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In Home Support for All: A Community Outreach Project

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Abstract

In Home Supportive Services Public Authority (IHSSPA) is a Medi-Cal funded organization that helps the elderly and disabled living in San Francisco find care and support at home. The Public Authority component of IHSS specializes in providing support to their clients or "consumers" when attempting to hire home care workers or "providers." However, IHSSPA services remain relatively unknown throughout many communities in San Francisco county and there is a need for increased community outreach. To address this problem, communities that are currently underserved by IHSSPA were defined by their zip code. These communities were compared with data indicating which areas have high instances of seniors living in poverty (for target consumers), and high instances of unemployment (for target providers). In addition, a provider Focus Group elucidated current issues that providers encounter when enrolling in IHSSPA and being matched with consumers. Participants also offered suggestions on how to increase outreach to new providers. Direct community outreach was initiated by visiting community centers in neighborhoods with lower instances of consumer/provider residences, high instances of seniors living in poverty, or high unemployment. Staff at the participating community centers were interviewed and their prior knowledge of IHSSPA was assessed. Two community centers in the Richmond district of San Francisco agreed to display IHSSPA materials and offer them to clients. Finally, an online provider survey was utilized to gather data from 52 additional providers on themes initially identified in the provider Focus Group. Survey data supported certain themes in the Focus Group such as the tendency for consumers to request unauthorized tasks from providers. However, unlike the Focus Group, the survey data seemed to indicate increased satisfaction with training and consumer matching. Results from the provider survey also indicated

there were few differences in opinion between those who had worked for a friend/family member, and those who had not.

Key Words: In Home Supportive Services, Home care, Seniors, Community-Based, Outreach, Disabled, Independent Providers, IHSS Consumers

Executive Summary

Agency Background

In Home Supportive Services Public Authority serves over 22,000 consumers in San Francisco and has currently enrolled 20,000 providers (IHSSPA, n.d.). Since 1992, the Public Authority component of IHSS has been integral to helping consumers find their appropriate home care worker or "provider." San Francisco's increase in price of living over the years has forced many seniors living alone into poverty, unable to afford the in home care they need. To combat the issue, IHSS uses Medi-Cal to pay for provider's wages, and offers providers health benefits if they join the Public Authority registry. The services performed by providers are therefore needed by many seniors living in San Francisco in various neighborhoods.

Project Aim

This project aimed to expand knowledge of Public Authority services to previously underserved neighborhoods containing individuals in need of in home care and those who are in need of employment. Therefore, the target population was both providers and consumers with the goal of matching the two parties within the neighborhoods where they live.

Data Collection

Previous literature has indicated that effective outreach should meet target audiences where they live and spend a majority of their time. Therefore, this project focused on gathering data to assess provider and consumer needs in their various communities. Firstly, consumer and provider addresses were gathered from the Public Authority's mailing list and categorized by zip code. Provider and consumer residences in each zip code were compared to existing census data from the database Policy Map, to show potentially underserved target populations. The assump-

tions here were that communities with high instances of seniors living in poverty would be more likely in need of IHSSPA services, and communities with high unemployment would be more likely to show interest in becoming a provider. Furthermore, a provider Focus Group indicated that community centers were helpful in informing them how to become employed by IHSS. Community outreach was performed by visiting and contacting different community institutions. Staff at the community organizations were interviewed to assess their level of knowledge about IHSS services, and the types of information their clients would need to become more informed about these services. Finally, an online survey was sent to providers in order to gather data about the challenges in enrolling for the position and being matched with a consumer.

Results

Data from provider and consumer mapping showed that residences for both parties were disproportionally located in one or two main zip codes. For consumers, the highest percentage of residences are located in the Tenderloin/ North of Market neighborhood, and for providers, the highest percentage lived in Crocker Amazon/ Excelsior, followed closely by residences outside San Francisco county. When performing community outreach it was discovered that out of five community resource centers visited, zero had any information posted about IHSS or even the overarching Department of Aging and Adult Services (DAAS). However, staff at two of the resource centers were eager to post information about IHSS including postcards on upcoming trainings and information on how to become a provider or consumer. Community center staff also expressed interest in having IHSSPA come to their space to make a presentation and educate their clients.

By increasing outreach to community resource centers, consumers could potentially find more providers that live within their own community and visa versa. An IHSSPA provider survey indicated that 72% of providers agreed that they would be able to take on more consumers if they all lived within the same neighborhood. To this point, providers may be able to handle more consumers and earn more money if the consumers they work for are centered in their own community. Unlike the Focus Group participants, survey participants believed that they were able to maintain a professional relationship with their consumer, and believed that the consumer was a good match for them. These opinions were consistent between providers who had worker for a friend/family member and those who had not.

Implementation and Recommendations

By presenting this data and points of communication to different community resource centers, IHSSPA can continue to perform community outreach even after this project is finished. This outreach will foster sustainable provider/consumer relationships in underserved neighborhoods. Sustainable outreach will involve keeping open lines of communication with community center staff, and replenishing educational materials at these sites when needed.

Literature Review

Introduction

Since 1973, In Home Supportive Services (IHSS) has served low income seniors (aged 65 and over) and disabled individuals in California (CICAIHSS, n.d.). These individuals are known as IHSS "consumers" who are matched with home care workers or "providers." A provider could be a chosen family member or friend, or someone independently contracted to provide assistance to the consumer with tasks such as bathing, cleaning, laundry, etc. Over the

years, some of the challenges IHSS has faced include engaging their target population of consumers and matching them with available providers. The consumers are often living alone with little social support and access to transportation, decreasing their reachability. Consumers also face challenges when enrolling for services because they may have auditory, visual, or cognitive disabilities. The multiple steps needed in order to apply for IHSS services, hire a provider, and manage provider time sheets can be overwhelming to this vulnerable population. For this reason, there is a high instance of consumer dropout. In San Francisco, the Public Authority component of IHSS has sought to decrease instances of dropout by providing consumers with additional support such as the use of mentors. Mentors are consumers who have successfully hired their own provider and have received training on instructing others to do the same. Mentors help guide the consumers through the process of enrollment and hiring a provider. However, multiple modalities of continual outreach may be needed to increase consumer enrollment and prevent consumer dropout. Some of these modalities include community-based outreach, referral-based outreach, and advertisement/informational outreach.

Another target audience to IHSS is comprised of the independent providers. Providers have their own challenges when enrolling and finding consumers for whom they feel comfortable working. Currently, a high percentage of San Francisco IHSS consumers have providers that live outside of San Francisco county and may travel as long as three hours to get to work. In addition, providers may have difficulty completing the enrollment process which takes time and additional cost. Fortunately, because provider demand is high in San Francisco county their is a good chance of employment for potential providers. However, outreach for both target audiences

needs to be improved upon so that consumers and providers may establish and maintain stable working relationships.

Challenges to Consumer Outreach

For consumers to enroll and participate in public health programs such as IHSS, substantial social support is often needed to guide them through the multiple steps. Social support comes from a variety of different sources such as family, friends, neighbors, social workers, support groups, and local resource centers (Li, Ji, & Chen, 2014). Social support has been found to increase emotional well being, self-efficacy, and quality of life among seniors (Belanger et al, 2016). These psychological factors play a large role in the ability to persevere through challenges in applying for IHSS and hiring a provider. For example, self-efficacy is needed in order for seniors to become capable employers and communicate their needs to a provider. Unfortunately, consumers often face difficulties when accessing social support due to physical disabilities that limit transportation and communication skills. According to a 2013 report by SFGOV, San Francisco residents above the age of 60 are more likely to live alone than their counterparts in any other county of California (SFGOV, 2013). Furthermore, a needs assessment conducted by the Department of Aging and Adult Services (DAAS) in San Francisco found that 40% of Adult Protective Services cases for those over 65, were pertaining to self neglect as a result of isolation (SFDAAS, 2016).

In order to help isolated seniors in the San Francisco area, the Department of Aging and Adults Services (DAAS) has increased funding to the Community Living Fund (CLF) which helps seniors who are at risk of being institutionalized stay in their homes. The CLF contributes to helping seniors find adequate healthcare and community resources through the use of a case

manager who may also offer IHSS services (SFDAAS, 2016). From 2015-2016 the CLF yearly budget was increased by 1 million dollars (SFDAAS, 2016). However, the DAAS has also included in their reports that case managers often struggle to meet the needs of their case load, resulting in fewer home visits and assessments (SFDAAS, 2016). In addition, there is a high turnover rate in the case management field because of low wages and increased work load (SFDAAS, 2016). Therefore, although there is funding available to help seniors stay in their homes, currently man power is lacking to handle the needs of this vulnerable population. The Public Authority has sought to increase support for consumers by integrating a mentorship program. The mentorship program assists newly enrolled consumers by arranging home visits from consumers who have successfully completed the program. While this method has benefitted many of their current consumers it does not address the problem of reaching out to potential consumers.

