

***PROGRESS REPORT TO THE
LEGISLATURE ON THE
STRATEGIC PLAN FOR AN AGING
CALIFORNIA POPULATION***

**Prepared to fulfill California
Commission on Aging's
Monitoring Role on the SB 910
Strategic Plan
May 1, 2005**

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I. Executive Summary

California is home to nearly four million people over age 65—the largest older adult population in the nation. The number of older Californians will grow exponentially over the next few decades. Baby Boomers are already beginning to retire and California is not fully prepared.

The *Strategic Plan for an Aging California Population—Preparing California for the Retirement of the Baby Boomers*, was written in response to Senate Bill 910 (Ch. 948/99, Vasconcellos) to help California prepare for this demographic shift. The plan was signed by the Governor in October of 2003.

The California Commission on Aging (CCoA) agreed to monitor implementation and periodically update the Plan. For the past 18 months, this has been done through a three-part approach. To work on Strategic Plan implementation, CCoA convened nine new stakeholder task teams and established partnerships with two previously formed stakeholder groups. The CCoA hosted a March 8, 2005 forum (see Appendix A) to dialogue with state officials and statewide aging/advocacy organizations on the Strategic Plan. As a part of this monitoring role, the CCoA distributed and compiled the results of a baseline questionnaire on the Strategic Plan's top 15 priorities.

Highlights of the Task Teams' Work:

The 11 stakeholder task teams are working on 10 of the 17 Strategic Plan elements: Economic Security, Elder Financial Abuse (a subset of Economic Security), Transportation, Housing, Wellness/Prevention, Oral Health, Mental Health, Palliative/ End of Life Care, Long Term Care, Provider Workforce, and Assistive Technology. Early efforts focused on selecting priority recommendations for each team to work on. Among this first wave of activity, teams are working on 33 of the 321 initial recommendations in the Plan, and working on 14 new recommendations that teams added to the Plan.

- The Economic Security Team is encouraging employers to develop flexible work options; is taking action to eliminate age discrimination, and providing job training and support for older job seekers
- The Elder Financial Abuse Team is expanding the state's public outreach and prevention efforts to raise awareness. They are developing a statewide Financial Abuse Specialist Team (FAST), which would meet monthly to share information and develop a long-term strategic plan to address elder financial abuse. The team is also working to amend the existing financial abuse definition to include consumer fraud.
- The Transportation Team has just concluded a mobility summit, which resulted in overwhelming support to establish a California Mobility Council and related Mobility Task Force, which will address transportation service

- integration and coordination. The team is also focusing on “walkability,” making streets and sidewalks safer and more accessible while promoting more physically active lifestyles
- The Housing Team has placed preserving existing affordable housing at the center of their efforts along with home modification.
 - The Wellness/Prevention Team is promoting healthy aging through civic engagement and volunteerism, and also through health education, screenings and referrals. Supporting worksite wellness programs rounds out their efforts.
 - The Oral Health Team has worked hard to develop a completely new paradigm for a holistic oral health system which will be published in the California Dental Association Journal as the August, 2005 issue.
 - The Mental Health Team, bolstered by the passage of Proposition 63, now known as the Mental Health Services Act (MHSA), supports focusing on an anti-stigma campaign, depression and suicide prevention, the integration of primary care and behavioral health care, and developing mental health training programs for first responders.
 - The Palliative/End of Life Team is supporting the efforts of the California Coalition for Compassionate Care, seeking to educate the public and health care providers on the purpose and value of hospice care. Another of their priorities is realigning reimbursement systems to cover individuals with certain chronic diagnoses that are not “terminal” but need palliative care. Along a similar theme, they would like to reexamine the “six month life expectancy” restriction on hospice reimbursement.
 - The Long Term Care Team is working on care navigation implementation, as described in SB 953. They also are working on providing feedback and support implementation of the “Money follows the person” California Department of Health Services pilot grant. Thirdly, the team will facilitate discussions of how to improve the non-Medicaid-eligible public’s access to personal care resources and program infrastructure.
 - The Provider Workforce efforts, spearheaded by the California Council on Geriatrics and Gerontology, include supporting and further developing education systems (Community Colleges, CSUs, UCs) offering geriatric curriculum. They have plans to develop an education career ladder that matches the career ladder of child service workers.
 - The Assistive Technology (AT) Team is continuing to build on their newly formed partnerships. One is with the California Association of Area Agencies on Aging (C4A) to establish the AT Advocate pilot project and the other with

the Independent Living Centers (ILC's) to develop training resources for older adults new to assistive technology.

Five of the 11 teams have requested that 19 new recommendations and new background material be added to the strategic plan.

The task teams have been working for various lengths of time, the oldest of the CCoA facilitated task teams started in October of 2003. The task teams have made significant progress in refining priorities and developing activity lists.

It is important to note that the current momentum of the task team progress is not being driven by legislation, but by volunteer effort fueled by the realization that implementation of the Strategic Plan will take commitment and action by not just government officials, but by coalitions and partnerships of state and local, public and private sector, community based organizations, professional associations, advocacy organizations and individual effort.

CCoA Statewide Forum and Questionnaire

The March 8, 2005 Statewide Forum dialogue on the Strategic Plan, and the questionnaires received from state officials and statewide aging/advocacy organizations conveyed a consistent message about implementation progress on the Strategic Plan.

State officials and aging/advocacy organizations agree that 'some' or 'a little' *incremental progress has been made* on many of the top 15 priority goals in the Strategic Plan in this first period of the Plan's implementation phase.

Many innovations are happening locally with potential for replication including a partnership between Independent Living Centers and local building organizations to expand home modification resources, and a one-stop shop in Fresno that has co-located senior services.

State agencies and departments are responding to some administrative challenges that will support more innovation at the local level, and better collect data to guide policy priorities at the state level. Examples include facilitating better interface of IHSS data system and the system for Medical eligibility and local data systems, and continued state commitment to the Long Term Care Integration Pilot Programs.

The State Legislature has passed laws that incrementally address many programmatic and administrative challenges within the system for older adults and persons with disabilities. A few examples include accessibility legislation for new construction of town homes, and the SB 910 care navigation concept being implemented through a recent grant RFP.

There have been some capacity increases in funding for the state home and community based services systems including the passage of the Mental Health Services Act, the increase in residential care facilities licensing, and an increase in numbers of people receiving IHSS.

State officials and statewide aging/advocacy organizations also conveyed some formidable *challenges* towards implementation of the Strategic Plan. There is significant competition for scarce state resources by localities. This competition showcases the overwhelming need for program dollars; for example, the money from Proposition 46 for home modification was extremely oversubscribed.

The implementation of the Strategic Plan is largely dependent on the availability of a combination of local, state and federal funding streams. The State Budget situation is challenging both because of scarce dollars and because of reduced staffing at the state level dedicated to new innovations. This is compounded by scarce local government resources due in part to economic downturn and pressure from the state budget. The proposed federal budget could mean deep cuts to the state for health, housing, and workforce investment programs.

There has not been a *coordinated, statewide* advocacy effort around either the Olmstead Plan or Strategic Plan for Aging, the most significant planning documents for aging and disabled Californians. (Note: the Olmstead Advisory Committee has had two meetings in March and May of 2005.)

There is a lack of coordinated effort among state departments and agencies administering long term care programs for older adults and adults with disabilities. For example, programs for these populations are spread out among many departments, are duplicative, and uncoordinated at the state level. The Long Term Care Council has not yet been able to accomplish such coordination. While radical reorganization proposals were on the table from the California Performance Review process, leadership commitment and timing towards these changes has not yet been revealed.

This Progress Report has identified four key factors/trends that led to successes towards implementation of several Strategic Plan priorities. There has been tremendous stakeholder effort working on task teams, and task teams and task teams with funding sources have resources and momentum to continue in their charge. State legislative mandates, administrative priorities, and consumer/constituent ballot initiatives have facilitated expansion in much needed service areas for aging and disabled Californians. These key factors are presented in the Conclusion of this Report as successes along with future challenges.

The Commission offers the following recommendations/opportunities for state leadership based on the review of progress to date:

State Budget challenges provide an opportunity for leadership to follow past recommendations to streamline duplicative services through reorganization at the state level.

Top down state leadership (both administrative and legislative) is needed to accomplish state aging and Olmstead planning efforts. They should use their political muscle to bring stakeholders, departments and agencies under their purview together and identify ways to overcome barriers. State leadership must also address federal barriers to implementation and advocate for preserved programs and services funding.

Without these two components, the Commission believes limited sporadic, piecemeal progress will be made in the state's service system for aging and disabled Californians. These conclusions are supported by other states' experience in attempting to accomplish meaningful change in the aging/disabled services systems (i.e. Oregon, Florida and Washington.) The Commission encourages state leadership to discuss their willingness to take on this role, and we accept a challenge of our own: to unite advocates.

II. Purpose of Report

The legislation that called for the development of the *Strategic Plan for an Aging California Population—Preparing California for the Retirement of the Baby Boomers* also called for periodic updates. The California Commission on Aging (CCoA) agreed to assume responsibility for these updates, and agreed to submit a report to the Legislature on the progress of the Plan's implementation on a biennial basis. This document is the first such update. It not only contains recommendations for updating the Plan, but also summarizes implementation activities that the Commission is aware of that have taken place since the Plan was completed in October of 2003. Most of the implementation activities reported on in this plan are around the top 15 plan priorities. Due to limited time and resources, the Commission chose to limit its monitoring to these priorities and the priorities chosen by the task teams.

III. Background

A. Who is the California Commission on Aging?

The California Commission on Aging was established in 1973 by the Burton Act. It was confirmed in the original Older Californians Act of 1980 and reconfirmed in the Mello-Granlund Older Californians Act of 1996.

The Commission serves as "*the principal advocate in the state on behalf of older individuals, including, but not limited to, advisory participation in the consideration of all legislation and regulations made by state and federal departments and agencies relating to programs and services that affect older individuals.*" As such, the CCoA is the principal advisory body to the Governor, State Legislature, and State, Federal and local departments and agencies on issues affecting older Californians.

B. SB 910—Aging Planning Legislation

California is home to nearly four million people over age 65—the largest older adult population in the nation. This number is expected to more than double over the next several decades as the baby boomers begin reaching this milestone. To address this impending reality, Senator John Vasconcellos wrote Senate Bill 910 (Ch. 948/99, Vasconcellos). The bill mandated that the California Health and Human Services Agency develop a statewide strategic plan on aging for long term planning purposes. On October 14, 2003, the *Strategic Plan for an Aging California Population—Getting California Ready for the Baby Boomers*, was completed with the major support of the CCoA and a plan development task team representing 25 older adult stakeholder organizations supported by 15 state departments. The Governor signed the plan in November 2003. (The Strategic Plan can be reviewed at http://www.calaging.org/works/population_files/population.pdf. See

Appendix A—Strategic Plan Table of Contents and Appendix B—Strategic Plan Top 15 Priorities.)

C. CCoA's Monitoring Role of the Strategic Plan

SB 910 calls for biennial updates so that it can be continuously improved and reflect new circumstances, new opportunities and the changing socio-political environment. The CCoA agreed to assume responsibility for the monitoring and updating the Strategic Plan. In this capacity, the CCoA is responsible for convening stakeholders, holding meetings, and monitoring the progress of priority action items outlined in the Plan. This report is the CCoA's first report to the Legislature and the Secretary of Health and Human Service Agency on the progress of the Plan's implementation, as well as suggested updates to the Plan's contents to reflect changing priorities and actions.

The CCoA's approach to monitoring the Strategic Plan's implementation during 2003-2005 includes:

- Encouraging/facilitating work on Strategic Plan implementation by convening nine new stakeholder task teams, facilitating initial meetings and establishing partnerships with two previously formed stakeholder teams.
- Dialoguing with state officials and statewide aging/advocacy organizations at the March 8, 2005 Forum on the top 15 priorities in the Strategic Plan.
- Distributing and compiling the results of a baseline questionnaire on the Strategic Plan's 15 Priorities. The questionnaire was distributed to state officials and statewide aging/advocacy organizations.

The CCoA limited the scope of its monitoring role based on resources and staffing available to dedicate to this effort. The Commission was successful in receiving reporting on all of the top 15 Priorities, though reports on some priorities were much more substantial in number than others. As reflected in the CCoA's monitoring approach above, reporting data on the top 15 Priorities came from two sources, forum dialogue and the baseline questionnaire. Those participating included state officials and statewide aging/advocacy organizations. This report includes local progress and innovative programs towards accomplishing top 15 Priorities as they were conveyed to us by the state level leadership. The CCoA felt it was not feasible to attempt individual surveys of every locality and every priority in the plan. One drawback to the Commission's approach is that the reports on plan progress are limited by the knowledge of the respondents, time available to speak to the Commission at the forum and/or complete the questionnaire, and the limited number of topics discussed at the forum.

IV. Report of Commission Monitoring Efforts

A. Statewide Forum

On March 8, 2005, the CCoA hosted an *Invitational Forum: Planning for an Aging California*. The purpose of the Forum was to review the implementation progress on the *Strategic Plan for an Aging California* (Strategic Plan) with California State Officials and aging/advocacy organizations prior to presenting the first Progress Report to the State Legislature. In addition the Forum provided a public reporting opportunity for the 11 stakeholder task teams, which were convened to work on plan implementation.

The Forum audience included California aging policy makers from the public, private and non-profit sectors. While the Forum focused on three elements of the Strategic Plan: Housing, Economic Security, and Long Term Care, the Forum was jointly planned and scheduled with a March 7, 2005 *United We Ride Mobility Summit* which addressed Transportation issues for aging, disabled and low-income persons.

For each element a select panel reviewed the Strategic Plan related to their topic. The highest priority recommendations from the Plan's "top 15 priorities" were reviewed first, followed by a presentation on the efforts of recently convened stakeholder task teams to implement recommendations around the three elements. Each Panel concluded with a dialogue based on prepared questions to determine the extent to which the top priorities of the Plan have been implemented, and to seek reactions to the work of the stakeholder task teams

Brief presentations were made on the work of the other eight stakeholder task teams.

B. Survey of State Officials and Aging/Advocacy Organizations

Questionnaire Methodology

Background:

The CCoA agreed to take on the role of monitoring implementation of the Strategic Plan and report progress to the Legislature. One method the CCoA used to collect baseline data on implementation progress was a series of questionnaires sent to state leadership on the top 15 priorities listed in the Strategic Plan.

Design:

Commissioners, along with Commission staff, designed eight questionnaires around the Strategic Plan's top 15 priorities based on the priorities' subject areas. The subject areas included housing, economic security, long term care, provider workforce, data systems, transportation, mental health, and health and wellness. The questions sought to determine the extent to which the various priorities were achieved, specific accomplishments made towards implementation, further efforts needed for achieving the priority, and overall adequacy of the various categories of services for older adults in California.

Intent:

The intent of the questionnaire was to gain baseline data on where California has progressed on implementing the Strategic Plan since adoption in October of 2003. The Questionnaire can assist the Commission to develop an overall rating of the state's progress in responding to each of the major issues associated with California's aging population. It can also be used as a self-measuring and tracking tool for progress for state entities, and to help identify target areas for grant applications and partnerships between public and private entities. The questionnaire assures that the Commission's report to the Legislature is as accurate as possible. Questionnaires were analyzed and tabulated by Commissioners and Commission staff.

Distribution:

The eight topical questionnaires were distributed to the following numbers of entities for completion:

- Housing - 15
- Economic security -19
- Long term care - 14
- Provider workforce - 11
- Data systems -13
- Transportation -12
- Mental health - 9
- Health and wellness – 10

The 103 questionnaires were distributed by mail in February 2005 to state officials and statewide aging/advocacy organizations. Recipients received a cover letter explaining the questionnaire's purpose and an instruction sheet for completing the questionnaire. Several recipients called the Commission and asked to receive the questionnaire electronically to aid in their completing it. A few questionnaires were faxed to the recipients to correct address errors. Recipients were asked to complete the questionnaire by March 1, 2005. Responses were mailed and faxed back to the Commission office. Survey recipients included relevant state officials and aging/advocacy organizations (for instance, transportation specific advocacy groups received the transportation questionnaire, while economic security relevant advocates received the economic security questionnaire) for a total of 39 recipient entities. The questionnaire did not ask for names/agency, but did ask the survey respondent to indicate whether they were from a *state entity, advocacy organization, provider organization or other entity.*

Respondents:

Out of the 103 questionnaires, 18 questionnaires were returned, and all 18 were considered valid. The total response rate was 17.5 percent. Seven of the eight questionnaires received numerous responses. The mental health questionnaire received one incomplete response. Survey respondents identified themselves as 'state entity,' 'advocacy organization' and 'other entity.' No respondents categorized themselves as 'provider organization.'

Questionnaire results:

The Questionnaire asked the respondent for a scale measurement of progress on the relevant top 15 recommendations, then asked for specific qualitative data on accomplishments, and further efforts needed. The Questionnaire further asked for a scale rating for the general adequacy of the topic for older adults in California (i.e. housing, economic security, long term care, depending on the survey topic).

Respondents were asked the extent to which various top 15 Priorities had been achieved. The respondents limited their answers to Somewhat, A Little, or Not at All (in a range of Completely, Mostly, Somewhat, A Little, or Not at All).

Respondents were also asked to rate the overall adequacy of the various categories of services for older adults in California. Of the seven responses received on this question, Fair was selected by 71 % of the respondents (in a range of Excellent, Very Good, Fair, Poor, or Very Poor).

Categories of respondents (state entities, advocacy and other organizations) appeared to agree on both ratings: the achievement of the top 15 priorities, and the adequacies of services for older adults in California.

The qualitative responses received in the questionnaires for each of the top 15 recommendations are located in section V, *Progress report on Top 15 Priorities*, of this report and are melded with the qualitative responses received from the forum dialogue.

