

THE
ACADEMY
FOR PROFESSIONAL EXCELLENCE

SAN DIEGO STATE UNIVERSITY SCHOOL OF SOCIAL WORK

In-Home Supportive Services, the Olmstead Decision,
and Possible Future Directions

Prepared by: Mina Nilchian, MSW Candidate

March 2018



INSPIRING INNOVATIVE SOLUTIONS
IN HEALTH AND HUMAN SERVICES

Executive Summary	2
Part 1: Assisted Living and the Olmstead Decision Overview	3
Americans with Disabilities Act	4
Deinstitutionalization	4
Olmstead Decision	4
Background of Court Case	5
Decision	5
Implications	5
California Olmstead Implementation	6
Conclusion	7
Part 2: California's IHSS Program	8
History	9
Challenges with IHSS Program	12
Attempts to Reform	13
Conclusion, and Important Considerations	14
Part 3: Possible Directions	15
Texas' In-Home and Family Support Program (IH/FSP)	16
Oregon: Adult Foster Care Model	17
Wyoming Home Services Program (WyHS)	19
Conclusion	20
References	21

In-Home Supportive Services, the Olmstead Decision, and Possible Future Directions

Executive Summary

The Olmstead Decision and the Americans with Disabilities Act (ADA) have played important roles in shaping In-Home Supportive Services (IHSS). Programs are required to keep community members integrated in the community and to avoid unnecessary institutionalization. California's IHSS program faces challenges in cost-efficiency. In addressing these challenges and possible directions, this report provides a background of the Olmstead Decision and the ADA, an analysis of the cost-driving factors of California's IHSS program, and highlights programs and models in other states worth examining. In aligning with the Olmstead Decision's mandates as well as the ADAs, this report finds that the most important considerations include proper targeting and providing services/care appropriate to recipient's level of need. In doing so, California's health and human service leaders may want to consider innovative options and approaches to fill need gaps, give consumers choices, and eliminate waste in programming.

Part 1: Assisted Living and the Olmstead Decision Overview

Americans with Disabilities Act

Understanding the significance of the Americans with Disabilities Act (ADA) of 1990 is an important precursor to understanding the implications of the Olmstead court decision, and the implementation of In-Home Supportive Services (IHSS) in California. The ADA made it illegal to discriminate against Americans with disabilities in a similar way that the civil rights act made it illegal to discriminate on the basis of race, religion, sex, and national origin. The ADA regulations apply to all areas of public life: jobs, schools, transportation, and all public and private places that are open to the general public. Public entities are required to make reasonable accommodations to allow individuals with disabilities to participate in public life.¹

The passage of the ADA was a politically charged event. In one direct action, activists who were disappointed in the slow process of its passage protested in a famous demonstration called “The Capitol Crawl.”² Individuals with disabilities, including those with wheelchairs, rallied at the capitol steps in support of the ADA. At the end of the rally, several individuals left their wheelchairs and crawled up the steps of the capitol. The moment had many powerful symbolic implications regarding accessibility for people with disabilities, and is credited as a key reason why the legislation was eventually passed.

Adherence to the regulations per the ADA is intended to allow disabled persons to remain integrated in the community. Without a proactive approach to promoting accessibility, many individuals are at risk of isolation and a diminished quality of life. The detrimental consequences of social isolation on both mental and physical health, and overall quality of life, are well documented.^{15, 16,17}

Deinstitutionalization

Another important consideration in studying IHSS programming is the trend of deinstitutionalization that began in the mid-20th century. The 19th century saw the rise of large asylums to house mentally ill and disabled individuals, which later came to be exposed for their poor treatment of patients, arbitrary assessment methods, and dehumanizing characteristics. Institutionalizing came to be known as a mechanism of social isolation and prejudice, and ultimately the failure of the state to adequately and compassionately care for individuals with higher needs.³ After a number of disturbing reports, the state began to close a majority of large institutions, and care for individuals with high needs has since moved toward more community-based sites for care.

Olmstead Decision

Both the ADA and the trend of deinstitutionalization help explain perhaps the most relevant legislative and judicial event in understanding the content of this report: the federal Olmstead decision.