Evidence-Based Models for Consumer Outreach

Community-Based Outreach. Community-based outreach is guided by the principle of increasing participation in a target population by meeting people where they are. Even though San Francisco residents are not considered to be living in a rural environment, there are still challenges surrounding transportation which inhibit individuals from accessing IHSS services. For example, individuals with disabilities and chronic conditions may need specialized modes of transportation or escorts to ensure safety. Past research has indicated that educational outreach performed in local institutions such as libraries, community resource centers, churches, etc. have increased attendance and participant retention (Broering, Chauncey, & Gomes 2006). Community based outreach models may also adapt to the specific needs of the individual community by offering materials in different languages and providing culturally relevant information. For ex-

ample, one study used local libraries to conduct workshops allowing seniors to learn how to look up health information over the internet (Broering et al, 2006). The study found out that attendance was improved over the course of several workshops because community notoriety had increased by word of mouth (Broering et al, 2006). In addition, the researchers found that they had increased positive feedback when they provided additional information that was relevant to a particular culture. To address this point, the researchers added how to access online information on Eastern medicine when holding workshops in Asian communities. One limitation of community based outreach is that it often delivers information in workshops or group settings where individuals may have a range of understanding and comprehension. Therefore, it is necessary to provide a diverse array of teaching materials and provide one-on-one support when necessary (Broering et al, 2006).

Referral-Based Outreach. Another outreach technique described by Bartsch and Rodgers (2009) aimed to utilize both traditional and non-traditional referral sources in order to improve health outcomes for seniors. These referral sources were trained to increase awareness of an informational hotline for local mental health services. The referral sources were rooted in certain counties of Washington state that had exhibited higher suicide rates for persons over 60. The non-traditional referral sources were trained staff in local retail outlets, restaurants, and senior centers so that they could identify older individuals in distress and living alone. Trainings were also provided to the more traditional referral sources such as nurses and physicians in the clinical setting. In one county the researchers found that 41% of seniors were referred to the hotline by non-traditional sources (Bartsch and Rodgers, 2009). In this sense, the model proposed in

this study is not unlike community-based outreach because it relies partially on word of mouth within the communities where seniors live.

Another type of referral-based outreach that may be applicable to IHSS consumers occurs around the period where patients are discharged from the hospital. Often times IHSS consumers may need assistance from providers during the time when they are discharged from the hospital and readjusting to life at home. Studies have indicated that if care is not properly coordinated for elderly patients after discharge they are at increased risk for at home injury and readmission to the hospital (Toye et al, 2015). Interventions to prevent injury at home include coordinated care with hospital nurses and family caregivers (Toye et al, 2015). In this case, nurses are trained to help a patient designate a home caregiver before discharge. The nurses then contact the family caregiver within each following week after discharge to address their comprehension of the discharge instructions and duties (Toye et al. 2015). This intervention could be very useful to those who can obtain a family caregiver to help them during their recovery period. However, for the many individuals who cannot procure such care, IHSS type services may be needed.

Advertisement/ Informational outreach. Another form of outreach that has shown to be effective within the senior population is through the use of media such as mail out booklets, flyers, and radio/newspaper ads (Olson, Grossman, Fu, & Sabogal, 2010). In this case, elderly individuals are given increased access to relevant information by having it sent or transmitted straight to their homes. In addition, having the multiple forms of media can accommodate persons with differing abilities. For example, radio advertisement may be more effective for those who are visually impaired whereas flyers may be more effective for the hearing impaired. Studies often find media outreach to be most effective when accompanied with a cue to action, such

as calling a support center to find more information (Olson et al, 2010). This strategy, while highly effective in smaller communities, may not be practical for San Francisco county because of the expenses associated with urban media campaigns.

Challenges to Provider Outreach and Retention

The complexity of consumer needs is also reflected in the high demand for providers. Currently, IHSS serves around 22,000 consumers in San Francisco County but there are only about 250 active providers on the Public Authority registry (IHSS, n.d.). This means that remaining consumers often use outside sources for finding providers such as asking friends and family or putting out help wanted ads. One of the reasons that individuals may not be attracted to working for consumers, is that often times consumers struggle with describing how IHSS works and cannot accurately portray their needs, making the job description unclear. In addition, consumers often live under poor living conditions where providers may be exposed to hazardous materials and inadequate equipment for performing tasks (Howes, 2004). The image of IHSS consumers has also been perpetuated negatively as individuals who have high needs, living in crowded spaces or cramped single resident occupancies (Howes, 2004). For this reason providers may seek employment at private caregiving agencies instead, which often provide the same wages. Furthermore, there are added pressures for providers outside of the registry because they receive minimum wage with no health benefits (Westerfield, 2015). However, the main issue is that most consumers and providers are of low socioeconomic status and underrepresented populations in our society (Westerfield, 2015). Therefore, both parties need increased support and resources from IHSSPA when becoming a part of the program.

Overcoming Challenges to Provider Outreach and Retention

While there is currently little research on evidence-based models for home care provider outreach, past research has indicated that provider retention is improved by establishing worker cooperatives or unions (Majee & Hoyt, 2009). Unions not only allow workers to advocate for their rights but also allow them to be a part of a larger community with interpersonal support systems (Majee & Hoyt, 2009). To this point, IHSSPA has established a provider registry which not only includes health benefits for providers but also training on how to help consumers with activities of daily living in a safe manner. However, as stated earlier, a large portion of providers are not enrolled in the registry. Similar to consumers, one of the main obstacles for providers not enrolling in the registry is lack of accessibility. In order to be listed providers need to be present at the Public Authority office in San Francisco to complete trainings and paperwork. Providers who live far from San Francisco may not prioritize the benefits of taking the time to enroll in the registry over added travel expenses. Therefore, providers may be in need of the same types of community-based outreach that consumers would benefit from. Community-based outreach should educate providers on the IHSS process as well as offering continuing support on how to handle challenges with consumers. Retention of providers will also likely increase if consumers are knowledgable about how IHSS works and what they need from their providers.

Conclusion

In order for IHSS to expand its services to more consumers in need of care and providers in need of work, the organization needs to provide more tailored, targeted outreach to local communities. IHSS can target areas of San Francisco that are currently underserved to both consumers and providers and increase accessibility to both groups. In addition, providers may be

more attracted to working for consumers that live within their own neighborhood because of decreased transportation time and familiarity. Outreach to providers in other counties is more complicated because each county has its own IHSS. However, the San Francisco IHSS may set an example by improving accessibility to the provider registry and by providing enhanced training toward consumers so they can become better employers.

Agency Profile

History

In Home Supportive Services began in 1973 with the goal of protecting the rights of independent providers, namely paid caregivers (CDSS, n.d.). In the 1990s, the addition of the Public Authority to the IHSS allowed independent providers (IPs) to be employed through this agency and listed on the provider registry (SFIHSSPA, n.d.). This benefitted IPs in San Francisco by allowing them to have a union contract, increased wages, and health and dental coverage (SFIHSSPA, n.d). In 2008, after drastic cutbacks were made to IHSS by the San Francisco government, over 4,700 consumers provided testimonies on how these cutbacks would cause personal hardship (SFIHHSPA, n.d.). As a result, the consumer mentorship program was re-instituted by the Public Authority to support seniors moving from institutions back into the community by guiding them through the IHSS program. In 2009, IHSSPA partnered with Laguna Honda Hospital to offer its services to hospital patients transitioning back to their homes (SFIHSSPA, n.d.). This partnership aimed to reduce the instances of re-hospitalization and accidents in the home. In recent years, the IHSSPA continues to form community partnerships with local organizations and healthcare centers.

Purpose

The Public Authority provides assistance to consumers enrolled in IHSS to help them find an appropriate independent provider. IPs offer support to consumers by assisting them with activities of daily living within the home. This service lowers the risk of accidents in the home and increases an individual's capability to live in their residence as opposed to a skilled nursing facility. In addition, about 60% of IHSSPA consumers choose their family members as their IPs, allowing them to be paid for work they might have done voluntarily (SFIHSSPA,n.d). For some families, this may decrease the financial burden of staying at home to take care of a loved one. When a consumer is not able to choose their own IP due to mental or physical disability, they may seek assistance from the non-profit Homebridge. Homebridge assigns providers to those who are in need of increased care through a process called County Contract mode. The Department of Aging and Adult Services (DAAS), which oversees IHSS, has also contracted Homebridge to provide specialized trainings to IHSS providers. These trainings are conducted by licensed home care workers and aim to increase the quality of care that IPs provide for their consumers.

Funding

The Public Authority is funded through Federal, State and County funding. In fiscal year 2015-2016, 56% of the budget was funded through Federal dollars, 42% was funded through County dollars and 2% was funded through State dollars (SFIHSS Public Authority, 2016).

Mission Statement

The mission of the SFIHSSPA 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" (SFIHSS Public Authority, 2018).

