STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES
744 P Street, Sacramento, CA 95814

September 13, 1994

ALL-COUNTY INFORMATION NOTICE I-32-94

TO: ALL-COUNTY WELFARE DIRECTORS

REASON FOR THIS TRANSMITTAL

[ ] State Law Change
[ ] Federal Law or Regulation Change
[ ] Court Order or Settlement Agreement
[ ] Clarification Requested by One or More Counties
[X] Initiated by CDSS

CDSS contracted with California State University Sacramento's Institute for Social Research (ISR) to conduct intensive research on the IHSS Program. The purpose of this All County Information Notice is to inform you that the first of six ISR reports has been released.

The six subjects ISR is researching are:

(a) California's IHSS Assessment and Authorization Practices: Their Reliability, Validity and Variability. This is the report being released with this ACIN.

(b) The development of an hours predictor process using validated, reliable functional rankings from the Uniformity system.

(c) An evaluation of the comparative quality of the Individual Provider (IP), Supported Individual Provider (SIP) and contract modes.

(d) A description of historical changes in the IHSS Program 1986-91.

(e) An evaluation of the comparative cost effectiveness of IP and SIP.

(f) An evaluation of the managed care mode as implemented in Tulare County.

A complete copy of the report, California's IHSS Assessment and Authorization Practices: Their Reliability, Validity and Variability, has been sent to each county welfare director. The executive summary is attached for your information.

ISR undertook significant research efforts to evaluate both historical and current data on the Case Management, Information and Payrolling System (CMIPS) data and gathered independent data from home visit interviews and observations of recipients and telephone interviews of providers. We believe that each of the reports will contain valuable information and data essential to make informed management decisions at the state and county levels.

Feel free to call (916) 387-4583 to order a copy of the complete report. Questions about the report may be directed to Joan Boomer at (510) 834-8605 or Carole Barnes at (916) 278-5737.

Joan V. Scott

for CAROL R. WIDEMON
Deputy Director
Adult Services Division

Attachment

EXECUTIVE SUMMARY

CALIFORNIA'S IHSS ASSESSMENT AND AUTHORIZATION PRACTICES: THEIR RELIABILITY, VALIDITY AND VARIABILITY

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CSUS

June 15, 1994

This report evaluates factors influencing the variation in California's IHSS functional assessments and authorized hours and the reliability and validity of the state's uniform assessment tool which establishes levels of need for in-home supportive services. Developed by Joan Boomer, analyst with California's Adult Services Division of the Department of Social Services, and introduced statewide in 1988, the functional index assesses, on a 1 to 5 scale, a client's ability to complete independently eleven functional tasks. The functional index is used to determine the hours and type of care a client would need to remain independent. In addition, a client's memory, orientation, and judgment are ranked, using the same range.

Three basic approaches were used to accomplish the research goals. First, a multiple regression analysis was used to identify factors related to the variability in functional assessments and authorized hours in counties throughout the state. Second, the reliability of the instrument was tested by the independent evaluation of IHSS clients already assessed by county social workers, using paired assessments by teams of ISR staff members. The paired assessments were correlated with each other and then with county evaluations of the same clients. The third approach used the state's CMIPS files to establish the validity of the functional index by analyzing the relationship between a county's functional assessment of its clients and the assessed hours assigned. Each approach considered demographic features of the counties, client characteristics, and service mode.

In-home support services are provided by three modes: individual providers, hired by the client; contract providers, hired and supervised by a private contractor; and homemakers, hired and supervised by the counties. With the exception of Tulare in 1993, all counties offer the IP mode. To distinguish them for analysis purposes, counties were classified by the other service options offered in addition to IP. Thus, contract counties were those in which some clients were assigned to a private contractor for the provision of in-home services; when 5% or more clients were served by county workers, these counties were designated "homemaker counties." Some counties in each of the three mode classifications also offer IP clients an enhancement called "supported IP;" counties with this feature help clients find providers and offer some assistance in supervision.

