California Master Plan for Aging: Stakeholder Advisory Committee Final Report

Table of Contents

Executive Summary

"The Golden State is getting grayer and we need to be ready for the major population changes headed our way. An aging population will introduce new opportunities for economic and community growth but also drive increased health and long-term care costs. We need a plan that brings everyone to the table — local communities, labor, private sector and philanthropy — to help us understand what's coming and guide us toward taking better care of older Californians."
Governor Gavin Newsom, June 2019

California Master Plan for Aging: Stakeholder Advisory Committee Report

In June 2019, Governor Newsom's [Executive Order N-14-19](#) called for the development of a [Master Plan for Aging (MPA)](#) to prepare the state for demographic changes that will impact communities, families and individuals of all ages and abilities. Among other provisions, the Executive Order called on the Secretary of the Health and Human Services Agency to convene a Stakeholder Advisory Committee (SAC) representing advocates, providers, academics and philanthropic partners to provide input to the administration on the development of the Master Plan for Aging (Master Plan). The Stakeholder Advisory Committee hereby presents its report and recommendations for achieving the goals set forth in the Executive Order.

The opportunities offered by a Master Plan are momentous; never before has a California governor committed to a sweeping system-wide review and long-range plan for the state's aging and disabled populations. By 2030, California's nation-state is slated to have twice as many older adults while becoming a majority-minority state. Our demographic reality touches each of us — as individuals, family members, friends and community members. It also affects our collective ability to provide and pay for the range of services and supports needed for the growing population of older adults and persons with disabilities.

We face the specter of ageism, ableism and systemic racism, all exacerbated by COVID-19 and its impact on older adults and people with disabilities, especially in Black, Native American and Latino communities. We need to change the paradigm: aging and disability should not equal loss and isolation. We need a new narrative. The Master Plan holds the potential to reframe our collective thinking and greatly improve the future health and wellness of all Californians.

This demographic shift provides an opportunity to design, develop and deliver a blueprint for California that is age-and-disability-friendly for all. We embrace the gift of a diverse population representing many races, ethnicities, religions, sexual orientations, gender identities and languages. We believe older adults and people with disabilities are what make us rich as a state; people with vast life experiences who contribute greatly to society. Unfortunately, to date, California has fallen short in investing in these populations — resulting in a fragmented and under-funded system of care, with services and supports that have not kept pace with these populations' needs.

Re-ImAGinE California

With this report, we seek to reimagine how we build a future where all individuals--- inclusive of race, disability, socio-economic status, ethnicity, gender, and sexual orientation--- have the opportunity to age with dignity and independence in the Golden State. We aspire to achieve a California where all communities, families and individuals thrive — whether young, middle age or advanced age. Together, we can build a California where, from youth to old age, we all contribute to our social fabric and economic prosperity. With a healthy and nurturing environment, we can ensure the opportunity for all Californians to live well into old age, inclusive of where we live, the color of our skin, the language we speak, our income level, and our sexual orientation.

Goals and Priorities

The Master Plan for Aging report addresses four broad goals:

1. **Long-Term Services and Supports**: We will live where we choose as we age and have the help we and our families need to do so.

2. **Livable Communities and Purpose:** We will live in and be engaged in communities that are age-friendly, dementia-friendly, and disability-friendly.

3. **Health and Well-Being**: We will live in communities and have access to services and care that optimize health and quality of life.

4. **Economic Security and Safety**: We will have economic security and be safe from abuse, neglect, exploitation, natural disasters and emergencies throughout our lives.

The Stakeholder Advisory Committee has outlined myriad recommendations within the above four goals which are outlined in the accompanying report. They are all vital to achieving a Livable California for All, together forming a comprehensive response to the Master Plan goals. Thus, each recommendation must be given full attention as we move towards implementation. Among these recommendations, however, we believe the following three are the most urgent and reflective of all we hope to achieve in this report:

- **Priority 1:** *Fix the Long-Term Services and Supports System*
- **Priority 2:** *Assure that California has Housing that is Affordable to All*
- **Priority 3:** *End Poverty*

We recognize that the challenges California faces, both in the short and long-term, are not inconsequential. We grieve the enormous toll the current COVID-19 pandemic and economic recession has taken on all of our communities, along with fires, heat waves and public safety power shut-offs. But with the Governor's bold leadership, we can and WILL recover.

Ultimately, the Master Plan should be a "living document" that responds to an ever-changing world but remains constant in its vision and goals—all with the understanding that the roadmap will be continually updated to reflect current reality and emerging opportunities.

The Importance of Equity

California is one of the most racially, ethnically and linguistically diverse states in the nation. Equity issues impact access to services across the state for under-represented, under-served and under-recognized communities. This is emphasized by the number of recommendations and comments herein addressing diversity, social justice, racism, health disparities, social determinants of health, discrimination, xenophobia, cultural humility and marginalization.

The Stakeholder Advisory Committee affirms the critical importance of equity in addressing the needs of older adults and people with disabilities, including the workforce, thereby eliminating disparities caused by systemic barriers. To achieve this aim, the Stakeholder Advisory Committee established an Equity Workgroup to ensure all Master Plan recommendations included in this report, uphold the core value of equity by meeting agreed-upon criteria.

The Critical Role of State Leadership

Our hope for the Master Plan lies in its potential for broad system change, and in the opportunity to fundamentally reframe the way we collectively view and serve California's older adults and people with disabilities. We need bold leadership from elected and appointed officials who are willing to invest in and prioritize the needs of this growing segment of our state's population. This leadership starts with the Governor and flows across agencies of Health and Human Services, Housing,

Transportation, Labor, Education, Employment and Veteran's Affairs, among others. Without strong leadership, nothing can be realized --- but with it, everything can be accomplished.

State Structure that Drives Change: To address the Master Plan priorities, leadership is needed to drive change, address systemic fragmentation of services and programs, hold state agencies accountable, as well as partner with the state legislature, local government and private sector in achieving stated Master Plan goals. Throughout the report, we outline several recommendations regarding leadership strategies at the agency and department levels. Specifically, we note other states' experiences in crafting efficient and responsive systems. At the federal level, the Administration for Community Living (ACL) consolidates some of the home and community-based services for older adults and people with disabilities into one unit. California needs to develop an organizational structure that best meets the needs of our diverse population; one that aspires toward a long-sought single point of entry for all services, including all health and LTSS services.

We realize that change begins at the top and influences all levels of government as well as the public and private sectors. To this end, we propose the following:

The Governor should appoint an individual ---a Deputy Cabinet Secretary or Special Counsel--- with the responsibility and authority to implement the Master Plan for Aging, developing strategies across state agencies and in partnership with the private sector. Given the complexity and range of issues impacting older persons and persons with disabilities, we further recommend that the Governor establish a Cross-Department Task Force chaired by the Deputy Cabinet Secretary/ Special Counsel. This Cross-Department Task Force would be charged with reviewing and updating the Master Plan for Aging on a bi-annual basis, detailing how these recommendations can be addressed and under what timeframe. Within one year, the Task Force will present a plan for reconfiguring how state government agencies and departments can execute on the Master Plan for Aging.

Our Core Priorities

The recommendations outlined across the four goal areas are all important. Yet, we recognize that not everything can be accomplished at once. As such, we highlight the following bold priorities that we believe will have the most immediate system-wide impact on our population. We selected the following three priorities which we feel can benefit from executive leadership and produce results in the short-and long-term:

Priority 1: Fix the Long-Term Services and Supports System

California's long-term services and supports (LTSS) system is unaffordable, difficult to navigate, and lacks the capacity to meet population needs. We need a system that ensures all individuals can live where they choose with the services and supports they need to honor their values and preferences. The following objectives are critical to achieving this goal:

- **Address the LTSS financing crisis:** California faces an unprecedented crisis related to the financing of long-term care. Typically, when paid services are needed, most Californians do not have the financial resources or reserves to cover these costs on an ongoing basis. State action is required to establish a new universal LTSS benefit that offers a flexible range of benefits that is sustainable and enables families of all incomes to plan and pay for their daily care needs both now and in the future.

- **Reform the system:** In order for California to be a state where everyone has the opportunity to age with dignity and independence, bold change is needed to reform the health and LTSS system as part of the broader service delivery system. This starts with building a unified state leadership structure to drive change that focuses on strengthening and coordinating services across the health, behavioral health, social service and LTSS continuum; building a high-quality paid and unpaid family caregiver workforce; and developing statewide service delivery capacity to ensure access to LTSS for all Californians.

- **Establish Home and Community Based Services (HCBS) as a right:** Californians often are unable to access the necessary services and supports in the home and community, whether due to long waiting lists or a lack of available options to meet their needs. The devastation of COVID-19 deaths in nursing homes and congregate settings reinforces the need for universal access to HCBS. As such, we believe that California should equalize access to HCBS as an alternative to institutionalization throughout the state. This requires the state to take the bold step of establishing a right to services and supports in an HCBS setting, while securing the funding to do so.

Priority 2: Assure that California has housing that is affordable to all

Every Californian should have access to housing they can afford. Unfortunately, many older adults and people with disabilities are denied this basic necessity. Housing is not only a human right, but a foundational component of our long-term services and supports system. Without housing, individuals have diminished access to preventative health care as well as appropriate medication and rehabilitation, resulting in increased use of hospital and emergency department care.

Housing provides the basic infrastructure that allows Californians to thrive. Shelter is the gateway for older adults and people with disabilities to live in and be engaged in communities that are age-friendly, dementia-friendly, and disability-friendly. Paired with affordable housing, accessible and affordable transportation allows community access at all stages of life. These resources enhance personal independence and foster engagement in the community's civic, economic, and social life.

Over the next 10 years, California should take the following steps to ensure the health and longevity of our older adults and people with disabilities through these housing strategies:

- **Ensure all older adults and people with disabilities have access to quality housing that is accessible and affordable to them:**

  o Increase the supply of affordable housing, using reliable data based on thorough measurement and assessment of the problem.
  o Prevent homelessness by keeping people housed with rental and mortgage assistance, and home modification, repair and redesign services.
  o Expand access to innovative housing models such as shared and intergenerational housing.

- **Help older adults and people with disabilities remain successfully housed:**

  o Create and expand service-enriched housing models, which help older adults age-in-place by allowing for the provision of home- and community-based services in the most integrated setting appropriate to an individual's needs.

Priority 3: End Poverty and Health Inequities

California has the second highest rate of senior poverty in the country, with growing rates of food insecurity and homelessness among older adults in the state. Black, Indigenous and Latinx older Californians are particularly impacted as over 40% of older adults from these communities are economically insecure; and women from these communities are at particular risk of aging into poverty. Persistent health disparities within low-income and racially and ethnically diverse communities impede access to affordable, integrated and quality health and medical services. To ensure the economic security and wellness of all Californians, we must make investments to ensure that we all have our basic needs met as we age. The following objectives are critical to achieving this goal:

- **Ensure economic security for all:** Many middle-income Californians are experiencing downward economic mobility as they age due to inadequate retirement income and rising health and long-term care costs. To reverse this trend, the state must adopt reforms to the

CalSavers program; explore developing a state-based program that would supplement Social Security benefits; increase work opportunities for older adults and people with disabilities and expand programs that cover the costs of health and long-term care.

- **Bolster programs that help older Californians' meet their basic social and health needs:** California has underinvested in programs that help older adults and people with disabilities meet their basic needs. The state should act now to ensure its anti-poverty, health, nutrition and homelessness services programs meet the needs of today's population while preparing for the future. This starts with restoring and expanding the State Supplemental Payment for those receiving Supplemental Security Income while also ensuring access to more coordinated, integrated services across the health and social services delivery systems. In addition, all efforts the state undertakes to reduce poverty, hunger and homelessness and expand health care access must include affirmative consideration and involvement of older adults and people with disabilities.

In Closing

California can and will become an age-and disability-friendly state where everyone is engaged throughout the life-span---dedicating our life-long energies, contributions and resources to our collective wellbeing. The Master Plan for Aging provides the blueprint – the strategies and recommendations – that can make this state a model for the nation; a society that will not only age but will also become more diverse by 2030. This report is the starting point for envisioning a dynamic and compassionate state that addresses its many challenges with courage and innovation.

But we must ask ourselves: what if we do not move forward with determination? If we default to the status quo, we will find that upwards of l0 million older adults will face even greater consequences of poverty and vulnerability than what we see today; and that will further exacerbate the economic toll on the state's resources. The social isolation, ageism, ableism and systemic racism that we see today will worsen and make California not just a less attractive state for retirees but a less attractive place for young families and private sector investments.

The Governor has a golden opportunity to show the nation and the world that among its great leadership and influence on issues of climate change, popular culture, technology and governance, will be the opportunity to re-imAGinE aging, to make all communities livable, presenting a transformative new image of what aging in a diverse state can be and should be. The Governor will rely on all of us--- including advocacy groups, non-profit organizations, city and county agencies, philanthropy, the private sector as well as members of this Stakeholder Advisory Committee--- to achieve the collective vision. We stand ready as partners to work in collaboration toward achieving the goals of the Master Plan for Aging.

May 2020

Master Plan for Aging Long Term Services and Supports Subcommittee Stakeholder Report

Acknowledgments

The LTSS Subcommittee would like to thank the following individuals and organizations for the assistance and input provided throughout this process: **Kim McCoy Wade**, Director of the California Department of Aging; the Department of Aging staff team; **Carrie Graham**, PhD, Consultant to the Master Plan for Aging; **Greater Good Studios** in partnership with The SCAN Foundation for use of the quotations and pictures; **AARP California** for the infographic; and members of the public for their comments submitted. We also wish to thank **Natalie Franks** for sharing the cover photo with the subcommittee.

We dedicate this report to California's older adults, people with disabilities, caregivers and families who all desire the opportunity to age with dignity and independence.

Front cover photo published with permission.

Photo shows Natalie Franks, Activities/ Food Supervisor | Acacia Adult Day Services |Garden Grove hugging her grandfather, who was a participant at the center.

Contents

Long-Term Services and Supports Subcommittee Members

Ana Acton, FREED Center for Independent Living and Nevada County Aging and Disability Resource Connection

Maya Altman, Health Plan of San Mateo *

Catherine Blakemore, Disability Rights California *

Kathryn Barger, Supervisor, Los Angeles County, District 5 *

Kristina Bas-Hamilton, United Domestic Workers of America/AFSCME local 3930 *

Donna Benton, PhD, USC Family Caregiver Support Center *

Patty Berg, Former Assembly member

Craig Cornett, California Association of Health Facilities *

Susan DeMarois, Alzheimer's Association *

Karen Fies, Sonoma County Human Services Department and Area Agency on Aging

Julia Figueira-McDonough, 2020 Soros Leadership in Government Fellow

Karen Keeslar, California Association of Public Authorities for IHSS

Peter Mendoza, Marin Center for Independent Living

Lydia Missaelides, Alliance for Leadership & Education

Marty Omoto, California Disability-Senior Community Action Network

Claire Ramsey, Justice in Aging

Ellen Schmeding, St. Paul's Senior Services and Member of the California Commission on Aging

Sarah Steenhausen, The SCAN Foundation

Jeff Thom, California Council of the Blind

Nina Weiler-Harwell, AARP California*

Brandi Wolf, Service Employees International Union Local 2015 *

* Member also serves on the Stakeholder Advisory Committee

Preface | May 26, 2020

The Master Plan for Aging Stakeholder Advisory Committee (SAC) unanimously approved the final draft of the Long-Term Services and Supports (LTSS) Subcommittee report in March 2020 - just before the COVID-19 pandemic fundamentally altered California lives, disproportionately impacting older adults and people with disabilities while also creating a massive budget shortfall. Since that time, the COVID-19 crisis has dramatically revealed and exacerbated the shortcomings in California's LTSS system. We are deeply concerned that the state's response to the crisis has been to propose cuts and program eliminations that stand to decimate the system of services and supports that Californians rely on to remain in the community and maintain dignity and independence.

Instead of cuts to the critical programs and services in California's LTSS system, we ask that you use the recommendations in this report to guide your thinking and approach. The response to the crisis should be driven by the values in the Master Plan and be forward-thinking about the future LTSS system.

The Master Plan for Aging should serve as the state's guardrails during challenging budgetary times, providing a lens from which to view any proposal for its impact on this population. Yet, what we see in the May Revision does not live up to the ideals outlined in the articulated values and goals of the Master Plan. In fact, all of the proposed cuts and eliminations negatively impact progress towards reaching each of these goals and contradict what is outlined in the Governor's Executive Order.

In this report, the LTSS Subcommittee affirms the importance of equity in addressing the LTSS needs of older adults and people with disabilities, with specific recommendations to eliminate disparities and increase equity, accessibility, and affordability in the LTSS system. We continue to stand by these recommendations. Further, we recognize that the COVID-19 crisis has laid bare tremendous system inequities and health disparities that directly result in racial and ethnic populations being at disproportionate risk to contract, to be hospitalized and to die from COVID-19. It has also highlighted the widespread ageism and ableism that infiltrate societal views of older adults and people with disabilities and diminishes their value.

Despite the system's shortcomings, this crisis has demonstrated that California absolutely can rise to meet the challenge of transforming its LTSS system when leaders at the state and local levels work together and move with urgency towards a shared goal. While not perfect in its execution, the response to COVID-19 has unleashed the power of creative problem solving and a willingness to act expeditiously to ensure people have the services they need to stay safe and healthy.

The devastating impact COVID-19 has had on the state's fiscal outlook cannot dampen the urgency for creative thinking, bold planning and prompt action to transform California's LTSS system. This pandemic was preceded by an acute need to accelerate preparedness for the state's aging population and increased incidence of disability. Bold planning does not require immediate resources, but it does require strong leadership that outlines a vision for what California's LTSS system should look like well beyond this moment to better meet the needs of all Californians.

It will take time to fully understand the COVID-19 crisis and its lessons, but it is clear today that the LTSS Subcommittee report offers many recommendations that are critically relevant now.

1. At the Gubernatorial level, there is need for coordinated, engaged leadership addressing issues impacting older adults and people with disabilities across all agencies.
2. In spite of efforts to temporarily expand access to health and social services information during COVID-19, ongoing challenges remain in how and where the public can learn about vital LTSS programs and services in the community.
3. The issues confronting both paid caregivers and unpaid family caregivers remain central to both the COVID-19 crisis and LTSS during ordinary times. This issue deserves focused attention with solutions identified in this report.
4. The shortcomings in licensed residential and skilled nursing care demand prompt scrutiny and systemic reform, with new models of care that prioritize funding, testing and support to further home and community-based living over institutional care.
5. COVID-19 has forever altered how services are delivered in the community, and LTSS programs have quickly demonstrated success using alternative methods. These innovative approaches should not be abandoned or limited to times of crisis and should enable more flexible, creative and person-centered approaches to meet people's needs for the longer-term.

At this critical juncture, it is incumbent upon all of us to seize this crisis as an opportunity to commit to equitable LTSS system reform and transformation because California's older adults, people with disabilities, and their caregivers deserve nothing less.

This page left intentionally blank

LTSS Subcommittee Stakeholder Report |Executive Summary

California's population is aging, and it impacts each of us —as individuals, family members, friends, and community members. It also affects our collective ability to pay for and provide the range of services and supports needed for California's increasingly diverse populations of older adults and people with disabilities.

This demographic shift provides an opportunity to design, develop and deliver a blueprint for California that is age-and disability-friendly for all. We embrace the gift of a diverse and growing populations of older adults and people with disabilities representing many races, ethnicities, sexual orientations, gender identities and languages. We believe older adults and people with disabilities are what make us rich as a state; people with vast life experience who contribute greatly to the fabric of our society. Unfortunately, to date, California has fallen short in investing in these populations - resulting in a fragmented and under-funded system of care, with services and supports that have not kept pace with these populations' needs.

In June, 2019, Governor Gavin Newsom signed an Executive Order to create a Master Plan for Aging (MPA). The opportunities offered by a Master Plan for Aging are momentous; never before has a California governor committed to a sweeping system review and long-range plan for the state's aging and disabled populations.

To inform the Master Plan for Aging, the Long-Term Services and Supports Subcommittee (Subcommittee) was asked to look at the challenges and identifying the policy opportunities related to California's long-term services and supports (LTSS) system. To this end, the Subcommittee examined how the system is (and isn't) working for our diverse populations of older adults, people with disabilities, their families, and their caregivers; and how we might build a strong foundation to create a person-centered system that ensures all Californians can live where they choose with the necessary services and supports they and their families need.

To ensure an inclusive and well-informed process, the Subcommittee is represented by a diverse membership representing consumers, LTSS providers, advocates, and caregivers. The Subcommittee convened 10 times in public meetings between October 2019 and March 2020, while also reviewing hundreds of comments and recommendations from key stakeholders and the public.

The Subcommittee identified five core areas of need: Navigation, Access, Affordability, Workforce, and Infrastructure. Accordingly, the Subcommittee urges California to commit to **five bold statewide Objectives,** as defined below and further expanded upon in the body of the report.

Aging is all of us and we all stand to benefit from making California a place where everyone has the chance to age with dignity and independence.

OBJECTIVE 1: A SYSTEM THAT ALL CALIFORNIANS CAN EASILY NAVIGATE

California will have in place an understandable, easy-to-navigate linguistically and culturally responsive LTSS system that includes both home and community-based and residential options. Californians will know how to quickly connect to services they need, no matter where they live or their economic status. People will find what they need wherever they enter -- whether through the health care system, the public benefits system, disability service system , including Regional Centers, or the community-based system.

OBJECTIVE 2: ACCESS TO LTSS IN EVERY COMMUNITY

California will have the country's most comprehensive LTSS system where people and their caregivers can find and afford the services they need and choose, where and when they need them. California must act urgently to fund statewide access to LTSS to ensure sufficient services exist to meet the growing needs of older adults and people with disabilities.

OBJECTIVE 3: AFFORDABLE LTSS CHOICES

California will shift the historical bias for institutional care toward Home and Community-based Services, (HCBS), thereby enabling all Californians who need these services the ability to access them. In addition, California will have in place a statewide universal LTSS benefit program that helps people pay for the Long-Term Services and Supports they choose, at home, in the community, or in residential settings. The LTSS benefit program will be available to people at all income levels and will help delay or prevent the need for people to exhaust all their personal resources in order to access Medi-Cal, including IHSS, for their LTSS needs. California must act now to fund its core programs while creating new sources of LTSS funding to help people avoid the need to spend down to poverty level.

OBJECTIVE 4: HIGHLY VALUED, HIGH QUALITY WORKFORCE

Recognizing personal preferences and labor market challenges, the state must: 1) provide maximum support to family caregivers who have additional jobs outside the family caregiving setting through family leave policies, including job protections, that allow unpaid caregivers the flexibility to continue to earn while providing needed family support and; 2) accelerate growth of the paid workforce to meet increasing demand for LTSS.

To further address this challenge, public and private partners, including educational institutions, should commit to a statewide goal of attracting, training and retaining workers to fill 1 million high-quality direct care jobs. These jobs will be valued by providing livable wages and benefits, as well as training, education

and advancement opportunities. Intentional policy and budget actions will result in improved job retention and satisfaction, thereby leading to a more stable workforce with less turnover.

OBJECTIVE 5: STREAMLINED STATE AND LOCAL ADMINISTRATIVE STRUCTURES

The California Health and Human Services Agency will have a dedicated cross-department unit focused on LTSS that has authority to develop an effective LTSS system that meets the needs of California's older adults, people with disabilities, caregivers and families; align administration of LTSS across departments; coordinate LTSS, including IHSS, to promote seamless access to services; promote integration and coordination of care for California's Medi-Cal/ Medicare enrollees; and drive innovation in LTSS service delivery.

NEXT STEPS AND THE IMPORTANCE OF STATE & LEGISLATIVE LEADERSHIP

Each of these five big objectives is followed by specific recommendations detailed in the attached report. As such, this report provides a broad 10-year vision for LTSS in California while making concrete recommendations for how to move forward toward that vision.

The report's recommendations span all aspects of the LTSS system, with varying timelines for implementation. While some recommendations represent longer-term strategies, others can be acted upon in the immediate future.

Recognizing the urgency for action, the Subcommittee identified 37 recommendations that are ripe for immediate action and system-wide investments. We can no longer afford to wait.

We believe that the Newsom Administration and Legislative leaders are well-positioned to act boldly now to address the pressing and long-neglected LTSS challenges facing older adults and people with disabilities, families and communities. We stand ready to work as community partners to advance the Governor's Master Plan for Aging.

LONG-TERM SERVICES AND SUPPORTS SUBCOMMITTEE REPORT

A BLUEPRINT TO DESIGN, DEVELOP AND DELIVER LTSS FOR ALL CALIFORNIANS

Introduction

California is made richer by its diverse and growing populations of older adults and people with disabilities. Our state is at the forefront of uncharted population change, providing a unique opportunity to address people's long-term services and supports needs now and well into the future. A thoughtful, intentional strategy and plan can engage state and local leaders, as well as the Legislature, the private sector and philanthropy in preparing for this historic demographic shift.

On June 10, 2019, Governor Gavin Newsom signed Executive Order N-14-19 calling for the development and issuance of a Master Plan for Aging (MPA) by October 1, 2020.

This order puts forward a vision for an intergenerational, integrated, coordinated approach to aging that includes all Californians across age, place, race, ethnicity, religion/faith, income, disability, sex, gender identify, sexual orientation and family status. In short, this is a significant undertaking benefiting Californians of all ages, in every community, for decades to come.

Acknowledging the urgency and importance of this work, Governor Newsom's Executive Order calls for the formation of a Long-Term Care Subcommittee ("Subcommittee") charged with preparing a report to the Governor by March 2020, including, but not limited to, the following:

1. The growth and sustainability of state long-term care programs and infrastructure, including In-Home Supportive Services (IHSS).
2. An examination of access to long-term care, financing for long-term care services and the quality of long-term care provided in a variety of settings.
3. An examination of the impact of program instability and other factors on labor supply and retention of the workforce providing long-term care services and supports.
4. Recommendations to stabilize long-term care services, including IHSS, as a foundation for implementing the Master Plan.

Scope of Report
The Subcommittee report focuses squarely on the Master Plan for Aging Goal 1:

"We will live where we choose as we age and have the help we and our families need to do so."

Definition of LTSS
LTSS includes a broad range of services and supports delivered by paid providers and unpaid caregivers to people who have limitations in their ability to care for themselves. These limitations are due to a physical, mental, cognitive, or chronic health condition that is expected to continue for an extended period. LTSS services can be provided in a variety of settings including at home, in the community, in residential care, or in institutional settings.

LTSS Subcommittee Values and Vision
Values: The Subcommittee affirms the values set forth in the framework adopted by the Master Plan for Aging Stakeholder Advisory Committee: Choice, Equity, Dignity, Inclusion and Partnership. In addition:

- The needs, values and preferences of individuals and their caregivers will be honored by the system and its providers.
- Services will be linguistically and culturally responsive and the workforce will reflect the strength of California's diverse communities.
- Financing and public policy will intentionally support the statewide infrastructure needed to foster quality options in all communities while reducing reliance on institutional placement.

Vision: A strong, shared vision must guide the transformation of how we deliver long-term services and supports for all Californians. The Subcommittee envisions a California where:
1) All Californians can easily navigate the LTSS system
2) There is access to LTSS in every community
3) LTSS choices are affordable
4) The workforce is highly valued and of high quality
5) State and local governments are organized to enhance access to LTSS

Importance of Gubernatorial Leadership
Governor Newsom's bold leadership to establish a Master Plan for Aging provides an historic opportunity to design, develop, and deliver an LTSS framework for all Californians that will serve as a blueprint for the state and local communities.

The Subcommittee recognizes that LTSS system change is impacted by broader issues and requires engagement and collaboration between state and local agencies, the Legislature, and the private sector. As such, we urge the Governor to establish a cabinet level position to elevate the importance of the Master Plan for Aging across all sectors and to ensure successful implementation.

Leadership

Our hope for the Master Plan for Aging lies in the potential for broad system change, and in the opportunity to fundamentally reframe the way we collectively view and serve California's older adults and people with disabilities.

Aging is all of us. It touches individuals, families, communities, employers and institutions. We are all impacted by the issues—whether a younger adult with a disability who needs services to remain at home, an older immigrant who struggles to find the LTSS they need, or the Millennial/Gen-xer caring for an aging loved one while balancing employment, education, and childcare issues.

As people live longer and healthier lives, they are contributing to communities and fueling economic growth well past the traditional retirement age, and in new and different ways. Individuals of all ages and abilities drive the California economy as taxpayers, employees, employers, students, volunteers and caregivers.

Bold leadership starts at the top with elected and appointed officials who are willing to invest in and prioritize the needs of this growing segment of our state's population. The leadership starts with the Governor and flows across agencies of Health and Human Services, Housing, Transportation, Labor, Education, Employment and Veteran's Affairs, among others. Meaningful change can be brought about by budget investments and policy developments that prioritize the needs of older adults, people with disabilities, caregivers and families.

Implementation of the issues and recommendations outlined in this report relies on strong leadership from the state, the Legislature, local governments and the private sector. Without strong leadership, nothing can be realized -- but with it, everything can be accomplished. We are optimistic that California is at the forefront of positive change, rooted in the combined strength of our leaders and stakeholders.

Equity

California is one of the most racially, ethnically and linguistically diverse states in the nation. Equity issues impact access to LTSS across the state for under-represented, under-served and under-recognized communities. This is emphasized by the number of recommendations and comments addressing diversity, social justice, racism, health disparities, social determinants of health, discrimination, xenophobia, cultural humility and marginalization.

The LTSS Subcommittee affirms the critical importance of equity in addressing the LTSS needs of older adults and people with disabilities, including the workforce, thereby eliminating disparities caused by systemic barriers. To achieve this aim, the Stakeholder Advisory Committee established an Equity Workgroup to ensure all Master Plan for Aging recommendations, including this report, uphold the core value of equity by meeting agreed-upon criteria.

> Research shows how discrimination influences and determines how long and healthy our lives are. "Experiencing discrimination day after day creates physiological responses that lead to premature aging (meaning that people are biologically older than their chronological age), as well as poorer health compared to other groups, and even premature death."
>
> (Robert Wood Johnson Foundation)

Big Ideas

This LTSS Subcommittee report is the culmination of months of stakeholder input, public comment, listening sessions, expert advice, educational webinars, data analysis, independent research, Subcommittee discussion and respectful dialogue.

We urge the Master Plan for Aging Stakeholder Advisory Committee to fully integrate the following recommendations within the broader context of the comprehensive Master Plan for Aging including livable communities, healthy aging, and protecting vulnerable populations.

The principle of equity underpins and informs the recommendations., reflecting the diversity of California communities. We believe the following five Big Ideas are core components needed to meet our population's LTSS needs. Each objective is interdependent. People need to be able to understand LTSS services and supports, how to find and navigate these systems and, importantly, services need to be available across the state. Availability has as much to do with where services and supports are available (access) as with the supply of workers to provide LTSS. Most people need help paying for LTSS and want to avoid spending down to poverty levels. New options for helping the middle class afford LTSS underpin our recommendations.

- Objective 1: A system that all Californians can easily navigate
- Objective 2: Access to LTSS in every community
- Objective 3: Affordable LTSS choices
- Objective 4: Highly valued, high-quality workforce
- Objective 5: Streamlined state and local administrative structures

We call on the state to adopt a plan and strategy that addresses each of these components, starting with the bold leadership needed for system change.

SUMMARY OF SUBCOMMITTEE OBJECTIVES

The Subcommittee respectfully recommends adoption of five bold objectives.

OBJECTIVE 1: A SYSTEM THAT ALL CALIFORNIANS CAN EASILY NAVIGATE

OBJECTIVE: California will have in place an understandable, easy-to-navigate LTSS system that includes both home and community-based and residential options. Californians will know how to quickly connect to services they need, no matter where they live or their economic status. People will find what they need wherever they enter -- whether through the health care system, the public benefits system, the disability service system , including Regional Centers, or the community-based system.

WHY: California's current LTSS system has many different public and private programs often operating without coordination, making it hard for people and their caregivers to locate and navigate services. This difficulty has real life consequences because it means people cannot easily connect to and use the services they need, when they need them.

California must ensure that, regardless of how complicated the system is behind the scenes, the experience for the person is coordinated, clear, and cohesive.

OBJECTIVE 2: ACCESS TO LTSS IN EVERY COMMUNITY

OBJECTIVE: California will have the country's most comprehensive LTSS system where people and their caregivers can find and afford the services they choose, where and when they need them. California must act urgently to fund statewide access to LTSS to ensure sufficient services exist to meet the growing needs of older adults and people with disabilities.

WHY: LTSS programs are not available or affordable for many Californians. Our state has laid a strong foundation over many decades but must expand proven programs to all corners of the state, while creating new innovative solutions using people and technology.

OBJECTIVE 3: AFFORDABLE LTSS CHOICES

OBJECTIVE: California will shift the historical bias for institutional care toward Home and Community-based Services, (HCBS), thereby enabling all Californians who need these services the ability to access them. In addition, California will have in place a statewide universal LTSS benefit program that helps people pay for the Long-Term Services and Supports they choose, at home, in the community, or in residential settings. The LTSS benefit program will be available to people at all income levels and will help delay or prevent the need for people to exhaust all their personal resources in order to access Medi-Cal, including IHSS,for their LTSS needs. California must act now to fund its core programs while creating new sources of LTSS funding to help people avoid the need to spend down to poverty level.

WHY: Many people will need LTSS at some point in their lives and paying cash out-of-pocket is unaffordable for most. Many people spend substantial resources on LTSS services, driving a significant number of Californians into poverty. This also puts enormous pressure on the Medi-Cal program to offer and pay for the majority of LTSS services, including IHSS and costly skilled nursing care.

OBJECTIVE 4: HIGHLY VALUED, HIGH QUALITY WORKFORCE

OBJECTIVE: Recognizing personal preferences and labor market challenges, the state must: 1) provide maximum support to family caregivers who have additional jobs outside the family caregiving setting through family leave policies, including job protections, that allow unpaid caregivers the flexibility to continue to earn while providing needed family support and; 2) accelerate growth of the paid workforce to meet increasing demand for LTSS.

To further address this challenge, public and private partners, including educational institutions, should commit to a statewide goal of attracting, training and retaining workers to fill 1 million high-quality direct care jobs. These jobs will be valued by providing livable wages and benefits, as well as training, education and advancement opportunities. Intentional policy and budget actions will result in improved job retention and satisfaction, thereby leading to a more stable workforce with less turnover.

WHY: Building a robust network of LTSS options relies heavily on a sufficient supply of both paid and unpaid caregivers. For the paid workforce, Department of

Labor statistics show that there are not enough direct care workers to meet population needs due to low wages, meagre benefits and low respect for demanding jobs requiring difficult physical and emotional work. Additionally, California's LTSS system is heavily dependent on immigrants. It is critical that we protect these workers who are the cornerstone of the paid labor force.

For unpaid caregivers, balancing caregiving responsibilities with employment and other obligations requires comprehensive solutions to address unique needs that are often unrecognized.

OBJECTIVE 5: STREAMLINED STATE AND LOCAL ADMINISTRATIVE STRUCTURES

OBJECTIVE: The California Health and Human Services Agency will have a dedicated cross-department unit focused on LTSS that has authority to develop an effective LTSS system that meets the needs of California's older adults, people with disabilities, caregivers and families; align administration of LTSS across departments; coordinate LTSS, including IHSS, to promote seamless access to services; promote integration and coordination of care for California's Medi-Cal/ Medicare enrollees; and drive innovation in LTSS service delivery.

WHY: An effective state and local service delivery system relies on effective, streamlined and coordinated leadership at the state and local levels. Yet, California's state and local program structures remain fragmented and siloed across 22 state departments and programs.

Objectives and Recommendations

OBJECTIVE 1:
A SYSTEM THAT ALL CALIFORNIANS
CAN EASILY NAVIGATE

"I am helping my 66-year-old brother navigate what is
possible for him...and it has been hit and miss in
terms of knowing where to go for resources that are
likely to be helpful."
Public Comment

California will have in place an understandable, easy-to-navigate LTSS system that includes home and community-based and residential options. Californians will know how to quickly connect to services they need, no matter where they live or their economic status. People will find what they need wherever they enter -- whether through the health care system, the public benefits system, the disability service system , including Regional Centers,, or the community-based services system.

1A: Develop a Comprehensive Statewide Navigation System
Issue: Many older adults, people with disabilities and their caregivers, and families face difficulty accessing the services and supports they need, when they need them. They don't know where to turn for help and don't understand the existing service system well enough to know where to start. Getting timely, accurate information that is linguistically and culturally responsive is critical to avoiding costly institutional care, preventing health and safety emergencies, or when seeking aid during emergencies and disasters. Current information and assistance services lack consistency, creating an opportunity to develop program standards that ensure quality local information and navigation services.

California has yet to design a statewide person-centered system for people with respect to age, disability and income that provides timely access to accurate information and assistance. Any organization serving older adults and people with disabilities should be able to help people navigate, exchange information, and connect to the services they need.

Recommendations:

1A i: Implement a statewide person-centered No Wrong Door approach to navigation at the local level with trusted community partners using common standards for a local information and assistance system that is open to all Californians.

1A ii: Fund and implement a web-based portal that would offer a public-facing, trusted source of information for people seeking accurate LTSS information anywhere in California. The platform should serve as a one-stop source of information and include home and community-based services, as well as residential and institutional care options.

1A iii: Build on existing local networks and statewide 24/7 call lines to create a system that offers culturally responsive, multi-lingual, and ADA accessible information and assistance to ensure equitable access.

1A iv: Develop and provide adequate resources to implement statewide quality standards for information and assistance services that are linguistically and culturally responsive to ensure consistency and accuracy. Evaluate local information networks such as Area Agencies on Aging, Independent Living Centers, and 211s for compliance and consistency statewide.

1A v: Conduct a statewide marketing campaign, using easily understood messaging that is linguistically and culturally responsive, to educate the public about how to connect with aging and disability information and resources.

1B: Streamline Access through Standardized Screening and Assessment

Issue: For people who need timely access to LTSS, the process of enrolling for services can be cumbersome and inefficient, requiring individuals to undergo separate eligibility and assessment processes, with no assurance that their needs will be met. For the person, this is tremendously frustrating and often creates delays in accessing needed services and supports. For the state, this disjointed assessment system fails to capture data that identify unmet needs and gaps in services, which is critical for system planning and improvement purposes. A "No Wrong Door" approach would create a more efficient process to determine the individual's broader LTSS needs so they can be guided to the organizations and agencies that best meet their needs.

Recommendations:

1B i: Work with stakeholders to identify the common standard questions that are linguistically and culturally responsive, and a set of data-informed public domain screening tools to identify functional, health, cognitive and social support needs and risk factors, while documenting the individual's goals and preferences. As appropriate, these questions should identify who is serving in the role of caregiver to determine if additional supports are needed.

1B ii: Adopt a common baseline of data elements across all LTSS programs that can be shared securely and quickly among LTSS partners.

1B iii: Pursue development of comprehensive assessment questions, to include physical, oral, cognitive and mental health, that are linguistically and culturally responsive, to be utilized across health and LTSS settings, with the necessary data, funding, and infrastructure to support its system-wide implementation.

1B iv: Ensure Californians with cognitive impairment are identified through a culturally and linguistically responsive intake process and assessed for risk. Currently, one in five persons with dementia lives alone and is at-risk.

1C - Expand Aging & Disability Resource Connection (ADRC) Statewide

Issue: California's ADRC network offers a model to streamline access to and coordinate LTSS through a "No Wrong Door" system. ADRCs are a key component in transforming how Californians access LTSS services. However, currently only six of California's 58 counties operate an ADRC, impeding access for consumers of all ages, income levels and disabilities in need of information and assistance. At present, ADRCs have limited ability to determine eligibility for those consumers who qualify for public benefits and programs.

Recommendations:

1C i: Empower consumers to make informed decisions about LTSS by funding ADRC Options Counseling statewide for anyone, across age, disability and income level, who requests information and/or services because of a disability, chronic condition or status as a family caregiver. Options Counseling includes a person-centered interview, decision-support, action plan development, referral to and navigation of services, and follow-up.

1C ii: Provide ongoing infrastructure funding to incentivize ADRC development and implementation statewide.

1C iii: Provide the California Department of Aging (CDA) with resources to support the ADRC initiative (e.g., training; technical assistance; policy and program guidance; monitoring and evaluation) to ensure consistency and quality of services statewide.

1C iv: Coordinate ADRC services closely with county Health and Human Services agencies and core partners including Area Agencies on Aging, Independent Living Centers, and Regional Centers.

1C v: Enable seamless access to public benefits and programs with the state taking the lead in partnering with local entities.

1D - Develop a Five-Year Plan for Integrated Medi-Cal Managed Care

Issue: The state's Medi-Cal CalAIM proposal seeks to improve health care through innovation and a whole-person approach to care. Among other provisions, the proposal outlines a broad framework for an integrated service delivery system for California's older adults and people with disabilities. We believe that a truly person-centered care system relies on coordination of all services- including physical health, oral health, mental health, cognitive health and LTSS—alongside and on behalf of the person. As such, we recommend the state develop a five-year plan that contains elements that are critical to meeting the populations' needs.

Recommendations:

1D i: Outline a five-year Medi-Cal/Medicare integration plan that commits the state to the highest level of integration possible. The plan must:

a. Ensure people who qualify have access to an integrated Medi-Cal/Medicare health plan and that those plans are federally defined Fully Integrated Duals Special Needs Plans; Highly Integrated Special Needs Plans; and the Program for All Inclusive Care for the Elderly (PACE).

b. Incorporate best practices from California's past integration efforts, such as requiring health plans to train staff on Alzheimer's and dementia, improve quality of care in nursing facilities, provide institutional long-term care diversion and transition services, ensure all Health Risk Assessments include standardized LTSS screening questions developed through a stakeholder process, and coordinate with programs and services that are not offered through Medi-Cal managed care.

c. Require strong consumer protections, improved access to home and community-based services, stakeholder engagement, ongoing evaluation, and provide incentives for contracting with local, trusted and linguistically and culturally responsive community-based organizations.

d. Ensure Medi-Cal/Medicare (dual eligible) recipients are included in all components of the Medi-Cal CalAIM proposed programs and services.

e. Implement a comprehensive set of Home and Community-Based Services (HCBS) as covered benefits in Medi-Cal, building on the voluntary services (federally defined "in lieu of services") proposed in Medi-Cal CalAIM.

f. Include these comprehensive services in all home and community-based services to help an individual avoid institutionalization, including adult day care, residential care facilities, and a purchased services model like that used in the Multipurpose Senior Services Program (MSSP) and PACE programs.

g. Establish incentives for health plans to build and provide or contract for these supplemental services.
Establish a policy and specific targets for reducing avoidable institutionalization.

1E - Establish a Statewide Integration Oversight Council

Issue: Stakeholder engagement in the planning and implementation of California's CalAIM initiative is critical to ensuring effective and high-quality integrated services. However, the state lacks a structure to engage consumers, providers, researchers and stakeholders on decisions impacting dual eligible individuals and Medi-Cal-only older adults and persons with disabilities relative to integrated service delivery.

Recommendation:
1E i: Establish a formal stakeholder council comprising health plans, consumers, advocates and healthcare providers on issues pertaining to integration of Medi-Cal/Medicare and Managed Long-Term Services and Supports (MLTSS). The council should be charged with exploring and analyzing emerging

implementation issues and challenges and provide recommendations for system-wide improvements.

1F - Create a Medi-Cal/Medicare Innovation and Coordination Office

Issue: At the federal level, the Medicaid and Medicare programs operate independently and under different funding streams. At the state level, this fragmentation often prevents individuals eligible for both programs from accessing the full range of health and LTSS services they need. Focused coordination can improve health outcomes and lower overall costs, especially for high cost populations. For example, Medicare and Medicaid will spend $195 billion in 2019 providing care to persons with dementia, 67 percent of total costs. While the state seeks opportunities to develop its CalAIM initiative, strong leadership to guide integration of Medi-Cal and Medicare, including LTSS, is critical to achieving the goal of a more person-centered efficient way to deliver services.

Recommendations:

1F i: Establish an office in the Department of Health Care Services to design and implement innovative strategies that are linguistically and culturally responsive to serve individuals and families from diverse backgrounds and experiences who are eligible for Medi-Cal/Medicare with a goal of improving how services are delivered at the local level across the health and LTSS systems. The office would explore new models in partnership with state and federal partners, while also overseeing implementation of related elements of Medi-Cal CalAIM initiative.

IF ii: Explore targeted demonstration programs intended to reach special populations with complex care needs (e.g. evidence-based interventions for Medi-Cal beneficiaries with Alzheimer's disease) whose Medicaid costs are currently 23 times higher than costs for older adults without a cognitive impairment.

1G - Simplify IHSS Program Administration

Issue: As the IHSS program has expanded and changed over the years, it has become more administratively complex for recipients, providers, and the counties. Some of this complexity is the result of managing a large, robust public benefit, but some of it is caused by unnecessary policies and procedures. This has real negative consequences for recipients, providers, and the counties.

Recommendations:

1G i: Evaluate which administrative rules are necessary and work with stakeholders to allow greater flexibility and simplify administration of the IHSS program, where possible.

1G ii: Simplify and improve the functional needs assessments while ensuring individual need is reflected and allow for simple re-determinations for recipients with stable conditions.

1G iii: Change the parent-provider rules to allow for a choice of providers.

1G iv: Streamline provider rules to ensure it is easy to hire and pay providers as quickly as possible.

1G v: Improve the coordination between the IHSS program and institutional settings to ensure there are no gaps in services for those being discharged.

1H - Enhance IHSS Public Authority Practices and Training

Issue: Public Authorities are mandated to provide services which supplement the IHSS program in their counties which include: a referral registry which recruits, screens, and matches workers with IHSS recipients; training for providers and recipients; and responsibility as the employer of record for bargaining with the union representing the IHSS workforce. Recipients who need a provider may become frustrated with the Public Authority registry and dissatisfied when providers on the registry are not able to serve additional clients or do not return phone calls.

Recommendations:

1H i: Identify and apply best screening and matching practices to improve recipient experiences.

1H ii: Increase and expand caregiver training delivered through multiple avenues.

1H iii: Provide IHSS provider training stipends. To achieve this goal, the state may need to work to eliminate state and federal rules prohibiting financial incentives.

1I - Improve Coordination Between IHSS, Health and Other LTSS Providers

Issue: Although IHSS is a Medi-Cal benefit, it is often seen as separate from all other LTSS and health programs and benefits resulting in a lack of coordination for recipients.

Recommendations:

1I i: Improve care coordination between the IHSS program and other LTSS and health providers including formal authorization for secure information sharing with managed care providers of health and LTSS services.

1I ii: Require the state to collect data and report on beneficiary access to services, including referrals and receipt of services, transitions and care coordination.

"I'd like for everyone to feel safe to grow old in this, the
richest country in the world, and feel like as you age, you can
age in place, you can age with proper supportive services.
You can age with the things that are just basic tenets to life,
things that we all should have."

Photo of Gwen Boozé, (Alameda County)

California will have the country's most comprehensive LTSS system where people
and their caregivers can find and afford the services they choose, where and
when they need them. To do this, California must act urgently to fund statewide
access to LTSS to ensure sufficient services exist to meet the growing needs of
older adults and people with disabilities.

2A - Remove Barriers to Community Living

Issue: A federal Supreme Court ruling, known as the *Olmstead* Decision, requires
states to ensure access to services and supports in the community as an
alternative to institutionalization. However, Californians continue to experience
barriers to community living, especially for those who have few resources or lack
people to serve as advocates when there is a personal crisis or hospitalization. An
individual's ability to remain in or return to the community setting of their choice is
often a function of their socioeconomic status; functional disability; or
geographic location. An emergency, hospitalization or unstable housing can
lead to an avoidable placement in a nursing facility.

Recommendations:

2A i: Develop a statewide institutional diversion and transition strategy including:

     a. Establish a California Community Living Fund as a "bridge" program that expedites the provision of goods or services – including rent – not available through other means to individuals either transitioning to the community or at-risk of institutionalization.

     b. Require that person-centered assessments and transition planning conducted in institutional settings are linguistically and culturally responsive to support an individual's return to the community.

     c. Expand California's Pre-admission Screening and Resident Review Program (PASRR) to all older adults and people with disabilities using Oregon's experience as a model. Currently, in California this program is only available to individuals with serious mental illness and individuals with intellectual or developmental disabilities.

     d. Authorize the California Community Transitions (CCT) program permanently. Streamline and improve its operation to more effectively provide transition services.

     e. Provide incentives for Medi-Cal managed care plans to participate in an institutional diversion and transition strategy.

2B - Invest in Public/Private Infrastructure Expansion for Local Communities

Issue: California's LTSS infrastructure, which is administered by a mix of government and private sector entities, has struggled to keep up with demand for services, due, in great part, to years of state budget disinvestments in LTSS services. State funding uncertainty and lack of attention to often outdated regulatory barriers that impact access have played a role in diminishing access to services and have inhibited private sector investment in LTSS.

Many LTSS programs have closed their doors, leading to negative consequences: consumers are left without access to care or must travel long distances to obtain needed services. These conditions are most pronounced in rural regions of the state but are not limited to rural service areas.

In addition, metrics to measure consumer access to LTSS services do not exist. Without such standards, the state cannot measure progress toward the overall goal of equitable access to services. For example, what is the desired ratio of residential options or adult day service enrollment per 1,000 population of older adults and people with disabilities?

Recommendations:

2B i: Adopt the following minimum core of services to serve as a local blueprint for LTSS infrastructure (alphabetical order):

– Adult Day Services (Adult Day Health Care and Adult Day Programs)
– Aging & Disability Resource Centers (ADRCs)
– Caregiver Resource Centers (CRCs)
– Care management
– Independent Living Center services

- Information and Assistance
- In-home care
- Nutrition services
- Older Americans Act Programs
- Older Californians Act Programs
- Program for All Inclusive Care for the Elderly (PACE)
- Residential housing options, including RCFEs and SNFs
- Transportation and mobility services

2B ii: Develop minimum standards for how easily Californians can access these core LTSS, including the time and distance it takes to get to a service outside of the home.

2B iii: Create and maintain a web-based database of LTSS programs to enable the state and local communities to assess current LTSS availability, identify gaps, support development of new resources, and measure progress.

2B iv: Include in the state budget immediate investments to build an equitable core LTSS system infrastructure at the local level:

   a. Fund expansion of services provided by Caregiver Resource Centers, including administering high-quality caregiver assessments by trained professionals, providing information and referral services using up-to-date resource lists, providing evidence-based/data-informed education and training programs, raising caregiver awareness, and supporting innovative programs, including digital and online programs, to meet the evolving needs of family caregivers.

   b. Invest in and enhance the state's contribution to the federal Title IIIE Family Caregiver Support program.

   c. Modernize the Multipurpose Senior Services Program (MSSP) by increasing total "slots," expanding to all counties, and changing eligibility to lower the eligibility age from 65 to 60.

   d. Use one-time state grants to spur development of non-profits interested in starting Adult Day Health Care (ADHC), Adult Day Programs, and Centers of Alzheimer's disease Excellence to support the person experiencing Alzheimer's disease or related dementia and their caregivers. Concurrently, amend Health and Safety Code 1579 to provide for more flexibility in how ADHC is delivered in rural communities (33 counties are currently without adult day services) and reimbursed under Medi-Cal Managed Care.

   e. Encourage expansion of PACE, especially in underserved regions of the state.

   f. Encourage Medi-Cal managed care plans to use incentive funding available through CalAIM to fund LTSS capacity in every community.

   g. Develop a plan and funding stream to make Traumatic Brain Services available throughout the state as outlined by SB 398 of 2018.

   h. Provide fall prevention programs through the Area Agencies on Aging (AAAs) to prevent primary and secondary falls and keep people safe in their homes.

i.   Expand the Assisted Living Waiver program to all counties in the state and increase the number of allowable slots to include those in the community on the waiting list and those in nursing homes who could benefit from a transition (approximately 18,500 total slots).

j.   Ensure that the No Wrong Door system includes linguistically and culturally responsive referrals for individuals in all care settings and stages of their life, including end-of-life and palliative care to reduce hospitalization and institutionalization.

2C - Increase Access to Home and Community-Based Waiver Programs

Issue: California's eight Home and Community-Based 1915(c) waivers provide critical services including in-home nursing care, case management, respite support, home modification, and others that enable individuals to remain at home and avoid institutionalization. However, the current waiver system is often unable to meet need, as evidenced by the long wait lists for waiver services.

Recommendations:

2C i: Analyze wait lists for and evaluate barriers to statewide access to the Home and Community-Based Alternatives Waiver, the Assisted Living Waiver, and the MSSP waivers.

2C ii: Expand waiver services into unserved counties with the goal of avoiding and eliminating wait lists for eligible recipients.

2C iii: Evaluate current waivers to determine how to improve access for Medi-Cal beneficiaries who are at risk of institutionalization or who are currently institutionalized and in need of transition to the community.

2D - Expand Access to Equitable, Accessible and Affordable Medi-Cal

Issue: Medi-Cal provides health insurance coverage to almost 2 million low-income older adults and people with disabilities in California. Medi-Cal is critical to ensuring that they have access to home and community-based services. Yet, Medi-Cal is not accessible to all low-income individuals, and the program's eligibility rules force older adults and people with disabilities to live in deep poverty in order to receive services. This is particularly true for older women, immigrants, racially and ethnically-diverse communities and LGBTQ individuals, who are more likely to rely on Medi-Cal. Additionally, people working while disabled face unique challenges because working can affect their ability to remain eligible for needed LTSS.

Recommendations:

2D i: Cover all undocumented older adults to ensure all Californians have access to health care.

2D ii: Substantially increase asset limits for Aged and Disabled Medi-Cal and eliminate asset tests for the Medicare Savings programs to ensure low-income individuals do not have to live in abject poverty to receive benefits.

2D iii: Explore options for "presumptive eligibility" to speed up access to IHSS where urgent need arises.

2D iv: Substantially increase the monthly Medi-Cal maintenance need income level for both community Medi-Cal and institutional care to make Medi-Cal affordable.

2D v: Make the spousal impoverishment expansion permanent to ensure married individuals can remain living at home.

2D vi: Simplify the renewal process for Medi-Cal and enrollment in Medicare Savings Programs to ensure maximum enrollment in the programs and less turnover in the program.

2D vii: Index these changes so the changes made as a part of this process continue to improve access, equity, and affordability now and in the future.

2D viii: Explore options to support people with disabilities who are employed but unable to access a range of necessary LTSS. These options may include expanding Medi-Cal coverage of assistive technology and other LTSS to people with disabilities who are employed and do not meet the threshold for the Working Disabled Program.

2D ix: Expand access to the Medi-Cal Working Disabled Program and increase the income eligibility threshold to meet population need.

2E - Improve Emergency Preparedness and Response in the LTSS System

Issue: Older adults and people with disabilities are two to four times more likely to die or experience a serious injury in a disaster or public health emergency. In California, these threats are increasing in frequency, intensity, scale, and duration because of climate-related changes, novel diseases and outdated infrastructure. Most recently, California's recurring Public Safety Power Shutoffs (PSPSs) place millions of older adults and people with disabilities' health and safety at risk, most acutely impacting low-income individuals. Effective emergency planning for any emergency or disaster requires partnerships among all levels of government, business sector, and community-based organizations.

Recommendations:

2E i: Develop a statewide, coordinated linguistically and culturally responsive disaster and emergency preparedness marketing and education campaign for older adults and people with disabilities.

2E ii: Provide funding to counties for outreach and coordination of services for vulnerable populations during times of a public health emergency and disasters.

2E iii: Require a mechanism for collaboration (e.g., a Memorandum of Understanding (MOU)) between local agencies, counties, community-based organizations, private LTSS organizations, Red Cross, FEMA and the state to coordinate services during disasters or a public health emergency such a disease outbreak. Require the MOU to include utility companies for coordination activities before and during a declared emergency or PSPS.

2E iv: Require county IHSS social workers to develop and review each IHSS recipient's personal emergency plan annually to update critical data for emergency response.

2E v. Establish an emergency back-up system of IHSS providers administered by Public Authorities for when a caregiver is unavailable to care for an IHSS recipient.

2E vi: Create a billing/payment category for emergency services that can be used to compensate IHSS providers for additional hours worked during emergencies or natural disasters.

2E vii: Mandate county staff attend shelter fundamental training and shelter management training, as appropriate.

2E viii: Provide funding for additional training for older adults and people with disabilities, including Access and Functional Needs (AFN) and Functional Assessment Services Team (FAST) training.

2E ix: Allow background checks from other entities to suffice for allowing a home care provider to provide care in an emergency shelter.

2E x: Expedite enrollment into Community-Based Adult Services (CBAS) programs on emergency basis; waive certain staffing and program requirements to be able to meet immediate shelter, food, health and safety needs of community members; allow for reimbursement during days of operation when requirements are waived.

2E xi: Coordinate with licensed care settings, e.g., Residential Care Facilities for the Elderly (RCFEs) and Skilled Nursing Facilities (SNFs), to ensure staffing is in place and transportation is available to assist all residents.

2F - Strengthen Quality and Choice in RCFEs and SNFs

Issue: Residential care settings, including RCFEs and SNFs, offer an important, and sometimes necessary, option for individuals needing LTSS. However, several issues impact residents' ability to access and afford a range of services within these settings. While there are many perspectives on the solutions, there is general agreement that there is an urgency to address several challenges in this area, as identified below.

Recommendations:

2F i: Expand supported residential options and identify and implement other affordable alternatives, e.g., foster adult and adult family home models.

2F ii: Integrate Skilled Nursing Facility licensure with other ancillary service (e.g. infusions, dialysis, laboratory services, x-rays, etc.) provider types to allow these services to be offered within the facility so residents do not need to go offsite for these procedures.

2F iii: Ensure those who are deaf and hard-of-hearing have access to communication devices, staff who can communicate in American Sign Language, emergency procedures that include methods accessible to persons with hearing impairments, and other modalities for meeting access needs.

2F iv: Provide for those with vision loss information on menus, daily activities, among other things, in large print or other formats, orientation and mobility instruction that enables these individuals to navigate the facility successfully, and assistive technology that allows for communication with others outside the facility.

2F v: Ensure appropriate oral health care is provided in SNFs.

2F vi: Strengthen training and incentives for quality improvement in SNFs.

2G - Strengthen Oversight of RCFEs and SNFs

Issue: Over the last decade, licensing agencies and the Long-Term Care Ombudsman program experienced state funding reductions. Though funding has been partially restored in recent years, the concern remains that these entities do not have adequate resources to meet the growing needs of older adults and people with disabilities.

Recommendations:

2G i: Fund fully the oversight and monitoring of SNFs by the California Department of Public Health and RCFEs by the California Department of Social Services licensing divisions.

2G ii: Fund fully the Long-Term Care Ombudsman program at the California Department of Aging to ensure that there are enough paid and volunteer ombudsmen to fulfill the responsibilities mandated by state and federal requirements.

2G iii: Ensure public disclosure of key data elements related to facility ownership, operations and cost reporting to enable consumers to make informed care decisions.

2H - Strengthen Remedies to Protect People Living in Residential Facilities

Issue: Older adults and people with disabilities who live in residential facilities may experience abuse, neglect, or rights violations. Some residents with certain disabilities, chronic conditions or cognitive impairments may not be able to address the abuse, neglect or rights violations by themselves. Many residents lack access to family or friends who can assist them, and most do not have access to legal resources. For some residents, enforcement systems and remedies may be inadequate and for others existing public systems are under- funded to provide meaningful recourse. These efforts should prioritize the most cost efficient and effective methods for providing a prompt resolution of the alleged abuse, neglect or rights violation and securing quality care for these residents.

Recommendations:

2H i: The Administration should work with stakeholders to:

   a: Identify ways to strengthen the public and private enforcement of current laws designed to protect older adults and people with disabilities living in facilities.

b: Identify additional public and private remedies to address abuse, neglect, and rights violations of older adults and people with disabilities living in all types of residential facilities.

c: Fund current and new public enforcement systems adequately.

2I - Avoid Inappropriate Transfer to Higher Care Levels for Persons with Dementia

Issue: Ninety-seven percent (97%) of individuals with Alzheimer's disease experience behavioral and psychological symptoms with prevalence, frequency, and severity increasing as dementia progresses. These challenges in the home often precipitate placement in long-term care facilities and drive premature transfer to higher levels of care.

Recommendations:

2I i: Conduct an inter-departmental examination of admission, retention and transfer policies within and between levels of care to prevent residents with dementia who have behavioral issues from being improperly displaced from residential settings.

2I ii: Explore Medi-Cal rate differentials to adequately reimburse for the cost of care for beneficiaries with complex needs including dementia and behavioral health challenges.

2J - Ensure Stability and Sustainability of IHSS Financing

Issue: IHSS is the largest personal care services program in the United States serving more than 613,000 people and projected to serve more than 930,000 people by 2030. IHSS is a recipient-driven program based on a social, not medical, model, serving persons with disabilities and older adults since the 1970s.

While there are concerns regarding the size and cost of the program, these concerns are largely explained by at least two forward-thinking state policies: 1) a reduction in the use of institutional care and 2) an increase in the state minimum wage. Several years ago, during the recession, California enacted massive across-the-board cuts to IHSS hours. Temporary restoration of hours approved in the FY 2015-16 state budget are proposed in the FY 2020-21 budget to be temporarily funded through December 31, 2023. The temporary nature of this restoration of hours creates uncertainty and worry among recipients and contributes to workforce instability.

Recommendations:

2J i: Restore, permanently, the 7% cut to IHSS hours by rescinding the authorizing statutes.

2J ii: Establish a time-limited workgroup that includes the state, counties, and key stakeholders and experts in IHSS to create a long-term funding plan to update and simplify the IHSS funding formula, ensure sustainability for county IHSS costs, and identify new, sustainable funding sources dedicated to the program. This should include examining ways in which non-Medicaid

eligible individuals may be able to "purchase" or "buy-in" to IHSS services utilizing the existing workforce and administrative systems.

2K - Improve Equity in and Access to the IHSS Program

Issue: Among the 613,000 IHSS recipients, almost 70% are people of color, almost 50% speak a language other than English as their primary language, approximately 39% are seniors age 65-84, and 15% are 85 years of age or older. Despite the number of people with visual and hearing impairments using the program, IHSS does not include reading and completion of documents for persons with vision impairments nor does it offer sign language interpretation for those with hearing impairments. This creates a major impediment to accessing services for recipients with visual or hearing impairments.