Services Provided

To provide individualized support the IHSSPA customizes their provider registry list to fit the preferences of each consumers. They also offer training programs on how to hire the right provider through phone interview. Their unique mentorship program is designed to pair up long-time consumers with new consumers to guide them through the program, through in person meetings. Mentors will meet their assigned consumer at their residence, to walk them through the steps and provide emotional support. In addition, the one of the main goals of the mentor is to help the consumer be their own advocate through becoming an employer of their IP. For providers, trainings are also given at the IHSSPA office to ensure they are conducting care safely.

Agency Staffing

The SFIHSSPA is made up of a paid Board of Directors and 20 paid staff members. The governing board is made up of consumers, public agency representatives, and worker and union representatives. Some of the positions held by staff are the Executive Director, Deputy Director, Director of Finance and Operations, Registry Program Manager, Mentorship Program Manager, Senior Human Resource Generalist, Mentorship Service Coordinator, Benefit Coordinator for IP's, One-Stop Center Resource Coordinator, Support Services Counselor, and On-Call Program Coordinator. The SFIHSSPA is also staffed by various mentors who are part of the Mentorship Program (SFIHSS Public Authority, 2018).

Target Population

IHSSPA's target population of consumers is low-income seniors and persons with disabilities, who qualify for Medi-Cal or who are receiving social security payments. The majority of SFIHSSPA consumers make around 800 dollars a month or less and are over the age of 60 (Gutierrez, 2018). Currently, about 38% of SFIHSSPA clients live in the Tenderloin neighborhood, in which an estimated 562 families are living below the poverty line (Gutierrez, 2018; SFDPH, 2012).The current SFIHSSPA consumers come from a diverse set of backgrounds, with many who do not speak English. SFIHSSPA has attempted to adapt outreach to their target audience by offering information about the organization in multiple languages and reaching out to underserved populations. Another target population to IHSSPA are the independent providers. Independent providers may be a friend or family member to the consumer, or an individual pursuing work in the health/home care field. Many providers work under San Francisco's IHSS because of the higher wages available and increased resources through the Public Authority. The PA is continually looking to build upon their provider registry so that they may offer a larger pool of providers to consumers in need of support at home.

Problem Statement and Study Aims

This project aimed to find potentially underserved target populations of IHSSPA in San Francisco County. In San Francisco, adults reporting disabilities are more likely to be low income compared to those without disabilities (SFDAAS, 2016). Thirty-five percent of adults in San Francisco with disabilities have an income that is 100% below the poverty line (SFDAAS, 2016). In addition, disability rates are continuing to rise as our aging population continues to increase (SFDAAS, 2016). It is important to support and spread knowledge about organizations

such as IHSSPA which allow these seniors to stay in their homes safely. In addition, it is important to make sure that there are enough providers to meet the needs of the growing senior population. Currently, provider demand is high, making it increasingly difficult for consumers to find available workers.

To address these issues, the project aimed to target both providers and consumers in communities that may currently lack the necessary information about IHSS and the Public Authorities services. Through provider and consumer mapping, a provider Focus Group, direct community outreach, and a provider survey, the project goal was to provide the Public Authority with a foundation for sustainable community outreach.

Methods

This study aims to find the best methods of recruiting new IHSSPA providers and consumers, with an emphasis on creating lasting working relationships between the two parties. Areas of San Francisco that may be currently underserved by IHSSPA were targeted for outreach. In addition, qualitative data was gathered from providers to see how future provider recruitment and retention could be improved.

Provider and Consumer Mapping

Sample. Provider and consumer addresses were compiled by the data manager at IHSSPA. These addresses were submitted to IHSSPA upon enrollment, when individuals signed up to be part of the organization's mailing list. The sample included 673 providers and 1036 consumers. All consumers live in San Francisco County, while providers often come from the larger Bay Area. To ensure privacy, all identities associated with addresses were omitted before sending the data electronically to the project manager.

Mapping Procedures. Provider and consumer addresses were mapped using the maps function in Google maps. Neighborhoods were defined as residences within the same zip code as listed by HealthySF.org. The maps were used to find areas of the city where there were fewer consumer and provider addresses. The website Policy Map was also used to find areas of high adult unemployment (14% or higher), and increased residents over 65 living in poverty (above 13%). This data was compiled from trends in the San Francisco census from 2012-2016. By triangulating the Policy Map data with consumer and provider addresses it was possible to hypothesize which neighborhoods are potentially in need of more support from IHSSPA. One of the limitations of using this data is that addresses are self-reported and updated by the participant themselves. In other words, providers and consumers may report their addresses incorrectly or submit no change of address after moving.

Focus Group

Sample. Participants in the Focus Group were current SFIHSSPA providers, selected from the provider registry. Twenty individuals were selected randomly from a subset of the registry who speak fluent English, and live within SF county. Mail out invitations were sent to these individuals two weeks before the Focus Group date, expecting a 25% response rate. Sending of IHSS invitations to providers was handled by the Registry Specialist. After one week of receiving fewer responses than expected from mail out invitations, a text blurb was sent out to the remaining 18 who agreed to SMS notifications from IHSSPA. The SMS notifications prompted more people to sign up for the Focus Group.

Focus Group Procedures. Focus Group invitations included the location of the Focus Group at the IHSSPA main office, and offered the incentive of a 10 dollar gift card upon comple-

tion of participating. The Registry Specialist submitted the final list of names who agreed to participate to the Focus Group leader. The Focus Group leader was responsible for developing the Focus Group questions, audio recording the Focus Group, and electing a notetaker. Questions were formatted based on the guidelines developed by Community Tool Box, an online database developed by the University of Kansas Center for Community and Health Development (See Appendix A, Focus Group Questions). The notetaker was given instructions to record notes on responses as well as non-verbal cues that indicate agreement, disagreement, points of consensus, etc. The notetaker was also requested to record observations on an individual level, indicating each participant as P1- P5 (no actual names recorded). Upon arrival each guest was given a name tag, and was provided with snacks and refreshments. Questions that required participants to make lists or vote on a certain topic were written up on large post it notes to encourage participation without prompt from the Focus Group leader.

Data was analyzed by giving codes or abbreviated titles to major themes among Focus Group answers. These themes were collected from the audio recording as well as the notetakers transcription which assigned statements to individuals. The Focus Group Leader also categorized areas of majority agreement versus disagreement based on verbal and nonverbal cues. The major findings were presented in a memo and distributed to key IHSSPA stakeholders such as the Deputy Director, Executive Director, and Program Manager.

Interviewing Community Center Staff

Five community centers were chosen for data collection, of which three were open to collaborating with my project as a part of IHSS. I visited each of the collaborating community centers to conduct a 10-15 minute interview with staff based on their availability. The questions of

this interview were focused on determining the staff's level of knowledge about IHSS services, the demographics of who comes to the community center, and their willingness to disperse IHSS information (See Appendix B, Community Center Interview Questions). A sample of IHSS materials were displayed to staff, including pamphlets, brochures, and postcards in different languages. Utilizing the information gathered in these interviews, the IHSSPA Resource Coordinator was consulted to build a packet of informational materials about IHSSPA services and upcoming trainings. These materials were suited to the language preferences and interests of each consenting community center. Once the packets were arranged, they were delivered to the community center staff along with contact information to IHSSPA for additional support and renewal of materials. In addition to the community center interviews, a 15 minute phone interview was conducted with a staff member at the local Community College career development center. This interview aimed to find out how IHSS might improve their outreach to younger individuals interested in starting their career in healthcare by becoming a provider.

Registry Provider Survey

Design and Sample. An electronic survey was prepared and emailed to 163 providers on the Public Authority registry. The survey included three preliminary questions which assessed if the provider lived in San Francisco County, their primary method of transportation, and if they had ever worked for a family member or friend as their consumer. Following the preliminary questions, there were nine statements which participants could indicate their response based on an agreement scale (Strongly Agree, Agree, Neither Agree nor Disagree, Disagree, or Strongly Disagree). A copy of the full survey can be found in Appendix C. The provider survey was emailed to the same 163 individuals twice, to acquire a final sample size of 52 participants.

Data Analysis. Data was collected and tabulated by a survey website, which collects the number of replies under each response category (Strongly Agree to Strongly Disagree). In addition, data was divided into response categories for the preliminary question "have you ever worked for a friend or family member as their provider," in order to see if there was any difference in opinions between these two groups.

Findings

Provider and Consumer Mapping

Results of consumer mapping from 1,060 addresses indicated that the highest percentage of IHSSPA consumers (38.8%) live within the 94102 zip code which encompasses the Tenderloin, Hayes Valley, and North of Market (NOMA) neighborhoods. Comparatively, all other neighborhoods in San Francisco show far fewer consumer residences ranging from 1% in West Portal to no addresses listed in SOMA, Potrero Hill, and sections of Chinatown.

For providers, on a list of 673 addresses the highest percentages were outside of San Francisco county (14.7%) and the Ingleside/ Excelsior/ Crocker- Amazon district (15%) . Of those living outside of San Francisco county, Daily City is the most common place of residence. However, providers also live as far as Riverbank, around 97 miles away from the IHSSPA office. Followed by Ingleside, most providers are living in the Bayview district.

