, and what might be done to improve the process of developing new public authorities. Our methodology (see Appendix I) included more than two dozen interviews with individuals from among the four stakeholder groups in all eight counties, as well as consultation with other key participants in the process.

The seven members of the Project Strategy Group — each of whom played a key role in or is currently involved in the creation of a public authority — represented all four stakeholder groups. This group oversaw the selection of those interviewed, assisted in developing the interview questions, and reviewed and deepened the analysis resulting from our interviews.

The remainder of this paper is divided into the following sections:

- ***Background*** includes a brief history of IHSS, the impetus for the public authority, and why other counties are currently working to establish public authorities;
- ***Stakeholder Groups*** identifies those having a major role in the development and functioning of IHSS and the county public authorities;
- ***Common Stakeholder Issues*** details the substantive issues raised by interviewees in all IHSS stakeholder groups;
- ***Lessons Learned*** compares the "process concerns" raised by the IHSS stakeholder groups and the lessons of the various stakeholders;
- ***Analysis*** describes common issues that framed the development of a public authority; and
- ***Conclusion*** summarizes our analysis.

Finally, we acknowledge that this paper is neither a scientific assessment nor a detailed history of California's public authority model. Instead, we hope that reviewing the experiences of the first public authorities through the voices of the four key stakeholder groups will prove of value to those who find themselves now facing similar challenges.

II. Background

In 1991, California's Little Hoover Commission released a report, "Unsafe in Their Own Homes," which spelled out, often in painful detail, concerns about In-Home Supportive Services (IHSS), the state's publicly funded in-home care program that, in 1991, served more than 170,000[4] persons who were elderly, blind, or living with disabilities. IHSS is funded through a combination of federal, state, and county funds and is administered by each county's social services department.

Persons eligible for IHSS are unable to live safely at home without assistance. In addition, they must meet certain Supplemental Security Income (SSI) eligibility requirements. Persons who receive IHSS assistance (called "recipients" by the IHSS administrative agency and called "consumers" in this report) are evaluated for appropriate services by county social workers and can be authorized for up to a maximum of 283 hours of services per month. Services include housecleaning, meal preparation, laundry, grocery shopping, and personal care services.[5]

Younger persons with disabilities, motivated by a desire for independence and control of their own services and assistance, were the key advocates for the creation of IHSS in 1973. Not only did these advocates win the establishment of an in-home care program, they also won the right for a consumer to hire, train, and if necessary, terminate his or her worker — this in comparison to a more traditional home care assistance program, which retains these rights and responsibilities within a contract agency.

The consumer-directed approach is called an "independent provider model," while the more traditional approach is called the "contract mode." Currently, over 96 percent of California's IHSS caseload receives services through the independent provider model while only 4 percent receive services from a worker who is directed by an IHSS contract agency.

"In our review, we also note that California's long-term care programs comprise a fragmented service system, but that efforts are underway to improve coordination."

— California Legislative Analyst, 2001

Established as a central part of California's long-term care system, improving IHSS became increasingly important as the number of consumers expanded within the program. Along with the rest of the country, California has experienced, and will continue to experience, an unprecedented expansion of long-term care needs and demands. In addition, the preference for in-home services and supports, compared to facility-based care, is increasing. Smaller family units and more dispersed family living arrangements are

[4]Today the IHSS program serves 274,000 consumers.

[5]IHSS personal care services include: bowel and bladder care, bathing, grooming, paramedical services, accompaniment to medical appointments, and protective supervision for persons whose mental status or cognitive functioning poses a threat to their safety and well-being.

increasing the demand for non-family home- and community-based long-term care options. Efforts by senior advocates to expose nursing home abuses have further contributed to a demand for noninstitutional options for long-term care.[6]

IHSS consumers "face abuse and fear in their own homes, or may fail to receive the help they need and are entitled to."

— "Unsafe in Their Own Homes," 1991

While consumers embraced the IHSS system because it provided consumer choice and direction, they also knew first-hand, and suffered the consequences of, the problems cited by the Little Hoover report: inherent structural and funding limitations, fragmented responsibility for the program, and difficulty ensuring quality care.

Consumers reported living in fear of losing their worker to a better paying job and not being able to find a replacement worker; according to these consumers, IHSS county administrative agencies provided little or no help in finding workers. Each consumer had to do his or her own advertising, screening, background checking, and training, which often proved all but impossible — particularly for the frail elderly who made up over 50 percent of IHSS consumers. IHSS social workers, with caseloads as high as 400 consumers, were faced with the unworkable responsibility of ensuring critically needed one-on-one services to consumers. Intended to enhance the long-term care consumer's peace of mind by letting him or her remain at home, the IHSS system could become so complicated and difficult to manage that a consumer could unwillingly have no choice but to "end up" in a nursing home.

Even as consumers experienced the shortcomings of the IHSS system, IHSS workers also fared poorly: They earned minimum wage ($4.25 an hour in 1991) and, despite serving the health care system, received no employer-based health insurance. Workers received no training, formal supervision, or support, and paychecks were often late, or lost entirely.

The combination of poor-quality jobs and growing demand for more home care workers spurred the Service Employees International Union (SEIU) and the American Federation of State County and Municipal Employees (AFSCME) to focus on organizing the California home care workforce. Yet, until 1993, independent providers were barred from bargaining for better wages and benefits: California courts had ruled, in a suit brought by SEIU in 1987, that IHSS workers were neither employees of the State of California (from whom they received their paychecks), nor employees of the county (to whom they submitted their semi-monthly time sheets). Rather, the courts concluded that

[6]In 1999, the U.S. Supreme Court decided a landmark case in the "Olmstead decision," which requires states to find the "most integrated" setting for Medicaid-funded long-term care consumers. Olmstead implementation plans, now being developed by most all states, including California, will further decrease the likelihood of institutionalization and in turn expand the use of in-home programs such as IHSS.

IHSS workers were independent "contractors" with no right to organize a union or bargain for better wages and benefits.

The difficult situation within IHSS worsened when, in October 1991, consumer hours were cut by 12 percent during a state budget crisis. Consumer advocates feared that weaknesses in IHSS might increase the likelihood that counties would adopt the contract mode of delivery — in which private agencies would employ and direct IHSS workers — thus threatening the consumers' hard-won right of self-direction. In response to these problems, the California Senior Legislature, a senior advocacy group whose 1992 top ten legislative priorities included the IHSS public authority, formed a coalition with the disability community and SEIU to fight for the public authority legislation.

While SEIU allied itself with the disability and senior communities and the consumer-directed mode of IHSS delivery, the United Domestic Workers (UDW), an independent union later to become affiliated with AFSCME, supported the contract mode of delivery. This rivalry played out repeatedly in the context of legislative battles and was not resolved until the end of the decade with the successful campaign to pass AB 1682, the public authority mandate legislation.

This division within organized labor not withstanding, the coalition of SEIU, seniors, and the disability community won landmark IHSS reform legislation in 1992 with the slogan, "Keep what works, fix what's wrong, and fund it!" Senate Bill 485, which was signed into law in September 1992 by then-Governor Pete Wilson, addressed the issues cited in the Little Hoover report and gave counties an option to increase their local control of IHSS while still maintaining the independent provider mode of delivery. Specifically, SB 485 authorized, although it did not mandate, the creation of a new quasi-governmental entity — an unprecedented "home care public authority" — with a single focus on IHSS delivery issues. This IHSS public authority would:

- Develop a **consumer-majority board** to direct or advise the public authority;
- Create an **employer of record** for the workers;
- Develop **a county-wide registry** to help consumers and workers find each other; and
- Provide **access to training** for consumers and workers.

"Right now, I'm looking for a new worker, and I'm scared of who will show up and want to share my home and time. . . . I'd like to find just one caring, reliable, honest, in-home care worker – one who would take good care of me because she cared."

— "Unsafe in Their Own Homes," 1991

As the "employer of record," a public authority could legally recognize a union as the legitimate representative of the home care employees — in essence, IHSS workers, in counties using a public authority, had won the right to organize.