- Posited that needlessly institutionalizing disabled individuals was a violation of the civil protections under the Americans with Disabilities Act.⁴

- Subsequent decisions began reinforcing the expectations that local communities provide appropriate services to disabled individuals, in a community context, that would protect them from needless institutionalization.
- California courts, in building upon these legal mandates, has established further structure and oversight to ensure mandates of the Olmstead decision are followed closely throughout the state.⁵

Background of Court Case

The Olmstead vs. L.C. case began with case of two women (L.C. and E.W.) with mental illness and developmental disabilities.⁶

- Both were voluntarily admitted to the psychiatric unit in state-run Georgia Regional Hospital. Their treatment eventually concluded, and mental health professionals had stated that each was ready to move into a community-based program.
- Both women remained confined several years after the conclusion of their treatment. Both had wanted to leave the institution and live independently, while receiving community-based supports to avoid having to enter an institutional setting again.
- It took years before said community-based supports were set up. A lawsuit was filed under the Americans with Disabilities Act in 1995.

Decision

The case eventually rose to the level of the Supreme Court. On June 22, 1999, the court ruled in favor of L.C. and E.W. The court held unjustified segregation of persons with disabilities constitutes discrimination. Public entities, it was held, must provide community-based services to persons with disabilities under three conditions:

- 1) when such services are appropriate;
- 2) the affected persons do not oppose community-based treatment; and
- 3) community-based services can be reasonably accommodated taking into account the resources available to the entity and the needs of others who receive disability services from the entity.⁶

Two evident judgments capture the underlying philosophy guiding the decision:

- *"institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable of or unworthy of participating in community life."*
- *"confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment."*

Implications

The federal Olmstead decision became an important landmark throughout the ongoing recognition of the legacy of institutionalization as a mechanism that can promote isolation and alienation. Title II of the ADA prohibits public entities from discriminating against "qualified

individuals with disabilities” by excluding them from services and activities due to their disability. Relevant to this case is the ADA’s regulation, “**The Integration Mandate.**” This mandate required public entities to administer services, programs and activities in the most integrated setting appropriate to the needs of the qualified individuals with disabilities. Thus, as argued by the Olmstead vs. L.C. decision, the onus of responsibility was on the state to move L.C. and E.W. out of the state hospital, and into a more appropriate community-based setting.

While the Olmstead decision had the most significant impact to our approach to In-Home Supportive Services, other cases have fine-tuned implied requirements of community support structures. For example, in 1995, the United States Court of Appeals for the Third Circuit, in the case of Helen L. v. Didario, found that a woman with a disability who was confined in a nursing facility had the right under the ADA to receive attendant care services in the community so she could leave the nursing facility.⁵ In most of the court cases that have applied Olmstead, the first and second requirements (see p. 5 above) have generally not been an issue.⁶ The third requirement, **that community-based services can be reasonably accommodated**, has been the focus of post-Olmstead litigation. In these subsequent lawsuits, it has been found that states must show that in allocation of available resources, immediate relief for plaintiffs would be inequitable given the responsibility the State has undertaken for the care and treatment of the large and diverse population of person with disabilities. The state could satisfy the reasonable modifications regulation if it demonstrated “that it had a comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings, and a waiting list that moved at a reasonable pace not controlled by the State’s endeavors to keep its institutions fully populated.”

Courts also ruled that the Olmstead decision applied to individuals living in the community who were at risk of institutionalization. Additionally, individuals who would rather die than enter a nursing facility were protected by Olmstead. Some courts have required that states provide additional Medicaid waivers in order to be in compliance with Olmstead. A Medicaid waiver is a package of Medicaid funded services that states can provide to specific types of people with disabilities in the community who qualify for institutional level of care.

While institutional care is an entitlement under federal Medicaid law, home and community-based services (HCBS) are still optional.⁵ This places states in a challenging position: Medicaid law entitles institutional care, but does not guarantee care for home-based community services.

California Olmstead Implementation

California has expanded the implications of the federal court case decision and taken proactive initiatives to ensure adherence to the principles of said decision.⁵ The California Olmstead Plan is a framework and a compass for the state to ensure that laws, regulations, and program initiatives are consistent with principles of the Olmstead decision. In 2003, the State of California put forth a plan of future actions:

- 1) **State Commitment:** Consistency with the Olmstead Decision; Financing Long-Term Services and Supports

- 2) **Assessment and Transition:** Assessment; Transition from Institutional Settings; Housing; Capacity Needs in the Community
- 3) **Diversions:** Services that Divert Individuals at Risk of Institutionalization; Consumer Information; Community Awareness; Comprehensive Care Coordination
- 4) **Data and Research:** Data; Quality Assurance