A brief summary of the major findings follows:

Chapter 2: Description of IHSS Clients

- More of California's seniors, blind and disabled have chosen to live in the more rural and moderately urban counties in the state. In contrast, the economically dependent aged are found in greater numbers at the population extremes -- in both the most urban and most rural counties. In general, San Francisco and the central valley attract more blind and disabled, while the rest of the Bay Area and southern California's urban counties have lower rates for both groups.

- IHSS participation rates vary from lows of 384 to 430 per 100,000 adult population in Ventura, Orange, Santa Clara and San Mateo counties to highs of 2,413 to 3,267 in Tulare, Lake and Sierra, with a statewide average of 964.

- With the exception of Los Angeles, IHSS participation rates per 100,000 are lowest in the urban counties and highest in the more rural. Los Angeles has the highest proportion of aged SSI/SSP recipients in the state, which probably accounts for its atypically high participation rates. Counties with higher proportions of seniors have higher participation rates, as do counties with more families earning under $10,000 per year. Irrespective of family income levels, participation rates are highest in the more politically competitive counties, where party registrations are more evenly balanced.

- IHSS participation rates are lowest in homemaker counties (803 - 834), roughly equivalent in IP and contract counties lacking supported IP (935 - 950), and highest in IP counties offering supported IP (1,186).

- In 1990 - 91, 90.5% of all clients were served by the individual provider mode, with another 8.7% by private contractors. Thirty-four counties offer only the individual provider mode. Private contractors serve a portion of the caseload in 15 counties, while 7 have at least 5% of their caseload covered by county homemakers.

- Although nine in ten clients were served by individual providers, slightly more elderly clients were served by the contract mode, somewhat fewer disabled. When clients are categorized by functioning level, differences in service mode are more dramatic. Private contractors served almost 20% of the more capable clients, but only 4% of the less capable ones.

- There were six elderly clients for every 4 disabled receiving IHSS in 1990 - 91. Two-thirds of the caseload were in the less functional category. Combining disabled status and functional ability, the groups most apt to be served by the program are the more functionally impaired elderly and disabled. Women outnumber men 7 to 3.

- Almost all (99%) IHSS recipients receive housework services. Other household and personal tasks are provided to fewer clients. In general, 85% or more clients receive all household services (housework, shopping, laundry, meal prep and clean-up). Fewer clients receive personal care.

- Most of the more time consuming and interpersonally demanding personal care is delivered by individual providers. Private contractors and homemakers mainly provide household services. The mode differential in services provided occurs whether the client is elderly or disabled, or more or less capable.

Chapter 3: Variations in the Functional Index and Assessed Hours by County and Client Characteristics

- County average functional index scores vary widely. On a scale of one to five, means vary from lows of 1.87 to 1.99 in four rural counties to highs of 2.83 to 3.24 in counties at the urban and rural extremes.

- Counties with proportionately more seniors have lower functional index scores while those with fewer seniors have higher ones. Moreover, there is no relationship at all between the rate of aged SSI/SSP recipients and the functional levels of clients in a county. One reason appears to be that the elderly are more functional than the disabled. Therefore, their presence in large numbers lowers the average functional index score in a county.

- A county's proportion of blind and disabled SSI/SSP recipients is also unrelated to its functional index scores. Clearly, county population characteristics are only one part of the explanation for variations in the functional index. The contributions of these characteristics will become clearer when other important variables are controlled in the multivariate analyses described in Chapters 6 and 8.

- Disabled clients under 40 are less functional than the most elderly clients (over 85). The severely disabled, with functional index scores over 3.0 constitute 12% of the IHSS caseload.

- Women clients are more capable than the men -- a difference which is partially explained by the fact that more of the men are disabled (over half compared with a third of the women). Men may also defer program entry longer because of greater resistance to the loss of privacy and implied acceptance of heightened dependency.