This new law — along with the infusion in 1993 of millions of dollars of new federal funding for IHSS through the Personal Care Services Program (PCSP) — became the impetus for key stakeholders to begin collaborative discussions about improving IHSS through the design of the new public authority alternative. These four key stakeholders in each county included:

- **Consumers** and advocates;
- **Workers** and organized labor;
- The county **IHSS administrative agency;** and
- The county **board of supervisors** and county departments.

In Alameda County, this collaborative effort was called the *Reorganization Working Group;* in San Francisco, it was called the *IHSS Task Force;* and in Santa Clara County, the *Coalition Building Advisory Committee.*

Along with similar efforts in other counties, these collaborations worked in a more organized fashion than ever before to develop consensus and make recommendations on how to improve IHSS within each county. Consumers, workers, and social workers told their stories and shared their fears: Many consumers — dependent upon their IHSS worker for bathing, feeding, and other essential functions of daily living — told of losing their worker to a higher paying job. Other consumers told of being put in a nursing home because they could not find a replacement when they lost their worker.

In turn, workers told of their long hours, their struggle to support their families on minimum wage work, and the frustration of being unable to provide adequate support and services to the consumers to whom they are so dedicated. Social workers talked about the desperate need for lower IHSS caseloads.

Members of the boards of supervisors in these counties — accustomed to being confronted with the impossible task of satisfying conflicting demands from traditionally competing IHSS stakeholders — expressed surprise and appreciation for the collaborative efforts of stakeholders presenting a common agenda. Of particular note: Advocates learned early that they could recruit passionate leaders on this issue, even among members of the board of supervisors or other elected officials, by identifying those who had personally experienced the difficulties of the long-term care system with a parent, family member, or friend.

Provisions of the 1999 Legislative Victories

- A consumer-majority IHSS advisory committee or board in every county;
- An "employer of record" for IHSS workers in every county;
- Full state participation in costs of IHSS public authorities; and
- State participation up to $12.10/ hour in IHSS provider wages and benefits (over five years), if General Fund revenue exceeds by at least 5 percent the revenue levels of the previous fiscal year.

IHSS Public Authority Highlights

1973 IHSS created

1987 Courts decide IHSS workers are independent contractors

1991 Governor Wilson cuts IHSS hours by 12%

1992 Legislation creating public authority options for the counties passed

1993 PCSP begins

1994 – 1999 Seven counties organize public authorities

1999 US Supreme Court Olmstead Decision: Legislation mandating consumer-majority committee and employer of record, and legislation requiring full state participation in wage and benefits above minimum wage.

2000 Eighth county establishes a public authority

2003 Target date to comply with AB1682

Between 1994 and 1999 seven counties — representing over 50 percent of the state IHSS caseload — created public authorities: Alameda, Contra Costa, Los Angeles, Monterey, San Francisco, San Mateo, and Santa Clara counties. Stakeholders in these counties helped spearhead statewide coalitions, including the Public Interest Center on Long Term Care and IHSS Agenda, whose dogged efforts kept IHSS improvements in the forefront with state legislators and the governor. By the close of 1999, public authorities were providing registry services, consumer-majority boards were functioning, and SEIU had won the right to officially represent and bargain for more than 100,000 workers in these counties — and wages and benefits soon increased.

Yet near the end of the 1990s, new tensions began to develop: a wage gap resulted between workers in public authority counties (earning from $6.75 an hour to $9.80 an hour) compared to workers in non-public authority counties (who still earned minimum wage pay), thus exacerbating vacancies and turnover in non-authority counties.

More importantly, the state was unwilling to share in the cost of any wage and benefit increases being sought in public authority counties. Without state participation, the county share for wages above the minimum increased and few, if any, counties could afford to pay these increased costs for very long.[7]

[7] Federal, state, and county dollars fund IHSS. If a consumer is eligible for the federal program, called the Personal Care Services Program (PCSP), their services are funded with 50 percent federal, 32.5 percent state, and 17.5 percent county dollars. If they are not eligible for the federal program (i.e., if they receive advance pay or have a close family provider), their services are funded with state (65 percent) and county (35 percent) funds only.

– Some analysts report that the state will reimburse nearly all of a county's costs for IHSS direct services, if the county uses their state reimbursed "realignment funds." For instance, San Francisco County, using this method, pays less than 5 percent of its direct service costs, for either PCSP or non-PCSP services. However, realignment funds are contingent on state tax revenues and involve a complex method of reimbursement often difficult for counties because there are no clear directions on how to use realignment funds for this purpose. Further, because it may take two years to receive the reimbursement, using realignment funds can create a cash-flow problem for a county. If a county is willing to use its realignment funds, funding wage and benefits improvements becomes more of a problem of political will and cash flow rather than the fiscal impossibility typically cited by counties. (For further analysis, contact the California Public Authority Council.)

In 1999, the existing public authorities, along with both SEIU and UDW/AFSCME, launched a statewide coalition to win changes in state policy and financing for the public authority model. Implementing a range of strategies — from grassroots actions in the streets to insider lobbying and arm-twisting of state legislators — coalition allies combined their strength and influence and produced a stunning, two-fold victory: 1) full state participation in public authority costs and wage increases up to $11.50 an hour and $.60 for benefits (over the next four years following fiscal year 2001); and 2) a mandate that, by January 2003, all counties must act as or establish an employer for IHSS workers and must establish a consumer-majority advisory committee.

Sacramento County — which had resisted establishing a public authority without the state's commitment to pay a share of the costs — enacted a public authority in September 2000, and is included in the eight public authorities considered in this report.

III. Stakeholder Groups

The author interviewed individuals representing four groups having a major interest in the development, funding, and on-going functioning of the IHSS public authorities. Not intended to describe all aspects and dimensions of any one of these stakeholders, the following provides a glimpse into the specific interests, fears, suspicions, history, roles, and functions played by each group within both the development of the public authority and the complex system of IHSS funding, access, and delivery.

All quotes within each stakeholder group description are taken directly from the interviewees within that group. That is, quotes from consumers and advocates appear in the "Consumers and Advocates" section; quotes from workers and organized labor appear in the "Workers and Organized Labor" section; and so on for the county IHSS administrative agencies and the county boards of supervisors and county departments.

Consumers and Advocates

Description

This stakeholder group is made up of individuals who receive IHSS and also includes persons from organizations who advocate for IHSS consumers, such as senior groups, disability groups, and other advocacy organizations. Individuals eligible for IHSS services are those who are disabled, elderly, or blind and are unable to live safely in their home without assistance. IHSS consumers are also required to meet certain Supplemental Security Income (SSI) eligibility requirements.

According to the California Department of Social Services Recipient Characteristics Survey (December 2001), IHSS consumer characteristics include:

- More than 274,000 recipients (called "consumers" in this report)
- 59 percent over the age of 65
- 66 percent women
- 44 percent white
- 23 percent Latino
- 18 percent African American
- 5 percent Chinese
- 8 percent other Asian
- 23 percent severely impaired (recipients who receive more than 20 hours per month of specific personal care services, such as respiratory care, feeding, dressing, and assistance in and out of bath)
- 81 percent of the caseload is in the Personal Care Services Program

Interviews with Consumers and Advocates

Many older IHSS consumers are frail and have cognitive disabilities; therefore, few senior consumers attended the many meetings and other activities required in the public authority development process.

> *"Senior participation should be greater because the portion of IHSS consumers that are seniors is high. But maybe they are too frail, ashamed, or scared to participate in the IHSS public authority."*

> *"My worst fear is that people who really need IHSS are not getting it because of language barriers and fear of not being approved. The public authority should be able to change this."*

Due to this dynamic, in the counties studied, the leadership in the development of the public authority was most frequently from IHSS consumers who were young and living with disabilities, rather than elderly consumers. Furthermore, to the extent the interests of older consumers were represented, this was done so primarily by organizationally based senior activists and staff representatives from senior service agencies — those who provide meals on wheels, case management, and other senior services.