Following this, Governor Schwarzenegger issued executive orders in 2004:⁵

- **Executive Order S-18-0416:** affirmed the state's commitment to provide services to people with disabilities in the most integrated setting. Through the Executive Order, the Governor directed the Secretary of the California Health and Human Services Agency (CHHS) to establish the Olmstead Advisory Committee, consisting of long-term care (LTC) consumers and other stakeholders to inform the Administration's understanding of the current LTC system and future opportunities. The Olmstead Advisory Committee is convened at the discretion of the Secretary of CHHS.
- **Executive Order in 2008 (S-10-08)18:** re-affirmed the earlier Executive Order and established that the Secretary has the discretion to convene the advisory committee. The committee met on a quarterly basis and provided recommendations to the Secretary on the implementation of the state's Olmstead plan and ways to improve LTC in California to meet the intent of the Olmstead decision.

Conclusion

Providing in-home support services as a community-based care service is important for adherence to the implications of the Olmstead Decision. Failure to do so, or to do so inadequately, is akin to discrimination by needlessly isolating members of the community. A challenge to this is Medicaid's institutional bias. While Medicaid funding *requires* the establishment of institutions, and thus provides funds for it, no such requirement exists for community-based care. The onus of responsibility falls on the state to accommodate and properly fund programs, creating a need for careful planning and innovative approaches.

Part 2: California's IHSS Program

History⁷

- The inception of California's **In-Home Supportive Services (IHSS)** program can be traced back to when post-polio and respiratory dependent individuals lived at Rancho Los Amigos in the 1950s, a rehabilitation facility in Downey, California.
- To save money, local administrators decided in 1953 to move about 100 patients into the community.
- March of Dimes, offered to pay for attendant care and decided to discontinue its support of the program after the anti-polio vaccine had been developed and was successful.
- Several people were affected by the cuts and approached California legislature to request funding. Legislature then provided limited funding for the Attendant Care Program.
- In the 1960s and very early 1970s: **Aid to the Totally Disabled (ATD)** program provided a monthly cash payment of up to \$300/month to disabled persons who needed attendant care.
 - Recipients would then hire and pay their provider.
 - The attendant care program came later to be part of the Social Services system instead of the medical system.
- In January 1974, Supplemental Security Income (SSI) was implemented.
 - It gave a flat grant to recipients for basic living costs. It did not cover costs for attendant care.
 - Since the ATD program was ending, California was forced to create a new program.
- The **Homemaker Chore Program (which later became IHSS)** was created as a replacement program
- In 1991, California faced a budget deficit. Advocates wanted Medicaid funding to be brought to IHSS. A recommendation was adopted: a shift from Social Services Block Grant to Medicaid.
- This was an issue with recipients who were no longer eligible for Medicaid funding. State responses was two parts:
 - 1) personal care services program for people who were eligible for 50% Medicaid funding
 - 2) IHSS residual program for people not eligible for Medicaid funding
- The **Public Authority (PA) concept** started coming to fruition in the late 1980s and early 1990s.
 - By then, there were issues with IHSS-coordinating employment, high turnover rate, and wage issues, leading to the creation of the public authority model to make IHSS work better for consumers and providers.
- **Legislation AB 1682** mandated an employer of record with an incentive to choose the PA as a mode of service by January 2003.
- Benefits of the PA model include collective bargaining power, better wages, trainings, and a registry to help find providers sooner.

Today, IHSS program components are as follows:⁸

Personal Care Services Program (PCSP)

- Began in April 1993, first IHSS program to obtain federal funding for recipients.
- Recipients are eligible because they have qualified for Medi-Cal on the basis of age, blindness or disability. Most IHSS recipients who do not qualify for the IHSS-CFCO (Community First Choice Option) program are part of the Medi-Cal PCSP.
- Beneficiary receives full-scope Medi-Cal with federal financial participation (FFP). Includes SSI beneficiaries; 1619 SSI beneficiaries (people who work even though disabled); Pickles; other Medi-Cal programs including Aged & Disabled Federal Poverty Level (A&D FPL); or Working Disabled; Developmentally Disabled (DD) Waiver & Nursing Facility (NF) Waiver recipients.
- Eligible for full scope Federal Financial Participation (FFP) Medi-Cal
- **Medi-Cal Services Funding: 50% Federal, 32.5 % State, and 17.5% County dollars.**
- PCSP recipients make up 55% of overall IHSS population

