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Assessing the Needs of IHSS Providers

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Assessing the Needs of IHSS Providers

Renesha Westerfield

Capstone Project

University of San Francisco

Executive Summary

San Francisco IHSS (In Home Supportive Services) Public Authority serves over 2,000 consumers and this number is growing daily due to the amount of people in need here in San Francisco. The consumers are in need of providers. Currently there is a lack of well-trained providers to aid in meeting the needs of the consumers. This has led to consumers going back to hospital for injuries and other complications that could have been avoided if they had providers who were properly trained on their condition. This is not the purpose of IHSSPA, they receive funding to prevent hospital recidivism but that is not the case and this has a huge impact on the growing number of consumers in the City and County of San Francisco.

Agency Background

San Francisco In Home Supportive Services Public Authority serves IHSS consumers in San Francisco County. The Public Authority was founded with the purpose of making IHSS work better for consumers. One method of achieving this goal is by the use of the registry. As an employer of record the Public Authority maintains and monitors the independent provider registry. Consumers can select and interview providers from the registry. The Public Authority in San Francisco has been established for over 20 years. City and state regulations have mandated the services remain focused on the meeting the needs of IHSS consumers. Outside of the registry the PA is mandated to not focus their resources on the providers. The providers' needs are to be met through the city or the union. The mission statement is as follows "The mission of San Francisco's IHSS Public Authority is to provide and promote a service delivery model of consumer directed, in-home support that maximizes the potential of older adults and people with disabilities to live independently and participate in their communities." Currently there has been

a shift the Public Authority is in the process of filing for non-profit status; this will allow them start a new organization. The new organization will be able to offer services to consumers and providers alike.

Target Population

The Public Authority currently serves over 2,000 consumers and this number is growing daily here in San Francisco. Consumers come from different ethnic and cultural backgrounds with varying abilities. The consumers are in need of well-trained providers. Currently there is a lack of well-trained providers to aid in meeting the needs of the consumers. This has led to consumers going back to the hospital for injuries and other complications that could have been avoided if they had providers who were properly trained on their conditions. The provider workforce is comprised mainly of women of color who are 55 and older. There are other populations of people who work as providers as well. The Public Authority has historically ignored providers and their needs. The PA has received funding to prevent hospital recidivism amongst consumers but this goal can't be met until the needs of the providers are met as well.

Literature Review

Introduction

The provider and consumer relationship is multilayered in a myriad of issues and challenges they face. The consumers are an underrepresented population that is comprised of people who are from a lower socio economic status. Many consumers are vulnerable, physically, mentally and in some cases both and this allows many of them to be taken advantage of and abused. The image of the mistreated consumer is perpetuated in today's society and this has created a demonized stereotype of the provider. The providers are also members of an underrepresented population. Many are from a lower socio economic status and are forced to

become a provider. Many have inadequate training and preparation for the position. The lack of monitoring by the overarching agencies leaves many in limbo. Many providers are subjected to abuse, harsh work environment, low pay which forces high turnover rates and increased tension amongst providers and consumers. The structure of IHSS does not provide any substantial support for the providers. When they complain or have any job related issues they are on their own to navigate it all. In essence, providers are an underrepresented population who serve another underrepresented population. They have needs that should be met so they can better serve vulnerable consumers.

History and Need for Intervention

Delp et al. (2010) investigated the determinants of job satisfaction amongst home care workers in a consumer-directed model. Home care workers are satisfied by the intrinsic rewards of helping others and this why they stay at their job. However these intrinsic rewards are coupled with physical and emotional demands that contribute to the stress that homecare workers experience. Some stressors include: unpaid overtime, financial strain, and health status. The conceptual framework Job Demand Control/Support model was used to examine the three dimensions of work related stress: job demands, control and support. The workers have a physical and emotional interaction with their consumers. This dual interaction has demands and rewards. The demands contribute to the work stressors the workers are exposed to. The policies, wages, benefits and schedule also contribute to the stress workers experience. The control is on two levels, workers are unable to make decisions on daily job tasks and on a larger level the workers do not have a collective voice that has control over decisions made in policies and job security. Support for the workers is usually their family, friends and some cases the consumer.

However workers do not have the traditional setting where they have a supervisor and coworkers and in many times they are isolated and this contributes to their inability to meet their job demands. California has the largest consumer-directed program in the country, which is IHSS and 200,000 workers are employed. These workers provide care to over 300,000 low-income elderly and disabled consumers. The results showed that workers experienced job stress and satisfaction at the same time. The range of demands (abuse from consumer, unpaid hours worked, and having multiple consumers) and job insecurity contribute to job dissatisfaction. These issues are intertwined with policies, the structure of IHSS, sociocultural and economic factors that these workers work in. To really fix these issues it must be dealt with on each level. Changing the policies and giving the workers a better work environment would allow them to remain in their positions.

Similar to Delp, Benjamin and Matthias (2004) examined the differences and outcomes for agency workers and consumer-directed homecare workers. The purpose of this study was to examine the differences between the workers who are employed directly by recipients versus the workers who are who are reliant on recipients who use an agency to employ a worker. Understanding the issues that workers face, concerns have been raised about the performance of paraprofessional workers providing care to elderly and people with disabilities. Majority of recipients depend on family members to help them, however there is an increasing demand for homecare workers and there is a question if these agencies can handle the demand. There are several dimensions of the homecare workforce 1) not enough workers due to high turnover rates 2) little is known about the quality of services provided 3) working conditions are difficult because they have little training and no supervision 4) workers received little recognition or respect for the work they do from employers (clients, their families and homecare agencies).

Most research has been focused on the workers employed by an agency. Little research has been placed on consumer-directed models. These models have impacted worker recruitments and turnover. Many states have adopted this model and have been able to recruit and hire their own workers without agency involvement. The older adults and those with disabilities were self-directed to finding their own worker. Having a consumer-directed model is concerning because it gives the control to the recipient (consumer) and the needs of the worker are overlooked. The results of the study found that consumer-directed model to be freeing to workers who felt that agency procedures were rigid.

Workers felt that the consumer-directed model allowed them to be more responsive to their consumer. Other workers felt that the consumer-directed model was undermining to the traditional structure (agency) and that it increased worker stress. Overall, the authors found that both scenarios are somewhat true and there isn't a difference between agencies and the consumer-directed model, when it comes to work-life differences.

Women in the Workplace

Women are affected by the homecare work industry as well; according to Hess (2011),

“In the United States, women are disproportionately affected by what some call a growing “care crisis” or “crisis of care”, this care crisis refers to the fact that the nation’s need for in-home care to assist elderly and disabled Americans is growing rapidly, while the care industry experiences a complex set of challenges including low wages for care workers and high turnover that makes it difficult to ensure the availability of quality in-home care. Although this care crisis affects all Americans,

women constitute the vast majority of those who both give and receive in-home care, rendering them especially vulnerable to the challenges experienced on both ends of the care relationship.” (Hess, 2013)

The aging population is a crisis but it is a gendered issue that must be addressed. These changes are fueled by the changes in the population demographics and family life. Marriage rates have declined and more women are working. Traditionally women have been the primary care providers in the home to elder and disabled family members and this explains their natural transition to this field. In 2010, the United States employed 1.9 million individuals as home health and personal aids, 90 percent were women, with 56 percent being women of color. (Hess, 2013)

Women are also more likely than men to be single and live and alone once they age. This puts women at an increased need for help from a worker. Also, this is attributed to women living longer than men, men are more likely to remarry after a divorce or a spousal death and unmarried men are more likely to live with others. The increase of the elderly population and the increase of women in the workforce have increased the need for in home care. Older women are a financially vulnerable because they on average have less access to a pension income than men do. Women earn less income than men, they are unable to accumulate the necessary assets and this leads to less Social Security benefits once they retire. All of these challenges create a financial vulnerability where many elderly women require a worker when the time comes. This financial vulnerability also impacts the providers as well, “most care workers in the United States receive limited monetary rewards and many struggle to make ends to meet. The median base hourly wages for in-home care providers in the United States are \$9.75 and the median weekly earning are \$315.00, which are considerably lower than figures for all civilian workers in

the U.S. workforce.” (Hess, 2013). This coupled with the stress and abuse endured in the workplace contributes to the strain of being a provider.

The devaluation of paid care work is a contributing factor to the in-home care industry. The predominance of women in this industry creates the perception that being a provider is seen as “woman’s work” and the work they do doesn’t significantly contribute to the economy and this validates the lower pay. Public policies must be revised to help providers earn a livable wage and create a more equitable work environment so they are better able to meet the needs of the recipients.

Work Demands

There is a high turnover rate among the providers and this is a reflection of the provider’s wages and work demands. With the amount of consumers in need and the amount of quality providers there is a gap between the consumers need and the availability of trained providers. Morris (2009) explains: “The “care gap” will likely be aggravated further by competition for workers brought about by strong demand in other entry-level occupations that tend to be less demanding and better compensated than home based direct care.” This causes the providers to work long and arduous hours in effort to make ends meet. Denton, Zeytinoglu, and Davies (2002) state: “Home support workers may split shifts, for example, getting clients up in the morning and putting them to bed in the evening. Earnings are typically paid on an hourly or per call basis. The unpredictable nature of home care work means that weekly earnings are unpredictable. Scheduling and hours of work are sources of stress and job dissatisfaction for home care workers.” The providers are also under a tremendous amount of stress that takes a toll

on the providers, which leads to high turnover as well. Many workers become very close to their consumers are placed in compromising situations. Denton et al., (2002) explains,

“Although relationships are primarily a positive feature of home care work, they are problematic. Role conflict may occur because home care work takes place in an environment, which assumes a dual function: it is a person’s home and a place of work. Expectations of clients and the worker may differ as the home care worker tries to exercise responsibility for the client, while the client seeks control in their own home.” (Denton et al, 2002)

This can cause strife between the consumer and provider, which can lead to burnout for the provider, which then leads to the needs of the consumer being unmet.

Gap in Data

Providers are a particular population that includes women and men of all cultural and racial backgrounds. There isn’t a lot of information available on IHSS providers and it has become a challenge to gather substantial data on IHSS providers in particular. However, there are other professions that face the same challenges that IHSS providers face. This section of the literature review will cover the experiences of other types of workers like homecare workers, long-term workers and childcare workers.