C. Task Team Process and Efforts to Date

Eleven Stakeholder Task Teams have been charged with identifying and focusing efforts on the recommendations they felt to be a priority. They have developed action plans to support or achieve implementation of these priorities and identified necessary amendments or additions to the original Plan. Some of the volunteer Task Teams have been meeting for close to a year though some Task Teams started their efforts later than others.

Written reports have been received from all Task Teams as to their progress through December of 2004—copies of these reports are available from the CCoA office. The choices and actions taken by the Task Teams are solely their own and do not necessarily represent the position of the CCoA.

The chart below identifies the 11 Task Teams and the current Chairs.

Task Team	Chair
Housing	Alisha Sanders, CA Association of Housing and Services for the Aging
Economic Security	Bonnie Parks, CA Employment Development Department
Elder/ Financial Abuse	Dick Ryder, CA Department of Corporations
Transportation	Peter Steinert, CA Department of Transportation
Wellness/Prevention	Laurie Vazquez, CA Department of Health Services
Mental Health	Ann Arneill-Py, CA Mental Health Planning Council and Maureen Price, CA Department of Mental Health
Oral Health	Paul Glassman, DDS, University of the Pacific School of Dentistry
Long Term Care	Beth Mann, CA Department of Aging, <i>Retired</i>

Task Team	Chair
Palliative/End of Life Care	Sally Adelus, Hospice of the Valley
Assistive Technology	Michael Sheffield, Integrated Senior Solutions
Provider Workforce	Pauline Abbott, CA Council on Geriatrics and Gerontology (CCGG) Liaison

1. Economic Security Task Team—Current Status

The Task Team began its work in June 2004, by reviewing the *Strategic Plan on an Aging California* including the full list of Economic Security recommendations. The Task Team worked through a selection process to identify three implementation priorities. The priorities represent what the Task Team members felt could be reasonably accomplished in the current environment. For each of these priorities, an Action Plan was created. As a final step, the Task Team compiled a list of barriers that hinder implementation.

The Task Force goal is to support programs that aid older workers to continue in the labor force for as long as they need to or want to work. To achieve this, the Task Force is striving to improve coordination between organizations that provide job-related supportive services for older workers including job placement, job skills training, and financial planning.

Members of the Task Team are working more closely together to support the individual programs of each member and to improve the coordination and effectiveness of the various programs as a whole. The Task Team will make a continuing effort to improve public access to resources by networking with each other. In addition, the Transportation Task Force impacts the Economic Security priorities because older workers cannot work if they have no transportation. One member of the Senior Worker Advocate Council is serving on the Transportation Task Force to insure that work issues are incorporated in the discussions.

Economic Security Implementation Priorities and Action Plan

Priority	Action Plan
Encourage employers to develop flexible work option plans	<ul style="list-style-type: none"> • Employers should develop mechanisms for improved work options including flexible scheduling, compressed work week, job sharing, part time/on call employment, “V-time” or voluntarily taking a portion of the year off, and telecommuting. • Provide incentives by offering prorated health benefits to part time employees.

Priority	Action Plan
<p>Encourage employers to develop flexible work option plans (continued)</p>	<p>Progress to date: The U.S. Department of Labor, Women’s Bureau has a workplace flexibility initiative called, Flex Options. This program works to get women owned businesses to start or expand flexible policies and practices for their employees. There are bimonthly national conference calls that feature best practices and role models. There are also working sessions that help business owners understand the various flex programs and how to get started.</p> <p>The Employment Development Department (EDD) Senior Worker Advocate Office provides various educational materials to assist employers, and older workers. The SWAO designed an Employer Tool Kit to assist employers in implementing age neutral-employment policies that will create flexible work places to meet all employee needs including older workers. The contents are based on input from the EDD Senior Worker Advocate Council (SWAC), the California Employer Advisory Council (CEAC) and business forums conducted by the U. S. Department of Labor. It includes best business practices to:</p> <ul style="list-style-type: none"> a) Create flexible work places to meet employee needs Recruit employees with specific skills including older workers b) Retain skilled employees of all ages c) Address older worker stereotypes d) Support training to maintain skill levels at all ages <p>The Employer Tool Kit is available on the EDD web site and has been marketed through the EDD California Employer, which is sent to every business in California. The Senior Worker Advocate Council, the California Employer Advisory Council and the California Coalition of Working Women have also shared it with their members. It has also been distributed to the members of the Economic Security Task Force for the <i>Strategic Plan for an Aging California Population</i>.</p> <p>The SWAO redesigned and improved automated educational materials on its web site to increase the accessibility and relevance of educational materials to older workers, job placement professionals, employers, and its partners. The SWAO solicits continual feedback to make the materials more useful to its stakeholders.</p>

Priority	Action Plan
<p>Take action to eliminate age discrimination</p>	<ul style="list-style-type: none"> • Change negative stereotypes of aging that exist in the media and throughout society by incorporating issues of diversity and elder involvement into the Stay Well public information program and on the Industry Coalition on Age Equity and the Media (ICAEM) agenda. • Strengthen and reinforce current employment law with regard to age discrimination by: <ol style="list-style-type: none"> 1) Expansion of employers awareness of the law 2) Clarification of who enforces the law 3) Strengthening enforcement procedures 4) Strengthening employee rights 5) Clarification and simplification of how employees file complaints <p>Progress to date: The Industry Coalition on Age Equity in the Media (ICAEM) works with the entertainment industry to improve the image of older adults that is portrayed by television and films. ICAEM works to have the portrayal of aging adults reflect the reality of a more active, creative, healthy and vital segment of society. The SWAO has partnered with ICAEM and the AARP to supply data on the aging workforce, which they have used to address negative stereotypes of aging that exist in the media.</p> <p>The AARP conducts surveys on major aging issues including the financial security of adults age 50 and over. The results of these surveys provide data on the need of adults over 50 to work. Because of this growing need for its members, AARP has established a list honoring the “Best Employers for Workers Over 50.” These companies and organizations, recognized for their best practices and policies for valuing the mature worker, are roadmaps for the workplaces of tomorrow. These employers are listed on their web site. The EDD refers older workers to the California companies on the AARP list.</p>

Priority	Action Plan
<p>Take action to eliminate age discrimination (continued)</p>	<p>The EDD Senior Worker Advocate Office conducts and supports various projects to address age discrimination in employment. The Stay Well public information program conducted by the California Department of Aging (CDA), The Senior Worker Advocate Office (SWAO) has partnered with the CDA to distribute positive images of aging by assisting distribution of the program information through the EDD partner One-Stop Career Centers.</p> <p>The SWAO organizes the Governor’s Older Worker and Exemplary Employer Awards Lunch during Older Americans Month in May. The Awards publicly recognize outstanding older workers and the employers who hire them. Statewide media coverage of the awards in newspapers and newsletters increase employer knowledge of successful business practices in employing senior workers. The SWAO partners with various public and private organizations including the SWAC, California Chamber of Commerce, CEAC, The California Department of Aging and the AARP to support the Awards.</p> <p>The SWAO trained over 150 One–Stop Career Center Staff from October 2003 to 2004 in response to local requests. The SWAO “Silver Tool Box” trains One-Stop Career Center staff and other local partners on how to assist older workers to overcome age discrimination barriers to employment.</p>
<p>Provide job training and support for job seekers</p>	<ul style="list-style-type: none"> • Consolidate and revitalize private non-profit and community-based organizations’ older worker programs. <ol style="list-style-type: none"> 1) Eliminate service fragmentation and add an older worker advocacy component. 2) Provide culturally relevant, job-related supportive services for older workers including: <ol style="list-style-type: none"> a. Personal and job counseling b. Job referral services

Priority	Action Plan
<p>Provide job training and support for job seekers (continued)</p>	<ul style="list-style-type: none"> c. Resume/job applications and supportive services to include: <ul style="list-style-type: none"> o Interviewing skills o Transportation o Health management o Appropriate supports for persons with disabilities d. Establish or revitalize job development relationships with business and labor. e. Coordinate relationships with educational institutions to provide appropriate opportunities for career enhancement, job training, retraining, and skill development. <ul style="list-style-type: none"> • Community College/Adult Education Job Support Programs: <ol style="list-style-type: none"> 1) Implement senior curriculum and services through the Community college system that will provide an array of educational and counseling options to help California's older residents enhance their skills and therefore, their opportunities to find and keep jobs. • CSU and university of California Job Support Programs: <ol style="list-style-type: none"> 1) Offer Extension courses that meet the needs of older working students who need to upgrade skills and/or participate in certificate programs in order to enhance career change/employment options. 2) Expand offerings over the Internet, grant work/life credits toward earning a degree, and similar creative methods to support the continuing education needs of the aging workforce. • Employers develop/provide internal career coaching, mentoring development programs.

Priority	Action Plan
<p>Provide job training and support for job seekers (continued)</p>	<p>Progress to date: The Senior Community Service Employment Program (SCSEP) is a federally funded training and employment program limited to individuals who are 55 years of age and older and whose income is within 125 percent of the poverty level. Some of the SCSEP programs provide culturally diverse programs, however resources are limited and the culturally diverse population in California is growing. The EDD partners with SCSEP to refer older workers to them who require culturally relevant, job-related supportive services.</p> <p>Adult Ed and Higher Education Institutions are responding to the aging student body by offering extension courses, certificate programs, internet courses, and work/life credits toward earning a degree. The SWAO provides information on job training resources to older workers, employers and other partners.</p> <p>One-Stop Career Centers provide universal service to all individuals who are seeking training and employment. They partner with the EDD and the SCSEP program and often partner with community colleges and adult education programs to refer older workers to low cost training. SWAO staff respond to daily telephone calls and e-mails from older workers requesting assistance in obtaining employment. The SWAO refers them to local organizations including the Career Centers.</p> <p>The EDD Senior Worker Advocate Office partners with many public and private organizations to increase coordination of efforts to assist older workers. The major partnerships include:</p> <ol style="list-style-type: none"> a. Older Worker Week Job Fairs—The SWAO staff coordinate Job Fair materials for older workers for National Employ an Older Worker Week in September. The SWAO partners with the EDD Job Service Division and Workforce Development Division, the California Department of Aging and the U. S. Department of Labor to distribute materials to EDD Job Service Field Offices, One-Stop Career Centers, the AARP and Senior Community Service Employment Offices in California. b. California Career Planning—The SWAO partners with educational institutions to provide appropriate opportunities for career enhancement, job training, retraining and skill development for older workers.

Priority	Action Plan
Provide job training and support for job seekers (continued)	The SWAO initiated and developed older worker segments for the 92 page statewide California Career Resource Network (CalCRN) guide that was previously oriented only for younger workers. The CalCRN includes Adult Ed and Higher Education Institutions. The EDD partnered with CalCRN to revise the guide, which is distributed to thousands of career counselors, students, job seekers and educators in California through a federal grant.

Barriers to Economic Security Priorities Implementation

The most significant barrier is lack of resources. Budget constraints make it difficult to implement and sustain support and educational programs aimed at both employers and older workers.

2. Elder Financial Abuse—Current Status

The Elder Financial Abuse Task Team met monthly from July to December 2004, to select priorities and develop an action plan for 2005.

The Task Team began its work by reviewing the *Strategic Plan on an Aging California* including the full list of Elder Financial Abuse recommendations. The Task Team worked through a selection process to identify two implementation priorities. The priorities represent what the Task Team members felt could be reasonably accomplished in the current environment. For each of these priorities, an Action Plan was created. As a final step, the Task Team compiled a list of barriers that hinder implementation.

Elder Financial Abuse Implementation Priorities and Action Plan

New Priorities not included in the original October 2003 *Strategic Plan for an Aging California Population* are shown in italics.

Priority	Action Plan
<i>Expand educational programs about fraud schemes to the senior and dependent adult communities, law enforcement, and prosecutors. Use the existing educational models from the Attorney General (AG) and Dept. of Corporations (DOC).</i>	<ul style="list-style-type: none"> • Education—By using the existing AG and DOC educational models, expand education to the senior and dependent adult communities, law enforcement, and prosecutors about the schemes used to defraud this demographic. The education component would: <ul style="list-style-type: none"> a) Make the elderly aware of such schemes, ways to avoid the schemes, and the importance of reporting questionable financial transactions early to the proper legal authorities.

Priority	Action Plan
<p><i>Expand educational programs about fraud schemes to the senior and dependent adult communities, law enforcement, and prosecutors. Use the existing educational models from the Attorney General (AG) and Dept. of Corporations (DOC)(continued).</i></p>	<p>b) Make law enforcement aware of the different schemes throughout the state and provide suggestions on how to coordinate their efforts with other agencies, and</p> <p>c) Keep the prosecutors’ offices aware of the prevalence of the schemes throughout the state and encourage those offices to actively prosecute offenders.</p> <p>Build on the experience of the SAIF Program to organize volunteers at the grass-roots level, and the experience of the Attorney General’s Office, which utilizes the media to get their prevention message out. Both models have proven to be a highly effective method of education and prevention.</p>
<p><i>Establish a highly effective enforcement initiative and senior fraud investigative team to provide an important vehicle to bring authorities earlier information about scams targeting seniors.</i></p>	<ul style="list-style-type: none"> • Coordinate well-trained volunteers, who are retired certified investigators and retired law enforcement personnel. They would attend and observe solicitation meetings. Approval, supervision and training by law enforcement officials would be necessary. Law enforcement now must rely upon victim complaints, and victims are often the last ones to realize that they have been defrauded. Through rigorous education and investigation, reports of scams can be identified while they are under way, rather than long after they have occurred. Earlier information not only facilitates effective investigation, but also will enable law enforcement to prevent losses to victims. • Establish an “Association of Senior Fraud Investigators.” • Develop a comprehensive training curriculum to be used by the Senior Fraud Investigative Team. • Gather evidentiary information and report it to the appropriate agencies for enforcement action. • Establish a system to track, monitor, and collect data on current senior fraud scams presently active throughout the state.

Barriers to Elder Financial Abuse Priorities Implementation

- Lack of awareness of the extent of the problem.
- Lack of program funding.

- Inability to implement many recommendations without specific authority.
- Law enforcement must rely upon victim complaints to learn of potential fraud, and victims are often the last ones to realize that they have been defrauded.

3. Transportation—Current Status

The Transportation Task Team was formed and led by the California Department of Transportation, with considerable support from the California Association for Coordinated Transportation (CalACT) and CCoA. Membership included representatives from the human service transportation industry, aging and disabled communities, economically disadvantaged, and other stakeholders.

The Task Team began its work by reviewing the *Strategic Plan on an Aging California* including the full list of Transportation recommendations. The Task Team worked through a selection process to identify four implementation priorities. The priorities represent what the Task Team members felt could be reasonably accomplished in the current environment. For each of these priorities, an Action Plan was created. As a final step, the Task Team compiled a list of barriers that hinder implementation.

The initial meeting was held on June 30, 2004. The team has met monthly since that date. Two subcommittees were established in July 2004: the Walkability Subcommittee and the Service Coordination and Transportation Alternatives Subcommittee. Both have been holding regular meetings since July.

The Walkability Subcommittee has two areas of emphasis: 1) to make neighborhood streets and sidewalks safer and more accessible so that seniors can choose to walk if they do not drive, and 2) to promote more physically active lifestyles. The benefits of physical activity are numerous, e.g., reducing the risk of premature mortality from coronary heart disease, hypertension, colon cancer, and diabetes mellitus, as well as from fall-related hip fractures. Additionally, walkable neighborhoods increase opportunities for social interactions, which are critical to preventing isolation and depression. Walking is an “easy fix” since it is the most inexpensive and popular form of physical activity for seniors.

A major effort for the Service Coordination and Transportation Alternatives Subcommittee was the application for federal funds to convene a Mobility Summit to further integration and coordination as recommended in the Strategic Plan. The Federal Transportation Administration provided funding for the Summit. The Transportation Task Team worked with the CCoA to conduct the Summit in coordination with the Commission’s Invitational Forum and White House Conference on Aging: Solutions Forum. The combined

three-day program was entitled, “Convening Aging & Transportation Leadership” and was held March 7-9, 2005 in Sacramento and resulted in overwhelming support to form a California Mobility Council and companion Mobility Task Force.

A number of public presentations have been made by the Transportation Task Team Chair to solicit Task Team participants, report on the status of the Task Team progress, and to garner support for the implementation of the Strategic Plan strategies.

Several related efforts are underway to help address other Strategic Plan recommendations. For example, the Department of Transportation has formed a TDA Working Group to examine the need for changes or clarifications to the TDA regulations, especially in relation to fare-box recovery ratio requirements. A subcommittee of CalACT is participating in state efforts to modify the state’s Medicaid program (MediCal). CalACT is focusing on reform issues, such as changing policy to permit MediCal funds to support transportation by transit, and adequate reimbursement of transportation costs for non-emergency medical trips. The Beverly Foundation, in conjunction with the Community Transportation Association of America, has recently published “Innovations for Seniors” as a guide to community transportation alternatives. Presentations have been made to Transportation Task Team members on these topics. The California Foundation of Independent Living Centers is researching methods to increase the availability of accessible taxis. They have convened a group of stakeholders that have met several times to discuss the issue.

An essential part of the Task Team’s success will be the ability to continue the momentum from the Mobility Summit and put some of the issues discussed into practice.

Transportation Implementation Priorities and Action Plan

Priority	Action Plan
Support Pedestrian-Oriented Facilities and Services	<ul style="list-style-type: none"> • Foster healthy pedestrian (walking) lifestyles <ul style="list-style-type: none"> a) Seek funding to replicate and sustain Safe Neighborhoods for Seniors (SN4S) programs, originally a public health demonstration project funded by the Robert Wood Johnson Foundation. These local coalition-driven projects work on environmental and social norm changes to make communities more walkable for seniors.