For both providers and consumers there is a general trend seen which shows that residences are dispersed throughout the city but at fairly low numbers. In particular, the Richmond district has a low number of both providers and consumers compared to its population size of approximately 59,297 and instances of individuals who are elderly and living in poverty. In Table 1 below, provider and consumer residences in each San Francisco neighborhood may be com-

pared side by side. Consumer and provider neighborhoods are categorized based on their zip codes, with the number of individuals living in these areas in parentheses as well as the percentage from total providers/consumers listed.

Table 1

Comparison of Provider and Consumer Addresses by Zip Code

Consumer Neighborhood/ zip code	Percent/ number of Consumer Residences	Provider Neighborhood/ zip code	Percent/number of Provider Residences
Hayes Valley/Tenderloin/ North of Market (94102)	39.6 % (411)	Hayes Valley/Tenderloin/ North of Market (94102)	4.6% (31)
South of Market (94103)	0	South of Market (94103)	5.4% (37)
Potrero Hill (94107)	0	Potrero Hill (94107)	2.3% (16)
Chinatown (94108)	0	Chinatown (94108)	2.2% (15)
Nob Hill/ Polk (94109)	6.9% (74)	Nob Hill/ Polk (94109)	4.1 % (28)
Inner Mission / Bernal Heights (94110)	7.6% (81)	Inner Mission / Bernal Heights (94110)	8.6% (58)
Ingleside-Excelsior/ Crocker Amazon (94112)	7.9 %(84)	Ingleside-Excelsior/ Crocker Amazon (94112)	15% (101)
Castro/ Noe Valley (94114)	1.9% (21)	Castro/ Noe Valley (94114)	1.1% (8)
Western Addition/ Japantown (94115)	5.3%(57)	Western Addition/ Japantown (94115)	3.1% (21)
Parkside/ Forest Hill (94116)	2.8% (30)	Parkside/ Forest Hill (94116)	3.4% (23)
Haight Ashbury (94117)	1.9% (21)	Haight Ashbury (94117)	.8% (6)
Inner Richmond (94118)	2.6% (28)	Inner Richmond (94118)	1.6 % (11)
Outer Richmond (94121)	2.6 %(28)	Outer Richmond (94121)	1.7% (12)
Sunset (94122)	3.1% (33)	Sunset (94122)	2.5% (17)
Marina (94123)	0.9% (10)	Marina (94123)	.4% (3)
Bayview/ Hunter's Point (94124)	4.7% (50)	Bayview/ Hunter's Point (94124)	10.1% (68)
West Portal/ Miraloma (94127)	1% (11)	West Portal/ Miraloma (94127)	1.0% (7)
Twin Peaks/ Glen Park (94131)	1.2% (13)	Twin Peaks/ Glen Park (94131)	1.1% (8)
Lake Merced (94132)	2.2% (24)	Lake Merced (94132)	2.2% (15)
North Beach/Chinatown (94133)	2.6% (28)	North Beach/Chinatown (94133)	4.4% (30)
Visitation Valley/ Sunnydale (94134)	3.0% (32)	Visitation Valley/ Sunnydale (94134)	8.7% (59)
		Daily City	28
		Other (outside SF County)	71
		Total percent	
		14.1%	

Policy Map Research

To elucidate areas in need of outreach from IHSSPA, Policy Map was used to find possible target populations. To find out where possible consumers are, the Policy Map database utilized data from the 2012- 2016 census to indicate which areas of San Francisco had higher instances of individuals 65 and over living in poverty. The data indicated that Mission, Bayview, Tenderloin, Western Addition, and Richmond districts all had residents over 65 living in poverty at 13% or more. To indicate where potential providers might reside, Policy Map was also utilized to elucidate areas of higher unemployment (14% or higher) in the broader San Francisco Bay Area. The database indicated that unemployment in San Francisco county is highest in Bayview and Ingleside. Outside of San Francisco County, unemployment is high in areas of Oakland and Richmond.

Figure 1. Policy Map Data of Seniors Living in Poverty in San Francisco

Figure 1. Policy Map data indicates areas with higher percentages of seniors living in poverty (13% or higher) in darkest purple color.

Figure 2. Policy Map Data of Unemployment in San Francisco.

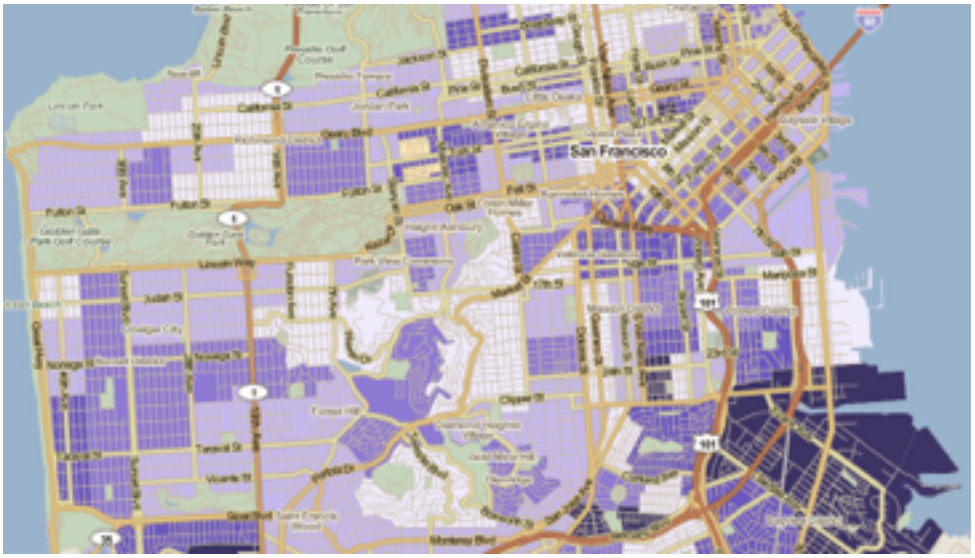

Figure 2. Policy Map data indicates areas with the highest percentages of unemployment in the darkest purple color (14% or more).

Provider Focus Group

The five participants of the provider Focus Group were all current and active members on the Public Authority's provider registry. During the provider Focus Group, participants were eager to contribute their experiences and ideas to improve IHSSPA services. The major topics covered were how the providers found out about IHSS, obstacles encountered in enrolling as an IHSS provider, the quality of their match with consumers, and how outreach to new providers could be improved. Several participants indicated that they had found out about IHSS from community centers or the local community college. Others indicated that they found out through a social worker or through their workplace at a skilled nursing facility. All group members indicated that they found out about the additional services of the Public Authority several weeks after enrollment. The major obstacles in becoming a provider seemed to be centered around the lack

of trainings and the length of enrollment process. Some providers indicated that the provider enrollment and background check took too long and caused additional expense. Others indicated that the trainings needed to become part of the registry were not frequent enough, and did not accommodate their schedule. One participant indicated that "there should be more trainings on how to say 'no' to consumers." This idea was rooted in a conversation between participants that even if providers make it through the enrollment process, they are often paired with consumers who may ask them to do unauthorized or even fraudulent tasks. Another individual suggested that there needs to be more training in completing more involved tasks for consumers such as tolieting and bathing.

When asked if they experienced good matches with consumers the majority of providers indicated that they had issues with consumers being too demanding and asking providers to do tasks outside of their capability. Due to the fact that there is a growing need for providers, participants also indicated that they felt they had taken on more consumers and working hours than they could handle. However, the high demand for provider support did lead to almost immediate employment after enrollment. All participants indicated that they would not recommend becoming an IHSS provider because of the low job security of the position. Participants indicated that difficult consumers sometimes find reasons to fire providers or ask them to share their earnings. One participant stated that in order to recruit more providers "the benefits of the registry should be emphasized." In this case, the participant was referring to the medical and dental benefits that registry providers receive. Participants also had ideas for outreach platforms that IHSSPA could utilize such as: radio ads, increased advertising at colleges and universities, and utilization of more current technology such as smartphone apps. In addition, all participants agreed that they

would benefit from increased trainings and opportunities for upward mobility. Some ideas for upward mobility included gaining certificates for trainings and increased opportunity to apply for on call positions with higher pay. Below in table 2 is a summary of important quotes from the Focus Group as well as major concepts that arose from the discussion.