Homecare workers

Denton et al. (2002) explains the structure of the in home workplace and how its organization lends its self to a stressful environment, that causes home care workers to suffer

from mental health issues. The structural conditions of homecare work are described by low pay, minimal benefits and high turnover rates. Homecare workers usually get paid less than those who work in an institutional setting. Low pay and no benefits is the cause of job dissatisfaction and turnover. Workers have unstable work hours and do not have a schedule of their shifts ahead of time. This is another factor that contributes to the instability of their pay and this all leads to stress and job dissatisfaction. Homecare workers are often working unpaid overtime to complete their work. Unsatisfied homecare workers demonstrate a low quality of work, which directly impacts the people, they work for.

The emotional working conditions for home care workers have been described as being positive at times and that they enjoyed helping others and it was nice to feel needed. There is a relationship that develops between the in homecare workers and the clients. This is seen as a positive characteristic to job satisfaction. Homecare workers usually find themselves performing job duties that are beyond their job descriptions and this contributes to their positive relationship. The role of the homecare worker can be blurred and in some cases this can lead to conflict. This is because the role of the homecare worker has a dual focus; the worker wants to begin taking responsibility for the client and the client is looking for control in their home. This is the result of the intimate relationship the homecare worker has developed with the client. This becomes a professional friendship that doesn't have clear boundaries where the tasks become ambiguous and the worker can be exploited and eventually burnout. Once the worker becomes burnt out they are no longer able to meet the needs of the client.

There are also physical conditions that have an impact on the homecare workers health. Homecare workers are at risk of the following: contagious diseases, skin irritants, allergies, infections and exposure to chemicals. Homecare workers have to go to homes in unsafe

neighborhoods. They are also at risk of being sexually and physically abused as well. Homecare work is comprised of repetitive movements and this puts them at higher risk of injury. They are required to lift clients, which requires them to twist and turn, over and over. Pulling or pushing a client is the source for many homecare workers back injuries. Traveling is also another aspect of homecare worker's frustrations. Many rely on public transportation and this at times impacts their ability to arrive on time and that creates tension amongst their clients.

Organizational working conditions could be improved to help better support homecare workers. Homecare workers are at risk for stress because they are isolated from peers and managers. Also, they are not informed about the status of their client prior to their arrival and this puts the homecare worker in a state of stress because they never know what to expect. Overall there are a myriad of issues that homecare workers like IHSS providers face that impedes their ability to be successful at their job.

Being cognizant of the increasing demand for homecare work and the harsh conditions, Morris (2009) explored how to make homecare jobs more attractive due to the high demand in Maine. High turnover and vacancy rates are a concern in the long-term care field and this is unfortunate because there is a huge demand for workers to provide in home care to elderly individuals. This is referred to as the "care gap" and is aggravated by other competition from other entry-level jobs that don't have the same demands as homecare work. More effort has been made at the local, state and federal levels to increase wages and provide benefits as well. It was recommended by the Paraprofessional Healthcare Institute (PHI) that the wages be increased, benefits, affordable health insurance and more hours are offered for homecare workers.

The study aimed to investigate the impact of wages, hours, benefits, perceived reward, work conditions, personal characteristics, and local labor market conditions, on the retention of home care workers. Medicaid and Medicare fund homecare wages, with both programs inundated with costs, it is unfeasible to increase the wages of the homecare workers. With that said the focus should be geared towards changing supervision practices to help improve work conditions for homecare providers. Improving supervision, training, and the schedule reduce the turnover rates. The results also showed that homecare workers value compensation over health benefits. This can be explained by majority of homecare workers are low-income and have access to Medicaid for health insurance. Or they are younger and are less interested in health insurance as a benefit. Although there is other incentives that could help retain homecare workers; policy makers still need to work at trying to increase the wages to make homecare work a viable career choice.

Long-term workers

There are a lot of people who are aging who will get dementia and knowing how to deal with them is imperative for better outcomes for seniors with dementia. Zimmerman et al. (2005) explored the job satisfaction amongst staff that cares for those with dementia. Properly training staff is a benefit for the client and the provider. The focus was placed on those who work in long-term care for residents in nursing homes and assisted living. The study was designed to look at the attitudes that long-term care workers have about dementia, their stress, and their job satisfaction.

They found that the longer someone has worked with people with dementia the rate of satisfaction decreases. This can be remedied by providing on going training and support to long-

term workers. The workers who had more education reported dementia-sensitive attitudes. Research also showed cultural sensitivity training would be relevant to help long-term workers provide better care to their clients. There is a lot of information available on the needs and how to care for people who have dementia. But the staff needs care as well and the best way to do that is to prepare them by using a person-centered perspective. Overall, there is a benefit to help train these long-term workers on how to care for those with dementia. The management team has to do their best to support these workers so they will remain healthy and happy workers.

Child Care Workers

Childcare workers like IHSS providers face the similar issues. Whitebrook and Phillips (1999) explored the issues child-care workers face. In 1991 two million people in the United States lived in poverty despite being employed full-time. For parents the number is higher 4.5 million children who have parents or a parent who works full-time live in official poverty. There is a real need amongst these families to find quality childcare while they are away at work. The childcare workforce is very necessary for working families and they are high in demand. Many workers are minority women who make very little money (\$6.70/hour).

Childcare workers spend their days caring and educating the children of working families. These workers work in unregulated facilities and are not properly trained to work with children. Despite the funding day care facilities are understaffed due to high turnover and low pay. Unequal access to training leads to unsafe conditions for a child. Childcare workers are exposed to illnesses and physical strain as well. They are subjected to working unpaid overtime and don't take necessary breaks. One-third of the nations childcare workforce leave their jobs for better paying jobs. The high turnover rates and the shortage of trained workers have created a

national staffing crisis. Reforming the U.S. welfare system is one solution to this crisis. Welfare needs to expand childcare services in efforts to help workers obtain childcare jobs that are financially sustainable

Best Practices

Understanding the home healthcare crisis and all of the challenges it faces, PHI National (2011) highlights a resource that is trying to make jobs easier for providers. Chesterfield Health Services, a home health care provider in Seattle invested in their home care aids by offering more training and providing opportunities for advancement. Chesterfield's founder and President, Stella Ogiale views her employees as customers as they are important members of the community. Stella has worked with others to help develop a curriculum that meets the needs of clients, home care aides and the organizations that hire home care aids. The curriculum has been incorporated into the SEIU Healthcare NW Training partnership "The training partnership's students work for employers that are covered by an SEIU contract. That includes the state, which is the employer of record for home care aides working in the independent providers (IPs) program providing Medicaid personal care services. The state's IP workforce makes up 75 percent of the Training Partnership's students. Chesterfield is the third-largest employer in the Training Partnership."

The training curriculum goes from entry level to advanced training. Entry-level or basic training uses the PHI Personal Care Services curriculum is geared to be adult learner focused. Some of the topics include: Working with Consumers, Supporting Consumers at Home, and Self Care. There are also population-specific courses that teach Home care aids how to work with people who have developmental disabilities, mental illness, dementia and physical disabilities.

Chesterfield has employer specific training as in addition to the entry-level training. This training provides home care aids non-clinical tasks like: how to plan your day with no on-site supervision, respecting patient privacy, presenting yourself professionally and cultural competency. Advanced training was designed to help home care aids advance in their career. The skills taught prepare home care aids to work in other settings like a hospital or a doctor's office. If they are interested in the advanced training, it helps homecare workers pursue higher education.

Another component that Chesterfield incorporates in their program is making sure the home care aid and the client match. This is an important factor in this field and creating a positive relationship between the client and the home care aid is a huge part of retaining employees in this industry.

Family Caregiver Alliance has focused on the education and support programs that have been shown to be effective amongst caregivers. There are many programs available that can educate and support a caregiver like: community workshops, family counseling, support groups and technology-based interventions. Family Caregiver Alliance (2004) says that selecting a program must be carefully considered to ensure the needs of the caregiver are met. "It is also essential to define goals of the program to be offered to caregivers. It is important to decide whether the program should reach out to all caregivers or whether it should target particular subgroups of caregivers. Casting a broad net is appealing because it enables an organization to reach out to the largest group of caregivers." Program selection is more than selecting an actual program it is also about selecting a population that will most benefit from the programs as well.

Implementation is another step to consider when selecting a program. Issues to consider include: training needs, recruitment strategies, screening participants, monitoring program

implementation and evaluation of program impact. After following the steps in program selection, Family Caregiver Alliance selected five programs for the caregivers and the classes covered topics like nutrition, how to care for frail older people with chronic disabilities, stress management, caring for people who have dementia and self care.

The American Association of Homes and Services for the Aging released a report by Barbarotta (2010) on strategies for retaining home care workers. Competitive wages and health insurance benefits greatly impact on the probability of becoming a direct care worker “the effect of wage increases and the availability of health insurance and on the probability of workers becoming certified nursing assistants (CNAs). He found that making health insurance available to workers had a large positive impact on the probability they would choose to become CNAs. However, the combination of increased wages and health insurance would result in the largest net gain in the number of CNAs.” (Barbarotta, 2010). There is a strong link between wages and insurance benefits. The wage that many direct care workers make comes from State Medicaid programs and those issues need to be addressed, “State Medicaid programs should increase pay and fringe benefits for direct care workers through such measures as wage pass-through, setting floor wages, establishing minimum percentages of service rates directed to direct labor costs and other means.” (Barbarotta, 2010) In the way of gaining health insurance the Centers for Medicare and Medicaid Services has received 5 grants to develop programs that test recruitment and retention strategies for direct care workers. The report offers many suggestions for the retention and recruitment of direct care workers. These suggestions are applicable to IHSS providers as they face the same challenges in their work place.

Much has yet to be done for providers who work for agencies like the Public Authority. More work needs to be done to help fill these gaps, the research has established the needs but

more has to be done to provide better support to these workers so the care of the elderly and disabled will be of the highest quality

SWOT Analysis

Organization: San Francisco IHSS Public Authority
Goal: Needs Assessment of independent providers

INTERNAL

| Strengths | Weaknesses |
|---|---|
| <ul style="list-style-type: none"> •Dedicated staff •Connection to the community •20 year history of working with consumers and providers in San Francisco Lists of the registry providers •Lists of the family providers •Mentors who can do phone banking in different languages •Staff that can translate surveys in different languages •Support from upper management and all other departments •Interest of the providers participating in the needs assessment | <ul style="list-style-type: none"> •Limited transparency from upper management •Negative attitudes from staff and the impact on the team •Staff conflicts •Poor communication among staff •Delegation •Scheduling conflicts •Not all mentors are skilled at administering surveys •Mentor turn-over |

EXTERNAL

| Opportunities | Threats |
|--|---|
| <ul style="list-style-type: none"> •Becoming a non-profit •Partnerships with USF and FCA •Opening of the One-stop center •Physical location of the public Authority •Increased attention to educational needs of in home care providers | <ul style="list-style-type: none"> •The Budget •City regulations •Homebridge •Once trained, providers may leave registry for better paying jobs |

Legend

FCA- Family Caregiver Alliance

USF- University of San Francisco

SF IHSS PA/PA- San Francisco In Home Support Services Public Authority/ Public Authority

How it Works

The consumers are those who are elderly or disabled and want to remain at home and live independently but are unable to do so on their own. They can contact SF IHSS PA for a list of providers who are on their registry. Providers are independently contracted workers who go into the homes of the consumers and provide basic services like cleaning, cooking, laundry etc. The mentors have been hired by the PA to help the staff with administering surveys and other tasks as well. They also play a role in helping consumers live independently.