Recommendations:

2K i: Meet the needs of a diverse IHSS population by ensuring the following:

    a: Improve language access by expanding the threshold languages.

    b: Fund linguistically and culturally responsive IHSS outreach to ensure all communities know about the benefit.

    c: Work with communities across the state to improve cultural responsiveness within the IHSS program.

    d: Include "reading services" and "sign language interpretation" to the list of allowable IHSS tasks.

    e: Improve access to protective supervision hours for persons with dementia.

2L - Increase Support for IHSS Recipients Who Need and Want It

Issue: A central tenet of the IHSS program is self-direction, and while it is imperative the state retain this principle, some recipients with certain disabilities, chronic conditions or cognitive impairments may not be able to successfully use the program if they have to independently manage their provider, including many who require protective supervision. This need exists across the age span and may be short-term or long-term and may create inequitable IHSS access for some recipients.

Recommendations:

2L i: Allow for and fund tiered levels of case management by county social work or public authority staff dependent upon need.

2L ii: Identify ways to improve coordination and integration of while it remains as a benefit outside of the managed care system:

    a. Expand access to voluntary IHSS contracted agency mode.

    b. Expand the use of supported decision-making including increasing funding for additional care coordination.

    c. Increase access to enhanced case management, including through the Multipurpose Senior Services Program (MSSP).

    d. Identify other methods to expand voluntary enhanced services for those who want and need support managing the IHSS program.

2M - Reduce Barriers to Accessing IHSS for Homeless Individuals

Issue: Currently, the IHSS program excludes individuals who are living on the street from receiving IHSS. Additionally, individuals in unstable or transitional housing have significant challenges getting on and staying on the IHSS program and some individuals living in shelters experience barriers to receiving IHSS services. This is largely due to the administrative complexity of applying for IHSS and how little assistance is available to support individuals who are at risk.

Recommendations:

2M i: Reduce barriers to eligibility and retention for those experiencing homelessness and housing instability.

2M ii: Increase administrative flexibility to meet the needs of this population.

2M iii: Invest in innovative solutions.

OBJECTIVE 3:
AFFORDABLE LTSS CHOICES

"There is no affordable alternative to nursing home care for adults needing less than full nursing but some level of assistance...toileting, dressing, supervision, meals etc....many [older adults and people with disabilities] live alone in dangerous circumstances or with family members who live with unbearable amounts of stress and worry."

Public Comment
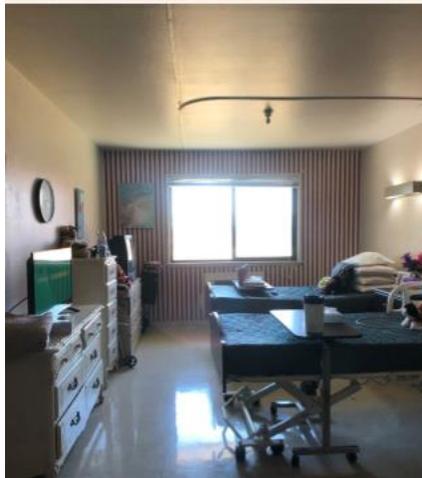
Photo of skilled nursing facility room with two empty beds

California will shift the historic bias for institutional care toward home and community-based services (HCBS), thereby enabling all Californians who need these services the ability to access them. In addition, California will have in place a statewide universal LTSS benefit program that helps people pay for the Long-term Services and Supports they choose at home, in the community, or in residential settings. The LTSS benefit will be available to people at all income levels and will help delay or prevent the need for people to spend down to poverty level to access Medi-Cal, including IHSS, for their LTSS needs.

3A - Create LTSS Financing Program

Issue: Californians of all ages and disabilities are at-risk of or forced to spend down assets to qualify for Medi-Cal in order to afford and access LTSS when the need arises. Middle income Californians pay out-of-pocket for most services and supports, and many go without needed assistance for lack of funds. Just one

example, the lifetime cost of Alzheimer's disease per person – a condition that impacts 670,000 Californians-- approaches $350,000, the median home price in Sacramento, the state capitol.

Recommendations:

3A i: Encourage the California Health and Human Services Agency to partner with the State Treasurer as well as public and private stakeholders including but not limited to the Department of Insurance, the insurance industry, labor unions, advocates and academics to advance a statewide public LTSS benefit to help the "forgotten middle" avoid spending down to poverty when LTSS becomes a need.

3A ii: Utilize the actuarial study currently underway at the Department of Health Care Services to assess the feasibility of creating a statewide public LTSS benefit.

3A iii: Conduct focus groups to assess the public interest in and need for such a program, following the publication of the actuarial study.

3A iv: Codify the program into law, including an oversight and governance board.

3B - Establish a Dedicated Funding Stream: HCBS as a Right

Issue: Californians often are unable to access the necessary services and supports in the home and community, whether due to long waiting lists or a lack of available options to meet their needs. Over the past decade, funding reductions and program eliminations have significantly weakened California's HCBS system. This ultimately harms the people who rely on these services, impeding their ability to remain in the community and avoid institutionalization. Under the federal Americans with Disabilities Act, and the United States Supreme Court *Olmstead* decision, individuals have the right to services and supports in the most integrated setting appropriate to their needs.

This issue, in part, is based on federal Medicaid requirements that require access to institutional care but make it optional for states to provide access to HCBS.

We believe that California should equalize access to HCBS throughout the state. This requires the state to take the bold step of establishing a right to services and supports in an HCBS setting, while securing the funding to do so.

Recommendations:

3B i: Establish the right for older adults and people with disabilities, up to 600% of the Federal Poverty Level, to receive services in a home and community-based setting as an alternative to institutionalization once they have exhausted any generic public or government resources that provide access to those services.

3B ii: Establish a dedicated funding stream sufficient to ensure access to HCBS.

3B iii: Ensure statewide access to services in the home and community that meet the identified service and support needs of older adults and persons with disabilities.

3B iv: Initiate a top-to-bottom review of regulatory barriers to accessing HCBS. This review would include, but not be limited to, how quickly people can access a needed service, what existing regulatory flexibility exists or is needed to encourage innovation in how services are delivered at the local level, especially in rural communities, and barriers to expansion of services in the community.

3C - Explore New Funding Streams for LTSS Through Medicare

Issue: At the federal level, new opportunities are emerging to pay for selected LTSS through Medicare. For example, the CHRONIC Care Act permits Medicare Advantage plans the flexibility to provide non-traditional supplemental benefits such as adult day care and meals as part of the plan benefits package targeted to members with complex conditions. Another option is to explore funding certain services through private Medigap insurance plans.

Recommendations:

3C i: Work with federal partners to explore broadening the approach to LTSS financing, including mechanisms that promote inclusion of LTSS benefits in Medicare and the private Medicare insurance market.

3C ii: Maximize new opportunities to expand access to non-medical Medicare benefits through new opportunities provided by the Chronic Care Act that permit Medicare Advantage plans the flexibility to provide new non-traditional supplemental benefits.

I really feel like, abandoned. So, it's really sad because it's like everybody has their own problems. They got their jobs, whatever, but I cannot get a job because I'm taking care of my mother. So…it's rewarding, but at the same time it's financially…a burden."

Photo of Maggie Marron-Edwards
Caregiver (Orange County)

Recognizing personal preferences and labor market challenges, the state must: 1) provide maximum support to family caregivers who have additional jobs outside the family caregiving setting through family leave policies, including job protections, that allow unpaid caregivers the flexibility to continue to earn while providing needed family support and; 2) accelerate growth of the paid workforce to meet increasing demand for LTSS.

To further address this challenge, public and private partners, including educational institutions, should commit to a statewide goal of attracting, training and retaining workers to fill 1 million high-quality direct care jobs. These jobs will be valued by providing livable wages and benefits, as well as training, education and advancement opportunities. Intentional policy and budget actions will result in improved job retention and satisfaction, thereby leading to a more stable workforce with less turnover.

4A - Expand Workforce Supply and Improve Working Conditions

Issue: California will face a labor shortage of between 600,000 to 3.2 million paid direct care home workers, and an estimated 4.7 million unpaid family caregivers. Caregiving is difficult and poorly compensated labor, performed overwhelming by women of color, many of whom are immigrants. Homecare workers earn less than half of California's median annual income and are twice as likely to live in a low-income household, with one in four falling below the federal poverty line. These workforce challenges are a significant concern for many LTSS settings and providers, requiring significant action to support direct care staff members.

Recommendations:

4A i: Establish a Direct Caregiver Workforce Development Task Force ("Task Force"), to be convened by the Labor & Workforce Development Agency. The Task Force will conduct research, assess public and private caregiver training and workforce development programs, expand apprenticeship programs, explore public-private partnerships and policy incentives for high-road employers, produce a blueprint for creating sustainable jobs, and implement demonstration projects to reach the goal of improving wages, working conditions, training, retention and care.

4A ii: Create and enforce comprehensive statewide workforce quality and safety standards for all businesses providing LTSS services in California, to be administered by the state. Quality standards must include wages, training and employee protections.

4A iii: Coordinate across state agencies and identify ways to streamline employee licensure, certification and registry,

4A iv: Invest in local, regional and statewide workforce development and career ladder training. This could include public education campaigns to attract employees to the field.

4B - Strengthen IHSS Workforce Through Statewide Collective Bargaining

Issue: More than 520,000 IHSS providers currently serve over 600,000 IHSS recipients. The average pay is just above the state minimum wage of $13/hour. IHSS providers do not receive vacation or paid holiday time off. They have limited access to employer-sponsored health benefits and no retirement security. A majority of IHSS providers are enrolled in Medi-Cal and other public assistance programs. Annual turnover in IHSS is 33%.

IHSS wages and benefits are significantly less than entry level wages in other industries. This has resulted in a severe shortage of IHSS providers around the state, often leading to recipients going without the services they need to remain safely in their homes. Wages and benefits for IHSS providers are negotiated at the county level through collective bargaining with unions. This has led to uneven wages and benefits across the state for the same work.

Recommendations:

4B i: Consolidate employer responsibility for collective bargaining to one entity at the state level that can negotiate with IHSS employee representative

organizations over wages, health benefits, retirement, training and other terms and conditions. This will allow the state to implement and have funding responsibility for policies that will increase recruitment and retention of the IHSS workforce as well as improve quality of services, for example, by offering a higher wage to providers who serve clients with complex needs.

4B ii: Expand eligibility for Unemployment Insurance Benefits (UIB) to IHSS providers who are the spouse or parent of their client. Parent and spouse providers are the only IHSS providers currently carved out of this protection.

4B iii: Implement a voluntary certified, standardized, and paid training curriculum for IHSS providers that offers career pathways and opportunities for increased pay for workers, increases their capacities to deliver care for the growing population of clients with complex care needs, addresses retention of the current workforce and attracts the workforce needed to meet future demands.

4B iv: Require workforce training to be linguistically and culturally responsive and include topics such as implicit bias, declining cognitive and physical abilities, Alzheimer's and dementia related conditions and social isolation. It should also include a special focus on training people with intellectual/developmental disability (I/DD) to do all or some IHSS tasks.

4B v: Ensure that individuals who agree to work as IHSS providers are enrolled into the system and paid in a standardized and timely manner.

4B vi: Repeal statutes that require IHSS providers to pay for their criminal background check.

4B vii: Establish statewide policies on sexual harassment prevention and workplace violence prevention in the IHSS program.

4C - Address Staffing Issues in Residential Settings

Issue: Providing round-the-clock care is labor intensive. There is widespread interest in addressing issues related to staffing patterns, staffing ratios, facility reimbursement, employee compensation, and staff training.

Recommendation:

4C i: The state should convene stakeholders, including the Department of Health Care Services and Department of Social Services, in a time-limited workgroup to address staffing challenges and respond to proposals calling for increased staffing ratios, elimination of current staffing ratio waivers, and linking Medi-Cal reimbursement directly to staffing.

4D - Address IHSS Social Worker Caseload, Training and Support

Issue: IHSS social workers currently have unacceptably high caseloads, which limits their ability to address individual needs, identify potential service needs, link recipients to other services, and coordinate with other programs. IHSS recipients may have complex health-related needs which would benefit from better coordination with medical providers.

Recommendations:

4D i: Increase funding to reduce social worker caseloads, with additional reductions for social workers with recipients requiring a higher level of care coordination.

4D ii: Provide increased funding in counties for Public Health Nurses who are critical in working with county IHSS and Adult Protective Services (APS) staff to identify health-related issues, serve as liaisons with medical, dental and mental health providers, and help recipients access needed medical services and devices.

4E - Build a Dementia Capable Workforce

Issue: By 2025, the number of Californians living with Alzheimer's disease will increase 25% from 670,000 today to 840,000 in 2025. Most persons with dementia live at home, in the community, relying on a network of family caregivers and home care providers. Within licensed settings (RCFEs and SNFs), estimates range from 50-80% of residents being affected by cognitive impairments, including Alzheimer's and other dementias. Forty to 50% of California's Adult Day Service participants are reported as living with Alzheimer's disease or related dementias. Staff understanding of the disease process is key to quality care regardless of the setting.

Recommendations:

4E i: Explore certification and career ladder programs to promote dementia specialization.

4E ii: Adopt the Dementia Care Practice Recommendations across all licensure categories.

4E iii: Restore the Alzheimer's Day Care Resource Center model to augment Adult Day Services expertise and extend it into the community.

4F - Ensure a Linguistically and Culturally Responsive Workforce

Issue: Person-centered care relies on understanding and accepting everyone's race, ethnicity, language, culture, faith tradition, sexual orientation, history, lived experience and preferences. California is among the most diverse states in the nation, with significantly increased diversity projected among the older adult and disabled populations over the next 10 years.

Recommendation:

4F i: Identify best practices in cultural responsiveness which may include implicit bias training and provide direct care staff with linguistically and culturally responsive education and resources to support them in their important work.

4G - Invest in LTSS Workforce Education & Training Strategies

Issue: There is a lack of opportunity and funding for training of new and experienced workers in the healthcare and caregiving professions. Increasing the availability of medical, social work, oral and mental health services and direct

care workers can only be achieved by expanding educational opportunities to develop a well-trained and diverse workforce.

Recommendations:

4G i: Support career pipelines for direct care staff focused on serving an aging population. This includes developing/expanding initiatives beginning with K-12 through community college and university to introduce students to prospective careers serving older adults and people with disabilities. This should include gerontology certificate programs in community colleges with specific linkages to advanced degrees with specializations in aging.

4G ii: Provide stipends and loan forgiveness for students entering the field, including high school, technical training programs, community and four-year colleges, and advanced degree programs.

4G iii: Support career ladders and mobility for direct care staff.

4G iv: Compensate caregivers for training time and reimburse mileage.

4G v: Coordinate requirements so that training leads to professional licensing and certifications.

4G vi: Establish and scale a universal home care worker family of jobs with career ladders and associated training.

4H - Support Family Caregivers by Expanding Nurse Delegation of Certain Tasks

Issue: Unpaid family or friend caregivers often face situations where they are challenged to perform health maintenance tasks for loved ones in the home setting, including but not limited to tube feedings, ventilator care, intramuscular injections, and ostomy care. For the unpaid caregivers who are unwilling or unable to perform this care, the preferred option is to hire a home health aide.

Yet, there is a lack of clarity about whether home health aides are authorized to perform these routine tasks, thereby requiring the family to hire a registered nurse (RN) or paraprofessional such as a Licensed Vocational Nurse (LVN) or psychiatric technician. Unfortunately, there are a number of barriers to obtaining these services through RNs, LVNs or Psych. Techs., including workforce shortages and cost of care which ranges from $10,000-$20,000 per year for two hours per day of paraprofessional services. For older adults living on fixed average annual median incomes of $50,000 or less, these expenses are cost prohibitive.

To address this issue, the state must clarify that home health aides can provide these services with proper training and supervision. This approach would benefit older adults and people with disabilities who need these health maintenance services and would offer much needed support to family caregivers who are unable to directly provide the services.

Recommendation:

4H i: Clarify, or revise existing requirements, to allow home health aides to provide health maintenance tasks including, but not limited to, tube

feedings, ventilator care, intramuscular injections, and ostomy care, with appropriate training and supervision.

4I - Paid Family Leave for All Working Caregivers

Issue: The aging of the population and increasing rates of disability have implications for all sectors of California and can no longer be viewed as a private, family-only issue. There are 4.7 million family caregivers in California who contribute an economic value of $63 billion. Many are the "forgotten middle" – not poor enough for Medi-Cal and not wealthy enough to pay for private care. Workforce caregivers who receive support save employers money by reduction of turnover, absenteeism, presenteeism, and staff morale. Despite the personal and financial value of all this care, state law does not currently provide job protection for people who work at companies with fewer than 50 employees. These family caregivers face the threat of losing employment for using paid family leave.

Recommendations:

4I i: California should immediately enact legislation to:
   a: Expand job protections for all caregivers, regardless of whether the individual is taking bonding leave or leave to care for a seriously ill adult.
   b: Broaden the definition of family member to allow a caregiver to designate a "family of choice" for the purposes of paid family leave.
   c: Expand funding for paid family leave outreach, with a focus on underserved communities, working with community-based organizations capable of delivering information that is linguistically and culturally responsive.

"When they implement something, I'm like, 'That doesn't make any sense for the family… who thought of this?' I wish they could see and hear the stories; you know?"

Photo of Natalie Franks, Adult Day Services Provider in Orange County, with her grandfather, who attended the CBAS Center

The California Health and Human Services Agency will have a dedicated cross-department unit focused on LTSS that has authority to develop an effective LTSS system that meets the needs of California's older adults, people with disabilities, caregivers and families; align administration of LTSS across departments; coordinate LTSS, including IHSS, to promote seamless access to services; promote integration and coordination of care for California's Medi-Cal/ Medicare enrollees; and drive innovation in LTSS service delivery.

5A - Establish New LTSS-Focused Unit at the Health and Human Services Agency

Issue: Older adults and people with disabilities often struggle to access LTSS due to the fragmented arrangement of state and federally funded programs spanning 22 different departments. There is little data sharing and coordinated policy development focused on the needs, priorities, and experiences of

individuals and their circles of support. This results in the inability to identify, plan, and effectively deliver services to Californians who need LTSS.

Recommendation:

5A i: Put in place a dedicated cross-department unit in California focused on LTSS in coordination with healthcare, led by a deputy secretary at the Health and Human Services Agency. Working with the 22 departments, this unit will examine options to align policies and administration of LTSS; coordinate efforts to support seamless access to LTSS, including IHSS; improve how to better integrate LTSS for California's Medi-Cal/Medicare enrollees; and promote innovation in LTSS service delivery, including technology.

5B - Re-Organize State Departments

Issue: While there are varying viewpoints on how best to organize state government, there is widespread agreement that any state reorganization effort should only proceed if it is grounded in system changes that will improve how state government meets the needs of older adults, people with disabilities, caregivers and families at the local level.

Recommendation:

5B i: Evaluate the current state administrative structure within the California Health and Human Services Agency, in consultation with stakeholders, to explore establishment of a new department within the Agency, providing state-level leadership in LTSS, healthcare, and home and community-based service delivery for older adults and people with disabilities. This department would encompass the current Department of Aging, among others, with the goal of enabling all Californians, across income and need, to age with dignity and independence in the setting of choice.

5C - Explore Feasibility of Integrating Aging and Adult Services at County Level

Issue: Often, at the local level, LTSS programs are fragmented and administered across multiple county-based and community-based agencies. This includes Aging and Adult Resource Connections (ADRCs); Area Agencies on Aging (AAAs); and county adult service programs; including IHSS; Adult Protective Services (APS), and Public Administrator/Guardian/Conservator programs. Local Regional Centers also interface with these county programs.

Recommendation:

5C i: Examine options to better integrate and coordinate service delivery across county health and human service programs at the local level. To this end, the Departments of Aging and Social Services should partner with counties and other entities including Area Agencies on Aging (AAAs) as well as IHSS, Regional Centers, Adult Protective Services and Public Guardian/Conservators to review options for consolidating administration

of services in order to provide older adults and people with disabilities with streamlined access to a fuller array of services at the county level.

5D - Explore Cross-Departmental Budgeting

Issue: LTSS financing in California spans multiple departments and funding streams based on annual population estimates or funding formulas for individual programs and services. This traditional budgeting practice prevents the flow of funds across programs and services based on individual needs and preferences. In contrast, flexible accounting provides the macro-level ability to move funds from one program to another based on patterns of use and emerging needs, as well as the micro-level authority to match care to an individual's needs.

Recommendation:

5D i: Explore options for developing a more flexible cross-department LTSS budget to accelerate California's rebalancing efforts and promote access to necessary services and supports according to individual needs and preferences. Specifically, the state should identify options for unifying the LTSS budget through a global/flexible budget across departments within a singular funding stream, or within and across multiple funding streams.

LTSS Stakeholder Subcommittee | Action-Ready Items

I.   Defining "Action-Ready" items

- **Immediate:** Ripe for immediate action
- **Tangible:** Gives "real people" something they recognize in the priorities
- **Touches all Californians in some way:** Impacts urban/rural, varying incomes; OAs and PWDs
- **Consensus:** Widely supported by a broad coalition
- **Equity:** Upholds equity values

II.   Initial Proposal for Action-Ready Items

1. A System That All Californians Can Navigate

- No Wrong Door: Web-based portal and standardized screening **(1A ii; 1B i)**
- ADRC program - No Wrong Door gateway: ADRC infrastructure & CDA funding **(1C ii; 1C iii)**
- Medi-Cal/Medicare coordination & integration: Establishment of Medi-Cal/Medicare leadership and innovation office* and 5-year integration plan* **(1D i, 1F i)**
- Navigation Quality standards: Statewide I&A quality standards **(1Aiv)**
- LTSS Coordination: IHSS & other LTSS coordination **(1Ii)**

2. Access to LTSS in Every Community

- Medi-Cal eligibility: Increase Medi-Cal asset limits and make Spousal Impoverishment avoidance provisions permanent **(2D ii, 2D v)**
- Stabilizing IHSS: 7% permanent & IHSS/homelessness* **(2J i; 2M i)**
- Equity & IHSS**:** Reading/sign lang. interpreters as IHSS services & Expand language access **(2Kiv, 2Ki)**
- Supporting Family/Friend Unpaid Caregivers: Caregiver Resource Centers and Title IIIE caregiver state matching funds **(2B iv a; 2B iv b)**
- Expanding Access to Services: Adult Day Services and related infrastructure grants; Multipurpose Senior Services Programs (MSSP) increase; & Assisted Living Waiver (ALW) expansion* **(2B iv c, 2Bi v d, 2B iv i,)**
- Community Living and Transition: Community Living Fund & Community Care Transition (CCT) permanence **(2A I a; 2A I d)**
- Emergency Preparedness: Emer. Prep. education campaign*; IHSS emergency back-up*; IHSS emergency billing*; background checks***;** expedited CBAS* **(2Ei ,2E v; 2E vi; 2E ix, 2E x)**
- LTSS Infrastructure: Core service mix **(2Bi)** & Analyze waitlist barriers **(2Ci)**
- Quality of Care: LTC Ombudsman full funding **(2G ii)**
- Institutional LTC: Public disclosure of LTC data **(2Giii)**

3. Affordable LTSS Choices

- Establish Framework for LTSS Benefit: Health and Human Services Agency – work with partners on advancement of statewide LTSS benefit **(3A i)**
- HCBS Regulations: Review HCBS regulations **(3Biv)**

4. **Highly Valued, High-Quality Workforce**
   - Supporting Paid Caregivers: Direct Caregiver Task Force **(4A i)**
   - Supporting Unpaid Caregivers: Expand job protections **(4I i a)**
   - Expand benefits for IHSS providers: Unemployment ins. benefits for spouse and parent providers **(4Bii)**
   - Build a Dementia Capable Workforce: Explore certification and career ladder programs **(4Ei)**

5. **State and Local Administrative Structures**
   - HHS Agency Health & LTSS Coordination Unit **(5A i)**

Appendix - Acronyms and Definitions

AAA   Area Agencies on Aging are a public, joint powers, or private non-profit local agency, designated by the state Department of Aging (CDA)to address the needs and concerns of all older persons at the regional and local levels. AAAs are authorized under the federal Older Americans Act (OAA) and the Older Californians Act (OCA) and administered at the state level by the CDA. The OAA contributes the bulk of funding but the state contributes funds through the annual state budget process. TAAA services are available to individuals aged 60 and older across all income levels.

ADP   Adult Day Programs are licensed by the California Department of Social Services as group settings that are open for less than 24-hours and serve anyone 18 and older who need assistance and supervision during the day. Programs serve people with intellectual or developmental disabilities or other adults with cognitive impairment such as Alzheimer's disease or another dementia. Most funding is private pay but some long-term care insurance plans and local AAAs or Caregiver Resource Centers (CRCs) may also provide funding for out-of-home respite care.

ADRC   Aging and Disability Resource Connections assist individuals with disabilities and/or chronic conditions in accessing health care, medical care, social supports, and other LTSS. ADRCs offer enhanced information and referral, long-term care options counseling (one-on-one decision support across all networks), short-term service coordination (when there is an urgent need for support until a longer -term arrangement can be made), and access to information. ADRCs operate in eight counties.

ALW   The Assisted Living Waiver provides home and community-based services in two settings: Residential Care Facilities for the Elderly or in publicly subsidized housing, with services provided by a Home Health Agency. Eligibility is limited to Medi-Cal beneficiaries over the age of 21. Services include, but are not limited to, assistance with activities of daily living; health related services including skilled nursing; transportation; recreational activities; and housekeeping.

CRC   Caregiver Resource Centers provide information and referral, short-term counseling, respite care, education, training and support to families and caregivers of adult onset, 18 and older with Alzheimer's disease, stroke, Parkinson's disease, multiple sclerosis, Traumatic Brain Injury and other disabilities or medical conditions at

eleven centers throughout the state. CRCs are administered by the Department of Health Care Services.

CBAS   Community Based Adult Services are Medi-Cal programs certified by the California Department of Aging and licensed as Adult Day Health Care (ADHC) facilities by the California Department of Public Health. Centers provide interdisciplinary health care and social services in a day-time group setting. Each center's multidisciplinary team of health professionals perform a comprehensive person-centered assessment of each participant to develop an individual plan of care. Required services include nursing; physical, occupational and speech therapies; mental health services; therapeutic activities; social services; personal care; nutritious meals and dietary counseling. Transportation is provided or arranged. CBAS is designed to support any adult over the age of 18 who has complex chronic conditions that limit physical, cognitive or mental functioning. The goal is to delay or prevent institutionalization. CBAS is offered as a Medi-Cal managed care benefit, although is not available in all communities (approximately 18 of 58 California counties have no CBAS at present).

HCBS   Home and Community-Based Services are designed to support community living and delay or prevent admission to an institution for persons with various disabilities. HCBS can include personal care (help with ADLs), transportation, shopping and meal preparation, home health aides, adult day services, and homemaker services. Assistance with managing medications or money also may be provided. HCBS can be paid for out of pocket or by private long-term care insurance, or may be funded by Medicaid, state general revenues, the Older Americans Act, or other programs. Medicaid is the primary source of public funding.

IHSS   The In-Home Supportive Services (IHSS) Program provides assistance to those eligible aged, blind and disabled individuals who are unable to remain safely in their own homes without this assistance. IHSS is an alternative to out-of-home care. Eligibility and services are limited by the availability of funds. Qualified recipients receive assistance with activities of daily living, including bathing, dressing, cooking, cleaning, grooming, and feeding. The IHSS program plays a significant role in helping people remain at home and avoid institutionalization and serves as a model of self-directed services. County social workers assess individuals using a standardized assessment to determine the need and then authorize service hours for the recipient. The recipient directs his/her services by deciding how, when, and in what manner IHSS services will be provided. IHSS is administered at the state level by the state Department of Social

Services (through an interagency agreement with the Department of Health Care Services), and at the local level through county human services offices.

LTSS   Long-Term Services and Supports refers to a broad range of services delivered by paid or unpaid providers that can support people who have limitations in their ability to care for themselves due to physical, cognitive, or chronic health conditions that are expected to continue for an extended period of time. Services can be provided in a variety of settings including at home, in the community, in residential care settings, or in institutional settings. Generally, LTSS includes assistance with activities of daily living (personal care needs) such as bathing, dressing, eating or transferring and instrumental activities of daily living (routine care needs) such as meal preparation, money management, house cleaning, medication management and transportation.

LTCO   The Long-Term Care Ombudsman Program investigates and endeavors to resolve complaints made by, or on behalf of, residents in long-term care facilities including nursing homes and assisted living facilities. The program seeks to advocate for the rights of all residents of long-term care facilities.

MSSP   Multipurpose Senior Services Program provides care management, and referral to adult day care, housing assistance, chore and personal care services (if the individual has used the allocated IHSS service hours), protective supervision, respite, transportation, meal services, social services and communication services for Medi-Cal eligible individuals over the age of 65 who meet clinical qualifications for nursing facility admission. This is a Medi-Cal waiver program administered by the California Department of Aging.

PACE   Program of All Inclusive Care for the Elderly is an integrated managed model providing Medicare and Medi-Cal covered benefits to eligible individuals who are age 55 or older, and who are certified to need nursing home care, but who are able to live safely in the community at the time of enrollment. The program is available in limited areas of the state. Oversight is provided by the Department of Health Care Services and Department of Public Health. Required services include:
- Medical care provided by a PACE physician
- Adult day health care (nursing; meals; nutritional counseling; personal care physical/occupational/recreational therapies)
- Home health care and personal care in the home
- Prescription drugs
- Social services

- Medical specialty services, and hospital, plus nursing home care, when necessary

Person-Centered

Person-Centered means treating individuals with dignity and respect; building on their strengths and talents; helping people connect to their community and develop relationships; listening and acting on what the individual communicates; taking time to know and understand individuals and the things that make them unique. Person-centered thinking involves a deep respect for individuals and their equality. Person-centered planning involves a process and approach for determining, planning for and working toward what an individual with older adults and persons with disabilities wants for his or her future. https://www.ddslearning.com/person-centered-practices

Person-Centered System

Person-centered System means individuals have access to a readily available network of affordable options that provides high-quality care and supports, allowing individuals to live well in their homes and communities ; the needs, values, and preferences of individuals and their caregivers are regularly honored by the system and its providers; knowledgeable health care providers connect individuals with available options; an array of home and community-based providers assist in navigating services and linking timely information to health care providers; providers recognize the value of health promotion activities as vital components of the system of care. All providers maintain integrated connections among the main serviced platforms – primary, acute, behavioral, and rehabilitative care with LTC – and place the individual in the center of the care experience. Collaboration and coordination at the regional and local level would facilitate access to services and supports in the community.

RCFE

Residential Care Facility for the Elderly provide a combination of housing, personalized supportive services, and 24-hour staff designed to respond to the individual needs of those aged 60 and above who require help with activities of daily living (ADLs). RCFEs are considered non-medical facilities, and are also referred to as Assisted Living Facilities, Memory Care, board and care homes, and are a component of Life Plan Communities (aka Continuing Care Retirement Communities, CCRCs). These senior housing options are non-institutional, home-like settings that promote maximum independence and dignity for each resident and encourage family and community involvement. The Department of Social Services licenses and monitors RCFEs.

Regional Centers	The 21 state-wide Regional Centers contract with the Department of Developmental Services to provide services to individuals with intellectual and developmental disabilities. The provide access to comprehensive services community-based services including outreach, intake and assessment, preventive services, and case management/service coordination. In addition, regional centers develop, maintain, monitor, and fund a wide range of community-based services and supports. Individual regional center consumers receive the services through an individual program plan funded by regional centers or other agencies.
SNF	Skilled Nursing Facilities are inpatient health care facilities with the staff and equipment to provide skilled nursing care, rehabilitation, and other related health services to patients who have more complex care needs, but do not require hospitalization. The Department of Public Health provides oversight.

For more information about the Master Plan for Aging
visit Engageca.org

####

California Master Plan for Aging: Goal 2: Livable Communities & Purpose

We will live in and be engaged in communities that are age-friendly, dementia-friendly, disability-friendly, and equitable for all.

GOAL 2: LIVABLE COMMUNITIES RECOMMENDATIONS

Jan Arbuckle•Cheryl Brown•Laura Carstensen•Clay Kempf•Jennie Chin Hansen•Karen Lincoln• Jeannee Parker Martin•Stacey Moore•Meghan Rose•Debbie Toth•David Ragland•Nina Weiler-Harwell

Table of Contents

MPA GOAL 2: LIVABLE COMMUNITIES – EXECUTIVE SUMMARY

Overview

Every Californian should live in and be engaged in communities that are age-friendly, dementia-friendly, disability-friendly, and equitable for all, where older people are valued, contributing, and socially connected as family members, employees, volunteers, mentors, and life-long learners of all abilities, races, religions, ages, and identities. In order to achieve livable communities, they must be safe and secure, have **affordable and appropriate housing** and **transportation** options, ability to participate in **paid work**, and offer **supportive community features** and services that can serve all residents, regardless of age or ability. [1]

The Master Plan for Aging provides the catalyst needed to prepare for the reality of an older population. For the last seven decades, the dominant development paradigm focused on meeting the perceived needs of families with children, leading the market to build predominantly single-family detached homes within auto-centric transportation networks separated from commercial and industrial uses.

To have truly livable communities, California must address the **systemic disparities** inherent in our built and social environments by intentionally advancing solutions that build toward equity. These disparities are the product of racially explicit government policies and a legacy of structural racism – from housing policies such as redlining to "urban renewal" and highway construction displacing Black, Latino, and low-income immigrant communities. The same laws and policy that segregates Black Americans and disenfranchises them from access to opportunity and intergenerational wealth-building through home ownership also marginalizes Latino, American Indian, and certain Asian American and Pacific Islander groups. Intentional action is required to advance livable communities that are truly for all.

Livable communities are interconnected and interdependent. Livable communities rest on a number of interconnected features including access to housing, safety, and transportation. To be truly livable, communities must *value* people of all ages, races, and backgrounds and fully integrate them into the social world. Social engagement not only improves quality of life, it affects physical health and ultimately length of life. **Social isolation** is one of the social determinants of health, posing the same risk to one's health as smoking up to 15 cigarettes a day. When we create places that inhibit, discourage or outright prevent older adults from interacting with others as they age — due to a loss of mobility or even poor home design — we contribute to the pandemic of social isolation rather than solving for it. Moreover, communities and the broader society benefit enormously from the engagement of its most experienced and seasoned residents.

California must prepare for this new aging reality and meet the needs of an increasingly diverse and multigenerational older adult population by taking measurable steps toward becoming more age-friendly and advancing efforts to create livable communities for all.

It is essential that all Californians have access to housing they can afford. Housing is not only a human right, but a foundational component of our long-term care system for older adults and people with disabilities. Paired with affordable housing, accessible and affordable transportation gives individuals choice in where they live and how they access their communities. Additionally, civic engagement, health care, parks, and public spaces demonstrate the best outcomes and greatest benefit to livable communities when housing and transportation exists at all stages of life.

Report Framework

The Network of Age-Friendly Communities Eight Domains of Livability is the framework for this report. The Eight Domains of Livability rubric is used by many of the towns, cities, counties and states enrolled in the AARP Network of Age-Friendly States and Communities to organize and prioritize their work to become more livable for older residents,

---

[1] The language in this overview section is taken from the AARP Livable Communities website: https://www.aarp.org/livable-communities/about/info-2018/aarp-livable-communities-preparing-for-an-aging-nation.html

people with disabilities and residents of all ages.[2] This report focuses on six of the eight domains as described in the background information on the following pages.

Guiding Principles

This report is designed with the following guiding principles:

- Housing is a foundational component of our continuum of care for older adults and people with disabilities.
- Transportation will be available, accessible, and affordable and meet the needs of older adults and people with disabilities.
- California must address the historic and systemic disparities inherent in our built environment by intentionally advancing solutions that build toward equity.
- Regardless of age, race, identity or background, older Californians will be fully integrated into all elements of the social world with barriers imposed by ageism and access removed.
- Each domain of livability is interdependent.

Recommendations

In developing the final recommendations for the **Master Plan for Aging, Goal 2 Livable Communities and Purpose c**onsideration was given to past, current and future issues related to housing, accessible transportation, parks and public spaces, social participation and leadership. Myriad communications with experts in each sector, input from the public, and discussions to assure inclusion, equity and accessibility were completed. The intersectionality of these complex elements resulted in the following recommendations, and others which are further expanded this report:

1. **Housing**

    - Increase the supply of affordable housing, using reliable data based on thorough measurement and assessment of the problem.
    - Prevent homelessness by keeping people housed with rental and mortgage assistance, and home modification.
    - Create and expand innovative solutions to housing older adults, such as shared housing programs, intergenerational housing, and service-enriched housing models.

2. **Accessible Transportation**

    - Expand and Improve Accessible Coordinated Transportation.
    - Implement Sound Planning and Policy Agenda.
    - Enhance Rural Services and Volunteer Programs.

3. **Parks and Public Spaces**

    - Address access by protecting and preserving funding for parks as part of our critical health infrastructure, and improve funding adequacy by creating new state-level grants, inclusive of age and equity in criteria.
    - Ensure state, county and local parks and recreation departments apply an age-friendly and culturally inclusive lens in park planning and programming.
    - Examine and adopt new methodologies in planning to improve quality, equity, and leverage parks innovations, informed by research and insights gleaned from ongoing monitoring.

---

[2] https://www.aarp.org/livable-communities/network-age-friendly-communities/info-2016/8-domains-of-livability-introduction.html

4. **Social Participation**

- Spearhead Action: Appoint and fund an "Engagement Czar" who is experienced in aging services.

- Fight Ageism and Engage Talent: Strengthen the deployment of anti-ageism campaigns and capitalize on the sub-optimized treasure of age, experience, time and wisdom represented in workers, leaders, and volunteers.

- Ensure Access and Honor Diversity: Enhance digital and physical accessibility in all counties in California, while honoring the tremendous variability in preferences for the amount and the type of social engagement individuals desire.

5. **Leadership**

- Establish an interagency process similar to the Strategic Growth Council to prioritize and implement all Master Plan for Aging components.

- Appoint a Cabinet member tasked with over all coordination, along with an Interagency Task Force on Aging and Disability with set goals.

- California joins the Network of Age-Friendly States and Communities (NAFSC) and develops a statewide partnership for age-friendly communities and organizations to collaborate, exchange local best practices, and help the state ensure policies are appropriate and relate to community as well as state need.

Conclusion

In a livable community, people of all ages and abilities safely and affordably have housing, use multi-modal transportation options to get around without a car, access services they need using tools with which they are most comfortable. They live safely and comfortably, work or volunteer, enjoy public places, socialize, spend time outdoors, can be entertained, go shopping, buy healthy food, find the services they need—and make their city, town or neighborhood a lifelong home.

Housing provides the basic infrastructure that allows Californians to thrive, for older adults to live in and be engaged in communities that are race, gender and disability **equitable, age-friendly, dementia-friendly, and disability friendly**. Paired with affordable housing, accessible and affordable **transportation** allows community access at all stages of life.

Every Californian must be able to actively participate in their communities through **civic and social engagement.** Paired with full access to health care, **parks and public spaces**, and work opportunities, we can advance the promise of a Livable California for All.

Ultimately, a Livable California for All cannot be realized without a strong, enduring commitment from statewide leadership at all levels, led by the Governor's Office, with the full support of all relevant state departments and agencies, all elected offices, and the legislature. Cooperation and sharing of best practices across all levels of government – state, regional, county, and local is essential in achieving a Livable California for All.

The recommendations contained in this report are substantive solutions addressing how the state can become more age-friendly, dementia-friendly, disability-friendly, and equitable in advancing a Livable California for All.

MPA GOAL 2: LIVABLE COMMUNITIES – REPORT FRAMEWORK AND CHAPTER SUMMARIES

Background

Every Californian should live in and be engaged in communities that are age-friendly, dementia-friendly, disability-friendly, and equitable for all. A livable community is one that is safe and secure, has affordable and appropriate housing and transportation options, and offers supportive community features and services that can serve all residents, regardless of age or ability. Once in place, those resources enhance personal independence, allow residents to age in place, and foster residents' engagement in the community's civic, economic, and social life.[3]

The Master Plan for Aging provides the catalyst needed to prepare for the reality of an older population. For the last seven decades, the dominant development paradigm focused on meeting the perceived needs of families with children, leading the market to build predominantly single-family detached homes within auto-centric transportation networks separated from commercial and industrial uses.

To have truly livable communities, California must address the systemic disparities inherent in our built environment by intentionally advancing solutions that build toward equity. These disparities are the product of racially explicit government policies and a legacy of structural racism – from housing policies such as redlining to "urban renewal" and highway construction displacing Black, Latino, and low-income immigrant communities. The same laws and policy that segregates Black Americans and disenfranchises them from access to opportunity and intergenerational wealth-building through home ownership also marginalizes Latino, American Indian, and certain Asian American and Pacific Islander groups. Intentional action is required to advance livable communities that are truly for all.

The COVID-19 pandemic exacerbated the long-standing inequities disproportionately affecting marginalized Californians. The policies and practices resulted in worsened health disparities and reduced economic opportunities for Black, Latino, American Indian, and some Asian and Pacific Islander communities, inhibiting the ability to live longer, healthier, and more productive lives. Moreover, land use, housing and transportation practices have re-segregated communities by forcing many members of diverse communities to live on the fringes of our urban areas, requiring longer and longer commutes, and forcing them to live in communities originally designed for agriculture.[4] Such communities may also lack basic services including access to convenient, affordable public transportation, healthcare, and in some cases, utilities such as fresh water and broadband internet.

These effects all greatly impact older Californians. For older adults, the equity in their homes may be their single largest source of savings, but for those who aren't homeowners, rent represents a greater burden than ever before. As reported by *Forbes*, 50 percent of renters age 65 or over now pay more than 30 percent of their income for housing. Another 30 percent are severely rent-burdened, paying more than 50 percent of their income on housing.

The vast majority of older adults, over 80 percent of adults age 65 or older, want to "age in place" in their homes and their communities. They like their community, like and know their doctors, and their doctors know them. They like living near their friends and want to remain close to children and grandchildren. Such connections are not just nice to have — they actually contribute to the health and well-being of older adults.

Livable communities' issues are interconnected. Social isolation is one of the social determinants of health, posing the same risk to one's health as smoking up to 15 cigarettes a day. When we create places that inhibit, discourage or outright prevent older adults from interacting with others as they age — due to a loss of mobility or even poor home design — we contribute to the pandemic of social isolation rather than solving for it.

---

[3] The language in this overview section is taken from the AARP Livable Communities website: https://www.aarp.org/livable-communities/about/info-2018/aarp-livable-communities-preparing-for-an-aging-nation.html

[4] For an analysis on how these practices have impacted minority communities in the Bay Area counties, see Alex Schafran. *The Road to Resegregation: Northern California and the Failure of Politics*. Oakland: University of California Press, 2018.

California must prepare for this new aging reality and meet the needs of an increasingly diverse and multigenerational older adult population by taking measurable steps toward becoming more age-friendly and advancing efforts to create livable communities for all.

As a vital first step, all Californians should have access to housing they can afford. Housing is not only a human right, but a foundational component of our long-term care system for older adults and people with disabilities. Paired with affordable housing, accessible and affordable transportation gives individuals choice in where they live and how they access their communities. Additionally, civic engagement, health care, parks, and public spaces demonstrate the best outcomes and greatest benefit to livable communities when housing and transportation exists at all stages of life.

Domains of Livability Framework

The Network of Age-Friendly Communities Eight Domains of Livability is the framework for this report. The Eight Domains of Livability rubric is used by many of the towns, cities, counties and states enrolled in the AARP Network of Age-Friendly States and Communities to organize and prioritize their work to become more livable for older residents, people with disabilities and residents of all ages. [5]

This report focuses on six of the eight domains, as some domains fall under other goal areas of the Master Plan for Aging. Chapter summaries by domain of livability follow and serve as abstracts of the challenges faced and top-level solutions. Each chapter in the report contains additional proposals.

Domain: **Housing**. Every Californian should have access to housing they can afford. Without housing, low-income individuals have diminished access to preventative health care, appropriate medication, and rehabilitation, resulting in increased use of hospital and emergency department care. This problem is compounded in California's diverse communities, and particularly African American and Latino households, where access to high-quality housing in high-opportunity neighborhoods has been hard to attain. To have truly livable communities, California must create housing options suitable for all people, regardless of age, race, income, ability, and life stage.

Solution: Recognizing that housing is a foundational component of our continuum of care for older adults and persons with disabilities, California should strive to ensure that access to quality housing is affordable and accessible to all Californians. A phased approach including short-term, mid-term, and long-term recommendations is offered to achieving the following goals:

- Measure and assess the problem with reliable data.

- Increase the supply of affordable housing.

- Prevent and end homelessness by keeping people housed and end homelessness by helping people transition into permanent housing.

- Create and expand innovative solutions to housing older adults, such as shared housing programs and intergenerational housing models.

- Develop policy solutions to help redress racially explicit housing policies and their resulting discriminatory systems, and ensure equitable access to housing.

- Create and expand programs that help older adults stay permanently housed and allow them to age in place.

Domain: Transportation. Transportation is the vital link that connects older adults and people with disabilities to social activity, health appointments, economic opportunity, and community services, hence supporting their independence. Currently, Californians "age out" of the ability to get from point A to point B while people with disabilities are often never afforded this "luxury." Every other mode of transportation, whether bike, pedestrian, commuter, train, or bus, gets full policy and funding consideration from the State. Accessible transportation has remained stagnant and invisible

---

[5] https://www.aarp.org/livable-communities/network-age-friendly-communities/info-2016/8-domains-of-livability-introduction.html

for decades. Without transportation, people are less able to remain in their homes and communities as they age. Many older adults need specialized transportation services such as door-to-door paratransit and escorts to physician's offices. Historic discrimination and the intersection of disability and discrimination must be part of the calculus in developing a rider centric system. Safe, available, affordable, accessible, dependable, and user-friendly options are needed to overcome the physical limitations associated with aging and living with one or more disabilities and/or being Black, Latino, Asian American and Pacific Islander, or a member of other marginalized populations, such as LGBTQ or low-income.

Solution: Prioritize the adoption and implementation of new and revised policies that focus on those who use the services. California must adapt the way in which the system delivers transportation to meet the needs of all Californians, including those without the ability to drive. The state has existing mechanisms that simply need more support.

Additional funding, supportive policies, and new measurement tools would enable rapid implementation of critical systemic improvements. These policies would help to ensure that the broader transportation system reflects the needs of older Californians and persons with disabilities. These will allow for multi-modal transportation methods that will enable Californians, regardless of age, race, economics or travel mode (walking, cycling, driving, etc.) to benefit equitably from these investments. Accessible transportation recommendations fall into the following key areas:

- Systemic statewide implementation of accessible coordinated transportation and mobility spanning the entire age/ability spectrum (local): Promote driver safety programs; expand the availability of accessible transit; increase community walkability; and improve accessibility to fixed route services, local/regional passenger rail, and other mass transit.

- Policy and Planning Imperatives (statewide): Ensure transportation system reflects the needs of older adults; create a CA coordinated transportation commission; measure impact and outcomes, etc.

- Rural Investments: Expand volunteer driver programs; expand RTAP; provide microtransit and flexible fixed route services.

Domain: Outdoor Spaces and Public Places. Public parks are important places for physical and mental health, building a sense of community, and social belonging. They are spaces belonging to everyone, regardless of age, gender, ethnicity, religion or income. The way that parks are designed, maintained, and programmed doesn't always reflect the purpose and promise of such uniquely public spaces. Sadly, many municipalities neglect their park networks or fail to invest in these vital places as their communities grow and change.

Solution: California must enact a policy of parks for ALL. This means mandating park design that is inclusive, adopts universal design features, and promotes intergenerational use that fosters opportunities for social interaction and learning opportunities for all ages. Park programming that is culturally inclusive and diverse across the age and ability spectrum will support parks that are truly for all Californians. Short-term, mid-term, and long-term recommendations fall into the following key areas:

- Protect and preserve funding for parks as part of our critical health infrastructure.

- Advance park design, planning, and programming that is culturally inclusive, dementia-friendly, disability-friendly, being diverse across the age and ability spectrum while eliminating disparities in older adult park use.

- Examine and adopt new methodologies in planning to improve quality, equity, and implement innovations.

- Improve parks and public space access and address funding adequacy.

Domains: Social Participation, Respect and Social Inclusion, and Civic Participation: In order to embrace an aging California and benefit from the richness aging and disability have to offer, we must intentionally create environments where all older people and persons with disabilities are included, productive, contributing, and socially connected members of society. They are family members, employees, volunteers, mentors, life-long learners, and social contributors. Californians of all abilities, races, religions, ages, and identities should be equally included and embraced as

valued members of our society. An age-friendly community encourages older adults to be actively engaged in community life and has opportunities for residents to work for pay or volunteer their skills.

Solution: The Director of the Department of Aging will appoint an Engagement Czar who be tasked to coordinate efforts, identify gaps, and advance progress within the social isolation/participation goals described in the Master Plan for Aging. The Minster of Engagement will also be an active player in the interagency process described further down. Additional recommendations align with the following goals:

- Intentionally age-integrate and foster intergenerational connections in public space, while increasing access to community colleges and workplace for older adults and people with disabilities.

- Implement a campaign to educate Californians about the diversity, value, and contributions of older people.

- Partner with counties and local partners to develop screening tools and interventions to detect social isolation and develop a coordinated, shared statewide platform mapping hot-spots and emerging needs in real time.

Domain: Communication and Information. We now communicate in ways few could not have imagined a decade ago. Communications with the public must be multi-modal as not everyone equal access to the internet. Communications related recommendations are contained in relevant chapters, such as Housing and Social Participation.

Solution: California must establish and implement policies that will provide all older Californians and persons with disabilities digital access, including statewide broadband, devices that accommodate sensory limitations, and training in digital literacy, and provide special content about topics ranging from fraud detection to app-based transportation services. Additional recommendations align with the following goals:

- Expand programs to bring broadband connectivity to older adults.

- Modify existing fund supports to expand broadband access to historically underserved communities, including low-income, Black, Latino, and rural households, through senior housing communities and senior centers.

Tying It All Together

Gubernatorial leadership and dedication are necessary for full implementation of the goals of the Master Plan for Aging. The Governor must be in the forefront, modeling state government commitment and stewardship. The Master Plan for Aging provides an historic opportunity to design, develop and deliver a true Livable California for All that will serve as a blueprint for the state and local communities, as called for in the Executive Order that created the Master Plan for Aging. Unfortunately, California lacks a coordinated, interdisciplinary mechanism to manage and oversee all the pieces necessary for the complete implementation of the Master Plan for Aging goals.

Solution: The state will establish an interagency process similar to the Strategic Growth Council that will prioritize and implement critical solutions to the implementation of all Master Plan for Aging components. Led by the Governor, California will launch an implementation of the Master Plan for Aging that ensures direct oversight by the office of the Governor while also delegating responsibility for implementing the sections of the MPA to the appropriate agency secretaries and department directors. To accomplish these goals, the Governor will also appoint a Cabinet member tasked with over all coordination, along with an Interagency Task Force on Aging and Disability with set goals. It should include all departments whose work touches on the NAFSC's domains of livability.[6] California will join the Network of Age-Friendly States and Communities (NAFSC) and develop a statewide partnership for age-friendly communities and organizations to collaborate, exchange local best practices, and help the state ensure policies are appropriate and relate to community as well as state need.

---

[6] https://www.aarp.org/livable-communities/network-age-friendly-communities/info-2016/8-domains-of-livability-introduction.html

MPA GOAL 2: LIVABLE COMMUNITIES – HOUSING

Goal 2. Livable Communities and Purpose – We will live in and be engaged in communities that are age-friendly, dementia-friendly, and disability-friendly.

Overview

Every Californian should have access to housing they can afford. Housing is not only a human right, but a foundational component of our long-term care system for older adults and people with disabilities. Housing is healthcare, and a major social determinant of health. Without housing, individuals have diminished access to preventative health care, appropriate medication and rehabilitation, resulting in increased use of hospital and emergency department care.

Access to affordable housing in California is next to impossible for many older adults. Nearly two-thirds who qualify for affordable housing do not receive it. Access to affordable housing is even harder for California's African American and Hispanic households, who continue to endure the negative impacts of discriminatory private and public housing policies.

California must create housing options suitable for all people, regardless of age, race, gender identity, sexual orientation, income, ability, and life stage.

The housing recommendations are designed around the following principles:

- Everyone should have access to quality housing that is affordable and accessible to them.
- Housing is a foundational component of our continuum of care for older adults and people with disabilities.
- To have truly livable communities, California must address the historic and systemic disparities inherent in our built environment by intentionally advancing solutions that build toward equity; and,
- Each domain of livability is interdependent.

The recommendations offer a phased approach to achieving the following goals:

1. Measure and assess the need for housing with reliable data.
2. Increase the supply of affordable housing.
3. End homelessness.
4. Create and expand innovative solutions to housing older adults, such as shared housing programs and intergenerational housing models.
5. Develop policy solutions to help redress racially explicit housing policies and their resulting discriminatory systems, and ensure equitable access to housing. And,
6. Create and expand programs that help older adults stay permanently housed and allow them age in place.

1. Background

1.1. Housing affordability is declining. California's increasing housing costs have particularly affected older adults and people with disabilities who are living on fixed incomes. As housing costs have risen, retirement and disability incomes, such as Social Security and Supplemental Security Income (SSI), have remained stagnant and many low-income individuals are finding it impossible to afford market-rate housing.[7] One in four people over 65 rely almost entirely on their social security benefit[8], which averages about $1,503 per month for retired

---

[7] "SSI/SSP Grants Are No Match for California's Housing Costs," Scott Graves, January 2020. California Budget and Policy Center. https://calbudgetcenter.org/resources/ssi-ssp-grants-are-no-match-for-californias-housing-costs/.

[8] "Housing America's Older Adults 2019," Joint Canter for Housing Studies of Harvard University. 2019. https://www.jchs.harvard.edu/sites/default/files/Harvard_JCHS_Housing_Americas_Older_Adults_2019.pdf.

workers and $1,258 for disabled workers.[9] The fair market rent for a one-bedroom apartment in California is $1,522[10], leaving the average elder renter with little or no money left over for food and healthcare costs.[11]

In California, over 1,280,000 households age 65 and over are housing cost burdened.[12] Of those households, over 700,000 pay more than half of their income toward housing costs.[13] Older adults with housing cost burdens are more likely to cut back on food and healthcare expenses. Nationally, severely burdened low-income households age 65 and over spent only $195 per month on food in 2018, while those without burdens spent an average of $368.[14] Spending on healthcare expenses is even more unequal, with severely cost burdened households spending 50% less on average ($174 vs. $344 per month) than those living in housing they can afford.[15]

As demand increases, access to affordable housing continues to decrease. Only one-third of people who qualify for rental assistance actually receive it.[16] At this rate, rental assistance will become harder to come by as the U.S. population of low-income older adult households increases from 5.3 million to an expected 7.9 million by 2038.[17]

1.2. **A legacy of racial discrimination and segregation has created lasting barriers to housing.**

For many Americans, a home is the most valuable thing they will ever own. Owning a home is viewed to be one of the most attainable ways to build wealth, but in reality, home ownership has not been available to everyone, especially African Americans.

The United States, at every level of government, has a long history of racially explicit housing policies that have defined where African Americans should live. Historian Richard Rothstein notes, "The stereotypes and attitudes that support racial discrimination have their roots in the system of slavery upon which the nation was founded."[18]

Racially explicit government housing policies have created a legacy of structural racism in our housing markets. Even after the passage of the 1968 Fair Housing Act (Act), which terminated the discriminatory practice of redlining, government reluctance to enforce provisions of the Act effectively preserved practices and patterns of discrimination already entrenched in the private housing markets.[19]

Today, three out of four neighborhoods "redlined" on government maps in the 1930s continue to struggle economically.[20] Additional enduring negative impacts of discriminatory housing policies include residential patterns, and household accumulation of wealth.[21] As of 2016, the net-worth of a typical white family is

---

[9] "Social Security Fact Sheet," U.S. Social Security Administration, 2019. https://www.ssa.gov/news/press/factsheets/basicfact-alt.pdf.

[10] "Out of Reach 2020: California," National Low Income Housing Coalition. https://reports.nlihc.org/oor/california.

[11] "Housing America's Older Adults 2019," Joint Canter for Housing Studies of Harvard University. 2019. https://www.jchs.harvard.edu/sites/default/files/Harvard_JCHS_Housing_Americas_Older_Adults_2019.pdf.

[12] "Housing America's Older Adults 2019: Data," Joint Canter for Housing Studies of Harvard University. 2019. https://www.jchs.harvard.edu/housing-americas-older-adults-2019.

[13] Ibid.

[14] "Housing America's Older Adults 2019," Joint Canter for Housing Studies of Harvard University. 2019. https://www.jchs.harvard.edu/sites/default/files/Harvard_JCHS_Housing_Americas_Older_Adults_2019.pdf.

[15] Ibid.

[16] Ibid.

[17] Ibid.

[18] Rothstein, Richard. The Color of Law: A Forgotten History of How Our Government Segregated America

[19] Taylor, Keeanga-Yamahtta. Race for Profit (Justice, Power, and Politics) The University of North Carolina Press.

[20] HOLC "Redlining" Maps: The Persistent Structure of Segregation and Economic Inequality
By Bruce Mitchell PhD., Senior Research Analyst and Juan Franco, Senior GIS Specialist, NCRC / March 20, 2018 / Research. https://ncrc.org/holc/.

[21] Ibid.

nearly ten times greater than that of a Black family.[22] It is important to note that wealth in Hispanic and certain Asian American and Pacific Islander families falls far below their white counterparts' wealth as well.[23]

Families who cannot build and inherit wealth are more likely to need affordable, subsidized housing. In the U.S., Black, Native American and Hispanic households are more likely than white households to live in low-income housing communities.[24] Between 1991 and 2013, the percentage of renter households paying 30 percent or more of their income toward housing costs declined from 54 to 43 percent. However, the percentage of renter households that pay 50 percent or more of their income toward housing costs, rose from 21 percent to 30 percent. Black and Hispanic households, a majority of whom live in rental housing, are disproportionately affected by this trend. Nearly a quarter of Black and Hispanic households spent more than half of their income on housing costs in 2013.[25]

Emerging research is uncovering large disparities in the urban heat environment, particularly in formerly redlined neighborhoods that remain heavily populated with low-income, Black and Hispanic households.[26] It can be 5 to 20 degrees hotter in formerly redlined neighborhoods during the summer than in wealthier, whiter neighborhoods.[27] These neighborhoods are more likely to have fewer trees and more pavement, creating a landscape that traps more heat.[28] Heat is the deadliest weather disaster in the U.S., killing as many as 12,000 people a year.[29] High heat, instigated by a lack of urban greening and park space, increases mobility issues and can exacerbate existing health issues for older adults and people with disabilities.[30]

While the systemic racism prevalent in our housing systems is a direct result of discrimination against African Americans, research shows that other racial and ethnic groups, particularly Hispanic households, have similar experiences to African Americans in many housing markets.

1.3. Homelessness Among Older Adults and People with Disabilities is Rising

Lack of access to affordable housing is causing homelessness among older adults and persons with disabilities to increase at an alarming rate. The Los Angeles Homeless Services Authority (LAHSA) reports that according to the 2019 Greater Los Angeles Homeless Count there are 13,606 adults age 55 and older experiencing homelessness in the Los Angeles Continuum of Care.[31] This older age group makes up 23% of the homeless population in Los Angeles County and is expected to grow rapidly over the next decade.[32] Older adult

---

[22] "Examining the Black-white wealth gap." Kriston McIntosh, Emily Moss, Ryan Nunn, and Jay Shambaugh, February 27, 2020. https://www.brookings.edu/blog/up-front/2020/02/27/examining-the-black-white-wealth-gap/.

[23] Systematic Inequality: How America's Structural Racism Helped Create the Black-White Wealth Gap" By Angela Hanks, Danyelle Solomon, and Christian E. Weller February 21, 2018. https://www.americanprogress.org/issues/race/reports/2018/02/21/447051/systematic-inequality/

[24] "Racial Disparities Among Extremely Low-Income Renters," National Low-Income Housing Coalition, Apr 15, 2019. https://nlihc.org/resource/racial-disparities-among-extremely-low-income-renters

[25] Matthew Desmond, "Unaffordable America: Poverty, housing, and eviction" (Madison, WI: Institute for Research on Poverty, 2015), http://www.irp.wisc.edu/publications/fastfocus/pdfs/FF22-2015.pdf.

[26] "How Decades of Racist Housing Policy Left Neighborhoods Sweltering," Brad Plumer and Nadja Popovich, New York Times, Aug. 24, 2020. https://www.nytimes.com/interactive/2020/08/24/climate/racism-redlining-cities-global-warming.html.

[27] Ibid.

[28] Ibid.

[29] Ibid.

[30] Ibid.

[31] "2019 Greater Los Angeles Homeless Count Results," Los Angeles Homeless Services Authority, 2019. https://www.lahsa.org/news?article=557-2019-greater-los-angeles-homeless-count-results.

[32] Ibid.

homelessness in Los Angeles reflects a problem facing California as a whole, nearly half of single adults experiencing homelessness are age 50 and older.[33]

Older adults experiencing chronic homelessness have health conditions and functional status similar to, or worse, than, adults in the general community.[34] Homelessness also reduces life expectancy and increases mental health and substance abuse challenges.[35] Moreover, as individuals experiencing homelessness age, they are likely to incur increasingly greater health care costs from hospitalization and nursing home placements.[36]

Among the nation's racial and ethnic groups, Black Americans have the highest rate of homelessness. California has the highest Black homeless rates in the country.[37] In San Francisco, for every 10,000 people, there are 591 Black individuals experiencing homelessness.[38] In Los Angeles City and County, for every 10,000 people, there are 284 Black individuals experiencing homelessness.[39]

1.4. Housing is a Foundational Component of California's Continuum of Care

Housing is a foundational component of our Long-Term Care system for older adults and people with disabilities, as well as a social determinant of health. The prevalence of chronic conditions and frailty increases with age.[40] In many cases, deteriorating physical and cognitive functioning impede the ability of these individuals to live independently in the community.[41] Without a safe, stable place to live, it is difficult for older adults and people with disabilities to receive proper and effective preventative care and treatment for chronic conditions.