Table 2
Focus Group Quotes from Participants and Major Concepts

Concept	User Quotes
Finding out about IHSS services	"I found out when I was in college, when I was taking care of my grandmother, our social worker recommended IHSS" "At the Cortland Avenue retirement community help center, near to where I live" "From the skilled nursing facility I was working at"
Encountering additional Public Authority Services	"..found out online, a few weeks after enrollment"
Obstacles in becoming a provider	"The process of enrollment was too long, it took months" "…trainings are not often enough"
Matching with consumers	"I was matched right away" "My First consumer was not a good match" "My consumer was bossy and did not know boundaries" "The need was so great that I had too many consumers, more than I could handle"
Recruiting/ recommending the provider position to others	"I would not recommend being a provider because there is little job security when dealing with difficult consumers" "The benefits of being on the registry should be emphasized" "The system needs to be fixed before more providers are recruited, we need more support from social workers"
Providing incentives	"There should be reimbursement for traveling into the city, especially for trainings" "There should be incentives for joining the registry" "Gift cards would be okay"
Outreach platform ideas	"Churches could help spread information" "You could try an ad on local radio" "There should be increased outreach at local colleges and universities" "IHSSPA could have an informational app"
Quality of Trainings	"The trainings were good but need to be a lot more often" "There should be more trainings for providers on how to say 'no' to consumers"

Community Center Visits and Interviews

Out of the five community centers visited, three facilities indicated a willingness to partner with IHSSPA. The five community centers were located in Bayview, the Sunset, and the

Richmond Districts. The three community centers that were interested in the project were Richmond Senior Center, Golden Gate Senior Center, and Jackie Chan Senior Center located in the Richmond district of San Francisco. Of the staff interviewed at each community center, only one indicated having prior knowledge of IHSS services. This staff member at the Richmond Senior Center had previous knowledge of IHSS because she is a licensed social worker, but was unclear about what the additional services of the Public Authority were. In addition, none of the centers had any existing information about IHSS on display. Two community centers in the Richmond District (The Richmond Senior Center and Jackie Chan Senior Center) agreed to display IHSSPA information.

Due to the large population of Chinese residents in the Richmond District staff indicated that informational materials should be in both English and Chinese. Both the Richmond Senior Center and Jackie Chan Senior center staff members believed that they currently had consumers who regularly visited the center with their providers. The same centers indicated that they believed most of the visitors where eligible for Medi-Cal. In addition, staff at the Jackie Chan Senior Center indicated that "sometimes younger people come in looking for job postings, to see if any of the seniors need care." For this reason, she believed that what was most needed were educational materials that explained the process of both becoming either a consumer or provider. In addition, the senior centers visited were open to the idea of having the center be a place where consumers could meet their providers and interview them. Staff members were also interested in having educational materials in order to have tools to educate interested individuals. Upon taking this information back to the Public Authority, the resource coordinator selected a few materials to be distributed to both centers in the Richmond district. These materials included two informa-

tional postcards about how to become a consumer or provider as well as a postcard about upcoming trainings hosted by IHSS, all information given was in both Chinese and English.

Community College Interview

The phone interview conducted with the Community College career center staff indicated that their office had no prior knowledge about IHSS. After presenting more information to staff, it was indicated that they were comfortable introducing IHSS as a possible source of employment to students. They also recommended that IHSS should post provider job offerings on the City College job portal website. Staff at city college also indicated that current providers might find home health aide courses helpful, which are free for San Francisco residents. This need was reflected in the Focus Group where participants indicated a need for more frequent trainings.

Provider Survey

Survey questions were designed to reflect key components of the Focus Group outcomes. Of the 168 registry providers the survey was sent to, 52 responded. Out of the 52 respondents, 79.5% lived in San Francisco County, 69% use public transport as their primary transportation, and 50% had worked for a friend or member before (See Appendix D, Figure 3). Contrary to the Focus Group, 86.2% of providers either agreed or strongly agreed that the Public Authority helped them find consumers that were appropriate for their skill set (See Appendix D, Figure 4). In support of the goals of this community outreach project, 71.5% of consumers indicated that they agreed they could take on more consumers if all their consumers lived within the same neighborhood (See Appendix D, Figure 5). In addition, 96% agreed or strongly agreed that they have been able to maintain strong professional relationships with their consumers (See Appendix D, Figure 6) and 80% agreed that Public Authority trainings were often enough. However, in ac-

cordance with the Focus Group participants, 48% of the survey respondents either agreed or strongly agreed that consumers often ask them to do tasks that are unauthorized (See appendix D, Figure 7). In addition, 39% of survey participants either disagreed or strongly disagreed with the statement “I would feel comfortable saying "no" to consumers if they ask me to do a task outside of my responsibility.”

It was taken into account that providers who have worked for friends or family members may have differing opinions about their consumers/consumer matching than those who had a consumer assigned by the PA. However, between the two groups a side by side comparison of the data revealed little change in opinion on their matches with consumers and their ability to maintain stable relationships with consumers. The only apparent difference was that 61% of providers who did not work for a friend or family member agreed more with the fact that consumers often ask them to do unauthorized tasks, compared to 31% who had worked for a friend or family member (See Appendix D, Figure 8).

Discussion

Finding Neighborhoods Underserved by IHSSPA

The purpose of this study was to assess the needs of current providers and consumers at IHSSPA and inform future community outreach protocols. Mapping of consumer and provider addresses indicated that the majority of consumers live in the 94102 zip code, close to the IHSS and DAAS headquarters. However, there are no consumer addresses listed for the SOMA area where the Public Authority office is actually located. This is surprising due to the fact that the Public Authority has partnerships with community centers around their office. This may be because SOMA residents today are mostly young professionals, and rent has increased significantly

in this area. It is also important to recognize that addresses and zip codes have varying definitions in terms of neighborhood. The lists of provider and consumer addresses were standardized and grouped based on zip codes defined by HealthySF.gov and not self-reported neighborhood. These neighborhoods were comparable to Policy Map definitions. Through Policy Map we can see that there are many other neighborhoods in San Francisco with high instances of seniors living in poverty. The Richmond was one of these areas, and was also selected for community based outreach because of the existing resources centers available to seniors in the area. However, there are many other areas that may need more support from IHSSPA. It is hoped that increasing knowledge about this organization will help the spread of information by word of mouth to communities across San Francisco. In addition, this project presents IHSSPA with a generalizable procedure on how to approach new community centers and understand their needs. This will increase the Public Authority's ability to connect with potential consumers and providers across the city.

Provider mapping indicated that there are high percentages of current providers who live in Ingleside/ Excelsior/ Crocker- Amazon and Outside SF county. Interestingly, Policy Map data has also indicated that unemployment also occurs at higher rates in the Excelsior/ Crocker- Amazon compared to most other SF neighborhoods. This may suggest that IHSS has successfully reached areas in need of work, but further action could be taken to reduce unemployment. It is possible that provider opinions about job security and stability may effect their willingness to recommend IHSS as an employer to their friends and neighbors. For this reason, community outreach should continue to provide information on provider support and assistance through the Public Authority and well as the added health benefits of joining the registry. In addition, the

Public Authority could consider incentivizing their current providers to recommend the position to others in their community.

Provider Focus Group

Current providers who participated in the Focus Group brought forth some interesting suggestions for new provider recruitment and retention. The participants seemed to suggest that before recruiting more providers more support needs to be given when experiencing challenges at work. Members of the Focus Group indicated that there is a need to educate consumers on what providers can and cannot do. In addition, members felt that there is low job security when dealing with difficult consumers. Consumers may let go of their providers at any time, possibly before receiving a first paycheck. This might deter current providers from recommending IHSS as a form of employment to others in their community. Therefore, it is necessary to also educate current providers about ways to access additional support from the Public Authority such as trainings hosted by the One-Stop resource center and educate consumers on appropriate expectations.

Providers also indicated a desire for more training and opportunities for upward mobility. Members would like the opportunity to earn more than minimum wage by participating in more training and becoming eligible for on-call status. Upward mobility could also be an attractive prospect to those who are unemployed or looking to begin their career in healthcare, such as new college graduates. Currently, there are many providers who commute to San Francisco because of the higher minimum wage. Opportunities for even higher pay and career advancement might attract more from the larger Bay Area and help compensate for the additional commute time.

Members of the Focus Group had several different ideas for outreach programs to reach new communities. These ideas included reaching out to community institutions such as community centers, churches, and local colleges. Based on these suggestions, I decided to contact local community centers and the career center at City College of San Francisco. However, it would be interesting for future studies to investigate the role that local San Francisco churches could have on recruiting new IHSS providers. In congruence with the research from Majee & Hoyt (2009) members of the Focus Group also shared the opinion that the benefits of becoming part of the registry are critical to attract new providers. New providers will likely be more interested in enrolling if they know that they are a part of a union and will receive medical and dental benefits.

Community Center Visits

Through my visits to five senior community centers in San Francisco, I found no information displayed about DAAS, IHSS, or the Public Authority. The Sunset Senior Center had the DAAS number to call for reporting a grievance about the services provided at the center, but no additional information. However, there are places where these centers display information about senior resources and referrals. Of the three centers that I was able to make connections with, the Jackie Chan Center Senior Center and Richmond Senior Center had increased accessibility to seniors with disabilities and programs free of cost. These centers also indicated that they would be comfortable with consumers interviewing potential providers at their facility. Contacts at these centers have been made in order to establish a line of communication with IHSSPA. The resource coordinator and outreach specialist have been given the contact information for these institutions and have agreed to answer any of their additional questions. IHSSPA will continue to supply these community centers with educational materials by mailing them if contacted by staff.