Priority	Action Plan
<p>Support Pedestrian-Oriented Facilities and Services (continued)</p>	<ul style="list-style-type: none"> b) Design and conduct an annual Universal Walkability Day that promotes walking for seniors (and for everyone). It could include best practice awards, walking contests, safe route maps, etc. to make it an entertaining and positive experience. Seek corporate and local business sponsors. c) Work in concert with Ride Share programs across the state to incorporate a “Walk Share” component that would utilize existing databases to promote the concept and to connect walking buddies. <ul style="list-style-type: none"> • Improve connections between destinations with safe walking routes <ul style="list-style-type: none"> a) Work with Department of Housing and Community Development (HCD) to include walkability in its guidelines to local governmental entities that inform development of local General Plans (e.g., select strategies to incorporate walking based on a walkability audit). <p>Note: HCD is the authority that accepts reviews and approves General Plans, and awards community development block grant funds based on those plans.</p> b) Develop and disseminate educational fact sheets for city and county planners, planning commissioners, public works directors, and traffic engineers to raise awareness on requirements set forth in state statutes related to accessible sidewalks. <p>Note: This is especially important for planning officials who review and approve senior housing projects. (Currently, they usually “pass” projects that adhere to the less stringent federal statutes). These educational fact sheets will also include examples of best practices and other positive outcomes to ensure that the tone is not punitive one. Letters disseminated by Attorney General on accessibility can serve as models. Seek advice from the Independent living Centers (ILC) who can offer examples of changes in “real time” that have been effective.</p> • Improve pedestrian access to transit <ul style="list-style-type: none"> a) Seek funding to conduct a survey of local transit stops. This would be the first step in determining what actions are needed to improve senior pedestrians’ ability to use transit.

Priority	Action Plan
Support Pedestrian-Oriented Facilities and Services (continued)	<p>Note: AARP’s <i>Livable Communities: an Evaluation guide, 2000</i> could guide the development of this survey. The SR4S projects should conduct these surveys as part of their scope of work—their ideas related to appealing and accessible solutions would inform subsequent actions.</p>
Plan and Implement Integration and Coordination Strategies and Provide a Continuum of Coordinated Services	<ul style="list-style-type: none"> • Host the Mobility Summit as described in the United We Ride application. <ul style="list-style-type: none"> a) A Mobility Summit Planning Committee is implementing this action item. The plan is to leave the March 7, 2005 Mobility Summit with specific next steps and a commitment to form a steering committee tasked with establishing the California Mobility Council and Mobility Task Force as described in the LRSPA. b) Continue the momentum from the Mobility Summit and put some of the issues discussed into practice. Our goal is to leave the Mobility Summit with the outlines of a work plan that will carry the TTT’s work into the future.
Strengthen Consolidated Transportation Service Agencies (CTSAs)	<ul style="list-style-type: none"> • Conduct an assessment of CTSAs and best practices. <ul style="list-style-type: none"> a) This will be an evolving document, which will continue to grow as interest increases.

Barriers to Transportation Priorities Implementation

The following barriers to implementation have been identified:

Barriers to Walkability

- Social norms that deem walking as “uncool” for people who can’t afford to do otherwise.
- Potential liability if seniors fall on premises when walking.
- Lack of funding and the concomitant challenge that funding silos present when funders do not allow flexibility when it can be demonstrated added value when funds are braided with other projects and resources.
- Lack of political will to make systematic changes.

Barriers to Integration, Coordination, CTSA's

- Lack of state and local leadership to coordinate programs and services
- Lack of regulatory authority to mandate that CTSA's be established and perform service coordination and improvement functions.
- Lack of incentives to coordinate or improve services.
- Lack of consensus by stakeholders due to programs being funded from different "silos" and subject to differing requirements
- Lack of resources, particularly funding and staffing, at the local and state level
- Lack of local leadership to coordination (for example between programs such as escort services, homebound meals and transportation for employment).
- Dollars need to follow the person (from various funders) not follow the program.
- Lack of political will to make systematic changes.

4. Housing—Current Status

The Housing Task Team began its work by reviewing the *Strategic Plan on an Aging California* including the full list of Housing recommendations. The Task Team worked through a selection process to identify four implementation priorities. The priorities represent what the Task Team members felt could be reasonably accomplished in the current environment. For each of these priorities, an Action Plan was created. As a final step, the Task Team compiled a list of barriers that hinder implementation.

Housing Implementation Priorities and Action Plan

Priority	Action Plan
Preservation of Existing Affordable Housing Inventory	<ul style="list-style-type: none"> • Coalition building to create a political mandate to preserve the existing stock of affordable housing. <ul style="list-style-type: none"> a) Plan to host a session that addresses this issue at Housing California's 2006 Annual Conference. b) Determine the feasibility of hosting a summit to bring stakeholders/advocates for older adults and persons with disabilities together to develop a concrete and detailed implementation plan to implement the highest preservation priorities.

Priority	Action Plan
<p>Preservation of Existing Affordable Housing Inventory (continued)</p>	<p>c) Track the funding status of Sections 8, 515, and 202 housing in California. Disseminate latest information to all older adult organizations in California.</p> <p>d) Partner with Housing California, HCD, county, and city governments to develop a tracking system to monitor “at-risk” affordable housing projects, privatization, gentrification, and redevelopment.</p> <p>Use our network to alert organizations, local governments, and AAAs about “at risk” housing projects and provide recommendations for taking action.</p>
<p>Sustainable funding for Affordable Housing</p>	<ul style="list-style-type: none"> • Work with other affordable housing advocacy groups to identify and advocate for a reliable permanent source of state funding for affordable housing. • Alert other older adult organizations of the need to identify a permanent source of funding and enlist their support.
<p>Affordable Assisted Living</p>	<ul style="list-style-type: none"> • Monitor and support the progress of the Assisted Living Waiver Pilot Project. • Encourage publicly subsidized housing sites in the targeted communities of San Joaquin County, Sacramento County, and a portion of Los Angeles County to participate in the pilot project. • Support efforts to document successes, barriers, and lessons learned in order to encourage replication and further sustainability of the model.
<p>Accessible Homes and Communities</p>	<ul style="list-style-type: none"> • Monitor Community Development Block Grant funding, a major source of financing for home modifications that is “at risk” for funding cuts. • Advocate for AB 63, which establishes an Elderly and Disabled Persons’ Revolving Home Improvement Loan Program within HCD. The bill, now in committee, would award grants to local public agencies or nonprofit corporations to administer no-interest home improvement loans to low-income elderly and persons with disabilities.

Priority	Action Plan
Accessible Homes and Communities (continued)	<ul style="list-style-type: none"> • Support and monitor the implementation of two Universal Design (UC) bills, AB 2787 and AB 1400. A two-tier or hybrid approach that integrates both bills is necessary to mandate basic accessibility requirements in new homes while requiring builders to offer additional features to the homebuyer. • To build support from the building industry, the HCD must insure that contractors and architects receive training on the broader issues of aging and disability. Housing professionals need to be involved in amending building codes and promoting UD features. • Encourage housing agencies to conduct comprehensive UD cost analyses to understand specific costs for builders and consumers. Such analyses should be readily available to cities and counties as they develop local ordinances. • Partner with the Transportation Task Team to create accessible communities with accessible homes connected to safe walking routes, pedestrian access to transit, and elder-friendly recreation trails.

Barriers to Housing Priorities Implementation

General Housing Barriers

- The sheer breadth and complexity of housing issues, and corresponding lack of coordination between and amongst housing organizations, non-profit, for profit, local and state government
- Lack of statewide and county level comprehensive data, both present and projected, about the supply of housing. This includes lack of specific data on the supply, both present and projected, at various affordability levels—extremely low income, low income, moderate.
- Perception that older adult housing programs hurt housing opportunities for persons with disabilities.
- Lack of a centralized clearing house and/or communication resource for getting information out in a timely and comprehensive manner.
- Lack of communication between organizations advocating for older adults and persons with disabilities.
- Lack of funding and man power for coordinated/ integrated programs such as mentioned above. Lack of funding for proven programs such as www.homemods.org.

- Perception—Some public agencies and advocates of affordable housing feel that seniors are already getting more than their fair share of funding for affordable housing and aren't supportive of additional funding being committed to senior only projects—a question of more than enough vs. a serious deficit.
- Lack of data about the true level of need for older adult housing in the state
- Funding—Will we be able to find the funding to host a summit on senior housing and preservation?
- Participation—Housing has traditionally not been the top priority for many senior groups. Will we be able to get people to participate in a summit on senior housing and preservation?

Barriers to Preservation of Affordable Housing

- Funding—Funding levels for affordable housing have declined at both the federal and state level. Given the budget challenges all levels of government are facing, this priority is unlikely to shift and funding is likely to continue declining.
- Market Forces—When given the chance to opt out of subsidy programs, CA owners know they can make a much larger profit by charging market-rate rents and, therefore, have less incentive to stay in HUD programs where rents are restricted. (Although state law requires advanced notification of an owner's intention to opt out of subsidized programs and gives purchase rights to non-profits, will the funding be available for non-profits to purchase these properties?)
- Gentrification—With the high housing costs in California, the only option for some people is to buy in more run down neighborhoods. When enough people start purchasing, however, the balance shifts and these neighborhoods start to become unaffordable.
- Neighborhood Rehabilitation—Cities face a fine line between preserving affordable housing and improving the economic vitality of deteriorating neighborhoods. This often means tearing down affordable housing stock (Single Room Occupancy hotels, for example). As improvements are made to a neighborhood and more people are willing to move in, that neighborhood becomes unaffordable.
- Speculation—People are buying less expensive houses (turning apartment complexes into condos, etc.) with the purpose of playing the rising house cost market and quickly turning the properties for a profit.
- Influence—Residents of affordable housing are generally not a powerful political constituency.

Barriers to Accessibility

- Added Costs—AB 2787 requires HCD to develop a voluntary model universal design ordinance for communities around the state to consider adopting. Most jurisdictions will likely face opposition from the building community to adopting such an ordinance because of the added costs.
- Awareness—If not disabled in some way themselves, many consumers may not consider the need for accessible features in their home. They also may not be thinking about disabled visitors, or their own future needs, or the needs of family members.
- Sheer Size of the State—How could this committee reach out to such a large number of communities to encourage them to adopt a universal design ordinance?

5. Wellness and Prevention—Current Status

The Wellness and Prevention Task Team started meeting in August of 2004 and met monthly thereafter. The Task Team consists of 28 members.

The Task Team began its work by reviewing the *Strategic Plan on an Aging California* including the full list of Wellness and Prevention recommendations. The Task Team worked through a selection process to identify three implementation priorities. The priorities represent what the Task Team members felt could be reasonably accomplished in the current environment. For each of these priorities, an Action Plan was created. As a final step, the Task Team compiled a list of barriers that hinder implementation.

In selecting priorities, the Task Team considered four overarching themes that became a guide for action:

- Develop a collaborative process to eliminate fragmentation, integrate funding and create a customer-centered, seamless system of long-term support for Wellness, Healthy Aging and Quality of Life.
- Foster collaboration among local Area Agencies on Aging, Park and Recreation agencies, and other community agencies.
- Direct intergenerational and family efforts toward health promotion that include caregivers, working adults, multi-ethnic groups, rural and urban seniors.
- Develop activities that allow aging boomers to volunteer at all stages of life in order to remain productive and connected to society; establish opportunities for seniors to optimize community involvement and demonstrate to society that they are vital, active, and possess great intellectual wealth to be appreciated by others. (This thought is derived

from Assembly Member Patty Berg’s *“Planning for an Aging California Population—Preparing for the Aging Baby Boomers,”* May 2004, page 5).

Wellness and Prevention Implementation Priorities and Action Plan

The team has outlined what needs to be accomplished in each of the three priority objectives.

Priority	Action Plan
<p>Optimize Senior Community involvement by promoting volunteerism</p>	<ul style="list-style-type: none"> • A “central clearinghouse” is needed to direct older adults to volunteer opportunities and to help agencies establish model volunteer programs. Centralized training information and technical assistance is needed—both for volunteer leaders and volunteers. Tool kits need to be available from the clearinghouse that provide the necessary information to develop and maintain new volunteer programs based on best practice models. Tool kits should include information such as: ways to establish community agency collaboration, how to foster volunteerism, multi and inter-generation concepts and effective ways to teach younger citizens how to work and communicate with older adults, and how to outreach to and identify “key leaders” with volunteer capacity. • Barriers to volunteering need to be explored—both from the perspective of the community agency and the older adult. The older adult may face barriers to volunteering. Barriers include inadequate: knowledge of volunteer opportunities, confidence that a person has something worthwhile to contribute, transportation, training opportunities for volunteer leaders and volunteers, volunteer opportunities that bring out individual talents or knowledge, and funds to cover the costs associated with volunteering—such as mileage or supplies. Agencies may also confront barriers to establishing volunteer programs such as: lack of knowledge of how to set up and maintain a program, space, leadership, a system of identifying older adults in the community who would volunteer, cost (i.e. liability), and time to provide on-going oversight that ensures stability of volunteers, etc.

Priority	Action Plan
<p>Optimize Senior Community involvement by promoting volunteerism (continued)</p>	<ul style="list-style-type: none"> • Incentives need to be available to promote volunteerism. These may include the following: provision of stipends for training, payment of supplies, mileage reimbursement, transportation, information about ways to write off expenses, local and state recognition through awards, luncheons, media feature stories, and gift certificates. Incentives identified that will encourage agencies to establish volunteer programs include the recognition of stellar volunteer programs with special awards, media feature stories, and publicizing best practice volunteer programs through the “clearinghouse.”
<p>Promote health and wellness among older adults through health screens, education and referrals to services and resources</p>	<ul style="list-style-type: none"> • The Preventive Health Care for the Aging (PHCA) program should be promoted through an augmentation of the state general fund so that it can reach seniors in every county of the state. The PHCA is an established program with experience that spans over a quarter of a century and has proven outcomes demonstrating its effectiveness in supporting wellness among seniors. • Model disease management programs needs to be promoted across the state. Programs such as the “Chronic Disease Self-Management Program” and the “Arthritis Self Help Program” emphasize developing and maintaining healthy lifestyles while living with chronic conditions. They are based on a model that supports master trainers and lay trainers with chronic conditions to guide seniors with chronic conditions to establish daily wellness and disease management regimes. • Broad-based health education efforts need to be encouraged. Models include the following: AARP health pamphlets, magazines and campaigns, the “Stay Well” (StayWell is one word) program that was previously provided by the California Department of Aging, Promotora programs, such as the “Milk Program” conducted by Project Lean, lecture events and large scale community conferences such as the “Healthy Aging Summit” sponsored by UC Davis and other local partners, and Senior Health Info Vans supported by the CA Department of Aging. “Parish Nursing” and “Health Ministry Programs” also represent programs that promote health in the community and should be encouraged.

Priority	Action Plan
<p>Promote health and wellness among older adults through health screens, education and referrals to services and resources (continued)</p>	<ul style="list-style-type: none"> • Free fitness programs for seniors need to be promoted across the state. The Active Aging Program should be promoted so that it will be available in every county. • A central “clearinghouse” of senior health information and resources is needed. This will help support the desired “seamless system of care” discussed in SB 910. Local “INFO” lines need to be available to inform seniors about free or low-cost health screens, education and resources. Clearinghouse information should include service eligibility requirements, cost or process for insurance billing, free vs. co-pay, hours of operation, etc. Support is needed to establish local coalitions that can develop local clearinghouses. Coalition development requires identification and training of lead agencies, support for conducting outreach to potential partners, and on-going administrative support. A model clearinghouse for senior information is the statewide Area Agency on Aging Info Line (1-800-510-2020). • Lifelong learning centers need to be supported to promote senior health and quality of life. Model programs include the following: University “Re-Entry” programs (i.e. CSUS), elder hostels, faith-based communities, Renaissance Centers, Adult Learning Institutes, and Community Beacon programs that encourage seniors to take computer classes in the afternoon. These programs can be venues for disseminating health information. Barriers to participation in these programs include the cost of parking, transportation and materials. Support to reduce these barriers is needed.
<p>Promote and expand worksite wellness programs in California</p>	<ul style="list-style-type: none"> • Information about model work-site wellness programs needs to be disseminated. Both public and private agencies throughout the state need to come on board with work-site wellness campaigns and programs. A central clearinghouse of information is needed. Tool kits are needed for both large and small businesses aiming to establish programs. Information needed includes liability coverage concerns, program guidelines, ideal and feasible course curriculum, training courses for leaders, and information on ways to mobilize employees to participate. Programs should promote healthy nutrition, physical fitness, disease risk factors, prevention and management. On-site health screens for blood pressure, cholesterol, osteoporosis

Priority	Action Plan
Promote and expand worksite wellness programs in California (continued)	<p>and other conditions can be done to promote early detection among working adults. On site disease self-management programs should be offered to employees who have chronic conditions, such as arthritis, diabetes and obesity.</p> <ul style="list-style-type: none"> • Barriers faced by employers and employees need to be addressed. • Incentives need to be established for employers and employees to engage in programs. The eight-hour workday needs to include 30 minutes of paid time for physical activity or wellness promotion. Employers who offer worksite wellness programs should be recognized through the “clearinghouse” and be given tax breaks and health insurance carrier discount incentives.

Barriers to Wellness and Prevention Priorities Implementation

- Lack of time and resources
- Adequate input from many stakeholders
- Insufficient designated staff to convene stakeholders, collect and organize information, and taking action on all components
- Legislation is required for some of the recommended components and thus legislative staff support is needed
- Lack of funding. Interested foundations should be contacted to ascertain if there is mutual interest in supporting these endeavors.
- Inadequate networking, or “person power” to make these connections and to lead in developing negotiations
- The resources and information exist, but need to come together under skilled and energetic leadership

6. Oral Health—Current Status

The Pacific Center for Special Care at the University of the Pacific School of Dentistry (Pacific) has been designated as the lead agency to form the Dental Task Team. Pacific established a Statewide Task Force on Oral Health and Aging several years ago. That Task Force is now serving as the California Commission on Aging (CCoA) Oral Health Task Team for the *Strategic Plan for an Aging California*.

The Task Force has been meeting two to three times per year. Approximately 30 to 40 individuals and agency representatives attend each meeting. Dr. Paul Glassman from Pacific has been serving as the Director of the Oral Health Task Team and representative to the CCoA.