The Project

San Francisco IHSS Public Authority has been a community resource for elderly and disabled consumers to find independent providers for 20 years. PA is interested in changing the services they provide to consumers and providers, they are developing a one-stop resource center. The center ideally would help consumers; providers and mentors get better access to training and other resources as well. Before the one stop can be developed the PA has to do a needs assessment of the consumers and providers to get an understanding for the types of programs that would benefit both the consumer and provider the most. The focus of this project is obtaining a needs assessment of the providers.

The internal strengths of the project include the 20-year history the PA has with the consumers and providers in San Francisco. This along with the dedicated staff gives them a strong connection to the community. Logistically when trying to do an assessment it is important

to have an internal system that allows the team to easily contact the providers. The list the staff provided included the name, phone number and addresses for all the registry providers. The staff went to an outside source to obtain a list of family providers (those that only work for their family members). Family providers are often more isolated than registry providers, reaching them and getting their input was very important to the project. The administering of the survey has been in the hands of the interns and mentors. The mentors who speak Spanish, Cantonese, Tagalog, and Russian have been instrumental in helping us reach the non-English speaking communities. Overall, without the support from upper management, mentors and the interest of the providers this project would not exist.

The internal weaknesses include the limited transparency between upper management to the rest of the staff. This has led to much confusion, wasted energy and tension amongst staff. This in some ways has led to the negative attitudes from staff and that impacts the team and the project overall. The staff conflicts have led to lost man-hours and created miscommunication between staff and upper management. Some members of the staff have issues with delegating tasks without micromanaging, which contributes to loss man-hours as well. There are many scheduling conflicts that really hinder work from getting done. Mentors are not skilled at administering surveys and often skip questions, which leads to gaps in the data. The mentors aren't always present at meetings or read their emails and this leads to staff and interns wasting time on constantly updating them. Upper management needs to be more transparent with the staff, this would remediate some the communication issues amongst staff. The mentors need more training from the interns and staff about the importance of making sure all the questions gets answered so the data accurately reflects the needs of the providers.

The external opportunities the project has is that the PA has applied to become a non-profit and this will allow them to apply for funding aside from the city of San Francisco to help fund the one stop center. The PA has developed a partnership with USF and FCA both of which can provide training for both consumers and providers. Once the one stop center opens it will provide support and resources to the community overall. The location of SF IHSS PA is centrally located and near many forms of public transportation which makes it very accessible to consumers and providers. Many providers feel safe and welcomed to the SF IHSS PA location. Overall, one of the outcomes of the project will be the increased attention to the educational needs of the providers, which only leads to better health outcomes for the consumers.

Currently there isn't a budget for SF IHSS PA to do anything for the providers. The City of San Francisco funds the PA and they are responsible for ensuring all the needs of the consumers are met and they are not to focus on the needs of the providers. The City has not allocated any money to the PA to develop any programming for the providers. The City mandated that Homebridge train all registry providers at SF IHSS PA and all other needs are to be addressed by the union (SEIU: Service Employees International Union). Homebridge is another organization that serves IHSS consumers and providers and is in direct competition with SF IHSS PA. Homebridge is using their classrooms as poaching grounds to obtain skilled providers. While conducting the training Homebridge's recruiting team looks for advanced trainees and approach them to work for their private homecare agency, which pays more than IHSS. This is a huge problem because that leaves many low-income consumers with less than adequate providers to help them live independently. Additionally, Homebridge is not providing adequate access to training for the PA; this has increased the amount of untrained registry providers who are in the field and unintentionally creating higher rates of hospital recidivism

amongst consumers. Providing adequate training to the providers feeds into the fear that once they are trained they will leave their jobs and work elsewhere. This is a real threat because IHSS's pay is below minimum wage. This threat will only be remedied once the federal and state government changes legislation and increases the wages for the providers. Whatever the outcome is on the federal and state level this does not negate change the need to for the providers to receive the appropriate training in order to help the consumers live healthy and independently.

Problem Statement

The problem is that the Public Authority is in a real need for providers who are well trained, willing to stay, do a job that is mentally, emotionally and physically strenuous for little pay. The Public Authority has no jurisdiction around how much the providers get paid. The union (SEIU) controls all collective bargaining and employment issues for the providers. This diminishes the ability of the PA to effectively meet the needs of the providers. The PA is aware of the tremendous work and stressors the providers are under and how they are in need of more support. The needs assessment will give them the foundation to create future programs that will better support them i.e. how to operate a Hoyer Lift, support groups and consumer and provider classes. The needs assessment is a way for the PA to meet other provider needs that are beyond pay and employment issues. The PA could offer support to the providers and this would act as an outlet to help them deal with their daily stressors. This support and other training would lead to healthy and better-qualified providers, who are more equipped at caring for their consumers. Hopefully more consumers will avoid hospitalization for preventable injuries and complications.

Goal 1: Needs assessment of providers.

Objective 1:

By May 1st IHSS Public Authority will have surveyed 200 out of the 303 independent providers and on-call workers on the registry at the Public Authority.

Activities:

1. *Design electronic survey*
Who is responsible: Renesha and Cecilia
Start date: February 05, 2015
End date: March 06, 2015
Tracking measure: Draft a written version of the survey based on brainstorming sessions with staff at IHSSPA
2. *Pilot electronic survey with 10 On-Call registry providers*
Who is responsible: Renesha and Cecilia
Start date: March 06, 2015
End date: March 06, 2015
Tracking measure: The survey will be modified based on the feedback from the workers with final version approved and available for use by March 19, 2015
3. *Develop a call list for registry and family providers for survey distribution*
Who is responsible: Renesha and Cecilia
Start date: February 19, 2015
End date: February 19, 2015
Tracking measure: Have an accurate call list of all providers on the registry and care for a family member.
4. *Train Mentors on how to conduct a phone survey.*
Who is responsible: Renesha and Cecilia
Start date: March 12, 2015
End date: March 12, 2015
Tracking measure: Help the mentors on how to conduct a telephone survey and how to use the script.
5. *Conduct the telephone survey of the providers*
Who is responsible: Renesha and Cecilia
Start date: March 19, 2015
End date: March 26, 2015 (unless more time is needed to attempt more people.
Tracking measure: Completed surveys
6. *Tabulate and summarize data and suggestions collected through survey*
Who is responsible: Renesha and Cecilia
Start date: April 02, 2015
End date: April 02, 2015
Tracking measure: Final summary report ready to present to program director

Objective 2:

Of the 200 surveyed independent providers and on-call workers 50 English speaking providers will be asked about their TAPCA (Homebridge) experience by May 1st.

Activities:

1. *Gather information from TAPCA (Homebridge) online and a site visit.*
 Who is responsible: Renesha
 Start date: March 04, 2015
 End date: March 16, 2015
 Tracking measure: Become a content expert on what TAPCA (Homebridge) offers IHSS providers.

2. *Review information and create questions about TAPCA (Homebridge).*
 Who is responsible: Renesha
 Start date: March 16, 2015
 End date: March 16, 2015
 Tracking measure: Create questions about the TAPCA (Homebridge) experience that in no way shape or form create any political issues with SFIHSSPA and TAPCA (Homebridge).

3. *Survey 50 English-speaking providers.*
 Who is responsible: Renesha
 Start date: March 19, 2015
 End date: March 26, 2015
 Tracking measure: Complete the survey.

4. *Tabulate and summarize data and suggestions collected through survey*
 Who is responsible: Renesha
 Start date: April 02, 2015
 End date: April 02, 2015
 Tracking measure: Final summary report ready to present to program director

Objective 3:

Learn about the community resources that can support providers by April 3rd.

Activities:

1. *Research the community resources.*
 Who is responsible: Renesha
 Start date: May 26th, 2015
 End date: August 03, 2015

Tracking measure: Become a content expert on the resources available to the providers.

2. Summarize data and suggestions collected

Who is responsible: Renesha

Start date: August 06, 2015

End date: August 06, 2015

Tracking measure: Final summary report ready to present to program director.

Methods

The project is a needs assessment and this required input from the Public Authority staff and other providers. It was important to the team that the ideas and concerns of other staff and providers were included in the creation of the survey. There were several meetings with the team to brainstorm issues that the survey should address. The Public Authority had never assessed the needs of the providers; this was the motivation to include all concerned parties (staff and providers). The counselors are staff members who are in charge of managing the registry for the PA. Their direct contact with the providers made them great candidates for the team to consult with. The common concerns amongst the counselors and other staff member were career advancement and training. With the input of the counselors and staff, the team created questions for the survey that covered the following areas: demographics, educational needs and desires, workplace satisfaction, and any suggestions the providers had for the public authority.

Training for the providers is a major concern and riddled in city and state policies. In an attempt to gain a better understanding of the situation a member of the team met with Homebridge/TAPCA (Training Academy for Personal Caregivers and Assistants) to get the full scope of the training Homebridge offers providers. With the information provided by the Homebridge/TAPCA, the team developed three questions that were training specific and these questions were not included in the survey, they were supplemental and only administered to

English speaking providers. Members of the team were the only people to administer those questions to providers.