Data from the California Department of Aging estimates that 44.5 percent of California's over 60 population identify as Non-White.[42] This number is projected to increase more than 20 percent by 2050.[43] In California, individuals identifying as Black and Hispanic are more than twice as likely as white counterparts to live

---

[33] "Brief Report: the aging of the homeless population: fourteen-year trends in San Francisco," Hahn JA, Kushel MB, Bangsberg DR, Riley E, Moss AR. J Gen Intern Med. 2006;21(7):775-778. doi:10.1111/j.1525-1497.2006.00493. https://pubmed.ncbi.nlm.nih.gov/16808781/.

[34] "Homelessness in Older Adults: Causes and Solutions," Margot Kushel, MD. LeadingAge California Engage Magazine, Fall 2016. https://cld.bz/bookdata/oSTzaT/basic-html/page-12.html#.

[35] "Homelessness Among Elderly Persons," National Coalition for the Homeless, September 2009. https://www.nationalhomeless.org/factsheets/Elderly.pdf.

[36] "A Research Note: Long-Term Cost Effectiveness of Placing Homeless Seniors in Permanent Supportive Housing," Joshua D. Bamberger and Sarah K. Dobbins. Cityscape: Journal of Policy Development and Research, Volume 17, Number 2, 2015. U.S. Department of Housing and Urban Development, Office of Policy Development and Research. https://www.huduser.gov/portal/periodicals/cityscpe/vol17num2/ch11.pdf.

[37] "Demographic Data Project: Race, Ethnicity, and Homelessness," Joy Moses. 2018. Homelessness Research Institute, National Alliance to End Homelessness.

[38] Ibid.

[39] Ibid.

[40] "Frailty and Chronic Diseases in Older Adults," Carlos O. Weiss, MD, MHS. Clin Geriatr Med 27 (2011) 39–52. Division of Geriatric Medicine and Gerontology, Johns Hopkins School of Medicine. https://www.geriatric.theclinics.com/article/S0749-0690(10)00077-7/pdf.

[41] "Exploring Financing Options for Services in Affordable Senior Housing Communities," Alisha Sanders, Robyn Stone, Marc Cohen, LeadingAge LTSS Center @UMass Boston, Nancy Eldridge, National Well Home Network, David Grabowski, Harvard Medical School Department of Health Care Policy. April 2019. LeadingAge LTSS Center @UMass Boston. www.ltsscenter.org/reports/Financing_Services_in_Affordable_Senior_Housing_FULL_REPORT.pdf.

[42] "2019 California Department of Aging (CDA) Population Demographic Projections by County and PSA for Intrastate Funding Formula," March 15, 2019. https://www.aging.ca.gov/download.ashx?lE0rcNUV0za6g%2fiYXuBV%2bA%3d%3d.

[43] "California State Plan on Aging, 2017-2021, Appendix G," https://www.aging.ca.gov/download.ashx?lE0rcNUV0zbUy1iwYmWKng%3d%3d#page=91.

below 100 percent of the Federal Poverty Line (FPL).[44] This income gap has resulted in health disparities in minority populations, including a higher prevalence of disability.[45]

Affordable housing properties linked with health and supportive services have proven to help significantly in meeting the varied needs of lower-income seniors and people with disabilities while also helping address multiple public policy priorities.[46] Senior housing communities provide unique opportunities for health care providers and community-based service organizations. Namely, these communities provide economies of scale, allowing providers to deliver on-site health care services to a large group of people.[47] These partnerships save providers, Medi-Cal and Medicare money while allowing individuals to age-in-place with better health outcomes.[48]

Long-term care is a matter of particular concern for the state because it constitutes nearly one-third of all Medicaid spending.[49] Although it constitutes a decreasing share of total expenditures, institutional care continues to account for more than half of Medicaid expenditures for long-term care services.[50] In California, the cost of keeping an older adult independent in their own home averages 64% less than nursing home care.

None of this is possible, however, without housing. California must prioritize the creation of affordable housing for older adults and people with disabilities and then create and expand programs to help them age in place.

Recommendations

2. **Recommendations for Immediate and Short-Term Action (0-3 years)**

   2.1. **Measure and assess the need for affordable and accessible housing among California's older adult population.** There is a lack of state-level data pertaining to the housing needs of older adults and people with disabilities. There is a particular need for data to assess rates of housing insecurity, homelessness, and the overall need for affordable housing and access to affordable housing. Additionally, the state should examine existing laws, such as Proposition 13 and local zoning ordinances, to determine if and how these laws limit the housing mobility of older adults. All metrics should require analysis of the data by the equity dimensions of race/ethnicity, income, age, gender and ability to prevent disparities in access to housing.

   2.2. **Adopt a Right to Housing Policy for all.** The State of California should adopt a Right to Housing Policy for all people, including older adults and people with disabilities. The policy should state that all Californians have the

---

[44] "California State Plan on Aging, 2017-2021, Appendix I,"
https://www.aging.ca.gov/download.ashx?lE0rcNUV0zbUy1iwYmWKng%3d%3d#page=93.

[45] "Racial/Ethnic Differences in the Development of Disability Among Older Adults" American Journal of Public Health. Dorothy D. Dunlop PhD, Jing Song MS, Larry M. Manheim PhD, Martha L. Daviglus MD, PhD, and ,Rowland W. Chang MD, MPH. December 2007. https://ajph.aphapublications.org/doi/full/10.2105/AJPH.2006.106047?url_ver=Z39.88-2003&rfr_id=ori%3Arid%3Acrossref.org&rfr_dat=cr_pub++0pubmed&.

[46] "Exploring Financing Options for Services in Affordable Senior Housing Communities," Alisha Sanders, Robyn Stone, Marc Cohen, LeadingAge LTSS Center @UMass Boston, Nancy Eldridge, National Well Home Network, David Grabowski, Harvard Medical School Department of Health Care Policy. April 2019. LeadingAge LTSS Center @UMass Boston. www.ltsscenter.org/reports/Financing_Services_in_Affordable_Senior_Housing_FULL_REPORT.pdf.

[47] Ibid.

[48] Ibid.

[49] "Medicaid Today; Preparing for Tomorrow: A Look at State Medicaid Program Spending, Enrollment and Policy Trends. Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2012 and 2013," Vernon K. Smith, Ph.D., Kathleen Gifford and Eileen Ellis, Health Management Associates. Robin Rudowitz and Laura Snyder, Kaiser Commission on Medicaid and the Uninsured Kaiser Family Foundation. October 2012. https://www.kff.org/wp-content/uploads/2013/01/8380.pdf.

[50] "A Short Look at Long-term Care for Seniors," Kaiser Family Foundation. JAMA. 2013. https://jamanetwork.com/journals/jama/fullarticle/1733726.

right to safe, decent, accessible and affordable housing and would serve to guide state legislative and administrative action and increase cross-sector collaboration among state agencies.

2.3. **Build more affordable housing for older adults and people with disabilities.** The single most important step to helping older adults and people with disabilities delay or avoid institutionalization is to facilitate aging-in-place. To do this, every older adult and person with a disability must have access to safe, quality housing that is affordable and accessible to them. It is very difficult to build affordable senior housing in California for a number of reasons, including: lack of state funding, high-development costs, and inadequate federal subsidies.

While seniors can live in non-age-restricted affordable housing, affordable senior housing plays an important role in California's continuum of care. Affordable senior housing is typically defined as affordable housing that is restricted to tenancy by individuals 55 and over or 62 and over, as well as individuals 18 and over with a disability.

Affordable senior housing is often a preferred option for older renters for a variety of reasons including onsite service coordination, age-appropriate social, health and wellness programming and linkages to community services including health care, transportation, and food. These services help older adults age safely in place and prevent social isolation. This is particularly important for older adults suffering from chronic illness, physical disability and cognitive impairment.

This recommendation has been prioritized because of the time it takes to put new housing developments in the pipeline. The state must act quickly to create and rehabilitate housing that will be ready for occupancy in the next 3-5 years and beyond.

2.3.1. **Examine existing affordable housing programs and adjust regulations to ensure that senior housing projects are funded proportionately and fairly.**

2.3.1.1. **State housing programs should fund senior housing at a rate proportionate to size of the need.** The need for senior housing can be roughly estimated by the size of California's older adult population, which is growing quickly. By 2030, California's over-60 population will account for over 25 percent of the State's total population.[51] California's funding allocations for affordable housing should reflect the projected size of the older adult population. For example, the State's Qualified Allocation Plan for the Low-Income Housing Tax Credit Program calls for a maximum 15 percent of funding to be allocated for senior housing. Other programs, like the Affordable Housing and Sustainable Communities program, do not set any goals for funding senior housing.

2.3.1.2. **Recognize the linkages between housing and transportation and update program objectives and scoring criteria to ensure the needs of older adults and people with disabilities are met.** Transportation is the vital link that connects older adults and people with disabilities to social activity, economic opportunity, necessities, and community services; hence supporting their independence. Despite the importance of accessible, affordable, and available transportation options for older adults and people with disabilities, state programs that seek to fund affordable housing and infrastructure projects near mass transit sites, like the Affordable Housing and Sustainable Communities (AHSC) Program and the Transit-Oriented Housing Development Program (TOD Housing Program), have consistently overlooked these needs. Each housing funding program has regulations that define the objectives of the program and detail which projects should receive priority for funding. Regulations for the AHSC and TOD Housing Program should be

---

[51] California Department of Finance Demographic Projections: Total Population by Age Baseline 2019. http://www.dof.ca.gov/Forecasting/Demographics/Projections/.

updated to reflect the housing and transportation needs of older adults and people with disabilities. For instance, the Transit-Oriented Housing Development Program (TOD Housing Program) guidelines state that the primary objectives of the program are to, "increase the overall supply of housing, increase the supply of affordable housing, increase public transit ridership, and minimize automobile trips."[52] The objectives of the TOD Housing Program should be updated to include "connect older adults and people with disabilities to essential services."

2.3.1.3.   **Update scoring criteria for housing funding by acknowledging that older adults have special needs.** Another way to help increase funding for affordable senior housing is to acknowledge that older adults are a special needs population. Some of California's housing programs have scoring criteria which award additional points to developers to build housing for special needs populations. While the definition of special needs populations varies from one program to another, one thing is consistent – older adults are not considered to have special needs in California's housing programs, and are therefore not given preference for housing development funding. There is ample evidence to support a categorization of low-income older adults as a special needs population, as the term relates to housing programs. In the U.S., 85 percent of older adults have at least one chronic condition and 56 percent have at least two chronic conditions.[53] Additionally, rates of mobility limitations[54] and cognitive decline increase[55] with age.

Updating scoring criteria to acknowledge that older adults have special needs will help create more housing opportunities for African American and Hispanic older adults and people with disabilities who are more likely than their white peers to live in affordable housing[56], and are more likely to suffer from one or more chronic health conditions.[57]

California's Multi-Family Housing Program awards points for projects that serve "frail elderly."[58] However, frail elderly is defined in a way that would limit occupancy to high-acuity individuals, who likely are not able to live independently without supportive services, which are not funded.

2.3.2. **Create a dedicated source of funding to build, rehabilitate, preserve and adapt accessible and affordable housing for older adults and people with disabilities.** Creating housing for older adults and people with disabilities should be a state priority. With recent declines in available caregivers, increased costs for long-term care and a reduction of available skilled nursing beds, California's long-term care system is not equipped to handle the imminent growth of our frail elderly population. Ensuring that our older adults have safe, stable housing and the services they need to age-in place

---

[52] "Transit-Oriented Housing Development Program Round 4 Guidelines, April 30, 2020," California Department of Housing and Community Development. https://www.hcd.ca.gov/grants-funding/active-funding/docs/TOD-Guidelines-4-30-2020.pdf.
[53] "Percent of U.S. Adults 55 and Over with Chronic Conditions," U.S. Centers for Disease Control and Prevention, National Center for Health Statistics. 2009. https://www.cdc.gov/nchs/health_policy/adult_chronic_conditions.htm.
[54] When Walking Fails: Mobility Problems of Adults with Chronic Conditions. Lisa Lezzoni. University of California Press. 2003.
[55] "Subjective Cognitive Decline — A Public Health Issue," U.S. Centers for Disease Control and Prevention, Alzheimer's Disease and Healthy Aging. 2019. https://www.cdc.gov/aging/data/subjective-cognitive-decline-brief.html.
[56] "Racial Disparities Among Extremely Low-Income Renters," National Low-Income Housing Coalition, Apr 15, 2019. https://nlihc.org/resource/racial-disparities-among-extremely-low-income-renters.
[57] "Health Disparities by Race and Ethnicity," By Sofia Carratala and Connor Maxwell, May 7, 2020. Center for American Progress. https://www.americanprogress.org/issues/race/reports/2020/05/07/484742/health-disparities-race-ethnicity/#:~:text=regardless%20of%20race.%E2%80%9D-,Health%20coverage,health%20insurance%20coverage%20in%202017.
[58] "Multifamily Housing Program Guidelines, Effective June 19, 2019," California Department of Housing and Community Development. https://www.hcd.ca.gov/grants-funding/active-funding/mhp/docs/Round-1-MHP-Final-Guidelines.pdf.

will help keep our long-term care system, and Medi-Cal from being overwhelmed.

Older adults and people with disabilities have special housing needs that are largely not met by existing housing programs. Creating a separate source of funding will help to increase the supply of housing for older adults and people with disabilities who have varied health needs. It will also fund home modifications, repairs and redesign services to help keep people housed. The fund could finance the following types of projects:

2.3.2.1. **Affordable senior housing and caregiver housing:** As stated above, affordable senior housing is often a preferred option for older renters for a variety of reasons including onsite service coordination, age-appropriate social, health and wellness programming and linkages to community services including health care, transportation, and food. These services help older adults age safely in place and prevent social isolation. This is particularly important for older adults suffering from chronic illness, physical disability and cognitive impairment.

Most affordable housing designs do not include space for live-in caregivers. With the high costs of housing in California, caregivers often cannot afford to live near their patients. Caregivers end up sleeping on the couch in their patients' homes. A dedicated source of funding for senior housing can explore new architectural design to allow for caregivers to have their own housing in and near where their patients live.

2.3.2.2. **Intergenerational housing and programming models**: Intergenerational living is an innovative concept that seeks to blend individuals of various ages, often within the same family, to build stronger communities, enhance our understanding of one another and reduce ageism. For older adults, intergenerational housing and programming can help reduce isolation and loneliness.

There are many examples of domestic and international housing developments, co-residence in congregate care settings and intentional design that have been developed over the past few decades. Many of the examples that promote reciprocity and relationships have worked well. Not all older adults would care for such design elements as evidenced by many properties that have been purpose built for the 55 years old and older persons and are heavily subscribed and long operating.

A dedicated source of funding for senior housing can help to fund multigenerational housing models for people of all-incomes. Funding can also help to bring multigenerational programming to existing housing communities.

2.3.2.3. **Accessibility, home repair, modification, and redesign:** California requires that all housing units be adaptable or accessible. With public funding, a development must include five to ten percent of units that are accessible and the rest only adaptable. Funding under this program should require a higher percentage of units to be accessible.

Home repair, modification and redesign programs are underfunded and fragmented. This fund should help supplant federal funding for home repair, modification and redesign that flows through the Area Agencies on Aging. Sometimes, just a simple fix, such as replacing doorknobs with pull handles can help an older adult maintain their independence and prevent accidents.

Changes can improve the accessibility, adaptability, and design of a home. Low-income older adults and people with disabilities should have access to funding to help improving

accessibility in their own homes, so they can remain housed independently in a safe manner.

Funding supports can be used to coordinate and expand existing local, state and federal programs that seek to help low- and middle-income homeowners make necessary repair and modifications to their homes that enable them to age in place.[59]

2.3.2.4. **Innovation, including assistive technology.** Combined with coordinated health and social service programs, technology can play a critical role for helping people with physical, cognitive and developmental limitations live safely at home independently, preventing unnecessary and unwanted institutionalization.

2.3.3. **Reduce barriers to development in California.** California's Roadmap HOME 2030* is a coordinated, statewide initiative to develop and implement a comprehensive plan to advance actionable solutions to increase the state's housing supply and end homelessness.[60]

While the Roadmap HOME 2030 is not specific to housing older adults and people with disabilities, it offers detailed, innovative approaches to reducing barriers to developing all types of affordable housing. The solutions outlined in Roadmap HOME 2030 partner well with the recommendations made here and if implemented concurrently would help to increase the supply of affordable senior housing and end homelessness for older adults and people with disabilities.

*Report to be completed Fall 2020.

2.3.4. **The Governor and Legislature must advocate for more federal funding.** Federal funding is responsible for the development and operation of much of the existing affordable housing for older adults and people with disabilities in California. In the absence of a statewide rental assistance program, California relies on federal rental assistance to keep rents affordable to extremely low-income (30 percent of Area Median Income) and very low-income (50 percent of Area Median Income) individuals. The Governor and Legislature should work with California's Congressional Delegation to secure funding for the following:

2.3.4.1. **Greater investment the Section 8 Project-based Rental Assistance Program, the Section 202 Supportive Housing for the Elderly Program, and the Section 811 Supportive Housing for Persons with Disabilities Program.** Rental assistance payments from HUD programs, like Sections 8, Section 202, and Section 811, keep rents affordable for low-income individuals. Federal rental assistance ensures that a person with qualifying income pays no more than 30 percent of their income toward housing costs.

In California alone, 248,400 older adults and 281,300 people with disabilities receive federal rental assistance, however, that is estimated to be only a third of those who actually need it.[61] Without rental assistance, many of these households would be at risk of eviction and becoming homeless. However, as housing costs have increased, rental assistance has been harder to come by.

---

[59] Examples of programs include:
Los Angeles County Program 20: Ownership Housing Rehabilitation Assistance: http://planning.lacounty.gov/housing/program20
CAPABLE Program: https://nursing.jhu.edu/faculty_research/research/projects/capable/capable-faqs.html
Area Agencies on Aging Older Americans Act Title III B Funding: https://www.n4a.org/Files/DataReport-Home-mod-508.pdf
[60] California Roadmap HOME 2030. https://roadmaphomeca.org/.
[61] Federal Rental Assistance Fact Sheets. Center on Budget and Policy Priorities. December 2019. https://www.cbpp.org/research/housing/federal-rental-assistance-fact-sheets#CA.

In addition to full funding for the renewal of existing Section 202, Section 811 and Section 8 Project-Based Rental Assistance rental assistance contracts, Congress should invest $1 billion a year for the development of new Section 202 homes. A $1 billion investment could produce more than 12,000 homes a year.

2.3.4.2. Greater investment in Service Coordinator Grants. Congress should invest $100 million a year for new Service Coordinator Grants to ensure that every federally subsidized housing community serving older adults has a Service Coordinator. Service coordinators, often trained in social work, assist elderly and/or disabled residents by identifying, locating, and acquiring the services necessary for them to age in place and live independently in their own homes.[62] Currently, about 40 percent of subsidized senior housing properties have on-site service coordinators. The availability of an on-site service coordinator at federally subsidized senior housing reduced hospital admissions among residents by 18 percent.[63]

2.3.4.3. Expand and strengthen the Low-Income Housing Tax Credit Program and create a credit to pay for supportive services. The Low-income Housing Tax Credit (LIHTC) is an essential tool for creating new housing and preserving existing housing. The program should be strengthened and expanded to build more housing, provide deeper affordability, and fund supportive services which are not funded in the current model.

2.3.4.4. Secure federal funding from the Centers for Medicare and Medicaid Services for an Integrated Care at Home Demonstration. The Center for Medicare and Medicaid Innovation (CMMI) is funded to support the development and testing of innovative health care payment and service delivery systems including Integrated Care at Home Demonstrations.

2.3.4.5. Create a Housing Assistance Entitlement. Congress should provide an entitlement to housing assistance for all households age 62 and over with incomes below 50% of area median income. Such housing assistance could be used toward rents, mortgages and taxes.

2.3.4.6. Create a unified National Home Modification Program. Currently, the United States has a patchwork of home modification programs. Congress should create an integrated national home modification program to ensure accessibility homes, both owned and rented, for older adults.

2.3.4.7. Bridge the digital divide in senior housing. Congress should invest $800 million to install and pay service fees for wireless internet services in individual apartments of federally-assisted affordable senior housing communities, the vast majority of which lack such service. Without wireless internet, federal-assisted seniors cannot take advantage of telehealth and are shut out of tools and programming to combat social isolation.

2.3.4.8. Increase funding through the Older Americans Act to enable Area Agencies on Aging and Aging (AAAs) Independent Living Centers (ILCs) to expand and create Adult and Disability Resource Connections (ADRCs) to better coordinate access to affordable housing. The AAAs and ILCs need more funding to expand and create ADRCs, which play a vital role in helping people locate and apply for affordable housing through relationships with local continuums of care, including local housing authorities, housing finance agencies and affordable housing providers. With the right support, ADRCs can help older adults and people with disabilities navigate through California's complex housing systems. Beyond housing, they can also help

---

[62] Service Coordination Fact Sheet." American Association of Service Coordinators. https://cdn.ymaws.com/www.servicecoordinator.org/resource/resmgr/files/Public_Policy/AASC_service_coordinator.pdf.
[63] "Senior Housing Coordinators Help Reduce Hospital Admissions" MacArthur Foundation. November 2015. https://www.macfound.org/press/publications/senior-housing-coordinators-help-reduce-hospital-admissions/.

identify resources to help individuals become or remain stability housed and access other needed supports while they are on housing waitlists.

2.4. Create a State Flexible Housing Subsidy Pool to end and prevent homelessness. California should create a Flexible Housing Subsidy Pool (FHSP) that leverages public and private funding to end and prevent homelessness. The FHSP should have a special focus on assisting special needs individuals, including older adults and people with disabilities. Special needs individuals experiencing homelessness are often among the highest utilizers of expensive health care services.[64]

Over 700,000 older adults in California are severely rent burdened – paying more than 50 percent of their income toward housing costs.[65] Many older adults and people with disabilities are living on fixed incomes that have not increased at the same rate as housing costs.[66] A flexible housing subsidy pool can help prevent these individuals from falling into homelessness by providing rental and mortgage assistance to those most in need. It can also fund programs that lift individuals out of homelessness and help them find and transition into permanent housing, with the supports and services necessary to remain successfully housed.

Modeled after Los Angeles County's FHSP, a state program could fund a variety of services including:

- Interim interventions and housing placement services;
- Intensive Case Management and Supportive Services;
- Operating subsidies; and,
- Move-in assistance, rental assistance and eviction prevention services.

A Flexible Housing Subsidy Pool would give California the ability to offer comprehensive solutions to ending and preventing homelessness.

2.5. Support and expand Shared Housing Programs. While building affordable housing for older adults and people with disabilities should remain a priority for California, the demand for affordable housing is so great, and the actual supply so low, that even with unlimited funding, it would take years to build enough housing stock to meet demand. One solution to this is shared housing. Shared housing allows individuals in homes with empty rooms or in-law quarters, to rent those spaces to older adults and people with disabilities who are in need of housing.

2.5.1. Incentivize local governments to invest in Shared Housing Programs. Most Shared Housing Programs are operated by nonprofits, who help connect homeowners with potential tenants. They provide matching, background checks, mediation and more at no cost. The programs typically operate with limited resources and are financed through a patchwork of funding sources including self-funding, municipal funding and support from other nonprofits and foundations. In light of the increased demand for affordable housing options, shared housing programs need additional funding and resources to scale-up their reach and community impact.

Shared Housing Programs need more investment from the localities they operate within. One controversial idea is to allow local governments to include affordable shared housing in their RHNA allocations. This would incentivize more municipal investment in shared housing programs. For this

---

[64]"Flexible Housing Subsidy Pool Brief Evaluation of the Conrad H. Hilton Foundation Chronic Homelessness Initiative," Conrad H. Hilton Foundation and Abt Associates. March 2017. https://www.hiltonfoundation.org/wp-content/uploads/2019/10/Flexible_Housing_Subsidy_Pool_Brief_Final.3.31.17-3.pdf.

[65] "Housing America's Older Adults 2019: Data," Joint Canter for Housing Studies of Harvard University. 2019. https://www.jchs.harvard.edu/housing-americas-older-adults-2019.

[66] "SSI/SSP Grants Are No Match for California's Housing Costs," Scott Graves, January 2020. California Budget and Policy Center. https://calbudgetcenter.org/resources/ssi-ssp-grants-are-no-match-for-californias-housing-costs/.

to work, there would have to be a cap on the number of shared housing rooms allowed in the allocation, as well as a way to ensure that the addition of shared housing does not offset local responsibility for creating affordable multifamily housing.

2.5.2. **Allow localities more flexibility to incentivize homeowners to build Accessory Dwelling Units (ADUs) and Junior Accessory Dwelling Units (JADUs) in exchange for affordability restrictions on units.** Allow localities to offer financial (e.g. forgivable loans) and other incentives (e.g. extra floor area or reduced parking requirements) to encourage homeowners to build ADUs and JADUs in exchange for an affordability deed restriction on the unit. This will help to increase the supply of affordable ADUs and JADUs that homeowners could place into shared housing programs.

2.5.3. **Request housing authorities create a shared housing voucher program.** California's Housing Authorities control millions of dollars of federal rental assistance funding through the Section 8 Housing Choice Voucher Program. Housing Authorities have the ability to allow vouchers to be used in a shared housing setting, thereby expanding affordable housing options for low-income individuals, but this is not offered by all housing authorities.

2.6. **Support local efforts to fight homelessness among older adults by assisting local governments in providing vital services to older adults.** Financing for homelessness services is fragmented and not equally available to cover all services. Three services are critical to help older adults at risk of, or experiencing homelessness, to access permanent housing with services: 1) Housing navigation to meet people on the streets, form trusting relationships, engage them in participating in services, connect them with local homeless systems, and assist in completing paperwork; 2) Tenancy transition services to help people move into and stabilize in housing; and, 3) Tenancy sustaining services, intensive case management promoting housing and health stability.

The Whole Person Care Program and the In Lieu of Services benefits within the California Advancing and Innovating Medi-Cal (CalAIM) proposal, are potential programmatic vehicles for these services.

2.7. **Expand existing programs to extend broadband connectivity to affordable housing.** On August 13, 2020, Governor Gavin Newsom issued an executive order, acknowledging the state's digital divide.[67] The executive order states that 34 percent of older adults do not use the internet, despite its importance for employment, health, public safety and community connection.[68] Under the Executive Order, the California Department of Housing and Community Development and the California Housing Finance Agency are directed to provide recommendations to the CPUC to increase free or low-cost broadband connectivity at all publicly subsidized housing communities for residential units.[69]

The Public Utilities Commission administers several programs that seek to ensure "fair, affordable universal access to necessary services that promote broadband access and adoption." However, these programs fall short of meeting these goals, particularly for low-income individuals, diverse communities, and rural areas.

Broadband access is particularly difficult for Black, Native American and Hispanic households, who are more likely than white households to live in low-income housing communities.[70] Further, Black and Hispanic households are less likely than white households to have broadband service in their home.[71] Nearly a

---

[67] California Executive Order N-73-20. https://www.gov.ca.gov/wp-content/uploads/2020/08/8.14.20-EO-N-73-20-text.pdf
[68] Ibid.
[69] Ibid.
[70] "Racial Disparities Among Extremely Low-Income Renters," National Low-Income Housing Coalition, Apr 15, 2019. https://nlihc.org/resource/racial-disparities-among-extremely-low-income-renters
[71] "The Digital Divide: Percentage of Households by Broadband Internet Subscription, Computer Type, Race and Hispanic Origin," The U.S. Census Bureau, September 11, 2017. https://www.census.gov/library/visualizations/2017/comm/internet.html

quarter of people living in rural communities report that access to high-speed internet is a major problem in their community.[72]

A cost-efficient and effective way to start to bridge the digital divide is to take advantage of the economies of scale provided by the density of senior housing communities, located in both urban and rural settings. Funding broadband services in senior housing communities is a way to bring connectivity to many people in one place. However, existing programs do not allow for this.

2.7.1. **Expand the language of the California Teleconnect Fund to include senior housing communities and senior centers:** The California Teleconnect Fund (CTF) provides discounts for telecommunications services to qualifying K-12 schools, community colleges, libraries, hospitals, health clinics, and community-based organizations. Currently, senior housing communities, even nonprofits, are not included as qualifying organizations.

2.7.2. **Change the language of the California Advanced Services Fund to "underserved":** The California Advanced Services Fund (CASF) provides both infrastructure and adoption grants to bridge the digital divide. In 2013, the Legislature added the Broadband Public Housing Account (BPHA) to the CASF to expand broadband access and adoption in affordable housing communities. In 2017, the Legislature restricted funding under the BPHA to "unserved" housing developments. This has effectively terminated funding for broadband infrastructure in affordable housing communities, since a building is not deemed unserved if at least one unit has broadband access. The language should be changed from "unserved" to "underserved."

2.7.3. **Work to expand and create public and public partnerships.** Public and private partnership can help to expand broadband and digital device access to historically underserved communities including low-income, Black, Native American, Hispanic, and rural households. [73]

3. **Recommendations for Mid-Term Action (3-5 years)**

   3.1. **Bolster Area Agency on Aging (AAA) and Independent Living Center (ILC) efforts to establish Aging and Disability Resource Connections (ADRCs) as a "No Wrong Door" entry point for Californians to find and apply for affordable housing.** Like navigating health care systems and long-term care options, navigating housing systems to find affordable housing and apply for waitlists is extremely complex and difficult. There is no single place to find information about affordable housing locations, income requirements and open waitlists.

      Ideally, California would have an integrated application system for affordable housing where an older adult would go to one place to identify housing communities in their desired location, determine their income eligibility, apply to be put on open waitlists and apply for temporary housing and/or rental assistance to help them become and/or remain housed until affordable housing becomes available. Unfortunately, there are many barriers to creating an integrated system like this, including funding, varying rules and regulations on each housing community, different types of applications, creating buy-in from housing providers, and managing waitlists and waitlist preferences.

      With or without an integrated application system for affordable housing, California should bolster the role ADRCs play and include them in providing assistance to help fill this gap in access to affordable housing. Aging and Disability Resource Connections work to inform older adults and people with disabilities about

---

[72] "Digital gap between rural and nonrural America persists," Pew Research Center, May 31, 2019. https://www.pewresearch.org/fact-tank/2019/05/31/digital-gap-between-rural-and-nonrural-america-persists/
[73] Examples of public and private partnerships:
   https://www.caregiver.org/internet-services-low-income-adults
   https://corporate.comcast.com/covid-19
   https://www.abc10.com/article/news/health/coronavirus/free-wifi-hotspots/103-8002bb36-b9f8-4c32-8801-7da31bfb8449

and connect them to vital community-based resources, including housing, and are an important part of the No Wrong Door system model. More funding is needed to establish ADRCs throughout the state and to formalize relationships with local continuums of care, including local housing authorities, housing finance agencies and affordable housing providers. With the right support, ADRCs can help older adults and people with disabilities navigate through California's complex housing systems. Beyond housing, they can also help identify resources to help individuals become or remain stability housed and access other needed supports while they are on housing waitlists.

3.2. **Offer a tax-credit incentive for homeowners to put rooms into shared housing programs at an affordable rate.** By offering tax credits in an amount equaling the difference between the affordable rent collected and the fair market rent, California can incentivize homeowners to put rooms into shared housing programs at a rate affordable to Extremely Low-Income (30% of Area Median Income) and Very Low-Income (50% of Area Median Income) renters.

3.3. **Expand funding for Permanent Supportive Housing Programs.** In California, there are thousands of older adults and people with disabilities experiencing homelessness or in temporary housing situations, and housed without the supportive services they need to successfully transition into permanent housing. Permanent Supportive Housing is an important tool in California's housing toolkit; however, it is severely underfunded. PSH is essential for ensuring housing success and positive health outcomes for persons exiting homelessness and/or those experiencing serious and long-term disabilities - such as mental illnesses, developmental disabilities, physical disabilities and substance use disorders.

3.4. **Examine and improve existing Medi-Cal Waiver Programs that allow low-income older adults to receive in-home care and community-based care.** California's Medicaid 1915(c) Home- and Community-Based Services Waivers, including the Assisted Living Waiver, the Home- and Community-Based Alternatives Waiver, and the Multipurpose Senior Services Waiver should be renewed, improved and expanded to serve more Californians. These waiver program promote: 1) aging in place, 2) improved health outcomes, 3) well-being, and 4) a reduction in unnecessary or avoidable healthcare utilization such as emergency department visits and hospitalizations.

3.5. **Create an Integrated Care at Home Demonstration to help older adults and people with disabilities who live in or near affordable housing communities age in place.** California should utilize lessons-learned from other states to create a demonstration to coordinate the resources of community health, social services and housing organizations to support older adults and people with disabilities who choose to live independently at home.

The Demonstration would serve those within the LTC at Home, or like, Benefit, but more importantly, would provide services and supports to those who do not qualify for LTC at Home. As drafted, the LTC at Home Benefit is limited to higher-acuity individuals who have care needs that make them eligible for institutionalization in a Skilled Nursing Facility (SNF). If a person does not meet the eligibility criteria for LTC at Home, they have very few options for affordable supports and services to help them remain independent in their own home. Having to choose between paying for medications or paying rent can lead to homelessness. An Integrated Care at Home Demonstration would seek to fill this gap in California's continuum of care for low- and middle-income older adults and people with disabilities.

An Integrated Care at Home Demonstration would require California to reform it's thinking about how care and services are provided to older adults. Integrated Care at Home would provide an avenue for California to meet the long-term care needs of low- and middle-income, while bridging the gap in health care access to minority populations and immigrant households where language barriers increase health inequities. This can be done without dismantling any of California's existing healthcare and long-term care programs.

The Integrated Care at Home Demonstration should be designed using elements of Vermont's Support and Services at Home Program (SASH) and the U.S. Department of Housing and Urban Development's (HUD) Supportive Services Demonstration, also known as Integrated Wellness in Supportive Housing (IWISH).

Vermont Support and Services at Home (SASH) Program: The State of Vermont's Support and Services at Home Program (SASH), has been extremely successful in improving population health, reducing costs and enabling aging in place safely. [74] The program was created as part of a larger healthcare reform initiative that utilizes the existing network of affordable housing as extenders to primary care practices.[75]

The SASH program facilitates a range of support and in-home services for participants, which includes Medicare and Medicaid recipients living in congregate affordable housing and in the surrounding community.[76] Services and supports are coordinated by an on-site wellness team that consists of a SASH Coordinator and a Wellness Nurse.[77] The on-site team coordinates with a core team of providers representing including social services, home health, mental health services and Area Agencies on Aging.[78] The on-site team also coordinates with primary care practices, hospitals and nursing homes.[79] Together the on-site team and the core team create comprehensive health and wellness assessments, individualized care plans, on-site one-on-one nurse coaching, care coordination, and health and wellness group programs.[80] Formal community partners collaborate with the core SASH staff to coordinate care and services for participants and offer on-site health and wellness programming. Each team oversees wellness coordination for 100 participants.[81]

The SASH Program is currently funded through an All-Payer Accountable Care Organization Model, with funding from Medicare, Medicaid and private insurers.[82]

In urban areas, SASH participants saw slower growth in Medicare expenditures of over $1,450 per beneficiary per year.[83] SASH participants also had slower rates of growth for hospital, emergency department, and specialty physician costs, as well as lower rates of all-cause hospital admissions compared to non-participants.[84] Among dually-eligible SASH participants, growth in Medicaid expenditures for institutional long-term care was significantly slower.[85] The average impact was $400 per participant per year.[86] Slower growth in expenditures has been sustained since the first evaluation in 2012. The SASH Program has also reported significant improvements among individuals with common chronic conditions

---

[74] "SASH Vermont Overview" https://sashvt.org/learn/.

[75] "Research Summary: Support and Services at Home (SASH) Evaluation: Highlights from the First Four Years," HHS Office of the Assistant Secretary for Planning and Evaluation, Office of Disability, Aging and Long-Term Care Policy, July 2017. https://aspe.hhs.gov/system/files/pdf/257926/SASH4hl-rs.pdf.

[76] Ibid.

[77] Ibid.

[78] Ibid.

[79] Ibid.

[80] Ibid.

[81] Ibid.

[82] "Vermont All-Payer ACO Model," Centers for Medicare and Medicaid Services. https://innovation.cms.gov/innovation-models/vermont-all-payer-aco-model.

[83] Support and Services at Home (SASH) Evaluation: Highlights from the Evaluation of Program Outcomes from 2010 to 2016," HHS Office of the Assistant Secretary for Planning and Evaluation, Office of Disability, Aging and Long-Term Care Policy, July 2019. https://aspe.hhs.gov/system/files/pdf/262061/SASH5hl-rs.pdf.

[84] Ibid.

[85] Ibid.

[86] Ibid.

such as high blood pressure leading to hypertension[87] and diabetes[88]. SASH has also shown to reduce social isolation and loneliness.[89]

The SASH Program has been successfully replicated in other states and more states are working on developing replicate programs.[90]

HUD Integrated Wellness in Supportive Housing (IWISH) Demonstration: The IWISH Demonstration leverages HUD's affordable senior housing properties as a platform for the coordination and delivery of services to better address the interdependent health and supportive service needs of older residents.[91] The demonstration is testing a model of housing and supportive services with the potential to delay or avoid nursing home care for low-income elderly residents in HUD-assisted housing.[92]

The IWISH model funds a Resident Wellness Director (RWD) and Wellness Nurse (WN) to work in HUD-assisted housing developments that either predominantly or exclusively serve households headed by people aged 62 or over.[93] The RWD and WN work together to create and implement a formal strategy for coordinating services to help meet residents' needs.[94] Some of the services include: developing Individual Healthy Aging Plans (IHAP), assisting residents with implementing these plans and accessing needed services and resources, motivating and encouraging residents to adopt beneficial behavior changes and follow-through with appointments and other activities, developing property-level programming based on identified resident needs and interests, engaging with community partners, formally and informally, to assist individuals and bring services and resources to the property, and more.[95]

HUD is implementing the 3-year demonstration in 40 affordable senior housing communities in California, Illinois, Maryland, Massachusetts, Michigan, New Jersey, and South Carolina. There are 15 IWISH Demonstration Sites in California, including nine in Southern California and six in Northern California.[96]

3.5.1. **Funding an Integrated Care at Home Demonstration:** Existing Integrated Care at Home models are predominantly federally funded. Vermont and other SASH models in Rhode Island and Minnesota seek to collaborate with future Integrated Care at Home models in Maryland and potentially California to seek an Integrated Care at Home Innovation grant from CMMI. This fits well with CMMI's purpose of supporting the development and testing of innovative health care payment and service delivery systems. CMMI was established as part of the Affordable Care Act in 2011 and receives $10B each decade to fund innovation demonstrations.

3.5.2. **California Integrated Care at Home Demonstration Framework:** California should develop an Integrated Care at Home Demonstration that builds upon the successes and lessons-learned from SASH and IWISH:

[87] "Outcomes of the SASH Hypertension Management Program" https://sashvt.org/wp-content/uploads/2018/11/2018-HTN-Management-Program.pdf.
[88] "SASH Impact November 2018: Tackling Diabetes on Many Fronts," http://www.resource.sashvt.org/sash/2018%20Nov%20SASH%20Impact.pdf.
[89] "SASH Combatting Loneliness and Social Isolation" https://sashvt.org/wp-content/uploads/2018/11/2018-Social-Isolation.pdf.
[90] "Healthy Aging in Affordable Housing: Baltimore Fact Sheet," Enterprise Community Partners.
[91] "Fiscal Year (FY) 2015 Supportive Services Demonstration for Elderly Households in HUD-Assisted Multifamily Housing Program NOFA," U.S. Department of Housing and Community Development. https://www.hud.gov/program_offices/administration/grants/fundsavail/nofa2015/ssdemo.
[92] Ibid.
[93] Ibid.
[94] Ibid.
[95] Ibid.
[96] "Supportive Services for Elderly in HUD Assisted Housing," World Health Organization. https://extranet.who.int/agefriendlyworld/afp/supportive-services-elderly-hud-assisted-housing/.

3.5.2.1.   Provides comprehensive care management and coordination at home. An Integrated Care at Home Demonstration should create a population health system where a team of providers supports a large number of participants in a flexible and cost-efficient manner, instead of a team of providers supporting one resident. A population health system can take advantage of the efficiencies provided by congregate housing communities like affordable senior housing buildings, where many participants are located in one place. This model creates a system of partnerships and communication networks that collectively support thousands of elderly as opposed to creating a separate partnership for each beneficiary.

3.5.2.2.   Located in an urban area with a high concentration of affordable senior housing communities: To create efficiencies and realize the greatest cost savings, the demonstration should be located in an urban area with a high concentration of affordable senior housing communities.

3.5.2.3.   Target population: Medicare and dually eligible recipients living in congregate affordable housing and in the surrounding community. By targeting Medicare recipients instead of Medi-Cal only recipients, California can provide much needed care coordination to those individuals in the "forgotten middle" – those who do not qualify for Medi-Cal, but cannot afford to pay out-of-pocket for long-term care.[97] Additionally, an Integrated Care at Home Demonstration would use housing as a platform for addressing health inequities in disadvantaged communities including low-income individuals, minorities and immigrants.

3.5.2.4.   Size of demonstration would depend on funding: Each on-site care team would oversee a participant pool of 100 individuals. In the SASH Program, at least one-third of participants do not live in the housing community, but in the surrounding neighborhood.

3.5.2.5.   Services provided by on-site care teams. Care teams would be placed on-site at affordable senior housing communities. Each onsite care team would consist of a full-time Community Health Worker and a half-time Wellness Nurse. The Community Health Worker helps participants identify their goals and connects them with health care and preventative programs and activities to help meet their needs. The Wellness Nurse checks-in regularly and provides health coaching, particularly for chronic conditions such as diabetes, hypertension, arthritis and behavioral health challenges including suicide. The nurse also helps participants make successful transitions following in-patient treatment at a hospital or rehab facility.

3.5.2.6.   Care and services are coordinated through the Core Wellness Team. The Core Team would meet once a month to coordinate care. The Core Team is comprised of community health, social services and mental health providers including the onsite team, AAA providers, ADRCs, County Mental Health and home health agencies. Coordination between the onsite team, the core team, and the community partners is essential to ensuring comprehensive care for each participant. Coordination ensures communication among providers and reduces inefficiencies by eliminating duplication of efforts. The provider networks are created through a series of Memorandums of Understanding and overseen by a program administrator.

Program would focus on three components of care management with the goals of improving population health, reducing costs and enabling aging in place safely. The three components of care management would include care transitions (i.e. helping individuals' transition from

---

[97] "NIC Middle Market Seniors Housing Study," Beth Burnham Mace, Nic, Caroline F. Pearson, NORC at the University of Chicago, Robert G. Kramer, NIC, Chuck Harry, NIC, Lana Peck, NIC, Charlene C. Quinn, University of Maryland School of Medicine, A. Rupa Datta, NORC at the University of Chicago, David C. Grabowski, Harvard Medical School, and Sai Loganathan, NORC at the University of Chicago. 2019. https://www.nic.org/middlemarket.

institutional care back to a community-based care setting), self-management of chronic conditions and care coordination.

3.5.3. Benefits of an Integrated Care at Home Demonstration:

3.5.3.1. **Improved health outcomes.** Participants in the SASH and IWISH (IWISH data has not yet been evaluated) programs are reporting improvement in and better management of chronic conditions, healthier lifestyles, and fewer hospitalizations.[98]

3.5.3.2. **Costs savings to Medi-Cal and Medicare.** The SASH Program evaluation reports Medicare savings of up to $1,450 per beneficiary per year and Medicaid savings of up to $400 per beneficiary per year.[99]

3.5.3.3. **Increased access to health care for minority populations especially African American and Hispanic individuals susceptible to COVID-19.** African American and Hispanic individuals are disproportionately represented in affordable housing.[100] Integrated Care at Home provides an opportunity for African American and Hispanic individuals living in and near affordable senior housing communities to receive quality care and services at home. African American and Hispanic individuals are less likely than white peers to have health care coverage and more likely to report their health as fair or poor.[101] They are also more likely than their white peers to suffer from chronic conditions like asthma, hypertension and diabetes.[102] The Integrated Care at Home model would provide participants with increased access to primary and preventative healthcare and mental healthcare, management of chronic conditions and health education.

3.5.3.4. **Increased access to long-term services and supports for the "forgotten middle."** There are many Californians who do not meet the income qualifications for Medi-Cal, but do not have the personal wealth to pay out-of-pocket for long-term care. These individuals are often forced to spend-down their resources on long-term care until they eventually qualify for Medi-Cal, and/or are prematurely admitted to skilled nursing. Many older adults who qualify for and live in affordable senior housing communities do not qualify for Medi-Cal. Creating a demonstration using Medicare eligibility instead of Medi-Cal eligibility as criteria for admissibility would allow these individuals to receive long-term supports and services that they would otherwise not be able to afford.

3.5.3.5. **Reduces social isolation and loneliness.** Having an onsite care team means that each participant will have regular face-to-face contact with the Community Health Worker or the Wellness Nurse. The onsite care team members would form personal connections with the participants, making it easier to recognize when someone needs more engagement. The care team would also facilitate group wellness events and educational classes to engage

---

[98] Support and Services at Home (SASH) Evaluation: Highlights from the Evaluation of Program Outcomes from 2010 to 2016," HHS Office of the Assistant Secretary for Planning and Evaluation, Office of Disability, Aging and Long-Term Care Policy, July 2019. https://aspe.hhs.gov/system/files/pdf/262061/SASH5hl-rs.pdf.

[99] Support and Services at Home (SASH) Evaluation: Highlights from the Evaluation of Program Outcomes from 2010 to 2016," HHS Office of the Assistant Secretary for Planning and Evaluation, Office of Disability, Aging and Long-Term Care Policy, July 2019. https://aspe.hhs.gov/system/files/pdf/262061/SASH5hl-rs.pdf.

[100] "Racial Disparities Among Extremely Low-Income Renters," National Low-Income Housing Coalition, Apr 15, 2019. https://nlihc.org/resource/racial-disparities-among-extremely-low-income-renters

[101] "Health Disparities by Race and Ethnicity," Sofia Carratala and Connor Maxwell, May 7, 2020. American Center for Progress. https://www.americanprogress.org/issues/race/reports/2020/05/07/484742/health-disparities-race-ethnicity/#:~:text=regardless%20of%20race.%E2%80%9D-,Health%20coverage,health%20insurance%20coverage%20in%202017.

[102] Ibid.

participants. Vermont SASH participants report improvements in social isolation and loneliness.[103]

3.5.3.6. **Increases individual participation in their own health care and likelihood of receiving preventative care.** Regular check-ins with the on-site care team build trust and connections. Having a relationship with the on-site care teams helps empower people to become more involved in their own care. It also increases the likelihood that a person will receive preventative healthcare and mental healthcare.[104]

3.5.3.7. **Easily Adaptable to telemedicine.** The Integrated Care at Home Program would, by nature, be easily adaptable to telemedicine. The on-site Wellness Nurse can assist with and participate in calls between a participant and their primary care and specialty health providers.

4. Recommendations for Long-Term Action (5-10 years)

4.1. **Evaluate progress made to date.** In five years, that state should evaluate the progress it has made under these recommendations by examining trends in data. All metrics should require analysis of the data by the equity dimensions of race/ethnicity, income, age, gender and ability to prevent disparities in access to housing.

4.1.1. Rate of housing cost burden among older adults and people with disabilities.

4.1.2. Rate of homelessness among older adults and people with disabilities.

4.1.3. Number of new and rehabilitated affordable age-restricted housing units created.

4.1.4. Number of new and rehabilitated affordable housing units created.

4.1.5. Total number of shared housing units.

4.1.6. Rate of Skilled Nursing Facility Admissions from community-based settings.

4.2. **Make housing a primary component of any statewide long-term care benefit that seeks to treat people at home.** Providing home- and community-based services to older adults and people with disabilities can help them live longer, age-in-place and avoid unnecessary or avoidable healthcare utilization such as emergency department visits, hospitalizations and skilled nursing admissions. Housing will be a primary component to any statewide benefit seeking to provide long-term services and supports (LTSS) at home.

4.2.1. **Define "home" broadly.** Any statewide long-term benefit that seeks to treat people at home must define the term "home" broadly to enable people to receive appropriate care in the setting of their choice. The term "home" can embody many types of housing models including independent living, residential care facilities and congregate care.

The State has an obligation under *Olmstead v. L.C.*[105] to provide services in the most integrated setting appropriate to an individual's needs. Ensuring that individuals are able to safely receive long-term care services and supports in the "home" setting of their choice will help ensure that California is meeting the requirements of *Olmstead*.[106]

4.2.2. **Serve more people, remedy health inequities and realize cost efficiencies by creating partnerships to serve congregate housing sites.** Housing settings like affordable senior apartment communities and mobile home parks provide unique opportunities for a statewide long-term care

---

[103] "SASH Combatting Loneliness and Social Isolation" https://sashvt.org/wp-content/uploads/2018/11/2018-Social-Isolation.pdf.
[104] "Network Success Story: Embedding Mental Health Care in Affordable Housing Sites," OneCare Vermont. 2019. https://www.onecarevt.org/embedding-mental-health-care-in-affordable-housing-sites/.
[105] *Olmstead v. L.C.*, 527 U.S. 581 (1999).
[106] Ibid.

benefit through economies of scale. Congregate low-income housing sites have large populations of Medi-Cal eligible older adults and people with disabilities.

Partnering with home- and community-based services organizations and housing providers to provide care to individuals at congregate housing sites will help to bring essential LTSS care to a greater number of individuals while creating cost efficiencies for the state.

Partnerships will also help to ensure access to LTSS benefits for minorities. African American and Hispanic individuals are disproportionately represented in affordable housing[107] and are more likely than white peers to experience inequities in access to health care and services.[108]

4.2.3. Any statewide long-term care benefit that seeks to treat people at home must serve low- and middle-income individuals. There are many Californians who do not meet the income qualifications for Medi-Cal, but do not have the personal wealth to pay out-of-pocket for long-term care. These "Forgotten Middle" individuals are often forced to spend-down their resources on long-term care until they eventually qualify for Medi-Cal, and/or are prematurely admitted to skilled nursing.[109]

The state should ensure that any long-term care at home benefit is accessible to middle-income older adults and people with disabilities. This can potentially be done using a sliding-scale payment model, where individuals with higher incomes would pay a higher share of cost.

4.3. Adopt a permanent and statewide Integrated Care at Home Program to help older adults and people with disabilities who live in or near affordable housing communities age in place. At the end of the Integrated Care at Home Demonstration, California should evaluate the lessons learned and create a permanent statewide program.

4.3.1. Expand Statewide: A permanent and statewide expansion of Integrated Care at Home should adopt the same framework and goals of the Demonstration, taking into consideration and adapting for lessons learned. Urban areas, with higher concentrations of affordable housing communities will create the most savings for Medicare and Medicaid. These savings can then be cost-shifted to underserved rural areas, who often lack access to health care and supportive services.

4.3.2. Funding Model: Financing an Integrated Care at Home Program in a state as large as California will require a well-coordinated statewide operating and training infrastructure to ensure volume-driven cost efficiencies. The Medicare-only or Medicaid-only approach to funding healthcare allows too many people to fall through the cracks. California already has a robust network of affordable senior housing communities, that can serve as the network in which the program will operate.

A multi-payer or all-payer model is the only solution to funding aging services on a permanent sustainable basis. In Vermont, the all-payer model includes funding from Medicare, Medicaid, and

---

[107] "Racial Disparities Among Extremely Low-Income Renters," National Low-Income Housing Coalition, Apr 15, 2019. https://nlihc.org/resource/racial-disparities-among-extremely-low-income-renters

[108] "Health Disparities by Race and Ethnicity," Sofia Carratala and Connor Maxwell, May 7, 2020. American Center for Progress. https://www.americanprogress.org/issues/race/reports/2020/05/07/484742/health-disparities-race-ethnicity/#:~:text=regardless%20of%20race.%E2%80%9D-,Health%20coverage,health%20insurance%20coverage%20in%202017.

[109] "NIC Middle Market Seniors Housing Study," Beth Burnham Mace, Nic, Caroline F. Pearson, NORC at the University of Chicago, Robert G. Kramer, NIC, Chuck Harry, NIC, Lana Peck, NIC, Charlene C. Quinn, University of Maryland School of Medicine, A. Rupa Datta, NORC at the University of Chicago, David C. Grabowski, Harvard Medical School, and Sai Loganathan, NORC at the University of Chicago. 2019. https://www.nic.org/middlemarket.

private insurance.[110] This ensures the focus is on improving health outcomes through comprehensive care, rather than piecing together allowable services under each payment system. The money flows through an Accountable Care Organization and the savings are used to pay for SASH. Health Homes funding through Medicaid can potentially be part of the funding equation. CMS support, coupled with California state support for a statewide Integrated Care at Home model will improve health equity and reduce costs for California's growing elderly population.

---

[110] "Vermont All-Payer ACO Model," Centers for Medicare and Medicaid Services. https://innovation.cms.gov/innovation-models/vermont-all-payer-aco-model.

MPA GOAL 2: LIVABLE COMMUNITIES – ACCESSIBLE TRANSPORTATION

Goal 2. Livable Communities and Purpose – We will live in and be engaged in communities that are age-friendly, dementia-friendly, and disability-friendly.

Overview

Transportation is the vital link that connects older adults and people with disabilities to social activity, economic opportunity, necessities, and community services; hence supporting their independence. California has longstanding, systemic policy, and funding disparities relative to transportation programs for this population (see Appendix A). Because of these disparities, people are less able to remain in their homes and communities as they age, have reduced quality of life, decreased participation in the economy, and suffer worse health outcomes. Many older adults need specialized transportation services such as door-to-door paratransit and escorts to physician's offices. Safe, affordable, accessible, dependable, and user-friendly options are needed to overcome the physical limitations associated with aging and living with one or more disabilities particularly when coupled with being a person of color or a member of other marginalized populations, such as LGBTQ. These needs can be met when transportation systems are built around the needs of the rider rather than the service provider.

Accessible transportation recommendations fall into the following key areas:

1. Accessible coordinated transportation and mobility spanning the entire age/ability spectrum (local)
2. Policy and Planning Imperatives (statewide)
3. Rural Investments

Adoption of these recommendations will:

- Transform and create a transportation system that is accessible and designed around the rider, not designed for the ease of the system

- Mitigate decades of underinvestment and unfulfilled policies in transportation/services for the population of older persons and those with disabilities, particularly minority populations

- Increase safety and support health

- Address identified needs statewide

- Bring an end to accessible transportation issues being regarded separately and unequally relative to every other mode of transportation

- Increase cost effectiveness and other systemic improvements

Background

Programs for transporting older Californians and persons with disabilities (referred to as accessible transportation in this document) are often limited in terms of availability, accessibility and quality; disproportionately impacting marginalized communities. This longstanding problem is not unique to California. In fact, state and federal studies have documented[111] this issue for decades with limited progress. The Coordinated Public Transit-Human Services Transportation Plan for the San Francisco Bay Area summarizes this problem concisely as a statewide issue:

---

[111]Transportation Task Team to the California Commission on Aging, 2005, 2007 reports:. "Barriers…, Lack of: 1) state and local leadership to coordinate programs and services, 2) regulatory authority to mandate that CTSAs be established and perform service coordination and improvement functions, 3) incentives to coordinate or improve services, 4) consensus by stakeholders due to programs being funded from different "silos" and subject to differing requirements, 5) resources, particularly funding and staffing, at the local and state level, Lack of local leadership to coordination. Lack of coordination incentives. Lack of political will to make systematic changes", and (the presence of) "Funding Silos", and "the need for "Dollars need to follow the person (from various funders) not follow the program." Government Accountability Office (GAO) reports 109878, 591707, 650079, 658766, 660247,

Current senior-oriented mobility services do not have the capacity to handle the increase in people over 65 years of age…the massive growth among the aging …points to a lack of fiscal and organizational readiness…the closure and consolidation of medical facilities while rates of diabetes and obesity are on the rise will place heavy demands on an already deficient system.

Magnification of the Problem with Changing Demographics: From the University of California Institute of Transportation Studies, "*The mobility needs of an aging population is one of the most substantial challenges facing California in the coming decades. The number of residents age 65 and older is expected to double between 2012 and 2050, and the number age 85 and above is expected to increase by over 70% between 2010 and 2030. Declines in physical function related to age may reduce mobility options dramatically.*"[112], Systemic racial inequities are further perpetuated as the demographics shift.

Three misconceptions about transportation services contribute to the lack of public and political support for their adoption. These include:

Misconception #1: *Public transit operators adequately fulfill accessible transit needs.* Public transit is spread too thin to adequately manage an accessible transit system for all users. Public transit is expected to help solve climate change, reduce commute congestion, provide expensive off-peak service, provide lifeline service for low-income populations, etc. The largest number of providers of accessible transit are non-profit organizations, not conventional public transit operators[113].

Misconception #2: *Non-profit agencies adequately fulfill accessible transit needs.* Historically underfunded, non-profit transportation agencies are forced to compete with public transit operators for funding; rather than cooperate and collaboration. Consequentially, systems end up in silos rather than consolidated to meet ALL needs. An analogy would be if the needs of commuters were being inadequately addressed forcing them to band together and form individual organizations to maintain and build their own roads and bridges to get to and from work and home.

Misconception #3: *Transportation requirements placed on health insurance and health care providers* **fill transportation gaps.** (Assembly Bill 2394, Garcia – 2015/16 NMT, Affordable Care Act, etc.) While these entities provide medically-related transportation, the approach often creates yet another silo, creates additional confusion, and worsens the already challenged accessible transit system. Such systems need to be person-centered rather than funder focused.

California's Transportation Plan 2040[114] unintentionally describes how the California's limited accessible transportation options impacts this vulnerable population, "*Limited access to quality transportation can affect health, particularly among vulnerable populations, such as the poor, the elderly, children, the disabled, and in communities of color. A safe and accessible transportation system allows members of vulnerable populations to more easily travel to supermarkets for fresher foods, to integrate daily walking as a form of exercise to meet physical activity needs, and to better access*

667361, et al: "…duplication of effort and inefficiency in providing transportation when agencies do not coordinate…", "….state and local agencies are unaware that they are...providing transportation services identical and parallel to those of another agency"…transit agency officials that we spoke with said that they would like to implement coordination efforts, but have been unable to get various parties to come together…", "continuing challenges such as insufficient leadership at the federal level and limited financial resources and growing unmet needs at the state and local level.", "…state and local officials expressed concern about their ability to adequately address expected growth in elderly, disabled, low-income, and rural populations.", "…agencies providing similar transportation services to similar client groups may lead to duplication and overlap when coordination does not occur."

[112] *Assessing and Addressing the Mobility Needs of an Aging Population*, April 2019, David R. Ragland, Ph.D., M.P.H. University of California, Berkeley, Kara E. MacLeod, Dr.P.H. M.P.H., M.A., University of California Los Angeles, Tracy McMillan, Ph.D., M.P.H., University of California, Berkeley, Sarah Doggett, M.S., University of California, Berkeley, Grace Felschundneff, B.S., University of California, Berkeley

[113] *American Public Association Transit Association Fact Book*, 2015

[114] Caltrans, 2016-California Transportation Plan 2040, https://dot.ca.gov/programs/transportation-planning/state-planning/california-transportation-plan

health care facilities, education, jobs, recreation and other needs". As a social determinant of health, transportation is highly linked to improved health and quality of life[115].

To create equitable access, significant investment and policy changes are necessary. Because accessible transit has been studied extensively, the path to improvement is well established. As described below, now is an ideal time to make improvements, significant funding and leadership at all levels and will be necessary for successful implementation.

The improvements to accessible transportation policies recommended in this document will:

- Mitigate decades of underinvestment

- Increase safety (i.e., health and well-being)

- Address identified needs statewide

- Bring an end to accessible transportation issues being regarded separately and unequally relative to every other mode of transportation

- Increase cost effectiveness and other systemic improvements implementation of increased coordination through the Consolidated Transportation Services Agencies (CTSA) model will produce[116]:

  1. Significant reductions in service costs

  2. Greater amount of available transportation

  3. Higher quality service by improvements in coordination and safety

  4. Access to increased funding by reducing duplication and silos

  5. Creation of a one-stop shop for finding local transportation options

Significant research and outreach examining how to improve accessible transit has been completed, the recommendations need to be funded. Now is the time for change.

Recommendations

1. Expand and Improve Accessible Coordinated Transportation

Current policies have Californians "ageing-out" of transportation options due to significant policy and funding disparities. Policies and funding should support accessible coordinated transportation and mobility that spans the entire spectrum of aging and ability statewide. Policies and programs should support a range of modalities (e.g., safe walking infrastructure, accessible transit, conventional transit, etc.) to meet the needs of passengers with disabilities and mobility **challenges.**

   1.1. **Acknowledge the obligation to provide equitable transportation improvements for this population.** While funding and program advances for accessible transportation have stagnated, systems for every other transportation mode and user group have continually improved and expanded. Roadway improvements for automotive travel, fixed-route bus, bicycling, pedestrian, passenger rail, new-wheeled mobility options (e.g., bikeshare, electric bikes or scooters) have all advanced. Accessible transportation has been inexplicably segregated from similar advances. The same multimodal approach must be implemented as it pertains to the life continuum for all people of all ages and abilities. The system must expand and improve affordable mobility options beyond just paratransit, including but not limited to: door through door services; wheelchair accessible transportation network companies (TNCs) and demand response real time ride systems; volunteer driver

---

[115] Bay Area Regional Health Inequities Initiative,2015- *Applying Social Determinants of Health Indicator Data for Advancing Health Equity: A Guide for Local Health Department Epidemiologists and Public Health Professionals,* https://www.barhii.org/sdoh-indicator-guide

[116] FTA, Accessible Transit Services For All, 12/14 | Transit Cooperative Research Program Rpt. 91, Economic Benefits of Coordinating Human Service Transportation and Transit Services | TCRP Report 101, Toolkit for Community Coordinated Transportation Services

program expansions; nonprofit service provider systems; stipends/free rides for caregivers; gas subsidies and more**.**

1.2. **Expand, improve, and empower CTSAs.** Poor accessible transit options can only be solved with systemic solutions. Improving CTSAs is a systems approach and elevates the statewide ability to coordinate, collaborate and improve comprehensive accessible transportation (see Appendix C for a consolidated CTSA summary). The objectives are: a) to have pervasive, consistently administered CTSAs providing accessible transit; b) to have higher quality, convenient accessible transit be the standard, rather than the rarity that it is now, and; c) coordinate the various transportation funding silos into a No Wrong Bus model that appears seamless to the rider despite a complexity of rules and funders. For decades there have been conferences, summits, reports117, etc. that all point to the need for robust coordination (which is the core CTSA function) to improve accessible transit. However effective coordination is a project in and of itself and as such it requires dedicated funding, leadership, and support, "…invocation of coordination does not necessarily provide either a statement of or a solution to the problem, but it may be a way of avoiding both when an accurate prescription would be too painful."118 This report is providing the accurate prescription, stronger policies and additional funding. Funding sources used by CTSAs are also used by public transit agencies. This competition suppresses the growth of CTSAs. A significant allocation of funding must be sole sourced to CTSAs and not be part of fixed route operations. CTSAs can house many functions which would be dictated by the locality, funding will eventually be used for direct service contracted or organized by the CTSA, including paratransit, travel training, mobility management, TNC (Lyft/Uber) enabled transportation, volunteer driver programs, , etc. A baseline level of funding should be made available so that rural communities receive equitable allocations to support adequate program infrastructure and produce successful services**.**

Examples (not exhaustive) of programs that must be included in CTSA implementation are detailed below:

a. **Promote Driver Safety Programs**

Giving up one's ability to drive can be a life changing and traumatic experience. Offering pathways to allow individuals to improve their ability to drive independently and be provided support in transitioning from a personal vehicle to alternative transportation options addresses both ends of the equation.