In addition, through my outreach, IHSSPA staff have been invited to make future presentations at these community centers and inform potential consumers and providers first hand.

Provider Survey

Interestingly, the provider survey displayed some contrary results to opinions voiced in the provider Focus Group. Many providers in the survey indicated that they are well matched with their consumer, and are satisfied with the frequency of PA trainings. This denotes the importance of eliciting a larger sample size when gathering opinion data. It was also surprising that there were only small differences in opinion between the subset of providers that had worked for a family member or friend and the subset that had not. This may indicate that providers who were matched with consumers by the PA continue to be satisfied with their working relationships. One difference that was noticeable between the two subsets however, was that providers who had never worked with a family or friend agreed more with the statement "consumers often ask me to do tasks that are unauthorized." This result indicates that providers who work with non-family members or friends may have a harder time communicating with their consumers. Alternatively, consumers who hire a family member or friend may be more educated on the types of tasks that their provider may perform for them.

Limitations

One of the major limitations for this study was that the data collected was self-reported from providers and consumers of IHSSPA. All provider and consumer addresses were given to IHSSPA by the providers and consumers themselves, and therefore some may be outdated or subject to human error. In addition, it is acknowledged that communities are complex and diverse, thus census data cannot explain the entire needs of community populations. The basis for

using Policy Map made certain assumptions that communities with higher instances of seniors living in poverty and higher instances of unemployment might be more interested in becoming consumers and providers respectively. However, the outreach portion of this study did not interview community members themselves, only staff members of community centers. Statistics on instances of low income adults with disabilities are more difficult to find specific to San Francisco neighborhoods, but perhaps would have illuminated additional need in underserved communities. Data indicating current populations that would be interested in becoming a provider is lacking. Besides unemployment it would be helpful to know in which communities low income families are providing home care for their loved one. In addition, it would be helpful to target individuals looking to pursue a career in healthcare. More data is needed from current providers themselves to indicate what might attract future providers.

The community targeted for direct outreach in this study was the Richmond district of San Francisco, due to their availability and acceptance of the project. However, future work should continue to pursue other communities that this project was not able to reach such as Bayview and the Sunset.

Implications for Practice

In order to monitor changes in where consumers and providers live, it is important that IHSSPA make sure to continually update their records of these addresses. Using these addresses to create maps can visibly indicate if targeted community outreach has been successful in enrolling providers and consumers from certain neighborhoods. It will also be important to continue collecting data on the needs of different communities. Introducing a survey to different community centers to distribute to clients could produce more instructive data on how to improve

their knowledge and perceived benefits about IHSSPA. Evaluation surveys could also be given out in the event that IHSSPA staff are able to make presentations at the different community sites. Surveys could be given out before and after the presentations to indicate increased knowledge and interest. On behalf of the providers, it is important to continue trying to understand their needs and obstacles. Unlike consumers, providers partake in IHSS as a means of employment and caring for others. In order to make the provider position more appealing to a larger audience, IHSSPA could continue to explore spreading interest in local community colleges or healthcare related certification programs. A description of the provider position could also be posted on community college job portals. Individuals who are looking to gain experience in the healthcare field may be interested in not only the provider positions but also the trainings that the Public Authority and Homebridge offers. Furthermore, the health benefits of joining the registry should be a primary selling point to potential providers.

For consumers, it will be important to continue to reach out to different community institutions in all different neighborhoods of San Francisco. IHSS has a longstanding partnership with Laguna Honda Hospital where staff mentors meet with inpatients before discharge to establish provider care for them when they return home. However, it may be worthwhile to expand partnerships with other hospitals across the city, and offer services to individuals who would like to return home from a skilled nursing facility. In addition, IHSS may be marketed to seniors as a precautionary measure to enroll in case a future injury occurs. Thus, they would not have to undergo the enrollment process while in recovering in the hospital. This precautionary measure may be more attractive to individuals who believe they can live independently most of the time. More educational materials, such as the postcards about how to become a consumer should be

given to hospitals and clinics to generate interest about IHSS, as a form of advertisement/ informational outreach.

Directions for Future Research

Future research could explore community outreach through other community institutions besides resource centers. Although resource centers are integral to community support, other institutions such as clinics, hospitals, churches, or food pantries could also be platforms to distribute educational information. Even if the potential consumer is confined to their home, they may have a family member or friend who would encounter these educational materials in their daily routine. Currently, IHSSPA has created high quality educational materials available in several languages. In order to use these materials to their fullest it is important that they are disseminated further into the San Francisco community. Future research might also experiment with the different modalities of distributing and replenishing educational materials. For this study, was recommended that the community centers contact IHSSPA when they are running low on materials, and the Public Authority could send them more by mail. However, future efforts could explore the possibility of inviting key community stakeholders such as the community center staff to IHSS conferences where information and presentations are readily available.

Future research might also focus on how to categorize residences on based on their associated community. Some studies in San Francisco, group community data together based on their supervisorial district. While these districts may be more equal in the amount of land they cover, residents and citizens in different districts still have varying densities. It may be helpful for future studies to do a more thorough analysis on where the most IHSS consumers and providers are living based on the size of their community. This analysis will also be important when continuing

to perform outreach and evaluating the growth of new consumers/providers in underserved communities.

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Appendices

Appendix A: Focus Group Questions

Focus Group script: IHSSPA providers (about 50 minutes)
Introduction: Hello and thank you for coming today, my name is Lily Moll and I am an intern here at the In Home Supportive Services Public Authority. I will be asking a few questions on how IHSSPA can improve the provider enrollment and hiring process. I would like your permission to take notes but all this information collected will be kept private. Feel free to have some snacks and drinks during this session.

Question #1

How did you first come to find out about IHSS?
When did you encounter the additional services of the Public Authority and provider registry?

Question # 2

Was the process of enrolling in the provider registry made clear?
Were there any particular obstacles in this process that you could point out?

Question #3

After becoming a provider, about how long did it take before you started to work with your first consumer?
Was your first consumer a good fit for you in terms of ability to get to their home and complete the tasks?

Question #4

In your opinion, what are some ways that IHSSPA could attract more providers?
Would you recommend becoming an IHSSPA provider to a friend or family member?

Question #5

What would make it easier for you to attend provider workshops and trainings?
Do you feel that information in these trainings was taught in an easily understood format?

Question #6

Is there anything else you would like to add about improving IHSSPA services for providers?

Appendix B: Community Center Interview Script

Thank you for meeting with me. As I mentioned earlier I am an intern with In Home Supportive Services and a Student at USF. The content of this interview will help inform my project through IHSSPA. I am estimating this should take about 15 to 20 minutes.

1. *Firstly, could you give me a brief overview of the services you provide at this facility on a day to day basis?*
2. *Can you give me a general sense of who comes to this facility? (ex. the predominate languages, and what kind of economic background they come from, eligible for medi-cal)*
3. *How familiar are you with In Home Supportive Services?*
4. *Are you aware of anyone here utilizing IHSS?*
5. *Are you aware of the additional components of the Public Authority?*
6. *What kinds of educational materials would be helpful for you clients to learn more about IHSS services?*

(show examples)

7. *Would you be comfortable displaying IHSSPA materials as a resource to your clients?*
8. *Could you envision this community center as a resource for both home care workers (providers) and their clients (consumers)?*

Appendix C: Provider Survey Questions

1. Do you live in San Francisco County?

- *yes*
- *no*

2. What is your primary method of transportation?

- *car*
- *public transportation*
- *transportation apps (lyft, uber, etc)*
- *bicycle*
- *other (explain)*