The senior activists who participated typically represented an organization, were accountable to that organization for positions they took in the public authority meetings, and brought input back from the organization regarding their IHSS constituents. In contrast, consumers who were younger and living with disabilities typically participated in the process as individuals, did not represent an organization, had no accountability to an organization for positions they took in the meetings, and were unlikely to bring input to the meetings from other IHSS constituents.

In addition, seniors and younger people with disabilities were motivated by different concerns. Seniors, motivated by issues of safety, generally wanted training and screening of providers. Younger people with disabilities, motivated by their desire for independence and control, insisted on their own training and screening.

These motivators were also reflected in the way each constituency reacted to union involvement in IHSS. Many seniors saw unions as a positive force for standards and training for workers and expressed little discomfort in having a union worker in their home. However, senior service agency participants, typically staff from nonprofit agencies who serve older persons, were less likely to support union involvement than were the other senior activists.

Many of the younger consumers with disabilities saw the union as potentially interfering with their relationship with their worker and, thus, were very troubled by the possibility of a unionized workforce. In particular, younger post-polio consumers, who often expressed the strongest fears of change within IHSS, were typically against union involvement.

> *"The union has used improving quality of care as their reason for the public authority. Now that we have a public authority and the workers are better paid, I hope the union will be just as aggressive in their desire to improve quality of care as they were before."*

> *"Our fears were worsened when we would see SEIU meeting with members of the board of supervisors without letting consumers know about the meeting. Everyone has their issues, but with coalitional relationships, consumers wanted, at least, to be informed of these meetings."*

Personal experience may have influenced these differing perspectives: Many senior activists involved in the public authority advocacy efforts were familiar with unions and some had themselves been union members; the younger activists with disabilities rarely had direct experience with unions. However, although consumer stakeholders expressed suspicion of the union at the beginning of the public authority development process, few reported fears later in the process.

Another prominent concern of both senior and younger consumers with disabilities was the functioning of the consumer-majority advisory committee or board, mandated in the public authority (SB 485) legislation. It is important to note here that every county's process for selection and operation of these committees/boards is unique — each county is allowed by the law to develop its own public authority's structure, by-laws, process for selection of advisory committee or governing board members, terms of office for these committee or board members, and mode of operation.

The consumers interviewed spoke extensively about the process of selecting people to serve on these consumer-majority bodies, how those board members should receive training, and how accountability must be established between these committees/boards and IHSS consumers. Interviewees expressed concern that consumers might be unfamiliar with, and even intimidated by, the many aspects of organizational functioning so important in the development and implementation of the public authority. Often daunting to consumers were not only complicated procedures, such as the requirements of the Brown Act and following Roberts Rules of Order, but even basic organizational tasks such as following an agenda and speaking only when recognized by the chair.

"The assumption that just because they are consumers that they will voice the right concerns is wrong. They may not have understanding of the issues and options and they may not do the right thing. We need training for these committees, from somewhere other than from the county."

"The Consumer Advisory Board is not very influential because the members don't really know what's going on. They don't go out and see what consumers and workers are doing. They listen to what the agencies say, rather than figure out what's really going on."

"The Consumer Advisory Committee should have influence, but who do they really feel they represent, other consumers or the county? The changes that are needed will never be realized if they feel they represent the county."

"They have to be knowledgeable about the issues but they cannot be intimidated by the county."

Workers and Organized Labor

Description

This stakeholder group is made up of IHSS workers, including both those who provide assistance to a family member and those who are non-family providers, and organized labor. Workers employed in a county with a public authority are still considered independent providers, although the authority is technically their "employer of record" for purposes of wages and benefits. Though San Francisco, San Mateo, and Santa Clara counties also employ workers through small IHSS agency-based contracts, these are contracts directly with the county, not with the public authority, and these agencies employ relatively few workers.

Statewide characteristics of IHSS independent providers (California Department of Social Services, IHSS Provider Characteristics, October 2001) include:

- More than 202,000 workers
- 77 percent are women
- 50 percent are between the ages of 41 and 60
- 40 percent are family members
- 75 percent work only with one consumer
- 60 percent work less than 23 hours per week
- 96 percent are independent providers — meaning that no outside agency is involved

- 79 percent are not receiving benefits from Medi-Cal, California's Medicaid program for low-income individuals
- $436 is the median monthly income for workers not earning wages outside of IHSS

The process for establishing union representation for IHSS workers is governed by the Myers-Milias-Brown Act (California Government Code 3505) relating to public employees. The public authority is the employer of record and has the discretion to select a minimum threshold, or the "showing of interest" among workers, that a union must demonstrate to trigger a representation election.

Recruiting union members in home care differs from most other industries, because home care provides no common work site — no shop floor where employees work together. Consumers typically prefer that union organizers not come to their home to meet the worker, so organizers instead often go to the workers' own homes to talk about joining the union. Organizers sometimes make thousands of individual house visits to recruit the number of members stipulated in the public authority's "showing of interest" requirement. While the house visit process can be tedious, union organizers report that workers sign up at a high rate and are excited to learn about other workers who are home care providers.[8]

In virtually every one of the eight public authority counties, workers voted overwhelmingly to be represented by SEIU. In particular, national attention focused on the election in Los Angeles, in which SEIU Local 434-B won the right to represent more than 74,000 IHSS workers in Los Angeles County — the largest single union vote anywhere in the nation in 60 years.

Once union representation is decided, each public authority determines the process that it will use to negotiate a union contract. For example, the San Francisco public authority uses "interest-based bargaining," in which negotiation issues are discussed by consumers and workers in an open forum, while some counties rely on their county Human Resources Department to conduct negotiations.

[8]The process for a union election is as follows: A public authority ordinance or a county resolution stipulates the percentage of workers who are required to indicate that they want to be represented by this union. The union must meet this "showing of interest" in order to request an election to represent these IHSS workers. Through house visits, mailings, and other outreach, the union makes contacts to recruit members. When they reach the percentage required in the "showing of interest," they present the membership cards signed by the home care workers to the public authority, which then verifies these cards against a list of current IHSS workers in the county. If the "showing of interest" requirement is met, the public authority authorizes an election in which all the IHSS workers will have an opportunity to vote on whether or not they want to be represented by this union. At this time, the public authority provides the union with a list of current IHSS workers, which the union uses in its election education and recruitment activities. An election with oversight from the state is held. Ballots are distributed by mail in all appropriate languages with a postage-paid return envelope and workers vote by mail, for, or against, representation by the union.

Interviews with Workers and Organized Labor

Among the worker and organized labor interviewees, the quality of consumer input on the consumer advisory boards/committees was a high priority. They worried that the consumer advisory committee members are unprepared for making the complicated decisions demanded of them.

> *"I think it is a big issue how assertive the consumer advisory committee is in any county. It is easy for these committees to be confused with legal or bureaucratic issues that counties sometimes present to them."*

> *"My fear was that we would get a consumer board that does not understand that improving IHSS means improving things for both workers and consumers and that we shouldn't talk about them like they are two separate issues."*

Similar to the consumers, workers and organized labor interviewees also talked about the need for training for the consumer advisory boards/committees and believed that this training should be provided independent of the county. They talked about their frustration in not having a clear message from consumers about issue priorities beyond wages and benefits.

> *"My goal was to have a consumer board that comes up with proposals to enhance services from a consumer's point of view. We don't have that unless the consumer board does it. We only have enhancements from the county's point of view, which may or may not serve consumer needs."*

> *"Absolutely. With increased wages and benefits, workers feel better about themselves. They feel more important knowing they have a union. At the same time, their consumers look at them with more respect."*

> *"The union is starting to make home care a visible profession and the workers feel more pride in their work. Increased wages and benefits and decreased turnover lead to stability of these workers and to better care for consumers."*

> *" Now the union is doing training (of workers) and this helps improve quality of care."*

Not surprisingly, workers and organized labor see improved wages and benefits and having a union as factors in improving quality of care. In addition, these interviewees frequently mentioned the political and legislative context of the battles with the state legislature for more money for IHSS.