- Create a Referral Program Between DMV & California Highway Patrol & Transportation Ambassadors. Using the options counseling approach, a locally designated Transportation Ambassador can work with individuals and family members to review transportation options available in the community, and develop a training program or referral process that best fits the needs of the individual transitioning from driving their own car to accessing other options.

- Promote driver participation in safety programs like CHP "Car-Fit" and AARP Driver Safety Program, and other similar courses designed to enable older adults to retain their ability to drive safely in their own vehicles.

---

[117] **Transportation Task Team to the California Commission on Aging**, 2005, 2007 reports. "Barriers…, Lack of: 1) state and local leadership to coordinate programs and services, 2) regulatory authority to mandate that CTSAs be established and perform service coordination and improvement functions, 3) incentives to coordinate or improve services, 4) consensus by stakeholders due to programs being funded from different "silos" and subject to differing requirements, 5) resources, particularly funding and staffing, at the local and state level, Lack of local leadership to coordination. Lack of coordination incentives. Lack of political will to make systematic changes", and (the presence of) "Funding Silos", and "the need for "Dollars need to follow the person (from various funders) not follow the program." **Government Accountability Office (GAO) reports** 109878, 591707, 650079, 658766, 660247, 667361, et al: *"…duplication of effort and inefficiency in providing transportation when agencies do not coordinate…", "….state and local agencies are unaware that they are...providing transportation services identical and parallel to those of another agency"…transit agency officials that we spoke with said that they would like to implement coordination efforts, but have been unable to get various parties to come together…", "continuing challenges such as insufficient leadership at the federal level and limited financial resources and growing unmet needs at the state and local level.", "…state and local officials expressed concern about their ability to adequately address expected growth in elderly, disabled, low-income, and rural populations.", "…agencies providing similar transportation services to similar client groups may lead to duplication and overlap when coordination does not occur."*

[118] Implementation: How Great Expectations in Washington Are Dashed in Oakland, Jeffrey L. Pressman, Aaron Wildavsky, 1984

b.   **Improve Community Walkability**

Walking is the oldest form of public transportation. It's the most cost effective, the most independent, and (provided safe paths of travel can be provided), the healthiest – for both the individual, the community, and the environment.

- Install pedestrian islands at intersections.

- Remove artificial barriers between businesses, housing & services, designed to discourage easily moving from one vendor to another.

- Amend the Government Code to require local jurisdictions to 1) circulate capital improvement plans, or other lists of significant public works to the local CTSA, 2) circulate general/specific plans to the local CTSA, and 3) respond to comments from the CTSA whose goal it is to ensure that local planning infrastructure investment incorporate accessible transportation issues.

- Establish a Vulnerable Road User (VRU) Law[119]: VRU laws provide legal protection to older adults walking on roads and sidewalks.

- Increase funding to the California Active Transportation Program (CATP) and provide legislative direction and support to more efficiently and equitably administer the program: State agencies, such as Caltrans, are charged with fulfilling the ATP objectives of N-19-19, have concerns with adequate staffing and resources. Legislation providing additional funding and direction can assist.

- Give cities and local transportation agencies the ability to lower speed limits on roads within their jurisdiction and direct the California Department of Transportation (Caltrans) to eliminate the 85th percentile rule in speed-limit setting: The 2019 Zero Fatalities Task Force Report contains further details on these two specific proposals, including extensive research on the ineffectiveness of the 85th percentile rule.

c.   **Improve Accessibility to Fixed Route Services, Local/Regional Passenger Rail, and Other Mass Transit Services**

High density transportation **benefits** communities financially, reduces air pollution, increases fuel efficiency, reduces traffic congestion, saves money, increases mobility, frees up time, and reduces traffic collisions and injuries. A few simple augmentations to existing systems will expand the availability of these services to be more easily utilized by older adults and persons with disabilities.

- Provide free rides for older adults and people with disabilities during off-peak hours.

- Provide safe and comfortable places to wait for the bus - benches, shelters to protect from rain and sun.

- Design transit stops in front of stores, rather than bordered by large parking lots. Or, as an alternative within existing malls, parking lots, etc., create driverless shuttles to take shoppers from the front door to bus stops. These systems solve the challenge of navigating a large parking lot between the store and the main roadway where buses are boarded.

- Adjust transit design to match changes in the shopping habits and evolution of shopping technologies

- Commission a California Vehicle Economy study: Conducted via a collaboration of research universities and state agencies, with the goal of providing a clearer financial assessment of the direct and indirect costs that California taxpayers pay per year to subsidize car-centric transportation infrastructure.

---

[119] League of American Bicyclists Model Vulnerable User Law: https://bikeleague.org/content/model-vulnerable-road-user-law

2. Implement Sound Planning and Policy Agenda

A statewide effort to expand and improve services will only succeed with the adoption and implementation of new policies, measurement tools, enhanced revenue, and comprehensive system design. These policies must address the provision of transportation services, as well as integrate & promote civic planning, public/private partnerships, and the inclusion of accessible transportation operations. Statewide efforts should build upon local coordinated public transit human services transportation plans, county unmet transit needs hearings and short-range transit plans (see Appendix B for a brief list).

2.1. **Ensure the Broader Transportation System Reflects the Needs of Older Californians (Caltrans):** Transportation planning and policies made advances in the last decade including policies and increased funding related to the complete streets, active transportation, context sensitive design, vision zero and other safety programs, and intelligent transportation systems120. Caltrans should ensure that Californians, regardless of age, race, economics, or travel mode (walking, cycling, driving, etc.), benefit equitably from these investments. The "equitable" standard needs to take in to account the vulnerability of the traveler and mode, as well as historic policy and expenditure inequities.

2.2. **Create a California Coordinated Transportation Commission:** The Commission will be immediately charged with implementing the recommendations of this document, emphasizing the coordination of accessible services under CTSAs. The Commission's ongoing role will include developing legislative recommendations that ensure emerging transportation technologies will benefit Californians of all ages, abilities, races, and be accessible regardless of existing income or place disparities. Lastly, the Commission will ensure the state has a strategic policy approach to understanding the rapid changes in revolutionary transportation technology, from consumer data privacy to automated vehicle technology to shared mobility devices.

2.3. **Measure Meaningful Transportation Impact & Outcomes:** Adopt new qualitative measurements of transportation impacts to augment or replace quantitative approaches. Rides serving challenged populations often lead to medical care revenue positive results by reducing hospitalization or other institutionalization or expensive interventions of the passenger. Unfortunately, traditional transportation measures focus on cost per trip, riders per hour, cost per mile, etc. Those measures reward systems that provide shorter trips to more mobile passengers and punish those that provide life-sustaining trips to physically challenged riders. Social service organizations are being held more responsible than ever to provide data that proves services have health benefits for those being served. It is time for public transit systems to be held to these same sorts of standards.

2.4. **Ensure no statewide budget or legislative bill related to transportation** omits consideration of accessible mobility options for older adults, people with disabilities and historically marginalized communities.

2.5. **Provide financial incentives for development projects** that integrate housing, grocery shopping, community services, etc. into the same development, thereby decreasing transportation demands. New building projects need to include Accessible Transportation considerations when being designed; not focusing merely on parking and fixed route.

2.6. **Evaluate effectiveness and adjust:**

- CTSA statutes: Ensure the creation, effectiveness, pervasiveness, and stability of CTSAs.

- Funding levels and policies: Funding, disbursement formulas, eligible activities, maintenance of effort, should be continually analyzed for effectiveness and to ensure service deficiencies are addressed with an unrelenting focus on issues of equity, age, race, cultural, etc.

- Oversight structure: Internal/External meta-review of oversight effectiveness.

---

[120] Links to Caltrans Programs: Complete Streets: Active Transportation, Intelligent Transportation Systems.

3. Enhance Rural Services and Volunteer Programs

Transportation in rural communities is challenged by a lack of infrastructure and resources to address accessible transportation needs. Tens of thousands of older adults and people with disabilities live in these rural communities, often due to urban housing shortages, requiring creative solutions for a truly age-friendly state to exist.

3.1. **Expand Volunteer Driver Programs**: Volunteer driver programs can be extremely effective in meeting the needs of older adults, especially in rural areas where service needs are episodic. To meet these needs, fund the Senior Volunteer Program[121] described in Older Californians Act (OCA), which would also augment volunteer-based programs like Health Insurance Counseling and Advocacy Program, Ombudsman, TCE/VITA, Meals on Wheels, etc. Provide a baseline level of funding so that rural communities receive enough of an allocation to provide adequate program infrastructure and produce successful services.

3.2. **Expand the Rural Transportation Assistance Program (RTAP):** Allocations would combine with OCA funding to establish or complement operating expenses for volunteer transportation programs throughout rural California. Using the RTAP resources for training, planning, and best practices will ensure the rural volunteer transportation programs are operating at the highest levels of efficiency and impact possible**.**

3.3. **Provide MicroTransit & Flexible Fixed Route services,** which allow low population density areas to adjust transit routes "on-the-fly" to pick up riders in need of services who do not live exactly on bus route. These variable routes work well in rural areas where a small route deviation will allow the pickup of additional riders without compromising the availability of fixed route services**.**

Summary

Transportation services must be designed for and benefit all Californians, especially people who can no longer drive, cannot afford a car, or who choose not to drive. Accessible, available, and affordable travel options enable people of all ages, abilities, and socioeconomic backgrounds to stay active and engaged in their communities. For some, regular, fixed-route public transportation services are ideal. For others, specialized transportation services are needed, such as paratransit, dial-a-ride, reduced-fare taxis, or rides in private vehicles through volunteer driver programs.

To succeed in meeting the needs of a diverse society, our success will depend on creating an equally diverse approach to transportation services. This diversity is our greatest strength as state, as a country, and as a society. It is essential that we develop an equally diverse approach to maximizing the mobility options for all; especially those targeted for service in this Master Plan for Aging.

---

[121] Welfare and Institutions Code: Div 8.5: MELLO-GRANLUND OLDER CALIFORNIANS ACT: Art. 3: Engaging Elders Through Volunteerism [9118 - 9118.5]

MPA GOAL 2: LIVABLE COMMUNITIES - PARKS AND PUBLIC SPACES

Goal 2. Livable Communities and Purpose – We will live in and be engaged in communities that are age-friendly, dementia-friendly, and disability-friendly.

Objective 1: California's neighborhoods will have the built environment to fully and meaningfully include older adults, people with disabilities, and people of all ages.

1. Overview

Role of Parks and Public Spaces in Livable and Age-Friendly Communities

Livable Communities are places where people of all ages and abilities can live healthy, independent lives. A livable community supports successful aging by promoting physical independence, and also by enhancing the quality of life and active social engagements of residents with one another. Equitable access to vibrant, age-friendly parks and public spaces are an essential element of livable communities.

Benefits of Parks and Open Spaces

Extensive evidence demonstrates that parks and open spaces improve physical and mental health and enhance community connections. In addition, parks provide tremendous economic value – increasing property values, tourism value, and health values.[122] Parks also play a vital role in climate change mitigation through storm water retention, air pollution removal and more.[123] Parks and public space also play a critical role in social inclusion, combating isolation and supporting civic engagement.[124] In short, parks provide tremendous value. Parks are especially valuable to older adults, who often utilize parks and open spaces to help promote physical activity, engage in social activity, reduce stress, and support faster healing and recovery.

1.1. Parks for ALL

California has a rich and diverse parks system, yet parks and public space are not adequately serving all. People over age 65 are the most underserved population in terms of having access to parks. This demographic is also most at risk for being inactive and experiencing social isolation. In a national study of parks, although older adults aged 60+ account for 20% of the population, they only represented 4% of total park users.[125] Many parks have not traditionally been built to serve a broader demographic, but have focused primarily on children and youth. Parks may lack features, amenities, facilities, and activities that support passive and active recreation by users of all ages. Park design that is inclusive, adopts universal design features, and promotes intergenerational use can foster opportunities for social interaction and learning opportunities for all ages. Improving park access for diverse communities and addressing the language needs of non-English speakers will support park inclusivity. Park programming incorporating dementia-friendly activities provides inclusive recreational opportunities for those living with memory loss and their caregivers. Park programming that is culturally inclusive and diverse across the age and ability span will support parks that are truly for all Californians.

---

[122] Clower, T.L.; Nguyen, D. The Economic Impact of Parks, an Examination of the Economic Impacts of Operations and Capital Spending by Local Park and Recreation Agencies on the U.S. Economy. National Recreation and Park Association. Center for Regional analysis, George Mason University. 2020

[123] Schottland, T. Parks as a Climate Solution. The Trust for Public Land. 2018

[124] Gies, E. The Health Benefits of Parks, How Parks Help Keep Americans and Their Communities Fit and Healthy. The Trust for Public Land, 2006

[125] Cohen, D.A.; Han, B.; Nagel, C.J.; Harnik, P.; et al. The First National Study of Neighborhood Parks: Implications for Physical Activity. American Journal of Preventive Medicine 2016, Vol 51, Issue 4, pgs 419-426

1.2. Park and Public Space Access

California must address the need for increased access to quality parks with features, amenities and programs that are age-friendly and inclusive of a variety of abilities. While parks are valued, many older adults have difficulty accessing parks and open space to enjoy the health, recreational, and social benefits they afford other residents. Many Californians live within a 10-minute walk of a park; however, fewer older adults live within a 10-minute walk – a significant barrier to use. Not owning or operating a vehicle should not be a barrier to park access. Lack of sufficient connections to parks through a variety of mobility options – including well-maintained sidewalks for walkability and rollability – are an access barrier. Lack of adequate safety features in the surrounding built environment, including lighting, designated crosswalks and signals, and appropriate signal-length times are additional barriers.

1.3. Park Equity

The same systemic inequities that are at the core of many housing and transportation disparities foster similar disparities in another key domain of the built environment – parks and public space. Efforts to advance park equity should specifically address systemic inequities in access for communities previously excluded from park infrastructure establishments and advancements by establishing parks in park poor communities. In addition to rural settings, many of these communities tend to be lower-income and with larger populations of Latino and Black residents.[126] However, Native Peoples, Asian and Pacific Islander residents, as well as areas with high immigrant populations are also affected by existing disparities. Many traditionally underserved communities are "park poor", either lacking in sufficient quantities of parks and green space for recreational opportunities or with inadequate parks that do not serve the community's needs. Revitalizing underperforming and underused parks and public spaces, and employing innovation and age-friendly design can help address **health equity** and the role that a lack of access to parks plays in social determinants of health.[127] Innovation and creativity in placemaking and siting of unconventional parks and parklets maximizes opportunities when land or funding is scarce. Programming and services should be reviewed and assessed relative to how well they meet the community's needs. **Equitable access** recognizes and responds to cultural differences in communities.

1.4. Park Design, Planning, and Programming

California's parks and public spaces must address the span of aging and abilities, improving existing park quality by making existing parks age-friendly and providing activities for all ages and abilities. Audit existing parks to determine and implement improvements for accessibility, age-friendliness, and programming that reflects the community. Establish parks in park poor communities and evaluate progress to achieve park equity. Incorporate age-friendly design principles into new park or revitalized park planning. Embed innovation in planning and programming and ensure activities are culturally inclusive and engaging. Doing so will energize more older adults to use parks, can help to create an age-friendly state, and address concerns preventing older adult park use. Dynamic public spaces require programming that is responsive to the community's needs and culture – often resulting from building partnerships and community participation.

---

[126] University of California, Berkeley. Disparities in Park Space by Race and Income Policy Brief. July 2011. University of California Regents.

[127] Jennings, Viniece; Larson, Lincoln; Yun, Jessica 2016. Advancing sustainability through urban green space: cultural ecosystem services, equity, and social determinants of health. International Journal of Environmental Research and Public Health, Vol. 13(2): 196-. 15 p. DOI: 10.3390/ijerph13020196; Jennings, V.; Baptiste, A.K.; Osborne Jelks, N.; Skeete, R. Urban Green Space and the Pursuit of Health Equity in Parts of the United States. *Int. J. Environ. Res. Public Health* 2017, *14*, 1432.; Jennings, V.; Osborne Jelks, N.; Dills, J. Parks and Health Equity: An Avenue to Support Health and Wellness for All. Parks & Recreation Magazine. Nov. 2018

Recommendations

2. **Recommendations for Immediate and Short-Term Action (0-3 years)**

   2.1. **Address access by protecting and preserving funding for parks as part of our critical health infrastructure.**

      2.1.1. Parks and open spaces are critical infrastructure and should be prioritized and protected from funding cuts. Ample research exists regarding the health benefits associated with park use. Increased use of parks and public space during the coronavirus pandemic is indicative of the critical role parks play for physical and mental health, offering recreation opportunities for all ages.

      2.1.2. Older adults, in particular, need safe spaces to exercise and engage in healthy behaviors. Prioritizing projects designed with age-friendly principles and that promote park equity in state administered grant and funding opportunities to local jurisdictions would support the needs of older adult park use.

      2.1.3. Protecting and shoring up park funding gaps at the local level due to the strain on local budgets, loss of permit fees, and increased spending on personal protective equipment due to pandemic response would position parks as a key component of critical health infrastructure, rather than discretionary expenses.

      2.1.4. Encourage localities to match Prop 68 funding with local municipal, private, and philanthropic funding to protect and support advancing parks projects. Preserve parks and support access to age-friendly parks by addressing deferred maintenance issues (e.g., broken bathrooms, lack of lighting, cracked sidewalks).

      2.1.5. Expand opportunities for public-private partnerships by encouraging implementation of programs such as adopt-a-park to advance private and community investment in maintaining park infrastructure and nurture volunteer programs at parks.

      2.1.6. Partner with health providers and include park access in community health needs assessments.

      2.1.7. Partner with the non-profit and health sectors to incorporate urban gardening, urban farming, and community garden information and resources into programmatic offerings, to increase access to produce and advance healthy habits. Include information and resources on state and local websites.

   2.2. **Ensure state, county and local parks and recreation departments apply an age-friendly lens in park planning and programming.** Whether developing new parks or revitalizing and improving existing park space, design public spaces with older adults in mind by embedding age-friendly parks principles into the process, which includes programming for older adults. Historically, younger generations received preferential treatment in considering park design and planning. The state's previous Parks Forward initiative offered recommendations for reaching younger and more diverse park users, but did not address the growing aging population.[128] Future efforts in planning, design, and programming must apply an aging and intergenerational lens.

      2.2.1. Encourage the inclusion and funding of age-friendly park features in General Plan and Parks/Open Space Master Plan, and Trails Plans at the state, regional, and local level. Examples of age-friendly park features include but are not limited to comfortable seating areas, shade and cooling features, adequate lighting, proper signage, restrooms with accessible and universal design features, pedestrian paths, and natural design features like community gardens that promote intergenerational programming.

---

[128] A New Vision for California State Parks, Recommendations of the Parks Forward Initiative, Feb. 2015

2.2.2. Seek participation and input from older adults and diverse communities when developing parks master plans and updates. Utilize successful community engagement interventions such as design charrettes and other interventions to engage older adults in determining programming that is desirable and diverse, culturally and across the age and ability spectrum. Implement and expand older adult-focused parks and public space programming.

2.2.3. Planning processes should encourage consideration of strategies to enhance access to existing park and public spaces across age demographics, for example joint-use agreements and partnership development.

2.2.4. Advance programming that is both intergenerational and educational at state, regional, and local parks to engage park users across the lifespan and foster knowledge about environmental resources and habitats. Foster opportunities for social inclusion and volunteerism for older adults by diversifying and increasing programming that reflects a range of interests, abilities, and is culturally relevant to the community.

2.2.5. Connect people to parks and public spaces by prioritizing planning and funding of pedestrian, bicycle, and public transit linkages that are well maintained and accessible. Well-maintained sidewalks and roads enable walkability and rollability, which are key to older adult park access.

2.2.6. Train and inform parks staff and planners to support their efforts to better meet the needs of older adults by incorporating age-friendly parks resources into staff and volunteer trainings. Leverage the existing work of nonprofit and partner organizations in trainings.

2.3. Examine and adopt new methodologies in General Plan, Parks/Open Space Master Plans and Trail Plans to improve quality and equity. Go beyond calculations of park acreage relative to area population when assessing parks. In urban environments, walking is second only to driving one's own car as the main means of mobility, particularly for lower-income older adults.[129]

2.3.1. Every resident living within half a mile or a 10-minute walk of a park should be a baseline goal, with added consideration given to how adequately those parks meet the needs of residents. California's Park Access Tool currently shows that nearly a quarter of residents live further than a half-mile (or 10-minute walk) from a park standard.

2.3.2. Consider models and measures that are adaptive to innovation, address equity and access, and are flexible across age demographics. Possible methodologies might evaluate factors including park size, features, transit connections, programming and more. Incorporate area demographic information into planning and ensure community input is inclusive of the communities served.

2.3.3. Assess opportunities to incorporate SMART Parks innovations into parks revitalization, maintenance, and new park planning.

2.4. Enhance access to the public realm and advance its' development and maintenance by encouraging state, county, city and interdepartmental cooperation. Residents do not often differentiate between city, regional, and state parks, or under which department's purview specific maintenance or programming falls. Enhance cooperation in the development of unconventional parks and open spaces, especially in areas where there is inadequate park space and in underserved communities**.**

2.4.1. Reclaim underused space and utilize unconventional space for parks, parklets, or community gardens when sufficient recreational space is lacking. Support funding placemaking – particularly in park poor

---

[129] Loukaitou-Sideris, A.; Wachs, M. Transportation for an Aging Population: Promoting Mobility and Equity for Low-Income Seniors

areas – to engage residents and businesses in demonstrating potential long-term livability improvements.

2.4.2. Support open streets festivals like ciclovías to provide greater access to safe, open spaces for recreation and physical activity for older adults and all ages and help residents envision and utilize streets and public space beyond vehicular traffic.[130]

2.4.3. Support slow streets movements to allow residents, and particularly older adults with limited park access, safe open space in which to engage in physical activity. Slow streets restrict vehicle traffic on designated streets to allow for increased active transportation modes, such as walking and cycling. Access to parks and sidewalks is associated with increased physical activity in older adults.[131]

2.4.4. Work with state agencies and city, county, and regional planning authorities to better identify, align, and implement investments in underserved communities utilizing California Climate Investment Program funds to offset the negative health impacts of environmental pollution through improvements to the built environment such as urban forestry.

3. Recommendations for Mid-Term Action (3-5 years)

3.1. **Improve access and address parks and public space funding adequacy by creating new state-level grants, inclusive of age and equity in planning criteria.** The state plays a critical role in expanding options for underserved communities through park grant administration. Proposition 68 (2018) created competitive grants to create new parks and new recreation opportunities in critically underserved communities across California. However, need greatly exceeds funding capacity as evidenced in the first round of Prop 68 grant funding. The Office of Grants and Local Services received over 478 applications for a funding request of $2.3 billion and was able to award $225 million in the first round, with $400 million available for future grants. Future state administered grant funding opportunities to local jurisdictions should prioritize projects designed with age-friendly principles that promote park equity to address existing disparities and support diverse and culturally inclusive programming for older adults.

3.1.1. Develop specific metrics to evaluate and increase the number of parks with age-friendly improvements or designs through the life of the Master Plan for Aging. Provide parks planners and staff with training and resources to better understand the needs and desires of people of all ages and abilities. Consider how data on age-friendly parks improvements and designs can be incorporated into California's Park Access Tool along with current data on disadvantaged communities to better support planning efforts.

3.1.2. Encourage thinking beyond ADA compliance to meet age-friendly design.

3.1.3. Incentivize collaboration amongst departments, and leverage public, private, and philanthropic investment in parks.

3.1.4. Increase funding for urban greening and forestry to combat negative health and environmental effects of historical housing policies, such as redlining and freeway construction displacement, resulting in predominately Black and Latino communities experiencing adverse health impacts from localized increases in heat during summer. A study of 108 cities and formerly redlined neighborhoods in the U.S. showed how these historical housing and land use policies have resulted in formerly redlined neighborhoods with summer temperatures between 5-12 degrees hotter than nearby non-redlined neighborhoods. Lack of investment in these communities, scarcity of trees and urban green space,

---

[130] Torre, A.; Sarmiento, O.L.; Stauber, C.; Zarama, R. The Ciclovia and Cicloruta Programs: Promising Interventions to Promote Physical Activity and Social Capital in Bogotá, Colombia. American Journal of Public Health. Feb. 2013; e23-e30.

[131] Booth ML, Owen N, Bauman A, et al. Social-cognitive and perceived environment influences associated with physical activity in older Australians. Prev Med. 2000; 31:15–22.

dominance of asphalt and concrete in surrounding environs and freeway bisection of neighborhoods contribute to disparities in local temperatures that are hazardous to health and disproportionately affect neighborhoods that are predominately Black and Latino.[132]

3.2. Promote a healthy aging population and eliminate disparities in older adult park use and access by design. People over the age of 65 are the most underserved population in terms of having access to parks. Eliminate existing disparities for older adult access to parks by design, in part by examining placement and accessibility by multi-modal mobility options. Examine park equity to ensure equal access to quality and age-friendly parks. All Californians deserve equal access to the outdoors as a right, not a privilege, but in many communities, this is not the case as unequal access to parks and public spaces is one element of the systemic disparities that negatively impact health and healthy aging. This is particularly the case for largely Latino, Black, and low-income communities; Native Peoples, Asian and Pacific Islander residents, and high immigrant population communities are also affected.[126]

3.2.1. Promote a healthy aging population and address existing health disparities by partnering with academia and health institutions to better determine the roles of park use and access as a means to address disparities and to increase positive and reduce negative health outcomes across the lifespan, including mental health. Build upon partnerships with health providers established through implementation of recommendation 2.1.6.

3.2.2. Encourage counties and cities to strategically site and design more parks with outdoor fitness equipment that meets the needs of park users of all ages and abilities. Outdoor fitness parks make the benefits of indoor exercise training free and accessible to the public. Utilizing equipment designed to use one's own body weight as resistance ensures each piece of equipment is age, gender, and ability based.

3.2.3. Address park safety and ensure parks are welcoming public space for all ages through design and inclusion of park features, amenities, and programming promoting intergenerational use and enhancing safety. Perceptions that parks are not safe or that older adults are not welcome are barriers to park use. Appropriate lighting, proper positioning of amenities such as restrooms, adequate signage, and programming that brings users to parks are just a few examples of park enhancements to improve safety and older adult use.

3.2.4. Examine the role of park entrance and parking fees as barriers to access and review existing income and age-based pass and fee reduction programs to determine adequacy in enhancing state park access by lower income and older adults.

3.2.5. Design opportunities for increased social interaction and reduced isolation by better addressing the needs of older and diverse Californians in public space programming, such as at senior centers and community centers, and by incorporating dementia-friendly programming. See the Social Inclusion section of this report for recommendations supporting more diverse and culturally inclusive programming and a richer array of services for all ages and abilities that combats ageism.

---

[132] Hoffman, J.S.; Shandas, V.; Pendleton, N. The Effects of Historical Housing Policies on Resident Exposure to Intra-Urban Heat: A Study of 108 US Urban Areas. MDPI, Jan. 2020

4. **Recommendations for Long-Term Action (5-10 years)**

   4.1. **Conduct a thorough review of all parks and public space measures and indicators identified for tracking and improvement within the Master Plan for Aging and implement adjustments as needed.**

   4.2. **Incorporate learnings from park use and access research (3.2.1) to identify interventions to employ, with a goal of reducing disparities and increasing positive health outcomes.**

   4.3. **Incentivize businesses to create and maintain green space on their campuses this could include living roofs, outdoor recreation areas, or indoor green space to increase green space in communities.**[133]

   4.4. **Identify a dedicated funding stream for parks and public space maintenance and programming.**

   4.5. **Identify and increase the implementation of successful park and public space innovations, including new ways to keep parks modern and build on SMART parks and age-friendly parks principles and models.**

   4.6. **Determine and adopt a statewide standard for all parks master plan, parks and trail plan updates every X-number of years and embed a review of how well parks meet community needs into the process.**

   4.7. **Partner with the private and philanthropic sectors to create and maintain a statewide, user-friendly, interactive map of green spaces (including parks and parklets) to help individuals find and foster use of public space.**

---

[133] Urban green spaces: a brief for action. World Health Organization, Regional Office for Europe. 2017.; Greater London Authority, European Federation of Green Roof and Green Wall Associations, and Livingroofs.org. Living Roofs and Walls, from policy to practice. 10 years or urban greening in London and beyond. 2019

MPA GOAL 2: LIVABLE COMMUNITIES – ENGAGEMENT, SOCIAL ISOLATION, SOCIAL INCLUSION

Overview

As longevity reshapes the distribution of age in the population, California is changing irrevocably.   More generations than ever in history are alive at the same time. Families *routinely* include four and five generations. Workforces include workers spanning five and six birth cohorts, all the while the ethnic, racial, and religious diversity of the population grows ever richer[1].

Viewed through the lens of social resources, diverse multigenerational societies can be better societies than we have ever known.[2] The challenge is to optimize the complementarity of strengths and vulnerabilities at different life stages and across segments of society with the aim of improving quality of life for all. While the current state of the state falls short, the potential to bring all Californians together as a vibrant and compassionate community is enormous.

At the same time California becomes an aging society, it will become a minority/majority state. Evolving models of social strength stand to benefit from the diversity of California's population, the practices of immigrant populations, lessons from affinity communities, and wide-ranging cultural norms. The richness of a population that includes Hispanics, Asian/Pacific Islanders, African-Americans, immigrants, and refugees has much to teach about filial piety, traditions, customs, and languages, as well as households that include multiple generations where younger people help elders and elders care for grandchildren. These traditions give elders a role in supporting their families and being cared for. Just as sure, the pandemic has revealed vulnerabilities in multigenerational families and the risk of social isolation. We must examine and understand the impact of the pandemic and how we can strengthen traditional intergenerational ties post-pandemic.

With sustained attention and deliberative planning, we can intentionally create and elevate environments where older people are valued, contributing, and socially connected as family members, employees, volunteers, mentors, and life-long learners of all abilities, races, religions, ages, and identities. Proximity is a powerful predictor of friendships, shared values, and collective actions.[3] Age segregation contributes to stereotyping, competition, and isolation.

---

[1] Gonzales E, Matz-Costa C and Morrow-Howell N (2015) Increasing opportunities for the productive engagement of older adults: a response to population aging. *The Gerontologist* 55(2): 252-261.

[2] Carr DC, Fried LP and Rowe JW (2015) Productivity & Engagement in an Aging America: The Role of Volunteerism. *Daedalus* 144(2): 55-67, Morrow-Howell N and Greenfield EA (2016) Productive engagement in later life. *Handbook of aging and the social sciences*. Elsevier, pp.293-313.

[3] Borgatti SP, Mehra A, Brass DJ, et al. (2009) Network analysis in the social sciences. *Science* 323(5916): 892-895, Eagle N, Pentland AS and Lazer D (2009) Inferring friendship network structure by using mobile phone data. *Proceedings of the National Academy of Sciences of the United States of America* 106(36): 15274-15278, Festinger

[4]Thus, whether in homes, workplaces, recreational areas, neighborhoods, or civic centers, Californians must be fully integrated into the social fabric of life. Age-integration must be achieved in all realms of life and age-discrimination must be eliminated.

Today's older Americans remain a largely untapped resource. Age-related increases in practical knowledge about life,[5] emotional resilience, [6] and prosocial inclinations,[7] point to the potential for improving society by actively integrating older people into communities and deploying their talents to help others and address broad societal challenges. Despite scores of effective programs such as the AARP Experience Corps[8], the Foster Grandparent program(Corps)[9], RSVP[10], EnCorps STEM Teachers Program[11], and Encore.org's Encore Fellowship program[12], such programs operate largely independently, face persistent funding challenges, and are subsequently constrained in their reach. Most older people do not participate in the paid workforce[13] and only a minority of older people volunteer.[14] All the while, many older people report feeling underutilized,[15] most perceive discrimination,[16] and a significant minority are

L, Schachter S and Back K (1950) *Social pressures in informal groups; a study of human factors in housing.* Oxford, England: Harper.

[4] Hagestad GO and Uhlenberg P (2006) Should We Be Concerned About Age Segregation?:Some Theoretical and Empirical Explorations. *Research on Aging* 28(6): 638-653, Portacolone E and Halpern J (2016) "Move or Suffer": Is Age-Segregation the New Norm for Older Americans Living Alone? *Journal of Applied Gerontology* 35(8): 836-856.

[5] Grossmann I, Na J, Varnum ME, et al. (2013) A route to well-being: intelligence versus wise reasoning. *Journal of Experimental Psychology: General* 142(3): 944-953.

[6] Carstensen LL, Turan B, Scheibe S, et al. (2011) Emotional experience improves with age: Evidence based on over 10 years of experience sampling. *Psychology and Aging* 26: 21-33, Charles ST and Carstensen LL (2010) Social and emotional aging. *Annual Review Psychology* 61: 383-409.

[7] Beadle JN, Sheehan AH, Dahlben B, et al. (2015) Aging, empathy, and prosociality. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences* 70(2): 215-224, Raposo S, Hogan CL, Barnes JT, et al. (2020) Leveraging goals to incentivize healthful behaviors across adulthood. *Psychology and Aging*. Epub ahead of print 2020/07/07. DOI: 10.1037/pag0000428, Sze JA, Gyurak A, Goodkind MS, et al. (2012) Greater emotional empathy and prosocial behavior in late life. *Emotion* 12(5): 1129-1140.

[8] AARP Foundation *A Triple Win for Students, Volunteers and Schools*. Available at: https://www.aarp.org/experience-corps/.

[9] Corps AS *Foster Grandparents*. Available at: https://www.nationalservice.gov/programs/senior-corps/senior-corps-programs/fostergrandparents.

[10] Retired Senior Volunteer Program (RSVP) Available at: https://local.aarp.org/volunteer-detail/rsvp-retired-senior-volunteer-program-volunteer-wa-131867.html

[11] EnCorps Available at: https://www.encorps.org/about.

[12] Encore.org Available at: https://encore.org/

[13] Bureau of Labor Statistics U.S. Department of Labor (2019) *Labor force participation rate for workers age 75 and older projected to be over 10 percent by 2026*. Available at: https://www.bls.gov/opub/ted/2019/labor-force-participation-rate-for-workers-age-75-and-older-projected-to-be-over-10-percent-by-2026.htm.

[14] Bureau of Labor Statistics U.S Department of Labor (2015, February 25) *Volunteering in the United States-2014*.

[15] Anderson GO, AARP Research (2020, January) Underemployment in Midlife and Older Workers. DOI: 10.26419/res.00344.001, Dixon AL (2007) Mattering in the Later Years: Older Adults' Experiences of Mattering to Others, Purpose in Life, Depression, and Wellness. *Adultspan Journal* 6(2): 83-95.

[16] Kita J, AARP (2019, December 30) *Workplace Age Discrimination Still Flourishes in America* Available at: https://www.aarp.org/work/working-at-50-plus/info-2019/age-discrimination-in-america.html , Wilson DM,

extremely socially isolated.[17]

A substantial number of older people also lag behind in the adoption of technology that can promote connection and engagement. A recent Pew study found that only 73 percent of people over 65 use the Internet[18]. Internet use, access to home broadband and smart phone ownership is even more limited among those ages 75 and up[19]. Expanding digital access and literacy is critical to reducing social isolation and giving older people access to services that will increasingly be made available primarily online.

The ways that older people are viewed and engaged has well-documented effects on physical health, cognitive functioning, and well-being. Studies show that ageism has negative effects on cognitive performance.[20]Social isolation heightens the risk of morbidity and premature death.[21] On the other hand, research on intergenerational connectivity attests to benefits for young and old alike.[22]). Nearly three decades ago, Johns Hopkins conducted a multiyear program that was rigorously implemented and studied to evaluate the impact of cross generational programming to see both the impact on the well-being of older adults living on modest resources and elementary school aged children. The results were impressive. Older volunteers displayed improved well-being, physical strength, and cognitive performance while academic and behavioral performance improved in the children.

Errasti-Ibarrondo B and Low G (2019) Where are we now in relation to determining the prevalence of ageism in this era of escalating population ageing? *Ageing Res Rev* 51: 78-84.

[17] Cudjoe TKM, Roth DL, Szanton SL, et al. (2020) The Epidemiology of Social Isolation: National Health and Aging Trends Study. *The Journals of Gerontology: Series B* 75(1): 107-113.

[18] Pew Research Center (2019, June 12) *Internet Broadband Fact Sheet*. Available at: https://www.pewresearch.org/internet/fact-sheet/internet-broadband/.

[19] Center PR (2017, May 17) *Technology Adoption Climbs Among Older Adults*. Available at: https://www.pewresearch.org/internet/2017/05/17/tech-adoption-climbs-among-older-adults/.

[20] Barber SJ, Hamel K, Ketcham C, et al. (2020) The effects of stereotype threat on older adults' walking performance as a function of task difficulty and resource evaluations. *Psychology and Aging* 35(2): 250-266, Barber SJ and Mather M (2013) Stereotype threat can both enhance and impair older adults' memory. *Psychological Science* 24(12): 2522-2529, Tan SC and Barber SJ (2020) Confucian Values as a Buffer Against Age-Based Stereotype Threat for Chinese Older Adults. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences* 75(3): 504-512.

[21] Berkman LF and Syme SL (1979) Social networks, host resistance, and mortality: A nine-year follow-up study of alameda county residents. *American Journal of Epidemiology* 109(2): 186-204, Pantell M, Rehkopf D, Jutte D, et al. (2013) Social Isolation: A Predictor of Mortality Comparable to Traditional Clinical Risk Factors. *American Journal of Public Health* 103(11): 2056-2062, Steptoe A, Shankar A, Demakakos P, et al. (2013) Social isolation, loneliness, and all-cause mortality in older men and women. *Proceedings of the National Academy of Sciences of the United States of America* 110(15): 5797-5801.

[22] Newman S and Hatton-Yeo A (2008) Intergenerational learning and the contributions of older people. *Ageing horizons* 8(10): 31-39, Parisi JM, Rebok GW, Carlson MC, et al. (2009) Can the Wisdom of Aging be Activated and Make a Difference Societally? *Educ Gerontol* 35(10): 867-879, Young TL and Janke MC (2013) Perceived Benefits and Concerns of Older Adults in a Community Intergenerational Program: Does Race Matter? *Activities, Adaptation & Aging* 37(2): 121-140.

An intergenerational theme of social activity, connectedness, interaction and interdependency is a likely antidote to undesired isolation and loneliness.[23] Although in many cultures intergenerational homes are more the norm, in California supporting communities to increase intergenerational connection has not been a part of policy, design, funding or programming.   Yet the possibilities are great. Taking a strength-based approach to support healthy and desired interconnectedness rather than age silos can help reweave the fabric of a multifaceted community to manifest social reciprocity, human connectivity, visibility, and personhood. Increasing connections among the generations can not only improve the lives of individuals but also strengthen the community overall and increase its resiliency.

The existing narrative of older adults as economic drains is not only ageist, it fails to recognize that older adults are huge drivers of the economy. In 2018, nationwide economic and societal contributions of adults age 50 plus was worth over $9 trillion, and 44% of all jobs were held or created by people age 50 plus. The nationwide economic value of the contributions of adults age 50 and older through unpaid activities like adult caregiving, child caregiving, and volunteering was $744.6 Billion. Recognizing the economic and societal value of older adults should be part of efforts to reframe the aging conversation to support efforts combating ageism.[24]

We maintain that California stands to gain from activating the rich resource represented in aging populations and supporting those who are vulnerable. Optimizing social determinants of health leads to higher functioning, improved communities, and longer lives. Importantly, it also entails cost savings.   Ignoring them is costly. One program called "Togetherness" created by CareMore for Medicare beneficiaries evaluated the impact of a 2017 program of 1000 enrolled participants[25]. The study showed a 3.3% reduction in emergency department use over 12 months as well as a 20.8% lower experience in hospitalizations in the enrolled population. Because many of those enrolled were eligible for both state and federal medical coverage it is clear there would be outright savings accrued to both levels of government if further focus and programming were extended to larger populations.

Indeed, California could serve as a model for other states around the country facing the challenges and opportunities of growing longevity and profound demographic shifts. Achieving this aim, however, will require a commitment to full inclusion and participation of older people

---

[23] Riley MW and Riley JW, Jr. (2000) Age integration: conceptual and historical background. *The Gerontologist* 40(3): 266-270.

[24] *AARP specific report on the economic impact of age discrimination*. Available at: https://www.aarp.org/content/dam/aarp/research/surveys_statistics/econ/2020/impact-of-age-discrimination.doi.10.26419-2Fint.00042.003.pdf, reference LORf Available at: https://www.aarp.org/content/dam/aarp/research/surveys_statistics/econ/2019/longevity-economy-outlook.doi.10.26419-2Fint.00042.001.pdfhttps://www.aarp.org/content/dam/aarp/research/surveys_statistics/econ/2019/longevity-economy-outlook.doi.10.26419-2Fint.00042.001.pdf.

[25] AJMC Available at: https://www.ajmc.com/view/efforts-to-target-loneliness-reap-health-benefits-caremore-finds

into communities, neighborhoods, and local and state leadership positions. Key barriers to realizing a high functioning multigenerational society include age segregation, ageism, and challenges in effectively reaching older people, especially in low-income and rural areas.

Recommendations

We endeavor to mold a multigenerational society that maximizes strengths and builds resilience and capacity that is also able to support and care for those with vulnerabilities when they emerge. We recommend the following:

Recommendation for Immediate Action:

(1) *Spearhead Action:* Appoint and fund an "Engagement Czar" (EC) who is experienced in aging services, knowledgeable about strengths and vulnerabilities related to aging, deeply connected to related communities, and passionate about dismantling ageism and promoting the inclusion of older Californians in all domains of life. The overarching charge is to create ways to encourage organic multigenerational integration and support and encourage social innovations, private and public partnerships, while creating opportunities for culture change.

The appointee will oversee the implementation of Recommendations 2 through 5 and coordinate new efforts with ongoing community, state, and national programs that share compatible aims. The appointee will monitor efforts to influence the social determinants of health throughout the life course (see Goal 3) and will work closely with the Research Subcommittee to monitor the effects of changes put in place and estimate cost savings that accrue in response to the implementation of the MPA. In particular, the EC will ensure that all recommended pursuits address equity by race, ethnicity, ability, identity, and religion.

The EC will support and evaluate the goals outlined below, while coordinating and expanding programs aimed at social engagement; including deploying a statewide social media education campaign to reduce ageism.

Recommendations for near-term (0-3 years) action:

(2) *Engage Talent:* Capitalize on the sub-optimized treasure of age, experience, time and wisdom represented in workers, leaders, and volunteers.
> a. Scale and lift effective organizations like Encore.org[26] to adapt their

---

[26] Encore.org Available at: https://encore.org/

efforts to California and expand their reach state-wide.[27]

b. Develop programs that will engage older adults to participate in paid and unpaid work through tax incentives, public recognition, and volunteer stipends—such as a statewide intergenerational service corps.[28]

c. Build on employer incentives to recruit and retain older workers

d. Conduct qualitative and quantitative research in low income neighborhoods to identify needs of and contributions made by older residents.

e. Establish and make widely available training for formal and informal volunteers.

f. Increase educational access for older people through community college courses, university-based programs. Examples include the Distinguished Careers Institute at Stanford[29], and online learning approaches e.g., Getsetup.com[30] Encourage California universities to endorse and adhere to the principles of Age Friendly[31] University Global Network.

(3) *Alleviate Isolation:* Reduce social isolation through a range of screening tools and grassroots efforts to detect and reduce loneliness.

a. In partnership with counties and designated local partners, develop a coordinated shared statewide platform to map hot-spots of needed focus (e.g., rural communities) and tailor interventions to increase engagement and improve mental health.

b. Identify and study communities where isolation is uncommon with the aim of identifying effective prototypes and models of social integration.

c. Identify, implement, and elevate grassroots efforts to engage with and assist elders, such as community members who regularly serve older adults, e.g., barbers and hairstylists, church members. Enlist community members to detect abuse, identify depression, isolation, loneliness, and cognitive decline, as well as distribute information about resources such as information on telehealth and organizations like Front Porch.[32]

d. Form partnerships with private sector companies, such as Wider Circle[33], that connect neighbors to one another through the formation of small

---

[27] Halvorsen C and Emerman J (2013) The encore movement: Baby boomers and older adults can be a powerful force to build community. *Generations* 37(4): 33-39.

[28] Gonzales E, Matz-Costa C and Morrow-Howell N (2015) Increasing opportunities for the productive engagement of older adults: a response to population aging. *The Gerontologist* 55(2): 252-261.

[29] Stanford *Distinguished Careers Institute*. Available at: https://dci.stanford.edu/.

[30] GetSetup Available at: https://www.getsetup.io/.

[31] The Gerontological Society of America Available at: https://www.geron.org/programs-services/education-center/age-friendly-university-afu-global-network.

[32] Hollister B (2013, December) *Model e-Health Community for Aging Executive Summary* Available at: http://fpciw.org/wp-content/uploads/sites/15/2016/05/MeHCA-UCSF-Final-Report.pdf.

[33] Wider Circle Available at: https://www.widercircle.com/.

groups that encourage neighborhood support and reduce loneliness with the aim of improving health outcomes.

e.

(4) *Fight Ageism:* Strengthen the deployment of anti-ageism campaigns

    a. Because ageism contributes to essentially all of the barriers to full age integration it demands comprehensive actions across agencies, departments, universities, and organizations.

    b. Leverage and contribute to dissemination of Age On, Rage On[34], Disrupt Aging[35] to strengthen collective efforts.

    c. Model the Older Women's League (OWL) and the Gray Panthers who fight ageism and sexism by united young and old in advocacy.

(5) *Ensure Access:* Enhance digital and physical accessibility in all counties in California.

    a. Make digital access broadly available for all older Californians, including statewide broadband, devices that accommodate sensory limitations, and training in digital literacy, and provide special content about topics ranging from fraud detection to app-based transportation services. Partner with nonprofits such as the National Digital Inclusion Alliance[36], the California Emerging Technology Fund[37], Older Adults Technology Services[38] and Televisit[39] to develop digital access and literacy strategies. Work with libraries that serve older adults and with community service programs at schools and universities to provide intergenerational technology tutoring.

    b. Utilize existing infrastructures for multigenerational opportunities, studying existing resources from an available time perspective, in addition to envisioning better use of locations. Utilize spaces like schools and day programs for evening and weekend activities.

    c. Remove legal and regulatory barriers to allow for more seamless access to multiuse spaces.

(6) *Honor Diversity:* Honor the tremendous variability in preferences for the amount and the type of social engagement individuals desire.

    a. Acknowledge cultural diversity and tailor opportunities for social engagement to cultural preferences, values, and traditions.

---

[34] Age On. Rage On. Available at: https://ageonrageon.com/latest-news/.

[35] AARP Disrupt Aging *The End of Anti-Aging with Allure: Beauty for the Ages*. Available at: https://www.aarp.org/disrupt-aging/.

[36] National Digital Inclusion Alliance Available at: https://www.digitalinclusion.org/join/.

[37] California Emerging Technology Fund Available at: http://www.cetfund.org.

[38] Older Adults Technology Services Available at: https://oats.org.

[39] Televisit Available at: http://www.televisit.org.

b. Accommodate the range of physical and mental abilities represented in the population and ensure access for the full range in programs and opportunities.
c. Provide a wide range of opportunities for activities that include individual as well as group socialization and virtual as well as in-person contact.
d. Age integrate senior centers with day care centers along with family resource centers.
e. Reimagine the role of libraries as community centers that can serve as hubs for community programming so that connections across generations develop organically.[40]
f. Support 55-plus communities, such as The Village Movement California[41] as well as other opportunities for older adult gatherings so that a range of preferences for age integration can be honored.[42]
g. Scale and expand programs like PAWS [43] which provide companionship and support with animals for people who prefer furry friends to other people.

Conclusion.

We are at an inflection point where we have both the opportunity and need to reassess and renew ways to maximize fuller participation of Californians at all stages of life. We must seize the opportunity to uncover and deploy the assets of all persons, especially older adults who have long been invisible for what they can contribute. Integrating older peoples' contributions will strengthen society and increase formal and informal support for older people when needs arise. Preparing for and purposefully building an interdependent society that invests in well-being throughout the life cycle can build reserves in both individuals and communities that can be tapped during periods of need and disability.

A Master Plan for Aging that successfully removes barriers to engagement, prevents social isolation, and fosters inclusion can reweave the fabric of increasingly multigenerational society.

---

[40] James R (2018, October 8) *Libraries as community hubs*. Available at: https://socialhistory.org.uk/shs_exchange/libraries-as-community-hubs/, Ng Y (2020) Finding fertile ground in libraries for intergenerational dance. In: M. Kaplan LLT, M. Sánchez, & J. Hoffman (ed) *Intergenerational Contact Zones: Place-based Strategies for Promoting Social Inclusion and Belonging*. Routledge, Sabo Robin M (2017) Lifelong learning and library programming for third agers. *Library Review* 66(1/2): 39-48.

[41]According to the Executive Director of the Village Movement California, the movement now has 10,000 members in 43 communities. https://villagemovementcalifornia.org/about-us/.

[42] Poor S, Baldwin, C., & Willet, J. (2012) The Village movement empowers older adults to stay connected to home and community. *Generations* 36(1): 112-117.

[43] Stanford Medicine *Scope 10K*. Available at: https://scopeblog.stanford.edu/2017/09/06/paws-stanford-medicines-therapy-dogs-program-turns-20/, ibid.

To do so, we must invest in a cultural shift that intentionally engages and makes more visible the assets of older adults into all aspects of the community. We must engender a sense of belonging, purpose, and worth for all Californians inclusive of all races, ethnicities, identities, ages, and abilities and find ways to organically support those who are vulnerable.

MPA GOAL 2: LIVABLE COMMUNITIES – STATEWIDE LEADERSHIP

Goal 2. Livable Communities and Purpose – We will live in and be engaged in communities that are age-friendly, dementia-friendly, and disability-friendly.

Overview

Simply stated, a Livable California for All cannot be realized without a strong, enduring commitment from statewide leadership at all levels, led by the Governor's Office, with the full support of all state departments and agencies, all elected offices, and the legislature.

In the United States, tens of millions of people in their 50s, 60s, 70s and 80s are leading longer, healthier, more productive lives. Currently, 10,000 people turn 65 each day, and that trend will continue for about 15 years. By 2050, people 65 and over will outnumber children 15 and under for the first time in history.

California's population is also aging rapidly. Today, more than 20% of the population is over 65, or nearly 1 in 5 people. The California Department of Finance projects that in 2030, those over age 50 will be nearly 15.5 million or nearly 37% of the total population projection of 42.2 million. (Source: California Department of Finance).

California must prepare for this new aging reality. Each of its 58 counties and 482 cities must also meet the needs of an increasingly diverse and multigenerational older adult population by taking measurable steps toward becoming more age-friendly and by advancing efforts to create livable communities for all Californians.

A livable community is one that is safe and secure, has affordable and appropriate housing and transportation options, and offers supportive community features and services. Once in place, those resources enhance personal independence, allow residents to age in place, and foster residents' engagement in the community's civic, economic, and social life.

In a Livable California for All, people of all ages and abilities, in all communities, can safely go for a walk, cross the streets, ride a bike, get around without a car, work or volunteer, enjoy public places, socialize, spend time outdoors, be entertained, go shopping, buy healthy food, find the services they need—and make their city, town or neighborhood a lifelong home. [179]

1.1. Gubernatorial Leadership must be front and center in leading the implementation of the MPA.

The Master Plan for Aging provides an historic opportunity to design, develop and deliver a true Livable California for All that will serve as a blueprint for the state and local communities, as called for in the Executive Order that created the Master Plan for Aging. The Governor must be in the forefront, modeling state government commitment and stewardship, and ensuring full implementation of the Master Plan for Aging's recommendations.

California lacks a coordinated, interdisciplinary mechanism to manage and oversee all pieces necessary for the complete implementation of the Master Plan for Aging goals. An intergovernmental process is one way to prioritize Master Plan for Aging recommendations. California already demonstrated its long-term willingness to prioritize critical issues using an intergovernmental process. Two examples are the state's focus on Climate Change (Strategic Growth Council) and Health Equity (Health in All Policies), both of which utilize this intergovernmental process. Similarly, led by the Governor, California can establish a long-term commitment to the Master Plan for Aging that ensures direct oversight by the office of the Governor while also delegating responsibility for implementing the sections of the Master Plan for Aging to the appropriate agency secretaries and department directors.

To accomplish the goals of the Master Plan for Aging, the Governor should appoint a Cabinet member tasked with over-all coordination, along with an Interagency Task Force on Aging and Disability, appointed by the

---

[179] The AARP Network of Age-Friendly States and Communities. https://www.aarp.org/livable-communities/network-age-friendly-communities/

Governor, with set goals. It should include all departments whose work touches on the Network of Age-Friendly States and Communities' domains of livability[180], including but not limited to the California Health & Human Services Agency (and all departments therein), the Department of Housing and Community Development, Caltrans, and the Department of Consumer Affairs, amongst others. This effort should also include the active engagement of all pertinent elected offices (Education, Insurance, Secretary of State, the Attorney General, State Treasurer and State Comptroller).

1.2. **The Legislature, private entities and private philanthropy must play a role.** All systems and programs examined under the Master Plan for Aging are impacted by much broader issues across the state and local agencies. They require the engagement of the Legislature along with the public and private sectors**.**

Recommendations

2. Recommendations for Immediate and Short-Term Action

2.1. **Establish a cabinet level position.** The Governor will establish a cabinet level position to provide sustained oversight and coordination of the Master Plan for Aging across all sectors and to ensure successful implementation, collaboration and cooperation across departments.

2.2. **Establish an inter-departmental collaboration model.** The Governor and the legislature will work together to establish an inter-departmental collaboration model similar to the Strategic Growth Council. This entity will be tasked with coordinating and working collaboratively with public agencies, communities, private entities, and stakeholders to achieve the goals of the Master Plan for Aging across all domains of livability including the dementia-friendly domains.

2.3. **Appoint an Engagement Czar.** The Director of the Department of Aging will appoint an Engagement Czar who be tasked to coordinate efforts, identify gaps, and advance progress within the social isolation/participation goals described in the Master Plan for Aging. The Minster of Engagement will also be an active player in the interagency process described in this section. The Minister must be knowledgeable about strengths and vulnerabilities related to aging, deeply entrenched in related communities, passionate about social inclusion and have a deep understanding of the intersection between many components of this plan and social inclusion. Lastly, the Minister will actively promote efforts to bridge the digital divide that is far too often present in the lives of older adults.

---

[180] https://www.aarp.org/livable-communities/network-age-friendly-communities/info-2016/8-domains-of-livability-introduction.html
Add appendix…

2.4. Join the Network of Age-Friendly States and Communities. By the end of 2020, California joins the Network of Age-Friendly States and Communities (NAFSC) and, in partnership with AARP, coordinates the leadership California's age-friendly communities and organizations 181. California's enrollment in the network would add value to the Master Plan for Aging by offering a unified yet flexible framework for guiding and supporting local jurisdictions in becoming more age-friendly. This is already in use by 50 cities and counties in California who are network members (representing over half of the state's population), along with 6 states and 476 local member jurisdictions nationwide.

2.4.1. By the middle of 2021, California includes the statewide partnership for age-friendly communities into its plan to join the NAFSC. The purpose would be to enhance relationships that encourage the exchange of local best practices, publicize the rich array of resources and tools available to local communities, and help the state ensure their policies are appropriate and relate to community as well as state need. To support this partnership at every level, the state should engage in a series of actions over the short, medium and long-term that are outlined below.

2.4.2. The State actively encourages philanthropic foundations to develop grants to support the work of cities and counties by adding capacity so that they can formulate and implement action plans as part of the NAFSC cycle of continuous improvement.[182]

2.5. Chart a Research Agenda. Work with statewide specialists consisting of academics, private and public sector experts to establish a Research Consortium that will formulate and drive a research agenda to inform continued implementation of the Master Plan for Aging.

3. Recommendations for Mid-term Action (3-5 years)

3.1. State Agencies are required to **consider the impact of policies and procurement on healthy aging**, and on each of the domains of livability including the dementia-friendly domains.

3.2. The Governor's office of Planning and Research includes each of the Domains of Livability into **state general plan guidance**.

3.3. Add valued partners. The Governor's office and appropriate departments bring in additional partners as key players in statewide work, including business groups and for-profit developers.

4. Recommendations for Long-Term Action (5-10 years) – (note that the other sections of Area 2 contain metrics, i.e., housing, transportation, etc.)

4.1. Pass legislation to require that all regional economic development plans include an age-friendly component.

4.2. Evaluate progress made to date. In five years, that state should evaluate the progress it has made under these recommendations.

---

[181] Established in April 2012, the **AARP Network of Age-Friendly States and Communities** is the United States-based affiliate program of the World Health Organization's Global Network of Age-Friendly Cities and Communities.

The AARP Network of Age-Friendly States and Communities encourages states, cities, towns and counties to prepare for the rapid aging of the U.S. population by paying increased attention to the environmental, economic and social factors that influence the health and well-being of older adults. By doing so, these communities are better equipped to become great places, and even lifelong homes, for people of all ages.

[182] For example, in San Francisco, the Metta Fund has supported the work of the Long-term Care Coordinating Council by, among other things, providing funding for the Friendship Line along with its anti-ageism initiative. In San Diego, "The **San Diego Foundation** created the **Age-Friendly** Communities Program to address the region's shifting demography and build communities where adults can **age** in place, stay connected to their communities, and remain independent and meaningfully engaged throughout their later years." https://www.sdfoundation.org/programs/programs-and-funds/age-friendly-communities/

MPA GOAL 2: LIVABLE COMMUNITIES – CONCLUSION   55

Conclusion

In a livable community, people of all ages and abilities safely and affordably have housing, use multi-modal transportation options to get around without a car, access services they need using tools with which they are most comfortable. They live safely and comfortably, work or volunteer, enjoy public places, socialize, spend time outdoors, can be entertained, go shopping, buy healthy food, find the services they need—and make their city, town or neighborhood a lifelong home.

> **Housing** provides the basic infrastructure that allows Californians to thrive, for older adults to live in and be engaged in communities that are race, gender and disability **equitable, age-friendly, dementia-friendly, and disability friendly**. Paired with affordable housing, accessible and affordable **transportation** allows community access at all stages of life.

> Every Californian must be able to actively participate in their communities through **civic and social engagement.** Paired with full access to health care, **parks and public spaces**, and work opportunities, we can advance the promise of a Livable California for All.

Ultimately, a Livable California for All cannot be realized without a strong, enduring commitment from statewide leadership at all levels, led by the Governor's Office, with the full support of all relevant state departments and agencies, all elected offices, and the legislature. Cooperation and sharing of best practices across all levels of government – state, regional, county, and local is essential in achieving a Livable California for All.

The recommendations contained in this report are substantive solutions addressing how the state can become more age-friendly, dementia-friendly, disability-friendly, and equitable in advancing a Livable California for All.

APPENDIX 1: TRANSPORTATION

Appendix 1-A: Evolution of Accessible Transportation via the Americans with Disabilities act of 1990

The 1990 passage of the Americans with Disabilities Act was not only landmark civil rights legislation for people with disabilities, but simultaneously catapulted specialized transportation into the modern world. Service was now mandatory for locations that had fixed route transit, and trip purpose was no longer a restraint to mobility. Unprecedented growth in the industry benefited both older adults and people with disabilities. Service provision became the responsibility of public transit agencies, both large and small, rather the programs often pieced together by underfunded grassroots organization. Public for profit companies proliferated, merged, and became true experts in the field. Smaller, community-based programs with varying operating models gave way to larger, homogenized systems with more service and more consistent service standards.

Not all problems were solved, however. The new "ADA paratransit" systems were often designed to meet ADA minimum standards rather than meet community needs. While many transit agencies exceeded those minimums, financial pressures, especially during economic downturns, often forced reduction in service areas and service models. The ADA paratransit programs were too often seen as the stepchild of traditional fixed-route transit; more costly per ride, more costly for passengers, and were "required" rather than being a primary goal of the public provider. ADA Paratransit is often limited to "where the buses go", to various operating windows, and to those who can meet the parameters of the service model, including costs, rather than servicing everyone in need, including those who can't afford ADA Paratransit fares.

Many ADA Paratransit services are now contracted with large for-profit providers whose focus is delivering service dedicated to meeting the requirements outlined in their contracts, rather than community need. While this focused approach to meeting the requirements of the ADA creates greater consistency of service, it shifts the service priority away from meeting the needs of the community to meeting the requirements of the local ADA plan and fixed route provider. Contracted out-of-area providers do NOT have community roots or priorities; instead, their loyalty lies with their contracting agency and corporate homes. This shift has changed the nature of system designs. In the past most specialized transportation programs were locally based and created to respond to community needs and challenges, but were woefully underfunded. Today, ADA Paratransit has replaced many of these agencies with a much better-funded model, but one that is less responsive to existing, to new and to emerging needs, including the inability to pay the required fares.