3. Have you ever worked for a friend or family member as their provider?

- *yes*
- *no*

4. The Public Authority helped me find consumers that were appropriate for my skill set.

- *Strongly Agree*
- *Agree*
- *Neither Agree or Disagree*
- *Strongly Disagree*

5. The Public Authority helped me find consumers that I could easily commute to.

- *Strongly Agree*
- *Agree*
- *Neither Agree or Disagree*
- *Strongly Disagree*

6. I believe that I could take on consumers if they all lived within the same neighborhood.

- *Strongly Agree*
- *Agree*
- *Neither Agree or Disagree*
- *Strongly Disagree*

7. I have been able to maintain professional relationships with my consumers.

- *Strongly Agree*
- *Agree*
- *Neither Agree or Disagree*

- *Strongly Disagree*

8. The Public Authority provides me support when I am experiencing challenges at work.

- *Strongly Agree*
- *Agree*
- *Neither Agree or Disagree*
- *Strongly Disagree*

9. The trainings that the Public Authority provides are often enough.

- *Strongly Agree*
- *Agree*
- *Neither Agree or Disagree*
- *Strongly Disagree*

10. I would feel comfortable saying "no" to consumers if they ask me to do a task outside of my responsibility.

- *Strongly Agree*
- *Agree*
- *Neither Agree or Disagree*
- *Strongly Disagree*

11. Consumers often ask me to do tasks that are unauthorized.

- *Strongly Agree*
- *Agree*
- *Neither Agree or Disagree*
- *Strongly Disagree*

Appendix D: Graphs from Provider Survey Results

Figure 3. Responses to Question 3 of the Provider Survey

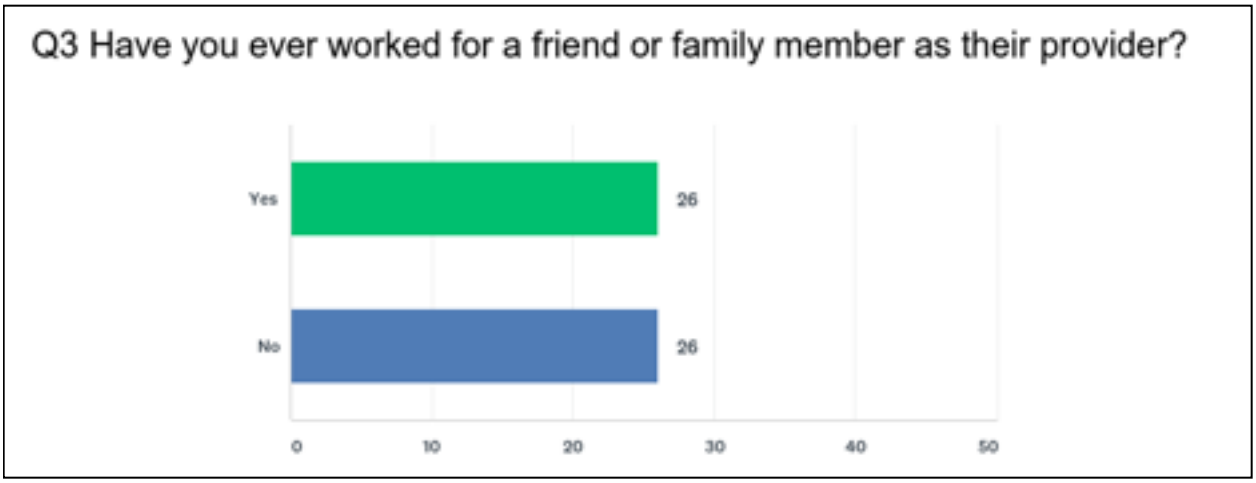

Figure 3. The graph indicates that fifty percent of respondents to the survey indicated that they had worked for a family member or friend as their provider and fifty percent had not.

Figure 4. Responses to Question 4 of the Provider Survey

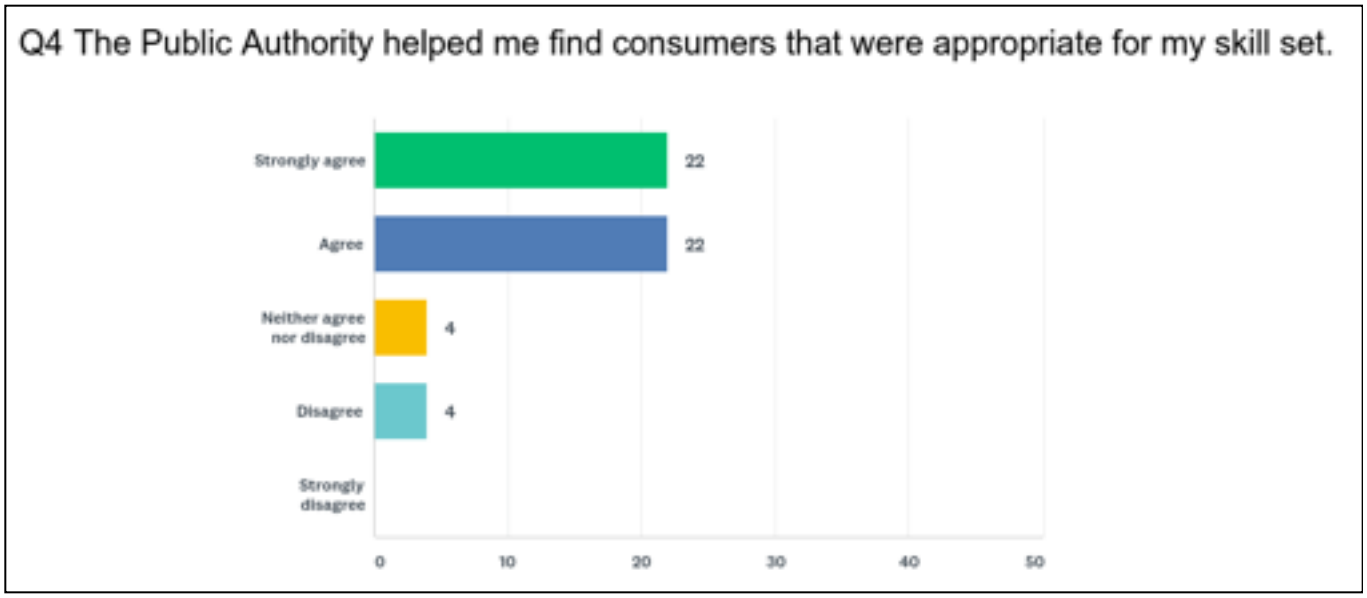

Figure 4. The graph indicates that most providers agreed or strongly agreed with the statement "The Public Authority helped me find consumers who were appropriate for my skill set."

Figure 5. Results to Question 6 of the Provider Survey.

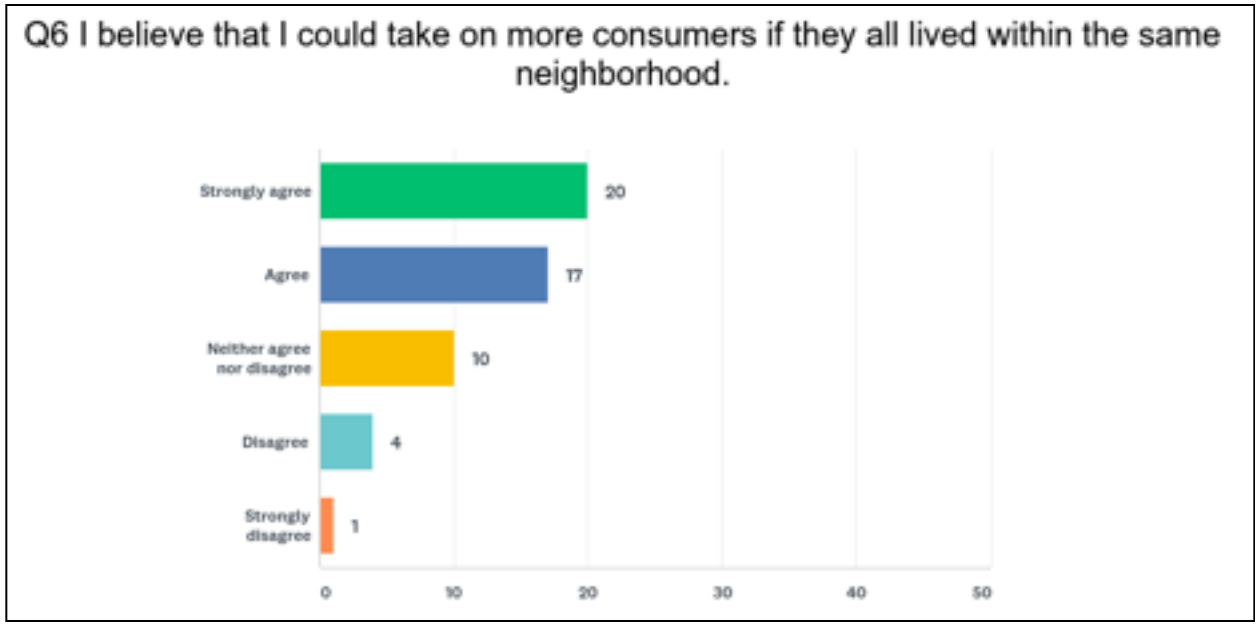

Figure 5. The graph indicates that about 71% of providers either agree or strongly agree that they could take on more consumers if they lived within the same neighborhood.