IHSS Plus Option (IPO)

- Recipients are eligible because they have qualified for Medi-Cal and are also part of one of the following groups: parent provider for a minor child, spouse providers, advance pay cases or meal allowance cases.
- The IHSS Plus Waiver was converted to the IHSS Plus Option (IPO) Program in September 2009. IPO pays parents or spouses to provide services to qualified Medi-Cal recipients. Eligibility for program participation includes persons who are 65 years or older, blind, or disabled who might be placed in an out-of-home care facility. The program allows participants to receive services at home.
- Services provided through IHSS include: housecleaning, meal preparation, laundry, grocery shopping, personal care services (such as bowel and bladder care, bathing, grooming and paramedical services), accompaniment to medical appointments, and protective supervision for the mentally impaired. Services can be provided by a parent, a spouse or a caregiver. Recipients may qualify for the option of receiving advance pay and restaurant meal allowance.
- Replaced IHSS Plus Waiver Demonstration Program
- Eligible for full scope FFP Medi-Cal
- Provides assistance to recipients who have parent-of-minor or spouse providers, or who receive Advance Pay, and/or Restaurant Meal Allowance
- IPO recipients make up a little over 2% of overall IHSS population

Community First Choice Option (CFCO)

- Established through Affordable Care Act of 2010
- Recipients are eligible because they have qualified for Medi-Cal and would otherwise need a nursing home level of care
- CFCO allows states to provide home and community-based attendant services and supports to eligible Medicaid enrollees under their State Plan who meet specific income criteria and meet the Nursing Facility Level of Care (NF LOC).
- **Funding: Provides states with 6% additional federal funding for services and supports**

- CFCO recipients make up about 41% of the overall IHSS population

IHSS Residual (IHSS-R), or the original IHSS Program

- The original IHSS program, now IHSS-R, began in 1974 and is a state-and-county funded program
- Individuals who are not eligible for full scope Medi-Cal (and therefore cannot receive services under PCSP or IPW) continue to receive services under the IHSS-R program. They can receive limited-scope Medi-Cal. These are usually persons with Satisfactory Immigration Status, such as non-citizens under the five-year ban, which denies them federal reimbursement.
- Recipients in the IHSS-R program are eligible for Medi-Cal only if they have had a Medi-Cal eligibility determination by a Medi-Cal eligibility worker and meet Medi-Cal eligibility criteria for coverage under one of the Medi-Cal programs appropriate for their status.
- **Funding: 65% state, 35% county of non-federal share**
- IHSS-R recipients make up less than 2% of overall IHSS population

A participant’s needs are assessed using the IHSS Functional Index (FI) Rankings⁹. The FI Rankings range from 1 to 6 (see below description) and indicate the level of assistance needed to perform tasks safely. A county IHSS social worker will assign a rank to each service category, as needed, to help determine the amount of assistance needed.

Rank 1: Independent. Able to perform function without human assistance. (IHSS not needed)

Rank 2: Able to perform a function but needs verbal assistance, such as reminding, guidance, or encouragement

Rank 3: Can perform the function with some human assistance, including, but not limited to, direct physical assistance from a provider

Rank 4: Can perform a function but only with substantial human assistance

Rank 5: Cannot perform the function, with or without human assistance

Rank 6: Requires Paramedical Services (prescribed by a licensed healthcare professional)

Hourly Task Guidelines

Social workers also use Hourly Task Guidelines (HTGs) as specified in State regulations to determine the appropriate time needed in each service category. **Regulatory Authority:** Manual of Policies and Procedures (MPP) section 30-757.11 through 30-757.14(k)

Service Category	Rank2 (Low)	Rank 2 (High)	Rank 3 (Low)	Rank 3 (High)	Rank 4 (Low)	Rank 4 (High)	Rank 5 (Low)	Rank 5 (High)
Preparation of Meals	3:01	7:00	3:30	7:00	5:15	7:00	7:00	7:00
Meal Clean-up	1:10	3:30	1:45	3:30	1:45	3:30	2:20	3:30
Bowel and Bladder Care	0:35	2:00	1:10	3:20	2:55	5:50	4:05	8:00
Feeding	0:45	2:18	1:10	3:30	3:30	7:00	5:15	9:20
Routine Bed Baths	0:30	1:45	1:00	2:20	1:10	3:30	1:45	3:30
Dressing	0:34	1:12	1:00	1:52	1:30	2:20	1:54	3:30
Ambulation	0:35	1:45	1:00	2:06	1:45	3:30	1:45	3:30
Transfer	0:30	1:10	0:35	1:24	1:06	2:20	1:10	3:30
Bathing, Oral Hygiene, and Grooming	0:30	1:55	1:16	3:09	2:21	4:05	3:00	5:06

Challenges with IHSS Program

The IHSS program is the fastest growing major social services program in California.¹⁰ In 200708, the average yearly cost of a Skilled Nursing Facility was over \$50,000 per person while the average cost of IHSS was about \$12,000 per person.