"The legislature is interested in our issue. They supported "Aging with Dignity" and the money for wages and benefits wasn't touched in the budget revision this year. No one suggested cutting our money even once while just about every other program in the state budget was cut."

"Keep showing the board of supervisors that you are working with the state legislature to get more money."

"SEIU is willing to go to the state to get more money for administrative costs. We should work together to get money for administrative costs from somewhere other than where the wage monies come from."

"A major problem in this system occurs when consumers and workers are pitted against one another — 'divide and conquer' tactics. In reality the money is there for both consumer and worker improvements, and labor is willing to work with consumers and the public authorities to demand the improvements."

County IHSS Administrative Agencies

Description

This stakeholder group is made up of staff of each county's IHSS administrative agency, including administrators and social workers. The county IHSS administrative agency is responsible for the initial assessment and re-assessment of hours, processing of time sheets of IHSS workers, and all other administrative aspects of IHSS.

Using California's Uniform Assessment Procedure, a social worker goes to a potential consumer's home to assess eligibility and level of need for IHSS services and then authorizes the number of hours the consumer will receive, with 283 hours the maximum allowable hours per month. Each consumer is assigned a social worker whom the consumer may call with problems, questions, re-assessment of hours, and other issues that might arise. IHSS workers also may call the IHSS agency for assistance when their paycheck is late.

Interviews with County Administrative Agency Staff

Concern for improving services for all consumers, including the registry and training services, was most prominent among the county IHSS administrative agency interviewees.

"The registry is way too small! We only have a couple hundred providers for thousands of consumers."

"The demand is huge and training providers is a huge issue; you have to free providers up. They have to be able to get where the training is."

"Once the ordinance was passed, my goals were to make the public authority as functional as possible in order to enhance IHSS for consumers and workers."

"Our public authority, like all the others from what I hear, has pushed for the needs of the younger disabled and the needs of the elderly have not been addressed."

Agency staff talked about their commitment to collaboration and their relationship with the union. While they expressed initial fear and suspicion of the union, they also described the need to work with the union. They also described how their feelings of suspicion about the union had lessened through the public authority development process.

"My goal with the public authority was to see if we could develop a partnership between aging, people with disabilities, and labor."

"There were always difficulties between groups, but we were willing to work things out."

"Seniors, people with disabilities, and IHSS social workers are supportive of each other's issues and we work together well."

"We have worked well with the union on getting data for the dues deduction, developing health benefits, and to develop the training program. One on one they're fine, but if they have an audience, they put out a different message."

"You can't just talk about consumer issues in IHSS, the worker issues are just as important."

Finally, agency staff also worried about the organizational capacity of the public authorities to carry out their legal mandates.

"There is a lack of knowledge and sophistication of the consumer board and all of this leads to a tremendous delay in meeting even the most basic requirements of the public authority."

"I would give the public authority more authority to handle their affairs — personnel issues, developing goals and plans — and I would not have the county do it for them."

"My fear was that the people who would run the public authority didn't know what they were getting into. They didn't know the complexity of the issues and didn't have the political savvy to know what was needed."

County Boards of Supervisors and County Departments

Description

This stakeholder group is made up of members of the counties' boards of supervisors and their staffs, along with other county departments including the chief administrative officer, county counsel, and staff of human resources departments.

Technically, the county board of supervisors creates a public authority by passing a county ordinance, which stipulates the public authority's formation, functions, and the public authority model the county will use. State law allows for two models: In the first, the board of supervisors itself becomes the board of the public authority, with a consumer-majority committee advising the board of supervisors. In the second, sometimes called the "stand-alone model," the consumer-majority board is the board of the public authority. Five of the eight counties, Alameda, Contra Costa, Sacramento, San Mateo, Santa Clara, have chosen the board of supervisors model. The remaining three counties, Los Angeles, Monterey, and San Francisco, have adopted the stand-alone model.

Whether a county selects the board of supervisors model or the stand-alone model may not be as important in determining effectiveness and viability as the degree of support from the board of supervisors (or the mayor, in the case of San Francisco), county departments, and the county IHSS administrative agency. Regardless of the model, the board of supervisors has the final decision about funding issues of the public authority and thus retains the "power of the purse." In addition, the board of supervisors is an important vehicle for ensuring broader public accountability for the authority's policies and implementation.

Interviews with County Boards of Supervisors and County Departments

Not surprisingly, fiscal and liability concerns for the county dominated interviews with the boards of supervisors and other county departments. More than any other group, these interviewees mentioned state participation in funding as key to their participation in the public authority effort to improve IHSS.

"The county always wanted to do a public authority, but we thought it would bankrupt the county and we couldn't put the county at risk."

"My worst fear was that increased costs of IHSS would have to come at the expense of other services and programs."

"My fear was that the public authority was established not so much for the quality of care but to force counties to pay for the wage and benefit increases."

"Money was the biggest concern, no one disagreed with the need to increase wages and benefits."

"I do have a fear that with an 8 – 10 percent growth in IHSS every year, that we will have trouble paying for this program in the future."

"My fear was that the state would not continue to fund this program and the county will get stuck with the bill to pay for this, which would mean reducing people or salaries in other departments. I wonder how solid the state's commitment is?"

"I am not resistant to increased wages and benefits; obviously these low-wage workers need lots of support. I am resistant to the state forcing us to pay when they should be paying."

"We always thought it was the state versus the county's inability to pay the costs incurred. We took a position against the public authority until the state said they would pay their part."

"We felt that in order to bargain in good faith, we needed more money than the county had, so that was why it was so important to get the state to increase its funding for wages and benefits."

IV. Common Stakeholder Issues

All four key stakeholders shared concerns, varying in depth from county to county, about the degree to which the public authorities were currently achieving their mandates.

Issues shared by all stakeholder groups included:

1) Consumer/worker matching, worker screening and training, and follow-up monitoring of the public authority's overall performance;
2) Workers' wage and benefit increases, improved morale, job satisfaction, and empowerment;
3) Consumer access to services and ability to design and develop those services ("Nothing about us without us"); and
4) Federal and state funding and technical assistance for public authorities.

These four areas of common concern are admittedly somewhat general, and the fact that all four stakeholder groups share these concerns may not seem surprising. However, these commonalities are indeed remarkable, for they exist despite serious differences between and within the groups. More tellingly, before the four stakeholders engaged in a collaborative process to develop a public authority, these perspectives were not in fact widely shared.

Many examples of pre-existing rivalries and divisions existed within and among the four stakeholders: The arch rivalry that once separated SEIU and AFSCME centered on whether workers should be independent providers or contract workers. Disagreement between seniors and younger people with disabilities had erupted annually over legislation mandating criminal background checks for IHSS workers. The highly emotional conflict between the disability community and SEIU over refurbishing or tearing down Laguna Honda, the largest county-owned nursing home in the country, centered on the belief — held vehemently by both sides — that neither side was willing to listen, to have an open discussion, or was able to "agree to disagree." The animosity between the IHSS administrative agencies and IHSS consumers centered on years of many consumers feeling mistreated by IHSS social workers. Long-standing suspicion and mistrust of boards of supervisors by both consumers and workers stemmed from decades of the counties' relative neglect toward this critical issue.

While the specific issues behind these conflicts have not gone away, in a wide range of examples the four stakeholders have also worked around their areas of disagreement — prioritizing and pursuing their joint goals and strategies within the common goal of improving IHSS through the public authorities.

> *"We disagreed on the finger-printing issue and there were some heated discussions, but it didn't mean that we stopped working together." (Workers and Organized Labor)*

"The union keeps pushing the county for money but I believe the board of supervisors when they say they have no money. But I also know that there have been other issues where they have said they have no money and then they find the money." (County IHSS Administrative Agency)

"I think the union is good if it keeps the public authority in line and actually I think that all groups keep each other in line." (IHSS Consumers and Advocates)

"We have had training for years and the workers don't attend the training. Now we're able to push the issue through the public authority." (Board of Supervisors and County Departments)

V. Lessons Learned

A common set of principles and dynamics framed the experiences of the key stakeholders in the first eight public authorities. In their working together in developing each public authority, stakeholders interviewed seem to have built a common appreciation for a process that aimed to be productive and respectful of all those involved. Underscoring these principles may provide valuable lessons for those currently involved in designing public authorities and offers an opportunity to improve upon both the process and the outcome of the public authority model statewide.