This survey was revised and formatted three times until the executive director approved it. Wanting to ensure that the survey was appropriate for providers the team consulted with seven on-call registry providers and pretested the survey. Several of the on-call workers mentioned that the survey was hard to follow because the survey was not numbered. However, they felt the questions were representative of their needs. The team made corrections to the survey and it was ready for launch. Administering the survey enlisted the help of staff and mentors. Internal systems made compiling a list of providers difficult, it took a week and half to get a comprehensive list of providers. The list of providers included those providers on the registry and those providers who are family members of their consumers. The survey was initially created in English and was translated into Cantonese, Spanish and Russian. These languages were selected based on the prior demographic data on providers collected by the staff. Initially it was explained to the team that due to budgetary constraints the surveys could not be translated into any language. This was a huge limitation during the initial stages of administering the survey. Mentors had a variety of skills and limitations but were the driving force in contacting providers and administering the surveys over the phone. The mentors were briefly trained on how to administer surveys; none of which had prior experience in administering surveys over the phone. During debriefings with the mentors it was mentioned by the bilingual mentors that there was difficulties in translating the surveys from English to their respective languages. Mentors said it took too long to translate over the phone and what should've been a 10-minute survey took 15-30 minutes. Many of the mentors had varying skills in their ability to read and comprehend English. Many mentors did not feel comfortable in their abilities in translating and it

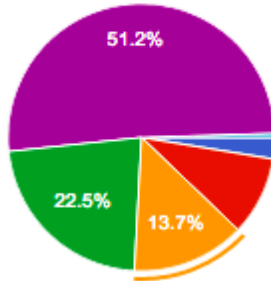
was apparent that this would impact data collection. This was made even more apparent once the surveys were collected; many questions were skipped and eventually made many surveys invalid. These concerns were brought to the executive director and the Public Authority staff translated the surveys. Once the surveys were translated the amount of completed surveys increased. Team members or mentors had a blank survey in front of them while asking the providers questions over the phone. An electronic version of the survey was created on Google Forms. Paper versions of the survey were recorded by hand and submitted on the Google Form. There were 387 completed surveys. The mentors were trained by the team on how to ask the questions and to not create any bias while administering the surveys. The team tried to demonstrate this through role-playing and discussing the possible outcomes and reactions the providers might have.

Findings

Mentors (volunteers) whom of which were briefly trained but as a result of budgetary constraints they were unable to be properly trained on conducting surveys. Mentors contacted providers by phone and conducted the survey. The questions have been divided into three categories: demographics, education, workplace satisfaction and benefits.

Demographics (Questions 1-8 and 17 on Survey)

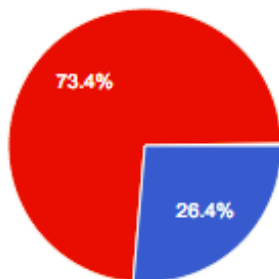
1. Age Group



| | | |
|----------------|------------|-------|
| 18-25 | 10 | 2.6% |
| 26-35 | 37 | 9.6% |
| 36-45 | 53 | 13.7% |
| 46-55 | 87 | 22.5% |
| 55+ | 198 | 51.2% |
| Did not Answer | 2 | 0.5% |

The providers vary in age and but the majority (51.2%) are over 55 years of age. The second highest (22.5%) age group of providers is between 46-55 years of age. The bold numbers reflect the actual numbers of respondents.

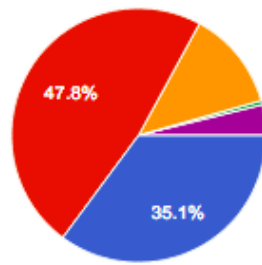
2. Gender



| | | |
|----------------|------------|-------|
| Male | 102 | 26.4% |
| Female | 284 | 73.4% |
| Transsexual | 0 | 0% |
| Transgender | 1 | 0.3% |
| Did not answer | 0 | 0% |
| Other | 0 | 0% |

Majority of providers are female and this reflects the data that is currently available for IHSS providers. However, there is a large group of males that may not have been previously recognized by SFIHSSPA. The low wage and high work demand contributes to this high rate of female workers, many men are the head of the household and are unable to support a family with the income provided by IHSS.

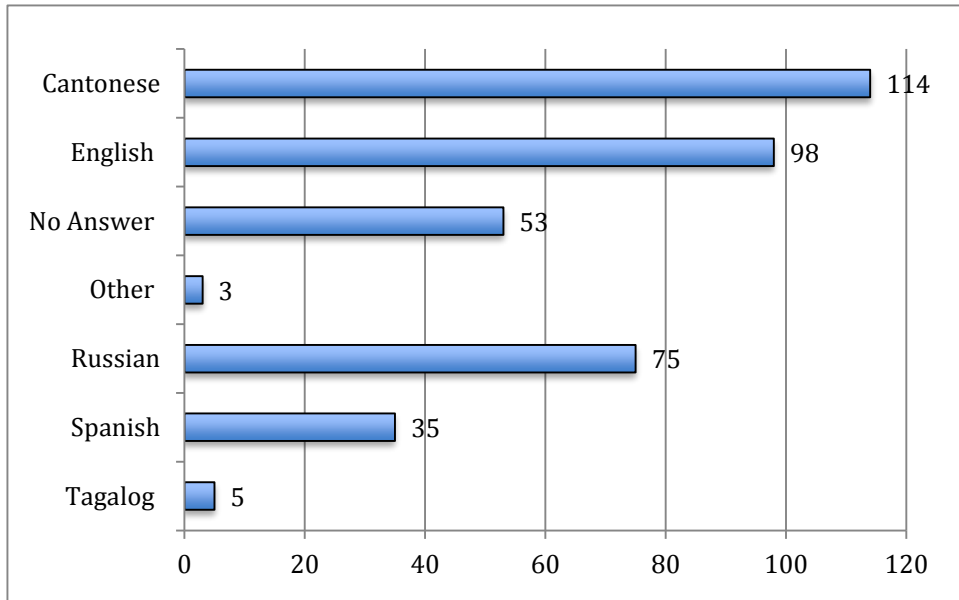
3. Marital Status



| | | |
|----------------|------------|-------|
| Single | 136 | 35.1% |
| Married | 185 | 47.8% |
| Divorced | 49 | 12.7% |
| Did not answer | 2 | 0.5% |
| Other | 15 | 3.9% |

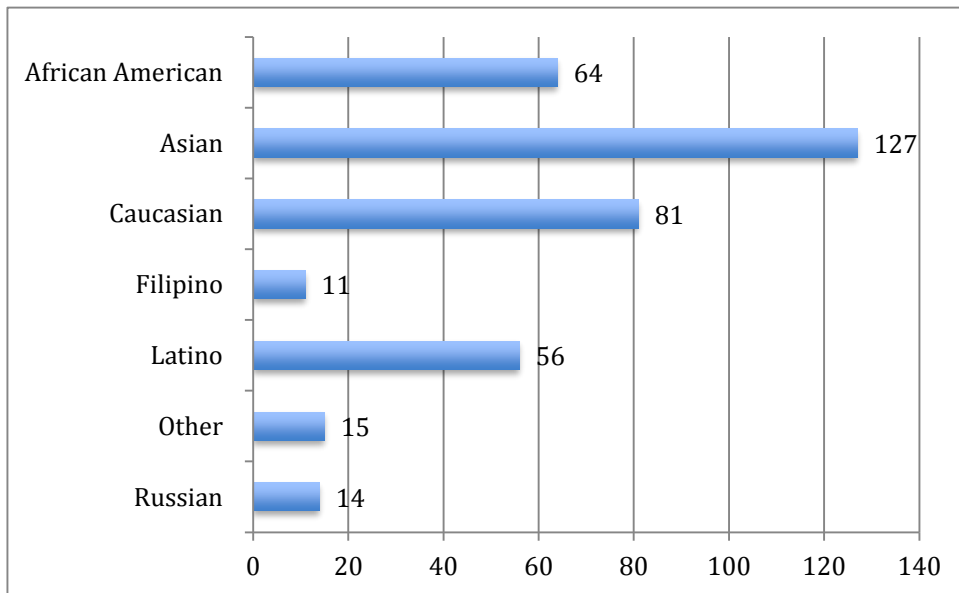
Close to 50% of the providers are married and almost 40% of the providers are single. Other is a category of providers who did not answer or declined to state for personal reasons. The high rate of married providers reflects that there are a many providers who have dual income in the home; they are able to live on the minimal income that IHSS provides.

4. Primary Language Spoken



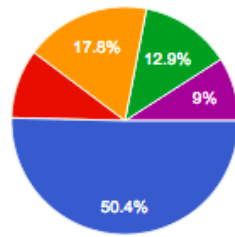
Mentors wrote what language the providers said they spoke. After tallying the responses they were then entered in to Excel to create a histogram of the data. The histogram reflects that 114 providers speak Cantonese and 98 providers speak English. During the administration of the survey there were some issues with getting surveys administered to the Russian and Spanish speaking populations. This was a result of the lack of efficient Spanish speaking and Russian speaking mentors. These numbers do not accurately reflect the true population of IHSS providers in San Francisco County.

5. Primary Language Spoken



Mentors wrote what ethnicity the providers said they belonged to. After tallying the responses they were then entered in to Excel to create a histogram of the data. The histogram reflects that 127 providers are Asian, 64 providers are African American. Again this data doesn't reflect the true distribution of ethnicities, the inability to contact the other non-English speaking populations impacted data collection. Other represents other ethnicities that were disclosed during data collection.

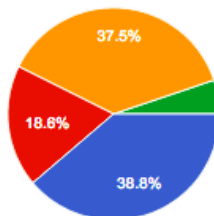
6. How well do you understand English



| | | |
|-----------------------------------|------------|-------|
| Read and write English very well | 195 | 50.4% |
| Understand, difficulty responding | 38 | 9.8% |
| Can't understand, know basics | 69 | 17.8% |
| Can't understand at all | 50 | 12.9% |
| Did not answer | 35 | 9% |

English literacy is a huge component of being a provider. There are many older consumers who only speak English and may have a provider who may have difficulty communicating in English. Just over 50% of providers can read, write in English very well. Now there is a bias of self-reporting present, providers have not been tested for their proficiency in their ability to understand English. Twelve percent of the providers can't understand English but know the basics, there is a lot that can be misunderstood and this can lead to tension and possible harm to a consumer.

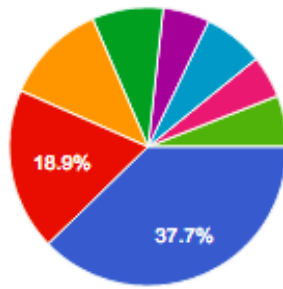
17. How comfortable are you with how well you read and write in English?



| | | |
|------------------------------------|------------|-------|
| Strong reader and writer | 150 | 38.8% |
| Comfortable | 72 | 18.6% |
| Need help with reading and writing | 145 | 37.5% |
| Did not answer | 20 | 5.2% |

This question reflects that providers are almost split down the middle when it comes to their perceived ability to read and write in English. Literacy and the ability to speak English are two different abilities and this question reflects that although many providers self reported to be strong readers and writers, may have some difficulty with reading and writing in English.