Thirty years after the passage of the ADA, it's time to revisit the ADA Paratransit systems if our hope is to insure equitable access to transportation options for these populations. Significant investment and policy changes are necessary. Because accessible transit has been studied extensively, the path to improvement is well established. As described throughout this document, the time is now to make improvements. Leadership and funding will be necessary for implementation, and coordination between ADA Paratransit programs and local communities and community-based and community-driven specialized transportation programs needs to be at the heart of that mix.

Appendix 1-B: Statewide Need: Excerpts from selected Coordinated Public Transit Human Services Transportation Plans, County Unmet Transit Needs Hearings and Short-Range Transit Plans document the need for additional funding throughout the state

- **Butte County:** *"Top-ranked barriers to accessing needed transportation: Funding challenges for directly operating or contracting for transportation…"*
- **Fresno County:** "*Lack of Funding: Funding is insufficient to meet needs for expanding fixed-route service and equivalent paratransit…Duplication and Redundancy: Various sources of funding restrict transportation services to specific populations for specific purposes...results in service duplication and redundancy…*"
- **Inyo-Mono Counties: "***The greatest barrier to coordination for all rural counties is lack of funding. There is simply not enough money available to meet all transportation needs for the target population… particularly in light of the dispersed communities and long travel distance…as such, the various human service agencies piece meal together trips for the most critical needs. Lack of funding/resources contributes to the limited staff time available for all agencies to pursue further coordination efforts*"
- **Kern County:** "*Priorities for the 2007 Coordinated Plan were identified as… Identify and pursue new funding sources…Barriers Identified: insufficient agency funding for Transportation…Very limited transportation funding was reported…difficulty in securing operating dollars to expand or develop new services in both rural communities and Metropolitan Bakersfield…transit systems are operating at their limits of their present funding base is among the most significant of constraints…*"
- **Kings County:** "*Increasing revenue resources: Identified as the core issue…an efficient coordination process must be established…there are many benefits to consolidating on a large scale…there has been no movement towards consolidating transportation entities…The greatest barrier to coordination is lack of funding…There is simply not enough money available to meet all transportation needs for the target population…human service agencies piece meal together trips for the most critical needs.*"
- **Lake County:** *"PRIORITY 1 – Critical: Pursue and secure funding to support, maintain, improve safety and enhance the Lake County public transportation network…" "…Continued priority must be placed on securing new funding sources…"*
- **Los Angeles County:** "*Roadblocks to further coordination. Several were identified, including the following: Funding restrictions; capacity constraints…*"
- **Madera County:** "*The greatest barrier to coordination for many smaller counties is lack of funding. There is simply not enough money available to meet all transportation needs for the target population, particularly in light of the dispersed development pattern and long travel distance in Madera County*"
- **Metropolitan Transportation Commission (San Francisco Bay Area):** "*Current senior-oriented mobility services do not have the capacity to handle the increase in people over 65 years of age…the massive growth among the aging …points to a lack of fiscal and organizational readiness…the closure and consolidation of medical facilities while rates of diabetes and obesity are on the rise will place heavy demands on an already deficient system.*"
- **Riverside County:** *"Securing funding is critical to maintain, enhance and expand transit services…Goal 1: Strategy: Secure Funding, including discretionary sources, to maintain, enhance and expand transit and specialized transportation…The STRATEGIC ASSESSMENT proposes various strategic actions to address system-wide deficiencies…3) Increase Funding…Goal 2 – Connect and Coordinate Services Improve connectivity among public transportation services and coordination with human service transportation…"*
- **Sacramento Area Council of Governments:** *"…gaps in service remain due to geography, limitations in fixed-route/demand responsive services, program/funding constraints, eligibility limitations, knowledge, training…"*
- **San Bernardino:** "*…Coordinated Plan strategies can be supported with 5310 funds …however, this competitive funding source is modest…*" "*…agencies and their transit programs need for assistance continues as they face funding uncertainties* ", "*…First Priority Strategies: Secure funding…to maintain, enhance and expand transit and specialized transportation services…*"

- **San Diego:** "*…gaps in service remain due to geography, limitations in transit service, funding constraints, eligibility, knowledge, and training….*"
- **Shasta County:** "*…limited resources in the form of staff availability, interest, leadership, service and/or capital capacity, funding, and time…*"
- **Stanislaus Council of Governments:** "*While public transportation services do receive Local Transportation Funds…and State Transit Assistance (STA) funds, it is generally not sufficient to address many of the service challenges, such as limited frequencies and longer service hours, which were common themes…*"
- **Tulare County:** "*Activities that better coordinate and consolidate transportation services and resources… Secure funding devoted to maintaining and strategically improving service levels…Secure funding and pursue low-cost, open source Find-a- Ride capabilities…*"
- **Ventura County:** "*…limited funds suggest that it will be critically important to seek other funding sources to address many of the proposed strategies. Such additional funding sources could include but are not limited to…State cap and trade funding…*"

Appendix 1-C: Consolidated Transportation Services Agency (CTSA) Summary Description

Below are excerpts from the California Association for Coordinated Transportation's CTSA eBook[183].

Consolidated Transportation Services Agencies (CTSAs) are designated by county transportation commissions (CTCs), local transportation commissions (LTCs) regional transportation planning agencies (RTPAs), or metropolitan planning agencies (MPOs) under auspices of the Social Services Transportation Improvement Act[184] to achieve the intended transportation coordination goals of that Act.

The Act, sometimes referred to as Assembly Bill 120 (Chapter 1120, Statutes of 1979), added Part 13 (commencing with Section 15950) to Division 3 of Title 2 of the Government Code and amended Sections 99203 and 99233.7 of, and added Section 99204.5 to the Public Utilities Code relating to transportation

Legislative Intent: The purpose of the Act was to improve the quality of transportation services to low mobility groups while achieving cost savings, lowered insurance premiums and more efficient use of vehicles and funding resources. The legislation took the middle course between absolutely mandating and simply facilitating the coordination of transportation services. Designation of CTSAs and implementation of other aspects of the Act were seen as a flexible mechanism to deal with the problem of inefficient and duplicative social service transportation programs that proliferated due to a dramatic increase in the number of social service programs offered by government agencies and private nonprofit organizations to meet their clients' mobility needs.

Who is Eligible to be Designated a CTSA?

Each CTSA shall be an entity other than the transportation planning agency and shall be one of the following: a) a public agency including a city, county, operator, any state department or agency, public corporation, or public district, or a joint powers entity created pursuant to Chapter 5 (commencing with Section 6500) of Division 7, Title 1 of the Government Code. b) A common carrier of persons as defined in Section 211 of the Public Utilities Code engaged in the transportation of persons as defined in Section 208. c) A private entity operating under a franchise or license. d) A nonprofit corporation organized pursuant to Division 2 (commencing with Section 9000) of Title 1 of the Corporations Code.

---

[183] California Association for Coordinated Transportation: Credit for most of the text in this CTSA eBook goes directly to individuals in the Division of Mass Transportation who created the Final Report to the Legislature (July 1982) related to the Act and specifically to the Project Manager, Ms. Chris Hatfield; and to the individuals who created the follow-up report, SB 157 Action Plan (January 1987), specifically to the Project Manager, Mr. Peter Steinert

[184] Gov Code: Title 2, Div. 3: Part 13: SOCIAL SERVICE TRANSPORTATION [15950 - 15986]

What are CTSAs Required to Do?

Before the Social Service Transportation Improvement Act became law, California had no requirement for the coordination of social service transportation services. It was enacted to promote the consolidation of such transportation services so that the following benefits may accrue:

1. Combined purchasing of necessary equipment so that some cost savings through larger number of unit purchases can be realized.

2. Adequate training of vehicle drivers to insure the safe operation of vehicles. Proper driver training should promote lower insurance costs and encourage use of the

service.

3. Centralized dispatching of vehicles so that efficient use of vehicles results.

4. Centralized maintenance of vehicles so that adequate and routine vehicle maintenance scheduling is possible.

5. Centralized administration of various social service transportation programs so that elimination of numerous duplicative and costly administrative organizations can provide more efficient and cost-effective transportation services permitting social service agencies to respond to specific social needs.

6. Identification and consolidation of all existing sources of funding for social service transportation services can provide more effective and cost-efficient use of scarce resource dollars. Consolidation of categorical program funds can foster eventual elimination of unnecessary and unwarranted program constraints.

The Act did not define social service agency transportation, so an advisory definition was promulgated for purposes of implementing all aspects of the Act. "Social Service agency" was defined as a public or private, nonprofit organization which provides services to any of these four target groups: elderly individuals, individuals with disabilities, youth, and individuals with low-income. The following nine functional areas were identified:

1. Services to children

2. Employment services

3. Provision of food, clothing, and housing

4. Guidance

5. Health services, both mental and physical, including services to individuals with disabilities

6. Recreation

7. Services to special groups, including non-English speaking individuals, individuals with alcoholism, et.

8. Welfare

CTSAs Designees Today and Yesterday

Prior to enactment of the Social Service Transportation Improvement Act, there was no previous requirement or large-scale experience with coordination in California, and as might be expected with such an ambitious undertaking, problems surfaced during implementation and exist even today. While intent of the legislation was to allow for a maximum degree of flexibility, the end result was vagueness in terms of several critical points. The Act:

1. Assumed that some form of coordination would be found feasible in each geographic area.

2. Lacked a clear definition of social service transportation services.

3. Used the terms coordination and consolidation interchangeably.

4. Mandated the creation of CTSAs without defining their function or limitations.

5. Made TDA Article 4.5 funds available to CTSAs at the discretion of the transportation planning agencies, but did not appropriate any additional funding for the purposes of planning or implementation.

6. Did not include a provision for updating either the inventory reports or the Action Plans.

7. Did not include sanctions for noncompliance by either the transportation planning agencies or social service agencies which provided some leeway to avoid fulfilling the coordination mandate.

8. Did not address nor mandate implementation of the Action Plans.

9. Specified that the Secretary of the Business and Transportation Agency (now called Business, Transportation, and Housing Agency) comment on the adequacy of each Action Plan, but did not provide for sanctions if the Action Plans were found to be inadequate.

APPENDIX 2: PARKS AND PUBLIC SPACES – ADDITIONAL RESOURCES

- AARP Network of Age-Friendly States & Communities: https://www.aarp.org/livable-communities/network-age-friendly-communities/

- AARP Livability Index: https://livabilityindex.aarp.org/

- Creating Parks and Public Spaces for People of All Ages, by AARP, 880 Cities, and The Trust for Public Land

- *Park Score Index, The Trust for Public Land:* https://www.tpl.org/parkscore

- Dementia-Friendly America: https://www.dfamerica.org/

- Seattle Dementia-Friendly Recreation: http://www.seattle.gov/parks/find/dementia-friendly-recreation

- Open Streets resources:
    - https://openstreetsproject.org/
    - https://www.ciclavia.org/

- SMART Parks Toolkit: https://innovation.luskin.ucla.edu/sites/default/files/ParksWeb020218.pdf

- 2020 City of San Diego Parks Master Plan , uses a methodology assigning point values for parks that are comprised of factors including park size, features, transit connections, programming and more. The methodology also considers insights from the City of San Diego Climate Equity Index Report in identifying and prioritizing opportunities for improvements to existing infrastructure. Index created by The Energy Policy Initiatives Center (EPIC) at University of San Diego.

- A Challenge to Cities: How Can We Incorporate Green Spaces? Nady, R. Arch 20

We will live in communities and have access to services and care that optimize health and quality of life.

Californians will live in communities with policies and programs that promote well-being throughout our lifespans.

Californians will have access to quality, affordable, and person-centered health care through delivery systems that are age-friendly, dementia-friendly and disability-friendly.

California Master Plan for Aging: Goal 3- Health and Well Being

Table of Contents

Executive Summary
Major Goals for Health and Well-Being of Older Adults and People with Disabilities in California

California's current health system serves older people and people with disabilities poorly. It is expensive, fragmented, and difficult for consumers and families to use. Goal 3 of California's Master Plan for Aging addresses the health and wellbeing of older Californians and people with disabilities. The recommends are as follows:

1) Rebrand aging as a positive healthy process and educate all ages about health and well-being throughout the lifespan.
2) One leader appointed by the Governor and in charge of delivering fully integrated health and LTSS services to every older and disabled Californian.
3) "Call to Action" to eliminate health disparities, racism, and discrimination in health care
4) "Call to Action" to reform and offer more alternatives to nursing home care.
5) By 2030, increase the number of interdisciplinary providers prepared to deliver person-centered, culturally and linguistically congruent, technology enabled care for older adults and persons with disabilities by 10,000.

The sections below lay out the philosophical underpinnings of our thinking and detailed recommendations for achieving these and other key improvements.

Introduction

Philosophical Underpinnings for Systems Change

Aging is a universal process throughout the lifespan and health shapes this experience, across physical, emotional, social, spiritual, and functional dimensions. Individuals age in the context of their multiple identities, influenced by our communities of belonging and the challenges and opportunities of our social and political world. Healthcare systems, at their best, are equitable, place the person at the center of care, embrace the fullness of each person, integrate care, and advance health goals according to individual preference and priority. Ideal health systems enable people to live their lives to the fullest and achieve the highest level of health possible. Healthcare should be shaped around the journey of life and the needs that naturally and commonly arise on that journey, rather than the priorities and convenience of the business of healthcare.

Current health systems fall short of the ideal, offering care that is fundamentally inequitable, institution and provider-centric, poorly coordinated, and often of low value. Existing services and supports for older adults and persons with disability are too often siloed. Failure to address social determinants of health and structural racism guarantees ongoing health inequality. Lack of coordination among providers and agencies serving older adults assures that people fall through the cracks and face negative outcomes as a result of system neglect. Maldistribution of expertise, favoring urban and wealthier neighborhoods,

exacerbates disparities in access. Lack of workforce preparation for the complexity of care for older adults and persons with disabilities limits the capacity of the healthcare system to deliver high quality and high value care.

Mahatma Ghandi famously stated that 'the true measure of any society can be found in how it treats its most vulnerable members.' Older adults and persons with disabilities deserve systems that anticipate and address their needs and systems that integrate services and supports so that when the individual is least prepared to coordinate their own care, the system takes care of that essential function. The third goal of the Master Plan for Aging envisions transformative change in how we view aging and disability and how we design healthcare systems to advance health for aging Californians across all communities, regardless of income, race, ethnicity, disability, gender and sexual identity, immigration status, education, or religion. We aspire to systems that recognize individual goals for health and afford dignity, grace, security and comfort.

Optimal wellness and health are salient for all people, regardless of age and disability, and are relevant across domains of health promotion, chronic disease management, acute illness and end-of-life. Negative stereotypes and fears of aging and disability have historically pushed aging and disability issues to the background and created a separation between those who deny their own aging and functional limitations and those who are dismissed as aged or disabled. Ageism, ableism, racism and sexism undermine health and promote structural inequality. The recommendations by this committee seek to dismantle these sources of disparity and promote healthier systems of care. While there are many things wrong with the health system for older adults and persons with disabilities, this goal focuses on areas with the greatest potential for state action and system integration. These priorities reflect the expertise and experience of the committee, with several topics heightened in the context of the pandemic. We also acknowledge that another Governor appointed entity, the Healthy California for All Commission, is addressing overarching issues like universal health care and how to pay for it.

Cross-cutting Issues

Equity
California is one of the most racially, ethnically and linguistically diverse states in the nation. Equity issues impact access to health care and related services for older adults and people with disabilities in under-represented, under-served and under-recognized communities. More recently, the COVID-19 crisis has dramatically revealed and exacerbated the shortcomings in California's health care delivery system. It has laid bare tremendous system inequities and health disparities that directly result in racial and ethnic populations being at disproportionate risk to contract, to be hospitalized and to die from COVID-19. It has also highlighted the widespread ageism and ableism that infiltrate societal views of older adults and people with disabilities and diminishes their value. To ensure an equitable system, we must address health disparities and social determinants of health while fighting

discrimination, xenophobia and marginalization. Collectively, we affirm the critical importance of equity in addressing the health care needs of older adults and people with disabilities, thereby eliminating disparities caused by systemic barriers.

Leadership

Our hope for the Master Plan for Aging lies in the potential for broad system change, and in the opportunity to fundamentally reframe the way we collectively view and serve California's older adults and people with disabilities. System change requires engagement and collaboration between the Governor, state and local agencies, the Legislature, and the private sector. And, as noted in the Long-Term Services and Supports Subcommittee Report, "Bold leadership starts at the top with elected and appointed officials who are willing to invest in and prioritize the needs of this growing segment of our state's population… Without strong leadership, nothing can be realized -- but with it, everything can be accomplished." Improving health and LTSS care for older and disabled Californians will require the appropriate structural configuration and leadership to provide the vision for (in partnership with older and disabled stakeholders) and implementation of this plan, integrating and administering all health and LTSS services provided to older and disabled Californians.

Integration: People First

Older adults and people with disabilities should have access to health and LTSS systems that are responsive to the individual as a whole—not idiosyncratic silos based on funding source, administering agency, or local oversight entity. A successful Master Plan will outline an approach that ensures individuals can readily access the information and services they need, when they need it—regardless of eligibility distinction, income level, or place of residence. The recommendations all call out the need for integration, reflecting the notion of building systems around the needs of the person, rather than forcing the person to adjust to the needs of the system.

Goal 3--Health and Well Being

California's Master Plan for Aging has the potential to reimagine aging—influencing how our communities across California think about, plan for, and respond to life's changes with age. Because aging is a lifespan issue, the topic is not limited to individuals over a certain age, but impacts young people, families, and communities alike. We aim to reframe how we perceive both age and disability to support health and function throughout the lifespan. Thus, we seek changes in current approaches to aging and disability by recognizing that effective healthcare systems benefit all ages. Embracing the strength of our diversity and transforming systems to be culturally and linguistically congruent and integrated will yield a healthier California, making us a national leader in addressing the demographic and social trends affecting the entire nation. To accomplish this goal, cross-system reform is needed at the population-level, system-level and provider level.

Goal 3--Health and Well Being is intended to address a disparate set of issues which together amplify shortcomings in the state's current approach to serving older adults and persons with disabilities and providing general and specific recommendations for reassessing the gaps in services, reframing how we view aging in California and transforming our system of care to better serve the needs of growing populations of communities of color, older persons and persons with disabilities. Therefore, this report examines a litany of issues: healthy aging, the workforce, care transitions, behavioral health, Alzheimer's, telehealth, palliative care, skilled nursing facilities and oral health. These issues may appear disparate but they are connected by the values inherent in this document; values of a more accessible, comprehensive, welcoming and effective set of programs, services and benefits that together, make it possible to age in this state, regardless of ones circumstances and to enjoy the longevity dividend of expanding life spans.

Person-level: Healthy Aging, Wellness and Prevention

Key Objective: Redefine healthy aging as the process of developing and maintaining wellbeing as we age. This objective focuses on advancing population health, honoring the voice and preferences of the person and their health-related behavior, and relying on system transformation to address disparities (e.g. racial, ethnic, gender, sexual orientation, geographic and income). Recommendations:

- Rebrand Aging in California to create a positive narrative about aging;
- Promote intergenerational healthy aging and wellness initiatives;
- Recognize and address social determinants of health including racism and climate change; and
- Enhance prevention and wellness

System-level: Health Care and Integrated Systems of Care.

Key objective: Develop integrated, coordinated quality health care and LTSS systems that addresses the whole needs of the person including preventive care, well-person care, and acute care coupled with access to long-term services and supports. Recommendations:

- *Leadership:* Provide leadership in system integration and eliminating disparities and racism: Focus on leading at the state level and across sectors to implement integrated and equitable service delivery across all California counties and for all older Californians and people with disabilities;
- *Skilled Nursing Facilities:* Re-imagine nursing home care and improve quality and safety; provide more alternatives to nursing homes; stabilize the work force; consolidate state leadership; and strengthen nursing home oversight and transparency.
- *Behavioral health:* Address issues related to system integration, access, planning, and workforce.
- *Oral health:* Focus on system integration, data and enhancing access to oral health services by expanding Medi-Cal and Medicare coverage.
- *Telehealth:* Expand access, institute payment parity for tele-video and telephonic services while aligning broadband funding, engage consumers, and address oversight issues.

- *Alzheimer's Disease:* Build out systems for screening, detection/diagnosis, documentation, care planning and care coordination. Implement care standards for plans and providers.
- *Palliative Care*: Expand access to palliative care services, grow the workforce, incorporate best practices and operationalize Advanced Care Planning

Provider-level: Professional Health Care Workforce Development.

Key objective: Prepare and grow California's health care workforce to meet the demands of an Aging California with high quality care and support. Recommendations:

- *Vision:* Adopt an organizing framework and strategy to grow the geriatric and gerontological work force.
- *Supply:* Increase the number of qualified providers in primary care and behavioral health
- *Training:* Prepare the workforce to provide person-centered, culturally-congruent, team-based and technology enabled care
- *Oversight:* Align regulations to support optimal access to geriatric care
- *Recruitment:* Incentivize geriatric workforce preparation

The recommendations in this report reflect the variety of issues affecting older adults and persons with disabilities and each are equally important.   We do, however, provide in this report a few overarching areas that reflect our values and highlight areas that can provide momentum for all issues in this report (e.g. leadership, reframing, investing in a workforce, cross-sector). In an ideal world, we would have universal and coordinated systems of services and benefits that would integrate our various concerns but until then, we compartmentalize our assessment and recommendations on each of these issues and build from a person to system levels.

Person-Level
Wellness and Prevention Across the Lifespan

Wellness and Prevention Background:

The benefits of integrating healthy aging in all aspects of state programs and initiatives can lead, in time, to a healthier population of older adults and persons with disabilities. California's racially and ethnically vulnerable communities, in particular, have great need for best practices given the social economic and racial inequities they face. Our objectives in this section are to redefine healthy aging as the process of developing and maintaining the functional ability that enables well-being in older adults and includes the role of health and behavioral health systems, individual responsibility, improvement in data and metrics for measuring outcomes, addressing racial, ethnic and income disparities and educating society to integrate best practices.

Wellness and Prevention Recommendations:

Goal 1. Implement a branding campaign that reframes the public narratives about getting old and about the value of engaging in practices to promote healthy aging, prevention, and wellness in early life. Most people are afraid to get old and view aging in negative terms and remain in denial until too late. This initiative will include the media (social, print, technology --Silicon Valley), entertainment (Hollywood), public agencies (DPH, CDA) and advocacy groups (AARP) that can make healthy aging trendy and "sexy" and can encourage younger groups to plan for a long life.

> A. *Implement a state level commission (or advisory group) to examine how we can educate, inform and otherwise convince Californians that they can expect (especially if they practice healthy lifestyles) to live up to l00 years of age and thus plan accordingly.* It will have valuable partners from the private and corporate sectors (e.g. Kaiser, Blue Cross, Aetna): insurers, payors and providers already understand the cost-benefit of motivating their consumers to engage in wellness and prevention practices to avoid higher costs.
>
> B. *Particular focus must be given to diverse communities, including those with lower life expectancies (African American and Native Americans) and those with higher life expectancies (Hispanic and Asian).* This would be a precedent-setting initiative having California show the nation how to "socialize" society to plan for a longer life beginning early in life to practice healthy and wellness norms.

Goal 2. Promote Intergenerational Educational Healthy Aging and Wellness Initiatives. Drawing on the life span perspective we recommend "drilling down" to the K-l2 level and all younger age groups to educate and inform about healthy aging practices. This goal is about reintegrating all ages through intergenerational connections but also to mitigate potential generational tensions (e.g. older voters opposed to school bond measures, younger voters opposed to nursing homes and senior programs in their neighborhoods). These include a variety of examples:

A. *Co-locate childcare and adult facilities to promote intergenerational experiences beginning in infancy.*

B. *Promote intergenerational programs beginning in elementary school.* Programs such as "Adopt a nursing home" or volunteer home visits that allow elementary student to engage with elders in both community and institutional settings; and engage in social and supportive activities

C. *Teach Disability Sensitivity beginning in Middle School.* Promote empathy and support for persons with disabilities through experiential learning (e.g. navigating with a wheelchair, hearing with cotton in ears, using glasses with limited vision) and valuing aging with a disability.

D. *Conduct "Healthy Practice" classes beginning in High School.* Incorporate learning targeted to longevity planning to include advanced directives, understanding mobility limitations, examining role of transportation and accessibility, assessing impact of unhealthy food and beverages on long-term health. Incorporate learnings on the important role of safe, stable and nurturing relationships and environments in reducing harmful effects of trauma on health.

E. *Orient college students to high risk behaviors.* Include education about unhealthy sexual, substance use, adversity and trauma, and diet and the consequences they may have in later life. Include education about positive social engagement, peer support, end-of-Life preparations (for older family members).

F. *Support and expand existing financial literacy and retirement reparation for young adults and families.* Income is a key aspect of acting on best practices. Most adults have not planned for retirement security (savings, investments, long term care) and thus enter older years dependent on public support (SSI, Medicaid, Social Security, IHHS). The CAL SAVERS is a national model for promoting savings among low income workers and can be a foundation for a state level financial and retirement efforts, especially among racially and ethnically vulnerable communities most likely to be financially insecure.

Goal 3. Recognize and address the Social Determinants of Health: Healthy aging and wellness is not just a medical or health issue; it is heavily impacted by broader issues of poverty, climate change, social isolation, housing affordability, poor nutrition, transportation barriers, educational disparities, racism and nativism and by geography (zip codes). The existing social and economic disparities of diverse, vulnerable populations (especially Black and Brown) forecasts a much larger population of older persons in 20-30 years facing poverty, poor health, vulnerability and greater dependence on the State and Federal government. Thus, it is to our cost-benefit advantage to address these disparities early on to lessen the public dependency later on.

A. *Promote funding to California Universities and Colleges to examine and test approaches for remediating the various dynamics of social determinants as they impact the aging of California's population.* Pay particular attention to the future of our State when it becomes majority -minority and its elder population faces the risks of greater social and economic vulnerability. Findings and recommendations can be made to the state legislature and Governor's office

and be part of the Public Narrative Rebranding and Intergenerational educational initiatives.

Goal 4. Prioritize prevention and wellness: Prevention is about proactive actions that avoid unnecessary problems and wellness is about positive actions that minimize harmful outcomes. Prevention activities at all levels – primary, secondary, and tertiary, are needed for all age groups. A variety of approaches can be considered in this space:

  A. ***Address the imperatives of social isolation and its connection to depression, dementias and suicides***. Fund Universities to investigating these concerns.
  B. ***Implement evidence-based initiatives to prevent falls among older adults and people with disabilities.*** Falls among the elderly are the leading causes of hospitalizations and institutionalization (and accompany decline and death). Models of effective falls prevention currently exists (such as Ventura County and the USC Falls Prevention Institute) ---support and replicate these effective programs and initiatives.
  C. ***Recognize the relationship between nutrition security and health outcomes, and address food insecurity by maximizing the reach of services such as Cal Fresh and Commodity Supplemental Food Program.*** Food insecurity and its resultant impact on health is a growing concern and food deserts in low-income areas persist. Enjoin the CDA and AAA's to spearhead food security strategies for older adults.
  D. ***Promote a senior campaign to raise awareness about the risks of prescription drugs, alcohol, and other substances in older age.*** Opioid Addictions and overmedication lead to harmful outcomes for older adults and persons with disabilities. This must be done in conjunction with acknowledging the realities of those with chronic pain.
  E. ***Promote holistic, complementary wellness approaches (e. g. Tai chi, Qigong, meditation, yoga, Pilates, music and pet therapy, massage) to promote healthy aging.*** Non-traditional and non-medical forms of exercise, stress reduction and prevention are proven to be effective in wellness improvements for all populations.   To reach vulnerable populations, enlist such practitioners to modify these practices for those with cognitive and physical limitations.

Goal 5. State Level Leadership and Coordination: There is currently no state-wide coordination or leadership in facilitating state-wide action in examining the barriers and impediments to promoting healthy aging, prevention and wellness nor working in partnership with others committed to these issues and branding healthy aging as a mainstream public issue.   The many different ideas, strategies and recommendations in this report require a 'home" that can integrate the big ideas and themes and its application to supporting a healthier diverse California as its ages.

  A. ***California should institute a state level entity (e.g. commission, advisory group) to evaluate each state agency with a "healthy aging" lens and lead the charge.*** This advisory body should coordinate with the California Department of Aging, California Department of Public Health, and California Commission on Aging to

ensure the healthy aging perspective is integrated into the work of all state agencies.

Wellness and Prevention Resources:

- Babey SH, Wolstein J, Diamant AL, Goldstein H. (2016).
- *Prediabetes in California: Nearly Half of California Adults on Path to Diabetes*. Los Angeles, CA: UCLA Center for Health Policy Research and California Center for Public Health Advocacy, 2016. http://healthpolicy.ucla.edu/publications/Documents/PDF/2016/prediabetes-brief-mar2016.pdf
- Wolstein J, Babey SH, Diamant AL. (2015). *Obesity in California*. Los Angeles, CA: UCLA Center for Health Policy Research,2015. https://healthpolicy.ucla.edu/publications/Documents/PDF/2015/obesityreport-jun2015.pdf
- Beard, J. R., Officer, A., de Carvalho, I. A., Sadana, R., Pot, A. M., Michel, J. P., Lloyd-Sherlock, P., Epping-Jordan, J. E., Peeters, G., Mahanani, W. R., Thiyagarajan, J. A., & Chatterji, S. (2016). The World report on ageing and health: a policy framework for healthy ageing. *Lancet (London, England)*, *387*(10033), 2145–2154. https://doi.org/10.1016/S0140-6736(15)00516-4
- Dugan, E., Porell, F., & Silverstein, N. (2018). *Highlights of the 2018 Massachusetts Healthy Aging Data Report*. http://mahealthyagingcollaborative.org/wp-content/uploads/2018/12/MA_Healthy_Aging_Highlights_2018.pdf
- USC Edward R. Roybal Institute on Aging. (2015). *The 2015 Los Angeles Healthy Aging Report*. https://roybal.usc.edu/wp-content/uploads/2016/04/USC_Roybal-LA_HealthyAging.pdf
- Lawrence, A., Jump, V., & Torres-Gil, F. (2020, January 15). *Healthy Aging*. https://www.chhs.ca.gov/home/master-plan-for-aging/master-plan-for-aging-engagement-activities/
- Fall Prevention Center of Excellence. (2020). Los Angeles, CA: USC Leonard Davis School of Gerontology. http://stopfalls.org
- Ventura County Area Agency on Aging. (2020). *Fall Prevention*. https://www.vcaaa.org/our-services/fall-prevention/
- Thrupp, A. (2019). CA Food is Medicine Coalition. https://www.dropbox.com/s/9zohhk0keel33lj/California%20Food%20is%20Medicine%20Coalition.pdf?dl=0
- CalSaver. (2020). https://www.calsavers.com
- CalFresh Food. (2019). http://calfresh.dss.ca.gov/food
- USDA. (n.d.). Commodity Supplemental Food Program. https://www.fns.usda.gov/csfp/commodity-supplemental-food-program

System Level
Health and Integrated Care

Health Care Integration Background:

Health Services are a key quality of life issue for older adults and people with disabilities. As we age, we have more chronic and acute health conditions and these conditions interact with functional limitations to create greater need for health and other services.   People of all ages with disabilities often have similar complex health and social needs. Currently, there is a bewildering array of providers and programs that a consumer and their family must navigate to maintain health and wellbeing. Our health care system often fails to provide the care and services older adults and people with disabilities and their families truly need. Because our multiple systems, both public and private, are difficult to navigate, our most vulnerable populations are left to coordinate their own care and coverage across Medicare, Medi-Cal, and other needed services. Fragmented care also disproportionately disadvantages many distinct populations, especially lower-income people and racial and ethnic minorities who historically have suffered from health disparities and racism.

Health care fragmentation and complexity create real world hardships for people and are especially fraught for individuals as they move from one care setting to another. For older adults and individuals with disabilities, particularly those with complex medical, behavioral, or social needs, such transitions are even more challenging. "Care transitions" involve an individual moving from hospital to home, hospital to a nursing home, or a nursing home to home or another setting. Successful transitions rely on timely access to services across the health and long-term services and supports (LTSS) continuum to meet an individual's health, functional (help with activities of daily living), and social support needs. However, many older adults and people with disabilities are discharged from hospitals or nursing homes without appropriate services and supports, placing them at greater risk for re-hospitalization or long-term stays in a nursing home.

Many of the problems related to care transitions are rooted in the federal/state breakdown between Medicare and Medi-Cal payment and service delivery as well as the fragmentation between medical services and social and LTSS service programs:

- *Medicare/Medi-Cal misalignment:* California's 1.4 million individuals eligible for Medicare and Medi-Cal ("dual eligibles") have high rates of chronic conditions and functional impairments and rely on access to services across health and LTSS programs, particularly during care transitions. Medicare pays for acute hospital care and other medical services (including short nursing home stays), while Medi-Cal covers long term stays in nursing home and other services designed to help people live at home or in other community settings. This fragmented fiscal arrangement dis-incentivizes providers and payers from investing in services according to individual needs and preferences and complicates or prevents good care transitions.

- *Medicare-only population challenges:* Since Medicare does not pay for LTSS, beneficiaries with complex care needs have great difficulty in affording functional support services (such as personal care services in the home) that are especially needed during times of care transitions, and must instead navigate a fragmented service delivery system without assurance that their needs will be met.
- *Fragmentation in health care and LTSS systems of care:* The lack of coordination across health care and LTSS systems writ large makes it difficult for individuals transitioning home to access health care and LTSS in a coordinated fashion. Sadly, often the default is a nursing home.

The Master Plan proposes a vision for integrated care with seamless access to coordinated services. Health care must be fully integrated across the continuum of care, offering a standard quality of care for all Californians, including preventive care, acute care and chronic disease care and management that is coupled with access to home and community-based services. Services must be person-centered and also include behavioral health (both mental health and substance abuse services); vision, dental, and hearing services; durable medical equipment, physical therapy, palliative and hospice care provided according to the individual needs of people, easily and flexibly accessed through appropriate modalities, including tele-health. Services should bridge transitions and be nimble enough to deliver care to those in need in a variety of settings, including the home.

Integrated Health Care Recommendations:

Goal 1: An integrated system of care requires strong leadership.

A. ***The Governor should appoint a cabinet-level leader with responsibility for all integrated services for older adults and people with disabilities.*** Such services would include but not be limited to health, behavioral health, long term services and supports (LTSS), and oral health. This position will create a vision and call to action for optimized and integrated services and lead implementation of that vision across state, federal, and private systems of care. The integrated care leader will be advised by a stakeholder advisory committee with subcommittees related to specific areas of concern. One of the primary charges for this leader will be the reduction of health disparities through effective integrated care.

Goal 2: The Governor should promote a "Call to Action" to eliminate racism and disparities in health care.

A. ***The Governor should call for explicit annual, five- and ten-year targets for the elimination of health disparities in the Medi-Cal program.*** As said by the newly appointed Director of Health Care Services, the COVID-19 pandemic "has been enabled by a pandemic of racism." The State should also take a strong stand against discrimination toward older adults and people with disabilities in all health programs, whether privately or publicly funded.

Goal 3: Commit to service and system integration as an explicit vision for the State.

A. *Establish a Medi-Cal/Medicare Innovation and Coordination Office in the Department of Health Care Services to lead all efforts around duals integration in the state.* Older individuals with multiple chronic conditions and/or functional limitations, people with disabilities, and residents of nursing facilities are largely dual eligible and are the most vulnerable in the COVID virus. For these individuals, the need for coordination across physical and behavioral health care, access to LTSS, and programs that address social support needs is more critical now than ever. This is a high priority equity issue since those dually eligible for Medicare and Medi-Cal (called "dual eligibles") are low-income, sicker, more likely to experience a serious mental illness, and more likely to be from populations systematically and historically disadvantaged. Dual eligibles have also suffered from much worse outcomes in the COVID pandemic.

B. *By 2025, assure that Medicare-Medicaid recipients (i.e., "dual eligibles") have a fully integrated option wherever they live in the state.* Duals now receive their benefits through up to eleven different delivery systems, depending on their specific conditions and where they live. A fully integrated option means access to health (both Medicare and Medi-Cal funded benefits) and the full range of LTSS, behavioral health, and oral health services in a coordinated and accountable system of care. These integrated options should also include strategies for incorporating social supports such as housing access, food security, and other nonmedical services. Integrated options can be built on existing accountable entity platforms -- Medi-Cal Managed Care, PACE, Dual Eligible Special Needs Plans, and other potential federal demonstrations or programs.

C. *Build off lessons learned from Cal MediConnect.* Cal MediConnect (CMC) combines the delivery of Medi-Cal and Medicare benefits through Medi-Cal managed care plans in seven California counties. CMC was authorized as part of the federal Centers for Medicare & Medicaid Services (CMS) Financial Alignment Initiative with the goal of developing person-centered care delivery models integrating the full range of medical, behavioral health, and LTSS for dual eligible individuals to the greatest extent possible. We recommend that the lessons learned from CMC evaluation inform future efforts, by providing a platform to build off integrated service delivery for California's dual eligible population.

D. *Identify best practices and build partnerships across health plans and home and community-based service providers.* Community-based organizations (CBOs) play a central role in delivering daily living support through collaborations with the health care sector. While health care and CBOs have been tackling the issue of care coordination and effective care transitions, they have been doing so in silos. Developing partnerships between health plans and CBOs is critical to realizing the vision of integrated care. The state should engage partners to identify best practices

such as those that bring together [health care, housing and CBOS](#) to leverage the strengths of each sector in developing integrated, coordinated systems of care.

E. ***Align Medicare/Medi-Cal funding streams through the D-SNP Platform.*** The [Coordinated Care Initiative](#) (CCI) is set to sunset in 2022. We recommend that the state build leadership and develop a strategy for the next phase of the CCI, using the Duals-Special Needs Plan (DSNP) platform to better align and coordinate care or whatever other federal integration vehicles may be available at that time.

F. ***Expand access to PACE.*** PACE is a growing and proven model of integrated care that is well suited to managing care transitions. We recommend that PACE be offered as a Medi-Cal plan choice, in areas where it is available. As with other managed care plan options, PACE would be included in all enrollment and outreach materials for dual eligibles and persons with disabilities, and that it be identified as a Medicare plan choice for dual eligible beneficiaries.

G. ***Pursue federal demonstrations to test new community-based integrated care models.*** Existing federal demonstration authority currently allows CMS to conduct demonstrations of adaptations of the PACE model to serve additional at-risk populations, including persons with serious mental illness, younger adults with physical disabilities, and older adults at risk of nursing home placement. The State should pursue these and other integration opportunities through CMS demonstration authority (see Goal 2 recommendation for an integrated Long Term Care at Home demonstration).

H. ***Ensure that any Medi-Cal reforms include a robust integration vision and strategy for older adults and people with disabilities.*** This includes as a first principle ensuring that any Medicaid reform includes dual eligibles. Duals comprise two-thirds of older adults and younger disabled on Medicaid in California. All Medi-Cal reforms should include an evaluation of impacts on older adults and people with disabilities.

Goal 4: Focus integration efforts on two key areas in Medi-Cal: Behavioral Health and LTSS.

A. ***Behavioral health services, including care for Alzheimer's and other cognitively challenged patients, should be integrated with primary care to avoid stigma and make them easily available.*** The State should end the carve-out of the specialty MH system and break down barriers for older adults and the younger disabled that exist among Medicare, Medi-Cal mild to moderate coverage, specialty mental health, and privately funded care.

B. ***Health care should be integrated with all Medicaid funded LTSS services.*** This includes IHSS, CBAS, and MSSP, including through Medi-Cal managed care health plans, PACE, and other integrated program platforms. Health care should also be

integrated with other LTSS services not currently supported by Medi-Cal funding, e.g., assisted living, adult day health care, and the full range of Area Agency on Aging services.

Goal 5: Incorporate strategies to include social determinants as part of integrated care.
Poor health is largely due to factors outside of health care: poverty; housing and food insecurity; and agism and racism, to name a few. Addressing these issues through health integration strategies can help alleviate health disparities and inequities. Ensuring there are specific goals to reduce disparities and monitor progress are essential for integration efforts.

   A. ***Encourage health plans to use screening tools to identify social needs, such as food or housing insecurity, and either refer to other services or develop their own interventions to address these needs.***

   B. ***Incorporate In Lieu of Services (ILOS) into Medi-Cal managed care plans.*** As recommended in the State's CalAIM proposal, allow Medi-Cal managed care health plans to provide housing, food, and other non-medical benefits to beneficiaries on an as needed and voluntary basis, and recognize health plan costs for these services through the ILOS mechanism. Current federal law permits states to use ILOS, as long as these are included in health plan contracts with the state. This can be implemented immediately by DHCS.

   C. ***Within three years, the State should develop a benefit package that includes non-medical services.*** Conduct a robust evaluation of the outcomes and cost savings of ILOS and from that evidence, develop a benefit package of ILOS that will be available through managed care plans statewide.

Goal 6: Use Care Coordination and Assessments to improve care across settings during transitions.

   A. ***Implement a comprehensive pre-discharge and in-home assessment.*** Prior to an individual's discharge from the hospital or nursing home, we recommend development of a uniform bio/psycho-social assessment of needs that builds off the individual's goals and preferences, along with a home assessment of falls risk. The assessment should build off the individual's goals and preferences to inform the plan of care.

   B. ***Implement a caregiver assessment before discharge.*** The at-home caregiver is critical to the successful transition and as such, we recommend that their needs should be assessed in a comprehensive manner.

   C. ***Promote Care Coordination that spans different settings.*** Care coordination is a cornerstone of a person-centered system of care, including care transitions, serving

as the lynchpin connecting individuals with a range of needs across the medical and LTSS delivery systems. As such, care coordination should be a critical component of any care transitions program.

Goal 7: Develop better integrated care options for Medicare-only beneficiaries.

A. ***Expand opportunities for the provision of non-medical benefits (called Special Supplemental Services) into Medicare Advantage Plans in California****. Federal law through the* CHRONIC Care Act *now permits Medicare Advantage plans the flexibility to provide non-medical benefits (e.g., special supplemental benefits for the chronically ill) as part of the plan benefits package.* Guiding Principles *have been adopted by a diverse group of stakeholders to help in the development, offering and implementation of non-medical benefits in Medicare Advantage. We recommend the state work with Medicare Advantage plans and Special Needs Plans operating in California to leverage opportunities to access to non-medical benefits. This framework would provide the structure needed to align incentives and improve care transitions for older adults and people with disabilities on Medicare.*

   o Convene California's Medicare Advantage plans to define a strategy to integrate chronic care benefits into their plans and gain their commitment to a timeline to implement that strategy.
   o Evaluate the costs and outcomes of specific non-medical benefits to guide California Medicare Advantage plans to provide the most beneficial services to Medicare beneficiaries.

B. ***Advocate for the inclusion of non-medical benefits in regular Medicare.*** *Only 40% of California Medicare beneficiaries have chosen to receive their care through Medicare Advantage plans. There should be options for beneficiaries in regular Medicare to also receive certain non-medical benefits, especially if these benefits have been shown to reduce the costs of care in the long term. The* Bipartisan Policy Center *conducted actuarial analysis showing that certain non-medical benefits for seniors with chronic conditions could save the program money. Through evaluation and advocacy, California should lead the way in advocating for the inclusion of these benefits in Medicare Part B.*

   o Advocate with the Federal Government to explore the inclusion of certain non-medical benefits into Medicare Part B that have been shown to reduce Medicare expenditures in the long term.
   o Explore opportunities to include Medigap carriers and Medicare Accountable Care Organizations in insurance regulation change that would allow these plans to offer complementary products to cover LTSS services.

C. ***Explore development of new community based integrated care models for Medicare beneficiaries through federal Medicare waivers and demonstrations through which PACE, Federally Qualified Health Centers, and other provider based risk bearing entities would provide integrated services to those not on Medi-Cal and middle income seniors and persons with disabilities,*** partially financed through income-adjusted premiums. DHCS should work with stakeholders and CMS to identify Medicare waivers and demonstration authorities that can be used for this purpose and support and advocate on behalf of promising demonstrations with CMS.

Health Care Integration Resources:

- Medicaid and CHIP Payment and Access Commission: June 2020 Report to Congress, Chapter 1, Integrating Care for Dually Eligible Beneficiaries: Background and Context; Chapter 2, Integrating Care for Dually Eligible Beneficiaries: Policy Issues and Options. Accessed on July 27, 2020 at:
- Aging and Disability Business Institute: *Integrating Care to Improve the Nation's Health*. Accessed July 5, 2020 at: https://www.aginganddisabilitybusinessinstitute.org/resources/integrating-health-and-social-care-to-improve-the-nations-health/
- Centers for Medicare and Medicaid Services: *Community-Based Care Transitions Program Fact Sheet*. Access on July 5, 2020 at: https://innovation.cms.gov/files/fact-sheet/cctp-fact-sheet.pdf
- Centers for Medicare and Medicaid Services: Community-Based Care Transitions Evaluation. Accessed on July 5, 2020 at: https://downloads.cms.gov/files/cmmi/cctp-final-eval-rpt.pdf
- *Partners in Care Foundation: A Change Agent in Community-Based Care*. Generations Magazine. Spring 2019. Accessed July 5, 2020 at: https://online.flippingbook.com/view/21895/34/
- Graham, Carrie, PhD: *The Impact of Cal MediConnect on Transitions to Community-Based Settings*. May 2017. Accessed on July 5, 2020 at: https://www.thescanfoundation.org/media/2019/08/the_impact_of_cal_mediconnect_on_transitions_from_institutional_to_community-based_settings_may_2017.pdf
- Center for Health Care Strategies: *Facilitating Community Transitions for Dually Eligible Beneficiaries, Health Plan of San Mateo's Community Care Settings Program and Inland Empire Health Plan's Housing initiative,* December 2019. Accessed July 27, 2020 at: https://www.chcs.org/resource/facilitating-community-transitions-for-dually-eligible-beneficiaries/
- Centers for Medicare and Medicaid Services: Preliminary Medicare COVID-19 Data Snapshot, July 2020. https://www.cms.gov/newsroom/press-releases/cms-updates-data-covid-19-impacts-medicare-beneficiaries#:~:text=The%20updated%20data%20on%20COVID,1%20to%20June%20

20%2C%202020.&text=Black%20beneficiaries%20continue%20to%20be,670%20hospitalizations%20per%20100%2C000%20beneficiaries.

- Bipartisan Policy Center. Next Steps in Chronic Care: July 2019. Expanding Innovative Medicare Benefits. https://bipartisanpolicy.org/wp-content/uploads/2019/07/Next-Steps-in-Chronic-Care.pdf

Skilled Nursing Facilities

Skilled Nursing Facility Background[1]:

Nearly one in four Californians will be aged 65 and older by 2060.[2] The number of California older adults with one or more limitations in activities of daily living (ADL) is projected to increase from one million in 2015 to 2.7 million in 2060.[3] As the population ages and adults with ADL limitations grow in number, the need for long term care will only increase.

Most individuals needing long term care prefer to live in their own homes or smaller residential care settings, not in restricted environments such as a long stay in a nursing home. While a myriad of programs has sought to create more long-term care options at home and community settings, the need for alternatives to living in congregate settings is greater than ever. We need a housing program that plans for and finances residential care and assisted living beds as well as independent living units in California. Such a program should focus on housing for low-income individuals who are aging or have disabilities, including homeless people, to avoid unnecessary nursing home use. The housing recommendations in this Master Plan, included under Goal 2, address these substantial housing issues. In the meantime, however, there will always be a need for some level of skilled nursing facility capacity throughout the State.[4]

At the same time, we need to "re-imagine" nursing home care in California. There has been a shift from nursing homes to home and community-based care over the past several years, although that shift has not occurred quickly enough. In fact, total nursing facility beds declined slightly from 2010 to 2016 in California, while use of home health, hospice, and other home or community-based services has grown.[5]   A ten-year roadmap calls for nursing homes to be smaller, more home-like, and focused on those patients who absolutely require this level of care.

The COVID-19 crisis has had a devastating impact on nursing home residents and staff. As of this writing, more than 32% of COVID deaths in California have been among NH residents; yet individuals admitted to NHs represent less than one percent of the state's population. Infections and deaths have had a disproportionate impact on racial and ethnically diverse residents and workers, highlighting the disparities in the long-term care system and the society at large. In response to COVID and to the longer-term challenges in NHs, California needs to develop a strategy for ensuring quality services through a combination of

---

[1] SNFs are a discreet licensing category and are generally short stay (more than 80% of nursing home patients have less than a three-months stay). SNFs also have long stay patients. Intermediate Care Facilities (ICFs) generally serve long stay developmentally disabled patients. Residential Care Facilities for the Elderly (RCFEs) are also touched on in this section. These are non-medical congregate living facilities and are often referred to as "Assisted Living."

[2] CHCF, *Long-Term and End-of-Life Care in California: Is California Meeting the Need?* (June 2020).

[3] Ibid

[4] Skilled Nursing Facilities will be referred to as "Nursing Homes" throughout this section.

[5] Ibid

leadership, workforce development, appropriate payment incentives and regulatory oversight.

Also, Intermediate Care Facilities (ICFs) for the Developmentally Disabled in California serve an important population that is often overlooked in discussions about the long-term care needs of Californians. Like nursing homes, some are supported by the State's fee for service system, while others operate in counties where managed care organizations have payment responsibility. These are generally small operations owned by families and need a great deal of support as well. Many of their residents transferred from recently closed State operated Developmental Centers (e.g., Agnew, Sonoma, Porterville). All NHs and ICFs are scheduled to operate under managed care within the next two years.

Finally, this section only touches on congregate living facilities such as Residential Care Facilities for the Elderly and other assisted living options which do not generally provide medical support. However, RCFE's are a critical resource for older adults and people with disabilities. RCFEs and the services they offer can provide alternative living options for individuals who might otherwise have to move to a nursing home.

Skilled Nursing Facility Recommendations:

Goal 1: Immediately stabilize the nursing home workforce in the face of the pandemic.
Many nursing facility staff, particularly part-time workers, reportedly do not have health insurance or adequate paid sick leave, which exacerbates long-standing staffing issues in a time of COVID. Black and Latino workers make up nearly half of the U.S. LTSS direct workforce[6], including many workers in nursing facilities. These staff are also most at risk of COVID infection and poor outcomes. Low pay and lack of benefits result in racial and ethnic disparities and income inequities**.** Nursing facilities have seen temporary increased reimbursement from Medi-Cal, Medicare, and the Federal Cares Act during the pandemic. The State should ensure facilities use this increased funding for the following**:[7]**
   A. *Health insurance and adequate paid sick leave (two weeks) during the pandemic. This will prevent workers from coming to work sick, reduce the need for workers to work multiple jobs and address racial/ethnic disparities and income inequities;*
   B. *Hazard pay for workers in SNFs with COVID outbreaks, regular testing of staff, and adequate PPE provision; and*
   C. *Adequate infection preventionist coverage.[8]*

---

[6] Chernof, Bruce and Mann, Cindy, *Building the Long-Term System of the Future: Will the COVID-19 Nursing Home Tragedies Lead to Real Reform?* Health Affairs (July 31, 2020).

[7] The State and CMS have indicated they will audit nursing home financial reports to ensure the additional reimbursement is being used for COVID related expenses.

[8] AB 2644 would require this:https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200AB2644.It is enrolled, but not chaptered as of this writing.

Goal 2: Establish immediate support for facilities to improve staff engagement and quality of care through comprehensive performance improvement. The Department of Health Care Services often partners with outside entities such as foundations and consultants, managed care plans, physician groups and consumers in quality improvement initiatives for physician providers and to increase the overall quality of health care available to California's Medi-Cal population. However, the current Quality Assurance Fee program is not adequately addressing improvement in quality. Although facilities are required to have quality improvement policies and programs, current data from surveys and complaints, as well as experience in the COVID crisis, does not demonstrate adequate quality in many nursing homes.

>   A. *Immediately explore and implement models such as that provided by the State of Oregon, which developed a foundational program for quality assurance and performance improvement in long-term care settings, using long term care facility fines and license fees to pay for the program.[9] The State should also explore the use of Quality Assurance Fund dollars for this purpose. DHCS and CDPH should be charged with leading this exploration collaboratively.*

Goal 3. Consolidate state leadership responsible for all aspects of NH and other congregate care. Currently there are several different departments involved in regulation and oversight of SNFs and Residential Care Facilities for the Elderly (RCFEs), resulting in a lack of accountability. These facilities share similar challenges although they also differ in important ways. While RCFE's typically do not include medical care, they need medical support both in emergency situations such as this pandemic and in normal times to ensure their residents can age in place.

>   A. *The State should create one leadership position in Health and Human Services to be accountable for and ensure coordinated NH, RCFE, and ICF oversight, and SNF and ICF payment.*

Goal 4: Promote a "Call to Action" to offer services in community-based settings instead of nursing homes. In 1999, the U.S. Supreme Court ruled in the case of *Olmstead v. L.C.*, finding that the unnecessary institutionalization of people with disabilities is a violation of the Americans with Disabilities Act of 1990 (ADA), thereby establishing the right of individuals with disabilities to receive services in the most integrated setting. To meet the intent of the *Olmstead* decision, it is the State's obligation to ensure that individuals have access to an array of supportive services that meet each person's needs and preferences, regardless of age or degree of disability. According to the 2017 Long-Term Services and Supports Scorecard, almost eleven percent of California's 101,000 nursing home residents—or 11,000 individuals--- are identified as having low-care needs. These individuals could be cared for in the community, as an alternative to skilled nursing care. But for many such individuals, the opportunities to transition either do not exist or they are unaware of the alternatives.

---

[9] See description at LiveWell Program website, https://www.livewell-oregon.com/

A. ***Continue developing urgent responses to the COVID pandemic to help people avoid nursing home care.*** The State is implementing several actions but needs to do more. The State should mobilize all tools available, including mobilizing Medi-Cal managed care health plans, PACE organizations, LTSS providers, hospitals, nursing homes, home health providers, community-based organizations, and housing providers to help with transitions and alternatives to nursing home care.

B. ***Develop goals and a plan for nursing home transitions.*** The State should set annual and five- and ten-year goals for nursing home transitions to community settings. The State should also develop specific plans for how to meet these goals, including specifying which services are needed and how each type of organization can contribute to meeting these goals. Possible metrics might include rate of nursing home admissions, rate of nursing home transitions to the community, and longevity in the community post nursing home discharge. The plan should include incentives and goals for managed care health plans and PACE organizations, either as convenors or as direct service providers. Any proposed program much be part of a coordinated strategy for reducing the population being care for in nursing homes through integrated services. Finally, the State's plan should include evaluations of why some programs and approaches work better than others in achieving successful nursing home transitions.[10]

Goal 5: Begin now to create the NH workforce of the future through higher pay and training to improve employee skills. Education, training, and pay and benefits are all key for improved recruitment and retention for NH staff. The average California nursing home had over 53 percent nursing staff turnover and over 50 percent turnover for all employees, according to an analysis of 2018 cost reports.[11] Pay for staff in nursing homes is low relative to many other health settings, resulting in income inequities and racial and ethnic disparities in the NH workforce, and the need for workers to work multiple jobs in different facilities.

- o Refer to MPA LTSS Subcommittee Report (May 2020) for recommendations for expanding LTSS workforce supply and improving working conditions; ameliorating staffing issues in residential settings; and investment in LTSS workforce education and training.
- o Develop strategies to improve conditions for NH clinical staff, through incentives to encourage NHs to increase wages and benefits for nurses, and to encourage NHs to employ and consult with physicians and other clinical staff with expertise in geriatrics, chronic care management, dementia, and mental health. Refer to recommendations in "Assuring the Workforce to Care for Older Adults" chapter under Goal 3.

---

[10]See for example, H. Stephen Kaye, *Evidence for the Impact of the Money Follows the Person Program,* UCSF (July 2019), which notes that California ranks 38th among all states in the rate of transitions per 100,000 population. https://clpc.ucsf.edu/publications/evidence-impact-money-follows-person-program
[11] See Charlene Harrington recommendations write-up.

Goal 6: Improve collaboration and coordination among state and local organizations responsible for oversight, payment, and quality in nursing homes. Since the establishment of the Coordinated Care Initiative in 2014, most NH care is now paid for by managed care organizations, including all NH care in LA County. County Organized Health System managed care organizations (MCOs) have long been payers for NHs. Despite this, and the planned shift of payment responsibilities to MCOs in all counties in the next one to two years, the State's overall strategy for ensuring quality in nursing homes through payment incentives, regulatory oversight, and close alignment with managed care plans is lacking. Even when payment responsibility is held by DHCS, there is little evidence of collaboration and shared strategic approaches among DHCS, CDPH, and DDS (responsible for some oversight of ICF-DD homes).

In addition, health care payers in general have increased reliance on payment arrangements that shape provider behavior (called value-based payments) to ensure cost-effective and high-quality health care. CMS has encouraged and incentivized this trend for all Medicare funded services. However, the use of these payment tools has lagged in Medi-Cal nursing home reimbursement strategies. Several Medi-Cal managed care plans have implemented value-based payments with nursing facilities prior to the COVID pandemic and with additional reimbursement to reward quality and safety during the pandemic.[12] The State has begun some work in this area with the AB1629 program; however, coordination with DHCS and Medi-Cal managed care plans that are responsible for payments to nursing homes is lacking.

A. ***Establish a consortium including state officials from CDPH, DHCS, DDS, health plans, and NH representatives to investigate strategies for improving quality through payment***. The consortium should be tasked with developing value-based payment arrangements that can be used by health plans and the State to incentivize improved quality care and staffing in nursing homes.[13]

Goal 7: Strengthen oversight and ensure adequate staff staffing to conduct oversight. According to the California State Auditor,[14] the State had a backlog of roughly 10,000 nursing home complaint investigations and incidents to investigate in 2014 which is still ongoing. In 2018 and 2020, the State Auditor found that the State was still unable to complete its required inspections and is not providing effective State oversight of NHs. In the year prior to the COVID outbreak, over 60 percent of California nursing homes were

---

[12] See for example Inland Empire Health Plan, Partnership Health Plan, and Health Plan of San Mateo.
[13] We understand that 2020 Budget Trailer Language required DHCS to convene a stakeholder process by September 1, 2021 to develop a successor supplemental payment or similar quality-based payment methodology to replace the current program. This process should include Medi-Cal managed care plans.
[14] California State Auditor. Skilled Nursing Facilities: Absent Effective State Oversight, Substandard Quality of Care Has Continued. 2017-2018. https://www.auditor.ca.gov/pdfs/reports/2017-109.pdf

found to have inadequate infection control plans by the federal HHS Office of the Inspector General (2019.[15]

    A. *Use multi-disciplinary state survey teams and ensure penalties are commensurate with the severity of the violation, especially for non-compliance with staffing, life safety, emergency preparedness, and infection control requirements.*

    B. *Explore elimination of state surveyor conflict of interest.*

    C. *Deploy state survey teams that are capable of coaching NHs to comply with standards and use penalties for NHs that are not cooperative.*

    D. *Increase transparency from survey results, e.g., by using a five-star rating system.*

    E. *Develop improved and transparent criteria for use of holds on admissions and temporary managers to force immediate compliance whenever resident safety is threatened.*

    F. *Explore consolidation of state and federal survey tools so that surveyors only need to survey once for similar issues.*

Goal 8: Stop inappropriate discharge and transfer of NH residents. Inappropriate discharge is the number one complaint ombudsmen receive from long term care residents. Two recent New York Times investigations reported on the extent of this problem nationwide.[16] This is a critical reform needed for responding to the current pandemic.

    A. *The State should enforce current requirements for thirty-day notice of discharge, consent signed by the patient or responsible family member, appeal rights, and assistance in finding an appropriate living arrangement and services. Enforcement should include appropriate fines and disciplinary action, including placing payment holds for future admissions if necessary.*

    B. *The State should work with local stakeholders to develop strategies for more residential options for patients with behavioral health and cognitive issues, since nursing homes are often not the best alternative for these individuals. However, finding appropriately staffed and high-quality community placements is exceedingly difficult and a payment source is mostly lacking.*

Goal 9: Ensure appropriate staffing levels. Multiple research studies and professional associations have identified minimum staffing levels needed to protect the health and safety of residents, recommending 4.1 total nursing hours per resident day (hprd) including 0.75 RN hprd and 2.8 CNA hprd.[17] Research shows that 75 percent of California nursing

---

[15] Office of the Inspector General, U.S. Health and Human Services. https://oig.hhs.gov/reports-and-publications/workplan/summary/wp-summary-0000471.asp

[16] New York Times: "*'They Just Dumped Him Like Trash': Nursing Homes Evict Vulnerable Residents,*" July 23, 2020; *"Nursing Homes Oust Unwanted Patients with Claims of Psychosis,*" September 19, 2020.*

[17] See for example: Harrington, C., Ross, L., Chapman, S., Halifax, E., Spurlock, B., & Bakerjian, D. (2020). Nurse Staffing and Coronavirus Infections in California Nursing Homes. Policy, Politics, & Nursing Practice. https://doi.org/10.1177/1527154420938707

homes did not meet the 0.75 RN hprd and 55 percent did not meet the 4.1 total nursing hours per resident day.

    A. *Increase nurse staffing levels over an appropriate time-period to meet the higher standards.*
    B. *Eliminate waivers of the minimum staffing level requirements for nurses and explore funding to cover actual direct labor costs.*
    C. *Conduct study on outcomes based on staffing levels to assure the ratio of FTEs to discipline is appropriate (i.e., what are outcomes if more CNAs or more LVN's are working in a facility?)*

Goal 10. Increase transparency associated with nursing home for-profit ownership and third-party transactions. In California, 89 percent of nursing homes are for-profit, and 75 percent of nursing homes are part of a nursing home chain. It is difficult to determine who owns many nursing homes and the related companies they hire for services. Some nursing homes have as many as eight or ten layers of parent companies and dozens of related companies that provide services to the nursing home. Also, by engaging in "self-dealing" or paying other companies that they own (related party individuals and organizations) for services that include management, nursing, and therapies, and lease arrangements and loans, nursing homes often siphon money out of the facilities as expenses and hide profits through these third party contractors.