As the cited LAO report (2010)¹⁰ suggests, however, these comparisons in many cases understate the true cost of keeping someone in the community. Some IHSS recipients, for example, may be receiving multiple services, such as a home-delivered meals or case management services that add to the overall cost of their community-based care. Given the diversity in the caseload, it is likely that a significant portion of recipients would not otherwise require institutional care. What this means is that there may be many cases in which IHSS currently over provides or often doesn't provide the appropriate level of care or type of services to clients, which may be driving up programming costs unnecessarily. Since Medicaid funding does not specifically guarantee funding for HBCS, financial prudence is key to the state's ability to continue funding IHSS and aligning with Olmstead decision guidelines.

The LAO report estimates that IHSS is probably not cost-effective in the aggregate. The report finds it unlikely that in the absence of IHSS, 58 percent or more (58% being the breakeven point) of the non-developmentally disabled IHSS recipients would enter a SNF.¹⁰

Research on the cost efficiency of long-term support service programs points in the direction of proper targeting and providing services/care appropriate to consumer's level of need. A paper by Chattopadhyay, et al. (2013)¹¹ algorithmically analyzes the cost effectiveness of long-term support service programs as funded by Medicaid in all states. California ranked among one of the least cost-efficient states. The research finds a few contributing factors to the cost effectiveness of programs, noting waste and duplication of services, as well as correct targeting. First, the study notes that the states with the lowest cost effectiveness rankings are states with large HBCS programs, introducing the possibility that these large programs have a harder time managing services, and that the administrative waste is undercutting cost efficiency. The paper also theorizes that states that require services be required for all eligible individuals are limited in their ability to carve out services by geography or cost. By utilizing waiver programs, wherein participants must be nursing home certifiable, states ensure that HBCS are offsetting a much more expensive cost.¹¹

In fact, the study finds that the utilization of waiver services was a strong predictor of the state's efficiency ranking: the greater proportion of the HBCS being waiver users, the more cost efficient.¹¹

Attempts to Reform

In 2009 and 2012, the state tried to apply three reforms to IHSS in to reduce costs (responding to budget crises in those years) that were challenged by lawsuits. The three reforms were as follows:¹⁵

- 1) *Stricter Threshold of Need for IHSS*
- 2) *Reduction of 20 Percent to IHSS Hours* (the reform would be “triggered” were the General Fund estimate to fall shorter than budgeted for the 2011-2012 Budget Act).
- 3) *Reduction of State Participation in IHSS Provider Wages and Benefits* (from a maximum of \$12.10 per hour to \$10.10 per hour). At the time this reduction was enacted, 50 percent of most IHSS program costs (including provider wages and benefits) were paid for by the federal government, with about 32.5 percent paid for by the state and 17.5 percent paid by the counties. The IHSS provider wages and benefits are determined by collective bargaining negotiations at the county level and therefore vary by county. This reduction would have required the state to contribute 32.5 percent to IHSS provider wages and benefits up to a maximum of \$10.10 per hour. Any provider wages and benefits above \$10.10 per hour would have been split 50-50 between the county and the federal government.

All three reforms were challenged by two separate court cases. The first two were challenged by **Oster v. Lightbourne, et al.** (referred to as Oster I and Oster II) on the basis of the reform violating federal Medicaid requirements, the federal Americans with Disabilities Act (ADA), and the federal Rehabilitation Act (which prohibits discrimination on the basis of disability in programs receiving federal reimbursement), as well as violation of due process under the 14th amendment. The third reform, regarding reduction of state participation in wages, was challenged by **Dominguez v. Schwarzenegger, et al.** (now referred to as Dominguez v. Brown, et al.). Similarly, the case was filed in regard to issues with alleged violations of federal Medicaid requirements (including the requirement for the state to conduct an analysis on the potential impact of a rate reduction on access to services), the ADA, and the Rehabilitation Act.