A recent meeting of the Oral Health Task Team took place at a major conference put on by Pacific in conjunction with the Statewide Task Force on Oral Health and Aging and the Statewide Task Force on Oral Health and People with Special Needs and with support from the California Dental Association Foundation. The conference took place on November 4, 2004.

The purpose of this conference was to explore the changing population of people with special needs, analyze the implications for the dental profession and society, and describe systems and strategies that might lead to improved oral health for these populations. Seven nationally recognized speakers presented draft papers on various aspects of this topic. There was time for audience reaction and discussion with the speakers. The speakers and a designated group of reactors (referred to as the panel) then developed a draft consensus statement with recommendations for addressing these issues.

Oral Health Implementation Priorities and Action Plan

In the coming year, the Oral Health Task Team will continue to meet and develop ways to implement the specific recommendations created in the November 4, 2004 conference and identify future action plans. New Priorities not included in the original October 2003 *Strategic Plan for an Aging California Population* are shown in italics.

Priority	Action Plan
<p><i>Develop a new model/system for delivering oral health services with the following characteristics:</i></p> <p>a) <i>A focus on prevention</i></p> <p>b) <i>A reward system that addresses services likely to improve oral health for these populations.</i></p> <p>c) <i>A system integrated with other community health and social service systems.</i></p>	<ul style="list-style-type: none"> • The results of the conference described above are currently being reviewed and compiled. They will be circulated for feedback and published in the August 2005 issue of the Journal of the California Dental Association. • The Oral Health Section of the Long Range Strategic Plan for an Aging California should now be replaced with the above referenced conference report. • The Oral Health Task Force will consider methods for implementing the recommendations in the report described above. This may involve developing a Health Workforce Pilot Program to establish the effectiveness of new models of oral health care delivery.

Priority	Action Plan
<p><i>Develop a new model/system for delivering oral health services with the following characteristics (continued):</i></p> <p>d) <i>A triage and referral system where oral diseases can be identified and people referred to care settings that best match their situation and needs</i></p> <p>e) <i>A tiered delivery system with oral health professionals serving as coaches, mentors, and supporters of other health and social service professionals.</i></p> <p>f) <i>A system that engages those caregivers closest to the individual in playing a major role in maintaining oral health.</i></p> <p>g) <i>A tiered delivery system where increasingly complex care is performed by those with most extensive training to deliver such care and less complex care is delivered by those with less extensive training.</i></p>	
<p><i>Provide adequate reimbursement for oral health treatment services. Provide a mechanism in the California Denti-Cal program to reimburse for extra time spent with a patient with special needs with medical or behavioral challenges.</i></p>	<ul style="list-style-type: none"> • The Oral Health Task Team will invite the Department of Health Services, Medi-Cal Dental Branch, to enter into discussions about reimbursement mechanisms that would encourage and reward dental providers to see patients who require extra time and expertise to treat.

Priority	Action Plan
<p><i>Develop oral health goals and standards for residential facilities and use quality improvement systems to improve compliance with these standards. Tie this to licensure and certification inspections.</i></p>	<ul style="list-style-type: none"> • The Oral Health Task Team has met with officials from state health care and community care licensing. It is clear that current licensing regulations in the area of oral health, especially those covering health care licensed facilities are not adequately monitored or followed. The licensing agencies agreed to increase training about oral health issues for their licensing inspectors. The Task Team will monitor progress of this training and its results.
<p><i>Recognize that many people with special needs require professional care from dentists with a higher level of training than is provided in dental schools. Require year of “service and learning” for all dental graduates in an advanced education program accredited by the Commission on Dental Accreditation for dental licensure in California.</i></p>	<ul style="list-style-type: none"> • The Task Team is working with leaders in the dental education community to expand the link between advanced education and licensure. The hope is to expand this link to ultimately require a year of service and learning to obtain a dental license in California.
<p><i>Increase training for all dental professionals in providing care for people with special needs. This includes providing didactic instruction and clinical experience in this area for dental and dental hygiene students. Make this a part of the accreditation requirements for dental and dental hygiene programs. Also require continuing education in this area for all dental professionals.</i></p>	<ul style="list-style-type: none"> • Pacific has designed an on-line curriculum which now satisfies the Dental Board requirement for a 150-hour curriculum in order to obtain the Registered Dental Hygienist in Alternative Practice (RDHAP) license in California. Dental Hygienists with the RDHAP license can practice independently in underserved areas and with underserved populations such as individuals in nursing homes and shortage areas.

Priority	Action Plan
<p><i>Coordinate data systems across state programs. Right now it is difficult to obtain good data about the oral health and other characteristics of people with special needs because information about them is tracked by differing state agencies using systems that do not allow cross-tabulation of data.</i></p>	
<p><i>Construct an index of dentally underserved populations, which would include ways to identify underserved populations of people with special needs.</i></p>	
<p><i>Catalog and publicize successful models. Fund replication and expansion of models that have been shown to be cost-effective addition to the current delivery system.</i></p>	
<p><i>Fund research on oral health delivery and prevention models for people with special needs.</i></p>	

Barriers to Oral Health Priorities Implementation

In order to realize the above priorities, it will take one or more of the following:

- A change in law or regulation governing the practice of dentistry.
- A change in reimbursement mechanisms for oral health services.
- Integration of oral health services with general health and social service systems.
- Training of oral health, general health, and social service professionals about oral health and prevention of dental diseases in older individuals, especially those individuals with complicated social, physical, or medical conditions.

If we use the analogy of a world with heart disease and only heart surgeons to treat this disease, we can see the advantage of a world where there are

heart surgeons, cardiologists, nurse practitioners, dieticians and physical fitness coaches. We also can see how these professionals might be supported by information about healthy diets, physical fitness programs, statin medications, and public awareness campaigns.

The challenge for the dental profession is to take the leadership role in finding the analogies to the heart disease world for dental disease. We have the opportunity now to design a new model for delivering oral health services that can better provide services for people with special needs and allow all of them to have a lifetime of oral health.

7. Mental Health—Current Status

The Mental Health Task Team (MHTT) was comprised of advocates, representatives from provider organizations, state government, and the private sector. They met a total of six times, plus three conference calls, in 2004. As with the other teams, the MHTT began its work by reviewing the *Strategic Plan on an Aging California* including the full list of Mental Health recommendations. The Task Team identified four implementation priorities to focus on. For each of these priorities, an Action Plan was created. As a final step, the Task Team compiled a list of barriers that hinder implementation.

The group chose a leader for each implementation priority to more evenly share the Mental Health Task Team workload. Leaders researched their topics through the internet and community resources in order to identify speakers to provide education to the task force in a face-to-face meeting. Conference calls were arranged in order to hear speakers from out of the area and to accommodate the Task Team members from out of the area. At the end of each topic presentation, implementation strategies and barriers to implementation were discussed.

Mental Health Implementation Priorities and Action Plan

Priority	Action Plan
Public Information Campaign to Combat Prejudice	<ul style="list-style-type: none"> • In conjunction with the California Mental Health Planning Council, convene a task force to develop an implementation plan to empower older adults with mental illness to access mental health services. <ul style="list-style-type: none"> a) Developing the theme for the anti-stigma campaign, contract for the production of materials b) Obtaining buy-in from stakeholders c) Develop a dissemination plan

Priority	Action Plan
Public Information Campaign to Combat Prejudice (continued)	<ul style="list-style-type: none"> d) Obtain funding from a variety of sources including financial and in-kind contributions, pursuing grants, and obtaining funds from the Mental Health Services Act • Develop partnerships between and among public sector mental health, public sector aging, older adult advocate organizations at both statewide and local levels to disseminate educational information. Potential activities include: <ul style="list-style-type: none"> a) Distribute materials, conduct an outreach and education campaign at Area Agencies on Aging sponsored programs serving older adults b) Disseminate information to local chapters of older adult advocate organizations such as local AARP chapters, the Older Women’s League of California chapters, and other community-based organizations serving older adults
Depression and Suicide Prevention	<ul style="list-style-type: none"> • Develop better screening and assessment by primary care physicians. • Support the efforts of the Mental Health Services Act (MHSA) effective January 1, 2005 to focus on suicide prevention, general prevention and early intervention services. • Advocate for the development and adoption of a state plan for suicide prevention. • Develop recommended objectives for implementing the 11 goals of the California Strategy for Suicide Prevention (see Attachment 1). • Promote the concept of giving primary care physicians training on suicide prevention. • Develop evidence-based diagnostic and screening tools for depression and suicide specifically for older adults.
Staffing of Behavioral Health Professionals in Primary Care/Outpatient Settings*	<ul style="list-style-type: none"> • Linkages: Mental health providers (LCSW, MFT, Ph.D. and M.D.) would provide assessment and behavioral health counseling at the primary care site through formalized, ongoing agreements. • Training: • Primary care providers:

Priority	Action Plan
<p>Staffing of Behavioral Health Professionals in Primary Care/Outpatient Settings (continued)</p>	<ul style="list-style-type: none"> a) Train primary care providers to identify and treat mental disorders, and promote mental health wellness and prevention. b) Train primary care practitioners to determine the severity of the disorder and when referral to mental health specialty care is needed. c) Train primary care providers on the availability of local mental health resources and how patients can access care from the mental health system. <ul style="list-style-type: none"> • Mental Health Providers: <ul style="list-style-type: none"> a) Train mental health providers to treat a range of diagnosis. b) Train mental health providers in crisis management. c) Train mental health providers to work in a shorter time frame (from 10-20 minutes) that emphasizes working with behavioral interventions. d) Train mental health providers to serve as support to the nursing and other staff members who need support and occasional specific skill development in dealing with challenging patients. • Funding Issues: <ul style="list-style-type: none"> a) Link the funding sources of mental health and primary care so both will share equally in the funding of positions. b) Lobby legislators to raise mental health funding to the level it shared with general health services in the past decade. c) Advocate to health plans that they discontinue carve out mental health services and move to collaborative care across disciplines in order to encourage and develop a team approach to patient care. d) Insure that provider reimbursement rates reflect the cost of providing services and the time spent on care coordination.

Priority	Action Plan
<p>Staffing of Behavioral Health Professionals in Primary Care/Outpatient Settings (continued)</p>	<ul style="list-style-type: none"> e) In fee for service arrangements, payers should develop billing codes that allow providers to be compensated for longer patient visits, when needed, and for the time it takes to collaborate with other health professionals. f) In managed care plans, payers should provide higher capitation rates for individuals with serious mental disorder and co-occurring health conditions. Any increased costs would be offset by reduced hospitalizations and office visits. • Program Evaluation and Outcome Measurement <ul style="list-style-type: none"> a) Develop programs linking public and private sector delivery systems in California to measure quality of service that integrates mental health and primary care services. b) Evaluate whether programs and policy initiatives regarding integration of services leads to the elimination of racial and ethnic health disparities and promote equal access to high quality health care. • Quality and outcome measures should be standardized across systems and levels of care. Data gathering would include: <ul style="list-style-type: none"> a) Use of emergency rooms for physical health care issues (pre-post integration). b) Admissions to psychiatric facilities and average length of stay (pre-post integration). c) Review of patient charts to confirm signed consent forms and indication that communication between mental health and primary care providers has occurred. d) Review of patient charts to confirm that medication prescribers have exchanged pertinent information on medications. e) Review of consumer and provider satisfaction surveys. • Report findings on a regular basis to determine outcomes and evaluate needed changes.

Priority	Action Plan
Staffing of Behavioral Health Professionals in Primary Care/Outpatient Settings (continued)	<ul style="list-style-type: none"> • Mental health consultation availability: develop capacity for mental health providers to provide support to primary care physicians through the use of psychiatric phone consultations, mobile mental health teams and telepsychiatry to rural areas.
Training for First Responders	<ul style="list-style-type: none"> • Support the continuation of the elder death reviews now taking place in Sacramento County, and advocate for implementation of this plan in every county in California. • Support training for both public and private emergency medical responders to meet the special needs of older adults with mental health concerns, dementia and other problems associated with aging. • Suggest a pilot program to use master level clinicians in training to assist emergency responders to complete accurate mental health assessments. • Study the feasibility of establishing a pilot program to provide on call social workers to ride along with first responders. • Recommend that a social worker familiar with older adult mental health issues be on call to support first EMS responders when needed. • Advocate for county regulation and program oversight of EMS services to be in place in every county. • Study the feasibility of public EMS contracting with private EMS services that have staff trained in handling mental health problems.

*Although many of these action items may be applicable to the public sector, this section was prepared with a focus on large medical/hospital plans in the private sector.

Barriers to Mental Health Priorities Implementation

Public Information Campaign to Combat Prejudice

- Obtaining adequate funding.
- Achieving consensus among stakeholders for the theme and messages of the anti-stigma campaign.
- Achieving a cohesive collaboration between mental health and aging stakeholders.

- Developing and following through on a sufficiently extensive dissemination plan so that the message really reaches enough older adults.

Depression and Suicide Prevention

- Establishing new medical school curricula in suicide prevention and intervention may be met with resistance. Mandatory continuing education units (CEU's) on this subject may be an option. The support of medical, nursing, and mental health provider groups would likely be necessary.
- Funding for public mental health prevention efforts has been historically limited. The passage of the Mental Health Service Act includes a specific component with designated funding to address prevention and early intervention.
- Generating enthusiasm for development of a State Plan for Suicide Prevention and Intervention.

Staffing of Behavioral Health Professionals in Primary Care/Outpatient Settings*

- Lack of training and practice guidelines: primary care providers are often not trained to identify those suffering from untreated mental health disorders and to provide appropriate treatment or referrals.
- Lack of guidance about treating mental disorders in primary care including which disorder and what level of severity can be effectively treated in primary care settings.
- Lack of time: most primary care practitioners are set up to deal with acute conditions, rather than chronic ones and primary care physicians often lack sufficient time to identify and treat mental disorders.
- Lack of adequate funding: payers have limited motivation to reimburse for integrated treatment programs when cost offsets are either uncertain or would benefit other service sectors. There is also limited financing from other sources for incorporating evidence based practice into most primary care practices. Insurance plans may not pay primary care providers for the additional time required to provide care to their patients with mental disorders.
- Research gaps: A body of research is being built on the treatment of depression in primary care. Little research, however, exists on the treatment of other mental disorders in primary care settings or on integrated services for people with severe mental illness.
- Lack of specialty providers: There is a shortage of specialty mental health providers who can serve as consultants or referrals for patients whose needs cannot be met solely by their primary care practitioners.

- Stigma of mental health.
- Lack of treatment designed to meet the needs of age, gender, race and culture.
- Some patients are unable to follow through on their own with recommended services from mental health professionals.
- Partnership between primary care and mental health providers have met with some issues based on different culture of care, including styles of communication and duration of office visits.

Training for First Responders

- County and city union contracts may prohibit contracting with private EMS firms that can provide specialized services to the aging population.
- Lack of “floating” mental health provider who could be available to go out with EMS personnel on calls where a mental health assessment is needed.
- Lack of training of EMS personnel and 911 dispatchers to identify calls where assessment of mental health issues is needed.
- Lack of funding for training of EMS personnel and 911 dispatchers to identify calls where assessment of mental health issues is needed.

8. Palliative/End of Life Care—Current Status

The Palliative/End of Life Care Task Team was formed in mid 2004 and met monthly. The Task Team began its work in June 2004, by reviewing the *Strategic Plan on an Aging California* including the full list of Palliative/End of Life Care recommendations. The Task Team worked through a selection process to identify two implementation priorities. The priorities represent what the Task Team members felt could be reasonably accomplished in the current environment. For each of these priorities, an Action Plan was created. As a final step, the Task Team compiled a list of barriers that hinder implementation.

The Task Team realized early that the Strategic Plan held important, but few recommendations on palliative and end of life care. Therefore, the team spent a great deal of time developing important additional background material and recommendations, which can be found in Appendix C of this report.

In 2005, this Task Team expects to move forward on implementation of priority recommendations and work on removing current barriers and reversing misconceptions.

Palliative/End of Life Care Implementation Priorities and Action Plan

New Priorities not included in the original October 2003 *Strategic Plan for an Aging California Population* are shown in italics.

Priority	Action Plan
<p>Expand public-private partnerships to support the education and training of health and social service professionals in the specialty of palliative care:</p> <ul style="list-style-type: none"> • Create a cadre of academic faculty trained in the principles of palliative care at all of the state’s medical schools and teaching hospitals and schools for related medical professionals (e.g., social workers, nurses, etc.). • Develop Quality of Care Protocols and Indicators for Palliative and End of Life Care, Including Pain Management Not Necessarily Limited to the End-of-Life Timeframe. Establish widespread adoption of one or more of the national guidelines and protocols in a wide range of health care settings. 	<p>The Task Team is working to develop action plans to implement many of these priorities.</p> <p>The action plan for implementation of ‘support the efforts of statewide coalitions ...’ is as follows:</p> <ol style="list-style-type: none"> 1. Provide in-kind support of the efforts of the California Coalition for Compassionate Care (Coalition) as the statewide convener of organizations committed to, and incubator of statewide projected aimed at, improving end-of-life care and palliative medicine. <ol style="list-style-type: none"> a) Each state agency and department involved in health and human services should designate an individual as a representative to the Coalition and make attendance and participation a priority. 2. Increase the capacity of hospitals to provide quality palliative care. <ol style="list-style-type: none"> a) Continue to provide training and mentorship to hospitals interested in establishing palliative care services, including a palliative consult services, palliative care beds, and outpatient palliative services. b) Strengthen and provide resources to the established network of California hospitals providing palliative care services to promote the development of standardized guidelines, protocols, data collection, and quality measurement. 3. Improve the competence of long-term care providers in recognizing, supporting and addressing the end-of-life needs of residents/clients and their loved ones. <ol style="list-style-type: none"> a) Develop new or modify existing training as appropriate to provide basic, but comprehensive end-of-life education for each of the varied settings in which long-term care is provided. b) Develop and implement statewide end-of-life curriculum for certified nurse assistants and similar personnel.