Lessons Recognized by All Stakeholders

1) Stakeholders shared an awareness of serious problems in IHSS, and developed a shared excitement about the potential of the public authority to address the problems;
2) The collaborative vision to improve the IHSS program was effective in galvanizing support because it incorporated goals from each of the stakeholder groups;
3) Through the collaborative process, stakeholders developed trust, the ability to communicate, and a shared recognition of the strategic value of cooperation; and
4) All groups are affected by the quality of the consumer advisory committees or boards, and therefore, people who serve on them must be carefully selected and provided greater support and training.

Discussion of Lessons

Lesson 1: ***Stakeholders shared an awareness of serious problems in IHSS, and developed a shared excitement about the potential of the public authority to address the problems.***

The problems confronting the IHSS system were visible and of concern to all stakeholder groups: Consumers knew the fear of losing their worker and not finding a replacement; workers found it impossible to take care of their family on minimum wage pay checks; social workers experienced unmanageable caseloads; and the boards of supervisors struggled to find funding for yet another burgeoning program. Furthermore, when counties were given responsibility for a share of IHSS costs with realignment in 1992, the program suddenly became visible to county boards of supervisors, with IHSS, for the first time, having to compete with other programs for county funding.

Yet consumers and workers were truly excited by the opportunity for empowerment provided by the 1992 SB 485 public authority legislation. With the enthusiasm of consumers and workers in the lead, the boards of supervisors and the county IHSS administrative agencies — further encouraged in 1993 by the infusion of federal PCSP funds into

county budgets — became increasingly interested. While there is no denying that stakeholders engaged to protect their own interests, it is also true they soon shared a common goal of taking advantage of this new opportunity to improve both the quality of jobs and the quality of care within the IHSS system.

"The public authority creates a great forum for talking about these issues because consumers and workers are always talking to each other." (Consumers and Advocates)

"Home care needs to be more visible so that workers will want to stay on the job." (Consumers and Advocates)

"We are all human beings and have to be recognized for what we do; these IHSS workers need to feel important." (Consumers and Advocates)

"My goal was to make home care a profession and without the public authority we couldn't make any changes." (Consumers and Advocates)

"Our major goal originally was to get the attention of politicians to see IHSS and the needs of consumers and workers. The public authority was a way to get IHSS to the 'front burner' to make some changes." (Workers and Organized Labor)

"The thing that makes the public authority more effective is that the legislature likes that it's not a 'cookie cutter' approach. Public authorities can create solutions that are locally based and work for the county in which it exists." (Workers and Organized Labor)

"You hear so much about the needs of child welfare but you rarely hear about long-term care. So the public authority can bring another voice to this issue and to the elderly and disabled people who need long-term care." (County IHSS Administrative Agency)

"There is no source of guaranteed funding at the local level and it is a continuous battle to obtain the county match. So any window that gives us a look at needs, problems, and what is going on is good." (County IHSS Administrative Agency)

"For a long time, I have recognized that providing services for people in their homes is better for consumers overall and is more cost effective than putting them in a nursing home." (Board of Supervisors and County Departments)

"My goal was to help chore workers get increased wages and benefits." (Board of Supervisors and County Departments)

Lesson 2: ***The collaborative vision to improve the IHSS program was effective in galvanizing support because it incorporated goals from each of the stakeholder groups.***

Interviewees from all groups shared a vision to improve quality of care and delivery of IHSS for all consumers, regardless of ethnicity, age, geography, and disability. While each county had its own unique process, each stakeholder group developed an awareness of IHSS problems in their county and, through meetings and discussions, worked with each other to understand how the public authority in their county would improve IHSS for each group at the table.

As the stakeholders learned more about each other, a shared vision that recognized commonalties and differences between the groups evolved. Their shared vision included improvements in all the areas fundamental to the public authority, including funding, access, delivery, and quality of care.

Initially, in an effort not to exclude any group or individual stakeholder, participants often alternated between being too prescriptive and too general about their vision and goals. Nonetheless, this collaborative spirit encouraged participants to see the issue beyond their own self-interest and their typical way of perceiving the issues. Together stakeholders developed a vision that combined some of each stakeholder's worldview, crafting new visions that embraced a significant portion of each of their goals.

For workers, the new collaborative vision included not just wage and benefit improvements, but also training on how to respect consumers' desires for independent living; for consumers, the new vision included a registry to help with screening of workers, while having a union involved in what was once a direct relationship with their workers; for the county IHSS administrative agencies, the new vision included sharing direction of IHSS with consumer-majority boards; and for the county boards of supervisors, the new vision included increasing funding for IHSS while also engaging and negotiating with a new union.

"Always before we have had to compete with McDonald's for workers and now we're above those jobs and we can get better quality people." (Consumers and Advocates)

"Our organization is heavily involved in health care and long-term care is a natural link. We care what happens to older people and want to make every attempt to keep them in their home instead of going to a nursing home. The public authority is tied to worker issues and it is an opportunity for consumers to help determine the character of the program. It is a natural for our organization to get involved." (Consumers and Advocates)

"We need to improve our system for long-term care, so we can help people before they end up in a nursing home." (Consumers and Advocates)

"The 283-hour cap is a huge problem and we need to increase the hours cap for severely impaired consumers. Consumers were concerned that the dollar cap in a proposed piece of legislation would force consumers to lose services and organized labor and consumers worked together to get the dollar cap removed from the legislation." (Workers and Organized Labor)

"What has to happen is in each individual situation the consumer and the worker have to sit down and talk about the problem they're having and try to work out some sort of a way that the worker and the consumer can be satisfied." (Workers and Organized Labor)

"The public authority strengthens influence for consumers because they have another entity to advocate and give voice to their needs to the board of supervisors and to the legislature." (County IHSS Administrative Agency)

"I think that increasing wages and benefits will enhance the pool of potential providers, which will lead to greater retention of workers, which means a consumer can ask more of their worker, like coming on time, doing the jobs they're asked to do, and not negotiating shorter hours." (County IHSS Administrative Agency)

"I did not expect such a successful and professional outcome, which is fiscally very reasonable without totally hammering the county." (Board of Supervisors and County Departments)

Lesson 3: ***Through the collaborative process, stakeholders developed trust, the ability to communicate, and a shared recognition of the strategic value of cooperation.***

Stakeholders were not always comfortable when they first came to the public authority development process, and it took time for them to develop trust and a willingness to communicate with each other. Early meetings of all stakeholders — sometimes four to five hours long — engaged all stakeholders in deciding on an agenda, ground rules, goals, and vision. Talking about each other's vision, goals, and issues, the first steps of a collaborative process, was key to understanding each other and to recognizing the need for the collaborative process itself.

Stakeholders soon recognized the value of this collaborative effort in achieving political successes that no one group could win alone — such as winning new state legislation and securing the additional funding essential to the operation of the public authority. While consumers worried about the union interfering in the consumer – worker relationship, they also recognized that the union's political influence was critical to winning in the state legislature. While the boards of supervisors and county department staffs didn't welcome dealing with another union, they recognized that to win full state participation in increased wages and benefits, they needed the political influence of organized labor. In turn, labor recognized that they could not win improved wages and benefits without support from both county officials and the consumer community.