Figure 6. Results to Question 7 of the Provider Survey

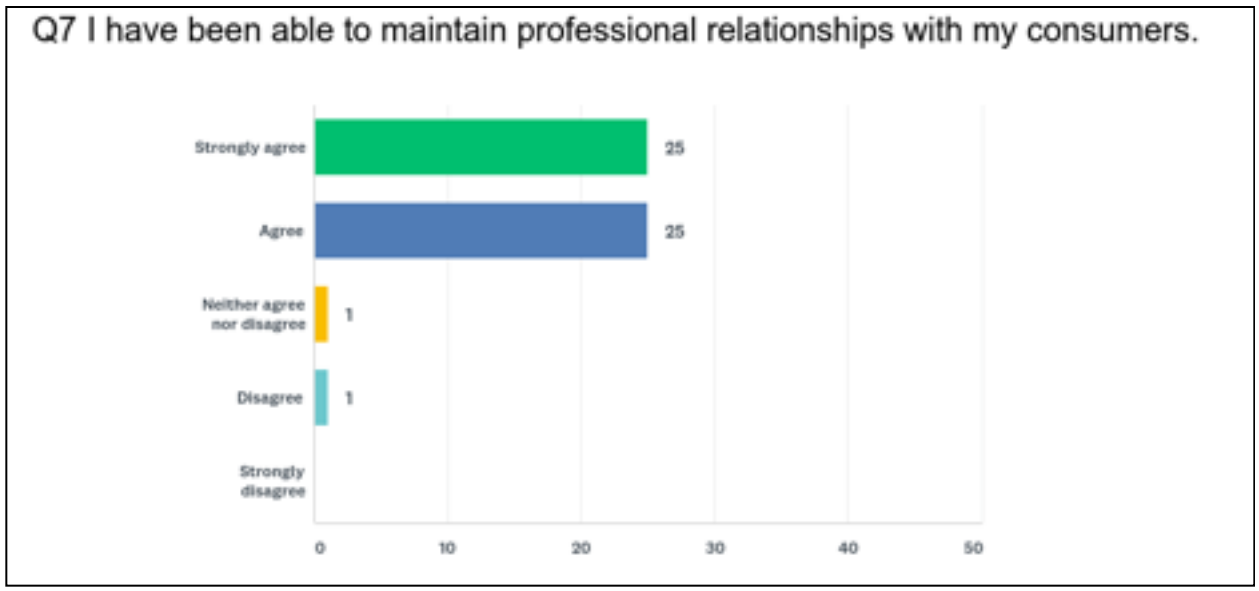

Figure 6. The graph indicates that a majority of providers agree with the statement "I have been able to maintain professional relationships with my consumers."

Figure 7. Results to Question 11 of the Provider Survey.

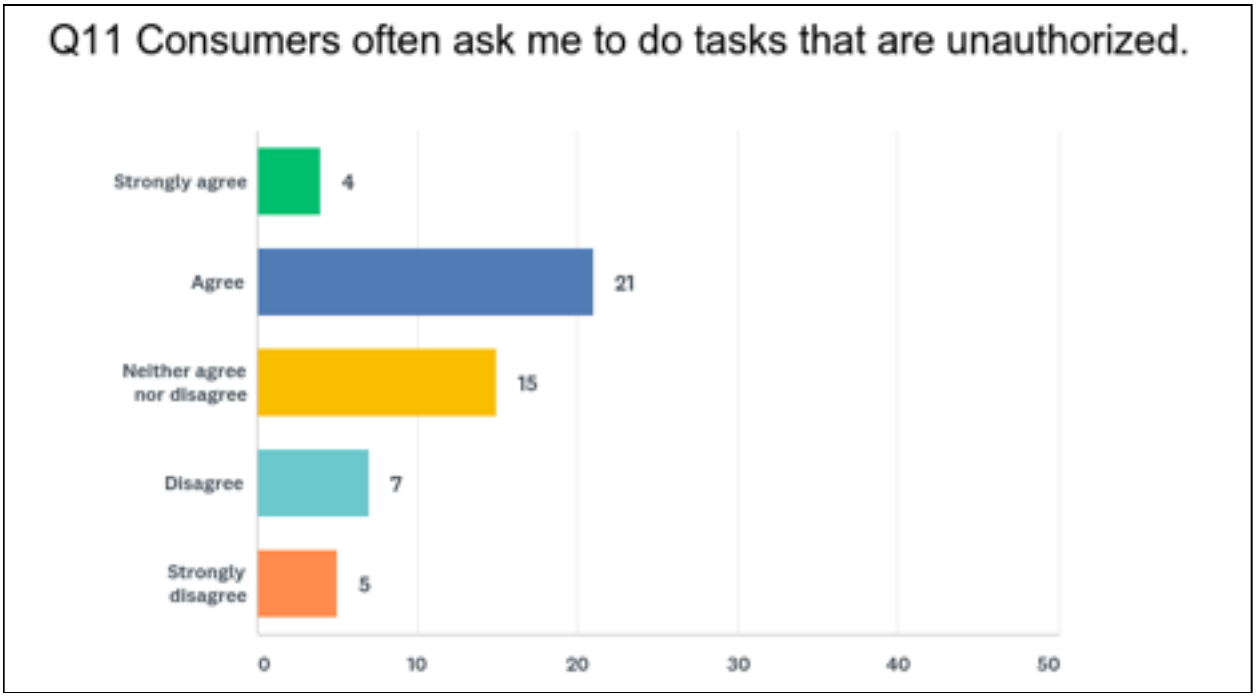

Figure 7. The graph indicates that 48% of providers either agree or strongly agree with the statement "consumers often ask me to do tasks that are unauthorized."

Figure 8. Results to Question 11 of Provider Survey, Cross-tabulated by Responses to Question 3: “Have you ever worked for a friend or family member as their provider.”

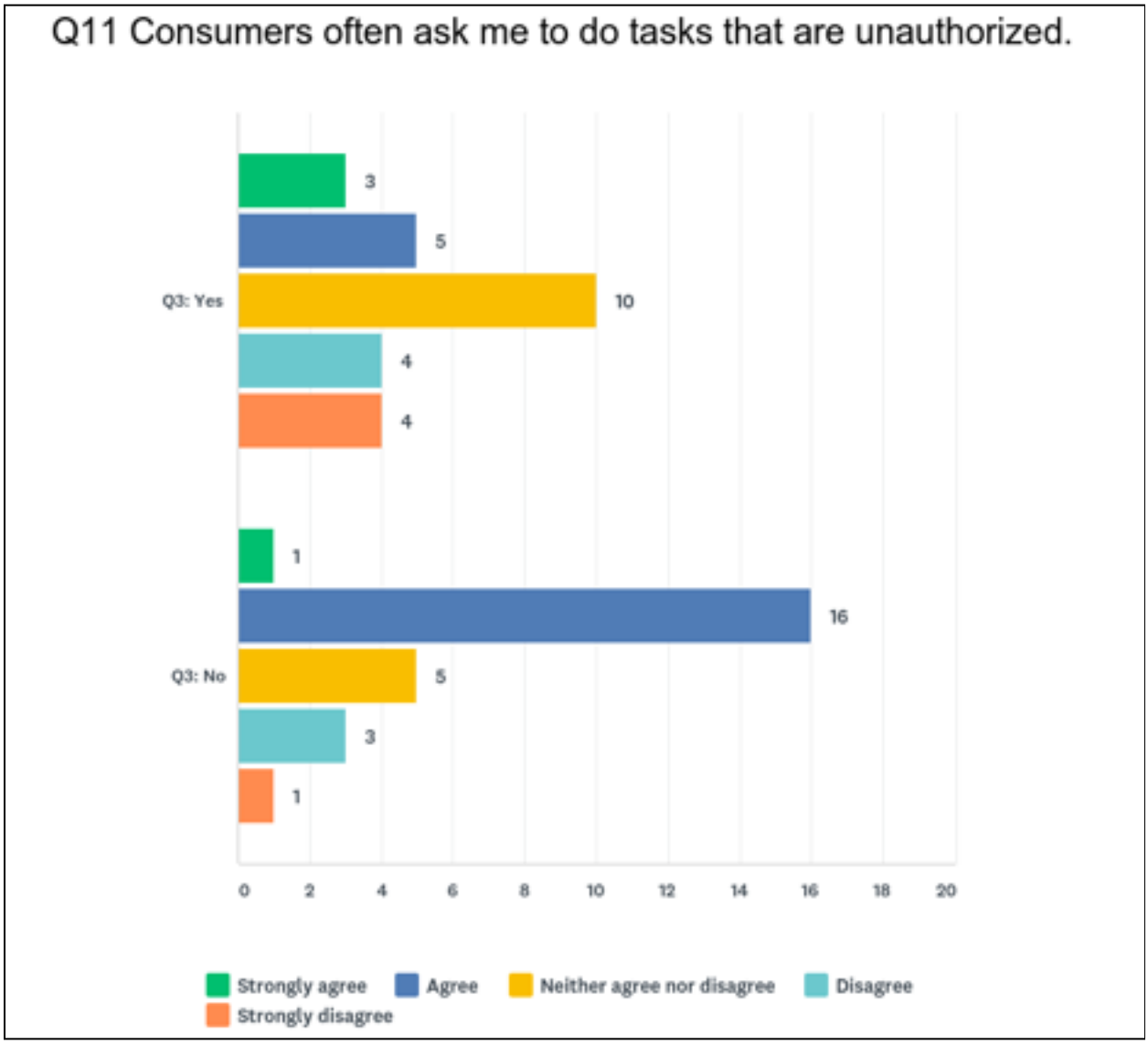

Figure 8. The graph shows a comparison of answers from Providers who have worked for Friends/ Family members and those who have not to Question 11. The top group of bars indicate participants who responded “yes” to the question “have you ever worked for a friend or family member as their provider” and the bottom group of bars indicate those who answered “no” to the same question. The answers indicated that respondents that had not worked with a family member or friend tended to agree more with the statement “consumers often ask me to do tasks that are unauthorized.”