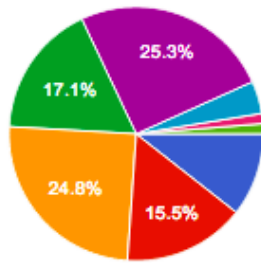
7. Income Level:



| | | |
|----------------|------------|-------|
| \$0-\$10,000 | 146 | 37.7% |
| \$11-\$15,000 | 73 | 18.9% |
| \$16-\$20,000 | 46 | 11.9% |
| \$21-\$25,000 | 32 | 8.3% |
| \$26-\$30,000 | 21 | 5.4% |
| \$31-\$40,000 | 27 | 7% |
| Did not answer | 19 | 4.9% |
| Other | 23 | 5.9% |

Income level is important for the Public Authority to know because it shows the providers economic needs. Many providers do not get paid well and this diagram reflects that. Close to 55% of providers make under \$15,000 a year. With many providers living in San Francisco Bay area where the median income is \$75,910 (Sfhip.org, 2015) that leaves many providers to live in the few low-income areas available. Other represents a mixture of providers who did not want to state their income level or made over \$40,000 annually.

8. What is the highest educational level you have completed? Please circle one.

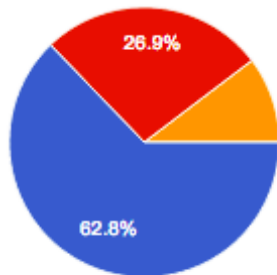


| | | |
|----------------------|-----------|-------|
| Primary (Grade) | 41 | 10.6% |
| Some High School | 60 | 15.5% |
| High School Graduate | 96 | 24.8% |
| Some College | 66 | 17.1% |
| College Graduate | 98 | 25.3% |
| Vocational Trade | 16 | 4.1% |
| Did not answer | 5 | 1.3% |
| Other | 5 | 1.3% |

Education is often an indicator of a persons earning potential. Those who have completed high school and beyond have a better chance at getting a job that would yield a livable wage. The data for these questions shows that providers have either at least completed high school (24.8%) or have graduated college (25.3%). There is a bias of self-reporting present and many consumers may have obtained their degree from outside of the country and due to language barriers they are unable to pursue higher paying careers.

Education (Questions 9-16 and 30 on Survey)

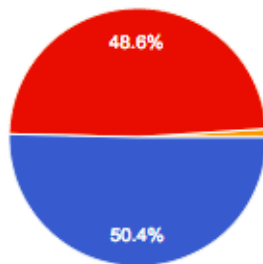
9. Do you have access to a computer?



| | | |
|----------------|------------|-------|
| Yes | 243 | 62.8% |
| No | 104 | 26.9% |
| Did not answer | 40 | 10.3% |

Having access to a computer helps providers gain access to community resources and health care. Over 62% of the providers have access to a computer and this can lead to further development of computer based training that will help providers navigate the internet and increase their ability to connect via the web.

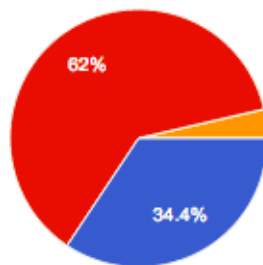
10. Would you be interested in furthering your education?



| | | |
|----------------|------------|-------|
| Yes | 195 | 50.4% |
| No | 188 | 48.6% |
| Did not Answer | 4 | 1% |

SFIHSSPA one stop resource center has a great opportunity to help both consumers and providers advance their education. There is an interest among providers who want to further their education. Fifty percent of providers are interested in furthering their education whereas 48% are not interested and this may be a result of the providers not having the necessary time to continue school or there may be other barriers preventing them from continuing their education as well.

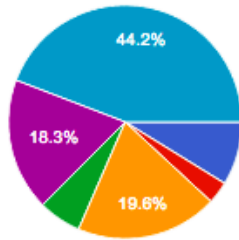
11. Would you like to know about the enrollment process for colleges in your area?



| | | |
|----------------|-----|-------|
| Yes | 133 | 34.4% |
| No | 240 | 62% |
| Did not answer | 14 | 3.6% |

This question is a reflection the perceived and actual barriers that prevent providers from interested in furthering their education. Many providers have never been asked questions about their educational needs and this explains the initial refusal of continuing their education.

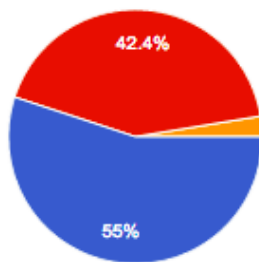
12. What would be the challenges that could prevent you from continuing your education?



| | | |
|--------------------|------------|-------|
| Childcare | 34 | 8.8% |
| Transportation | 12 | 3.1% |
| Caring for someone | 76 | 19.6% |
| All of the above | 23 | 5.9% |
| Did not answer | 71 | 18.3% |
| Other | 171 | 44.2% |

This question asks the providers about the physical barriers that prevent providers from continuing their education. Other represents other reasons providers cannot or will not continue their education and they include: mental and physical disabilities, financial, age, time and not being interested in attending. This is an area that SFIHSSPA could explore with a follow up assessment to discover other barriers that prevent providers from continuing their education

13. If IHSS PA offered college credit courses would you attend?

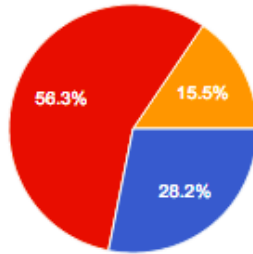


| | | |
|----------------|------------|-------|
| Yes | 213 | 55% |
| No | 164 | 42.4% |
| Did not answer | 10 | 2.6% |

The Public Authority has the opportunity to provide courses with the help local community colleges to the providers. Providers especially those who are on the registry are very familiar with the location and would feel comfortable attending classes there. Fifty-five percent

would like to attend classes at the Public Authority; this shows that if one of the perceived barriers (location) is removed the providers will show an educational interest.

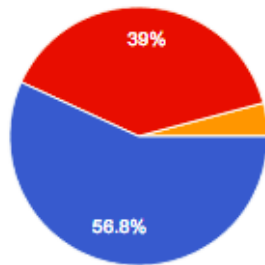
30. Would attend evening classes?



| | | |
|----------------|------------|-------|
| Yes | 109 | 28.2% |
| No | 218 | 56.3% |
| Did not answer | 60 | 15.5% |

The providers were asked if they had would attend evening classes, 56% said they were not interested. There is an opportunity for the Public Authority to further assess this question.

14. If IHSS offered a certificate program would you be interested in participating?

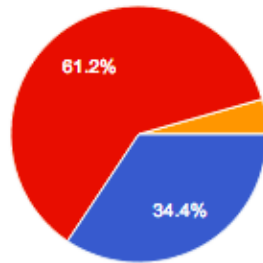


| | | |
|----------------|------------|-------|
| Yes | 220 | 56.8% |
| No | 151 | 39% |
| Did not answer | 16 | 4.1% |

This question reflects that many providers are interested in obtaining a certificate. The way the question is asked has an impact on the provider’s response. College or continuing education may seem too abstract for the providers they may not think about education in the traditional academic setting. This question reflects that providers understand that obtaining a

certificate could further their career and increase their pay. In conjunction with provider’s positive relationship with the PA, a course could be developed and offered to the providers on site.

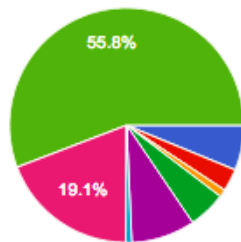
15. Do you have any other training such as, Certified Nurse’s Assistant, Homecare etc?



| | | |
|----------------|------------|-------|
| Yes | 133 | 34.4% |
| No | 237 | 61.2% |
| Did not answer | 17 | 4.4% |

Over 60% of the providers surveyed have not received other health care training and this could contribute to their desire to receive further health care training.

16. If the services were free, what services would you like IHSS PA to provide to you?

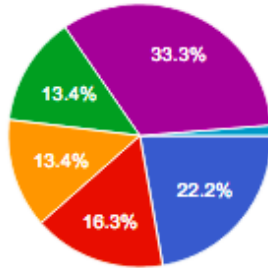


| | | |
|-------------------------------|------------|-------|
| Introduction to Computer | 24 | 6.2% |
| ESL | 12 | 3.1% |
| Soft skills trainings | 4 | 1% |
| First Aid/CPR | 20 | 5.2% |
| Advanced health care training | 34 | 8.8% |
| G.E.D. | 3 | 0.8% |
| Did not answer | 74 | 19.1% |
| Other | 216 | 55.8% |

This question reflects that if the financial barrier is removed the providers show more interest in taking courses. Other represents those providers who wanted a combination of courses offered, all of the courses provided or none of the courses offered.

Workplace Satisfaction and Benefits (Questions 1-38 on Survey)

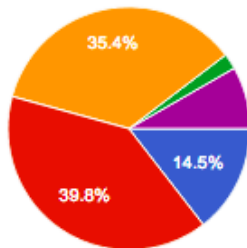
18. How long have you been a provider?



| | | |
|----------------|------------|-------|
| 1-2 years | 86 | 22.2% |
| 3-4 | 63 | 16.3% |
| 5-6 | 52 | 13.4% |
| 7-8 | 52 | 13.4% |
| 9-10 years + | 129 | 33.3% |
| Did not answer | 5 | 1.3% |

Over 33% of providers surveyed have been a provider for over 10 years. With that addressed there is something beyond the pay that keeps providers working in this field. There is also a large population of providers who are new to the profession as well. This question reflects that over time this is a growing profession for many.

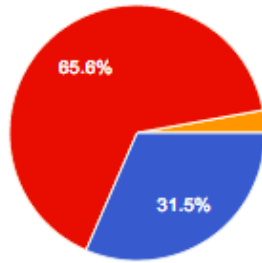
19. Do you get along with your Consumer?



| | | |
|----------------|------------|-------|
| Fair | 56 | 14.5% |
| Good | 154 | 39.8% |
| Excellent | 137 | 35.4% |
| Not well | 8 | 2.1% |
| Did not answer | 32 | 8.3% |

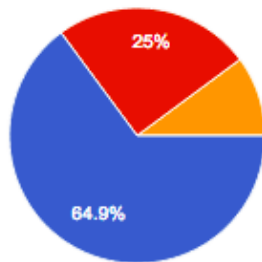
Many times providers are demonized as uncaring neglectful people who are only in it for the money and this question demonstrates otherwise. Over 88% of the providers get along well with their consumers.