Priority	Action Plan
<p>Expand public-private partnerships to support the education and training of health and social service professionals in the specialty of palliative care (continued)</p> <ul style="list-style-type: none"> • Support the efforts of statewide coalitions, such as the California Coalition for Compassionate Care, seeking to educate the public and health care providers on the purpose and value of hospice care. • <i>Recommend that State of California mandate and fund state run medical schools (UCLA, UCSD, UC-Davis, UCSF, UCI) to develop departments of palliative care within the Division of Medicine.</i> 	<ul style="list-style-type: none"> c) Work with law enforcement community to promote policies and procedures that enhance quality end-of-life care. d) Develop end-of-life resources to assist professionals working with persons suffering from dementia or developmental disabilities. <p>4. Encourage consumers to talk with their loved ones about their end-of-life wishes.</p> <ul style="list-style-type: none"> a) Promote public dialogue about end-of-life issues. b) Normalize advance care planning a component of good preventative healthcare. c) Encourage every person over the age of 55 to name a surrogate decision maker and to have a conversation with that person about their end-of-life preferences. d) Establish competence in palliative medicine as a consumer expectation for the physicians and hospitals from which they receive care. <p>5. Change physician behavior so that advance care planning discussions are a normal part of the physician-patient relationship.</p> <ul style="list-style-type: none"> a) Reimburse physicians for the time necessary to have a quality advance care planning conversation. b) Establish advance care planning as a competence all physicians should possess. c) Develop mentors to role modeling quality advance care planning physician-patient conversations. <p>6. Promote the development of resource and professional competence around diversity and end of life.</p> <ul style="list-style-type: none"> a) Continue to develop resources specific for various cultural communities in California. b) Increase the sensitivity to and competence of professionals working with seniors and people at the end of life in handling diversity issues.

Priority	Action Plan
<p>Expand public-private partnerships to support the education and training of health and social service professionals in the specialty of palliative care (continued)</p>	<p>7. Work with Northern California Pain Initiative (NCPI) and Southern California Cancer Pain Initiative (SCCPI) to improve pain management policy and practices in California. (NCPI is a project of the American Cancer Society devoted to the improvement of pain management. SCCPI is a nonprofit volunteer interdisciplinary organization made up of physicians, nurses, pharmacists, social workers and other professionals dedicated to the relief of cancer pain.)</p>
<p>Restructure Reimbursement Systems for Palliative Care</p> <ul style="list-style-type: none"> • Realign reimbursement systems to cover individuals with certain chronic diagnoses that are not “terminal” but need palliative care. • Reimbursement systems should consider the projected mortality rates for specific diseases and examine the “six month life expectancy” restriction on hospice reimbursement. 	<p>1. Changing care for those at the end of life will require leadership, funding, education and research. In order to substantiate anecdotal evidence that hospice and palliative care services are less costly than mainstream curative medical care, researchers need to look at:</p> <ol style="list-style-type: none"> a) An analysis of whether a case-mix payment system is feasible. b) Analyses of treatment costs for hospice enrollees of a certain type versus non-hospice patients with the same disease. c) Analyses of varying life spans and related costs. d) Demonstration projects analyzing innovative funding mechanisms. e) Demonstration projects analyzing alternatives to the six-month hospice eligibility requirement. f) Identification of best end-of-life practices in the field and development of practice guidelines.

Barriers to Palliative/End of Life Care Priorities Implementation

- While a palliative approach is often appropriate in advanced geriatric illness, only seldom is this course considered, much less followed.
- Too few physicians have any training in the palliative/end of life issues faced by most seniors, and this deficiency is especially telling in the degenerative neurological diseases and other non-cancer illnesses.

- Medical training and practice in academic institutions is largely compartmentalized along traditional disciplinary lines, which seldom focus on treatment or research at the end stage of disease, or have an interdisciplinary orientation.
- Academic experts in palliative care often find themselves isolated in departments of Neurology, Oncology, Internal or Family Medicine, were they are viewed as necessary but non-financially productive members.
- Palliative services, which by their nature are cognitively focused, time consuming and generally non-procedural, are poorly reimbursed.
- Since most of health care still functions on a modified fee-for-service basis, the cost savings of palliative care interventions may be seen as diminishing rather than enhancing the bottom line. As a result even prominent palliative care opinion leaders often have little sway in hospital or medical hierarchies.
- In California there are but a few “centers of excellence” in palliative care, and none of the major teaching institutions have a strong program in this area.

9. Long Term Care—Current Status

Contributors to the Long Term Care Task Team represent a variety of perspectives. The Task Team met three times during the fall of 2004. Membership at Task Team meetings has varied—possibly due to the enormity of the topic and the eventual narrowing of issues that impact individual interest.

The Task Team began its work by reviewing the *Strategic Plan on an Aging California* including the full list of Long Term Care recommendations. The Task Team worked through a selection process to identify three implementation priorities. The priorities represent what the Task Team members felt could be reasonably accomplished in the current environment. For each of these priorities, an Action Plan was created. As a final step, the Task Team compiled a list of barriers that hinder implementation.

Long Term Care Implementation Priorities and Action Plan
(shown on following page)

Priority	Action Plan
<p>Implementing the care navigation component of SB 953 (the 'no wrong door approach').</p>	<ul style="list-style-type: none"> • Follow the distribution of the Wellness Foundation grant on care navigation and partner with the recipient to further this effort. In addition, the task team felt strongly that the state needs to make building a comprehensive, integrated data system a high priority. Indeed, this was one of the top 15 'most urgent' recommendations in the entire the Strategic Plan. Therefore, the task team plans to proceed with complementary work to the Wellness grant. (Whether it is seeking private sector funding, sponsoring legislation, or advocacy work around the data system needed.) • Continue to follow and input into the AB 10 process. • Serve as a conduit for information sharing on these two efforts to those stakeholders who are not a part of the task team. • Investigate whether or not AARP has done consumer surveying to see where older adults get long term care information. This research will help guide the care navigation system being built.
<p>Implementation of the Department of Health Services' (DHS) Money Follows The Person (MFTP) grant from CMAS (the 'money follows the person' concept)</p>	<ul style="list-style-type: none"> • The Task Team will relay information to other stakeholders about process for input as it is communicated. • The Task Team will accept suggestions from other stakeholders and the DHS as to possible steps for implementing MFTP outside the DHS grant.
<p>Partnership between public authorities and private provision of in home care = seamless system (improved access to the LTC system regardless of MediCal eligibility)</p>	<ul style="list-style-type: none"> • The Task Team will participate in either informational hearing or stakeholders group on this issue in 2005 hosted by Senate Subcommittee on Aging and/or Assembly Committee on Aging and Long Term Care.

Barriers to Long Term Care Priorities Implementation

Barriers to Implementation of Care Navigation

For statewide care navigation and data systems to be realized, there needs to be buy-in from all the right stakeholders. This group is at the beginning of bringing the right people to the table. The current fragmented system was built up by stakeholders over time in which various geographic or service

oriented groups developed their own part of the system in which they have a vested interest. One of the reasons the fragmentation exists is due to lack of consensus among stakeholders as to what to do about it coupled with very strong feelings about certain approaches. Multiple funding streams of various I&A systems that duplicate each other also pose barriers. At this point, it is not clear whether or not the administration wishes to implement the care navigation system if it is designed. If they wish to, there are unknowns costs associated with this. Additionally, lack of information on how older adults and caregivers access long-term care information pose barriers to the quality of system which will be set up.

Barriers to Implementation of Money Follows the Person Grant

- Unclear timeline of input on the DHS grant.
- Fiscal climate of California budget situation may not enable any ongoing effort after the grant runs out.
- Many more stakeholders need to be brought to the table in order to determine other possible implementation steps for MFTP.
- The New Olmstead Advisory Committee will be an asset to implementation of MFTP.

Barriers to Implementation of Public/Private Partnership of In Home Care

- Funding streams for MediCal eligible cannot be used to fund system for non MediCal eligible. Both public authorities and private providers are integral to the LTC system, however, have separate organizational structures, goals and reside in different sectors.

10. Provider Workforce Development—Current Status

Charged with the leadership of the Provider Workforce Development Task Team, the California Council on Geriatrics and Gerontology (CCGG) embarked upon nine activities focused on workforce development in 2004. These activities (described in more detail in the complete Provider Workforce task team report available from the CCoA office) included:

1. Legislative Hearings
2. Statewide Policy Conferences on Gerontology/Geriatric Education
3. Faculty Mentoring/Training
4. CSU System Wide Summits to strategize for accessible trainings for workforce development.

5. CSU System-wide On-Line Certificate/Classes for Workforce Development
6. Work Force Development and AARP partnerships
7. Support for Continuance of the San Francisco State University Gerontology Program
8. Coordinated Gerontology Program Access Across All California Systems of Higher Education: A grant submitted to the Federal Dept of Education to the Fund for the Improvement of Post Secondary Education (FIPSE) from the CCGG
9. California Social Work Education Center Aging Initiative for Workforce Development

Provider Workforce Development Implementation Priorities and Action Plan

A task force of representative professions and key stake holders will be convened for input from the workforce to assist with identifying best practices and the education required to support the workforce needs, including the preparation of older adults re-entering the workforce.

Future goals include:

- Continued hearings and annual conferences, on-going commitment to support and further develop the educational systems (community college, CSU, UCs and private colleges/universities) offering gerontology and geriatric education.
- Development of Education Ladder that matches Career Ladder (based on the Child Service Worker model).

Barriers to Provider Workforce Development Priorities Implementation

Program funding is undoubtedly the most serious barrier to implementing the Strategic Plan recommendations on provider workforce development.

- Healthcare and social service workforce development has and will continue to be largely dependent upon public higher education, from vocational schools and Community Colleges, to the CSU and UC systems.
- Higher education in California suffers the same economic challenges experienced by all state institutions. Lack of funding creates a domino effect of additional barriers.

11. Assistive Technology—Current Status

Assistive technology (AT), for the purposes of this section is defined as any item, piece of equipment or product system, whether acquired commercially, off the shelf, modified or customized that is used to increase, maintain, or improve functional capabilities of individuals with disabilities. The Assistive Technology Task Team is made up of participants working with the disability community, the aging community, and the private sector. Participants are from government, non-profit, and private organizations. The team met monthly from August through December of 2004, and continues to be active.

The Task Team began its work by reviewing the *Strategic Plan on an Aging California* Assistive Technology recommendations. The Task Team identified three implementation priorities. For each of these priorities, an Action Plan was created. As a final step, the Task Team compiled a list of barriers that hinder implementation.

To address one of the barriers, the Task Team brought the Project Director of the AT Network together with the Executive Director of California Association of Area Agencies on Aging (C4A) to share expertise and develop a model plan for establishing a network of AT Advocates within the Area Agencies on Aging (AAAs).

The team is working on a plan to create a pilot Assistive Technology program at a single AAA site (or possibly pilot projects at multiple sites). Such a program would foster collaboration with other existing initiatives, provide education on AT, and demonstrate unmet needs.

Assistive Technology Implementation Priorities and Action Plan

New Priorities not included in the original October 2003 *Strategic Plan for an Aging California Population* are shown in italics.
(As shown on next page)

Priority	Action Plan
<p>Expand programs to educate seniors and persons with disabilities on what Assistive Technology is, how it helps, how much it costs and where to get it, from high tech to low tech.</p> <p>The AAAs should be encouraged to have AT Advocates that focus on AT for older adults, as the independent living centers (ILC) do for persons with disabilities. The AAA should collaborate with the ILCs on this critical service.</p>	<ul style="list-style-type: none"> • Building on the Task Team meetings between the AT Network and the C4As, work with them to establish a pilot Assistive Technology program in at least one AAA service area. The goals of a pilot program would include: <ol style="list-style-type: none"> a) Developing a reliable program model that will collaborate/coordinate with other AT initiatives and programs. b) Developing a methodology to determine and demonstrate unmet need within that community. c) Developing an AT education program based on the ILC model. d) Development of a multicultural community outreach program. e) Helping senior consumers understand individual funding rights and community opportunities for funding of assistive devices. f) Having a staff advocate who, in addition to program responsibilities, would serve as a member of the existing AT Network of advocates, receive training and contribute to the AT community through joint outreach events and network steering meetings. • Contact marketers of Assistive Technology and encourage them to use proven guidelines to promote Assistive Technology in a neutral, non-stigmatized way in order to develop a new image of persons who use Assistive Technology.
<p><i>Conduct research to locate non-governmental funding sources that can be used for education, for outreach, and for actual Assistive Technology equipment to increase the quality of life for older adults.</i></p>	<ul style="list-style-type: none"> • <i>Once the above-mentioned site is established the AAAs will have a system and a model in place as a reference for proposals in seeking funding.</i> • <i>Pursue possibilities that funding could be similar to existing state funding provided to maintain AT Advocates in the ILCs. Support an amendment to the current legislation, if necessary.</i>

Priority	Action Plan
<i>Strong advocacy must push for AT policy change with the Legislature and administration.</i>	<ul style="list-style-type: none"> • <i>Team members will actively participate in the Olmstead advisory committee to ensure that Assistive Technology is included as part of the implementation plan.</i> • <i>Team members will encourage legislative initiatives that promote telecommunications access.</i>

Barriers to Assistive Technology Priorities Implementation

- There is a lack of coordinated leadership. Several organizations are chartered with providing Assistive Technology information and services to seniors but they all tend to have very different organizational structures and funding sources. May be difficult to get these groups to work together and support the common cause.
- Many organizations serving the aging need to focus on service delivery making buy-in and support for Assistive Technology a challenge.
- There is general lack of knowledge or discomfort with high technology.
- Many older adults believe there is a stigma associated with using Assistive Technologies and this seems to carry over into the senior support organizations.
- Funds or sponsorships are needed in order to use mainstream media, particularly television, to promote public education and outreach.
- Assistive Technology vendors may prefer to continue having their products perceived as medical equipment, since this enables them to charge more money for their products. Third-party funding sources such as Medicare tend to cease funding technologies that have become mainstreamed.

V. Progress report on Top 15 Priorities

This section has organized reported progress on the top 15 priorities by dividing the priorities into the topical categories of housing, economic security, long term care, provider workforce, data systems, transportation, mental health, and health and wellness and by listing each top 15 priority and the response received. The reported progress as printed below was gleaned from the CCoA's February 2005 Questionnaire, and the March 2005 Statewide Forum dialogue, and was given to the Commission by state officials and aging/advocacy organizations. In both the Questionnaire and the Forum, respondents were given the opportunity to report on priorities other than those in the top 15. Progress reported on these other priorities are listed at the end of each topical section under the category of "Progress on other Strategic Plan Priorities." Occasionally, the CCoA abbreviated a response for inclusion.

A. Housing:

Strategic Plan Priority: "Expand Smart Growth models of housing and land use that incorporate livable, walkable, mixed use, intergenerational components."

Progress reported on this goal:

- Acknowledgement by local officials and the public that we need to work on this, a raised public consciousness has been achieved: we now know what 'Dumb Growth' is—what we've been doing for the past 25+ years!
- Change in attitude of city planners in developing zoning laws, used to be more exclusionary in focus to segregate land use, now the benefits of multiple zoning for residential and commercial uses are evident and being used more frequently.
- SB 223 (2005-06 legislative session) offers loans to local government for planning, as it is in many cases very costly to update zoning that will allow more Smart Growth. Additionally, legislation this year (SB 521) may help broaden the definition of 'blight' to allow for more targeted resources for redevelopment around transit stations.
- Multifamily housing applications and applications for a number of other state funded housing programs already utilize Smart Growth principles and have produced small islands of progress across the state (Sacramento and Oakland are two recent examples of transit stations/commercial/residential mixed use developments).
- Business Transportation and Housing secretary, Sunne Wright McPeak, is very supportive of Smart Growth efforts.
- Inclusionary housing policies have helped integrate communities, thus making them more 'livable' for everyone there.

- Housing California is launching a campaign for permanent funding towards a housing trust fund; a ballot measure is scheduled for November of 2006.
- The California DHS Center for Physical Activity and Epidemiology and Prevention for Injury Control Branch has made some progress through external grants: Robert Wood Johnson Foundation and others.
- CFILC has a staff member who is on the board of Housing California. This participation makes state advocacy much stronger.

Challenges reported in achieving this goal:

- Funding to build affordable housing is in jeopardy. The three-legged stool for funding includes state/local/federal sources. At state level, a permanent funding source for housing is needed; Proposition 46 money is almost gone. The state has a 'housing trust fund' to serve as this permanent source, but it does not have any funding in it. Local governments are extremely tight with state budget cuts, and very large budget cuts are currently being proposed for housing at the federal level that are impossible to replace with local or state dollars.
- Prices of housing and mismatched wages are causing younger people to leave because they can't afford to live here, they leave families who want to age in place.
- The most challenging communities to integrate Smart Growth are suburbs, yet we know that a significant number of the aging population live and wish to age in place there.
- More incentives for builders to use Smart Growth models need to be developed.
- The Legislature has worked to make sure that locals approve good projects, and are not deterred by community opposition based on misperceptions. Many times zoning is not approved for higher densities needed to accomplish affordable Smart Growth housing due to these misperceptions.

Strategic Plan Priority: "Strengthen support for repairs and home modifications by community based organizations in every county."

Progress reported on this goal:

- SB 1025 (2003-2004 legislative session) was enacted that requires 10 percent of all new townhomes to be accessible. This law becomes effective in July 2005.
- Per AB 2787 (2001-02 legislative session) the California Department of Housing and Community Development (HCD) are creating a model universal design ordinance that hopefully will be adopted by

communities across the state. It also will include a check list for new buyers to use.