- IP clients, irrespective of the other modes available in their county, have the highest average functional index scores (2.75), with contract clients averaging 2.02 and homemaker clients 1.67. Clearly, clients requiring fewer services are assigned to the contract and homemaker modes. This difference in functional levels is consistent with the types of services provided under the different modes.

- Among counties, the average assessed hours varies even more than the average functional index scores. While the highest mean functional index score for a county is 1.7 times higher than the lowest, the ratio of assessed hours in the highest and lowest counties is 4 to 1 (145 vs. 35). Whether the greater variation in assessed hours is inappropriate cannot be determined without analyzing the relationship between hours and functional level -- the goal of a later section of this report.

- In general, average assessed hours per county increases with the size of the adult population and with the proportion urban. Los Angeles constitutes an exception to that pattern, with lower assessed hours than other counties in their size and urban category. Totally rural counties are another exception; their assessed hours are more comparable to the most urban ones.

- With the exception of counties where more than 22% of the adults are over 65, the larger a county's proportion of seniors, the <u>lower</u> the assessed hours.

- By themselves, the rates of aged, blind, and disabled SSI/SSP recipients per 100,000 adult population in a county have no relationship to a county's assessed hours.

- Like the functional index, assessed hours for disabled clients under 40 are higher than for the elderly. Only the frail elderly, over 85, receive service levels similar to disabled clients in their 40s.

- Men receive more hours of care than women (94 vs. 83 hours per month).

- Clients served by individual providers receive twice as many hours as contract clients (91 vs. 44) and 3.5 as many as those served by county homemakers. This difference reflects the greater personal needs of the more impaired recipients typically served by individual providers.

- These mode differences remain when IP clients in mixed mode counties are compared with clients in those counties served by the contract or homemaker mode.

- The differences in hours by service mode reflect the different functioning levels of the clients served by each mode. IP clients have higher functional index scores, indicating less capable clients, while contract and homemaker clients have much lower functional scores. The mode differential in both the specific services provided and the number of hours assigned is also a reflection of the maximum level of client support paid by the state. An hour cap of 283 per month is multiplied times $4.25 an hour, the wage paid individual providers. Since the cost to the state for contract clients is more than double that amount, contractors can only provide roughly half as many hours as individual providers. As county employees, homemakers are more expensive still and can therefore provide even fewer hours.

- The variation in functioning levels and assessed hours between clients served by different modes is consistent with variations in the types of services provided.

- At the county level of analysis, the relationship between average functional scores and assessed hours is contrary to expectations. Clients in the smaller homemaker counties have the lowest functional index scores, but the highest number of assessed hours. Conversely, clients in the larger IP without SIP counties have the highest functional index scores, but the lowest assessed hours.

Chapter 4: County Inconsistencies in the Relationship of the Functional Index to Assessed Hours

- Average functional index scores for California's counties are significantly skewed toward the lower scores. Two of the most frequently authorized services, laundry and shopping, are most responsible for this skew. Many clients in 27 counties

have low levels of need for these services. Lower levels of need for meal-prep and cleanup, housework, bathing and dressing also contribute to lower functional index scores in these counties.

- These lower levels of need are most often expressed in very low functional scores for household tasks (housework, laundry, shopping and meal prep). Personal services are provided to a more dependent population whose task needs are more accurately reflected in their functional scores.

- The data suggests that applicants with lower levels of need are more often granted IHSS entry in the rural and predominantly agricultural counties than in the rest of the state. In other words, rural counties, with higher concentrations of seniors, have a lower threshold for entry to the program, regardless of mode.

- In contrast to the functional index, average assessed hours are skewed in a positive direction; 18 counties award unusually high assessed hours relative to the rest of the state.

- There is a tendency for some counties to award more assessed hours than their average functional index scores would suggest. These include some of the state's more rural counties (Butte, Glenn, Humboldt, Siskiyou, Amador, San Benito), its vacation counties (Mendocino, Monterey, Napa, Marin, Sonoma, Trinity and Inyo), and a few urban centers (Sacramento, Placer, El Dorado, Santa Clara, and Fresno). Only four counties award markedly fewer hours than their functional scores would indicate (Sierra, Calaveras, Los Angeles and San Mateo).