20. Do you have multiple Consumers?



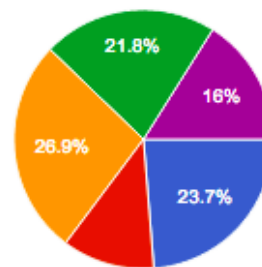
| | | |
|----------------|------------|-------|
| Yes | 122 | 31.5% |
| No | 254 | 65.6% |
| Did not answer | 11 | 2.8% |

if yes, how many?



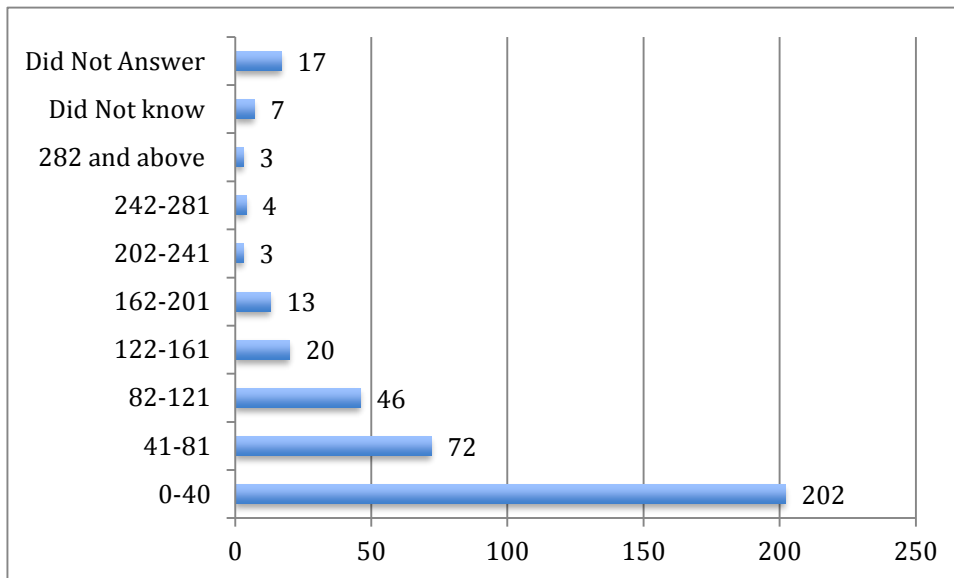
| | | |
|----------------|-----------|-------|
| 1-2 | 96 | 64.9% |
| 3-4 | 37 | 25% |
| Did not answer | 15 | 10.1% |

21. How long have you had multiple consumer?

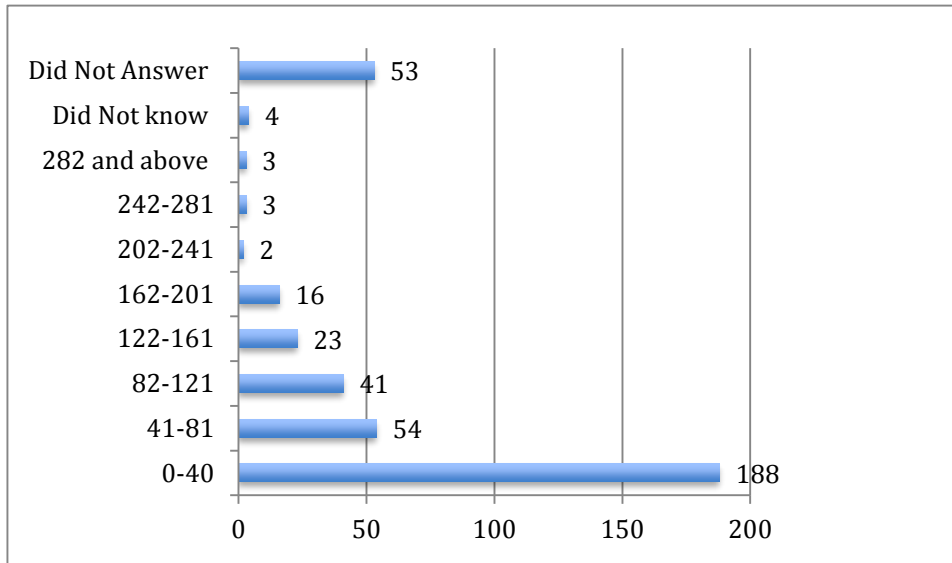


| | | |
|----------------|-----------|-------|
| 1-2 years | 37 | 23.7% |
| 3-4 years | 18 | 11.5% |
| 5-6 years + | 42 | 26.9% |
| Does not apply | 34 | 21.8% |
| Did not answer | 25 | 16% |

Providers may have more than one consumer; question 20 shows that 65% of providers do not have multiple consumers and of those 31% that do have multiple consumers, they have 1-2 consumers. Those providers (26%) that have multiple consumers have had multiple consumers for over 6 years.

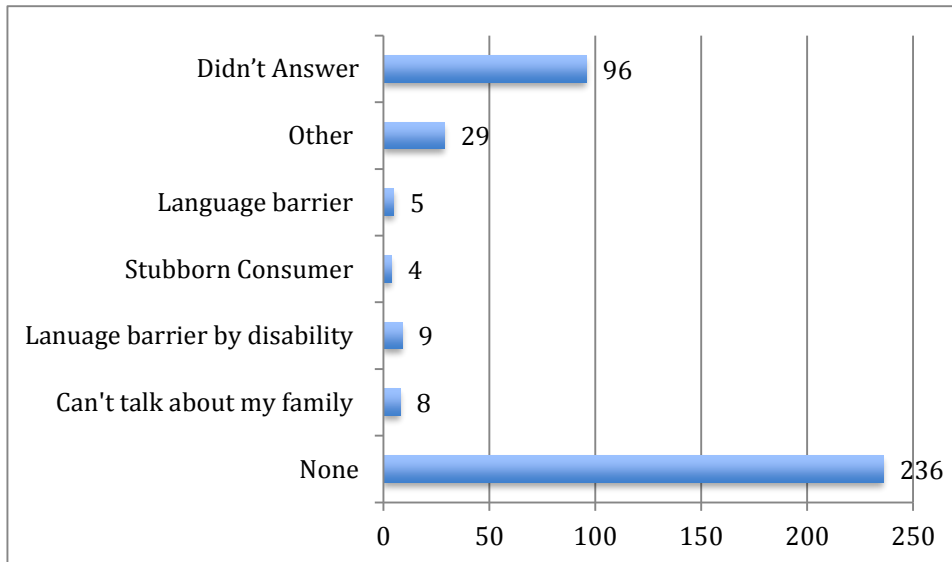
22. How many hours do you work?

Mentors wrote how many hours' providers said they worked. After tallying the responses they were then entered in to Excel to create a histogram of the data. Each IHSS consumer gets a set amount of hours that can be used to pay his or her providers. Providers often find themselves working hours that may or may not meet their financial needs. Two hundred two providers work 0 to 40 hours.

23. How many hours do you prefer to work?

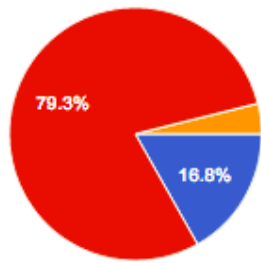
Mentors wrote how many hours the providers said they preferred to work. After tallying the responses they were then entered in to Excel to create a histogram of the data. Providers disclosed how many hours they would actually like to work, 188 providers would like to work 0-40 hours. This reflects that providers have no desire to work more hours despite the financial demand. The job demands for providers can be quite arduous and working more hours does put a significant mental and physical strain on the providers.

24. What kind of situations /obstacles make it difficult for you to communicate with your consumer/s?



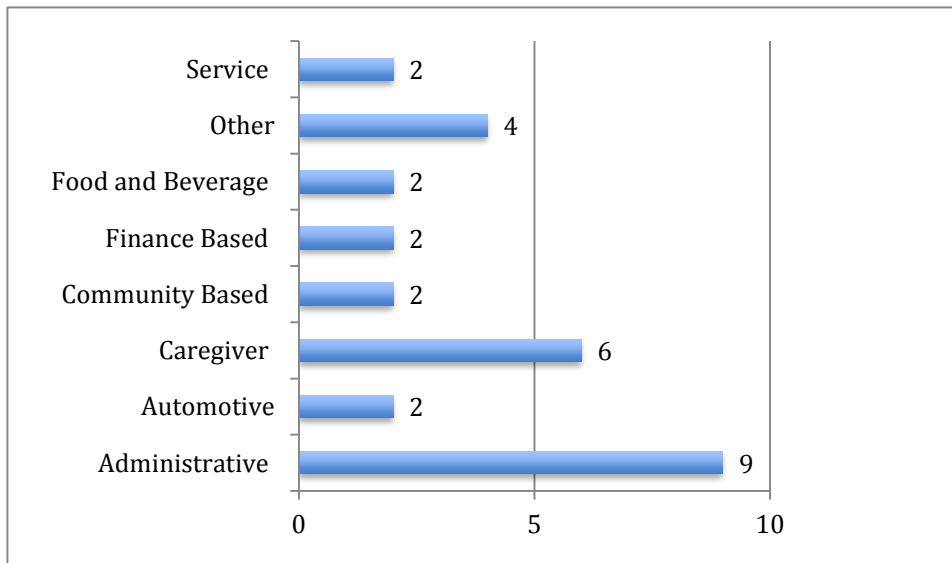
Mentors wrote what issues providers said they had with their consumers. After tallying the responses they were then entered in to Excel to create a histogram of the data. Providers disclosed any issues that strained the relationship between them and their consumers. Two hundred thirty-six said that they do not have any issues with their consumers.

25. Are you currently working in another position other than with the IHSS Registry?



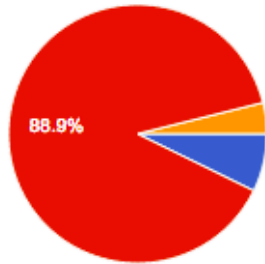
| | | |
|----------------|-----|-------|
| Yes | 65 | 16.8% |
| No | 307 | 79.3% |
| Did not answer | 15 | 3.9% |

If yes, what position?