- Money was made available through Prop 46 for home modifications to rental housing. In all, HCD gave out 16 awards for a total of \$4,750,000. Of this amount, the city and the county of Sacramento each got \$500,000. CalHOME money can also be used for home modification. The extraordinary demand for these grants shows how great the need is for the service.
- A few Independent Living Centers have local programs for home modification. FREED organization in Nevada County has a “Fix It” program with pooled funding (AAA funding, County funding, Prop 46 funding) and a lot of volunteers from the building industry. The Westside Center for Independent Living got a \$150,000 grant to do exterior accessibility for renters. The Modesto ILC has worked with Del Valley Homes on a partnership. Del Valley will designate over 40 homes with wheel chair accessibility and universal design features.
- Events such as the Commission on Aging’s March 8 Forum help build partnerships, share information and encourage local implementation of many of these programs by other Cities.
- Programs such as Rebuilding Together make a tremendous difference locally, and build community awareness for the need for resources for home modification.
- The housing task team is working on educating senior groups on the need for Universal Design and home modifications in order to build support among this constituency.
- www.homemods.org offers resources and examples of home modifications for use by advocates, developers, etc.

Challenges reported in achieving this goal:

- Builders are not always favorable to the universal design model ordinances and may oppose their enactment locally. Academic research shows that mandates as opposed to voluntary universal design standards create more housing with universal design.
- Limited funding sources. As stated above, state and local funds for housing are tight. Secondly, the Community Development Block Grant money slated for 50 percent cut at the federal level is the primary source for home modification and if the cut is taken, it will have a devastating impact on the ability to provide home modifications at the inadequate level that we have been, let alone strengthen the support for such programs. President Bush’s ‘Strengthening Communities,’ misleadingly named, is the source of these cuts.

- While Prop 46 money did help exterior home modifications to rental units, there is still a great need for modifications to homes that are owned and to also do interior modifications to both rentals and owned dwellings.
- Locally, there needs to be active public support for accessibility and affordable housing. CFILC has great resources on their website (www.cfilc.org)—two policy pieces in layman’s language describing housing accessibility and affordability, and visitability/universal design to educate local communities and build public support for this. Local advocates should emphasize that ‘universal’ design helps everyone live better, i.e. parents with strollers, families, etc., to draw a wide range of persons into the advocacy.
- Energy Weatherization programs for lower income people in the 70s and 80s were well funded, what is the funding status of these kinds of programs today?

Other Strategic Plan housing recommendations, progress and challenges:

- HCD currently funds a number of housing preservation programs. There is a lot of technical assistance offered to those engaging in housing preservation activities.
- The Legislature has done almost everything they can do on the issue of preservation in the last 15 years. They have developed notice requirements of owners wishing to sell or opt out of renewing affordability contracts, they have required right of first refusals to be offered to those entities wanting to buy a property to keep it affordable, they have developed a bridge loan program for those that wish to purchase but cannot come up with the permanent financing quickly enough. Any more is difficult because we cannot force private owners to extend on a deal they only agreed to for 20 years (or whatever the term). Additionally, we cannot force them to sell if they wish to keep the property.
- For both aging people, and people with disabilities, there simply is not enough affordable housing in the state, let alone accessible.
- More work is needed to deter the ‘fiscalization of land use’. Local governments cannot see housing as a drain on local resources simply because other types of zoning (commercial, etc.) currently can bring in more local sales tax revenues. In tight local budget times, this is particularly apparent and damaging to development of needed housing. Senators Perata and Torlakson are both interested in pursuing efforts related to this.
- An assisted living waiver providing 1000 units of affordable assisted living is unfolding in 3 counties. More needs to be done in order to

expand the waiver to apply to RCFE's and other housing options typical to someone transitioning from a nursing home to the community.

B. Economic Security:

Strategic Plan Priority: "Provide education/training to develop or enhance skills so older adults can move into second career options."

Progress reported on this goal:

- The California Department of Education (CDE), through the Adult Education Office, monitors state funding for Older Adult Programs to increase English language literacy, workforce development, personal growth, computer training, and social skills. These programs operated by local education agencies link to community services such as the California Employment Development Department's (EDD's) one-stop career centers, counseling, transportation, and other programs. CDE does not have data specific to education/training to develop or enhance skills so older adults can move into second career options, rather they focus on educating the entire community to be able to enter the work force.
- The EDD's website EDD Job Service, and One-Stop Career Centers provide job search training and information on job training resources to older workers, employers, and other partners. One-Stop Career Centers provide universal service to all individuals who are seeking training and employment. They partner with EDD and the Senior Community Service Employment Program (SCSEP) and often partner with community colleges and adult education programs to refer older workers to low cost training. The EDD Senior Worker Advocate Office (SWAO) staff respond to telephone calls and e-mails from older workers requesting assistance in obtaining employment. The SWAO refers them to local training resources including One-Stop Career Centers. Additionally, SWAO provides the One-Stops with training on age discrimination and older worker imaging.
- SWAO staff currently help older workers file age discrimination claims.
- The SWAO staff coordinate Job Fair materials for older workers for National Employ an Older Worker Week in September. The SWAO partners with the EDD Job Service Division and Workforce Development Branch, the California Department of Aging and the U.S. Department of Labor to distribute materials to EDD Job Service Field Offices, One-Stop Career Centers, the AARP, and SCSEP offices in California.
- The EDD has an Older Worker Council that they use to help them coordinate services and partner with other aging and disability groups and programs.

- The SWAO partners with educational institutions to provide appropriate opportunities for career enhancement, job training, retraining, and skill development for older workers. The SWAO initiated and developed older worker segments for the 92 page statewide California Career Resource Network (CalCRN) guide that was previously oriented only for younger workers. The CalCRN includes Adult Ed and Higher Education Institutions. The EDD partnered with CalCRAN to revise the guide that is distributed to thousands of career counselors, students, job seekers, and educators in California through a federal grant.
- The SCSEP is a federally funded training and employment program limited to individuals who are 55 years of age and older and whose income is within 125 percent of the poverty level. Some of the SCSEP programs provide culturally diverse programs, however resources are limited and the culturally diverse population in California is growing. The EDD partners with SCSEP to refer older workers to them who require culturally relevant, job-related supportive services.
- Adult Education, Community Colleges, and Higher Education Institutions are responding to the aging student body by offering extension courses, certificate programs, Internet courses, and work/life credits toward earning a degree.
- See progress made on provider workforce priority following economic security priority as it relates to training of healthcare workers.
- The IHSS program has made working easier for IHSS recipients by allowing IHSS workers to provide service hours at the person's place of employment. This has removed barriers to working for many persons with functional limitations.
- While older Californian's generally don't view themselves as having functional limitations, many of them do, and are therefore eligible for disabled students programs at the community colleges offering high tech centers and training programs on technology to help in education and work. SSI and SSDI recipients, many of which are older Californians, are eligible for fee waivers at the Community Colleges. Extended Opportunities Programs also through the Community Colleges offer specialized counseling, help with books and supplies and immigrant students' services.
- The Department of Rehabilitation has funding for training of workers, but they do have eligibility criteria to try to serve the persons with higher levels of significant disabilities. These programs include multiple services over extended periods of time. If the person is found to be not eligible, they are given information and referral.

- The DHS has a 250 percent work disable program which enables very low income older adults who are eligible for IHSS and MediCal to retain their health benefits while working if they work at a place that doesn't offer health benefits. Persons with sensory or physical functional limitations can earn up to \$42,000 and pay premiums to stay on MediCal.
- There is a new wave of volunteerism beginning. Volunteer work offers the opportunity to learn new skills that may lead to permanent employment.
- There are a number of online training opportunities available to everyone, however older Californians often don't have access to technology that would enable them to take advantage of these trainings. State government surpluses a number of computers each year, should look at targeting these to persons that need them.
- The EDD website has a number of best practices promoting the benefits of optional work conditions such as part time work/flexible hours/job sharing in order to encourage more employers to offer this.
- An Employer Toolkit is available that is age neutral on employment policies and practices. This toolkit is promoted at Chamber of Commerce and other industry association meetings.
- The Governor's Older Workers and Exemplary Employer Awards Luncheon is held every year to recognize older workers and employers with practices supporting older workers. It is an excellent public relations opportunity to combat age discrimination and change the way the public looks at older workers.
- The SWAO has been moved within the EDD to the workforce development branch in order to create more efficiency in the program and to integrate EDD's programs and services.

Challenges reported in achieving this goal:

- Due to limited state funding, adult education programs specifically targeted to older adults are not available at every adult school and/or county.
- Coordination needs to be improved between government agencies and private organizations to enhance the employment opportunities provided to older workers. Agreements similar to the Home Depot age neutral hiring program need to be replicated.
- Services need to be improved to older workers through the One-Stop Career Center system. Partnerships need to be strengthened between the One-Stop Career Centers, SCSEP, Area Agencies on Aging, Adult Education and Community Colleges to improve access to services to

help older adults obtain the support services and training they need to remain in the workforce.

- Job Clubs need to be expanded to provide increased networking opportunities for older worker employment. Networking is the most effective method of obtaining employment, according to professional career consultants, and Job Clubs are proven, low cost re-employment programs. Since most job clubs currently reside in EDD Job Service locations, efforts should be made to expand this program to local One-Stop Career Center locations to increase statewide access to this program.
- The state needs to support the January 31, 2005, U.S. Department of Labor ETA Notice (TEN) 16-04, Protocol for Serving Older Workers in the Workforce Investment System. The goal of the ETA Notice (TEN) 16-04 is to enhance the services provided to older workers and to infuse the One-Stop Career Center system with innovative strategies for successfully employing older workers.
- The U.S. Government Accounting Office (GAO) issued a report on Older Workers. Gao-030350. Issued January 2003, it recommends that the Workforce Investment Act performance measures be changed to improve access to career center services for older workers. The Performance Measures require that the One-Stop Career Centers put workers in full-time employment with salary equal to or greater than they previously earned. It is harder for older workers who are downsized to get jobs at the level they were previously earning. Many workers over age 65 need part time jobs to supplement their retirement. The Performance Measures do not encourage One-Stop Career Centers in providing services to workers who fit in the above categories, and should be changed to keep the One-Stops from 'creaming'—i.e. enrolling only the population that would be more likely to make the mark on the performance measures.
- In general, there is inadequate education and training programs funding for older workers.
- Under-employment and unemployment among older adults, significant number of older adults who are disabled, age discrimination in employment, illiteracy and low-literacy among older adults, and inadequate low-cost public transportation services (especially in rural areas) all pose challenges to job training for this population.
- Research is needed on where the workers are, what their skill sets/knowledge are currently in order to better prepare to fill in the skills gaps. Community colleges can develop appropriate programs if they have the parameters of what is needed.
- There is potential to streamline resources and draw on expertise of county welfare departments 'Welfare to Work' employment programs

and partner with programs for older workers, but this has not happened to date.

- Older American's Act programs including the SCSEP are frustratingly underfunded to reach all eligible older people who wish to return to work and participate in the program.
- Since Workforce Investment Act funding focus has been taken off of targeting certain populations, there is not a direct target for older workers programs although there have been discussions in the past on this.
- Disabled persons that built up private pensions get penalized for this in accessing benefits in the future if they need them. Additionally, as disabled persons get ready to retire after 25 years, they find they can't retire because they can't keep their health insurance. The public policy arena has not kept up pace with the realities of disabled workers' needs.
- There is great need for funding of Assistive Technology to assist people to be able to work. Additionally, people can't work from a nursing home. Affordable housing and transportation are key to employment as well. Aging partnering with the disability community on advocacy around these issues is vital.
- The Workforce Investment Act dollars have been reduced 28 percent posing difficulties for funding training for all populations.
- The CCoA needs to emphasize cooperative collaboration on these issues, and help the bureaucrats push out of their silos and work more effectively together.
- The Department of Rehabilitation is working on implementation of AB 925 (2001-02 legislative session), breaking down barriers to employment for persons with disabilities. There is an opportunity to encourage the LTC Council to work on economic security issues and barriers. We should continue work on the image of aging and change the thinking that because you are an older person or because you are a person with a disability you can't work! When images of older adults are shown, it helps combat this myth to show persons in 'vital aging' roles (i.e. working, volunteering etc.) that have a disability, i.e. a cane, an assistive device, etc.
- Advocacy needs to be supported and coordinated among aging and disability groups.

Other Strategic Plan economic security recommendations progress and challenges:

- There has been an increased awareness for the economic security of grandparents raising grandchildren. In the foster care system, half the children in care are with family members. There are over 100,000 family members taking on this duty of fostering their relatives, 40,000 of them are grandparents raising grandchildren. The KinGap program offers a modest stipend (\$500-\$600 per month) to 15,000 of the relatives providing this relative fostering. It is not realistic that a family caretaker could work 40 hours a week and provide care for a troubled youth; therefore, KinGap tries to make it more economically feasible for families. To make kinship care successful, there are needs for respite care, transportation assistance and health care (while the fostered child is provided with health insurance, the relative caregiver is not).
- When SB 2199 (1997-98 legislative session) created the statewide Adult Protective Services system in 1997, advocates had severely underestimated the need for such services. The APS system remains underfunded and simply not able to investigate all the alleged abuse reports.
- Without early warning signs of financial abuse, aging and dependent adults lose thousands of dollars of irreplaceable assets and savings. AB 1605 and SB 1018 (2005-06 legislative session) currently being debated would require mandated reporting by bank and financial institution employees of suspected financial abuse which will help with early detection of abuse cases. When the baby boomers retire, there will be the greatest transfer of wealth in the history of mankind and we are not prepared to deal with the many scammers who have already figured this out.
- Local communities should explore FAST team model and lessons learned from communities that currently have these teams investigating financial abuse.

C. Provider Workforce

Strategic Plan Priority: “Address California’s health and social workforce deficit. Ensure the recruitment and retention of health care professionals, allied health, mental health and paraprofessionals.”

Progress reported on this goal:

- On November 17, 2004, the Employment Development Department (EDD) announced the availability of up to \$22 million in a Solicitation For Proposals (SFP). The funds include up to \$20 million of Workforce Investment Act Governor’s 15 Percent funds. The Governor’s three funding categories for this SFP are: 1) Growth Industries—High Wage,

High Skill Job Training, 2) Removing Barriers for Special Need Populations, and 3) Industries with a Statewide Need—Nurses and other health-related industries.

- To encourage individuals to enter the health care field, the EDD Labor Market Information Division has created career summaries of 48 health related occupations. Health Care Careers summarizes health care occupations requiring a bachelor's degree or less and shows possible career pathways.
- On September 29, 2002, grants were awarded to 13 partnerships that will conduct Nurse Workforce Initiative projects throughout California. The Governor's Nursing Workforce Initiative grants funded 13 regional partnerships with the intent to put nearly 2,000 nurses into the workforce. The initiative incorporates both short-term and long-term measures to recruit, train, and retain a culturally diverse nursing workforce to meet the state's health care needs.
- On January 31, 2001, 12 grants totaling \$25 million were awarded to train caregivers and healthcare professionals to attract, train, and retrain workers to address the critical shortages of healthcare workers.
- Health Organizations such as Kaiser are providing grants to expand nursing programs. Kaiser provided \$134,433 grant to Southwestern College to support the training of 40 new nurses.

Challenges reported in achieving this goal:

- State and federal initiatives indicate that policy makers are aware of the problems associated with a shortage of a skilled nursing workforce. On February 18, 2003, Congress passed the Nurse Reinvestment Act (PL 107-2050). The Fiscal Year 2003 appropriations equal \$113 million, a \$20 million increase over FY 2002. If forecasts of a massive gap between the supply and demand for nurses in the future are correct, it is likely that the scope of initiatives will need to be expanded to reverse current trends.
- Wellness programs and health care coverage are needed for health care workers, if workers remain healthy, they will remain in the workforce longer.

D. Long Term Care/Data Systems:

Strategic Plan Priority: “Build a comprehensive, integrated data base on aging and disabled Californians for longitudinal studies and care navigation.”

Progress reported on this goal:

- Within the California Department of Social Services (DSS), the Case Management, Information and Payrolling System (CMIPS) system provides a data base for IHSS recipients. The CMIPS system interfaces with the Department of Health Services’ (DHS) Medi-Cal Eligibility Data System (MEDS) and the Statewide Automated Welfare System (SAWS), which in turn interfaces with the four county welfare systems (LEADER, ISAWS, C-IV, CalWIN). The DSS is currently working on development of the CMIPS II. The IHSS data has been used by researchers at UCSF, Community Colleges, and California State University Sacramento.
- The Health and Human Service Agency has released a grant to be awarded to further develop the CA Care Network DSS website. Currently consumers can access electronically information on long-term support services. The consultant awarded the grant will offer options to expand the porthole and develop standards for navigating the current long-term support system by consumers and service providers.
- The Long Term Care Council had a workgroup on this issue, they surveyed what databases were developed, what they contained for the purposes of finding a common data set among databases and the possibilities for integration of databases.
- The California Performance Review proposal to reorganize health and human services in California is an excellent opportunity to collocate aging/disabilities services programs together to make database development and integration more feasible.
- Recommendations in an SB 910 commissioned report by Neuhauser, Brady, and Seligman suggested that a Comprehensive Database on Aging Californians include changes in how data is collected by AAA’s, Community Care Licensing Division of the DSS, nursing homes, and the Long Term Care Integration Pilot Projects. The California Department of Aging (CDA) was not able to receive data electronically from all AAAs three years ago, now they have the capacity. While the CDA had the ability to collect data to report to the federal government, they were not able to run reports on the data for their own use, now they have the capacity. The CDA is moving towards collecting a common data set. Before databases are integrated between departments, each department itself has to have its house in order.