> *"It is hard to develop a strong relationship between the union, the county, aging, and people with disabilities, but if you do it, the results will only be positive. My advice would be to get consumers, labor, and the county to the table early on before you have a plan and work together to develop the plan."* (County IHSS Administrative Agency)

> *"One of the major strengths of this effort to get the public authority was to get the different stakeholders together and, in my opinion, that's what made the difference. Working together made it possible to highlight the issue. Disabled and senior consumers gave a softer face to the issues than organized labor."* (Consumers and Advocates)

> *"I don't like the union… I don't like their tactics. However, the reality is that without the union we would have no wage increase. Their political influence has made that victory possible and obviously increased wages are critical for this program, so we need the union."* (County IHSS Administrative Agency)

"This dialogue has to be on-going, it can't stop at any point. People come and go but this process of communication and the history of this effort has to be there for others to learn from." (Consumers and Advocates)

"Once the county made the decision to establish a public authority, consumers and labor became our allies. There was no rudeness or nastiness, but we all clearly understood each other's positions." (Board of Supervisors and County Departments)

"The teaming up of the SEIU and the consumers makes the public authority a powerful advocate — much more powerful than either consumers or the union alone." (Workers and Organized Labor)

Lesson 4: ***All groups are affected by the quality of the consumer advisory committees or boards, and therefore, people who serve on them must be carefully selected and provided greater support and training.***

Interviewees in every stakeholder group noted the impact of consumer input on the functioning of the public authority. There was widespread recognition that, in order to benefit from the public authority, the voices of all consumers — seniors, those with developmental disabilities, ethnically isolated groups, and less vocal consumer groups — had to be heard, a full realization of the consumer's call for: "Nothing about us without us." Within that concern was the fear — which often proved true — that only vocal consumers would benefit from the public authority, leaving less vocal consumers with no more influence than they had had without a public authority.

All stakeholders recognized that managing a public authority is a complicated set of tasks, and that the consumer-majority advisory committee or board may be confused and intimidated with a barrage of formulas and figures from county fiscal staff. Every stakeholder group wanted more training for the consumer-majority committees or boards, but many were concerned that the committees or boards needed help to seek out the training and assistance they need.[9]

"The most important thing in this whole process is to get real consumer participation in an educated way and you should do everything you can to make this happen." (Consumers and Advocates)

[9]With so many public authorities now in existence — as well as their association, the California Public Authority Council — it is likely that there are colleagues in other counties who may be willing to share their experiences and expertise.

"People with cognitive disabilities, brain injuries, Alzheimer's may be the type of consumer who are less benefited by the public authority because they are less vocal in stating their issues." (Consumers and Advocates)

"I would recommend the appointment of people with some professional experience, who know administrative policies, understand business, and people who have some power and connections to the board of supervisors, funders, and legislators." (Consumers and Advocates)

"These committees are not used to operating within these legal and bureaucratic contexts and they need training." (Workers and Organized Labor)

"Pick a consumer board that understands IHSS and pick members who have time for the public authority. And you need a watch-dog group, an on-going coalition, to monitor the public authority." (Workers and Organized Labor)

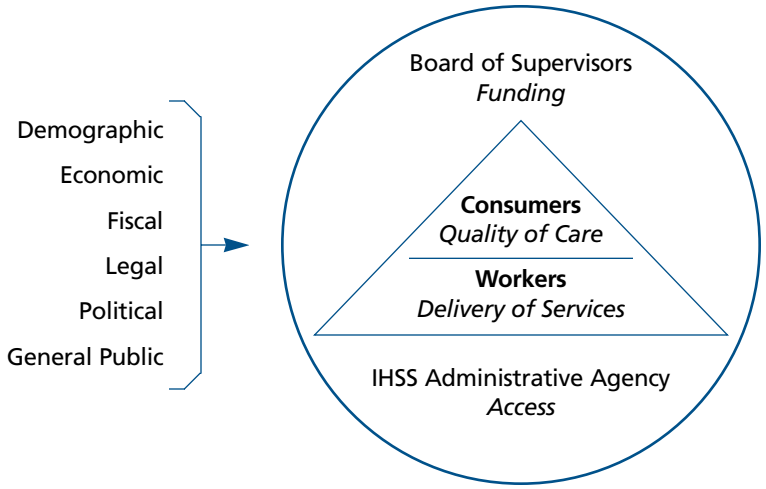
"Most of the public authorities do not offer services in languages other than English and so for a consumer whose primary language isn't English, they won't know about or be able to access the services." (Consumers and Advocates)

VI. Analysis

Each of the four common issues within the public authority — funding, access, delivery of services, and quality of care — matches the primary role of one of the four stakeholder groups. The board of supervisors has primary responsibility for funding; the county IHSS administrative agency addresses access; organized labor has responsibility for IHSS delivery; and consumers bring quality-of-care issues to the table.

These four roles all play out within the limitations of the demographic, economic, legal, political, and fiscal phenomena specific to each county. Within these confines, a public authority functions best when each stakeholder is conscious not only of its own primary role but also of the roles of the other stakeholders — allowing the stakeholders to engage with one another, both competitively and cooperatively, to protect their self-interests while also improving both the quality of jobs and the quality of care.

IHSS Public Authority Stakeholders, Factors, and Functions



Although obvious, it is important to emphasize that creating a public authority is intensely political and open to public scrutiny. The entire process, from the initial planning meetings to on-going public authority activities, is subject to the requirements of the California Brown Act, which mandates open meetings and the pre-posting of agendas and items for action. The election of the members of the boards of supervisors creates a highly political atmosphere for debate about public authorities and about funding for improvements in IHSS.

In fact, each year the annual budget deliberations of the state legislature and the governor decide the fate of IHSS and the public authorities for the following year. Specifically, the annual wage increases promised to public authority workers in the 1999

legislative victories are triggered each year if the state's general fund meets certain minimum income thresholds. Therefore, determining wage and benefit funding at both the state and county levels is an open, participatory, and very political process. Given all these constraints and limitations, the fact that public authorities were formed and now function at all is a tribute to the stakeholders and their leaders.

It may be enlightening to consider how the collaborative framework described here can help address one of the most difficult issues for a public authority: finding the additional funds necessary to increase wages and benefits for IHSS workers. While interviewees from all stakeholder groups agreed on the importance of raising wages and benefits for IHSS workers, one group, the board of supervisors, is on the "hot seat" on this issue. Due to their broad funding responsibilities, members of each board of supervisors have to consider funding for their public authority within the context of the entire county budget, not simply the IHSS budget. Typically, the board of supervisors is convinced that the county does not have adequate funds for wage increases, while consumers and workers are equally convinced that the county does have the funds.

Collaboration provides the greatest opportunity to develop "win-win" solutions, rather than solutions where some groups win, others lose, and relationships of trust are damaged.

To bridge such divergent perspectives, all stakeholders must talk about and make a conscious commitment to working collaboratively to address this issue. They can agree that no one issue should destroy their collaborative relationship — that there will be issues beyond this particular funding issue, in which stakeholders will want and need to maintain their collaborative relationships. Stakeholders can be reminded that if the battle gets too ugly, they may not be able to re-establish trust and a working relationship — they may then be unable to win on issues that are too big for any one stakeholder, such as joining together to secure greater funding support from the state legislature.

More specifically, stakeholders can assess together the fiscal implications for the county of higher funding of wages and benefits, including an estimate of the amount of savings the county has enjoyed since the federal funding of the Personal Care Services Program began in 1993. Data from the public authorities that have been able to get nearly 100 percent of their costs for IHSS direct services reimbursed by the state through realignment funds can also be presented to the board of supervisors. Public authorities that have received this higher rate of reimbursement can talk with county fiscal staff and the board of supervisors. The consumer community can suggest funding that might result from implementation of the

Olmstead decision, while organized labor may be particularly capable of directing its political influence for more funding at the state level.

All stakeholders can present options for solving the issue and stakeholders can collectively examine each option, reminding each other that they must go beyond their own interests and understand the public authority from the perspectives of the other stakeholders. All stakeholders can appreciate the very real budget problems facing the board of supervisors, and the board of supervisors can in turn show appreciation and openness to suggestions from other stakeholders.

Finally, all stakeholders must recognize that there may be issues that are beyond any one group's willingness to collaborate. Each must learn how to "agree to disagree" on any one particular issue, in order to win on others — avoiding distrust that might sever the potential of re-establishing future collaboration.