The providers were asked if they worked other jobs besides their job as an IHSS provider, 307 providers said that they do not work another job. Those providers (65) that said they worked another job work in positions in other fields like administrative and other caregiver positions that aren't affiliated with IHSS.

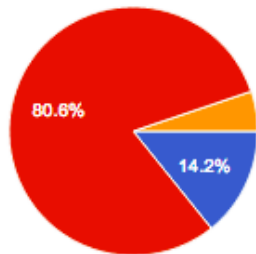
26. Do you work for another homecare agency as a care provider?



| | | |
|----------------|-----|-------|
| Yes | 28 | 7.2% |
| No | 344 | 88.9% |
| Did not answer | 15 | 3.9% |

Providers were asked if they are working for another homecare agency as a care provider and 88% providers said they do not, the 7% represents the providers that do work for another care agency they work with various staffing agencies, and other healthcare facilities such as: Homebridge, Institute for Aging Hospice Care, Accent Care and other healthcare agencies in the Bay Area.

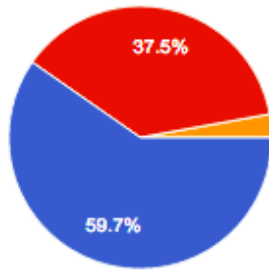
27. Are you an On-Call worker and on the Registry?



| | | |
|----------------|-----|-------|
| Yes | 55 | 14.2% |
| No | 312 | 80.6% |
| Did not answer | 20 | 5.2% |

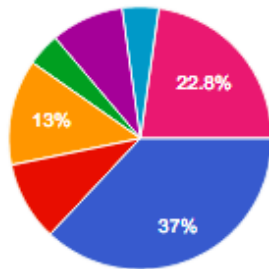
This question asks if the provider is an on-call registry worker. This question was asked to further define who the providers are. Eighty percent of the providers surveyed are not on the on-call registry at SFIHSSPA.

28. Are you related to the Consumer you work for?



| | | |
|----------------|------------|-------|
| Yes | 231 | 59.7% |
| No | 145 | 37.5% |
| Did not answer | 11 | 2.8% |

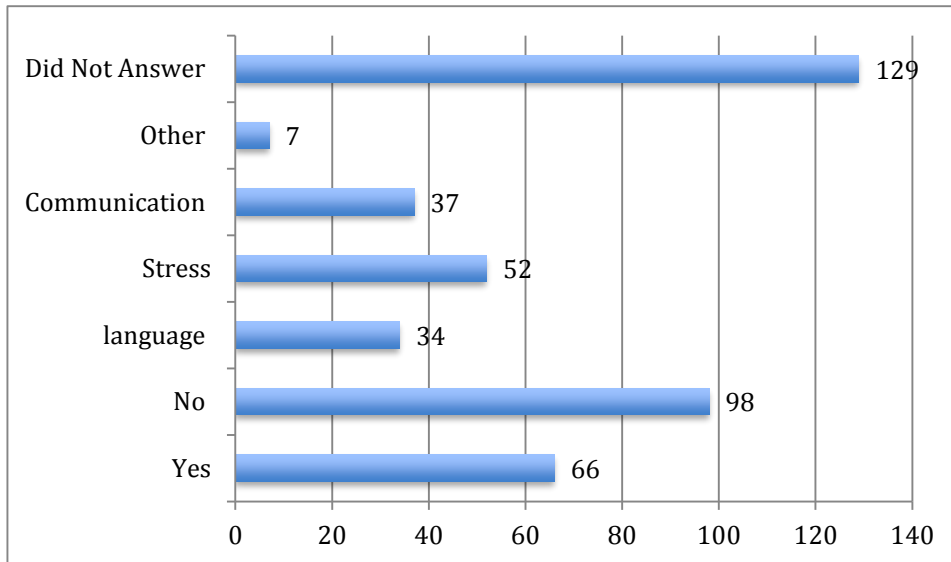
If yes, what is your relationship?



| | | |
|----------------|-----------|-------|
| Mother | 91 | 37% |
| Father | 24 | 9.8% |
| Child | 32 | 13% |
| Aunt | 10 | 4.1% |
| Friend | 22 | 8.9% |
| Did not answer | 11 | 4.5% |
| Other | 56 | 22.8% |

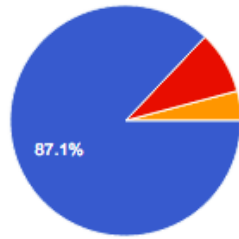
Family providers were surveyed as well and in efforts to provide support to all providers SFIHSSPA needs to know how many providers are working for a family member or a friend. Of the providers surveyed close to 60% are related to the consumers they work for. Of that 60% they are working for their mothers. Other represents the family providers who are working for other relatives like: children, grandparents, a combination of family members and spouses.

29. If IHSS PA offered programs/classes that would strengthen the working relationship between you and your consumer would you be interested?



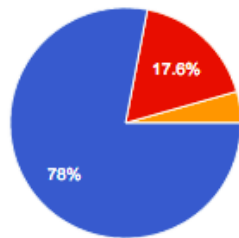
Providers were asked about their working relationship with their consumer/s and if they felt classes on communication issues, stress reduction or language issues were appropriate. Majority of the providers surveyed that answered the question, weren't interested in the programs or classes. Some providers felt that they weren't necessary because they have a good relationship with their consumer/s. Sixty-six providers felt that the classes should be offered.

31. Do you have medical insurance?



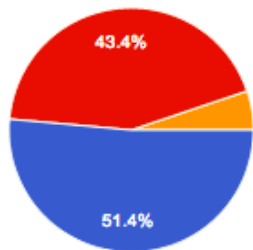
| | | |
|----------------|------------|-------|
| Yes | 337 | 87.1% |
| No | 34 | 8.8% |
| Did not answer | 16 | 4.1% |

32. Do you have dental insurance?



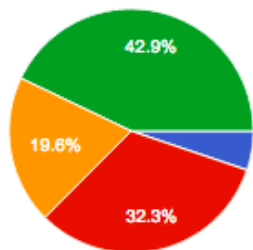
| | | |
|----------------|------------|-------|
| Yes | 302 | 78% |
| No | 68 | 17.6% |
| Did not answer | 17 | 4.4% |

33. Are you familiar with the Medicare Part A,B,C, and D Plans?



| | | |
|----------------|------------|-------|
| Yes | 199 | 51.4% |
| No | 168 | 43.4% |
| Did not answer | 20 | 5.2% |

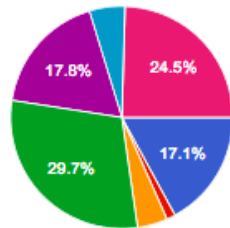
34. Would you like more information on the Medicare program?



| | | |
|----------------|------------|-------|
| Workshop | 20 | 5.2% |
| Brochures | 125 | 32.3% |
| Did not answer | 76 | 19.6% |
| Other | 166 | 42.9% |

When providers are working they are eligible to receive medical and dental coverage. Questions 31 and 32 asked providers about their current coverage. Eight seven percent of providers have medical coverage and 78% of providers have dental coverage. Many of the providers are over the age of 55 and many may be eligible for Medicare benefits. Over 50% of surveyed providers were aware of the Medicare Part A, B, C, and D plan. Providing information to providers is an achievable task, providers had mixed responses to how they would like to be notified about Medicare. Majority of the providers selected other on the survey; from there it was apparent that the providers want to be informed by means of brochure about the Medicare program.

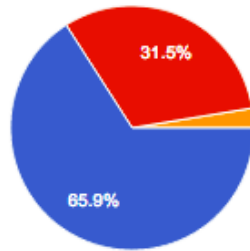
35. Why did you become a care provider?



| | | |
|--------------------------------|------------|-------|
| Out of financial need | 66 | 17.1% |
| Giving back | 5 | 1.3% |
| Compassion | 17 | 4.4% |
| Taking care of a family member | 115 | 29.7% |
| All of the above | 69 | 17.8% |
| Did not answer | 20 | 5.2% |
| Other | 95 | 24.5% |

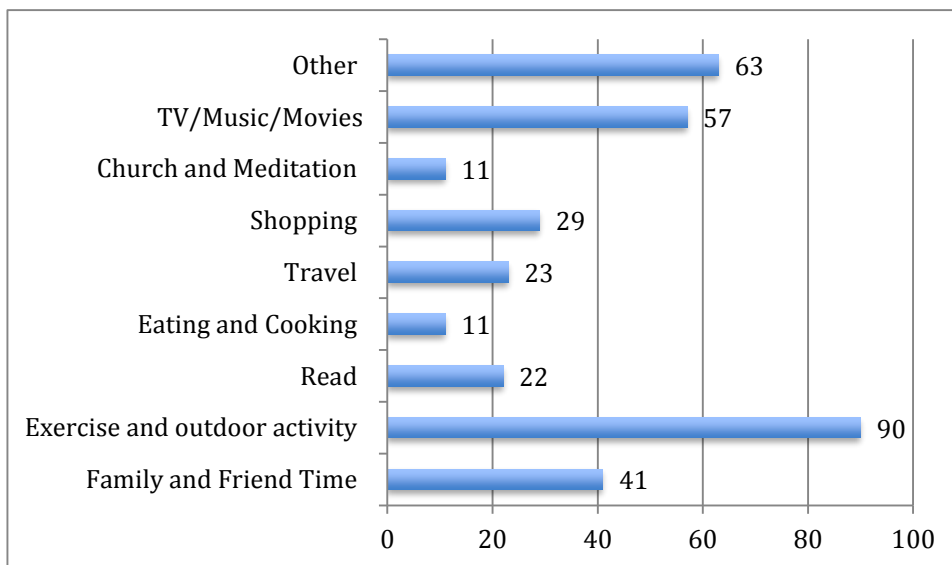
Twenty-nine percent of the providers became a provider because they took care of a family member. Other reflects the various combinations of the provided reasons why they became providers, within that; financial need and taking care of a family member were the main reasons providers became providers.

36. Do you take time for yourself?

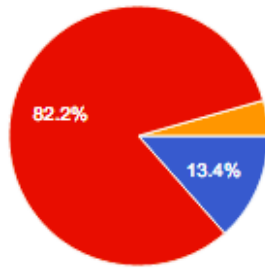


| | | |
|----------------|------------|-------|
| Yes | 255 | 65.9% |
| No | 122 | 31.5% |
| Did not answer | 10 | 2.6% |

If so, what kinds of activities do you like to do?