- The hours awarded for household tasks do not seem to mirror the low levels of need for these services. The state's time per task standards for housework, laundry and shopping permit limited -- and more normally distributed -- variability in hours for these tasks, even though counties admit clients with minimal need for these services. For other tasks lacking specific standards (specifically meal prep and clean-up, mobility inside and transfer) assessed hours far outstrip functional levels. Thus, for two different reasons, hours assessed may exceed functional need in the program's most frequently awarded services. Basic household services may be provided to clients with limited needs because of the lower threshold of entry in rural counties. And several borderline personal care needs may be awarded excessive hours.

- When the relationship between functional index scores and assessed hours is analyzed at the individual client level, rather than with separate county averages, and mean per client differences are averaged for each county, there is an even stronger tendency for rural counties to award more hours -- and urban counties

to award fewer -- than an individual client's functional index would dictate, relative to statewide averages on both indicators.

- Counties are authorizing far more hours for laundry and dressing than the clients' functional levels would indicate. Meal prep and clean-up and shopping are two other tasks where this type of imbalance occurs. Conversely, respiration is actually skewed in a negative direction, with more counties awarding clients fewer hours than their condition would indicate. Bathing and grooming is also more heavily weighted in a negative direction than the remaining tasks.

Chapter 5: Reliability of the Functional Index

- Correlation is a statistical method which measures the degree to which two measures for a set of individuals vary together. Perfect correspondence is indicated by a correlation of 1.00, no relationship between the two by a correlation of 0. If pairs of scores increase in tandem, the correlation is a positive one; if one increases while the other decreases, the relationship is a negative one. Correlations that are closer to 1 (above .5) are less likely in large samples. In samples over 1,000, it is very unlikely that correlations greater than .5 have occurred by chance.

- The functional index was administered by eleven teams of ISR staff and found to be highly reliable, with an obtained correlation of .91 for 1,432 clients. This clearly demonstrates that the assessment tool can be applied in a very consistent manner by a well-trained staff. Correlations for individual components of the functional index were lower, but still highly significant, as were those for the mental functioning scale (.73).

- The internal consistency between the ranks assigned to tasks and the overall functional index score was higher for ISR than county staff on all but four functions: dressing; transfer; mobility; and bowel, bladder and menstrual. For both groups, personal tasks were more highly correlated with the functional index than household tasks. Internal consistency for county staff was generally greater in 1993 than in 1990 - 91.

- Correlations between the evaluations of ISR staff and those of county social workers were lower (.70) with a still lower, but significant, correlation between the two on the mental functioning scale (.38).

- Correlations -- between the evaluations of ISR staff pairs and between ISR and county social workers -- were consistently higher for personal rather than household tasks. Personal tasks included bathing and grooming, dressing, bowel,

bladder and menstrual, feeding, mobility, respiration and transfer. Household tasks included housework, laundry, shopping, meal prep and clean-up. All correlations, however, were highly significant.

- Correlations between ISR and IHSS assessments of the same clients were highest in Stanislaus and Tulare counties (.81 and .76 respectively) and lowest in Los Angeles and San Francisco (.53 and .52).

Chapter 6: Determinants of Variation in the Functional Index

- When the client variables of gender, elderly/disabled status, age and service mode, and the county variables of adult population size, proportion urban, caseload size, and service mode are entered into a regression model predicting a client's functional index score, the included variables account for 9% of the variation in the functional index. If the proportion of the poulation receiving SSI/SSP is added to the model, the proportion explained doubles (18%). In other words, county characteristics unrelated to client functioning, with some contribution from client characteristics such as age, gender and disabled status, account for almost 20% of the variation in functional index scores among IHSS clients. If ISR's independent evaluation of 1,432 interviewed clients in five sample counties is used as an estimate of actual client functioning levels, the proportion of explained variance increases to 54%. In addition to sampling error, most of the remaining 46% of the variation in functional scores is due to differences in the way workers assess recipients.