    A. *Require a consolidated cost report for the owner/operator of every nursing home chain and/or parent company that includes every nursing home and related party companies and individuals they contract with to reveal self-dealing profits and losses.* Require that the consolidated cost report be certified by a CPA.
    B. *Enforce the current requirement that all nursing homes owned or operated by individuals or corporations fully report all their parent companies and all related party companies along with an organizational chart for the complete chain to CDPH and OSHPD.*

Goal 11: Enforce minimum criteria for the purchase or management of NHs.

    A. *While prior approval of applications for ownership and management changes is required within 90 days of when a change is requested, regular enforcement is lacking.*

Goal 12: Provide easily accessible information for consumers

    A.   Support CalQualityCare.com which provides comprehensive quality information about skilled nursing, assisted living, ICF-DD, and other LTSS services.

Goal 13: Create a long-term care strategy that allows for an individual to be cared for in the least restrictive setting. Despite projections for significant growth in the numbers of older people and people with disabilities in California, the number of nursing home facilities has declined in the state in recent years.[18] There is also a maldistribution of nursing home beds and facilities. Some communities, where land is limited and expensive. rural areas, and inner-city urban areas, have more limited access to nursing homes and residential care, while there is excess bed capacity in other regions. Nursing home bed availability in the San Francisco Bay Area has declined markedly in recent years, creating placement difficulties for mainly Medi-Cal patients, especially those who experience behavioral challenges.[19] While the State should rightly focus on reducing reliance on NHs and providing alternatives to NH care, there will always be a need for some NH care that is high quality and culturally appropriate.

    A.   Develop a statewide benefit for long term care delivery in the community, whether it be in an individual's home, independent affordable housing, residential care facilities, or other community settings. As many people as possible should be diverted for NH level of care to these community alternatives.

    B.   Ensure an adequate supply of residential care/assisted living beds and independent living units in California, with a special focus on meeting the housing and services needs of individuals with behavioral health or cognitive difficulties, to facilitate moving nursing home residents to more home like and less restrictive settings and to avoid inappropriate nursing home stays.[20]

    C.   Commission a study to determine projected need for NH beds, assuming NH alternatives are implemented and will be available. This study should consider differences in need by geography.

Goal 14: Refashion architectural models of facilities to modernize and promote smaller, home like models that are recommended for infection control, staff satisfaction, and resident quality of care. Most nursing home buildings in California are old, outdated, and poorly configured, and often do not meet contemporary seismic standards. There have been many models, like The GreenHouse Project,[21] that are architectural designs that use single occupancy rooms and group living spaces. These models have been studied and shown to improve the well-being of residents, improve job satisfaction of workers, and are well designed for infection prevention.

---

[18] CHCF, *Long-Term and End-of-Life Care in California: Is California Meeting the Need?* (June 2020).

[19] County of Santa Clara, *Santa Clara Gap Analysis on Care Facilities and Transitional Housing, November 2016.*

[20] See housing recommendations under Goal 2 for more information.

[21] https://www.rwjf.org/en/how-we-work/grants-explorer/featured-programs/the-green-house-project.html

A. ***Establish a state commission to reimagine the nursing home of the future.*** This commission should also direct the remodeling, refinancing, and replacement of outdated CA nursing homes and residential care facilities and replace them with models that are more home like and help prevent the spread of infection.
B. ***Expand existing financing programs that incentivize remodeling nursing facilities and residential care facilities.***
C. ***Set new minimum standards and establish financial mechanisms for remodeling or replacing non-conforming nursing homes and residential care facilities within the next ten years.***

Goal 15: Evaluate progress. The State should evaluate the progress it has made under these recommendations by examining trends in data at regular intervals. All metrics should require analysis of the data by the equity dimensions of race/ethnicity, income, age, and ability to prevent disparities.

- Quality metrics in NHs
- Number and frequencies of complaints and violations
- Rates of staff turnover in facilities (nursing and all staff)
- Extent of value-based payment arrangements implemented by managed care organizations and the State
- Rate of NH admissions from community-based settings
- Rate of NH transitions to community-based settings
- Longevity in the community of those individuals transitioned from NHs to community settings
- Satisfaction ratings among SNF residents and SNF residents transitioned to the community, trended over time.
- Satisfaction ratings among staff in NHs, trended over time

Skilled Nursing Facility Resources:

- CHCF, *Long-Term and End-of-Life Care in California: Is California Meeting the Need?* (June 2020).
- CHCF, *COVID-19 Tracking Poll: Most Front-Line Staff at California Nursing Homes See Infections at Work, July 16, 2020.* https://www.chcf.org/blog/covid-19-tracking-poll-most-frontline-staff-nursing-homes-see-infections-work/
- Harrington, C., Ross, L., Chapman, S., Halifax, E., Spurlock, B., & Bakerjian, D. (2020). Nurse Staffing and Coronavirus Infections in California Nursing Homes. Policy, Politics, & Nursing Practice. https://doi.org/10.1177/1527154420938707
- https://www.rwjf.org/en/how-we-work/grants-explorer/featured-programs/the-green-house-project.html
- LiveWell Program. Accessed on July 27, 2020 at: https://www.livewell-oregon.com/what-we-do
- Manatt, *Recommendations to Strengthen the Resilience of New Jersey's Nursing Homes in the Wake of COVID-19,* June 2, 2020

- County of Santa Clara, *Santa Clara Gap Analysis on Care Facilities and Transitional Housing, November 2016.* Access on July 27, 2020 at: https://sccgov.iqm2.com/Citizens/FileOpen.aspx?Type=1&ID=7735&Inline=True
- Chernof, Bruce and Mann, Cindy, *Building the Long-Term System of the Future: Will the COVID-19 Nursing Home Tragedies Lead to Real Reform?* Health Affairs (July 31, 2020).
- California Association of Health Facilities, *2020 Quality Report.* This and other quality related materials can be found at: https://www.cahf.org/Reports.

Behavioral Health

Behavioral Health Background:

Older adults in California with behavioral health problems, which include both mental health and/or substance abuse issues, are unserved and underserved relative to their needs[22]. For example, adults age 65 and above were 16.0 % of the adult Medi-Cal population, but only 1.7% received one or more specialty mental health services (SMHS) during the year (FY 2016-2017). Priority concerns include the need for more systematic data collection, shortages in geriatrically-prepared behavioral health workforce, geographic and racial disparities in service availability, and a lack of state guidance and leadership to promote an older adult system of care for behavioral health services. Older adults with behavioral health needs, coupled with common physical health issues, are best served with integrated health models that increase access and convenience to meet their needs.

Geographic disparities in access to behavioral health care remains a pressing issue for older adults. Even in counties that offer innovative programs that are tailored to meet the needs of older adults, their reach is usually limited to a small proportion of older adults with need who are located in a specific geographical area of the county or, in some cases, are members of a special population group. In some counties, specialized mental health programs for older adults are only available in certain geographic areas, typically the cities or more densely populated areas. In other counties, even basic services are not available in certain geographic pockets. These geographic barriers are seen as especially challenging for older adults who are more likely to have mobility limitations and are at heightened risk due to social isolation.

Integrated care can address geographic barriers to receiving care, an issue especially relevant in rural counties and in rural pockets of large counties where there is little or no service delivery infrastructure. Co-location of behavioral health services with primary care improves access to care, especially for older adults who are more likely to have multiple chronic conditions.

The deleterious impact on substance abuse and addictions, depression, and mental illness shortens the life span and leads to an assortment of debilitating illness, diseases and morbidities. Other components of the Master Plan address these issues in great deal but we draw on several that are pertinent to this Goal.   We specifically applaud those recommendations that designate a new older adult administrative unit within HCS and we recommend drawing on innovative early intervention and prevention programs. Geriatric/gerontology behavioral expertise and standardized geriatric training is crucial given the rising needs of an older population including culturally and racially appropriate services for racially and ethnically vulnerable older populations. The UC System can play an

---

[22] https://www.ncbi.nlm.nih.gov/books/NBK201404/,
https://www.calbhbc.com/uploads/5/8/5/3/58536227/2017_18_statewide_summary_of_all_2017_data_notebooks_12.31.2018__final.pdf and http://healthpolicy.ucla.edu/publications/search/pages/detail.aspx?PubID=1710).

important role through its graduate programs in medicine, public health, nursing and social work by incentivizing them to address geriatric/gerontology education, training and best practices. We suggest financial support to encourage members of racial, ethnic and immigrant groups to seek advanced degrees in these areas. Proposition 63 provides crucial resources for behavioral health services and we recommend accountability and oversight of how these funds target and benefit older adults

Behavioral Health Recommendations:

Goal 1. Document and address the scope of behavioral health needs and unmet needs among older adults and people with disabilities in California.

A. ***Institute mandatory and standardized data reporting requirements at state and local (county) levels.*** Counties should systematically investigate and document the unmet needs and measure and monitor their progress in serving the behavioral health care needs of older adults. *(Note: The UCLA Center for Health Policy Research has developed and published a recommended essential set of data elements to measure older adult outcomes in the public mental health system [see* http://healthpolicy.ucla.edu/publications/search/pages/detail.aspx?PubID=1559)].

B. ***Conduct dedicated outreach and document unmet need among older adults with mental illness and behavioral health issues.*** Outreach strategies must be specific to older adults, take into account where and how best to identify those in need.

C. ***Ensure geographic equity in access to behavioral health services.*** Older adults and people with disabilities who live in rural counties and communities often do not have access to needed services due to small networks of providers, large geographic distances to travel and lack of providers who are linguistically appropriate for population needs. The cost of delivering services and the need for incentives to recruit the necessary providers needed is not being accounted for in the current funding formula. The funding formula should be increased to assure that rural counties are provided the necessary funding needed to address critical geographic disparities in service delivery.

Goal 2. Increase access and service delivery to older adults and people with disabilities to address unmet need.

A. ***Designate a new older adult administrative unit (administrator with geriatrics/gerontology expertise and support staff) within the California Department of Health Care Services, Behavioral Health unit***. This new unit will provide leadership to improve older adult service delivery and work collaboratively across state departments and with county mental health and aging units. *Note: AB 480 (Salas) is a model legislative effort that was not approved in 2019 awaiting the development of the Master Plan on Aging* (see http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200AB480).

B. ***Include engagement with stakeholders and consumers in Behavioral Health Planning.*** For service planning, consumer advocates and/or people with geriatric/gerontology behavioral expertise should be "at the table" within important statewide agencies and professional organizations, with designated slots or committees organized around the issues of older adult behavioral health.

Goal 3. Increase service integration, especially the integration of medical, behavioral health, aging, and substance use services. To effectively integrate services at the point of service delivery, the funding sources, health plans and administrative agencies must first align. This requires coordination across the relevant state and county administrative agencies, health plans, and funding sources. At the point of service delivery, this type of systems integration would support more opportunities for physical co-location and service integration.

A. ***Task the new Behavioral Health services administrator (see Goal 1. A. above) to establish a system of care collaborative across relevant departments and units at the state level.*** This will include building functional bridges and agreements with health services, aging services, health equity, OSHPD, county mental/behavioral health departments and other departments/units to assure a seamless continuum of care for behavioral health services.

Behavioral Health Resources:

- *Geographic disparities (excerpted from the California Mental Health and Older Adult Study Deliverable 3 report (access at*: http://www.healthpolicy.ucla.edu/Older-Adult-Mental-Health)
- http://healthpolicy.ucla.edu/publications/search/pages/detail.aspx?PubID=1559)].
- *AB 480 (Salas) is a model legislative effort that was not approved in 2019 awaiting the development of the Master Plan on Aging* (see http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200AB480).
- https://www.ncbi.nlm.nih.gov/books/NBK201404/,
- https://www.calbhbc.com/uploads/5/8/5/3/58536227/2017_18_statewide_summary_of_all_2017_data_notebooks_12.31.2018__final.pdf and
- http://healthpolicy.ucla.edu/publications/search/pages/detail.aspx?PubID=1710)

Alzheimer's and Dementia Care

Alzheimer's and Dementia Care Background:

California leads the nation with the largest and most diverse population directly impacted by Alzheimer's and related dementias: currently 690,000 individuals are affected and 1.6 million family members provide hands-on, direct care and support to a loved one with the disease. These numbers are slated to grow by 22 percent by 2025. In its February 2019 *Measuring Public Health Status Report*, the California Department of Public Health documented Alzheimer's as the second leading cause of death in California. For the most recent period evaluated, there were nearly 1 million annual emergency room visits in California by patients with dementia.

The burden of Alzheimer's is large and growing, especially among women and people of color. The impact of the disease on individuals, families, communities and health systems is significant. Costs, to the public Medicaid program where costs are 23 times higher for beneficiaries with dementia than those without – and to families, who spend in excess of $50,000 annually for assisted living or more than $100,000 annually for skilled nursing care, are unsustainable at nearly $350,000 per person over the average 7-10 year course of the disease.

Alzheimer's and Dementia Care Recommendations:

Goal 1. Improve care for older adults and people with disabilities who have Alzheimer's and related Dementias.

  A. ***Improve screening and detection*** – All managed care health risk assessments and service provider initial intakes/functional assessments should include validated screening questions to detect cognitive impairment. Medicare, through the annual wellness visit, covers a brief, validated structured cognitive assessment tool.
  B. ***Increase the number of Californians who are aware of their diagnosis*** – When an individual self-reports symptoms or concerns, or when a screening tool warrants, or upon referral, the patient should receive a comprehensive assessment. The California Alzheimer's Disease Centers have produced a toolkit for primary care physicians to guide in this process. Healthy People 2020 Goal DIA-1 calls on the nation to improve the percentage of all people aware of their diagnosis from just 62 percent.
  C. ***Improve systematic documentation of Alzheimer's and related dementia diagnoses*** – If a patient is diagnosed with Alzheimer's disease, mild cognitive impairment, dementia, or related condition, the diagnosis should, first, be disclosed to the patient, and then documented in the medical record and made available through the electronic health record.

Goal 2: Ensure Californians with Alzheimer's and related dementia receive care coordination and care plans.

A. ***Provide Care Planning to patients and families with Alzheimer's and related dementias*** – California pioneered the Alzheimer's Disease Clinical Care Guideline for post-diagnostic treatment and, since January 2017, Medicare has covered a comprehensive dementia care planning benefit. Yet, only about one percent of beneficiaries have been provided with a care plan.

B. ***Improve Care Coordination***– Without a diagnosis or a care plan, care coordination is unattainable. Nearly all persons with dementia have at least one co-occurring chronic condition and, increasingly, many live alone (estimates are one in five). Several groundbreaking CMS Innovation projects have been successfully piloted in California, including UCSF Dementia EcoSystem and UCLA Coordinated Alzheimer's and Dementia Care, as well as ongoing Administration on Community Living (ACL) Dementia Care Management grants to California Department of Aging.

Goal 3. Integrate care for Californians with Alzheimer's and related dementias.

A. ***Invest in home- and community-based services***. Because age is the greatest risk factor for Alzheimer's, the vast majority of people affected are Medicare beneficiaries and many are dually eligible for Medi-Cal. With this population, the need to integrate the two funding streams – and invest savings in home and community-based supports – is paramount.

B. ***Improve hospitalizations for people with Alzheimer's and related dementias.*** With nearly 1 million high cost emergency room visits recorded each year in California. Healthy People 2020 Goal DIA-2 calls for a reduction in avoidable hospitalizations. West Health has set the national standard for Geriatric Emergency Departments and many Californians with Alzheimer's and dementia have directly benefited from the model, most notably with reductions in hospital readmissions.

C. ***Improve care transitions.*** An area where lack of integration is pronounced and costly is care transitions; persons with dementia who cycle between residential care or skilled nursing and hospitals, driving costs up in both the Medi-Cal and Medicare programs with little benefit to the resident; in fact, often to the resident's detriment with transfer trauma.

Goal 4. Address the needs of California caregivers

A. ***Caregiver Identification and Assessment.*** Because of the progressive, degenerative nature of Alzheimer's disease, it's imperative to establish a care team early. Physicians, health plans and community-based service providers are encouraged to identify and document a family caregiver, assess caregiver strain, and develop care plans for the caregiver. The Family Caregiver Alliance and the 11 Caregiver Resource Centers are national leaders in this work.

Goal 5. Create a dementia capable workforce in California

    A. *Workforce* – Persons with Alzheimer's, over the long course of the disease, rely on the full array of health professionals, from direct care workers to specialty physicians and every level of job category in between. It's challenging to promote dementia training across such a wide spectrum of educational backgrounds, licensure categories and employment models. Models exist, including the California Long-Term Care Education Center training IHSS workers, statutorily required dementia training in all RCFEs, and training of care managers in health plans under the ACL grant noted above.

Alzheimer's and Dementia Care Resources:

- California's statewide network of Alzheimer's disease centers https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/CDCB/Pages/CaliforniaAlzheimersDiseaseCenters.aspx
- California Primary Care Physician Toolkit for Dementia Diagnosis https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/CDCB/CDPH%20Document%20Library/Alzheimers'%20Disease%20Program/ACCT-AD%20Toolkit%2012%2027%2018.pdf
- California post-diagnostic Alzheimer's clinical care guideline https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/CDCB/CDPH%20Document%20Library/Alzheimers'%20Disease%20Program/ALZ-CareGuidelines.pdf
- Stanford's Geriatric Dementia and Depression Scale http://med.stanford.edu/svalz/apps.html
- Centers for Disease Control Healthy Brain Initiative https://www.cdc.gov/aging/healthybrain/index.htm
- UCSF Dementia Care Ecosystem https://memory.ucsf.edu/research-trials/professional/care-ecosystem
- UCLA Alzheimer's and Dementia Care Management Program https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3889469/#:~:text=The%20UCLA%20ADC%20program%2C%20which,centered%20care%20for%20patients%20with
- Alzheimer's Association https://www.alz.org/professionals
- National Institutes of Health https://www.nia.nih.gov/health/alzheimers

Telehealth

Telehealth Background:

California was one of the first states to pass a telehealth law with the [Telemedicine Development Act of 1996](#). At the time, the bill was considered progressive legislation and provided model language for other states. However, in the almost two decades that followed, telehealth law in California essentially remained unchanged, even as technology and its penetration rapidly evolved. Progress was made with the [California's Telehealth Advancement Act of 2011 (AB 415)](#) which went into effect in January of 2012 and in recent years, the language put in place by AB 415 has been amended, with the most significant change occurring with the passage of AB 744 in 2019.

With his signature, Governor Gavin Newsom positioned California back to the forefront of telehealth policy. One of the most substantial revisions, which applies to health plans issued, amended or renewed on or after Jan. 1, 2021, requires payers to reimburse for telehealth services on the same basis and to the same extent, as well as at the same rate as an equivalent service when delivered in person. With this law, California became one of roughly a dozen states to require payment parity. Newsom also signed into law [AB 1264](#). The bill adds California to the growing list of states and government entities embracing asynchronous (or store-and-forward) telehealth, which allows patients to submit questions or answers and provide data that providers can review at their discretion.

Although California is ahead of many if not most for patient and provider friendly telehealth legislation, there is still significant room to enhance our state's leadership to better serve the population, particularly the aging and disabled. The Covid19 pandemic has brought to light the importance of telehealth enabled care. Telehealth is one of the few subjects that has achieved bipartisan support. This is exemplified in the June 17th, 2020 [letter](#) to Senate leadership signed by at least 30 senators from both sides of the aisle calling on Congress to "expand access to telehealth services on a permanent basis so that telehealth remains an option for all Medicare beneficiaries both now and after the pandemic. Doing so would assure patients that their care will not be interrupted when the pandemic ends.

Particularly with California's and the rest of the nation's experience with Covid-19; the ongoing vulnerability and increasing isolation among frail seniors, as well as the rapid rise of the aging population in California over the coming decade, telehealth is an imperative that not only can be used to improve patient experience and health outcomes but also be a lifeline to seniors and other high-risk individuals who are not able to seek care in doctor's offices or clinics amid COVID-19 and after.

Today, with waivers in place that allow reimbursement at parity, verbal consent and cross state practice, challenges still exist. Public awareness of what telehealth is and how telehealth can be accessed through their providers and health plans is still lacking. Overall visits for chronic care are down and as noted by national media, people are avoiding getting the care they need and in turn, their conditions are becoming increasingly worse.

Robust education and public awareness campaigns geared towards seniors and the disabled are needed to help stem this trend.

Concerns are that as the national emergency ends and the waivers are rescinded that many of the restrictive telehealth policies will be put back into effect. Requiring an additional telehealth specific consent when consent for treatment has already been signed or the lack of payment parity for Medi-Cal are examples of operational and reimbursement restrictions. These restrictions have been barriers to adoption and threaten to leave citizens without appropriate access to care if put back into effect. Recommendations ensuring that California continues to lead nationally will help all citizens, particularly the aging and disabled, receive the right care at the right time and at the right location.

Telehealth Recommendations:

Goal 1: California should expand coverage of telehealth services:

A. *Statutory definition of telehealth should be inclusive of telephonic services that are important for low-income communities that lack internet/broadband access and also easier to use with seniors.* California should permanently remove any geographic restrictions to ensure that patients can receive telehealth services regardless of their location. Expand coverage to include behavioral health, remote patient monitoring, advance care planning and goals of care conversations, dental care and technologies that address social isolation.

Goal 2: Ensure Telehealth payment parity for Medi-Cal managed care and Denti-Cal:

A. *State plans should also guarantee payment parity for telehealth services.* While AB 744 guarantees payment parity for commercial plans, many seniors and disabled Californians rely on Medi-Cal managed care and Denti-Cal plans.

Goal 3: Reduce Licensing Board and practice restrictions:

A. *Ensure that Licensing Boards do not unnecessarily make the use of telehealth onerous or burdensome (i.e., extra credentialing or registration).* As long as meeting standard of care, the practitioner should be able to provide care via telehealth.

Goal 4: Improve coverage and reimbursement:

A. *Ensure Medi-Cal allows use and reimbursement of all modalities of telehealth.* Medi-Cal should cover services provided via remote patient monitoring which has been shown to improve health outcomes and reduce costs, particularly patients with chronic conditions.

Goal 5: Provider education and awareness.

A. *Resources should be expanded or devoted to provider education on not only how to use telehealth in their practices, but also what are the existing policies and how to*

bill for services. COVID-19 showed that providers need technical assistance not only in starting and ramping up telehealth programs, but also understanding the myriad of telehealth policies, some of which they are unaware of.

B. *Ensure the language used by commercial and state plans clearly identifies reimbursable codes and services that are covered.*

C. *Ensure consistency in how to bill and what is covered.* Lack of consistency on what is covered and now to bill across different payers creates confusion and frustration for many providers. While clarity on policies will help, more consistency will alleviate this burden on providers and make it more attractive to utilize telehealth in their practices.

Goal 6: Bridge the digital divide by expanding telehealth.

A. *Expand telehealth access to low income families by aligning funding to improve internet access to underserved and rural communities.*

Goal 7: Improve Consumer education and awareness of Telehealth availability:

A. *Initiate public awareness campaign to educate seniors about telehealth and provide robust training resources to seniors and family caregivers to support them in their use of technology.* Create public awareness by informing consumers on what telehealth is and how telehealth can be accessed through their providers and health plans.

Goal 8: Create consistency across the state

A. *Create a state telehealth coordinator to ensure state agencies are aware and familiar with the different telehealth policies and who will also engage with outside stakeholders on a regular basis.*

Telehealth Resources:

Patient and Provider Educational/Training Resource Links

1. CHHS website on telehealth for consumers - https://covid19.ca.gov/telehealth/#top
2. UC Davis - https://health.ucdavis.edu/cht/clinic/index.html
3. CHCF videos on consumer and patient perspective - https://www.youtube.com/watch?v=wwVOebpljCI&feature=emb_title
4. DHCS: https://www.dhcs.ca.gov/provgovpart/Pages/Telehealth.aspx
5. HHS Telehealth Website - https://telehealth.hhs.gov/
6. AARP: Telehealth & the Coronavirus - https://www.aarp.org/health/conditions-treatments/info-2020/telehealth-faq.html
7. AARP: New Patients Share Their Telehealth Experiences - https://www.aarp.org/health/conditions-treatments/info-2020/telehealth-benefits-for-patients.html

8. Mid-Atlantic TRC "Helping A Patient/Client Understand Telehealth"- https://www.matrc.org/matrc-telehealth-resources-for-covid-19/
9. West Health resources for senior focused telehealth - https://www.westhealth.org/telehealth/

References and resources used for MPA recommendations

1. Letter to Senate Leaders CONNECT for Health Act 06.12.20.docx: https://www.schatz.senate.gov/imo/media/doc/Letter%20to%20leadership_CONNECT%20for%20Health%20Act_06.12.20.pdf
2. Center for Connected Health Policy, The National Telehealth Policy Resource Center: https://www.cchpca.org/
3. California Telehealth Policy Coalition: https://www.cchpca.org/about/projects/california-telehealth-policy-coalition, West Health Institute is a member of the coalition and its Education Subcommittee
4. Morning Consult, Shelley Lyford, Congress Should Act Swiftly to Make Telehealth Expansion Permanent: https://morningconsult.com/opinions/congress-should-act-swiftly-to-make-telehealth-expansion-permanent/

Palliative Care

Palliative Care Background:

Palliative care is specialized medical care for people living with a serious illness. This type of care is focused on providing relief from the symptoms and stress of the illness. The goal is to improve quality of life for both the patient and the family. Serious illness is defined as a health condition that carries a high risk of mortality and either negatively impacts a person's daily function or quality of life or excessively strains their caregiver.

Palliative care is provided by a specially trained team of doctors, nurses and other specialists who work together with a patient's other doctors to provide an extra layer of support. Palliative care is based on the needs of the patient, not on the patient's prognosis. It addresses and relieves suffering across all aspects of the person: mind, body, spiritual, and relationships. It is appropriate at any age and at any stage in a serious illness, though it should start at the point of diagnosis, and it can be provided along with curative treatment. Palliative care improves health care value by both improving quality and reducing costs of care for the sickest and most complex patients. Learn more about palliative care.

Advance care planning is the process by which people think about, document and communicate their preferences for medical care should they become unable to speak for themselves. It can improve the quality of care and the patient and family experience during serious illness by aligning medical treatment with patient preferences. Thoughtful conversations are a key element of advance care planning. But to ensure people's wishes are known and honored, it's important to have documentation in the form of an advance healthcare directive (AHCD) or the Physician Orders for Life-Sustaining Treatment (POLST) form. Each form has a different purpose and should be used in the correct situation. Learn more about AHCDs. Learn more about POLST.

Palliative care is not routinely made available to patients who would benefit from receiving the services. For example, fewer than 1 in 20 hospitalized patients who could benefit from palliative care actually receive it.[23] Palliative care is often misunderstood by both health care providers and the general public. The barriers posed by race, ethnicity, culture and language sometimes interfere with people getting the best care possible. In addition, palliative care access can be limited by a lack of providers trained in the specialty, especially in rural areas and in smaller hospitals. According to a 2017 California Health Care Foundation report, inpatient palliative care capacity for the entire state was estimated to be sufficient to meet 43% to 66% of need, and community-based capacity was estimated to be sufficient to meet between 33% and 51% of need.

In the current health care environment, there is too often a substantial misalignment between the medical care people want during serious illness and the care they actually receive. People are often not empowered to speak up for the kind of care they want, and

---

[23] National Palliative Care Registry. [Accessed March 12, 2020]; Palliative Care Service Penetration by Hospital Size. 2015.

clinicians are often not trained to have conversations with patients about their values, goals over time, treatment options and preferences. When it does happen, the documents that record these preferences are not readily available in the medical record or through an electronic registry to guide treatment during a medical emergency.

Palliative Care Recommendations:

Goal 1. Expand Access to Palliative Care Services: Develop and implement strategies that make palliative care available to all seriously ill Californians across settings, including hospitals, clinics, nursing facilities, residential care, and home-based care.

   A. *The state should incentivize health plans financially to expand the availability of palliative care in their geographic areas.*

   B. *Require hospitals to have a palliative care consult service as a part of licensing.*

   C. *Develop and implement strategies to support the sustainability of interdisciplinary home-based palliative care, such as adequate value-based payment, [consensus standards](#) for payer/provider contracts, and programs to support referrals.*

   D. *Provide information to social service providers to increase their understanding of palliative care and engage them in identifying and referring appropriate consumers for palliative care services.*

Goal 2. Incorporate Palliative Care Best Practices: Identify and incorporate current best practices into care delivery, for example those put forth in the [Clinical Practice Guidelines for Quality Palliative Care (4th edition](#)), developed by the National Consensus Project for Quality Palliative Care and the National Coalition for Hospice and Palliative Care.

   A. *Regulate minimum standards for healthcare providers offering a "palliative care" service to patients and survey to ensure compliance.*

   B. *Institute pay-for-performance add-ons to Medi-Cal reimbursements, as well as Medicare and commercial reimbursement, for superior palliative care as demonstrated by OASIS scores or other existing measurements.*

Goal 3. Grow Palliative Care Workforce: Require the Office of Statewide Health Planning and Development and the California Health Care Workforce Policy Commission to assess the general and specialty palliative care workforce needs in the state, and to take steps to mitigate shortages.

   A. *Provide incentives to encourage a more culturally-diverse and culturally-sensitive palliative care workforce*.

Goal 4. Educate the Healthcare Workforce in Principles and Practices of Palliative Care: Implement strategies around workforce education in palliative care across disciplines.

   A. *Require a minimum level of exposure to primary palliative care in pre-professional/pre-licensure education for physicians, physician assistants, nurse practitioners, nurses, and social workers.*

   B. *Conduct a healthcare provider awareness campaign through a public-private partnership to increase accurate understanding of palliative care as care during serious illness.*

   C. *Incentivize continuing education in specialty-level palliative care.*

   D. *Subsidize palliative care training for Medi-Cal providers.*

   E. *Require skilled nursing facility staff to be trained in palliative care principles and practices using the [CARE Recommendations](#) as the foundation for the training.*

Goal 5. Empower Persons' Decision Making: Empower older adults to engage in conversations with family members and healthcare providers about serious illness and end of life, and optimize their ability to make and record their decisions about their own care.

   A. *Conduct a statewide communications campaign through a public-private partnership to increase awareness of advance care planning and encourage all adults to complete an advance directive with an emphasis on naming a surrogate decision maker.*

   B. *Review and update California laws regarding the requirements for making an advance directive or POLST form legally valid in light of COVID-19, electronic completion, and current thinking.*

Goal 6. Operationalize ACP: Engage large healthcare providers (e.g., integrated healthcare systems, medical groups, hospitals, and payers) in establishing systems within their organizations for consistently and reliably soliciting, documenting, retrieving and honoring patient treatment preferences.

   A. *Require electronic health record software to include one-click access to advance care planning documents, including advance directives and POLST forms.*

Goal 7. Honor wishes of Californians at the end of life: Create a statewide system for making information about patients' specific treatment preferences available to healthcare providers whenever and wherever it is needed, with advance healthcare directives and POLST that are incorporated into electronic systems so that this information is prominent and readily available and can be honored.

A. *Implement a statewide registry for electronic exchange of POLST.*

Palliative Care Resources:

- Consensus Standards for Community-Based Palliative Care in California. https://coalitionccc.org/wp-content/uploads/2017/11/CAIC-Standards-for-CBPC-Oct-2017.pdf
- About Palliative Care. https://www.capc.org/about/palliative-care/
- Advanced Care Planning Resources. https://coalitionccc.org/tools-resources/advance-care-planning-resources/
- POLST Forms https://capolst.org
- CHCF Report on Palliative Care. https://www.chcf.org/publication/palliative-care-california-narrowing-gap/
- CARE Recommendations. https://coalitionccc.org/wp-content/uploads/2015/08/2015_CARErecs_web_final.pdf

Oral Health

Oral Health Background:

The oral health status of older adults and people with disabilities is of critical importance to their overall health. Unfortunately, the attention to the oral health needs of older adults and people with disabilities has been inadequate. Consequently, older adults have significant unmet oral health needs impacting their overall health and emotional and social wellbeing. For example, 50 percent of older adults living in nursing facilities and 33 percent in the community have untreated tooth decay. We also know that poor oral health disproportionately impacts older adults of color, individuals with disabilities, and those residing in institutional settings and rural areas. Nationally, for example, 31 percent of Black older adults have complete tooth loss compared to 15 percent of white older adults.[24]

Untreated oral health needs complicate chronic conditions like diabetes and heart disease, increase the likelihood for infection, and have significant impact on emotional and overall wellbeing. Seniors and persons with disabilities frequently have more difficulty accessing dental care because their health conditions result in dental procedures taking more time, being performed over multiple rather than a single visit, or requiring adaptations that involve additional costs besides time. Denti-Cal procedure payments are based on "typical" patients and have not recognized these additional costs. Legislative interest in 2018-19 led DHCS to initiate a single flat supplemental payment for seniors and persons with disabilities whose care was more costly.[25] The supplemental payment was a positive development. Recognizing the variation in additional costs for different dental procedures and persons with different conditions is, however, essential to equitably assuring better dental care access for seniors and persons with disabilities.

Oral Health Recommendations:

Goal 1. Improve research and evidence around oral health care for older Californians and people with disabilities. Today, there is a nearly complete absence of data on the oral health status of older adults and people with disabilities, their treatment needs, insurance

---

[24] Centers for Disease Control and Prevention, "Oral Health Surveillance Report 2019, Trends in Dental Caries and Sealants, Tooth Retention, and Edentulism, United States, 1999-2004 to 2011 to 2016" (2019)(herein after "Oral Health Surveillance Report"), available at https://www.cdc.gov/oralhealth/pdfs_and_other_files/Oral-Health-Surveillance-Report-2019-h.pdf.

[25] SB 1464 in 2018 with Sen. Weiner as first sponsor and Sens. Mitchell, Nguyen, Nielson and Pan as co-sponsors and AB316 in 2019 with Asm. Ramos and Robert Rivas as co-sponsors.

coverage, and utilization of services.[26] This makes it particularly difficult to assess the extent of need, develop solutions, and target resources. This is especially true for measuring disparities. Available California and national data demonstrate significant disparities in oral health outcomes based on race, but California data is not disaggregated for older adults and is outdated. Data based on disability and by residential setting (e.g home, residential congregate setting, rural, urban) is non-existent.

   A. *Collect Oral Health Data on Older Californians and People with Disabilities.* It is especially important to collect oral health data by age, disability, race, and setting.

Goal 2. Include Older Adults and People with Disabilities in Oral Health Statewide Plan and Local Oral Health Plans. California has developed a statewide oral health plan, but the plan contains few objectives aimed specifically at improving oral health outcomes for older adults or individuals with disabilities.[27] With funding from Proposition 56, counties have also developed local oral health plans under the leadership of the statewide Office of Oral Health. Unfortunately, most of these local plans also omit older adults and people with disabilities or include few objectives to improve their oral health.

   A. *The Office of Oral Health should develop objectives specific to older adults and people with disabilities to implement statewide and to guide local oral health planning.* At a minimum, such planning objectives would include:
      o Expansion of teledentistry, the virtual dental home, and co-location of services to better connect older adults and people with disabilities to oral health services in their homes and communities.
      o increase in number of providers trained and able to provide care to individuals with complex and chronic health care conditions.
      o Better integration of oral health into medical care.
      o Addressing oral health disparities based on race, ethnicity, disability, and residential setting.

Goal 3. Improve access to Dental Coverage for older adults and people with disabilities on Medi-Cal. Federal rules do not require states to include dental coverage for adult Medicaid recipients. Consequently, California has eliminated adult dental coverage in the past during times of budget shortfalls and threatened such cuts in the 2020-21 budget. Such cuts are short sighted. Cutting oral health coverage increases other costs to Medi-Cal, such as emergency room use costs for oral health problems that could be treated elsewhere and costs associated with chronic conditions. Such cuts also disproportionately impact communities of color. Of those who lose coverage, 73% are from communities of color: 48%

---

[26] California Department of Public Health, "Status of Oral Health in California: Oral Disease Burden and Prevention 2017," available at
https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/CDCB/CDPH%20Document%20Library/Oral%20Health%20Program/Status%20of%20Oral%20Health%20in%20California_FINAL_04.20.2017_ADA.pdf
[27] California Department of Public Health, "California Oral Health Plan, 2018-2028," Jan. 2018, available at
https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/CDCB/CDPH%20Document%20Library/Oral%20Health%20Program/FINAL%20REDESIGNED%20COHP-Oral-Health-Plan-ADA.pdf

are Latinx, 8% are black, and 15% are Asian American/Pacific Islander American.[28] California should make adult Medicaid dental coverage a permanent benefit.

   A. ***Commit to Continued Medi-Cal Dental Coverage.*** California must commit to continued Medi-Cal dental coverage, treating this benefit as mandatory, not optional.

Goal 4. Develop Statewide Medi-Cal Dental Advisory Board and Set Utilization Targets for Older Adults and People with Disabilities. The most recent Medi-Cal dental utilization data indicates that fewer than 1 in 4 older adults had an annual dental visit in 2018, and just over 1 in 10 accessed a preventive service.[29] There is no utilization data for people with disabilities. The Department of Health Care Services has established statewide Medi-Cal utilization targets for children. Unfortunately, no such utilization targets are in place for older adults and people with disabilities. With the known impact untreated oral health needs have on chronic conditions like diabetes and heart disease and the increased risk for infection, it is critical that older adults and individuals with disabilities are connected to oral health treatment.

   A. ***California should create an evidence-based advisory group for the Medi-Cal dental program to guide decisions and make sure they are based on the best evidence and science and not merely on cost***.[30] This advisory board could also establish Medi-Cal utilization targets for older adults and people with disabilities.
   B. ***California must put in place utilization targets for older adults and people with disabilities and ensure that such targets are also being met based on race, ethnicity, and residential setting.***

Goal 5. Integrate Dental and Physical Health Care in the Medi-Cal Program. A growing body of evidence shows that investing in the maintenance of a person's oral health has benefits for their overall health and well-being. Gum disease has been associated with respiratory disease, cardiovascular disease, and diabetes; poor oral health is associated with chronic pain and inappropriate use of the emergency department[31]; and for diabetics, oral health and properly controlled blood sugar go hand-in-hand. People with diabetes are twice as likely to develop gum disease, and in turn, infected gums make it harder to control blood sugar. Infections can cause gums to bleed, feel swollen and tender, and can lead to tooth

---

[28] Families USA analysis of American Community Survey (ACS) data for 2018. IPUMS USA, Minnesota Population Center, University of Minnesota, https://usa.ipums.org/usa/www.ipums.org.

[29] Department of Health Care Services, Adult Dental Utilization CY 2017 and CY 2018, available at https://www.dhcs.ca.gov/services/Pages/DentalReports.aspx.

[30] Little Hoover Commission, "Fixing Denti-Cal," April 2016, available at https://lhc.ca.gov/sites/lhc.ca.gov/files/Reports/230/Report230.pdf

[31] Improving Access to Oral Health Care for Vulnerable and Underserved Populations. Washington, D.C.: Institute of Medicine and National Research Council; 2011.

loss. Nearly 14% of Californians have been diagnosed with diabetes, and the numbers are rising rapidly[32]. Diabetes costs in this state exceed $24 billion each year[33].

Despite the link between dental health and overall health, dental and medical services have traditionally been delivered by separate systems. The Medi-Cal program reflects this, with enrollees enrolled in managed care for medical benefits and the fee for service Denti-Cal system for their dental care. Patients access dental care largely on their own and little supporting infrastructure exists to allow the medical and dental systems to make connections when needed for a patient's overall health. Under the current model, it is difficult to coordinate care to improve patient health or measure outcomes and achieve cost-savings for the overall system. The State has approved two pieces of legislation to address these issues. In 2019, the State approved a dental integration program in San Mateo County, to be administered by the Health Plan of San Mateo. The program is set to begin in 2022. In 2016, the State approved AB 2207 requiring Medi-Cal managed care plans to connect their members to oral health care, i.e., provide a dental screening for every enrolled member as part of the initial health assessment; refer members who have oral health needs to a Medi-Cal dental provider; and identify health plan liaisons to establish relationships with dental providers to assist referrals from dental providers to the health plans for health plan covered services. However, the Department of Health Care Services has yet to issue guidance to health plans on these requirements.

A. ***Develop an integrated dental and physical health program in Med-Cal by 2030.*** CalAIM proposed the development of pilot programs to include, among other services, the integration of oral health in Medi-Cal managed care. These pilot programs should be pursued, with the long-range goal of integrating all dental services in Medi-Cal managed care. The State should establish objectives for improving access to oral health care through managed care, including access to dental prevention services, and measure the cost impact of integrating dental care, such as reductions in emergency room visits due to dental pain and dental procedures performed in a hospital setting.

B. ***Immediately, the State should issue guidance to health plans and enforce current Medi-Cal managed care plan responsibilities to connect members to oral health care.***

Goal 6. Support Federal Medicare Coverage for Dental Care. Today, traditional Medicare does not include dental coverage. As a result, nearly 37 million older Americans have no dental coverage. Efforts are underway to expand Medicare to include coverage for routine and preventive oral health care. A Medicare oral health benefit would provide coverage to all 6.2 million Medicare enrollees in California, including the 1.4 million Medicare beneficiaries dually enrolled in Medi-Cal.

A. ***California should support efforts to expand this federal coverage through its federal lobbying efforts.***

---

[32] California Diabetes Program. California Diabetes Fact Sheet, 2012, Technical Notes. www.caldiabetes.org. 2012.
[33] Dall TM, Zhang Y, Chen YJ, Quick WW, Yan WG, Fogli J. The economic burden of diabetes. Health Affairs. 2010;29(2): 297-303

Oral Health Resources:

- Centers for Disease Control and Prevention, "Oral Health Surveillance Report 2019, Trends in Dental Caries and Sealants, Tooth Retention, and Edentulism, United States, 1999-2004 to 2011 to 2016" (2019) (herein after "Oral Health Surveillance Report"), available at https://www.cdc.gov/oralhealth/pdfs_and_other_files/Oral-Health-Surveillance-Report-2019-h.pdf
- California Department of Public Health, "California Oral Health Plan, 2018-2028," Jan. 2018, available at https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/CDCB/CDPH%20Document%20Library/Oral%20Health%20Program/FINAL%20REDESIGNED%20COHP-Oral-Health-Plan-ADA.pdf
- California Department of Public Health, "Status of Oral Health in California: Oral Disease Burden and Prevention 2017," available at https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/CDCB/CDPH%20Document%20Library/Oral%20Health%20Program/Status%20of%20Oral%20Health%20in%20California_FINAL_04.20.2017_ADA.pdf
- Cabezas, Martita, DDS, MPH, County of Los Angeles Public Health, "Identifying Dental Deserts in the Los Angeles Safety Net Using GIS Maps," (2016), available at https://www.nationaloralhealthconference.com/docs/presentations/2016/04-19/Maritza%20Cabezas-Dental%20Deserts%20of%20the%20Los%20Angeles%20County%20Safety-Net%20Dental%20Clinics%20Using%20GIS%20Maps.pdf
- Center for Oral Health, "A Healthy Smile Never Gets Old: A California Report on the Oral Health of Older Adults," Nov. 2018, available at https://www.centerfororalhealth.org/wp-content/uploads/2018/11/Oral-Health-of-Older-Adults.pdf
- Little Hoover Commission, "Fixing Denti-Cal," April 2016, available at https://lhc.ca.gov/sites/lhc.ca.gov/files/Reports/230/Report230.pdf
- Department of Health Care Services, Adult Dental Utilization CY 2017 and CY 2018, available at https://www.dhcs.ca.gov/services/Pages/DentalReports.aspx
- Justice in Aging, "Oral Health in California, What About Older Adults?" July 2016, available at https://www.justiceinaging.org/wp-content/uploads/2016/07/Oral-Health-in-CA_What-About-Older-Adults.pdf
- Oral Health America, "An Oral Health Benefit in Medicare Part B: It's Time to Include Oral Health in Health Care," https://www.justiceinaging.org/wp-content/uploads/2018/07/Medicare-Dental-White-Paper.pdf

Provider Level
Assuring the Workforce to Care for Older Adults

Workforce Background:

The Aging sub-committee of the California Future Healthcare Workforce Commission deliberated for over a year on the demands of the future and the requisite make-up and preparation of the workforce to care for all Californians[1]. These recommendations draw on the work of the Commission, who envisioned older adults aging in place with dignity and respect in an engaged community and a fully integrated person-centered and technology-enabled team (medical + social + behavioral) to deliver appropriately timed, evidence-based best practices, and culturally and linguistically congruent care. Actualizing that vision requires 1) Adequate supply of health care professionals, distributed equitably across both geography and underserved communities. Importantly, the workforce should mirror the diversity of the population necessitating strong pipeline programs to recruit from under-represented groups, career path and mentorship support and incentives to work with older adults across settings; 2) Appropriate preparation: Nationally, less than 5% of the workforce of health care professionals (nurses, physicians, pharmacists and social workers) are certified in geriatrics, yet almost all health care professionals encounter older adults and persons with disabilities in their practice. Older adults and persons with disabilities need competent health care professionals, prepared with competency in geriatrics, dementia care, palliative care, behavioral health, as well as the ability to work in interdisciplinary teams and use enabling technology[2]; 3) Optimal regulations to ensure quality and encourage innovation so that all members of the care team practice to the full extent of their education and preparation and are compensated accordingly through value-based reimbursement; and 4) Incentives to attract and retain health care professionals in geriatrics/gerontology across settings.

Enacting the vision requires an organizing framework. Two initiatives provide examples: The Geriatric Emergency Department initiative[3] and the Age-Friendly Health Systems initiative[4]. These programs have resulted in fast deployment of improved and well-informed care for older adults, offering a practical and rapid approach to deploy evidence-based geriatrics training. Older adults and persons with disabilities with multiple chronic medical conditions are well managed by an integrated and interdisciplinary workforce. Interdisciplinary teams, exemplified by The Program for the All-Inclusive Care of the Elderly (PACE)[5,6], improve outcomes including better survival, improved functional and cognitive outcomes and lower rates of healthcare utilization[7,8,9]. The recommendations build on the essential elements, increasing supply, competence, regulatory support and incentives to promote the workforce to address the future needs of all Californians.

Workforce Recommendations:

Goal 1: Increase the supply of qualified providers to assure access to person-centered, team-based and technology-enabled care.

> A. *Expand the number of primary care physician and psychiatry residency positions, yielding an increase of 1,872 primary care physicians and 2,202 psychiatrists by*

2030.[1] There is an inadequate supply of primary care and psychiatry providers for the growing population of older adults and persons with disabilities and there are many areas of the state that are underserved, with health disparities based on multiple dimensions including race/ethnicity, geography, LGBTQ status, disability, and economic disadvantage.

B. ***Develop a psychiatric nurse practitioner program that recruits from and trains providers to serve in underserved communities to address access gaps in behavioral health by treating over 350,000 patients over five years.***[1] There is inadequate access to psychiatric and behavioral health care with particular emphasis in rural and urban underserved communities. Lack of integration of behavioral health care exacerbates chronic disease burden and compromises quality of life outcomes.

C. ***Maximize the role of gerontologists (e.g., Master's in Gerontology graduates) and geriatric social workers on care teams and in appropriate roles, such as care coordination.***   Gerontologists and geriatric social workers improve the quality of life and promote the well-being of persons as they age within their families, communities and societies through research, education, and application of interdisciplinary knowledge of the aging process and aging populations. Gerontologists and geriatric social workers perform key roles in care transitions and care coordination and can be reimbursed through Medicaid Waiver programs. Given the shortage of geriatrically-prepared health and social service professionals, gerontologists should be utilized in primary care and team care delivery to older adults.

D. ***Scale the engagement of community health workers, promotores, and peer providers through certification, training, and reimbursement, broadening access to prevention and social support services in communities across the state.***[1] It is vital to increase the capacity of primary care and behavioral health teams to support better outcomes for all and to promote recovery and self-sufficiency for people with mental illness and substance use disorder. Engaging community health workers, *promotores* and peer providers expands access and increases cultural appropriateness of care.

E. ***Develop the pipeline by infusing curricula around health professional careers in high school health academies with priority targets for underrepresented populations, support pipeline programs at colleges and universities to recruit the future workforce***. The projections of the inadequate supply of health care professionals to care for older adults and persons with disabilities in California extends decades into the future. To achieve health equity and access, recruitment efforts today at the high school level can influence outcomes in a decade. Pipeline programs that target diverse youth across urban and rural communities are essential to assure that the future workforce represents the population of older adults in California and is positioned to provide culturally and linguistically appropriate care. Investment all along the pipeline is required to motivate and support promising health care professionals to achieve their career goals.

Goal 2: Increase the number of providers prepared to deliver person-centered, culturally and linguistically congruent, technology enabled care for older adults and persons with disabilities by 10,000 by 2030

A. *Promote inclusion of competencies to care for older adults and persons with disabilities, work in teams and use enabling technology in health workforce curricula at ALL levels.* Curricula in health professions education vary in the extent of content in geriatrics/gerontology, dementia care, palliative care and behavioral health. The American Geriatrics Society published multi-disciplinary competencies to prepare all entry-level health care professionals at a minimum, addressing health promotion, evaluation and assessment, care planning and coordination, interdisciplinary and team care, caregiver support and healthcare systems and benefits. The American Geriatrics Society competencies reflect consensus on basic preparation[2]. Very few health care professionals are prepared to care for older adults and persons with disabilities, work in teams and use technology to improve access and delivery.

B. *Require physicians, nurse practitioners, physician assistants, nurses, and social workers to obtain 10 hours of continuing education (CE) in geriatric and dementia competencies.* The incumbent workforce is not sufficiently prepared to care for older adults and persons with disabilities and those with dementia.

C. *Encourage development of continuing educational offerings designed for multi-disciplinary audiences by streamlining the CE accreditation application and approval process through standardization across and reciprocity between CE accrediting bodies.* The growth of team-based care calls for rethinking and redesigning our continuing education accreditation process that currently evaluates educational offerings from the perspective of disciplinary silos.

D. *Support state and federal programs and legislation that increases hospice and palliative care workforce and funding (ex. PCHETA, new APM).* Require a minimum level of exposure to primary palliative care in pre-professional/pre-licensure education for physicians, physician assistants, nurse practitioners, nurses, and social workers. Conduct a healthcare provider awareness campaign through a public-private partnership to increase accurate understanding of palliative care as care during serious illness. Incentivize continuing education in specialty-level palliative care. Subsidize palliative care training for Medi-Cal providers. Health care professionals are not sufficiently prepared nor incentivized to provide end-of-life care.

E. *Establish a certification process for behavioral health peer-support specialists, including those trained to provide services to older adults, through future legislation.* All counties should develop peer-training programs that involve people with lived experience to provide culturally appropriate auxiliary or additional behavioral health services for older adults and others with complex medical needs. The behavioral

health peer support workforce is not sufficiently prepared to provide comprehensive care for older adults and persons with disabilities in California.

F. ***DHCS should direct the California Institute for Behavioral Health Strategies (CIBHS) to utilize its funding to develop and deliver a geriatric curriculum to the existing behavioral health workforce in order to inform and better prepare their work with older adults and persons with disabilities.*** The incumbent behavioral health peer support workforce is not sufficiently prepared to provide comprehensive care for older adults and persons with disabilities in California.

G. ***California's higher education programs for the disciplines in the behavioral health workforce should ensure that geriatric topics are included in the core curriculum, and that geriatric behavioral health elective courses for specialization are available and are promoted to students.*** Community colleges and university extension programs should develop career technical education programs and peer education programs to support the development of paraprofessionals in geriatric behavioral health. The behavioral health workforce is not sufficiently prepared with geriatrics and gerontology content to care for older adults and persons with disabilities.

H. ***Adopt statewide toolkit for primary care providers, to best practices and facilitate early diagnosis and treatment of dementia as required by Medi-Cal, DMHC, and others.*** Primary care providers across the state are not sufficiently prepared to identify and manage care for persons with dementia.

Goal 3: Align regulations to support optimal access

A. ***Maximize the role of advance practice providers (e.g., nurse practitioners and physician assistants) as part of the care team to fill gaps in primary care, helping to increase the number of nurse practitioners to 44,000 by 2028, and providing them with full practice authority***[1]. There is inadequate access to primary care that is cost-effective, high-quality, person-centered and comprehensive, particularly in underserved communities. Even with expansion of medical school slots, the projected supply is insufficient. Furthermore, the supply of health care professionals who reflect the communities they serve falls short of demand. Nurse practitioners and physician assistants can advance access to high quality care.

B. ***Maximize the role of gerontologists (e.g., Master's in Gerontology graduates) on care teams and in appropriate roles, such as care coordination.*** Nationally, there are over 650 programs producing well-trained gerontologists, many of these programs are within California. Gerontologists improve the quality of life and promote the well-being of persons as they age within their families, communities and societies through research, education and application of interdisciplinary knowledge of the aging process and aging populations. There are national examples of gerontologists performing in key roles in care transitions and care coordination and being reimbursed through Medicaid Waiver programs. Given the shortage of geriatrically-

prepared health and social service professionals, gerontologists should be utilized in primary care and team care delivery to older adults.

C. ***Under OSHPD, conduct Healthcare Workforce pilot demonstration projects of nurse delegation in community to provide oversight to direct care workers in performing medical/nursing tasks***[10]. Most older adults and persons with disabilities age in place in the community, supported by family caregivers and direct care workers. With increasing complexity of health and social care needs, the direct care workforce has the capacity to manage some tasks previously limited to licensed nursing scope of practice (such as medication administration, wound care, tube feeding) through the mechanism of Nurse Delegation. This evidence-based practice has been adopted in many states, and involves RNs assessing the older adult or person with disability to establish care needs, instructing the direct care worker and assuring their ability to perform the task, and monitoring the situation to assure ongoing safety. Other states (e.g., Washington and New Jersey) have advanced new models of care delivery and have conducted evaluative research to evaluate the implications for safety and access.

Goal 4: Incentivize optimal workforce preparation to care for older adults and persons with disabilities

A. ***Adopt an organizing framework to inform system change, based on Healthy People 2030 goals for older adults, the Age-Friendly Health Systems initiative and the Geriatric Emergency Department initiative.*** An organizing framework with strategic incentives can inform system change to optimize care for older adults and persons with disabilities by providing a compelling vision and goals in prioritizing decisions. To optimize addressing complex social and health care needs for vulnerable older adults and persons with disabilities, fundamental changes are required in how care is delivered, such as interdisciplinary teams that include gerontologists, community health workers, peer counselors and promotores. Enabling technology can maximize care access, especially in rural and underserved geographic regions.

B. ***In its next five-year plan for the Mental Health Service Act's Workforce, Education and Training (WET), The Office of Statewide Health Planning and Development (OSHPD) should include a requirement for counties to designate priority slots in future loan forgiveness and stipend programs for trainees who are interested in geriatric behavioral health services***. The percentage of slots so designated should be consistent with each county's prevalence of older adults with behavioral health needs. Data reporting on this requirement should be mandatory[11]. There is a lack of incentives to increase the geriatric expertise in the public mental health workforce among behavioral health trainees. Several counties (e.g., Los Angeles) are already doing this and have been able to create a better trained geriatric behavioral workforce.

C. ***OSHPD should include special considerations in WET funding for promoting the geriatric behavioral health workforce in small and rural counties***. For example, strategies might include adjusting the funding formula, providing designated funding allocations and a streamlined application process. There are significant geographic disparities in availability of behavioral health workforce in the public mental health system.

D. ***Accrediting bodies and professional organizations should include geriatric behavioral health competency expectations as a component of curriculum review and set standards for prioritizing this area of expertise within programs***. There is inadequate support and motivation for setting competency standards for the geriatric behavioral health workforce

Workforce Resources:

[1] California Future Health Workforce Commission. https://futurehealthworkforce.org/

[2] American Geriatrics Society, Multidisciplinary Competencies in the Care of Older Adults at the Completion of the Entry-level Health Professional Degree https://www.americangeriatrics.org/geriatrics-profession/core-competencies

[3] American College of Emergency Physicians. Geriatric Emergency Department Accreditation Program. https://www.acep.org/geda/ Accessed July 2020

[4] The John A. Hartford Foundation. Age-Friendly Health Systems Initiative. https://www.johnahartford.org/age-friendly-health-systems-initiative Accessed July 2020

[5] Leavitt, M. (2009). Interim report to Congress. The quality and cost of the Program of All-Inclusive Care for the Elderly.

[6] Kane, R. L., Homyak, P., Bershadsky, B., Flood, S. (2006). Variations on a theme called PACE. Journal of Gerontology Series A, 61 (7): 689-93.

[7] Sommers, L. S., Marton, K. I., Barbaccia, J. C., & Randolph, J., (2000). Physician, nurse, and social worker collaboration in primary care for chronically ill seniors. Archives of Internal Medicine, 160, 1825-1833.

[8] Stuck, A. E., Siu, A. L., Wieland, G. D., Adams, J., & Rubenstein, L. Z., (1993). Comprehensive geriatric assessment: A meta-analysis of controlled trials. Lancet,34, 1032-1036.

[9] Wieland, D., Stuck, A. E., Siu, A. L., Adams, J., & Rubenstein, L. Z., (1995). Meta-analytic methods for health services research: An example from geriatrics. Evaluation and the Health Professions,18, 252-282.

[10] Young, HM and Siegel, EO. (2016). The Right Person at the Right Time to Ensure High Quality and Value Person-Centered Care for Older Adults: Scope of Practice and Other Systems-Level Factors. Generations, 40(1): 47-55.

Additional Workforce Resources:

- U.S. Department of Health and Human Services, Health Resources and Services Administration Bureau of Health Workforce. National and Regional Projections of Supply and Demand for Geriatricians: 2013-2025. Rockville, MD: DHHS; 2017. https://bhw.hrsa.gov/sites/default/files/bhw/healthworkforce-analysis/research/projections/GeriatricsReport51817.pdf. Accessed April 29, 2018.
- American Geriatrics Society. State of the Geriatrician Workforce. New York, NY: AGS; 2018. https://www.americangeriatrics.org/sites/default/files/inlinefiles/State%20of%20the%20Geriatrician%20Workforce_10%2001%2018. pdf. Accessed April 29, 2018.
- Health Resources and Services Administration. HHS awards $35.7 million to improve care for older adults [press release]. July 13, 2015. https://hrsa.gov/ about/news/ pressreleases/ 150713geriatricworkforce.html. Accessed October 2018
- Frank, J.C., Kietzman, K., Damron-Rodriguez, J., et al. (2017). California Mental Health Older Adult System of Care Project Deliverable 3 Report, http://www.healthpolicy.ucla.edu/Older-Adult-Mental-Health
- Damons, J. (2001). Program of All-Inclusive Care for the Elderly (PACE) Year 2 Overview. Long-Term Care, Bureau of TennCare, Tennessee.

APPENDIX

Goal 3 Appendix: Other Health Issues

Health is a broad goal area. We chose to focus on areas that we felt provided the greatest potential improvement for older adults and people with disabilities. There are many other issues and recommendations which could have been considered. We include here several areas where work is being done in the state and that also deserve mention.   Groups working with these areas requested that the following recommendations be considered; the Health Team did not have time to review and incorporate them into the body of the report.

Goal 1: Health and Nutrition

   A. ***Define nutrition security as a human right and as a foundational goal to achieving many of the other goals of the Master Plan.***

   All Californians should have access to affordable and culturally appropriate healthy food to support nutrition security. Nutrition security is defined as a situation that exists when all people, always have physical, social, and economic access to sufficient, safe, and nutritious food that meets their dietary needs and food preferences for an active and healthy life (USDA, 2017). While food security generally focuses on the availability of *calories* to all people, nutrition security requires the intake of a wide range of foods which provides the essential nutrients that individuals need to maintain or improve their health status, including meeting specific needs related to chronic and other health conditions (NLM, APLU, 2020).

   Nutrition security is not only a human right but is a foundational component of health and well- being for all ages, particularly for older adults and people living with disabilities. Sixty percent of deaths in the United States – from heart disease, diabetes, stroke and cancer – are related to poor eating habits, and research consistently demonstrates that addressing nutrition security improves health outcomes and quality of life while reducing health care utilization and costs.

   Nutrition security is critical for chronic disease prevention and treatment. In particular, the home delivery of medically-tailored meal interventions (MTMs) to older adults has been shown to reduce hospitalizations (up to 63%), reduces medical costs (by up to 32%), and improves health outcomes overall (www.fimc.org/resources).

   B. ***Explicitly recognize the relationship between nutrition security and health outcomes.***

   - Nutrition security is the goal. Eliminating hunger does not ensure nutrition security, and nutrition security is equally important if the broader aims of the Master Plan are to be achieved.
   - While CalFresh is a vital part of a nutrition security system, it will not meet the nutrition security needs of many older adults or people living with disabilities. Therefore, other nutrition programs, such as delivery of medically tailored meals

and/or groceries, senior meals programs, and produce prescription programs need to be included in the Master Plan.

C. ***Standardize the assessment of nutrition needs and referral to nutrition services across all agencies and programs serving older adults and people living with disabilities.***

To meet nutrition security goals, older adults and people with disabilities should be consistently screened to assess nutritional needs. We recommend the development of a standard food and nutrition screening tool that would be used in all eligibility assessments and care transition assessments across programs and departments. This should include, at a minimum:

    a. The two-question food insecurity screen
    b. Assessment of chronic disease related nutritional needs
    c. Functional capacity to shop and cook a nutritionally appropriate diet

This assessment should lead to a standard set of referrals that encompasses the full range of food and nutrition supports, from CalFresh enrollment to home delivered and medically tailored groceries and meals.

D. ***Integrate and fund a comprehensive set of nutrition services that meet the diverse needs of older adults and people living with illnesses or disabilities.***

The Master Plan should integrate and recommend funding for a comprehensive set of food and nutrition services to address diverse needs, from those who are able-bodied to those living with chronic health conditions and who have functional needs that prevent the ability to shop and cook a nutritionally appropriate diet. California's nutrition security system for older adults should include not only simplified access to CalFresh, but also funding for:

    A. Increased availability of fresh fruits and vegetables through produce prescription and market match programs
    B. Food and produce pantries at senior centers
    C. Enhanced support for senior meal programs to improve food quality
    D. Medically tailored meal programs for those living with chronic health conditions who are not able to shop and prepare a nutritionally adequate diet

Goal 2: Village Movement and Community Building

Public health professionals can partner with "Villages," grassroots consumer-driven community-based organizations that aim to promote aging in place by combining services, participant engagement, and peer support. First emerging in the early 2000s, currently there are more than 200 Villages in the United States in operation or development. Studies suggest that Villages are a promising approach to increasing members' social engagement and connecting with a variety of formal and informal community supports (including those offered by public health departments) plays a critical role in their ability to do so.