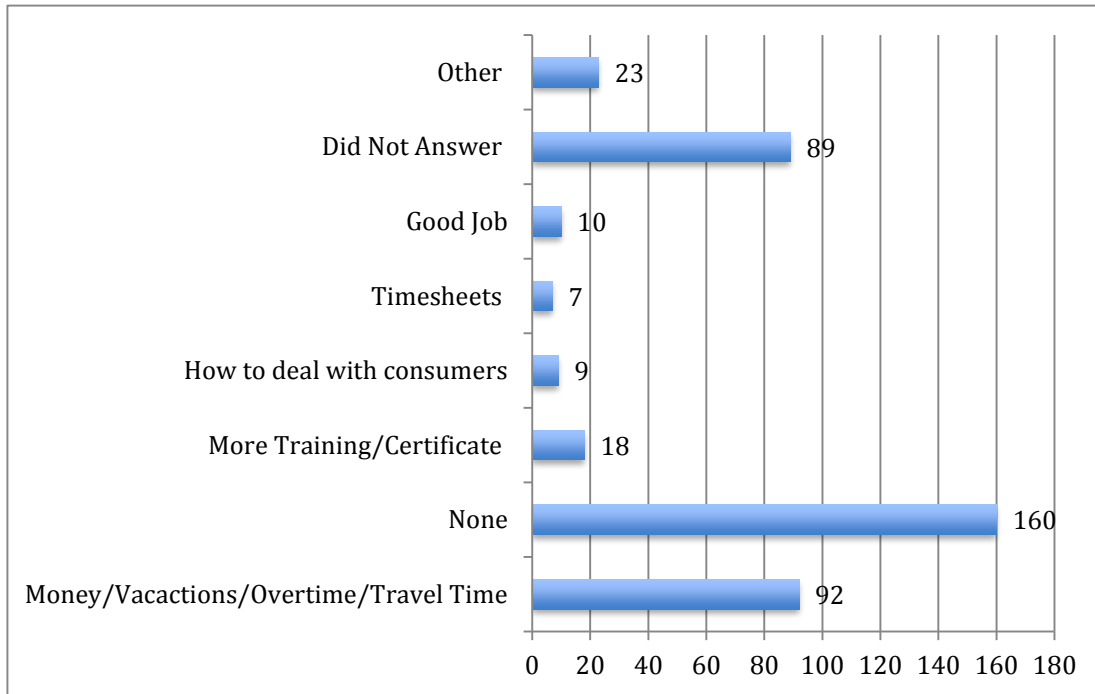
Providers have lives outside of their profession and that is what gives their lives meaning and balance. Of the surveyed providers 65% take time for themselves. Of those providers that take time, some of the activities they enjoy include exercise, outdoor activities, and TV/Music/Movies. Other represented a group of miscellaneous activities that providers enjoyed on their time off.

37. Do you receive SSI, SSA, or Public Assistance?

| | | |
|----------------|------------|-------|
| Yes | 52 | 13.4% |
| No | 318 | 82.2% |
| Did not answer | 17 | 4.4% |

To get a clear idea of what the financial situation looks like for providers they were asked if they received SSI (Supplemental Security Income), SSA (Social Security Administration) or Public Assistance. Of those surveyed 82% said they do not receive SSI, SSA or Public Assistance.

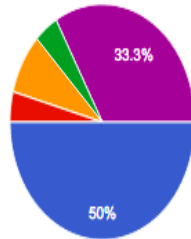
38. What suggestions would you like to offer to the San Francisco IHSS Public Authority?



In order to create services for providers SFIHSSPA needs hear from providers about what they want or need. Of the surveyed providers 160 providers did not have suggestions after that 92 providers were concerned about their pay. This is obviously out of scope for the PA but the data collected from this question could be used for further research if needed.

TAPCA Questions

1) Where did you receive your training?



| | | |
|---|-----------|-------|
| Training Academy for Personal Caregivers and Assistants (TAPCA) or Homebridge | 12 | 50% |
| City College of San Francisco | 1 | 4.2% |
| Arriba Juntos | 2 | 8.3% |
| Did not answer | 1 | 4.2% |
| Other | 8 | 33.3% |

Providers are to be trained and this is a requirement for it protects the consumer from getting sick or hurt. Of the providers surveyed 12 were trained at the TAPCA/Homebridge facility.

2) Please tell us about your experience in your classes.

| | |
|--------------------------|----|
| Nice Class Useful | 15 |
| Didn't like the location | 1 |
| Class Schedule Issues | 3 |

Of those providers surveyed 15 of them felt their training experience was useful.

3) Do you feel that the training you have received has prepared you for your job?

| | |
|---------------|----|
| Yes | 19 |
| Waste of time | 1 |

Of those providers surveyed 19 people felt that their training prepared them for their job.

The TAPCA questions were not made available to all providers, only English-speaking providers were surveyed by members of the team and not by the mentors.

Overall, the sample size is 387. Initially there were more surveys collected but were removed if found incomplete. Providers were free to answer each question based on their comfort level, mentors were trained to not force providers to answer any question they did not feel comfortable with. Every question may not have the same amount of responses as a result. There weren't any incentives given to providers to take the survey, this was done to avoid bias and the budget could not withhold such a cost as well.

Implications

The goal of the project was to assess the needs of the providers at the PA. Providers have many needs and this was observed in the needs assessment. These needs could be met but there are barriers that prevent this from happening. Some of the barriers include: City regulations and funding, lack of staff and politics between SEIU, IHSS, and the Public Authority. In an effort to avoid these barriers the Public Authority has applied for non-profit status and this will allow them to gain funding from other sources outside of the City of San Francisco. The future funding

can go to the development of programs that help providers directly. Currently, there is nothing that can be done for the providers through the Public Authority, for the purposes of this paper implications will be discussed within the future and ideal development of the Public Authorities' non-profit, Thriving in Place.

Developing programs for the providers will be a first for the Public Authority and the focus should on launching classes that will effectively help be the most providers. The goal of the programs would be to get the providers familiar with coming to the Public Authority (Thriving in Place) and using the services. The non-profit, Thriving in Place is in its early development stages and it is currently unclear what the services may be provided.

English and literacy was a prevalent issue amongst providers. Offering an English literacy course alongside an ESL (English as a Second Language) course would greatly help providers. Providers may speak English but may have difficulty reading and writing in English, this program would greatly help the providers. Thriving in Place can use community resources like City College of San Francisco to provide ESL and literacy courses to providers. This would be a great community resource for Thriving in Place to connect and build with.

More than half of the providers have shown an interest in attending college courses if the PA offered them. This could be another positive outcome from the possible partnership with City College of San Francisco. Thriving in Place would have to do another assessment to see what classes would be the most appropriate for the providers.

Introduction to computer is a program that would give providers the added advantage of gaining much-needed computer and Internet knowledge. There are community resources that provide free computer classes to seniors. This is applicable to the providers, where over 50% of the providers are over the age 55.

Close to 60% of the surveyed providers are related to their consumers, Thriving in Place can use this information as a way to reach out and provide support to the family providers who do not have regular contact with other providers. Further assessment would be necessary to find out in which ways providers need support. Creating Support groups and providing information on how to get respite care for family providers could really benefit family providers. Either way Thriving in Place can become a great asset in the community for all providers.

For all the programs it will be very important for them to be properly evaluated. A program manager will need to be hired to ensure these programs have metrics; this is the only way to maintain funding. Utilization (sign-in sheet) would be necessary to help monitor how many people are attending the classes. Attendance will indicate if the class is a success or not. It could reflect if there are issues with the times the classes are offered as well. Ideally it would be helpful to measure job satisfaction before and after the launch of the programs but that would be difficult because of the independent nature of being a provider. More realistically, the program manager could measure the provider's knowledge about the topics covered in the programs. A survey could be created that evaluated the level satisfaction and any suggestions the providers have on how to improve the classes.

The needs assessment has a lot of data that reflects many possible programs that Thriving in Place could provide to all providers. The recommendations provided were based on the data collected. Once Thriving in Place is established, program selection would have to be selected by the established team and stakeholders. This assessment provides a great foundation of data that has never been available to the Public Authority before.

Discussion

Thriving in Place has a great foundation of data to use in the future. The data was reflective of the current needs of the population. There were some questions whose results were not what were expected and further research should be conducted. For question 8, which asked, “What is the highest educational level you have completed?” it was expected that many of the providers would have some high school completed, but the majority of providers had completed some college or were college graduates. This could be attributed to majority of the providers were family providers. Statistically family providers have been found to be more educated than those who are providers for the general public. For question 10 asked, “Would you be interested in furthering your education?” Fifty percent responded yes and 50% responded no to this question, which was not expected, and could be indicative of the population surveyed. Other questions about education seemed to gain more interest and maybe attributed to what the question was asking. For example questions that asked more specifically about education, “Are you interested in participating in a certificate program?” this question showed more interest amongst the providers. This might reflect an immediate need to get educated so providers can obtain better jobs and more money. The idea of long-term education may not be necessary or a concern for those who already have a college degree as well.

Some questions were skipped by providers, many felt that the questions on survey were too personal and felt uncomfortable answering the questions. This was understood because many providers have never been asked questions of this nature before. Some providers expressed their skepticism and fear, the project team understood this but it did become an issue with data collection for certain questions.

Limitations

Many of the limitations come from the agency itself. The Public Authority is a consumer-focused organization that does not have the budget to do anything for the providers. Initially the surveys could not be translated into other languages besides English and this was very limiting for data collection. These circumstances required bilingual mentors to translate the survey from English to their respective languages as they went along, this proved difficult for the mentor and consumer. Once this was properly conveyed to the director the surveys were translated. This did remediate some issues. However, the mentor who was bilingual in Spanish and English was not reliable and left many surveys incomplete. Many Spanish-speaking providers couldn't be reached as a result.

When the providers were asked about their TAPCA/Homebridge training experience it left a lot providers feeling vulnerable, they did not answer that portion of the survey. Many providers have not been trained and felt that if they completed the TAPCA/Homebridge portion of the survey they would be penalized. This explains the low response rate for those questions.

When mentors initially tried to contact providers many them were currently working during the hours mentors were conducting the survey. The time for the mentors to conduct surveys was changed to later in the afternoon, which was helpful. Ideally, it would have been better to conduct the survey after 5pm when many providers were done working for the day. It was not possible for the mentors to contact providers outside of the time provided because of the organizations business hours and policies. Again, the limitations previously stated has created data that is not representative of the entire population of providers in San Francisco County and the results may not be the same if replicated.

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