The objective of this process is to move each stakeholder beyond seeing the problem as the county's problem to seeing it as a problem for all of the stakeholders. Collaboration provides the greatest opportunity to develop "win-win" solutions, rather than solutions where some groups win, others lose, and relationships of trust are damaged. Although requiring constant attention, and not a little risk, collaboration maximizes the likelihood of securing lasting solutions that best address the needs of all stakeholders.

VII. Conclusion

This report is intended to be a candid look into the development of the first eight California public authorities through the eyes of the four stakeholders, other key participants, and the Strategy Group formed to guide our analysis. Not one person interviewed said the process of developing a public authority is easy, and not one person interviewed said the process is impossible.

In nearly all interviews, stakeholders reflected understanding and patience, along with suspicion and competition, toward their collaborative partners. In describing the experiences of stakeholders, it is clear that developing and implementing a public authority is exceptionally complicated, with many potential disagreements between, and even within, stakeholder groups.

However, the collaborative process described here eventually provided a framework, however imperfect, to help stakeholders appreciate the value of education, training, and mutual support on both the content and the process of creating a public authority. A conscious, explicit commitment to collaboration among the key groups is an essential first step, helping each build beyond its own self-interest, by learning how to perceive an issue from the point of view of multiple stakeholders. Of equal importance, stakeholders must be prepared, in advance, to agree to return to collaborative discussions after they are, inevitably, divided on a particular issue.

The story of the creation of the first eight public authorities is, despite many subplots of tensions and disagreements, a remarkable one in which true benefits have been secured for both workers and consumers. Much is still left to be achieved, not only within these eight counties, but also in the California counties now facing the challenge to create their own public authorities. We therefore hope this analysis will prove of value to all stakeholders who are committed to improving both the quality of care and the quality of jobs within California's IHSS program.

Appendix I:
Methodology

This analysis of California's public authorities examines the primary organizations and interest groups that helped shape the In-Home Supportive Services (IHSS) program and their struggle to improve IHSS' critical services. In the initial eight public authority counties, four stakeholders — consumers and advocates, workers and organized labor, the county IHSS administrative agency, and the county board of supervisors and county departments — engaged in an often-lengthy process to develop and implement their public authority. These stakeholders struggled, sometimes as allies and sometimes as adversaries, to design and finally implement their vision for both improved jobs and improved care.

The Paraprofessional Healthcare Institute created a Project Strategy Group (listed on the inside cover of this publication, whose make-up also reflects the four stakeholder groups) to develop a list of categories from which interviewees were to be drawn. The categories for interviewees included: younger disabled consumer, older consumer, IHSS advocate, non-family provider, family provider, local union staff, county counsel, chief administrative officer, member of the county board of supervisors, IHSS administrative agency social worker, and IHSS administrator.

The author then contacted public authority directors in the eight counties, briefed them on the project and asked them for suggested individuals to be interviewed. Based on input from the Strategy Group and the public authority directors, availability of potential interviewees, and staff capacity, the author selected interviewees from among the various categories across the eight counties.

While this process clearly did not produce a scientifically selected, random sample, we chose individuals carefully to ensure as balanced representation as possible from among the four stakeholder groups. By the end of the project, the author had interviewed more than two dozen individuals who played a central role in the creation of these public authorities.

As in the actual public authority development process, interviewees were not evenly distributed by county or by stakeholder group. Specifically, there are more consumer and worker interviewees than IHSS administrative agency and board of supervisors interviewees, and there are more interviewees from counties with larger IHSS caseloads than from counties with smaller caseloads.

The author conducted interviews by telephone over a three-week period in July and August of 2001. All interviews were anonymous and confidential. The author asked interviewees to recall the development of the public authority in their county, their goals, fears, and areas of resistance. Interviewees were asked about the registry, the union, their

allies and adversaries, beneficiaries of the public authority, and both divisive and "bridge" issues. The author then asked for advice to help stakeholders in counties who are about to enter the same development process.

A questionnaire, found in Appendix II, served as a framework for all interviews. The author allowed interviewees to talk as little or as much as they desired about any or all questions, with the length of the interviews ranging from 15 minutes to 60 minutes. Generally, interviewees were remarkable in their willingness to talk frankly and openly about their opinions and experiences. The author categorized interviewee responses by question and by stakeholder group and, then, further summarized these results into the issues and concerns detailed in this report.

Appendix II:
Stakeholder Interview Questionnaire

Introduction to interviewee

As an individual from a county with a public authority, we are interested in the issues and concerns that you had as you were developing and are now implementing the IHSS public authority. Identifying and talking about your experiences will be useful for other California counties who are now in the process of developing a public authority. We will be interviewing all stakeholders: consumers and advocates; workers and organized labor; staff from the county IHSS administrative agency; and staff from the county board of supervisors and county departments, to learn about the public authority development process from each of their perspectives.

Everything you say in this interview will be completely confidential and anonymous. Your name will not be used in any way in the publication and discussion of these results. I hope we can finish the interview in 30 – 45 minutes, but we can talk as long as you want to.

Questions

1. What did you consider your primary stakeholder group during the public authority development process?
2. What were your major goals for the public authority as it was being developed?
3. What were your fears and "worst case scenarios" for the public authority as it was being developed and have they been realized?
4. Were you resistant to the public authority when you were developing one and have your views changed?

5. Do you think the registry will improve quality of care for IHSS consumers? If so, how? For instance, improved matching, orientation, training, late check assistance, etc.
6. Do you think that increasing wages and benefits and having a union improves quality of care?
7. Does the public authority strengthen or weaken your ability to influence IHSS or the services your receive?
8. Do you think the public authority addresses the needs of all consumers and workers? If not, which groups do you think benefit the most from the public authority?
9. Which of the major stakeholder groups — consumers, organized labor, county IHSS agency, or the board of supervisors — did you consider your most dependable ally? Were there instances in which this relationship was broken?
10. Which of the major stakeholder groups — consumers, organized labor, county IHSS agency or the board of supervisors — did you consider your most frequent adversary? Were there instances in which this adversarial relationship was bridged, where stakeholders reached across their divides and cooperated with each other?
11. Now that you see how the public authority functions, what would you do differently or what advice would you give to counties that are in the process of developing their public authority?

Appendix III:
Statuatory changes in the in-home supportive services/personal care services program*

- **1973** The In-Home Supportive Services Program was created to enable elderly, blind and disabled to live independently in the community.
- **1978-1981** Equity Assessment Project, three-year project conducted by the University of California at Berkeley, in three counties, Alameda, Contra Costa, Marin. Project used historical needs assessment data to predict the assessment level of need for IHSS services. Permitted similar awards to individuals with similar dysfunctions thus promoting equity.
- **SB 633 Chapter 69 Statutes of 1981,** introduced the first state time per task standard, known as the Domestic Services Standard. (The standard is now included in the IHSS Division 30 regulations.)

- **AB 223 Chapter 323 Statutes of 1983,** provided for Welfare and Institutions Code Section 12301.2 that stated that counties shall not use time per task guidelines in assessing the need of eligible individuals for the services described in subdivision (a) of Section 12304. Shopping errands and laundry are excluded from the Section 12304 (e) listing.
- **SB 485 Statutes of 1992** added Section 12301.6 to the Welfare and Institutions Code to allow the board of supervisors to contract with a non-profit consortium for the delivery of In-Home Supportive Services, or to establish by ordinance, a public authority for the delivery of In-Home Supportive Services.
- **AB 1773, Chapter 939, Statutes of 1992,** amended the Welfare and Institutions Code Section 12300, to add Personal Care Service (PCSP), including protective supervision, to the PCSP definition.
- **November 2, 1992** State Plan Amendment for PCSP was approved.
- **AB 5, Chapter 7, Statutes of 1993,** amended the Welfare and Institutions Code Section 12300 and 14132.95, to make Personal Care Services a Medi-Cal benefit, and deleted protective supervision from the definition of Personal Care services.
- **April 1, 1993,** the PCSP Program was implemented.
- **SB 35 Chapter 69, Statutes of 1993,** created the In-Home Supportive Registry Model Sub-Account in the sales tax account for the purpose of implementing the provisions for the delivery of IHSS by a public authority or non-profit consortium.
- **AB 2779 Chapter 329, Statutes of 1998,** amended Welfare and Institutions Code Section 14132.95 to include the medically needy aged, blind and disabled persons under the scope of personal care services provided under the Medi-Cal Program.
- **AB 2401 Chapter 479, Statutes of 1998,** authorizes San Francisco City and County to implement a pilot project for at least three years to implement the provision of pooled services under the in-home supportive services (IHSS) program, through a modified delivery system in no more than five HUD-subsidized senior housing facilities owned by nonprofit organizations.
- **AB 668 Chapter 896, Statutes of 1998,** requires the provision of waiver personal care services as defined under the Medi-Cal Program to persons meeting specified requirements.
- **April 1, 1999** State Plan Amendment approved to allow income eligible IHSS recipients to receive personal care services.
- **July 1, 1999** State Plan Amendment for the implementation of AB 668 was approved.