A. ***Articulate the importance of community engagement and partnership with grassroots efforts***.

We know from public health practice, particularly around health equity efforts developed over the past decade, that community engagement and partnership are best and necessary practices. We will never have equity if systems are not engaging with community, including investing resources in grassroots efforts. Solutions lie with the people who are impacted.

B. ***Village Movement* California belongs as a best practice in prevention and wellness***.**

Villages use an evidence based, grassroots and community driven approach to address social isolation, loneliness, and social determinants of health to help older adults thrive in the places they call home.

Graham, Carrie L., Scharlach, Andrew E., Wolf, Jennifer Price, (5.5.2014). The Impact of the Village Model on Health, Well-Being, Services Access, and Social Engagement of Older Adults. *Health Education and Behavior*. 41 (1) pp 91S- 97S.

Trust for America's Health report, *Creating an Age-Friendly Public Health System: Challenges, Opportunities, and Next Steps*:

Goal 3: Assistance with Medicare, Medi-Cal and other Health Insurance Coverage

California Health Advocates provides quality Medicare and related health care coverage information, education, and policy advocacy. It provides education, training, and technical assistance to local HICAPs and to other groups and advocacy organizations. We are concerned about a lack of focus on how consumers get the information they need to choose appropriate health care coverage and make the best use of the benefits they have.

HICAP is a state and federal funded program to assist Medicare beneficiaries and their families with information on Medicare, supplemental benefits, services, assistance, and insurance benefits for long term care. CHA provides information and resources to the local HICAPS and the public that will help them understand the complexity of some of their health care choices and direct them to the most appropriate resources for their needs.

Many of the clients coming to CHA and local HICAPs come for assistance with health and long term care benefits and services and are in the process of using up their resources paying for care, or paying for insurance to cover the cost of their care, or both. They are not yet low income, but many will become so in their later years.

Consideration of HICAP and the assistance it provides in navigating difficult insurance and coverage options faced by older adults should be included in the next stage of the Master

Plan process. The program is an integral part of the Area Agencies on Aging and has a legislative requirement to educate and counsel the public and their clients on long term care planning, education, and insurance. As insurance companies withdraw from selling free-standing long-term care insurance and convert to high cost financial products, moderate income consumers are left with few options to cover the cost of long term care. In addition, recent premium increases have reduced the ability to pre-fund long term care costs and caused policyholders to reduce existing benefits to offset the increased cost of coverage. HICAPs help these consumers determine the best choices for their economic circumstances and maintain appropriate coverage.

HICAPs help consumers understand complex health care choices based on the services and providers they need to best meet their needs. Their choices may include a Medicare Advantage option or original Medicare. Their preferred providers may or may not be part of a restricted network, their premiums and out of pocket expenses vary with each choice, and their choices will affect their income and resources. Often HICAP clients are low income individuals eligible for Medicare and Medi-Cal who need help understanding eligibility and enrolling in the appropriate programs for their needs. And sometimes older adults are faced with draconian choices about their health care and long-term care coverage following the death of a spouse and the resulting drop in income.

HICAPs provide invaluable counseling and information that allow their clients to make the most cost effective choices about their health and long term care benefits, retain their access to chosen providers, and help delay the need to access public programs and benefits.

> A. *Until we have a single health and LTSS coverage program in California the State must assure that appropriate information and counseling is provided to older adults. HICAPs provide that information.*
>
> B. *HICAPs are already providing information about integrated care, medical resources, and long-term care insurance. California needs to provide additional support to provide services for the growing numbers of people who are aging in the state.*

Goal 4: Affordable Medications

Millions of Californians rely every day on prescription drugs to maintain their health. The United States pays the highest prices in the world, and the result is that many older adults must choose between filling their prescriptions and buying food.

Drug price increases remain out of control. According to AARP Research, in 2018, brand-name drug price increases occurred at more than twice the rate of inflation.[i] The average annual cost of four widely used prescription drugs increased nearly 58 percent between 2012 and 2017, while annual incomes across America increased by just over 13 percent.[ii]

Meanwhile, the average older American typically takes 4.5 prescriptions regularly on a chronic basis.[iii] In California, the average annual cost of prescription drug treatment increased 57.8% between 2012 and 2017, while the annual income for Californians only increased 12.5%.[iv]

California residents of all ages are impacted by high prescription drug costs, especially if they lack insurance or are underinsured. Due to the high cost of Rx drugs, AARP estimates that in 2017, 22% of California Residents stopped taking medication as prescribed due to cost.[v] For example, AARP has found that the cost of these three commonly prescribed, brand name medications have increased significantly between 2012 and 2017[vi]:

- Revlimid, which is used to treat some cancers, increased from $147,413 a year to $247,496 a year;
- Lantus, which is used to treat diabetes, increased from $2,907 to $4,702 a year;
- Aggrenox, used to treat heart disease, increased from $3,030 to $5,930 a year.

There are serious consequences for patients who do not adhere to prescribed medication regimens. According to The Centers for Disease Control and Prevention (CDC), "non-adherence causes 30 to 50 percent of chronic disease treatment failures and 125,000 deaths per year in this country. Twenty-five to 50 percent of patients being treated with statins (cholesterol lowering medications) who stop their therapy within one year have up to a 25 percent increased risk for dying."[vii]

The state has already enacted legislation or Executive Orders aimed at lowering the cost of prescription drugs. These steps have included banning Pay for Delay agreements that impede access to lower-cost generic drugs[viii], using the significant buying power of California to create a bulk buying program for prescription drugs purchased by state and even county entities [ix], and creating transparency by requiring that drug companies give 60 days' notice to public and private purchasers before raising the wholesale acquisition cost of a prescription drug costing more than $40, if the wholesale acquisition cost exceeds 16% over a two year period. [x]

However, there are steps that California can take to help reduce prescription drug prices in the aggregate. We recommend that California undertake the following changes:

A. *Enact legislation that:*
- ***Authorizes the CA Health & Human Services Agency to develop a comprehensive importation plan, which, upon approval by the FDA, would enable the state to operate a wholesale drug importation program for state purchases. Such action has already been taken in Florida and Vermont.***
- ***Prohibits insurers, during a policy year, from removing a drug from a formulary, moving a drug to a new tier with greater cost-sharing requirements, or adding utilization management restrictions (e.g., prior authorization).***

Goal 5: Explore issues and recommendations in the area of vision, hearing, and podiatry care.

Several individuals noted that Goal 3 Health includes recommendations for oral health but not vision, hearing, and podiatry care. The invisible aspects of healthy aging often have to do with one's feet, ears, and eyes. While the Stakeholder Advisory Committee health team did not have time to explore these issues in depth, we recommend they be considered in the next phase of the Master Plan.

[i] Stephen W. Schondelmeyer and Leigh Purvis, "*Rx PriceWatch Reports*. Washington, DC: AARP Public Policy Institute, June 2019. https://doi.org/10.26419/ppi.00073.000.

[ii] Stephen W. Schondelmeyer and Leigh Purvis, "Rx Price Watch Report: Trends in Retail Prices of Brand Name Prescription Drugs Widely Used by Older Americans, 2017 Year-End Update," AARP Public Policy Institute. Washington, DC, September 2018.

[iii] Ibid.

[iv] Based on the price associated with taking four widely used brand name prescription drugs. Income is based on median person-level income.

[v] Among 19-64 year old population. State Health Access Data Assistance Center (SHADAC) analysis of National Health Interview Survey data, State Health Compare, SHADAC, University of Minnesota, statehealthcompare.shadac.org, Accessed September 5, 2019

[vi] Stephen W. Schondelmeyer and Leigh Purvis, "*Rx PriceWatch Reports*. Washington, DC: AARP Public Policy Institute, June 2019. https://doi.org/10.26419/ppi.00073.000.

[vii] Federal Drug Administration. "Why You Need to Take your Medications as Prescribed or Instructed". February 16, 2016. https://www.fda.gov/drugs/special-features/why-you-need-take-your-medications-prescribed-or-instructed#:~:text=Taking%20your%20medicine%20as%20prescribed%20or%20medication%20adherence%20is%20important,important%20part%20of%20medication%20adherence. Accessed August 26, 2020

[viii] AB 824 (Wood), Chapter 531, Statutes of 2019. A Pay for Delay agreement allows drug companies to pay competitors to delay creating and selling less expensive generic equivalents of their brand-name medications.

[ix] Executive Order N-01-19, dated January 7, 2019. https://www.gov.ca.gov/wp-content/uploads/2019/01/EO-N-01-19-Attested-01.07.19.pdf.

[x] SB 17 (Hernandez), Chapter 603, Statutes of 2017.

August 2020

CALIFORNIA'S

Master Plan for Aging

Goal 4: Economic Security, Safety & Emergency Preparedness

We will have economic security and be safe from abuse, neglect, and exploitation throughout our lives.

Ana Acton, Janny Castillo, Andy Imparato, Vivian Kwok, Darrick Lam, Vivianne Mbaku, Christina Mills, Trinh Phan, Kevin Prindiville, Patti Prunhuber, Claire Ramsey, and Nari Rhee.

Table of Contents

Introduction

As we age, we all deserve to be economically secure and to be safe from abuse, neglect, exploitation and the harms of natural disasters and other emergencies. If our basic security and safety needs are not met—in a way that also ensures our dignity and self-determination—we will not be able to achieve the other, laudable and important goals of the Master Plan for Aging.

The recommendations for Goal 4 fall into three broad categories, with several subcategories under the first category.

1. Economic Security

   A. Economic Security for All

   B. End Poverty, Hunger and Homelessness

   C. Expand Work Opportunities

2. Elder Justice & Abuse

3. Emergency & Disaster Preparedness & Response

Economic Security

Economic security addresses the need we all have for sufficient income and assets to meet basic needs like health care, housing, and food. It provides the foundation a place to live and healthy food to eat, and it provides the foundation needed for each person to achieve each of the Master Plan goals. To ensure a California for all, this foundation needs to be strengthened for low-income seniors and people with disabilities.

Unfortunately, for Californians of all ages, economic insecurity is on the rise. Extreme income inequality has created a situation where a relatively small number of people have historically high levels of income and wealth, while large numbers of families struggle to afford housing and other basic necessities. This is also true for older adults and people with disabilities.

Per the California Elder Index, more than one quarter (26%) of all older adults in California do not have enough income to meet their basic needs, with nearly half (46%) of older adults living alone unable to meet the basic needs threshold.

Older adults from communities of color are at higher risk of economic insecurity as they age. While about 1 in 4 white older adults in California have income less than 200% of the federal poverty level, about 1 in 3 Asian older adults and over 40% of Latino (43%), African American (41%) and Native American (42%) older adults fall below the threshold for 'poor' or 'near poor.'[1] Rates of economic insecurity are also higher for older women, older immigrants, older people with disabilities and LGBTQ older adults.

---

1   See, *Demographics & Economics of Aging in California*, Steve Wallace, Center for Health Policy Research, UCLA at https://ccoa.ca.gov/Initiatives/Elder_Economic_Forum.

These groups face higher risk of economic insecurity because of the discrimination—racism, sexism, xenophobia, ableism, homophobia—they experience throughout their lives, resulting in disparate access to education and employment opportunities and lower wages while working.

Disparities in income security in older age are closely related to gender and racial wealth inequality, also known as the women's wealth gap and the racial wealth gap. In addition to having higher incomes, older men and white older adults typically have more wealth—assets and savings—than older women and older adults of color.

Improving the economic security of older adults and addressing these disparities and inequities will require a lifespan approach. Such an approach will necessarily include policies that allow all people—especially women, people of color, immigrants and LGBTQ people—to earn and save more of their income while they are working. It must also include policies that better support those older adults who are aging without enough income to meet their basic needs, including policies that boost retirement income and provide support for basic needs like housing, health care and food.

This report provides three sets of recommendations to improve economic security as we age. The first section outlines recommendations for increasing retirement security by supplementing retirement income and savings while making health and long-term care more affordable. The second section offers recommendations for ending poverty, homelessness and hunger for older adults and people with disabilities in California. The third section offer strategies for expanding work opportunities for older adults and people with disabilities.

Economic Security for All

Background

Economic insecurity for older adults in California is driven by a combination of inadequate retirement income and the rising costs in spending categories that make up a higher proportion of older adults' budgets—in particular the rising costs of housing, health and long-term care. People with disabilities face similar challenges with inadequate support from income security programs and high costs related to health and long-term care throughout their lives, including when they are older.

Retirement security has traditionally relied on three pillars: personal retirement savings, defined benefit pensions and Social Security. Unfortunately, two of these sources are becoming less and less available to most Americans and the third, Social Security, needs to be expanded to meet the rising expenses facing middle-income older adults.

Across the country personal retirement savings rates are low. Nearly half (48%) of all households headed by someone aged 55 and older had no retirement savings. Low savings rates are driven by low real wage growth and rising health care costs that leave low- and middle-income Americans with little income to save for the future.

Low rates of retirement savings come just as the availability of public and private pensions are declining. Fewer and fewer workers have any defined benefit pension available to

them. Even those who have earned pension benefits are at risk of losing them as public and private employers seek to alter the terms and decrease the payments provided by those pensions.

Longstanding employment discrimination and the shift from tradition, employer-based pension to 401(k)s has increased gaps in retirement preparedness based on race, ethnicity and gender. The result is an economic disaster for lower-income (and many middle income) Black, Hispanic, non-college educated and single workers, who are nearing or entering retirement with inadequate retirement savings.

The decline in retirement savings and pension benefits is leaving more older adults increasingly reliant on Social Security. Social Security is the most successful anti-poverty social insurance program in the world, lifting more than 21 million Americans out of poverty each year. An increasing share of older people across the country rely on the program for the majority of their retirement income. About half of older adults rely on Social Security for half of their income, and about 1 in 4 rely on Social Security for 90% of their income.

The reliance on Social Security is even higher for older adults from racially and ethnically diverse communities. For example, among African American older adults, 35% of elderly married couples and 58% of unmarried older people rely on Social Security for 90% of their income. The average monthly Social Security benefit in 2019 was just $1,438 per month, or $17,251 per year.

The crisis of insufficient retirement savings and income is exacerbated by rising health and long-term care costs for older adults and people with disabilities. Older adults and people with disabilities spend on average a higher portion of their overall income on these expenses compared to younger and non-disabled people. Medicare is a wonderful health care program, but there are many gaps in coverage and out of pocket expenses that require older adults and people with disabilities to incur significant health and long-term care costs each year. In 2016, the average Medicare beneficiary spent $5,460 on out-of-pocket health care costs.

For individuals who have long term care needs, the expenses are overwhelming for all but the wealthiest families. In 2012, the average cost of private room in a nursing facility was over $80,000 a year; a home health aide was over $43,000 a year.

While housing issues are broadly covered in the Goal 2 recommendations, it is critical to note that many older adults spend a significant portion of the income on housing costs. In California, about 1.3 million households age 65 and over are housing cost burdened, paying more than 30% of their income for rent. Of those households, over 700,000 pay more than half of their income toward housing costs.[2]

To address these issues, California should adopt policies that preserve and boost retirement savings and income and that help older Californians and people with disabilities cover housing, health and long-term care costs.

---

2   "Housing America's Older Adults 2019: Data," Joint Center for Housing Studies of Harvard University. 2019. Available at: https://www.jchs.harvard.edu/housing-americas-older-adults-2019.

RECOMMENDATIONS FOR ECONOMIC SECURITY FOR ALL

1. Increase incentives and opportunities to save for retirement by adopting several modifications to the CalSavers program.

The CalSavers program is a retirement savings program created by the Legislature in 2016 to respond to the fact that most working age adults have no retirement savings, and millions of Californians lack a way to save for retirement at their job. Most employers who do not offer their own retirement or pension plan will be required to offer this option by 2022. The savings plan sets up an automatic, voluntary contribution of 5% of earnings, with employees allowed to "opt out" of the program. Early launch results indicate that when the CalSavers program is offered through the workplace, 70% of workers choose to participate, even though contributions are solely employee-funded. CalSavers can offer an important way for workers to more easily save for retirement, but several modifications are necessary for the program to reach its potential.

a. Add systematic enforcement of the employer mandate in SB 1234 starting in 2023 as part of the recommendations for CalSavers.

CalSavers' enabling legislation, SB 1234 (2016), has two critical features: first, an employer mandate requiring firms that do not offer their own retirement plan to participate in the state-sponsored auto-IRA, and second, auto-enrollment of eligible employees. The combination of these two provisions is necessary to broadly expand retirement plan coverage in a way that opt-in and marketing-only approaches demonstrably cannot. These features are also necessary to achieve the economies of scale that make low program fees sustainable.

Marketing and outreach are an appropriate focus during the launch phase, which will continue through summer or fall 2022, when the smallest firms covered by SB 1234—down to five or more employees—are required to register for the program. A carrot approach is particularly appropriate while employers and workers become acclimated to the program's existence and while the state is defending the program against legal challenges backed by a hostile Trump Administration. After this last deadline passes, however, the state should focus on identifying non-compliant employers starting with the large firms with 100 or more employees. These firms are currently required to register with CalSavers by September 2020.

Ultimately, CalSavers is unlikely to reach the scale that was projected in the original feasibility study, and a large share of eligible workers will not have the opportunity to save for retirement, unless the state eventually enforces the employer mandate systematically. Complaint-driven enforcement will not be adequate. SB 1234 already has provisions for financial penalties for non-compliant employers. CalSavers should work with EDD and the Division of Labor Standards Enforcement to develop a rigorous enforcement protocol to be implemented starting 2023 at the latest to ensure that every eligible worker has the opportunity to save for retirement—as intended by SB 1234.

b. Amend SB 1234 to cover employees who are excluded from their employer's retirement plan, e.g., because they don't meet plan eligibility rules related to hours worked or length of service.

Even after full implementation of CalSavers and SB 1234, a significant group of workers still will not have access to a workplace retirement savings. SB 1234 exempts firms that offer a retirement plan to any of their employees. But under federal law, firms like WalMart can—and do—exclude workers who work part-time and/or those who have worked for the company for less than one year. This effectively cuts out most of their frontline workforce. Of the three states that offer a state-sponsored IRA, Oregon Saves has the most expansive policy, covering all workers who do not have access to a retirement plan, subject to minimum hour and service thresholds that are more inclusive than federal (ERISA) thresholds. California should follow suit and expand SB 1234 to workers who are ineligible for their employer's retirement plans.

c. Explore options for CalSavers to add an open Multiple Employer Plan (MEP) that can receive voluntary employer contributions as a sidecar to CalSavers Individual Retirement Accounts (IRAs).

Employer contributions are important to help workers build a retirement nest egg, but federal regulatory constraints make it impossible for the CalSavers auto-IRA program to receive even voluntary employer contributions. However, it is possible to set up a sidecar program—an open Multiple Employer Plan (open MEP) for which employers, especially small employers, can voluntarily sign up and to which they can contribute. Massachusetts currently operates a successful open MEP 401k (Massachusetts CORE Plan) for nonprofit organizations with less than 20 employees. Due to economies of scale, CORE charges significantly lower fees than average for this employer size class. Open MEPs can be structured to require auto-enrollment of employees by participating employers, which helps minimize fees. An open MEP attached to CalSavers could offer the same low-cost investment options that CalSavers already offers.

2. Expand outreach and encourage enrollment into the CalABLE program to allow people with disabilities to save for future expenses without jeopardizing eligibility for income and health care programs.

People with disabilities are disincentivized to save money for future expenses, including retirement, by Medi-Cal and SSI program eligibility rules which require individuals to have limited or no assets to qualify. The CalABLE program, the state's version of a program created under federal law, now allows qualifying people with disabilities to save up to $100,000 without risking eligibility for these programs. More outreach and marketing of this program is needed to ensure that more people enroll and take advantage of this program. State leadership and members of Congress should also support federal legislative efforts to expand eligibility for the program.

3. Monitor income replacement and changes in the standard of living for the bottom-third and middle-third of California retirees in relation to pre-retirement standards, taking into account sources and composition of income (Social Security, pensions, income from assets, housing tenure and housing wealth, and public assistance).

Downward economic mobility is a significant concern for many middle-income workers heading into retirement today. There is already evidence of a sagging middle. Median household net worth, measured as a multiple of annual income, has stagnated across age brackets over the last two decades. This is concerning because households need to accumulate greater private financial assets to compensate for increased life expectancy, the increase in the Full Retirement Age for Social Security benefits, and declining traditional pension coverage.

To make matters worse, middle class seniors' capacity to supplement Social Security with earnings is constrained by marked labor market polarization. Jobs held by seniors are concentrated in elite professional occupations—lawyers, professors, dentists—and low-wage service occupations—drivers, retail clerks, and cleaners.

Large-scale downward mobility of middle-income retirees—borne through significantly reduced spending—poses negative fiscal and economic implications for the state. (See for example Pennsylvania Treasurer's Office study on impact of insufficient retirement savings on state budgets.) While we are used to seeing downward mobility in later retirement—evidenced by higher poverty rates among those age 80 and older—private asset spend-down and impoverishment is likely to happen sooner with late baby boomers. This issue warrants close study at the state and national level as it will be a significant change from previous decades.

4. Defend and adequately fund public employee pensions. Ensure continued progress towards a full funding policy for CalSTRS.

Pensions may be declining, but they warrant protection as the last bulwark of middle-class retirement security. A significant minority of older middle-class households has the retirement asset trifecta—Social Security, pension, and a private nest egg—necessary to support middle-class retirement income security. These households generally have at least one member who worked for a significant period in the public sector or in the unionized private sector.

Traditional pension income also generates fiscal and economic benefits by supporting local consumer spending.

Pensions contribute to greater retirement equity by income, race, and gender compared to 401(k)s. The 401(k) based system has had the unintended consequence of contributing to increasing financial inequality in the US—by income, wealth, and race—through differential access, participation, and contribution. In contrast, public employee pensions are particularly significant for middle class black households. Traditional pensions also soften the impact of gender inequality. Its backloaded benefit structure reduces the early career caregiver penalty compared to 401(k)s. While women are generally worse off than men in retirement income, women's retirement security is uplifted by pensions from employment in education, healthcare, and government. In California, CalSTRS received

inadequate contributions until the state enacted a plan in 2014 to fully fund teacher pension 32 years. Since then, CalSTRS has increased its cost estimates through revised actuarial assumptions. This year, there is a partial funding holiday in response to the fiscal crisis caused by the COVID-19 pandemic. After the crisis is over, the state should commit to an updated full funding policy for CalSTRS to ensure the retirement security of the state's teachers, the vast majority of whom have put in at least 20 years of service by the time they retire.

5. Explore potential policies to create a layer of secure retirement income to compensate for inadequate Social Security benefits and declining defined benefit pension coverage in the private sector, including but not limited to a secure income option for CalSavers and the State Supplemental Social Security (which is different from SSI) proposal from Economic Opportunity Institute.

California should undertake a study of the feasibility and the impact of a state program that would supplement federal Social Security payments for all workers. California currently provides a supplement to SSI recipients, who are low-income older adults and people with disabilities (see discussion below). As with Social Security, the state supplemental payments could be funded by a payroll tax on employers and employees.

6. Reduce health care costs for older adults and people with disabilities by expanding Medi-Cal eligibility and enrollment commensurate with other populations, including for undocumented populations.

The Master Plan offers an opportunity to make health care more affordable for older adults and people with disabilities by improving access to the Medi-Cal program. Medi-Cal provides health insurance coverage to more than 1.2 million low-income older adults in California and is critical to ensuring that older adults have access to the services that help them remain living in their homes and communities. Yet, Medi-Cal is not accessible to all low-income individuals, and the program's eligibility rules force seniors to live in deep poverty in order to receive services—this is particularly true for older women, immigrants, and populations of color who are more likely to rely on Medi-Cal.

Below are eight recommendations to make the Medi-Cal program more affordable, accessible, and equitable for older adults and people with disabilities.

a. Expand Medi-Cal Coverage to Undocumented Older Adults

Undocumented adults in California are aging. Currently, ten percent are estimated to be older than 55. Because undocumented older adults have typically lacked access to health care coverage throughout their lives, when they seek treatment it is through costly emergency room visits or when their conditions have become serious. Ensuring that undocumented seniors and people with disabilities can count on routine and preventive medical care is vital to their well-being and long-term health. California should continue its successful efforts toward universal health care coverage by becoming the first state in the nation to remove immigration status as a barrier to full-scope Medi-Cal for all income eligible undocumented adults, including those aged 65 and older.

b. Increase the Medi-Cal Aged & Disabled Asset Limit

Medi-Cal's outdated asset test forces seniors and people with disabilities into deep poverty, disproportionately impacting seniors of color. Most older adults and people with disabilities enrolled in the Medi-Cal program are restricted to $2,000 in a bank account and a couple to $3,000. These limits have not changed since 1989. The current asset limit prevents people from having adequate resources to weather a crisis, such as an eviction, a leaking roof, or a vehicle repair. Forcing older adults and people with disabilities into poverty puts them at risk of foregoing needed services and homelessness.

Furthermore, the current asset test contains exemptions that aren't even updated in the regulations so many applicants don't know what they can exclude. The largest exemption, the home, advantages white applicants, who have higher rates of homeownership due to decades of discrimination in banking and housing. Increasing the asset limit will ensure more people of color have access to Medi-Cal.

California should increase the asset limits for most Medi-Cal programs to $10,000 for an individual and $15,000 for a couple with annual indexing and expand and simplify the list of excluded assets. Raising the Medi-Cal asset limit, as many states have done, and simplifying asset counting rules will significantly increase the financial stability of seniors and people with disabilities.

c. Eliminate the Asset Limits for Medicare Savings Programs

For many low-income older adults and people with disabilities, Medicare is not affordable without help from a Medicare Savings Program. For those in a Medicare Savings Program, Medi-Cal pays all or part of their Medicare premiums, deductibles, and co-pays. These critically important programs reach more than 43,000 people with Medicare in California who are too poor to be able to afford Medicare but do not qualify for other Medicaid programs. Currently, the asset limits are $7,730 for individuals and $11,600 for couples.

To increase the number of seniors and people with disabilities who can access Medicare Savings Programs, California should eliminate the asset test entirely. More than one third of California's seniors live above poverty—and therefore are ineligible for public benefits—but are too poor to afford their most basic needs. Eliminating the asset test will increase the affordability of Medicare and help improve the economic security of Californians who don't qualify for full-scope Medi-Cal programs.

d. Increase the Monthly Medi-Cal Maintenance Need Income Level

When a senior or a person with a disability has even a small increase in their income, it can negatively affect their Medi-Cal by making them pay a high share of cost. A share of cost is the difference between a beneficiary's countable income and the Maintenance Need Income Level, which is a fixed monthly amount that is supposed to be sufficient to cover basic living expenses, such as rent, food, and utilities. In California, the monthly Maintenance Need Income Level is $600 for an individual and has not changed since 1989. Any income a person earns over $600 in a month becomes that individual's share of cost. So, for example, a senior or person with a

disability with a monthly income of $1,300 would have to pay $700 for their health care before Medi-Cal begins paying for services, leaving them with just $600 a month to live on.

California should increase and annually index the monthly Maintenance Need Income Level to ensure that the Medi-Cal share of cost is affordable for low-income older adults and people with disabilities. Six hundred dollars is not enough to cover the necessities of life in California, thus it forces seniors to choose between food and rent or health care.

e. Make Spousal Impoverishment Protections for HCBS Permanent

Married seniors and adults with disabilities overwhelmingly want to live at home and age in place. To make this happen, Medi-Cal rules have to prioritize home and community-based services, which allow people to stay in their homes and in their communities. Congress helped these efforts by expanding a Medicaid eligibility rule, known as the spousal impoverishment protection, to individuals eligible for home and community-based programs. The protection makes it possible for an individual who needs a nursing home level of care to qualify for Medi-Cal while allowing their spouse to retain a modest amount of income and resources. While this protection is permanent for a spouse in a nursing facility, the expansion of the spousal impoverishment protection to home and community-based services is set to expire on November 30, 2020, unless Congress acts. To ensure Californians do not lose access to this important eligibility rules, California should make the spousal impoverishment protection permanent.

f. Increase Nursing Home Personal Needs and Home Upkeep Allowances

People on Medi-Cal who live in a nursing facility are only allowed to keep $35 of their income per month, an amount that has not changed since 1985. The rest of their income must be paid to the nursing facility for their care. This is too little to pay for essential items a resident might need that are not provided by the facility, such as clothes and personal care items. California should increase the personal needs allowance to at least $80 per month.

Additionally, individuals on Medi-Cal who must temporarily live in a facility are at risk of losing their home because their Medi-Cal share of cost does not leave them with sufficient funds to pay their mortgage or rent. The Home Upkeep Allowance was created to help solve this problem by allowing a person to keep some of their income to maintain their home while they were temporarily in a facility. Currently, the Home Upkeep Allowance is only $209 per month—too low to actually ensure anyone can pay their rent or mortgage while in a nursing home. California should increase the home upkeep allowance to at least $1,000 per month to ensure people have a home to return to after a short nursing facility stay and also revise the rules to allow people who may not yet have a home to begin saving so they are not released to the streets.

g. Simplify Medi-Cal Renewal Process for Medi-Cal Aged & Disabled and Enrollment in Medicare Savings Programs

When the Affordable Care Act was implemented in California, the application

and renewal processes for Medi-Cal were simplified. One key simplification was the statutory requirement to use pre-populated renewal forms and notices. When a county eligibility worker checks available eligibility information, such as federal and state databases and other information in an individual's case file, the worker sends a renewal notice to those individuals who appear to remain eligible with the information used to make the determination. To those for whom more information is needed, a prepopulated renewal form is sent with all of the available information filled in.

Unfortunately, this system was only implemented for populations using the Affordable Care Act income counting rules known as "Modified Adjusted Gross Income." Most seniors are excluded from this system and still use the old Medi-Cal rules. However, they too would benefit from pre-populated renewal forms, particularly those on fixed incomes whose circumstances rarely change. Further, since most seniors are still subject to the asset test, California should implement self-certification of assets, particularly at renewal.

California should also ensure all counties are properly screening Medi-Cal beneficiaries for eligibility and enrollment in Medicare Savings Programs (MSPs). Today, only 67 percent of those eligible in California are enrolled. California also has not entered into a Part A buy-in agreement with Social Security, which provides an addition barrier to enrollment in MSPs. A buy-in agreement would simplify enrollment into an MSP for people without free Part A. It would prevent gaps and delays in Medicare coverage by allowing these individuals to enroll in Medicare throughout the year without being limited to a standard enrollment period. This is particularly important for women and immigrants who are less likely to qualify for free Part A in Medicare. California is one of only 13 states that still have not entered into a Part A buy-in agreement. This change, which would also streamline state program administration, is long overdue.

h. Index All Medi-Cal Eligibility Changes Recommended Above

Many of the problems described above were created because California set a fixed dollar amount as part of its Medi-Cal eligibility rules and never indexed the dollar amount to increase over time. Because of inflation, fixed dollar amounts lose ground over time and are not worth as much as when they were originally set. Simply raising the dollar amounts again will perpetuate this problem. Instead, California should ensure that when improvements involving dollar amounts are made, whether that be an income or asset limit, those improvements should contain a mechanism for indexing increases over time.

7. Reduce long term care costs for older adults, people with disabilities, and their families by adopting the LTSS recommendations to expand current Home and Community Based Service (HCBS) programs and to create a statewide universal long-term care benefit.

As the older adult population in California grows, the need for affordable HCBS programs will only increase. Additionally, COVID-19 has exposed and exacerbated the risk of living in congregate settings. To ensure older Californians have real choices so they can age safely in their community and with dignity, California must expand its HCBS programs as well as invest in a statewide universal long-term care benefit. These proposals are

described in-depth in the MPA LTSS Report dated May 2020. Enacting these solutions will help ensure that do not have to spend down all their savings to pay for HCBS by providing for more Medi-Cal funded HCBS and for a social insurance LTC benefit.

End Poverty, Hunger, Homelessness

Background

California has the second highest rate of poverty among older adults in the country. Per the Supplemental Poverty Measure about 20% of people 65 and over in California (over 1 million people) live in poverty. As with the economic security data summarized above, there are significant racial, ethnic and gender disparities in who is aging into poverty in California and across the nation. Women, Black, Latinx and immigrant older adults are more likely to age into poverty than white men due to numerous systemic barriers—including racism, sexism, xenophobia and other injustices—that these communities face to education and employment opportunities throughout their lives.

California greatly exacerbated its senior poverty crisis by cutting, during the last recession, the State Supplementary Payment (SSP) that augments the federal payments made to low income older adults and people with disabilities under the Supplemental Security Income (SSI) program. SSI is a federal program that provides a very basic income for 1.2 million older adults and people with disabilities in California who have little to no income or resources. Due to the cuts, which were never restored, SSP/SSI benefit levels are now so low that they do not cover the cost of a studio apartment, food and healthcare in any county. For those who can obtain below-market rent, grants are still insufficient to meet basic needs for utilities, food, medicine, toiletries, clothing and other necessities that higher income Californians take for granted.

The high rate of senior poverty in the state has led to increasing levels of food insecurity and homelessness among older people as well.

Based on data from the UCLA Center for Health Policy Research, before COVID-19, nearly forty percent of low-income California seniors are food insecure, representing a twenty-one percent increase in the last fifteen years. Rates of food insecurity are significantly higher among Latinx, Black, and Asian communities than among white elders. Access to affordable and culturally appropriate healthy food is a foundational component of health and well-being for all ages, particularly for seniors and people living with disabilities. The lack of access to consistent, nutritious food brings significant negative health consequences, especially in later life.

Food insecurity among older people is exacerbated by the fact that many of the food access and nutrition programs that could improve food security and nutrition security among older adults are severely underutilized. Nationally, home-delivered and group meals have decreased by nearly 21 million since 2005, according to a Kaiser Health News analysis of federal data. Only a fraction of those facing food insecurity get any meal services under the Older Americans Act; a U.S. Government Accountability Office report examining 2013 data found 83% got none. This is especially painful because connecting older adults to food assistance through programs like CalFresh achieves tremendous

gains, annually saving more than two thousand dollars in healthcare expenditures and lowering the likelihood of admission to a hospital (-14%) or nursing home (-23%).

California's high senior poverty rate is also linked to the rising numbers of homeless older adults in the state. Adults over age 55 are the fastest growing population of homeless persons in many parts of California.[3] Because many have limited opportunity or ability to work, they rely on a fixed income. As housing costs continue to rise across the state, they are forced to pay a higher share of their limited income towards housing. This makes it hard for them to save and leaves them more susceptible to losing their housing.

Older homeless adults have medical ages that far exceed their biological ages. Research has shown that they experience geriatric medical conditions such as cognitive decline and decreased mobility at rates that are on par with those among their housed counterparts who are 20 years older. As a result, health care and nursing home costs are likely to increase significantly over the next 15 years.[4]

The Master Plan should include a goal and set of integrated policies that prioritize ending poverty, hunger and homelessness among California's older, low-income adults. Most, if not all of the policies adopted in pursuit of this goal will also benefit younger people with disabilities.

RECOMMENDATIONS TO END POVERTY, HUNGER AND HOMELESSNESS

1. Commit to ending poverty, hunger and homelessness among older adults and people with disabilities.

One of the overarching goals for the Master Plan for Aging should be to end senior poverty, hunger and homelessness. Together, these recommendations bring us closer to the goal of all seniors and people with disabilities having the security of enough income to meet their basic needs, access to consistent and nutritious food, and a safe home.

2. Adopt and regularly update the California Elder Index, using it to inform program eligibility and benefit levels, design interventions, and measure success.

Public programs that low-income elders and people with disabilities depend on to make ends meet often base their income eligibility on the Federal Poverty Level (FPL) guidelines, which do not take into account higher health care costs incurred or the local cost of living—a significant disadvantage in a high-cost state such as California. The California Elder Index, a more accurate measure of poverty that takes into account local conditions, shows that seniors need approximately twice the FPL to meet the cost of their basic needs. Using the California Elder Index will ensure that income eligibility for our public programs reflects the real costs faced by seniors and people with disabilities in the state.

3. Increase the state portion of the SSI grant to an amount that reflects the real costs of

---

3   Culhane, Dennis et al., "*The Emerging Crisis of Aged Homelessness: could Housing Solutions Be Funded by Avoidance of Excess Shelter, Hospital and Nursing Home Costs?*" 2019

4   Culhane, Dennis et al., "*The Emerging Crisis of Aged Homelessness: could Housing Solutions Be Funded by Avoidance of Excess Shelter, Hospital and Nursing Home Costs?*" 2019

living for seniors using the [California Elder Index](#).

The cuts to the state supplement to the SSI grant that were made during the recession (mentioned above) have never been restored, leaving low income seniors and people with disabilities struggling to survive with an income far below the real cost of living in our state and pushing more people into homelessness. We can change this harmful trajectory by investing in SSI/SSP so that seniors and people with disabilities who receive SSI/SSP can live and grow old safely and with dignity.

Beyond the moral imperative, investing in SSP and enabling older adults to have a modest income sufficient to meet basic needs will also stimulate the economy in our communities that need it most. According to the IMPLAN economic analysis, every $10 million in increased State Supplementary Payments supports $15 million in economic output (a multiplier of 1.50), creates 93 jobs, and returns $0.9 million in state and local tax revenues.

4. Make the cost of living adjustment for the SSP mandatory and calculate it based on the full SSI/SSP grant.

The benefits meant to support those with the greatest need should be protected from erosion as a matter of course. The recession-era cuts were exacerbated by California's failure to provide annual cost of living adjustments (COLA) to the SSP grant, causing SSI/SSP recipients to experience an additional cut as grants lost their value to inflation. To ensure that the SSP grant can keep up with the rising costs of housing, food, and other basic needs, the SSP COLA should be provided automatically and should be calculated based on the full SSI/SSP grant.

5. Expand outreach to ensure that all immigrants who are eligible receive Cash Assistance Program for Immigrants (CAPI) benefits.

CAPI provides state-funded benefits for certain immigrants who previously would have been able to receive SSI, but are no longer eligible for SSI due to federal welfare legislation that placed restrictions on non-citizen eligibility in 1996. Lack of outreach has meant that individuals who qualify for the program and community organizations who may be able to help them do not even know that the program exists. Expanded outreach can help this program, created by California in the face of federal attacks on immigrants, meet its promise of providing economic security to immigrant seniors and people with disabilities.

6. Work with stakeholders and the Social Security Administration to improve the customer experience and outcomes for individuals applying for disability benefits.

The state has an interest in ensuring access to federal disability benefits for those who qualify, and the state Disability Determination Services agency plays a critical role in that process by determining disability for Social Security benefits at the first two decision-making levels. It can take years for people with disabilities to make it through the SSI application process and be approved, during which time they face the real risks of getting sicker, depleting their savings, and becoming homeless.

The barriers are particularly high for individuals who do not have the capacity to manage a complicated administrative process, whether due to a disability or due to

circumstances such as having few financial resources, limited education, access to transportation, or limited family and social connections. Increasing the quality of the application process will help people eligible for disability benefits qualify more quickly.

7. Fill the hole in the safety net represented by the current woefully inadequate General Assistance (GA) benefit.

GA is an important bridge program to SSI for people with disabilities while they are applying for SSI disability and to older adults before they become age-eligible for SSI. A robust GA program is therefore a critical part of the safety net. However, the current GA benefits are woefully inadequate as they are based on an ancient funding standard of 40 percent of the 1991 federal poverty level for a single person. Additionally, counties are permitted under state law to limit GA to three months out of twelve. Having higher benefit amounts, increased eligibility for assistance or having the state take over the GA program with more robust benefits and eligibility are critical to filling the hole in the safety net.

In addition, increasing the flexibility of the Housing and Disability Advocacy Program to allow for cash payments rather than having funding be exclusively restricted to housing assistance would make the GA program more effective. Cash payments would help these extremely low-income individuals, who are likely eligible for SSI and applying for disability benefits, to pay for utilities and other basic costs that are not included in the housing assistance.

8. Support efforts at the federal level to expand SSI and Social Security.

SSI and Social Security provide a foundation of economic security for 6.8 million Californians. Bolstering these programs at the federal level would ensure a more secure baseline for developing state-level policy.

When SSI was signed into law in 1972, it promised to serve as a safety net for those who (through disability or age) were unable to work and had little to no pension, savings, or Social Security benefits. However, important aspects of the program have not been updated in more than 40 years, leaving some of our country's most vulnerable seniors and people with disabilities deeper in poverty today than they were then, without the ability to budget appropriately. This inequity can be corrected by updating income and asset limits to better reflect reasonable assistance in today's dollars, such as increasing the general income disregard to $123 (currently $20), increasing the earned income disregard to $399 (currently $65), and increasing the resource limit to $10,000 for an individual and $20,000 for a couple (currently $2,000/$3,000).

As the main source of income for the majority of retirees, Social Security retirement, survivors', and disability insurance should also be expanded and improved to better meet our needs as we age, such as by providing a minimum benefit that is 125% of the poverty level, using a more accurate cost-of-living measurement that takes into account rising health care and housing costs that have a significant impact on the budgets of older adults, and paying for these improvements by having wealthy Americans pay their fair share of Social Security taxes.

9. Maximize participation in CalFresh by older adults, and all eligible Californians.

CalFresh benefits are 100% federally funded, and as the nation's largest anti-hunger program represents the single greatest opportunity to reduce hunger, improve health, and support local economies. The Master Plan comes at a key time in the historic CalFresh Expansion to SSI (the "Expansion"), with 400,000 SSI consumers enrolled since June 2019. There is still much work remaining to fully realize this policy, and among non-SSI older adults, California's participation badly lags the national average (19% vs. 42%). Fulfilling the Expansion should start by meeting enrollment targets and re-assessing those targets to enroll all newly eligible SSI recipients into CalFresh, as national analyses suggest that this population is about 800,000 Californians. Further strategies should include: enabling application and recertification over the phone, and providing flexible interview options in all counties (telephonic signature access); adopting all elements of the Elderly Simplified Application Project to minimize burdens on applicants and counties; leveraging the agency partnerships established through the Expansion to expand and continue CalFresh outreach and broader collaboration across the agencies that serve the same older adults and people with disabilities; and sustaining effective efforts pioneered in the Expansion, such as IHSS social workers providing CalFresh information, to encourage cross-program coordination.

The Plan should also address language inequities that are one reason for low enrollment among California's older adults. This means ensuring robust, real-life translation and language resources, including ensuring that CalFresh application and recertification are supported in all threshold languages spoken by older adults and people with disabilities. According to a 2019 report, addressing language inequities is at the heart of improving CalFresh participation.

10. Ensure that the two hold harmless programs created when SSI cash-out ended truly protect households from losing CalFresh benefits.

The state should use the past year's experiences with the Expansion to review the Supplemental & Transitional Nutrition Benefits and ensure that they truly hold harmless the highly vulnerable older adults and people with disabilities and their families from losing food aid because of the Expansion. This would be achieved by adjusting benefits from the initial projection to account for actual household losses to the greatest extent possible, and improving the ability of clients to retain benefits in order to prevent churn and the permanent loss of aid due to administrative barriers.

11. Supplement CalFresh for people who do not pay rent and receive only the $16 minimum benefit by raising this minimum benefit to $50 a month.

Unhoused seniors and people with disabilities face the difficult and costly challenge of having enough to eat while living outside. With no refrigerator, cooking facilities or place to store food, and often living in food deserts, they must pay more to purchase enough food. Increasing the minimum CalFresh benefit for those individuals who can't document a shelter cost will support the ability of older adults experiencing homelessness to meet their nutritional needs.

12. Ensure statewide access to other key food and nutrition programs serving older adults.

In addition to CalFresh, there are opportunities to improve food security by expanding the reach of and coordination among the other important food programs serving older adults. Many of these programs are tailored to promote aging with dignity and independence, and prevent costly health care utilization through nutrition as a social determinant of health, including for individuals who have functional and transportation limitations that require fully prepared meals or home delivery of appropriate food and nutrition services.

  a. Home Delivered Nutrition Program ensures that adults have food access in their homes: Invest $17.5 million in new, ongoing funding for Senior Nutrition to provide nutritious meals to an additional 12,000 older Californians.

  b. The Commodity Supplemental Food Program provides food security and community by providing food in congregate settings: Ensure the program is available state-wide, from the current 10 agencies, so that it reaches low-income communities in every county.

  c. The Senior Farmer's Market Nutrition Program is a partnership between CDA & CDFA that provides vouchers for low-income older adults to purchase fresh produce at farmers markets: Provide a 5-fold increase in the number of vouchers, as local agencies report receiving vouchers for only approximately 20% of eligible recipients now.

  d. Senior Brown Bag Programs target free groceries to older adults and people with disabilities at high risk of hunger but who can and want to make their own meals: Triple prior state funding as Brown Bag programs are extremely cost effective. In FY 2009-10, the state issued local providers three months of funding; that funding was never restored, despite restorations to other programs.

  e. Create a Farm to Seniors program to provide locally grown food to seniors. Model the program on the existing Farm to Schools program, which has successfully facilitated institutional purchasing of local food by school districts, to facilitate institutional purchasing of local food by senior-serving institutions like long-term care facilities, skilled nursing facilities, home delivered meal providers and congregate meal sites.

13. Improve data collection and program coordination among food programs serving older adults.

As there are several food programs serving older adults and people with disabilities, administered by multiple Departments, there are excellent opportunities to improve their reach and impact through enhanced data collection and coordination. Data exist on individual programs, but not across programs and Departments, to understand barriers to access in certain regions and among certain languages or other populations, as well as to identify programmatic or policy solutions. The CHHS Open Data portal is an excellent foundation from which improved data collection and analysis could occur, and CDSS has provided a tremendous window into the CalFresh Expansion through their enhanced Data Dashboard.

There is a need for increased coordination between CDSS and CDA, given CDA's administration of Meals on Wheels and Area Agencies on Aging, while CDSS operates CSFP, TEFAP and CalFresh. The COVID crisis has further shown the need to [coordinate with County Emergency Operations Centers](#) to ensure timely, effective response during disasters.

Improving coordination on food access for seniors and people with disabilities, such as sharing referrals and resources, ensures that no matter who the adult approaches for services, programs are aligned to achieve a 'no wrong door' outcome and offer all available options. Such enhanced coordination will also incubate new innovations, such as the Home-Delivered Grocery program that is presently underwritten by San Francisco County. It is an example of potential coordination with IHSS such that IHSS workers can get additional hours to serve as proxies to pick-up groceries for their consumers at nearby food pantries.

14. Provide a rental supplement to very low-income seniors and people with disabilities who have a housing cost burden exceeding 50% of their income.

Preventing homelessness and promoting policies that allow seniors to remain in their homes is both cost-effective and promotes generational diversity in our communities. Many low-income seniors are severely rent burdened, and are unable to meet rising rent costs with their fixed incomes. One highly effective way to prevent people from becoming homeless is for the state to provide a rental supplement for very low-income seniors or people with disabilities whose housing cost burden exceeds 50% of their income. Studies have shown that a person or household that pays more than 50% of their income toward rent or housing costs, is precariously housed; it takes only one emergency or unexpected bill to cause them to lose their housing. The amount of the supplement would be modest, much less than a full subsidy, but by providing enough income to keep the person housed, this homelessness prevention measure leads to substantial savings. Both Los Angeles County and the City of Santa Monica have successfully piloted similar rental supplement programs targeted to very low-income renters with high rent burdens as an effective means of preventing homelessness and displacement, with Santa Monica's program specifically targeting seniors and LA County's program setting aside 20% of its slots for seniors. In order to maximize the ability to preserve existing tenancies, these rent supplements should be available to low-income renters who are severely rent burdened, before the landlord has initiated eviction proceedings.

The state can identify those in greatest need of help with housing costs through existing programs, particularly CalFresh. Now that California allows SSI recipients to apply for CalFresh, 400,000 recipients have newly enrolled. To determine the CalFresh grant amount each applicant provides to the county the cost of their housing. Those with high housing costs get higher CalFresh grants. Thus the state has an existing database that identifies those seniors and persons with disabilities who are severely rent burdened and could target assistance to those most at risk of becoming homeless. The state should also use CalFresh data to do further targeting, such as by identifying all SSI recipients claiming the CalFresh homeless shelter deduction and helping them get permanent affordable housing and providing rental assistance if needed.

15. Expand the number of assisted living units—using Medi-Cal and other state and federal funding to make more units affordable to extremely low income, disabled seniors.

Assisted living units can be a positive model for older adults who need some level of assistance with personal care and daily living. However, many of these units are currently too expensive for extremely low income, disabled seniors. During the pandemic, increase safety precautions for seniors entering and living in assisted living units, especially individuals with complicated health problems including homelessness.

16. Create a state subsidy program to transition seniors and persons with disabilities experiencing homelessness into a range of permanent, deeply affordable and accessible housing, with wrap-around services.

Providing new, deeply affordable housing options with wraparound services will counteract the expected tripling of the number of older adults (65 and over) expected to become homeless by 2030.[5] It is also needed for people with disabilities who are homeless. This could be modeled after the federal Veterans Affairs Supportive Housing (VASH) program, or the Shelter Plus Care program. VASH combines Housing Choice Voucher (HCV) rental assistance for homeless Veterans with case management and clinical services provided by the Department of Veterans Affairs (VA). Shelter Plus Care is a federal program funded by the U.S. Department of Housing and Urban Development (HUD) designed to provide rental subsidies and supportive services to homeless individuals with disabilities, primarily those with chronic mental illness or high users of medical services.

17. Build upon Project Roomkey to Homekey to accelerate the transition from temporary placement of older adults experiencing homelessness during the COVID-19 pandemic into long-term, deeply affordable housing, with coordinated supportive, medical and case management services.

Project Roomkey has allowed cities and counties to lease hotels and motels to provide temporary, non-congregate shelter to thousands of Californians experiencing homelessness who are most at risk of serious health consequences due to COVID-19, prioritizing those with pre-existing health conditions and those age 65 and over. Project Homekey will extend shelter options, expediting the purchase and conversion of hotels and other existing surplus buildings to move unsheltered or temporarily sheltered seniors into transitional and permanent housing. These initiatives should focus on the unique housing needs of older adults experiencing homelessness, to ensure that any housing that is developed takes into account their mobility restrictions, as well as their needs for assistance with personal care, activities of daily living, social, and medical needs. To successfully navigate this transition to permanent housing, any services that were put in place for an individual temporarily housed in Project Roomkey should follow the person as they move to interim and then permanent housing.

---

5   Dennis Culhane, et al., "The Emerging Crisis of Aged Homelessness: Could Housing Solutions be Funded by Avoidance of Excess Shelter, Hospital and Nursing Home Costs?" Available at: https://www.bcsh.ca.gov/hcfc/documents/white_papers/dennis_culhane-the_emerging_crisis.pdf

18. Ensure In-Home Supportive Services are available to disabled, medically vulnerable seniors who are unhoused, unstably housed, and transitionally or temporarily housed.

Currently, the IHSS program excludes individuals who are living on the street from receiving IHSS. Additionally, individuals in unstable or transitional housing have significant challenges getting on and staying on the IHSS program and some individuals living in shelters experience barriers to receiving IHSS services. This is largely due to the administrative complexity of applying for IHSS and how little assistance is available to support individuals who are at risk. The creation of Project Roomkey has expanded opportunities for providing IHSS for disabled Californians who need help to live independently by giving them a stable, if temporary, place to live. California should work to maximize enrollment in IHSS for people being housed under Project Roomkey and should ensure that those people retain access to IHSS services as they transition to more permanent housing, and even if their access to temporary housing ends.

19. Create a state program to support organized informal settlements, aka encampments.

Support should include access to public land and basic necessities like hygiene, water and trash pick-up with a strong and coordinated exit strategy to the deeply affordable housing described in Numbers 16 and 17. Providing hygiene stations and sanitation services to organized settlements of unsheltered seniors is even more important now because of COVID-19. Quickly identify land where people in settlements can live free from eviction until we provide housing or living situations better than what they have created for themselves.

20. Collect and make available county-level data regarding older adults experiencing homelessness.

The Master Plan should include a detailed plan for robust, transparent, inter-agency data collection and analysis. Data collected should include county-level data on the number and percentage of rent-burdened and severely rent-burdened seniors as they age and by race/ethnicity; the number and percentage of unhoused seniors by race/ethnicity; the number and percentage of temporarily housed seniors by race/ethnicity; and the number of new, deeply affordable permanent housing units created; and the number of those units that meet accessibility standards. Homelessness data should be collected for three age cohorts: those age 55 and over, 62 and over, and 65 and over.

Expand Work Opportunities

Background

One of the most important contributors to economic security for older adults and people with disabilities is work opportunity. California must build an inclusive economy that ensures that people with disabilities and older adults will have an opportunity to work. To have true economic safety and security, California must address the systemic disparities inherent in our workplaces and economy by intentionally advancing solutions that build toward equity.

Life expectancy, financial need, and desire have changed the number and employment trends of older adults in both the paid and unpaid work force. According to the Labor & Workforce Development Agency, older Californians (55+) account for 21% of the civilian labor force. Further, over the past five years the number of employed Californian ages 55+ increased by 449,400. Older Californian workers (55+) accounted for 29% of all new employment since 2014.

The benefits of older workers have not always been included when framing work opportunities. The 50+ segment of the workforce continues to be the most engaged age cohort across all generations. Other advantages of workers age 50+ include their experience, professionalism, work ethic, lower turnover, and knowledge. Additionally, older workers comprise a large portion of the unpaid work force. Trends among older adults (55+) have included a decline in their unemployment rate from 5.7% to 3.3% over the past five years. Workers ages 55+ are employed heavily in the educational and health services; and the professional and business services industries, with over 600,000 employed in each.

Despite the benefits and positive trends, discrimination and ageism plague workplaces and prevent older workers from being hired and retained. Often, older adults are described as economic drains. This is not only ageist it also fails to recognize that older adults are huge drivers of the economy. In 2018, nationwide economic and societal contributions of adults age 50 plus was worth over $9 trillion, and 44% of all jobs were held or created by people age 50 plus. The nationwide economic value of the contributions of adults age 50+ through unpaid activities like adult caregiving, child caregiving, and volunteering was $744.6 billion.[6, 7] Recognizing the economic and societal value of older adults should be part of efforts to reframe the aging conversation to support efforts combating ageism.

In addition to the value to society, work opportunities are also valuable to older adults and people with disabilities. As with other workers, older adults and people with disabilities value work for reasons beyond the income it provides. Good jobs provide access to valuable benefits, such as health insurance and retirement savings plans, that may not otherwise be available or affordable. These benefits (or lack of them) can be an important factor in whether and when a person has the choice to retire from work. Work also provides important opportunities for social engagement and purpose that are crucial for every person's well-being, including older adults and people with disabilities.

WORK OPPORTUNITY RECOMMENDATIONS

1. Measure and assess the need and desire for work opportunities for older adults and people with disabilities with reliable data for informing data-driven solutions that promote equity.

It is prudent to utilize statewide data to explore the landscape of older adults and people

---

6 AARP specific report on the economic impact of age discrimination: https://www.aarp.org/content/dam/aarp/research/surveys_statistics/econ/2020/impact-of-age-discrimination.doi.10.26419-2Fint.00042.003.pdf

7 Longevity Outlook report for reference: https://www.aarp.org/content/dam/aarp/research/surveys_statistics/econ/2019/longevity-economy-outlook.doi.10.26419-2Fint.00042.001.pdf

with disabilities and their work opportunities. California should also develop a strategy for increasing the availability of statewide data that allows for specific examination of disparities in work opportunity for older adults and people with disabilities based on race, ethnicity, class, geography, immigration status, language, religion/faith, sex, gender identity, sexual orientation, and family status.

2. Design and monitor solutions with the specific intent of removing barriers to work for *all* older adults and people with disabilities by recognizing the strengths and assets of each community and the intersectionality of race, ethnicity, class, immigration status, language, religion/faith, sex, gender identity, sexual orientation, and family status.

Using data from the first recommendation, the State will be able to identify communities where there appear to be relatively high and relatively low barriers to employment. In the meantime, through working with community stakeholders, best practices will be identified and adapted for targeting improvement in high-barrier communities. These learnings and best practices will be incorporated into the other recommendations listed below.

3. Expand the reach of proven best practices for supporting older adults and people with disabilities who are currently working, job seeking, or planning for retirement.

California should expand subsidized training, refresher courses, technology training and English language training for older adults and people with disabilities based on proven models, such as the Employment Training & Economic Development program offered by Self-Help for the Elderly which includes the Older Americans Act Title V Senior Community Service Employment Program, and the Integrated Employment Supports to People with Disabilities in Alameda offered by East Bay Innovations. In addition, California should increase support and funding for older workers' classes and workforce training through local city colleges and community colleges, as well as identify supportive work opportunities for formerly incarcerated older adults entering the workforce.

4. Increase sustainable work opportunities for older adults and people with disabilities.

California should create a partnership with the Department of Aging as the lead agency—along with other aging experts—to monitor, develop, and promote State and local partners; expand legislation to increase the hiring of older adults and persons with disabilities not only in state government, but also in local governments and private companies; develop more incentives for employers to offer employment for older adults and persons with disabilities; create a statewide database of "pledged employers" dedicated to hiring older adults and persons with disabilities into meaningful employment; educate employers so that they understand the importance of creating and promoting flexible work schedules and work arrangements (e.g., telecommuting) for employees; and learn from experiences and models adopted during the COVID-19 pandemic to identify emerging best practices that can be used to lower barriers to employment for older adults and people with disabilities.

5. Decrease misconceptions about older workers and workers with disabilities.

California needs to create a statewide campaign on not only fighting ageism and the misconception of disability as a liability but on starting to think in terms of assets.

Research studies on breaking the stereotypes on older adults included a 2009 report from the Sloan Center on Aging & Work, and a 2012 meta-analysis of age-stereotypes on more than 208,000 individuals by the University of Hong Kong. According to the Sloan Center on Aging & Work, hiring managers gave older employees high marks for loyalty, reliability and productivity; this is contradictory to a common myth that older adults are more likely to be burned-out, absent due to illness, poor at working with younger supervisors, and reluctant to travel. According to the University of Hong Kong, older workers are found to be as motivated, willing to change, trusting, and healthy as younger workers.

In September 2008, the U.S. Equal Employment Opportunity Commission (EEOC) issued the guidance on "Applying Performance and Conduct Standards to Employees with Disabilities" which stipulated that "an employee with a disability must meet the same production standards, whether quantitative or qualitative, as an employee without a disability in the same job. Lowering or changing a production standard because an employee cannot meet it due to a disability is not considered a reasonable accommodation. An employer should evaluate the job performance of an employee with a disability the same way it evaluates any other employee's performance." What EEOC did has effectively helped to break the stereotype that "managers cannot expect the same level of performance from employees with disabilities." In the meantime, the Society of Human Resources Management—with a mission to empower people and workplaces by advancing human resources practices and by maximizing human potential—pointed out there are many qualified candidates with disabilities. Employers should not assume that people with disabilities lack the necessary education, training and experience for employment, and would not be able to perform essential job functions. Many employees with disabilities require nothing more than the same consideration an employer may already be providing to its nondisabled employees, such as flexible work schedules, telecommuting or restructured workstations.

Elder Justice & Abuse

Background

Elder abuse is a pervasive problem in the United States, ruining lives and costing victims and the state billions of dollars each year.[8] The National Elder Mistreatment Study found approximately 10% of older adults living at home will experience some kind of elder abuse every year. This study excluded older adults who lack telephones, capacity to participate in a phone survey or reside in a facility, therefore the prevalence of abuse is likely higher. Elder abuse is also incredibly costly to communities. Studies estimate the financial losses of elder abuse victims to "range from 2.9-35.5 billion dollars annually. Elder abuse comes in many different forms (physical, sexual, financial, psychological etc.) and is perpetrated by strangers and people known to the victim. In fact, elder abuse manifests differently in distinct cultural and racial groups. The vast range of abuse types makes elder abuse a difficult problem to tackle. Regardless of its form, elder abuse has a direct impact on the health of victims "increase[ing] a victim's risk of hospitalization by three times, nursing home admission by four times, and mortality by three times."

---

8   https://ncler.acl.gov/pdf/Legal-Basics-Elder-Abuse.pdf

Elder justice advocacy is founded on two key principles: keeping older adults safe from all types of abuse while also honoring their autonomy and decision-making abilities. Balancing these two priorities can be achieved by centering elder justice in the Master Plan on Aging. Centering elder justice allows us to simultaneously combat elder abuse, affirm the autonomy and independence of older adults, and ensure equity in access to the justice system and other social services resources. The following recommendations center elder justice with an end goal of ending elder abuse in California. Further, many of the interventions outlined in this document will benefit not only older Californians but also people living with disabilities.

ELDER JUSTICE & ABUSE RECOMMENDATIONS

1. Form a California Elder Justice Coordinating Committee, modeled after the federal EJCC established in the Elder Justice Act.

Collaboration among members of the elder justice network will be key to achieving our Master Plan goals. Preventing and ending elder abuse in California requires effective collaboration between all members of the aging network.[9] Currently, there is no statewide hub for elder abuse advocacy or elder abuse data collection. The creation of a state coordinating committee, modeled after the federal EJCC[10] and operated within the Department of Aging, would centralize research, best practices, and other state work related to elder abuse. The committee would be a part of state government and composed of representatives from many government agencies and non-governmental groups that are a part of the elder justice network (for example: Adult Protective Services, LTC Ombudsman, Area Agencies on Aging, CCoA and CEJC). In mirroring the federal committee, committee membership should reach all areas of government, not just those who traditionally focus on aging, i.e. Department of Consumer Affairs and the Attorney General's Office.[11]

The California Elder Justice Coordinating Committee would also house a central repository for data and research that would simplify the discovery of deficiencies in systems and foster more research on elder abuse. This is particularly important in ensuring that older adults from marginalized groups (older adults of color, LGBT older adults and non-native/limited English proficiency older adults) are receiving and utilizing elder abuse preventions systems at the same rates as white older adults.[12]

---

9   A similar committee was recently created in Maine via Executive Order. Governor Janet T. Mills ., "An Order Establishing the Elder Justice Coordinating Partnership", (October 23, 2019), available at https://www.maine.gov/governor/mills/sites/maine.gov.governor.mills/files/inline-files/11_FY_19-20_ElderAbuse_%20EO.pdf

10   Administration for Community Living, "Elder Justice Coordinating Council", December 9, 2019, available at https://acl.gov/programs/elder-justice/elder-justice-coordinating-council-ejcc

11   The Federal EJCC includes representatives from various federal agencies including the Department of Health and Human Services, Consumer Financial Protection Bureau, Social Security Administration, Federal Trade Commission, and the U.S. Department of Agriculture.