Challenges reported in achieving this goal:

- While incremental progress is being made by some agencies and some databases, throughout the state a comprehensive, fully integrated statewide database on aging and disabled Californians does not exist. Policy makers currently don't have the numbers about the needs of people they require to make sound policy decisions. Data is integral to this.
- There is always a challenge to working with databases; there is always a risk of violating the privacy of the consumer.
- Stakeholders need to ask themselves, who is this database for? What is its purpose? One website doesn't fit all. If an informational website is going to be built for consumers, it should be developed by young and old, all the types of consumers that will be using it. It should be fully accessible to persons with disabilities that may need to use screen readers, have cognitive impairments, or other disabilities. The service should use empowering language such as "service or support navigation" not paternal like "care navigation."
- One challenge to databases relates to the type of data collected, certain programs are only required to report aggregate data, which does not offer the information policy makers need about individual seniors' needs.
- The State Legislature doesn't have the data it needs on who is being served by what programs in what quantity. The Legislature needs to take the initiative to require a solid data infrastructure, in order to justify the reallocation of or increase in financial resources to serve this population.

Strategic Plan Priority: "Build and implement a 'no wrong door' care navigation system."

Progress reported on this goal:

- County departments of social services do have 'one stops' where a person can inquire about county run programs, including Medi-Cal, IHSS and Regional Center Services that may be available to meet their specific needs.
- The Olmstead plan identified the need for providing service plans based on uniform assessment to clearly identify the range of services needed and preferred to support the person in the community such as medical care, personal care, residential supports, housing and transportation. The implementation of such an assessment would provide a 'no wrong door' of sorts for aging and disabled persons.
- The Mental Health Services Act provides a permanent funding source for mental health services. This money will be used to transform the mental health system and to increase the availability of services to unserved

and underserved individuals with serious mental illness. There are many opportunities at both the local and state level to obtain input from stakeholders on how to spend this money.

- The Governor's budget this year includes provision for an Acute and LTC Integration plan within MediCal Redesign. This will provide additional funding in three counties to integrate all Medicare and MediCal services. A central database at the local level will accompany this and should help provide 'no wrong door'. All services will be under one window, for example home and community based services, IHSS, etc. The plan presents a consumer-centered approach that recognizes the preferences for consumers of home and community based services. The integration eliminates incentives for funding to go towards one part of the system over another. It also focuses on keeping people healthy and avoiding putting them in situations in which they will require institutionalization.
- The State Plan on Aging reflects that the need for consumer information and assistance programs remain a lynch pin service for seniors; people don't know how to find the right door. There is a technological component to this service besides the type of person providing the information - both are needed. The AAA's are working on this at the local level. One example of this is the Fresno Area Agency on Aging who has collocated a number of aging services under one roof including public services such as a café and public library.

Challenges reported in achieving this goal:

- Recent budget constraints have put on hold state agency and stakeholder discussions on developing a uniform application to be used in conjunction with the Medi-Cal eligibility applications.
- Progress on implementation of the state's Olmstead Plan has been stagnant until the recent formation of the Olmstead Advisory Committee.
- In light of the proposed budget cuts in many federal and state programs, there may be fewer or no doors at all and whether or not a consumer reaches a 'wrong' door will be a moot point.
- A single system with every service under one window puts a lot of power with one "gatekeeper." Diverse consumers prefer diverse types of service providers; people may prefer to be assisted by someone that looks like them and shares their values.
- While the need for diverse service delivery styles is recognized, we can't spend precious resources duplicating systems that already exist. AAAs witnessed this firsthand in the Medicare Modernization Act rollout. MMA provided money for information to get out on the prescription drug coverage, but they set up a duplicative system that did not interface well with the AAAs' health insurance and advocacy program.

- It is not always the person needing the service knocking on doors. The system should be sensitive to caregivers or family members that approach the door panicked because their relative is in a crisis.
- Perhaps Prop 63 is a model, and we should advocate for a funding source to rebuild the long-term support system.

Strategic Plan Priority: “Build capacity into community-based long term support services to prevent unnecessary institutionalization.”

Progress reported on this goal:

- The State Independent Living Council and the Department of Rehabilitation have some funding to help assist in getting people out of institutions.
- The In-Home Supportive Services Program (IHSS) is an entitlement program providing services at home that would otherwise need to be provided in an institutional setting on a long term basis. This program has continued to grow and be fully funded despite and increase in the budget of this program by 47.6 percent in the past five years. This is a significant increase in capacity of community-based support. Additionally, there has been a 10 percent increase in Residential Care Facility licensing, many are assisted living type facilities. This is a reflection of money going into capacity of home and community based services. There is always more than one way of doing clustering/reorganizing of long-term support services, the important piece is forced collaboration by leadership.
- Two counties are proposing a pilot program that allows IHSS recipients with dementia to receive personal care services outside their home at local licensed Adult Day Centers.
- Programs in Santa Rosa and the Westside Center for Santa Monica are moving people out of institutions and locating community resources for people on an individual case-by-case basis. It is hopeful, however, that some models will come out of these innovative programs. For example the Agnews Center for persons with developmental disabilities is closing, and a unique financing arrangement between the city and county is helping to fund housing for community placement.
- The DHS received a \$750,000 Money Follows the Person Grant. They are partnering with the Department of Aging and their Medicaid waiver programs to connect persons moving out of institutions with appropriate case management services. Assessment protocol for those in institutions to determine their wants and needs for long-term support services is being developed as a result of this grant. As people begin to move out of institutions, capacity of the community will increase, the two have to happen together, one will not happen independently of the other.

The Assisted Living Waiver Pilot Project will provide some housing slots for persons moving out.

- The mental health system will receive a shot in the arm for capacity building from the Mental Health Services Act. In addition to increased dollars for direct services to consumers and families, money will also be available for education and training, capital facilities and technology, local planning, and prevention and early intervention. It is interesting to note that 40 percent of those with long-term support needs also have mental health needs.

Challenges reported in achieving this goal:

- There is a need not only for a good assessment instrument for people in institutions wanting to get out, but a need for a community assessment for services.
- We need to break down existing silos to implement Olmstead, the questions need to move from, “What are people’s ages?” to “What are people’s functional abilities,” and “What are people’s wants/how do they want to receive services?” There are many community-based programs that contribute to the fragmented systems due to their categorical funding streams (i.e. serving only older persons or only younger disabled persons). If we are to achieve an integrated system for all those with functional disabilities, we must break down these program silos.
- Affordable housing is one of the most lacking community resource that needs to be augmented to meet the needs of older adults and persons with disabilities.
- Some advocates believe that until funding is diverted from nursing homes, we will not have the resources to expand home and community based services. One way the state could show support for this diversion of funding is by commitment to closing down nursing homes. The independent living centers feel that in general, nursing home staff discourage independent living center staff from coming to the nursing home to advocate on behalf of residents wishes. Additionally, there is a need to bridge partnerships between Ombudsmen and independent living centers. Independent living centers report that due to funding streams/mission, Ombudsmen do not handle complaints or concerns of residents that they do not want to be in the facility. Ombudsmen need to be educated to refer to independent living centers and other community based services to advocate for the residents if the Ombudsmen can’t in that situation. Even if this changes and the referrals start coming, the independent living centers do not yet have the capacity to serve all those who would wish to transition out of nursing homes, there would have to be a large expansion of this capacity.
- Nursing homes are underfunded in California, in fact they are 46th in nation in per bed spending, and 51st in nation at per capita Medicaid

spending. Perhaps a good private/public partnership would be to create a profit incentive in home and community based care so nursing homes could shift from institutional to community services for long-term support.

Strategic Plan Priority: “Develop and expand comprehensive, integrated care models.”

Progress reported on this goal:

- The Long Term Care Integration (LTCI) Pilot Projects were began in 1995 by the passage of AB 1040. Currently, the two active pilot projects are being funded through two grants administered by DHS. San Diego County is exploring integrating nursing home, acute care and home and community based programs. Contra Costa County has integrated a majority of their services for aging and person with disabilities through one department. An Acute and Long Term Care Integration (ALTCI) Program is being proposed in the Governor’s 05-06 Budget as part of MediCal redesign in order to address the problems of acute and long term care system fragmentation. The two LTCI grantees, Contra Costa County, and San Diego Counties, together with CalOptima Health Plan for Orange County would start ALTCI program in 1-1-07, 3-1-07, and 9-1-06 respectively. This collaboration will offer seniors and persons with disabilities a greater choice in the health and community based services they need to be independent.
- The IHSS Plus Waiver was established by SB 1104 (2003-2004 legislative session) to eliminate exceptions to the Personal Care Services Program (meaning there is federal financial participation for all eligible for IHSS in California).
- The DSS and DHS are working towards increasing IHSS hours to the maximum allowed during the first 90 days after a transition from an institution to the community: a particularly critical, vulnerable time for those living alone.

Challenges reported in achieving this goal:

- While integration is happening at the local level in some areas, integration at the state level has not been accomplished. Additional work could be done at the state level to support efforts at the local level.

Strategic Plan Priority: “Develop a collaborative process to eliminate fragmentation, integrate funding, and create a customer-centered, seamless system of long term support.”

Progress reported on this goal:

- Olmstead advisory committee has potential to do this as does the Long Term Care Council. The inventory of long term care programs and

options done by the council in 1999 was a good start. In addition, the Long Term Care Integrations workgroups were set up by the Long Term Care Council to discuss shared data elements across the five programs represented on the workgroup, the opportunity to create a data warehouse to store appropriate client information, and the need for protocols to support electronic client information sharing that would meet the HIPPA confidentiality requirements.

- See Long Term Care Integration Pilot Projects under the previous priority.

Challenges reported in achieving this goal:

- Neither advocates or state leadership is currently coordinating the discussion of what this system would look like in detail or how we would get there.

Overall recommendations to CCoA on implementing these priorities:

- Advocate for co-location of aging and disabled services in Health and Human Services Agency redesign.
- Continue to advocate for integration of all funding sources for long-term support (Medicare, Medicaid, Older American's Act, Older Californian's Act) to facilitate building a client-based system.
- Involve younger people with disabilities in setting up the client-based system. Eliminate paternalism in serving aging and disabled persons.
- Bring in older persons with disabilities to advise aging programs/services. Break down funding silos in the Family Caregiving program, merge funding into existing programs.
- Get involved locally and at the state level in the community planning process of Mental Health Services Act funding.
- Work with Legislature and keep issues and ideas on the radar screen (especially COORDINATED efforts between many aging and disabilities groups). This is particularly important with term limits and the need to educate policy makers on these issues and their ability to make change.
- Help provide consumer and advocate's advice to the DHS's many projects in long-term support.

E. Transportation:

Strategic Plan Priority: “Provide a full continuum of transit services for seniors and persons with disabilities.”

Progress reported on this goal:

- The California Foundation for Independent Living Centers is working on trying to improve accessibility of taxicabs in order to accommodate persons with disabilities. While a bill was initially considered to require a quota of accessible taxis, now the organization is studying and working on local and regional solutions with the taxi industry, city and local officials and stakeholders to find some promising solutions for application statewide. Some of the local solutions include city ordinances, and regional partnerships that have worked together to implement accessible taxi programs in several cities around the state.
- The Public & Specialized Transit Advisory Committee of San Bernardino convened a workshop on Health Access to report on a two-year study that addresses Health and Transportation access. The workshop was held on March 22, 2005; proceedings from the workshop are forthcoming. Preliminary findings identify inter-regional non-emergency medical transportation as a significant problem, a need for significant coordination between health and public transportation, and a need to improve public transportation connections.
- Since the adoption of the Strategic Plan for an Aging California, the California Association of Coordinated Transportation has held three round tables for CTSA’s (coordinated transportation service agencies). These round tables are resulting in sharing of local coordination of activities and strategies. The round tables were held in San Diego in the Spring of 2004, Sacramento in Autumn of 2004, and Riverside in the Spring of 2005. A fourth round table is planned for the Autumn of 2005.
- The IHSS program provides funding for service providers to assist with transportation to and from medical appointments, appointments necessary for fitting of health related devices, and IHSS services provided in lieu of IHSS. This transportation is provided once social service staff have determined that Medi-Cal will not provide transportation.
- The March 7, 2005 United We Ride Mobility Summit was held for the purposes of convening transportation and human services leadership to coordinate and improve transportation for aging, disabled persons and those of limited means. The proceedings from the summit will be important to communicating the issues to leadership to maintain the momentum of progress in this area. These proceedings are expected to be out in July of 2005. Testimony on the issue of coordination of human services transportation was given at the March 9, 2005 White House

Conference on Aging Solutions Forum held in Sacramento. The importance of the issue was also reiterated at the Olmstead Advisory Committee meeting on March 11, 2005.

- The Center for Healthy Aging in Santa Monica has received a one-year planning grant to develop an Independent Transportation Network (ITN) program modeled on the Portland, Maine ITN program. The ITN program involves the use of volunteer drivers to provide transportation, using their own cars, to senior citizens. The program is designed to supplement other transportation programs serving older adults, and to be entirely self-sustaining, relying on member dues and contributions, with no government funding after a start-up period. It is available 24 hours a day, 7 days a week. Drivers provide door-through-door assistance to riders at both ends of the trip. Riders become members of the organization, and establish an account with the agency; ride costs (primarily based on mileage) are charged against the account.

Challenges reported in achieving this goal:

- Counties are looking more closely at minimal ADA compliance with eligibility criteria for paratransit. Since there is no specific ADA funding for this, the counties perspective is that they are more wisely stretching their resources, but the result for the consumer may be less access to paratransit. More dollars and commitment from counties is needed for transportation of the aging and disabled population.
- The Beverly Foundation's work with supplemental transportation programs has publicized a number of model programs to duplicate.
- IHSS service providers would like to see the IHSS funding for transportation include the time spent waiting at medical appointments.

Strategic Plan Priority: "Amend the State Transportation Development Act (TDA) and related regulations to ensure that all unmet transit needs in rural areas that are reasonable to meet are adequately identified and addressed."

Progress reported on this goal:

Caltrans has convened a TDA Advisory Group that is meeting regularly to identify issues with farebox recovery and identifying best practices in conducting the current unmet needs process.

F. Health/Wellness/Prevention:

(Note: The CCoA received one questionnaire response on Health/Wellness/Prevention.)

Strategic Plan Priority: “Greatly expand health insurance coverage.”

Progress reported on this goal:

- Potential progress could be made if HMO’s will be able to serve older adults and people with disabilities better than the traditional Medi-Cal fee for service system.

Challenges reported in achieving this goal:

- Health insurance access includes accessibility standards for physical and program access for people with functional limitations. This is not always the case no matter what the insurance (Medi-Cal or private). Being able to get into a doctor’s office, get on an exam table, understand what information is being given to you, regardless of your disability needs work. Enforcing these standards is critical.

Strategic Plan Priority: “Expand the Preventive Health Care for the Aging program as an investment that avoids even more costly acute, primary care and long term support expenditures.”

Progress reported on this goal:

- No progress reported.

Strategic Plan Priority: “Greatly expand health care access in rural areas.”

The CCoA did not receive responses or progress reports on this priority.

G. Mental Health

Strategic Plan Priority: “In every county, greatly expand community based mental health promotion, recovery, education, and outreach for older adults; identify and incorporate mental health prevention best practices

Please see Long Term Care/Data Systems (Section D) for reports on the Mental Health Services Act funding for mental health services.

VI. Proposed Additions to the Strategic Plan

All stakeholder task teams actively reviewed the Strategic Plan recommendations. Six teams concluded that no changes were warranted at this time. Five teams suggest the following additions to the Plan:

A. Economic Security Element

The Elder Financial Abuse Task Team recommends the following additions to the Strategic Plan Economic Security Element, Abuse Prevention Section:

1. Expand the state's public outreach and prevention efforts to raise more awareness of financial elder abuse. Use two existing and highly effective statewide models already in place:
 - The California Department of Corporations (DOC) SAIF Program;
 - The California Attorney General's (AG) Elder Abuse Media Campaign.

The expanded statewide public outreach campaign will operate at both a grass-roots level and through major media channels to reach out to the public across the state.

2. Support ACR 8 (Dymally) "Month of May as Elder and Dependent Adult Abuse Awareness Month."
3. Develop a statewide volunteer certification-training program utilizing a peer-to-peer model to teach financial elder abuse prevention and education.
4. Develop a comprehensive training curriculum to be used by the volunteers and others involved in the statewide education and enforcement initiatives.
5. Modify the existing financial elder abuse definition to include language that identifies financial elder abuse to also be committed by professional financial predators targeting elders.
6. Develop a statewide Financial Abuse Specialist Team (FAST) Team which is required to meet at least six times a year to share information and implement a long range strategic plan to address the financial abuse of elders and dependant adults.

B. Health and Long Term Care Element—Oral Health Section

The Oral Health Task Team requests that the following background be added to Section II, F, 2 of Strategic Plan.

1. People with special needs including elderly individuals who have complex medical, physical and psychological problems; or who have social barriers to achieving optimal oral health including language, cultural and economic barriers, are having increasing difficulty finding oral health services and obtaining good oral health.
2. There is inadequate training for dental professionals in treatment of individuals with the complex situations described above. There are currently no accreditation requirements for dental schools to provide any treatment experiences for their graduates for these groups of people.
3. There are inadequate incentives for dental professionals to become involved in treatment of individuals with the complex situations described above who may take more time to treat and may produce less income for the dental professional.
4. The predominant funding mechanism for oral health care for people who are disabled and consequently have lowered incomes is Medicaid. In California as in most states, this reimbursement system does not recognize the issues in caring for people with special needs including the need for increased consultation and more time to complete procedures.
5. The current system of care relies predominantly on dental offices and clinics to provide all levels of oral health services including screening, oral health education, minor procedures and complex procedures. A dental office or clinic may not be the only place where some of these services can be provided and for some services it may not be the best place. In particular preventive services may be more effectively delivered in settings closer to where people live and spend the majority of their time.
6. The separation between the oral health care system and other health and social services systems leads to lack of integration of oral health issues into general health treatment and funding mechanisms.
7. Those caregivers who work with people with special needs on a daily basis are typically not educated, motivated or engaged in efforts to prevent dental disease in the people they are caring for.
8. Quality improvement systems in place in residential facilities for people with special needs including nursing homes, licensed health care facilities, and community living facilities often do not consider the extent to which oral health services are being provided or not in these facilities.

9. Policy makers who calculate current and future oral health workforce needs typically do not consider the needs of underserved populations such as people with special needs. Many workforce projections assume that people who are currently outside of the currently delivery system will continue to stay outside.