- Three county characteristics contribute significantly to variation in functional index scores: its caseload, the size of its adult population, and the proportion of blind SSI/SSP recipients. All other things being equal, the larger a county's caseload, the lower its clients' functional index scores. Consistent with caseload size, larger adult populations in a county also depress functional levels. Greater concentrations of blind SSI/SSP recipients lower functional scores.

- Two client characteristics, their mental functioning and service mode, are similarly important in explaining variation in functional scores. Clients with more impaired mental functioning have higher functional scores. Those served by private contractors have lower FI scores than clients with individual providers.

- The availability of residential and nursing care facilities has an important effect on the functional index scores of a county's clients. It appears that counties with residential care options lose some of their more functional clients to these facilities. Conversely, when more nursing care beds are available, the resulting IHSS client population is a more functional group.

- A regression model predicting functional scores among the interviewed clients identified client service mode and years of service with IHSS as the most important predictive variables in the absence of any direct measure of client functioning. These variables remain strong even when they are overshadowed by the addition of ISR's client evaluation to the model.

Chapter 7: Validity of the Functional Index

- As expected, assessed hours increase directly with increases in functioning rank for all tasks.

- The most time-consuming tasks are meal prep and clean-up (39 hours/month), bowel, bladder and menstrual (21 hrs), feeding (20 hrs), transfer (14 hrs), and bathing and grooming (13 hrs). Housework, laundry and shopping, governed by time and task standards set by the state, vary in the 5 to 7 hours/month range.

- Almost all IHSS clients receive housework, laundry and shopping services, with slightly fewer getting assistance with meal preparation and clean-up. Bathing and grooming is provided for 72%, help with dressing for 54% of all clients. The more personal services are received by a third or less of the clients.

- Contract counties award more hours for basic household services (housework, laundry and shopping) than IP counties and, with the exception of shopping, more than the homemaker counties as well. Relative to all other counties, homemaker counties award an excessive number of hours for meal prep and clean-up (52 hours in homemaker counties vs. 39 in the rest of the state). They are also significantly higher on mobility (15 hrs vs. 11 - 12) and respiration (13 vs. 10 - 11).

- As expected, IP clients in mixed mode counties, who are generally more impaired than those assigned to the contract and homemaker modes, receive more hours for each task than clients served by the other modes. Clients in IP only counties have lower average hours because the caseload includes the more functional clients typically assigned to the contractor in mixed mode counties.

- With the exception of three tasks, IP clients in contract counties also receive more hours than IP clients in IP counties -- even though their functional index scores are <u>lower</u>. With two task exceptions (respiration and bathing and grooming) and the lowest rank for three others (dressing; bowel, bladder and menstrual; and feeding), the higher hours for IP clients in contract counties, relative to those in IP counties, holds true at every rank. It therefore appears that IP hours in contract counties are inflated relative to functional levels. There must be

something about the presence of the contract mode that drives up the cost of individual providers in counties with that option.

- In homemaker counties, IP clients' assessed hours for many services (shopping and errands, meal prep, mobility, bathing and grooming, dressing and respiration) are the highest in the state -- even though their functional ranks are lower still. On three tasks (meal prep, mobility and respiration), IP hours in homemaker counties exceed the others by at least 25 to 30%. Since meal prep is one of the most frequently provided services, the awarding of excessive hours for this service alone generates inequitable funding to small counties with modest caseloads. The cost is small in comparison to the total IHSS budget, but perhaps significant relative to county expenditures for the program.

- Counties that award far more hours than their individual clients' functional index scores would indicate do so in the areas of personal care, awarding a third to 40% more hours than typical counties for bowel, bladder and menstrual, meal prep and clean-up, mobility inside, and transfer. Dressing and feeding require roughly a fourth more time in these counties as well.