- **AB 1682, Chapter 90, Statutes of 1999,** requires counties to act as or establish an employer for In-Home Supportive personnel for purposes of collective bargaining. This legislation also requires counties that had not established a public authority for the provision of IHSS services, to establish an advisory committee to provide recommendations on certain modes of service delivery to be utilized in the county for IHSS. It also eliminated the In-Home Supportive Service Registry Sub-Account from the sales tax account in the local revenue fund and transferred any moneys to the General Fund.
- **AB 515, Chapter 804, Statutes of 1999,** makes specific that personal information of IHSS providers is not subject to public disclosure pursuant to the California Public Records Act except under certain conditions.
- **AB 155, Chapter 820, Statutes of 1999,** allows the disabled with income meeting the criteria as outlined in this bill to be eligible for Medi-Cal subject to payment of premiums. This bill impacts the Personal Care Services Program.
- **AB 530, Chapter 845, Statutes of 2001,** also allows In-Home Supportive Services clients and personal care services recipients under the Medi-Cal program to submit fingerprints of persons providing those services to the Department of Justice (DOJ) for criminal background checks. The DOJ is required to provide subsequent arrest notification if certain conditions are met.
- **AB 2876, Chapter 108, Statutes of 2000,** establishes a formula with regard to provider wages or an increase in benefits, negotiated or agreed to by a public authority or non-profit consortium. It specifies the percentages to be paid by the state and counties with regard to the non-federal share of any increases. This legislation provides for the following increases in state participation in wages and benefits for program providers:

  Non-public authority counties

  For Fiscal Year 2000-01, the state will pay 65 percent and each county will pay 35 percent of the non-federal share of any increase to individual provider wages a county chooses to grant, up to 3 percent above the statewide minimum wage. This is not a mandatory requirement; counties have the discretion to provide or not provide a wage increase. This section is effective January 1, 2001.

  Public Authorities

  This legislation provided for increases in wages and benefits for Individual Providers in Public Authority counties: The state will pay 65 percent, and each county will pay 35 percent, of the non-federal share of wage and benefit increases negotiated by a public authority or a non-profit consortium and associated taxes.

- The state will participate in wages up to $7.50 per hour and individual health benefits up to sixty cents ($0.60) per hour for all public authority and non-profit consortium providers.
- The state will participate in a total of wages and individual health benefits up to nine dollars and ten cents ($9.10) per hour if wages have reached at least seven dollars and fifty cents ($7.50) per hour.
- Gradual wage and benefit increases are allowed for these specified providers over the next four years following fiscal year 2000-01 up to a combined $12.10 per hour in the fourth year.
- Each of the subsequent increases will be dependent on the county previously having reached the $7.50 level and General Fund revenue exceeding by at least 5 percent the revenue of the previous fiscal year.
- Any state participation in wage and benefit increases would be limited to an increase of $1.00 per hour for any fiscal year.

Contract Counties

Funding was also provided in the fiscal year 2000-01 budget for the State share of the cost of existing contracting counties electing to increase their maximum allowable contract rates. (Wages and benefits for contract providers are negotiated between the contractor and their local unions.)

- **AB 288, Chapter 445, Statutes of 2000,** requires each county that has not established a public authority for the provision of In-Home Supportive Services (IHSS) to establish an advisory committee. It also requires the advisory committee in each county to provide recommendations on certain modes of service to be utilized in the county for IHSS. The advisory committee membership must include one IHSS provider for a county that has an IHSS caseload of less than 500 and two IHSS providers for a county that has an IHSS caseload of more than 500. This legislation also allows for the reimbursement of the advisory committee's administrative costs.
- **AB 2877, Chapter 93, Statutes of 2000,** added Section 14005.40 to the Welfare and Institutions Code. This bill authorized funding and directed the Department of Health Services to implement a Medi-Cal benefit with no share of cost for qualified medically needy, aged, and disabled persons. This program is known as the Aged and Disabled Poverty Level Program.

*Source: California Department of Social Services

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An introduction to coaching supervision: how coaching differs from traditional supervisory practice, the skills needed to become an effective coach, and the organizational structures that make coaching effective.

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CASE STUDIES

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This case study traces the early development of a home care cooperative, initiated as a sectoral development project, in Manchester, New Hampshire. The study draws attention to key "lessons learned" in the areas of financing, leadership, market analysis, and customer development.

"We Are the Roots: The Culture of Home Health Aides," by Ruth Glasser and Jeremy Brecher. In the *New England Journal of Public Policy.* Vol. 13, No. 1. Fall/Winter 1997.
This article focuses on the contribution of the workers' culture to the success of Cooperative Home Care Associates.

POLICY PAPERS

Cheating Dignity: the Direct Care Wage Crisis in America, by the Paraprofessional Healthcare Institute. AFSCME, August 2001. (40 pgs.)
A detailed analysis of how our nation fails to pay our direct-care staff "self-sufficient" wages and benefits.

"Direct Care Health Workers: You Get What You Pay For," by Steven L. Dawson and Rick Surpin. In *Generations.* Vol. XXV, No. 1. Spring 2001. (6 pgs.)
This paper examines labor supply and demand and suggests that improving the price of labor, through changes in policy and practice, is the only way to attract workers to long-term care.

"The Home Health Aide: Scarce Resource in a Competitive Marketplace," by Steven L. Dawson and Rick Surpin. In *Care Management Journals.* Vol. 2, No. 4. Winter 2000. (6 pgs.)
The authors argue that employers must create higher quality jobs for home care workers to compete successfully for workers in today's economy.

Direct Care Health Workers: The Unnecessary Crisis in Long-Term Care, by Steven L. Dawson and Rick Surpin. The Aspen Institute. January 2001. (33 pgs.)
Dawson and Surpin examine the structure of long-term care, its financing, and the current labor crisis, arguing for sectorwide restructuring supported by labor, welfare, and health care policies that work together to support high-quality care for consumers, decent jobs for workers, and a more rational environment for providers.

"Toward a Stable and Experienced Caregiving Workforce," by Mary Ann Wilner. In *Generations,* Vol. XXIV, No. 3. Fall 2000. (11 pgs.)
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Health Care Workforce Issues in Massachusetts, by Barbara Frank and Steven L. Dawson. Presented at the Massachusetts Health Policy Forum, June 22, 2000. (32 pgs.)
Arguing that the price of labor must rise to attract direct-care workers, Frank and Dawson make a number of key recommendations for changes in state policy and provider practice.

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This essay confronts the caregiving crisis by offering a closer look at paraprofessional caregivers and the nature of their jobs, summarizing some of the public policies that currently shape the quality of those jobs, and proposing some possible steps that policymakers could take to start rebuilding our nation's direct-care workforce.

Paraprofessionals on the Front Lines: Improving Their Jobs—Improving the Quality of Long-Term Care, by Mary Ann Wilner and Ann Wyatt. A conference background paper prepared for the AARP Long-Term Care Initiative. AARP, 1998. (75 pgs.)
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Welfare to Work: An Employer's Dispatch from the Front, by the Cooperative Healthcare Network. January 1998. (10 pgs.)
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