The state reached a settlement under both cases on March 27, 2013, resolving both cases. The settlement entailed the following provisions:

- Repeal of the three budget reductions at issue in the litigation
- Implementing an 8 percent reduction to IHSS hours beginning July 1, 2013 for the duration of 2013-14 (or for 12 consecutive months), followed by an ongoing 7 percent reduction to IHSS hours in future years (subject to a “trigger off” provision discussed below).
- The 8 percent and 7 percent reductions would apply to all IHSS recipients and would not include a supplemental care application process for full or partial restoration of reduced hours.
- If an IHSS recipient chooses to appeal the 8 percent or 7 percent reduction, the settlement agreement provides that his/her request can be administratively denied.
- The recipient, in such an appeal of the 8 percent or 7 percent reduction, would not receive what is known as “aid-paid-pending”—service hours provided at the same level as before the reduction while the recipient awaits an appeal decision.

- IHSS recipients retain their rights under existing law to request a reassessment of service hours based on a change in personal circumstances.

Conclusion, and Important Considerations

Reducing costs is a difficult endeavor, considering the long-standing implications of the Olmstead Act. The onus of responsibility for providing adequate community-based care is on the state. Additionally, we see the state also being responsible for providing quality care, and attempts to reduce the budget to be difficult because of the buy-in of multiple actors--the state, disability advocates, patients, and workers. Research also continues to demonstrate the importance of providing IHSS services for the well-being of community members.

New directions must take these things into consideration. As it stands, addressing cost effectiveness must make use of innovation to adequately and appropriately address community members' needs. The issue may not be of restricting use, but rather, presenting a wealth of options that best align with an individual's needs.

Part 3: Possible Directions

Understanding how different states approach community-based care may uncover insights on how not to limit the capabilities of IHSS or reduce its ability to care, but to enact care in a way that is efficient and appropriate. As the previous section noted, cutting IHSS funding is a difficult and controversial endeavor. IHSS is a popular program that is associated closely with the rights guaranteed by the Americans with Disabilities Act, and with the well-being and dignity of members of the community who face institutionalization.

Taking into account the history of IHSS and the research presented in the previous sections, below are notable models of care being used in other jurisdictions to potentially consider.

Texas' In-Home and Family Support Program (IH/FSP)¹²

Note: The In-Home and Family Support program (IH/FSP) ended Aug. 31, 2017, because it was not funded during the 85th Texas legislative session. Texas is not a Medicaid Expansion State.

The Texas In-Home and Family Support Program (IH/FSP), also referred to as the Community Services IHFS grant, granted individuals with physical disabilities, but not intellectual disabilities up to \$3,600 a year. Approximately 6,000 Texans received the grants each year and were given considerable flexibility on how they chose to spend the amount. Allowable expenses included:

- Assistive Technology
- Assistive Technology Training
- Attendant Care
- Counseling
- Durable Medical Equipment
- Environmental Adaptations
- Health Services
- Home Health Aides
- Home Modifications (to accommodate for their disability)
- Homemaker Services
- Out-of-pocket medication costs
- Respite Care
- Transportation

Pros

- One of the intentions of the grant was to prevent institutionalization of individuals, which aligns with the parameters of the Olmstead decision
- Flexibility in spending offers better targeting
- Consumers are empowered in their decision on how to spend grant

Issues

- Limited evidence or literature on its utility
- Lack of funding may indicate it wasn't powerful enough to be retained as a resource
- Possibility that if the support was insufficient it would be a violation of the ADA

Oregon: Adult Foster Care Model¹³

An adult foster home (AFH) is a type of licensed community-based care (CBC) setting that provides residential, personal care, and health-related services, primarily to older adults. Oregon's model was developed in the 1980's. AFH's offer and coordinate services on a 24-hour basis. AFH settings, while maintaining appropriate licensing and skillsets, emphasize choice, dignity, privacy, individuality and independence. The setting is a home within the community, rather than an institution. A helpful and highly recommended report on the model in Oregon (OHCA report) demonstrates:

- Shorter lengths of stay, with 30 percent of AFH residents staying less than 90 days compared to 18 percent in the other CBC settings
- More residents with Alzheimer's disease or other dementias, with 49 percent compared to 46 percent in other CBC settings
- Lower rates of falls in AFHs (15 percent) compared to other CBC settings (27 percent)
- A higher use of antipsychotic medications, with 34 percent of AFH residents taking an antipsychotic medication compared to 26 percent in other CBC settings
- Oregon invests more in-home and community-based services as a percentage of long term care service spending than any other state (OHCA report)
- Oregon has the lowest nursing facility utilization rate in the nation and ranks third in nursing facility hospitalization rate (OHCA report)

Licensing for Adult Foster Care Homes comes in different levels depending on an individual's ADL:

- CLASS 1: A class 1 license authorizes the licensee to admit residents who may need assistance with up to four of their ADL's. The applicant must pass the department's basic training course and examination.
- CLASS 2: A class 2 license may be issued if the applicant has two or more years of experience providing care to adults who are elderly or physically disabled. This AFH may admit residents who require assistance in all ADLs but require full assistance in no more than three ADLs. In addition, the applicant must complete and pass the department's basic training course for AFH potential licensees; or
- CLASS 3: A class 3 license may be issued if the applicant is a currently licensed health care professional in Oregon or if the applicant possesses the following qualifications:
 - Has at least three years of experience providing care to adults who are elderly or physically disabled and require full assistance in four or more of their ADLs.
 - Has satisfactory references from at least two licensed health care professionals who have direct knowledge of the applicant's ability and experience as a caregiver.

Sixty-three percent of the responding AFHs had private-pay residents. Providers were asked to describe the average total monthly private-pay charge for a single resident living alone and receiving the lowest level of care in a private room. The mean monthly charge for the 191 responding AFHs was \$3,202. When comparing the average total monthly charges by the four regions in Oregon, the highest rates were found in the Portland Metro area, and the Willamette Valley/North Coast.

Payment:

- Basic monthly rate, which includes:
 - Basic services to be provided (room, meals, laundry, and other specified care and services);
 - Refund policy;
 - Conditions under which the rate may change.
- House policies, including:
 - Any restrictions on the use of alcohol, tobacco, legal medical marijuana, pets, dietary restrictions, religious preferences or visiting hours;
 - Fees (such as for storage or to hold a bed);
 - Any limitation to the implementation of advance directives on the basis of conscience.
- Optional fee for additional services such as:
 - Incontinence care;
 - Assistance with eating;
 - Diabetic care;
 - Special diets;
 - Transportation;
 - Mobility and transfers;
 - Skilled nursing tasks;
 - Night-time care; and
 - Dementia care.
- Medicaid financial assistance
 - To use a facility with Medicaid fund, the site has to be contracted to accept Medicaid
 - Private pay remains the largest source of funding in assisted living at 51%. The percentage of care funded through Medicaid is 39%, its share increasing from 31% in 2008. Other payers for assisted living in Oregon include private long-term care insurance at 5%, the Veterans Administration (VA) at 2% and Other at 2%.

Pros

- Again, alternative model offers flexibility and more targeting. The levels of licensing can align with specific needs.
- As shown above, the OHCA report highlights positive outcomes

Issues

- It is up to facilities whether or not they choose to accept Medicaid -- this can create issues of access
- Licensing and approval process can add additional administrative costs

Wyoming Home Services Program (WyHS)¹⁴

Based on a previously cited study, Wyoming is the most cost-effective state in providing home-based community services.

The Wyoming Home Services (WyHS) program is used to provide home services to those qualified individuals who are at risk of premature institutionalization. The services intend to prevent institutionalization for as long as possible, while keeping people in the community.

WyHS entails:

- **Care Coordination** – Assistance either in the form of access or care coordination in circumstances where the person and/or their caregivers are experiencing diminished functioning capacities, personal conditions or other characteristics which require the provision of services by formal service providers. Activities of case management include assessing needs, developing care plans, authorizing services, arranging services, coordinating the provision of services among providers, follow-up and reassessment as required.
- **Personal care** – Providing personal assistance, stand-by assistance, supervision or cues for persons with the inability to perform with one or more of the following activities of daily living; eating, dressing, bathing, toileting, transferring in and out of bed/chair, or walking.
- **Chore services** – Providing assistance to persons with the inability to perform one or more of the following instrumental activities of daily living; heavy housework, yard work, or sidewalk maintenance.
- **Homemaker services** – Providing assistance to persons with an inability to perform one or more of the following instrumental activities of daily living; preparing meals, shopping for personal items, managing money, using the telephone, or doing light housework.
- **Respite care** – Respite care services offer temporary, substitute supports, or living arrangements for older persons in order to provide a brief period of relief or rest for family members or other caregivers.
- **Personal Emergency Response Systems** – Electronic warning device informing emergency personnel of an accident or safety hazard to a client in their home.
- **Adult day care** – Provision of personal care for dependent adults in a supervised, protective, congregate setting during some portion of a twenty-four-hour day.
- **Hospice** – Services provided to the terminally ill, allowing him/her to remain at home with their family.