- Because of the extreme diversity in assessment and authorization practices throughout the state, three criteria were utilized to identify six normative counties whose procedures could be used to set standards for other counties. These counties (1) were in the center of the distribution on the functional index and assessed hours; (2) had a strong correlation between the two measures; and (3) had minimal differences, on a client by client basis, in the standardized functional index score and assessed hours. These counties are: San Bernardino, Riverside, Nevada, Santa Barbara, Orange and Ventura.

- In general, the normative counties award more hours than the sample counties, but fewer than the remaining counties in the state.

- One test of the validity of an instrument is whether it varies, as expected, in relationship to variables that should influence it. Two indicators from the client interviews were expected, a priori, to influence functional level, and through it, assessed hours of care. These were the number of hospital trips made in the past year and the length of time receiving IHSS. Hospitalization, with an implied period of greater dependency, could be expected to raise the functional index and hours of in-home care. Regarding years of experience with IHSS, the expectation is that the elderly would gradually deteriorate, requiring more support as they become more frail. For the blind and physically disabled, who in general are much younger, physical condition should be more consistent over time. The pattern with respect to hospitalization is as predicted. For both the disabled and elderly, functional scores and hours increase directly with the number of hospital

trips, with the greater increase in both measures occurring among the elderly. Contrary to expectations, there was more change in the condition and hours of the disabled over time than there was among the elderly. The disabled declined at twice the rate of the elderly and their hours grew at 2 to 4 times the rate of increase in their functional score. In contrast, the increase in hours for the elderly was consistent with the increase in their functional scores. Observations made during client interviews with the disabled, and confirmed by those of program staff, suggest a possible reason for this unexpected result. The younger disabled are more adept at defining their needs and more articulate in describing them to their social workers. They also have more energy than the elderly, who lack the assertiveness -- and perhaps even the lobbying support -- to argue effectively for their needs. The elderly are often afraid of losing what they have and, in doing so, their independence as well.

- Another test of the accuracy of the functional assessment process was to compare ISR staff assessments with each other and with those of county social workers for the same clients. The differences between ISR staff assessments were expected to be smaller than those between ISR and the county for several reasons. First ISR staff had experienced an intensive week of training with the author of the functional index, with practice field assessments reviewed during the training sessions. When they completed approximately 150 client assessments in 8 weeks, they could concentrate on just two tasks: the assessment process and a quality of care interview. This gave ISR staff the luxury of fine tuning their assessments -- a luxury social workers with high caseloads and more complex responsibilities do not have. And, finally, the researchers were unaware of the organizational implications of the functional index and lacked a vested interest in its outcome. As expected, ISR staff differed little in the functional index scores assigned to clients. The difference between ISR staff and IHSS social workers was 5 times greater. With two exceptions, counties consistently assessed clients higher on components of the functional index than ISR did; the two exceptions were feeding and respiration.

- A third test of the validity of the functional index is the correlation of a client's functional rank with their assessed hours. The substantial and highly significant correlations between the overall functional index and assessed hours, not only for county social workers who are routinely responsible for both, but for the organizationally independent assessments of ISR staff as well, suggests that the five sample counties are awarding hours in a highly consistent manner relative to the client's actual functioning level. The actual correlations were .87 and .73 respectively, with 1.00 indicating perfect correspondence between the two measures. How close to 1.00 these figures "ought" to be is a matter of policy and not statistics. Clearly, the functional index is serving its intended purpose, offering a mechanism for the equitable provision of in-home supportive services.

- The overall index, however, is more consistently related to assessed hours than the individual components. Functional ranks for household services have either chance or weak relationships to assessed hours, strongly suggesting that the state's time and task standards discourage counties from trying to vary hours for these tasks in accordance with client need. On the other hand, correlations for the personal care tasks were strong and, on several (meal prep, mobility, dressing and transfer), extremely similar for county workers and ISR staff.