12   The Committee would also be ideal for creating and coordinating a network of statewide Multidisciplinary Teams (MDT). Currently, there are MDT's established in various cities and counties around the state, but there is no standardized network. The Committee could provide support in creating more MDT's around the state and establishing best practices and collaboration across counties. A similar committee was recently created in Maine via Executive Order. Governor Janet T. Mills ., "An Order Establishing the Elder Justice Coordinating Partnership", (October 23, 2019), available at

2. Increase Government Support of Legal Services Providers.

Legal Services attorneys serve an integral role in allowing older Californians to age in peace and dignity. The benefits of legal services extend beyond the older adult being assisted. In 2017 alone, legal services attorneys served over 60,000 adults over the age of 60 in California.[13] These attorneys help older adults preserve their housing, preserve public benefits and prevent abuse, free of charge. Their work also helps keep families and communities together. In California, more than 293,000 grandparents are responsible for grandchildren that live with them.[14] Older adults often live in multi-generational households where many people rely on them for income support and child care. All of the benefits from a legal services attorney are bestowed upon not just the older adult, but also their entire family.

California must commit to ongoing funding and support of legal services for older adults throughout the state, but especially in rural areas where lawyers are few and far between. Each year, the State Bar of California grants around $30 million in IOLTA funds to legal services organizations.[15] Unfortunately, IOLTA funding is generated by interest on client trust accounts, making it highly susceptible to changes in the legal market influenced by the overall health of the economy. Due to the COVID-19 pandemic, the National Association of IOLTA programs anticipates IOLTA revenue to drop "by as much as 75% over the next year."[16] Any drop in funding puts critical legal services programs at risk at a time when we know there will be an incredible surge in demand for legal services. With a predicted 1.6 million eviction filings possible at the end of any eviction moratoriums, legal services attorneys are desperately needed now.[17]

California can also provide additional supports to legal services organizations that serve older adults through the state Legal Assistance Developer (LAD). The Older Americans Act provides funding for every state to have a Legal Assistance Developer to secure and maintain the legal rights of older adults, increase the capacity of the state to coordinate legal assistance, and provide technical assistance and training to legal services providers. [18] With the LAD, the state can engage with legal services and other aging network providers to ensure they are reaching all older adults in need of legal help and utilize unique sources of funding and support (i.e. FEMA and law school partnerships) to provide more services to older Californians.

California must support legal services organizations and the critical work they do to protect older adults by ensuring they are funded despite any economic downturns. By ensuring adequate funding for legal services we protect older adults.

---

https://www.maine.gov/governor/mills/sites/maine.gov.governor.mills/files/inline-files/11_FY_19-20_ElderAbuse_%20EO.pdf

13 LAAC Client Data 2017, https://secureservercdn.net/50.62.89.138/zzg.f6f.myftpupload.com/wp-content/uploads/LST-FC-Working-Group_Client-date-report-2017_Oct15.pdf?time=1595129580

14 https://www.grandfamilies.org/Portals/0/State%20Fact%20Sheets/Grandfamilies-Fact-Sheet-California.pdf

15 https://www.calbar.ca.gov/Access-to-Justice/Legal-Aid-Grants#:~:text=What%20is%20a%20Legal%20Aid%20Grant%20under%20the%20IOLTA%20Statute%3F&text=(the%20Statute).,to%20approximately%20100%20nonprofit%20organizations.

16 https://www.abajournal.com/news/article/legal-aid-programs-likely-to-be-hard-hit-by-drop-in-iolta-funds-group-warns

17 https://bit.ly/evictionestimates

18 https://ncler.acl.gov/pdf/Essential%20Role%20of%20the%20LAD%20-%20Powerpoint.PDF

3. Lower the threshold age for age-related services to 50 for homeless individuals.

Medical research shows that homeless individuals experience old age diseases earlier in life, and that they are aging at a faster rate, exacerbated by being unsheltered or living in places not fit for human habitation.[19] Further, more individuals are experiencing homelessness for the first time in older age because of rising housing costs and cost of living.[20] Currently, nearly half of all single homeless adults are over 50 years old, but many aged based social services are not available until an individual has reached 60-65 years old.[21] Age-based services like transportation, nutrition, caregiving, income support and case management are integral to keeping people housed.[22] Making these benefits available to a wider group of homeless older adults at a younger age will keep older adults housed and prevent older adults from falling into homelessness.

4. Target resources and research for Elder Abuse Prevention at both the general public and distinct communities.

Research shows that older adults in different communities of color experience abuse in distinctly different ways from white communities, and elder abuse among these communities is chronically underreported and under-researched. For example, Black older adults are significantly more likely to be victims of financial exploitation and psychological mistreatment,[23] while Asian American older adults are more likely to view elder abuse as existing only within the family, making the risk of abuse from outside actors higher.[24]

Elder abuse prevention and research must target not only the general public, but also be tailored to accommodate the different ways abuse manifests among various cultural groups. Resources, services and information provided to older Californians must be culturally aware and available in all threshold languages. Language, race, cultural background, or any other designation should not be barriers to ending elder abuse in California.

By centering the experiences of older adults of color in our elder abuse research, the state more effectively focuses funding on programs that work for different groups and ensures that elder abuse is fought in every community in California.

---

19 Dennis Culhane, et al., "The Emerging Crisis of Aged Homelessness: Could Housing Solutions be Funded by Avoidance of Excess Shelter, Hospital and Nursing Home Costs?" Available at: https://www.bcsh.ca.gov/hcfc/documents/white_papers/dennis_culhane-the_emerging_crisis.pdf.

20 Adam Nagourney, "Old and on the Street: The Graying of America's Homeless", May 31, 2016, available at https://www.nytimes.com/2016/05/31/us/americas-aging-homeless-old-and-on-the-street.html

21 Dr. Margot Kushel, "Aging Among the Homeless Population: Causes, Consequences, and Solutions", October 16, 2019, available at https://uccs.ucdavis.edu/events/2019-October-16-Kushel

22 It should be noted that any lifting of age based requirements will most likely be limited to state based programs because of federal funding restrictions.

23 National Center on Elder Abuse, "Mistreatment of African American Elders", 2016, available at https://ncea.acl.gov/NCEA/media/Publication/ResearchToPracticeAfAm.pdf

24 National Center on Elder Abuse, "Mistreatment of Asian Pacific Islander (API) Elders", available at https://ncea.acl.gov/NCEA/media/Publication/Mistreatment-of-Asian-Pacific-Islander-API-Elders-2013.pdf

5. Re-examine the relationship between law enforcement, entities that play a role in preventing elder abuse and victims of elder abuse.

Any strategy to prevent and end elder abuse must examine the systems that confront the abusers and purports to assist victims. Part of this examination is acknowledging the different ways older adults of color experience policing, in contrast to white older adults. Not honoring lived experiences of older adults of color in any policy advocacy is a disservice to them and antithetical to the goal of ending elder abuse. The state of California has an obligation to honor the lived experiences of older adults of color. Black older adults have lived through systemic racism and discrimination. Many have only had negative experiences with policing in this country.

In the United States, 9 out of 10 calls for police assistance are for nonviolent issues.[25] This means that armed officers are interfacing with the public for overwhelmingly nonviolent situations. But as we have seen, many nonviolent interactions turn violent and deadly very quickly.[26] Police are trained "in use-of-force tactics and worst-case scenarios to reduce potential threats", not engaging with people experiencing mental health struggles and, of particular interest to elder abuse prevention advocates, older adults experiencing the immense complexities of elder abuse, cognitive decline, and limited mobility. [27] It is estimated that nearly half of those who die at the hands of police have a disability. [28] Further, research demonstrates that Black older adults are likely not to seek help from abuse because of the risk of racial discrimination.[29]

In honoring these experiences, California must look at how law enforcement interacts with our older Black adults and older adults of color and change where policing is doing more harm than good. To start, the Department of Aging should create a task force that will focus on centering California's elder abuse response on racial equity. The committee would examine the relationships between elder abuse, racism and policing, with an aim to discover alternatives to policing in elder abuse cases. The committee would provide a report with findings on how the state can better serve older adults of color, center racial equity in all state elder abuse responses, and how to integrate their findings into state government structures. The committee would also provide goals and timelines for reforms.

The committee should consider the following:

- Policing, with respect to elder abuse, is a blunt instrument response to a nuanced problem.

- Police are not trained to handle the complexities of known perpetrator elder abuse.

- A police response is not trauma-informed.

- An elder abuse victim of color may be less likely to report abuse for fear of police involvement.

25 https://www.brookings.edu/blog/fixgov/2020/06/19/what-does-defund-the-police-mean-and-does-it-have-merit/
26 See the death of Rayshard Brooks and various other young black men, https://www.vox.com/2020/6/13/21290334/atlanta-police-shooting-wendys-video
27 https://www.brookings.edu/blog/fixgov/2020/06/19/what-does-defund-the-police-mean-and-does-it-have-merit/
28 https://www.nbcnews.com/news/us-news/half-people-killed-police-suffer-mental-disability-report-n538371
29 https://www.researchgate.net/publication/341566015_Elder_Mistreatment_Across_Diverse_Cultures

- Policing is not a culturally competent response to elder abuse.

- Police may not be helpful in cases of self-neglect.

- There are many other government and non-governmental organizations that are trained and equipped to confront elder abuse in a person-centered manner, but are chronically underfunded.

6. Create a statewide, easy-to-access database of elder abuse information.

Currently, elder abuse data is stored across state, county, and local entities (police, APS, ombudsman, Dept. of Aging). Whrn information is siloed within different levels of government, trends and patterns in abuse are difficult to ascertain. Combining all available information into a statewide database helps advocates track perpetrators and scams in real time. The database would be accessible by attorneys, law enforcement, researchers, and other members of the aging network, and include civil and criminal elder abuse offenses. Bringing all data together in one searchable database would help facilitate more research and discovery of elder abuse patterns.[30]

7. Encourage use of Advanced Health Care Directives.

Advanced Health Care Directives are one of the tools an older adult can use to express their wishes regarding health care decision making. These documents encourage older adults to make decisions for themselves and maintain control over their lives as they age. They are especially useful for homeless older adults as they may not have the ability to carry this type of vital document with them.

To encourage the use of these documents, the state can implement several strategies. First, the state should focus efforts to increase the use of advanced health care directives by targeting Medi-Cal recipients with an information campaign. Medi-Cal currently allows doctors to bill the state for discussions regarding advanced health care planning. [31] The state should implement a communications campaign that informs Medi-Cal recipients of this benefit and encourages them to take advantage. The state should identify opportunities for implementing processes to assist individuals experiencing homelessness in end-of-life planning and completion of advance directives, as these individuals may have limited access to needed supports and services or lack the ability to independently complete and maintain documentation.

 Second, the state should also increase funding to legal services organizations and Medical-Legal Partnerships (MLP) to encourage their clients to draft advanced health care directives. Lawyers in MLP's are often housed within a medical provider's office and are able to interact with clients during scheduled medical appointments. These directives are 'living documents' that may need to be updated periodically; legal aid organizations are well equipped to store these documents for their clients and help with updates.

---

30 Connecticut recently passed a bill authorizing the creation of a similar statewide 'Elder Abuse Registry'. The registry is a publicly available website housing information about offenders who have committed elder abuse. State of Connecticut Senate Bill 832, "An Act Concerning Registries of Persons Found Responsible for Assaults or Other Abuse, Neglect Exploitation or Abandonment of Elderly Persons or Persons With Disabilities", October 1, 2019, available at https://www.cga.ct.gov/2019/act/pa/pdf/2019PA-00116-R00SB-00832-PA.pdf

31 https://coalitionccc.org/2016/06/medi-cal-reimburses-advance-care-planning/

8. Promote alternatives to guardianship through the creation of a WINGS program.

As an individual ages, the need for help with decision-making may increase. While guardianships have traditionally been the standard method of arranging for assistance in decision making, they are often not the best option for an older individual. In fact, the American Bar Association has encouraged state legislatures to amend guardianship statutes to require courts to consider supported decision making before any guardianship order is entered.[32] This is due to the abuse and fraud that is all too common in the guardianship system. As an alternative, supported decision-making ensures that the rights and wishes of the protected person are considered, and that any orders are limited to exactly what is needed for the individual, avoiding blanket court orders that do not consider the abilities of the protected persons. These reforms protect the rights of not just older adults, but also disabled adults who often experience the same fraud and abuse in this system as older adults. Alternatives to guardianship (i.e. powers of attorney, health care surrogates) elevate the voice and choice of older individuals.

The state of California should establish a Working Interdisciplinary Network of Guardianship Stakeholders (WINGS) program to evaluate and drive change in our guardianship policy. WINGS is a program funded by the Administration for Community Living and administered by the ABA Commission on Law and Aging and the National Center for State Courts.[33] WINGS allows states to establish less-restrictive alternatives to guardianship, promote supported decision-making, and address guardianship abuse. By using the ABA WINGS Replication Guide and the other resources created while establishing WINGS programs in many other states, California can build on the work done around the country and work towards a court system that does not depend on guardianship in serving older adults with diminished capacity.

9. Create a statewide network of Elder Abuse Shelters.

Victims of elder abuse often find themselves unable to live in their own homes and at increased risk for experiencing homelessness as a result of elder abuse. Complex medical issues may also make a traditional shelter an inappropriate placement for a victim. By creating a statewide network of Elder Abuse Shelters, victims can be appropriately housed and receive services to return them to their original housing or find alternative safe housing options. Elder abuse shelters can be brick and mortar or 'virtual' (i.e. placement in a long-term care facility or motel/hotel).[34, 35]

---

32 American Bar Association, "ABA Urges Supported Decision Making as Less-Restrictive Alternative to Guardianship", October 15, 2018, available at https://www.americanbar.org/groups/law_aging/publications/bifocal/vol_38/issue-6--august-2017-/aba-urges-supported-decision-making-as-less-restrictive-alternat/

33 https://www.americanbar.org/groups/law_aging/resources/wings-court-stakeholder-partnerships0/about-the-grant/

34 Spring Alliance, "Joining the Global Elder Abuse Shelter Movement", 2019, available at http://springalliance.staging.wpengine.com/wp-content/uploads/2019/05/Weinberg-Shelter-FAQ-2019.pdf

35 Currently, Sonoma County Adult and Aging Division operates an Elder Abuse shelter. Joy Solomon, Esq, "2018 State of the Spring Alliance", 2019, available at http://springalliance.staging.wpengine.com/wp-content/uploads/2019/05/2019-Symposium-2018-State-of-the-SPRiNG-Alliance-v3.pdf

10. Increase consumer protections through the creation of a state consumer protection agency.

Older adults are often the target of predatory or fraudulent financial products or schemes. For example, Spanish speaking older adults are being targeted for fraud related to the 'Property Assessed Clean Energy Program' (PACE).[36] PACE is a federal program that helps fund renewable energy improvements. Often, scammers deceive low-income homeowners into signing up for solar panels without the knowledge that the loan is secured by the home and may dramatically increase property taxes. Increased state consumer protections are needed to combat the increased complexity of scams targeted at older adults. This spring, Los Angeles County ended its PACE program after years of complaints, citing a lack of "adequate consumer protections."[37] PACE is just one example of the gap in consumer protections that exists here in California.

This year, Governor Newsom proposed creating a state consumer protection agency in the state budget.[38] While these plans have been put on hold due to the budget deficit, California should aim to create this agency in the future. A state-based consumer protection agency would have the ability to recognize statewide fraud trends and collaborate with stakeholders that serve older adults and examine the needs of other groups like disabled adults. This agency could also field complaints from the public and pursue greater prosecution of financial fraud. In addition, in a dedicated agency, a unit aimed at protecting older adults could be created.

Emergency & Disaster Preparedness & Response

Planning – Response – Recover Before, During & After:

California needs a coordinated communication system that increases the wellbeing, safety and independence of people with disabilities and older adults when disaster and emergency occur. We need an infrastructure that provides consistency and serves as a back and forth communication hub between the state, counties and CBO's. As Climate Change continues to impact our environments there is an urgent need for consistent guidance and communication on how to support and ensure that emergency services and programs are both physically and programmatically accessible when they are created and when they are stood up during a disaster or emergency. Time and time again we see the lack of inclusive disaster and emergency planning that takes into account people with disabilities and older adults that have access and functional needs.

---

36   PACE loan contractor prosecuted by LA City Attorney. Case states that contractors sought out Spanish speaking communities. Andrew Khouri, "Homeowners were defrauded through the PACE lending program, L.A.'s city attorney alleges", April 4, 2019, available at https://www.latimes.com/business/la-fi-pace-solar-lawsuit-20190404-story.html

37   Andrew Khouri, "L.A. County ends controversial PACE home improvement loan program", https://www.latimes.com/homeless-housing/story/2020-05-21/la-fi-pace-home-improvement-loans-la-county#:~:text=Los%20Angeles%20County%20has%20ended,risk%20of%20losing%20their%20homes.

38   Aarthi Swaminathan, "'A major, major initiative': California wants to create its own Consumer Financial Protection Bureau", February 10, 2020, available at https://ca.finance.yahoo.com/news/california-mini-cfpb-133209881.html?guccounter=1&guce_referrer=aHR0cHM6Ly93d3cuZ29vZ2xlLmNvbS8&guce_referrer_sig=AQAAAE-6O4usCnSPp4Pq3d18n9-aSYkHcQ_Qwj9_wmlcZeENNLlaAvW3JnwxzbrFP_09ZA2i59XTmGEX5Zzi3de2vTZvjoR-ju9XT4IvGnugT5u79YTPlzDplOtYRr8Ciy3E9quDPqYXd5c5i5uAoioGo3Nv0zdh-ctP2LMSvJINbV7dYr

California is in desperate need of physical and programmatic standards that must be followed by public/county emergency shelters, cooling centers, community resource centers and other short-term facilities available during a disaster. Signage that identifies what services are available at the shelter and where to go are needed. Accessible hand washing stations and restrooms should be a requirement at all public/county shelters and shelter personnel should have a list of what local CBO's to contact for additional support.

Shelters, cooling centers, community resource centers and other short-term facilitates must have professional and experienced individuals with disabilities and older adults who can provide the onsite guidance and support needed for staff and community members in need of specialized services.

Often when people with disabilities and older adults are evacuated they are forced to leave without the opportunity to take their personal assistive technology (communication devices, cell phones with activities of daily living apps, etc.), and durable medical equipment (hearing aids, wheelchairs, walkers, canes, etc.). Most of the time it is because emergency vehicles are not equipped to take equipment/devices or due to the emergency individuals are rushed from their home before they have a chance to retrieve what they need to take with them. When this happens individuals are often dropped off and hospital rather than shelters. If they are dropped off at shelters without their aids they are often transitioned to the hospital because the shelter staff doesn't know how to assist the individual and believes the hospital would be a more appropriate location. These situations put individuals with disabilities and older adults at risk of staying at a hospital for longer periods of time and many end up unnecessarily in long-term facilities such as nursing homes. This can be avoided if first responders were provided training and refresher training on essential questions that should be asked when evacuating people. Not every evacuation would allow the time for such questions, but there are times when more time is available.

Shelter staff do not typically have a background in social work or experienced in working with individuals with disabilities and older adults. There is often a misconception among those who are less familiar with the community and therefore do not feel that individuals with disabilities can have their needs meet in a shelter environment. While that can be the case there needs to be alternatives to hospitalization. Shelters need to be able to provide alternative short-term housing (accessible motel/hotel vouchers) food stipends and transportation. They should not refer disabled individuals to hospitals. In addition, shelters need to have ongoing training and consistency who to go to for durable medical equipment, incontinent supplies, Personal Assistance/caregiving support, ASL interpreters, etc. Short-term housing is not a way to segregate individual with disabilities, but when it is offered it needs to

also include all of the supports and services that an individual would get if he or she were to stay at the shelter. When short-term housing is provided food, transportation, communication and caregiving becomes a problem.

Individuals with access and functional needs in shelters are often left without access to their prescription drugs and do not have accessible transportation to get them while at the shelter. Having a shelter staff responsible for RX pickup and accessible transportation for those in need would be an improvement.

While the state has taken the pandemic into account when opening disaster and emergency shelters in 2020, there has been unforeseen gaps that have risen due to not having people with disabilities at the planning table. For example, food disruption at shelters has changed to decrease cross contamination, but an unintended consequence of providing individually wrapped food items has made it increasingly difficult for those in the shelter that have medical dietary needs. Alternative meals were easier to make in a buffet and are now completely unavailable.

Currently, there are social service agencies in California that are required to ask if an individual has a personal preparedness plan. As an example, this question is asked by In Home Support Services Social Works. The question requires the social worker to check a box and does not require any type of confirmation or further discussion that could potentially lead to more effective personal emergency planning. Personal preparedness plans are an essential way to ensure that an individual is aware of what could happen to them if a disaster were to occur. It's a missed opportunity to now require all public social workers and managed care coordinators to not work with individuals to develop or update a personal preparedness plan on at least an annual basis.

Public Safety Power Shutoffs (PSPS) events and other types of emergencies need to be defined as disasters. The level of supports and services needed for individuals that rely on assistive technology (AT) and durable medical equipment (DME) that is powered by electricity can be the difference between life or death. California cannot go without offering disaster related services during a PSPS event.

State, counties, utility companies and CBO advisory committees need to be developed in each county. Committees must work in collaboration to better serve individuals with AFN through inclusive and equitable disaster and emergency systems.

Managed Care Organizations that give prescriptions to individuals to secure AT and DME that require electricity also need to be accountable for providing backup power to those same individuals.

Nursing facilities and other congregate settings need to be required to have not only a disaster plan to secure their licensing and renewal, but emergency plans that include PSPS events, other types of power outages, active shooter, pandemic and any other type of emergencies.

Recommendations:
1. Appoint experienced people with disabilities and older adults to serve on statewide disaster, emergency and climate change advisory committees and commissions to ensure that individuals with access and functional needs are prioritized and further disaster and emergency recommendations can be provided on an ongoing basis.

2. Appoint a person with a disability to serve in the Governors office to be the disability and aging community advisor on disasters and emergencies. The appointee should be connected to the community and have the ability to coordinate stakeholders as well state partners on disability disaster and emergency communications that are provided to the administration and the public.

3. The administration would benefit from working in partnership with the CalOES Access and Functional Needs Advisory Committee, Disability Access Commission and California Certified Access Specialists to develop standards for all emergency shelters, cooling centers, community resource centers and other short-term facilities during disasters.

4. It typically takes longer for people with disabilities and older adults with access and functional needs to evacuate during an emergency. It is critical that there are resources available and allocated to individuals with AFN who receive emergency warning alert to voluntarily evacuate. While CBO's and counties are providing support there is no funding to assist when there is a voluntary evacuation warning put out to the public. Waiting for a mandatory evacuation alert is often too late for someone with AFN to get out safely with their daily living aids. California needs to change the way emergency resources are allocated to the AFN population. The way the system is currently setup leaves counties and CBO's hesitant to assist AFN evacuees due to cost and reimbursement from the state. Counties and CBO's need to be reimbursed when assisting individuals with AFN in evacuating during a warning and mandatory evacuation.

5. California needs to require that Managed Care Organizations provide backup electricity when prescribing a device that requires power through the renal of the 1115 waiver.

6. Telecom companies need to provide shelters with smart phones for evacuees while at the shelter and long-term for those who have no home to return to. The device can assist individuals in communicating with loved ones while at the shelter, but also identify resources to assist in recovery efforts. Individuals who need the cell phone on a long-term basis should be able to keep it for 6 – 12 months and should be tracked by a CBO to perform wellness checks and assistance in finding housing as well as other resources after disaster loss.

7. Telecoms should provide high speed internet at shelter sites and have smart devices hot spot equipped.

8. California's low income housing buildings and congregate living facilities that reside in CPUC wildfire threat tier 3 and tier 2 areas need to be required to enroll in the Self Generated Incentives Program (SGIP).

California Master Plan for Aging: Equity Work Group Recommendations

In furtherance of the goals outlined in the introduction and principles, the EWG has drafted the below recommendations. The recommendations have three components: Structures and Systems, Program Development, and Evaluation and Assessment.

Structures and Systems

It is critical that the Administration and the broader aging and disability services and advocacy communities establish structures and systems to ensure that the actions undertaken in the MPA are centered in equity.

Recommendations:

- **As a primary goal of the MPA, address inequities in how we age that result from systemic racism and other forms of discrimination and bias.**

- **Create a permanent Equity Advisory Committee comprised of representative stakeholders that reflect the communities served to advise and monitor implementation of the MPA.**

- **Continuously update and use the Equity Tool to design and refine programs related to the MPA.**

- **Building from the MPA, develop a Master Plan for Equity for all Californians across state government.**

- **Create a Director of Equity position within the California Department of Aging (CDA). This person would be responsible for ensuring that CDA's programs advance equity**. Similar positions should be considered within other agencies and departments.

- **Require Diversity, Equity and Inclusion (DEI) training for all CDA staff that is tied to specific outcome measures and data with clear intent about the purpose and goals of the training.** Other state agencies should do the same. DEI trainings should explicitly address ageism and ableism and their intersection with racism, xenophobia, sexism, homophobia, and transphobia.

- **Require that all aging and disability services organizations receiving funding from CDA create, implement and evaluate a DEI plan for their organization.** CDA should also provide funding to support these DEI efforts.

- **All aging and disability services providers, advocacy organizations, and foundations in California should develop their own DEI plans.** Plans should include evaluation of the diversity of their board, leadership, staff and making those data publicly available. If staff and volunteers are not representative of communities served, the organization should have a plan for alignment.

Program Development

It is critical that the MPA include programs that advance equity and that meet the needs of specific populations within the aging community experiencing disparate outcomes in aging due to systemic inequities they have faced throughout their lives, including: BIPOC, immigrant, LEP, LGBTQ+, people with disabilities and women. The following recommendations apply to any programs developed under the Master Plan.

Recommendations:

- **Know your audience**. Use existing data such as the [Healthy Places Index](#) to know your demographics.

- **Partner with the community.** Partnership may be in the form of collaborating on community strengths and needs assessments or focus groups to understand specific needs within a population.

- **Include the community in the planning process and throughout.** "Nothing about us without us" – a mantra from the disability movement that conveys that people with a disability know what is best for them and, therefore, ought to have a seat at the table at the beginning of the planning process.

- **Advance equity through planning, delivery, and outreach by taking into account linguistic and cultural nuances, accommodations for disabilities, immigration status, religious diversity, and the digital divide.**

<div align="center">

Evaluation and Assessment

</div>

Despite its importance, measurement is an underused tool for reducing disparities in aging and disability services. Measurement allows policymakers, providers, consumers, and other stakeholders to identify disparities in their communities, target resources and interventions that can reduce those disparities, and monitor the improvement or worsening of disparities in response to these interventions or other changes. However, to be an effective tool for advancing health equity, the implementation of performance measurement must specifically account for disparities in risk factors, experiences, access, quality of care, and wellness outcomes. To structure performance measurement to promote equity, we provide the following recommendations along with example guidelines and frameworks to support this effort.

Recommendations:

- **Develop an inclusive assessment and evaluation plan to identify gaps in data, prioritize problems, select appropriate outcome indicators, set targets, and measure results.**
  - Families USA Health Equity Task Force's [Framework for Advancing Health Equity and Value: Policy Options for Reducing Health Inequities by Transforming Health Care Delivery and Payment Systems](#)

- **In recognition that there is a paucity of data on the experience of diverse older adults and their families, it is advised to identify available tools and frameworks to identify local factors that determine inequity in community conditions.**
  - Pulling from [No More "One Size Fits All" Research: We Need Multicultural Data for Meaningful Patient- and Family-Engagement in America's Health and Social Care Systems](#)
  - California [Healthy Places Index](#) to identify highly vulnerable communities and intervention targets
  - [International Classification of Functioning, Disability and Health](#) to organize and document functioning and disability as a function of individual health, environmental factors and personal factors

- o [The California Health Interview Survey (CHIS)](#) to utilize the nation's largest state health survey to obtain health data about the state's various racial, ethnic and other diverse groups
- o [The Elder Economic Security Standard™ Index (Elder Index)](#) to provide an evidence-based indicator of the actual basic costs faced by older adults (ages 65 and over)

- **Directly measuring inequities and the progress toward eliminating them requires using disparities-sensitive measures that detect disparities in populations as well as equity measures that assess whether programs and services that increase equity are being implemented.** Accordingly, we recommend that the development and use of reliable disparities-sensitive and equity measures to assess the MPA goals is a priority. Specifically, we recommend that disparities-sensitive measures be based on the following criteria:

  - o A condition's prevalence among populations with social risk factors
  - o The size of the disparity
  - o The strength of the evidence linking improvement on the measure to improvement in target outcomes for populations with social risk factors
  - o The "actionability" of the measure

  For equity definitions and subsequent measurement, both qualitative and quantitative, visit: https://www.urban.org/sites/default/files/publication/101052/the_state_of_equity_measurement_0.pdf

- **Report performance data stratified by race, ethnicity, language, socioeconomic status, age, sex, gender identity, sexual orientation, disability, and other demographic factors to identify disparities and evaluate the impact of specific service delivery changes on outcomes for members of underserved and under-resourced communities and whether they are reducing or widening disparities.**

California Master Plan for Aging: Equity Work Group Equity Tool

To guide other MPA subgroups and subcommittees, the EWG developed a set of equity tool questions for use while forming these deliverables. This tool should also be used to inform the implementation of the MPA.

QUESTIONS

1. What needs, gaps, and/or organizational barriers are you addressing to further diversity, equity, and inclusion in your recommendations?

2. How were the basic needs, gaps, and/or organizational barriers to equity determined when designing the recommendations? (i.e. primary research, secondary research, key informant interviews, subject matter expertise).

    a. Who was involved in determining the recommendations? Were stakeholder groups with membership directly impacted by the policy included?

    b. If so, which ones engaged and how did you ensure that their recommendations/considerations were included in your recommendations?

3. Do the resulting recommendations take into account the cultures and languages of impacted communities? For example, in determining those needs, was key information (access to services, forms, teaching materials, social media, phone lines) collected directly from the communities and made available in-language and in-culture?

4. How do the data/research inform or support the recommendations, statements, strategies, or conclusions? Did you refer to research conducted in a way that was/is inclusive and reflective of the demographic and cultural makeup of California?

5. How do the resulting recommendations build on the strengths and assets of the impacted communities?

6. Do the proposed recommendations take into account impacts on, and the rights of, people with disabilities? Please refer to the Olmstead Act for guidance.

California Master Plan for Aging: Equity Work Group Glossary

Ableism: Ableism is oppression, disqualification, discrimination and injustice targeting people with disabilities based on a belief in the superiority and privilege of ability.

Ageism: Ageism is stereotyping and/or discrimination against individuals or groups on the based on their age. It can apply to any age group or generation. This may be casual or systematic. Robert Neil Butler's definition was modified to include all ages and generations to reflect current realities.

Bias is a predisposition to see events, people or items in a positive or negative way. It is an attitude or belief.

- **Unconscious/Implicit Bias** refers to the attitudes or stereotypes that affect our understanding, actions, and decisions in an unconscious manner. Implicit biases are activated involuntarily and without an individual's awareness or intentional control. Implicit biases are pervasive. Everyone possesses them, even those with avowed commitments to impartiality. (Adapted from Cook Ross).

Cultural Competence: Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. 'Culture' refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. 'Competence' implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities. (Adapted from Cross, 1989).

> *Note: Several EWG members prefer using the terms Cultural Responsiveness, Cultural Appropriateness, and/or Cultural Humility*

Disability: A physical or mental impairment that substantially limits one or more major life activities.

Discrimination: the unequal or unfair treatment of a person based upon one or more personal characteristics including, but not limited to: race, gender, sexual orientation, gender identification, nationality, ability, age.

- **Historic Discrimination**: Discrimination against Blacks, it appears to be equal but has adverse impact on African Americans. (Griggs vs Duke Power, Supreme Court). Now includes other races and LGBTQ (recent case law).
- **Historic Racism** – State sponsored discrimination against Black/ African American people after the Reconstruction period. Jim Crow laws were state and local laws enforcing racial segregation. These laws were enacted and enforced between 1876-1965 and included redlining and housing covenants. The impacts of these laws and ongoing discrimination continue to have economic, political, and educational impacts on Black/ African American people.

Disparity is a lack of similarity or equality; inequality; difference: a **disparity** in age; **disparity** in rank. (Dictionary.com)

- **Health Disparity:** A "*health disparity*" refers to a higher burden of illness, injury, disability, or mortality experienced by one group relative to another. (Kaiser Family Foundation)
- **Health Care Disparity**: A "*health* care *disparity*" typically refers to differences between groups in *health* insurance coverage, access to and use of care, and quality of care. (Kaiser Family Foundation)

Diversity is the condition of having or being composed of differing elements, *especially* the inclusion of different types of people (such as people of different races or cultures) in a group or organization. (Merriam-Webster)

Equality generally refers to equal opportunity and the same levels of support for all segments of society. **Equity** goes a step further and refers offering varying levels of support depending upon need to achieve greater fairness of outcomes. (Diffen.com)

Equity is an approach that ensures everyone has access to the same opportunities. Equity recognizes that advantages and barriers exist, and that, as a result, we all don't all start from the same place. Equity is a process that begins by acknowledging that unequal starting place and makes a commitment to correct and address the imbalance. (General Assembly)

Equality

Equity

© 2017 Robert Wood Johnson Foundation. May be reproduced with attribution.
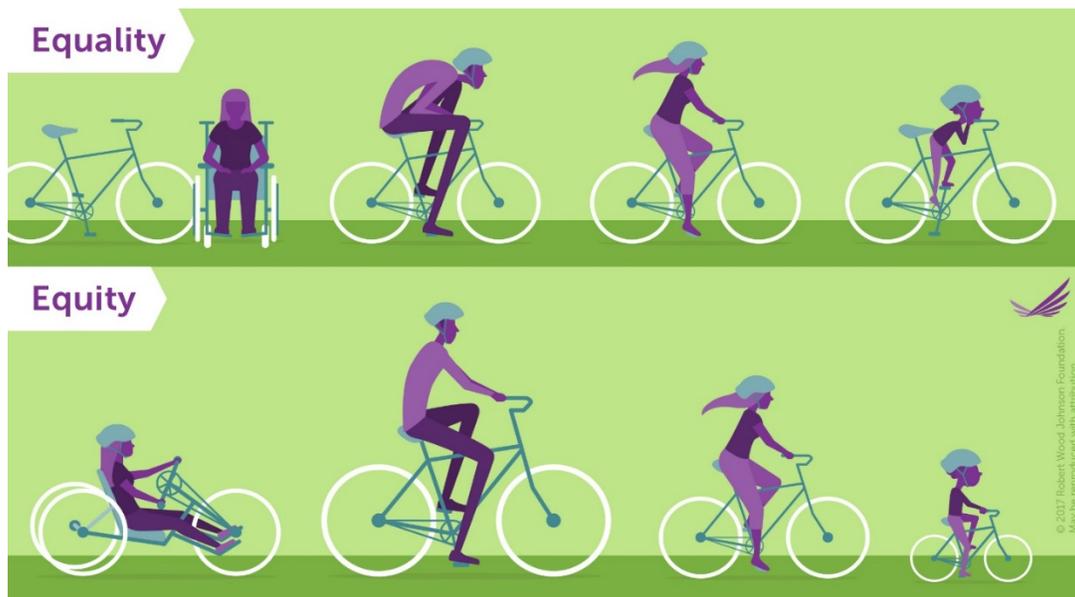
Source: Robert Wood Johnson Foundation

- **Health Equity** means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, personal biases and their cause: systemic racism resulting in lack of access to good jobs, quality education and housing, safe environments, transportation, and quality health care insurance. (modified RWJ) "Health Equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care." (Robert Wood Johnson Foundation)

Eugenics: English statistician Francis Galton developed the word "eugenics" in 1883 to describe improving the qualities of the human population by discouraging reproduction of persons with presumed genetic defects or inheritable undesirable traits (negative eugenics) through methods like coerced sterilization, or encouraging reproduction by persons presumed to have inheritable desirable traits (positive eugenics). Negative eugenics also involves the identification of intersectional, socially constructed moral, physical or mental defects targeted for erasure. (*Dictionary.com* & *Merriam-Webster Dictionary*)

Inclusion is about folks with different identities feeling and/or being valued, leveraged, and welcomed within a given setting (e.g., your team, workplace, or industry). "Diversity is being asked to the party. Inclusion is being asked to dance." ([General Assembly](#))

Intersectionality: The interconnected nature of social categorizations such as race, class, and gender as they apply to a given individual or group, regarded as creating overlapping and interdependent systems of discrimination or disadvantage. Coined by Kimberle Crenshaw, in 1989, to explain the interplay of inequities, siting at the intersections of race and gender. Black women were too Black to be female and too female to be Black.

LGBTQ+: Acronym for lesbian, gay, bisexual, transgender, queer, and other gender and sexual identities and orientations. Sometimes, when the Q is seen at the end of LGBT, it can also mean questioning. LGBT and/or GLBT are also often used. The term "gay community" should be avoided, as it does not accurately reflect the diversity of the community. Rather, LGBTQ community is preferred. ([GLAAD's LGBTQ Media Reference Guide](#))

Lifespan: The duration of existence of an individual. ([Merriam-Webster](#)).

Nativism: Discrimination based on one's country of origin. This includes a wide range of immigrants from various parts of the world including Syria, Iraq, Afghanistan, Iran, Armenia, Somalia and countries from the Pacific Rim--Mainland China, Taiwan, South Korea, The Pacific Island (Guam, Samoa) and of course Hispanics from throughout Mexico, Central American and South America. Nativism is similar to "Racism" given it involves discriminating against individuals that are considered different. However, "Racism" is focused on Race (not ethnicity or country of origin) and is generally viewed in the public narrative as a "Black/White" dichotomy which tends to overlook those from other parts of the world. And in this case, Hispanic is not a "RACE" but an ethnic group.

Racism (implied): Racism is different from racial prejudice, hatred, or discrimination. Racism is one group having the power to carry out systematic discrimination through the institutional policies and practices of the society and by shaping the cultural beliefs and values that support those racist policies and practices.(b) Racism is a system of beliefs and practices that serves to reinforce the power and well-being of whites at the expenses of African American, Native American, Latinx, Asians and all people of color. (c) Racism is a system of structuring opportunity and assigning value based on race that unfairly disadvantages the protected class.

- **Institutional/ Systemic Racism**: Discriminatory policies and practices favorable to a dominant group and unfavorable to another group that are systematically embedded in the existing structure of society in the form of norms.

- **Historical Racism –** State sponsored discrimination against Black/ African American people after the Reconstruction period. Jim Crow laws were state and local laws enforcing racial segregation. These laws were enacted and enforced between 1876-1965 and included redlining and housing covenants. The impacts of these laws and ongoing discrimination continue to have economic, political, and educational impacts on Black/ African American people.

Redlining: A nationwide system of federal, state, and local policies and private practices originating in the 1930's that mandated segregation and restricted locations where Black people could live and own property. Provisions explicitly prohibited selling homes in federally subsidized suburban communities to Black individuals, who were also refused mortgages and home insurance, charged high rates, and pushed into urban housing projects excluded from economic opportunity. The effects of these policies

remain today. (See [The Color of Law: A Forgotten History of How Our Government Segregated America](#), Rothstein, Richard.)

Xenophobia: Relevant to nativism; a "fear of foreigners" and those not part of the dominant group in a particular location.

California Master Plan for Aging

Equity Work Group Members

Marcy Adelman, Ph.D., California Commission on Aging

Silvia Austerlic, Senti-Pensante Connections

Donna Benton, Ph.D., USC Research Associate Professor of Gerontology

Catherine Blakemore, J.D., Disability Rights California

Assembly Member Cheryl Brown (ret.), California Commission on Aging

Hon. **Betsy Butler**, CA Commission on Aging, CA Women's Law Center, Los Angeles Probation Commission

Le Ondra Clark Harvey, Ph.D., California Council of Community Behavioral Health Agencies

Marielle Kriesel, Disability Community Resource Center

Darrick Lam, MBA, MSW, ACC Senior Services

Karen D. Lincoln, PhD, MSW, MA, FGSA, University of Southern California

Marty Lynch, Ph.D., LifeLong MediCal Care (Retired)

Kori Novak, Ph.D., MBA, Toiyabe Indian Health Project, Inc.

Berenice Nunez Constant, MPH, Altamed

Kevin Prindiville, JD, Justice in Aging

Jeffrey Reynoso, DrPH, MPH, Latino Coalition for a Healthy California

Rigo Saborio, MSG, St. Barnabas Senior Services

Rita Saenz, AARP California

Kiara Harris, Sistahs Aging with Grace & Elegance

Carmelita Tursi, AARP National Office (Retired)

Linda Tenerowicz, California Pan-Ethnic Health Network

Valentine M. Villa, Ph.D., CSULA/UCLA

Edie Yau, Alzheimer's Association

Climate Change and Aging

WHAT THE MASTER PLAN ON AGING CAN DO

CONTRIBUTORS: MARTY LYNCH •JEANNEE PARKER MARTIN

Climate change represents an inevitable, massive threat to global health that will likely eclipse the major known pandemics as the leading cause of death and disease in the 21st century.

Dr. Dana Hanson, the president of the World Medical Association

Impact of Climate Change on Human Health

https://www.cdc.gov/climateandhealth/effects/default.htm
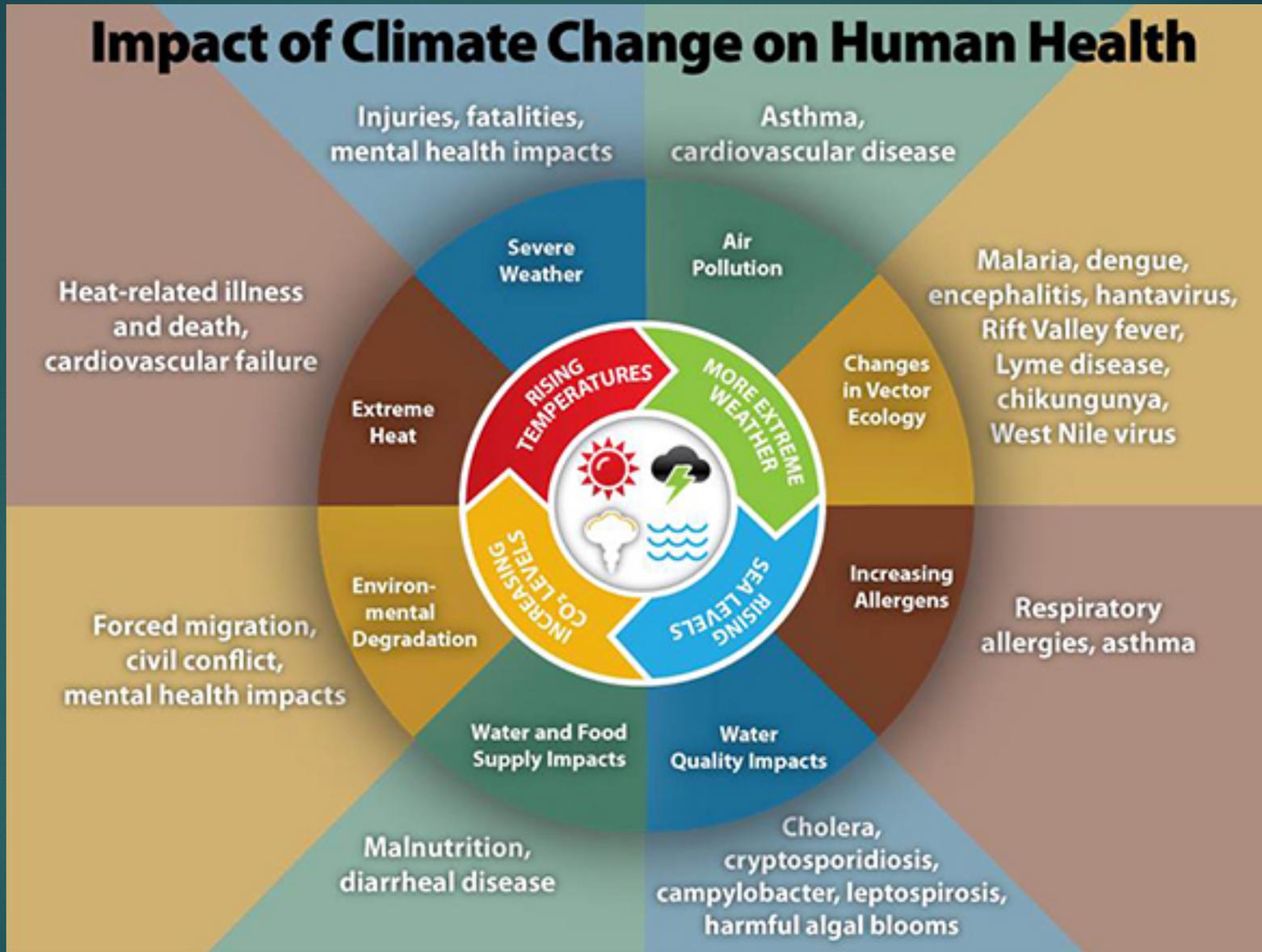
Major Climate Issues
Affecting Older Adults and People with Disabilities

- Rising temperatures, volatile weather events, wildfire, smoke, flooding, pollutants
  - Extreme heat – heat stroke, heart issues
  - Decreased air quality – cardiovascular and neurological problems
  - Power outages
- Disparate impacts on populations, esp. brown and black; disabled
- Impact on nature and its healing effects
- + COVID

Major Climate Issues
Impact on Equity

- Disparate impacts on populations, esp. brown and black; disabled
- Agriculture and service jobs outdoors in hottest parts of the state
- Red-lined and poorer neighborhoods
    - Hotter
    - Closer to freeways and sources of pollution
    - COVID outcomes worse
- Fewest resources to mitigate the impacts, i.e., air conditioning, air purifiers, ability to move to better locations
- Immigration from climate impacted areas

Big Picture:
What Can Master Plan for Aging Do?

► Climate change may be largest health issue facing our constituents

► Link MPFA to Governor's climate change strategy, Call out that link in our presentations

► Aging and Disability advocates add support of carbon neutral/reduction policies to our legislative agendas

   ► Educate constituents about the importance and impact of climate change to our communities

   ► Adopt green policies to reduce non-renewable and carbon footprints

   ► Zoning decisions to promote green dense senior housing development near transit centers

MOST IMPORTANT THING WE CAN DO: *Green* the Aging and Disability Network

- **Educate clients, staff, and boards** about impact on them and what they can do
- **Prepare them** for what to do in extreme heat, power outages, evacuations
  - Agencies can develop strategies to **buy sustainable materials, lower energy use, change energy sources to renewable, avoid toxics**
  - Encourage our own **move away from gas and oil use : to electric**
    - **Encourage and incent telecommuting**, walking, biking, and public transportation to work, move to electric vehicles and solar, green buildings
- **Most IMPORTANT**: Work with **partners and political leaders** like the Governor to **change policy and economy for California**

Technology & Aging: Overview & Discussion

David Lindeman, PhD
Center for Information Technology Research in the Interest of Society

Jeannee Parker Martin
LeadingAge California

Rigo Saborio
St. Barnabas Senior Services

Together We
ENGAGE
Master Plan for Aging

Technology Agenda for the Master Plan on Aging

2020-2030

Goals

Technology can offer a rapid, efficient, cost-effective means of improving the health, well-being and quality of life of older adults, persons with disabilities, and other vulnerable populations in California. Given the rapid changes and capabilities of technology that are expected over the coming decade, technology will enable older adults to better manage their own well-being and improve their ability to thrive. In addition, technology can improve the means in which providers and family caregivers alike can support and protect older adults.

Technology is not an end in itself, but when applied to the areas of focus of the California Master Plan for Aging, technology-enabled solutions can significantly benefit older adults, persons with disabilities, persons with dementia, caregivers and the aging and long-term care workforce; remedy inequities; and help reach considerably more older Californians then is currently possible. The following recommendations are intended as a lens to determine how to most effectively apply technology-enabled solutions to all areas addressed by the Master Plan for Aging to better achieve comprehensive, sustainable, system-wide changes to improve the lives of older adults and people with disabilities.

Guiding Principles

Recognizing that California's older adults, persons with dementia, and persons with disabilities are socio-economically diverse and have a range of capabilities and needs, these recommendations for applying technology-enabled solutions are guided by several key principles:

- Promote <u>equitable access to technology-enabled solutions</u>, specifically addressing the needs of low-income, racially and ethnically diverse,   at-risk individuals to reduce the digital divide, ensuring that "no one is left behind."

- Address the <u>wide variation of need, resources, and capacity of California's diverse population</u>.

- Promote options that are <u>evidence-based and can be efficiently and cost effectively implemented</u>.

- <u>Maximize public/private collaboration</u> to ensure the widest impact possible (PUC, FCC, ACL)

- <u>Build on existing resources, infrastructure and programs</u> wherever possible before advancing solutions that must be developed de novo.

Selection of Technology-Enabled Solutions

Central tenets in selecting impactful technology-enabled solutions for consideration for the Master Plan for Aging are that they **improve accessibility and affordability** of technology for the most at-risk older adults and persons with disabilities (e.g., low-income, limited English speaking, persons with dementia, etc.). In light of variations in accessibility and affordability to broadband, devices and training across the state, we recommend **actionable, proactive** technology-enabled solutions that:

1) have the greatest impact and benefit,

2) focus on the most vulnerable, under represented, under-served and under resourced segments of the older adult and disability communities,

3) are actionable, replicable and rapidly scalable, and

4) can be sustained and serve as a platform for long-term support for older adults and persons with disabilities.

Technologies for Older Adults

Technologies that are used by older adults continue to expand, covering a vast array of technology-enabled solutions that range from "low-tech" to those considered "high-tech". Technologies that currently benefit older adults and persons with disabilities include, but are not limited to, the following:

- Low-tech (telephones, canes, etc.)
- Communication, social networking, and smart phones
- Engagement, games, fitness and legacy technologies
- Assistive technologies
- Vision, hearing and voice first
- Medication management
- Falls prevention and detection
- Cognitive technologies
- Digital health
- Telehealth and remote monitoring
- Sensors, wearables and smart home (IoT)
- Robotics and machine learning
- Transportation
- Virtual reality/Augmented reality
- Financial technology and fraud detection
- Data analytics and machine intelligence (AI and predictive analytics)

Technology Solutions for LTSS

Technologies for older adults address multiple goals of long term supportive services (LTSS) by providing new opportunities for socialization, engagement, and education; assisting in self-management of chronic diseases; and expanding access to healthcare, preventive services, and wellness activities. Ultimately these technology solutions lead to an improvement of quality of life, ensuring safety and security, and maintaining or reducing costs to individuals and society. Technology-enabled solutions support LTSS solutions that ultimately support older adults being able to reside independently and interdependently in communities.

Short-term Priorities
- Technologies that support services such as care management, communications, ride sharing, access to food and other essential goods, remote caregiving
- Technologies that support engagement to reduce social isolation
- Technologies that promote connectivity, health education, financial education, digital literacy, access to programs and services, including support for communications, training, and technology maintenance

Mid- to Long-Term Priorities
- Support broadband as a statewide utility to provide universal internet access.
- Advanced technology solutions such as autonomous vehicles, smart homes

Housing and Congregate Setting Technologies

Housing remains a critical issue for older adults and persons with disabilities in California, particularly when compounded by socio-economic and health challenges experienced by many older adults. Given housings central role for older adults we recommend technology-enabled solutions that:

1) Enhance Independent Living, Affordable Housing, Assisted Living, and Skilled Nursing Facilities to support persons at the least restrictive level

2) Support the development of Smart Homes, home design, and home re-design to increase independence

Short-term Priorities

- Technologies that support engagement to reduce social isolation, enhanced communications, improved mobility and accessibility, caregiver physical assistance

Mid- to Long-Term Priorities

- Streamline and strengthen regulations and payment policies that govern home accessibility standards in order to promote uniform standards allowing efficient use and changes in technological support systems.
- Develop integrated systems, enhanced mobility systems, robotics, advanced batteries, voice-first, and other technologies for smart homes

Health Care and Digital Health Technology

Technology plays a major role in older adults health and mental health, whether it is used to empower older adults to manage their own health and well-being; provides better access to health care and health care providers; or it offers health care providers new tools to diagnose, treat and manage older adults and persons with disabilities. Health care and digital health technologies will play an increasing role in active and passive management of older adults health. We recommend technology-enabled solutions that focus on:

1) Personal digital health technologies

2) Health technology solutions for providers

3) Expanded Telehealth availability and reimbursement

Short-term Priorities
- Expanded telehealth and remote monitoring, care management, translation, medication management, cognitive training, falls prevention and tracking, end-of-life planning and directives

Mid- to Long-Term Priorities
- Predictive diagnostics; disease prevention; connected Electronic Health Records; personal health management and monitoring; vision, hearing and assistive device innovation; nutrition management; behavioral health innovation; universal broadband access.
- Expand Health and Community Information Exchanges to connect data needed by seniors.

Safety and Emergency Response Technology

Given the dangers that have emerged due to the Covid-19 pandemic, the numerous natural disasters that continue to impact California, and the increasing level of elder abuse, and the growing number of persons with dementia and cognitive impairment, we recommend technology-enabled solutions that address:

1) Covid-19 and future health emergencies

2) Natural Disasters and Emergencies

3) Physical and Financial Safety and Security

Short-term Priorities

- Covid-19 testing/contact tracing, data maps, streamlined communication systems, interactive PERS
- Automated emergency alert system, data tracking, and resilient communication technologies for emergencies
- Reporting system to rapidly identify and mitigate elder abuse, abuse of people with disabilities, and fraud and scams

Mid- to Long-Term Priorities

- Automated warning systems, data bases and predictive modeling for abuse and fraud; financial monitoring and warning systems
- Interoperable and more effective emergency communications systems in which the needs and capabilities of older people are included for existing and future wireline and wireless voice, data, image, and video technologies

Technology to Improve the Workforce

Technology can both enhance the workforce that supports older adults as well as be a critical resource in supporting the meaningful and gainful employment for aging populations and individuals with disabilities, enabling a more inclusive and productive workforce. We recommend technology-enabled solutions that:

1) Support improving the skills of the Aging and Long-term Care (LTC) Workforce
2) Support Older Adults entering or staying in the Workforce, leading to improvement in economic development as well as asset building

Short-term Priorities
- Technologies that enhance diagnostic, support, and training of aging and LTC workforce.
- Programs that provide digital literacy and technology maintenance and technical support.

Mid- to Long-Term Priorities
- Providing technology innovations that enhance the skill sets of the Aging and Long-term Care Workforce, such as AR/VR, predictive analytics, and embedded sensors.
- Providing (re)skilling and training in technology tailored to the cognitive and physical attributes, needs, and skills of diverse individuals; facilitate more inclusive job discovery, selection, and access; and enhance and augment an individual's skills.

Technology Training

A key barrier to the use of technology is the lack of training for both older adults as well as the workforce that supports them. Thus, it is critical that California develop and expand training programs for older adults and persons with disabilities in the use of technology, to strive for universal digital literacy among older adults. Technology training should aim to achieve:

1) Digital literacy of older adults, particularly the most vulnerable, in particular the under-represented, under-served and under-recognized communities.
2) Digital literacy for family caregivers and aging providers

Short-term Priorities
- Implement digital health literacy training for all older adults and persons with disabilities.
- Provide ongoing training in technology-enabled interventions that could ultimately support and provide technical assistance to families and the entire aging and long-term care workforce.

Mid- to Long-Term Priorities
- Develop technologies for older adults that require minimal training and maintenance, and effectively learn from the older adult.
- Develop training methods and smart technologies that maximize technology skill sets.

Data and Data Analytics

Data and data analytics provide the underpinnings of all technologies that support older adults. Computing and data, including the management of data, data analytics, machine learning, artificial intelligence, and compute power, permeate and shape technologies that benefit older adults. Given its importance as to how data supports technologies for older people and the aging and Long-term Care workforce, data must follow strict provenance guidelines.

Short-term Priorities
- Improve data sources that will contribute to technologies that will enhance California's aging population.
- Support the use of data visualization and dashboards as part of the MPA.

Mid- to Long-Term Priorities
- Apply next generation data methodologies that can rapidly improve the well-being of older adults, family caregivers and the workforce (e.g., predictive analytics).
- Proactively apply next-gen data management and data analytic tools to current and future aging programs, such as Quantum computing, cloud, 5G, etc.

CROSS CUTTING ISSUES

Require Interoperability of Technology Platforms

Protecting Privacy and Security

With increased use of technology comes a concomitant need to insure personal privacy and information security for older adults. We recommend technology-enabled solutions that protect Personal data, Personal health information, and Financial information through protocols for data ownership, including standards for ownership, collection, access, control, and notices for use of data as well as intrusion detection and prevention.

Inclusive Design and Technology Innovation

As technology solutions are increasingly used by older adults it is incumbent upon the state and key stakeholders to insure that technology innovation involves the end users in order to improve adoption and efficacy. Innovative technology solutions developed by either public and private entities should be reviewed for inclusion of older adults in the design process as well as for employment of co-creation, human-centered design principles.

SUMMARY: TECHNOLOGY AND OLDER CALIFORNIANS

The MPA Stakeholder Advisory Committee assumes that technology will be a fundamental part of life for older adults and persons with disabilities over the coming decade. These recommendations are intended to insure that:

- All Californians should have equitable access to affordable technology solutions.
- Technology-enabled solutions are applied to improving care and services while maximizing the independence of the individual.
- Technology solutions lead to reducing costs and improving efficiencies, while empowering older adults and ultimately improving their well-being and quality of life.

Ultimately, California should harness its cutting edge private and public sector technology innovation ecosystem and serve as a national and international model of technology-enhanced life for older adults and persons with disabilities.

Research Agenda Overview & Discussion

Laura Carstensen, PhD
Stanford Center on Longevity

David Lindeman, PhD
Center for Information Technology Research in the Interest of Society

Research Agenda
for the Master Plan on Aging

MPA Research Subcommittee

2020

Research Agenda – Master Plan for Aging

- **MPA Executive Order** included a Research Subcommittee tasked with ensuring that the MPA was developed and implemented in an evidence-based manner.

- **Stakeholders** submitted over 100 recommendations that called for data collection and/or evaluation of various policies and services across Goal 1, 2, 3, and 4.

- **The MPA LTSS Subcommittee Report** included several recommendations that called for data collection, research, and evaluation to strengthen various services and supports for older adults and people with disabilities in California.

- **The MPA Equity Workgroup** called for an MPA research agenda that would collect data on the experience of diverse older adults, identify local factors that determine inequity; use disparities-sensitive and equity measures to assess the MPA; and report performance data stratified by race, ethnicity, language, socioeconomic status, age, sex, gender identity, sexual orientation, disability, and other demographic factors.

- **MPA Research Subcommittee** met six times and developed this proposed 3 part research agenda.

Proposed MPA Research Agenda Mission

- Establish a partnership of world-class experts in health and aging: including California policy makers, researchers, providers, advocates, older adults, and people with disabilities to guide and evaluate the MPA using data and evidence.

- Achieve a deep understanding of the diversity of the aging trajectories of Californians through the synthesis of multiple data sources and the engagement of the state's top aging researchers and data management scientists.

- Provide evidence-based guidance to the MPA as it unfolds, and simulate social, health, and economic projections that will inform California's future.

- Elucidate aging in California now and in the future at the level of ethnicity, race, gender, geographic region, and economic status.

- Identify outcomes of MPA policies and remedy inequities quickly so that all Californians can age well.

Three Components of the MPA Research Agenda

1) Advisory Consortium
2) University-Based Research Alliance
3) Data Action Center

Governance: Advisory Consortium

The advisory consortium of experts can include California policymakers, researchers, providers, consumers, and other stakeholders charged with overseeing core projects, generating key questions and hypotheses, and ensuring that the overall MPA goals and objectives are achieved.

- Convene meetings of participating stakeholders and researchers
- Determine the most important research questions, evaluation plans, and data collection priorities for the MPA.
- Review proposals from researchers and other organizations who wish to use the dataset (see data action center)
- Produce an annual state of the State of Aging in California report and other policy briefs
- Guide updates to the data dashboard

University-based Research Alliance

A university-based research alliance can include multiple California universities and research centers to engage world class researchers and experts in aging, disability, and health.

- Generate state of the art analyses to support implementation of the MPA.

- Model outcomes of MPA policy implementation and simulate individual trajectories and future scenarios about aging California.

- Disseminate MPA research at state and national conferences and peer reviewed journals.

- Host traineeships with graduate students and post docs to conduct analysis and train future generations of aging and health policy experts.

Data Action Center

A funded "Data Action Center" (a.k.a. data warehouse) that will work closely with the state to integrate data on aging Californians from several agencies/programs.

- The Center will host the largest integrated dataset on aging indicators for the state of California.

- Will provide technical assistance to researchers and policymakers using the dataset (who have received approval from the Advisory Consortium) and assist individual researchers with study design, research questions, and analysis.

- The Center will conduct rapid response analysis for state policymakers and evaluators to answer pressing policy questions related to MPA implementation.

- Oversee the public-facing MPA data dashboard,

- Execute data use agreements and ensure HIPAA compliance across research studies.

Expected Outcomes

- Evaluation of MPA efforts as they are implemented, with an equity lens.

- Connecting disparate state data sources and filling data gaps to provide evidence to make sound and equitable policy decisions.

- Creating an unprecedented a policy collaborative across sectors: Policymakers, Academics, Advocates, Service Providers and Consumers to bridge the divide between aging research ->aging policy-> and service delivery in California.

- Create cost savings for the state through more efficient, evidence-based service provision.

- A new generation of policy makers and academics who understand how to work together to implement evidence-based policy that is age-, disability-, and dementia-informed.

- Improved quality of life for aging Californians.

Timeframe and Budget

- The MPA Research Consortium will operate over 10 years to guide and evaluate the implementation of the MPA policies

- A budget of 40M across 10 years (approximately 4M per year) is needed (see full proposal for details)

- Additional funding will come through researchers who are part of the MPA Research Alliance who will bring in National Institutes of Health/Aging grants, foundation funding, private industry funding, etc.