What is notable is eligibility requirement: a client must be 18 years of age or older, and, through an ongoing evaluation, *at risk of premature institutionalization*.

Pros

- Eligibility requirement makes sure the people receiving this level of service are at risk of premature institution, which contains the same cost driving factors that are driving up California's costs

Issues

- Largely reliant on community block grants, which are currently under risk

Conclusion

The above models reflect different modes of providing care to disabled and older adults in our communities. The previous section of this report noted that issues with cost-efficiency in California may be related to targeting services and administrative costs. In aligning with the Olmstead decision and the inherent values of the ADA, it is important to make care available and immediately accessible to any community member at risk of isolation and institutionalization. Presenting alternative, less intensive supports for community members who are not necessarily at risk of institutionalization may contain costs.

References

1. What is the Americans with Disabilities Act (ADA)? (ADA National Network)
<https://adata.org/learn-about-ada>
2. Disabled Persons Rally, Crawl Up Capitol Steps: Congress: Scores protest delays in passage of rights legislation. The logjam in the House is expected to break soon (LA Times, 1990) http://articles.latimes.com/1990-03-13/news/mn-211_1_capitol-steps
3. Deinstitutionalization and reinstitutionalization: major changes in the provision of mental healthcare (Journal of Psychiatry, 2005)
<https://www.sciencedirect.com/science/article/pii/S1476179307001085?via%3Dihub>
4. Supreme Court Upholds ADA 'Integration Mandate' in Olmstead decision (The Center for an Accessible Society) <http://www.accessiblesociety.org/topics/ada/olmsteadoverview.htm>
5. Implementing Olmstead in California (The SCAN Foundation, 2011)
http://www.thescanfoundation.org/sites/default/files/ltc_fundamental_5_0.pdf
6. Olmstead: Community Integration for Everyone (US Department of Justice, Civil Rights Division) https://www.ada.gov/olmstead/olmstead_about.htm<http://www.cicaihss.org/ihss-public-authority-history>
7. The History of In-Home-Support Services and Public Authorities in California (California In-Home Supportive Services Consumer Alliance CICA), <http://www.cicaihss.org/ihss-public-authority-history>
8. In-Home Supportive Services (IHSS) Program (Department of Social Services, 2018)
<http://www.cdss.ca.gov/inforesources/IHSS>
9. Functional Index Rankings & Hourly Task Guidelines (California Department of Social Services) http://www.cicaihss.org/sites/default/files/1-fact_sheet_fi_rankings-htg_table_accessible.pdf
10. Considering the State Costs and Benefits: In-Home Supportive Services Program (Legislative Analyst's Office, 2010) <http://www.lao.ca.gov/Publications/Detail/2176>
11. Cost-efficiency in Medicaid long-term support services: the role of home and community based services (SpringerPlus, 2013)
<https://springerplus.springeropen.com/articles/10.1186/2193-1801-2-305>
12. In-Home and Family Support (IHFS) <https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/home-family-support-ihfs>
13. Community-Based Care Resident and Community Characteristics Report (Oregon Department of Human Services, 2016) <http://www.oregon.gov/DHS/SENIORS-DISABILITIES/Documents/AFH%20Summary%20Report%20for%20DHS%20-%202016.pdf>
14. Wyoming Home Services WyHS (Wyoming Social Resources Information, 2018)
https://www.wyosocialresources.info/social_resources/wyoming-home-services-wyhs/
15. The Surprising Effects of Loneliness on Health (The New York Times, 2017)
<https://www.nytimes.com/2017/12/11/well/mind/how-loneliness-affects-our-health.html>
16. Why You Should Treat Loneliness as a Chronic Illness (Everyday Health, 2015)
<https://www.everydayhealth.com/news/loneliness-can-really-hurt-you/>
17. Analysis of Settlement Agreement for In-Home Supportive Services (IHSS) Lawsuits
<http://www.lao.ca.gov/Recommendations/Details/745>