- Individually, the sample counties varied in how closely their clients' functional index scores predicted the same clients' assessed hours. The triangulation analysis identifies Stanislaus, whose functional assessments were extremely close to those of ISR, as a county with tight assessment practices and consistent policies in awarding assessed hours. The correlation between ISR's assessments and county-awarded hours was lowest in Los Angeles and San Francisco (.52 and .56 respectively vs. .81 in Stanislaus).

- When the same analysis is done separately for each functional task, county-awarded hours do not correlate with ISR's evaluation of client functioning for seven of the 11 tasks. It appears that county workers, based on years of field experience, have a good feel for a client's overall needs, awarding hours accordingly, if not with absolute precision. But, caseloads and job responsibilities being what they are, the workers probably do not have the time to assess every component of the functional index.

- The reliability of the above analysis was tested by comparing the relationships between ranks and hours per task as measured by county workers statewide in 1990 - 91. The results mirror those described above for the interviewed client sample in 1993. That is, the relationships are lowest for those components governed by time per task standards (housework, laundry and shopping), a little stronger for mobility and dressing, and strongest for the remaining personal tasks (except respiration). The statewide results confirm a weak relationship between functional rank and assessed hours for all tasks. At best, functional rank predicts 25% of the variance in assessed hours; at worst, 1% or less.

Chapter 8: Determinants of Variation in Assessed Hours

- The county assigned functional index, along with the client and county variables described in Chapter 6, were used to predict the total assessed hours. The values of the functional index should drive the values of total assessed hours. As expected, its addition increases the proportion of explained variance in the statewide and sample county models to 77%. The remaining variance would be

due to county and worker differences in evaluating functioning level and in the assignment of assessed hours.

- When ISR's functional assessment and mental functioning scale replace the county's assessments in the model, the proportion of explained variation drops to 57%. The differential effect of the counties' and ISR's assessments on the models' efficiency indicates a significant disparity in the two groups' assessments of the same clients. The greater consistency in ISR's assessments leaves more of the variance in the county's assessed hours to be explained. This disparity is partly the result of inconsistent assessments by county workers and partly the result of their inconsistent awarding of assessed hours. The nature of this disparity was discussed in the paragraphs summarizing the findings in Chapters 5 and 7.

- When the counties' functional index is used in the model predicting interviewed clients' assessed hours, the size of the county's adult population is the second most important variable; all other things being equal, the more populous counties have lower assessed hours. Older clients and a higher proportion of aged SSI/SSP recipients in a county also depress assessed hours. When ISR's functional index is used instead, client service mode, the rate of blind SSI/SSP recipients, and more than six years of service with IHSS become the most important secondary variables (after the functional index score) in predicting assessed hours. Contract clients have fewer hours; longterm clients, independent of their functioning levels, have more hours; and clients in counties with more blind SSI/SSP recipients receive more hours. Men, independent of their functioning level, received more hours than women.

- The complete statewide model, predicting assessed hours in 43 counties with 96.33% of the state's IHSS caseload (eliminating the smallest counties with insufficient caseloads for this type of analysis), identifies population size and caseload as the most important variables, besides the functional index, predicting assessed hours. Comparable clients receive fewer hours in the more populous counties with the larger caseloads. The larger a county's caseload, the greater and more negative, its effect on assessed hours. Finally, the larger the proportion of aged (and to a lesser extent the blind) SSI/SSP recipients, the lower the hours, while the proportion of disabled has a similar but opposite effect.

Conclusions

- The state's functional assessment tool was found to be highly reliable by teams of independent evaluators in a sample of 1,432 clients. In some of the sample counties, workers' assessments of overall client functioning were strongly

correlated with ISR's, but in the larger counties, the correlations were much weaker. All sample counties assessed higher than ISR's evaluators. The data suggest that the state needs to promote greater consistency in the application of what was found to be a very good instrument.

- Although the counties' functional index scores appear to be predictive of assessed hours, there is very little relationship between functional rank on the individual tasks and hours assigned for that task. This suggests that a larger problem exists with authorization procedures than with the assessment instrument. This problem will be addressed by the development of an hours predictor, which is being developed in phase two of this research.