The Oral Health Task Team further requests that the oral health recommendations of the Strategic Plan in Section II, F, 2 be amended to add the following:

11. Develop a new model/system for delivering oral health services with the following characteristics:
 - a. A focus on prevention
 - b. A reward system that addresses services likely to improve oral health for these populations.
 - c. A system integrated with other community health and social service systems.
 - d. A triage and referral system where oral diseases can be identified and people referred to care settings that best match their situation and needs
 - e. A tiered delivery system with oral health professionals serving as coaches, mentors, and supporters of other health and social service professionals.
 - f. A system that engages those caregivers closest to the individual in playing a major role in maintaining oral health.
 - g. A tiered delivery system where increasingly complex care is performed by those with the most extensive training to deliver such care, and less complex care is delivered by those with less extensive training.
12. Provide adequate reimbursement for oral health treatment services. Provide a mechanism in the California Denti-Cal program to reimburse for extra time spent with a patient with special needs with medical or behavioral challenges.
13. Develop oral health goals and standards for residential facilities and use quality improvement systems to improve compliance with these standards. Tie this to licensure and certification inspections.
14. Recognize that many people with special needs require professional care from dentists with a higher level of training than is provided in dental schools. Require year of “service and learning” for all dental

graduates in an advanced education program accredited by the Commission on Dental Accreditation for dental licensure in California.

15. Increase training for all dental professionals in providing care for people with special needs. This includes providing didactic instruction and clinical experience in this area for dental and dental hygiene students. Make this a part of the accreditation requirements for dental and dental hygiene programs. Also require continuing education in this area for all dental professionals.
16. Coordinate data systems across state programs. Right now it is difficult to obtain good data about the oral health and other characteristics of people with special needs because information about them is tracked by differing state agencies using systems that do not allow cross-tabulation of data.
17. Construct an index of dentally underserved populations, which would include ways to identify underserved populations of people with special needs.
18. Catalog and publicize successful models. Fund replication and expansion of models that have been shown to be cost-effective addition to the current delivery system.
19. Fund research on oral health delivery and prevention models for people with special needs.

All above recommendations can be found in the report: *Oral Health for People with Special Needs - Implications for the Dental Profession* from the Pacific School of Dentistry Oral Health Conference, November 4, 2004.

C. Health and Long Term Care Element—Palliative/End of Life Care Section

The Palliative/End of Life Care Task Team recommends updating the Strategic Plan Section II, F, 5 by adding under the first Palliative and End of Life Care Recommendation, element “d” as follows:

- d. Mandate and fund state run medical schools (UCLA, UCSD, UC-Davis, UCSF, UCI) to develop departments of palliative care within the Division of Medicine.

The team also requests the addition of back ground material relative to the above recommendations. See Appendix D for full text.

D. Health and Long Term Care Element—Long Term Care Section

The LTC Task Team offers the following thought related to diversion from and relocation from institutional care for inclusion in the Strategic Plan Update:

Housing is an integral factor in both diversion from and relocation from institutional long-term care. A current significant step forward in the state of California is the Assisted Living Waiver Pilot Project (ALWPP) in which MediCal-funded assisted living is being explored. Stakeholders are concerned that the criteria for assisted living facilities is too stringent, leaving out a significant number of residential care facilities for the elderly (RCFEs). These stakeholders recommended amending ALWPP statute in order for meaningful involvement of RCFEs in a pilot for persons who are in nursing homes even though they have only custodial needs as opposed to skilled nursing needs.

E. Infrastructure Element—Assistive Technology Section

The Task Team recommends updating the Strategic Plan Section II, G, 5 by adding the following two new recommendations:

3. Conduct research to locate non-governmental funding sources that can be used for education, for outreach, and for actual Assistive Technology equipment to increase the quality of life for older adults.
4. Strong advocacy must push for AT policy change with the Legislature and administration.

VII. Conclusion

State officials and aging/advocacy organizations agree that a synergistic combination of grass roots and state department efforts are facilitating incremental steps on achievement of several top 15 priorities in this first period of the Plan's implementation phase. It is equally clear that much more needs to be done to build on these successes and further utilize alternative funding streams.

This Progress Report has identified four key factors/trends that led to successes towards implementation of several Strategic Plan priorities. These are presented below as successes along with future challenges. This conclusion also identifies significant recommendations/opportunities for state leadership at this point in time to further implementation of the Strategic Plan.

Success: Unlike other strategic plans required by the Legislature, this plan has involved the work of over 100 stakeholders on 11 different task teams to implement plan priorities. This shows the topics are considered vital to systemic and programmatic development change. Task team participants are in demand as speakers for community meetings and statewide conferences. Many task teams are continuing their work. Future groups may form as interest grows for important elements of the Plan not yet addressed.

Challenge: Stakeholder groups working independently cannot achieve widespread accomplishment of all priorities in the plan. Commitment and action is required by coalitions of state and local, public and private sector, community based organizations, professional associations, advocacy organizations and individual effort.

Success: Task teams supported by private foundation and/or government sources of funding have resources and momentum to continue with their charge.

Challenge: The strategic plan priorities may not be the 'hot topic' or priorities of foundation or federal funding sources. However, these priorities are just as worthy of work due to their importance to the consumer.

Success: State Legislative mandates and budget priorities can facilitate expansion of much needed programs. (IHSS is an entitlement program, and as a major home and community based service for older persons and persons with disabilities, will continue to expand with the needs of this population in the state.)

Challenge: The State Budget continues to be stretched and expansion of health and human services programs are vulnerable to yearly budget scrutiny and debate.

Success: Consumer/constituent ballot initiatives can offer specific budget direction to much needed service areas for aging and disabled Californians.

Challenge: Funding an appropriate mix of services should be assured in order to avoid intergenerational fighting, competition between populations, etc.

Additionally, through this monitoring process, the Commission on Aging has identified several significant opportunities for state leadership for furthering implementation of the Strategic Plan.

While the restricted State Budget poses many challenges to implementation of Strategic Plan priorities, it also provides an opportunity to streamline duplicative services and programs and inspire creative thinking in how to provide public services more efficiently and effectively. Earlier this year, radical reorganization proposals for aging and disabled services were proposed by the California Performance Review. Leadership commitment and timing towards these changes has not yet been revealed. In addition, other state entities and reports have suggested restructuring alternatives that have not been acted upon.

State leadership (both administrative and legislative) should have political will to accomplish what has been recommended by state aging and Olmstead planning efforts. The Strategic Plan cannot be successfully implemented on its own; rather it must be achieved through the vehicle of broader implementation of the Olmstead Plan. California cannot afford more systems design duplication. State leadership should use their political muscle to bring stakeholders under their purview together and identify ways to overcome barriers. Top down commitment and united department leadership, such as could happen within the Long Term Care Council is needed to provide inertia, place importance on priorities, and eliminate bureaucratic barriers. Advocates have their part to play in encouraging this leadership. In turn, state leadership should draw upon the knowledge and expertise in the advocacy community to work together. State leadership must also address federal barriers to implementation and advocate for preserved programs and services funding.

This recommendation/opportunity of improved state leadership and/or leadership reorganization is not new. It was recently reiterated by the Little Hoover Commission's May 2004 report, *Real Lives, Real Reforms: Improving Health and Human Services* which states, "the Health and Human Services has been unable to coordinate state activities among its 13 different diverse departments" (pg. i). The Little Hoover Commission further recommended unified leadership for Health and Human Services Agency so it can "ensure consistency across state operations, promote collaboration across departments and track progress towards the State's goals for children, adults and families...", "Agency and Department directors should come together as an agency cabinet" (pg. ix).

In December 1996, the Little Hoover Commission conveyed in their report *Long Term Care: Providing Compassion without Confusion*, "If the State is serious about creating an effective long-term care system, then it must reorganize departments

into a single entity to oversee all long-term care.... The new department should take advantage of the opportunities presented to create a consumer-centered philosophy that maximizes choice, effectiveness and efficient use of multiple resources“ (pg. v).

Without state leadership commitment (both administrative and legislative), the Commission believes only limited sporadic, piecemeal progress will be made in the state’s service system for aging and disabled Californians. These conclusions are supported by the experiences of other states that now have a reputation for providing exemplary services to seniors (i.e. Oregon, Florida and Washington) as outlined in Assembly Member Patty Berg’s report entitled *Planning for an Aging California Population: Restructuring the California Department of Aging and Long Term Care Services in California (2004)*. The Commission encourages state leadership to discuss their willingness to take on this role and we accept a challenge of our own: to unite advocates.

The charge in the 2003 Strategic Plan is just as relevant today, “It is now up to every organization that works with or on behalf of older adults throughout California to study this plan and determine what they can contribute toward its implementation. Leadership must emerge for every Plan element. Simultaneously, collaborative relationships must be developed across Plan elements. These actions will lead to meaningful implementation. With participation and collaboration from all sectors and with the state in the role of convener, this plan can move forward... one step at a time from any and every sector.”

Appendix A

Planning for an Aging California: An Invitational Forum

TUESDAY, MARCH 8, 2005

8:00 am REGISTRATION (Room 202)

8:30 am OPENING AND INTRODUCTIONS

- Nancy Dolton, Chair, California Commission on Aging
- Lora Connolly, Acting Director, California Department of Aging

9:00 am BACKGROUND – *Strategic Plan for an Aging California* – Commissioner Celia Esquivel and Cheri Jasinski, Consultant

9:15 am HOUSING PRESENTATION – Commissioner Jon Pynoos

Response from Panelists:

- Catherine Campisi, Director, CA Department of Rehabilitation
- Christopher Westlake, Assistant Director, CA Department of Housing and Community Development
- Mark Stivers, Consultant, Senate Committee on Transportation and Housing
- Alisha Sanders, Associate Director of Public Policy, California Association of Homes and Services for the Aging
- Julie Spezia, Executive Director, Housing California
- Yvonne Hunter, Legislative Representative, League of California Cities

10:45 am ECONOMIC SECURITY PRESENTATION – Commissioner Leah Wyman and Bonnie Parks, Executive Director, Senior Worker Advocate Office

Response from Panelists:

- Catherine Campisi, Director, CA Department of Rehabilitation
- Dennis Petrie, Deputy Director, CA Employment Development Department
- Frank Mecca, Executive Director, County Welfare Directors Association of California
- Mike Collins, Executive Director, State Independent Living Council

12:15 pm Lunch (Room 204)

- Honorable Lynn Daucher, Vice-Chair, Assembly Committee on Aging and Long Term Care
- Fernando Torres Gill, Ph.D, Director, Center for Policy Research for Aging, UCLA

2:00 pm LONG TERM CARE PRESENTATION – Commissioner Andrew Scharlach and Pat Fox, Professor, Department of Social and Behavior Sciences, UCSF

Response from Panelists:

- Lora Connolly, Acting Director, CA Department of Aging
- Tom McCafferty, Chief Deputy Director, CA Department of Health Services
- Robert Sertich, Chief Deputy Director, CA Department of Social Services
- Sarah Steenhausen, Assistant Secretary, CA Health and Human Services Agency
- Carol Hood, Deputy Director, CA Department of Mental Health Service
- Patricia Yeager, Director, CA Foundation for Independent Living Centers
- Gary Passmore, Director, Congress of California Seniors
- Ron Errea, President, California Association of Area Agencies on Aging

3:30 pm OTHER STRATEGIC PLAN TASK TEAM ACTIVITIES – Cheri Jasinski and Task Team Leaders

4:00 pm TRANSLATING THE *STRATEGIC PLAN FOR AN AGING CALIFORNIA* INTO LEGISLATIVE ACTION:

Honorable Patty Berg, Chair, Assembly Committee on Aging and Long Term Care

5:00 pm Closing – Nancy Dolton, Chair, California Commission on Aging

Appendix B

Strategic Plan for an Aging California Population Getting California Ready for the Baby Boomers

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III. In Conclusion – Top 15 Priorities and Next Steps

Appendices:

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Appendix C
California Strategic Plan for An Aging Population
Top 15 Priorities

Of the many high priority recommendations set forth in this Strategic Plan, the following are most urgent. The urgency is due to their impact on older adults, the long lead-time required to complete implementation, and the critical path some of these recommendations play in the course of achieving other goals.

1. Greatly expand health insurance coverage.
2. Provide education /training to develop or enhance skills so older adults can move into second career options.
3. Build a comprehensive, integrated data base on aging and disabled Californians for longitudinal studies and care navigation.
4. Address California's health and social services workforce deficit. Ensure the recruitment and retention of health care professionals, allied health, mental health and paraprofessionals.
5. Provide a full continuum of transit services for seniors and persons with disabilities.
6. Amend the State Transportation Development Act and related regulations to ensure that all unmet transit needs in rural areas that are reasonable to meet re adequately identified and addressed.
7. Expand Smart Growth models of housing and land use that incorporate livable, walkable, mixed-use, intergenerational components.
8. Strengthen support for repairs and home modifications by community-based organizations in every county.
9. Expand the Preventive Health Care for the Aging program as an investment that avoids even more costly acute, primary care and long term support expenditures.
10. Greatly expand health care access in rural areas.
11. In every county expand community-based mental health promotion, recovery, education and outreach for older adults; identify and incorporate mental health prevention best practices.
12. Build and implement a "no wrong door" care navigation system.
13. Build capacity into community-based long-term support services to prevent unnecessary institutionalization.
14. Develop and expand comprehensive, integrated care models.
15. Develop a collaborative process to eliminate fragmentation, integrate funding, and create a customer-centered, seamless system of long term support.

Appendix D

PALLIATIVE/END OF LIFE CARE RECOMMENDED ADDITIONS TO STRATEGIC PLAN FOR AN AGING CALIFORNIA

1. Expand public-private partnerships to support the education and training of health and social service professionals in the specialty of palliative care

Palliative care represents a new paradigm in health care for the majority of U.S. physicians and other health care professionals. During the 20th century the primary focus of medical care was on the diagnosis and treatment of acute illness, the objective usually being cure or life prolongation. The clinical and research concentration on the prevention and treatment of acute illness has been a success by any measure, with the average life expectancy increasing by more than 40 percent over the past century. However, society and contemporary medicine are now challenged to provide care to an aged and aging population of individuals having multiple medical infirmities, many of whom will succumb to chronic degenerative diseases (e.g. cancer, Alzheimer's disease) or advanced cardio-respiratory conditions. For this rapidly enlarging population of patients, seldom are cures or meaningful life prolongation realistic goals. With the anticipated financial strain that the infirmed elderly will place on governmental budgets, society has a responsibility to ensure that health care resources are invested in practical and problem oriented programs likely to produce tangible good, rather than on technologically based gestures having poorly defined or unrealistic objectives.

The goals of elderly patients for meaningful and dignified care, and of society for equitable and cost-effective solutions, are increasingly finding a common ground in the practice of palliative care. Simply defined, palliative care is focused on the maintenance of comfort and quality of life, the provision of social support, and assistance in planning for end of life. By extension, a core component of palliative care is the development of coherent and well-integrated inter-disciplinary teams, since unlike acute care, success in the management of chronic and advanced disease requires the collaboration of diverse medical and social care disciplines.

Prepared by Neal Slatkin, M.D. and Michelle Rhiner, RN, MSN, NP

2. Develop quality of care protocols and indicators for palliative and end of life care, including pain management not necessarily limited to the end-of-life timeframe

Definition of terms

The above charge appropriately reflects a more expansive concept and definition of palliative care, such as the following that has been offered by Dr. Charles von Gunten of the San Diego Hospice: “Palliative care is the relief of pain and suffering.” It is a model of care that is often contrasted to curative or disease-directed interventions. However, emerging models, characterized as “simultaneous care,” recognize that curative and palliative measures can, and often should proceed in tandem, particularly when the patient has months or years of anticipated survival.

Existing standards

There are quite a few clinical practice guidelines and protocols for palliative care (broadly defined as above) that have been promulgated by interdisciplinary panels of prominent experts in the field. Among the first were the Agency for Health Care Policy and Research Clinical Practice Guidelines for acute (1992) and cancer (1994) pain. In 1996, the American Board of Internal Medicine (ABIM) published “Caring for the Dying: Identification and Promotion of Physician Competency,” in which core competencies in end-of-life care were identified and explained. In 1998, the American Medical Association established the Education for Physicians in End-of-Life Care Project (EPEC). Its goal was to create and disseminate a continuing medical education curriculum that would equip all physicians with the core competencies necessary to provide minimally acceptable palliative care to their patients. Both the ABIM and EPEC initiatives are based upon the premise that all physicians, not just pain and palliative care sub-specialists, should be capable of providing competent palliative care.

In 2002, the Last Acts Project published “Means to a Better End: A Report on Dying in America Today.” This report sets forth principles of palliative care, and then evaluates (assigning grades of A through F) the extent to which each state meets 8 separate criteria: advance directive policies; location of death, hospice use, hospital end-of-life services; care in ICUs at the end-of-life; pain in nursing home residents; state pain policies; and palliative care-certified physicians and nurses. California received a “C” grade.

In 2003, the National Consensus Project for Quality Palliative Care issued extensive “Clinical Practice Guidelines for Quality Palliative Care.” The guidelines are organized around eight domains of care: structure and processes; physical aspects; psychological and psychiatric aspects; social, spiritual, and existential aspects; cultural aspects; care of the imminently dying patient; and ethical and legal aspects.

A good example of a set of indicators for palliative and end-of-life care has been developed by Joseph Fins and colleagues (*Journal of Pain & Symptom Management* 1999; 6:6-15) called the “Goals of Care Assessment Tool

(GCAT).” Among the GCAT indicators for a shift in emphasis from disease-directed to palliative therapy are: diagnosis of terminal condition or life-expectancy of less than six months; acute decompensation such as ARDS, sepsis, shock, transfer to an ICU; patient expressions of awareness of or wish for impending death; staff identification of patient as dying.

The relationship between clinical practice guidelines and the standard of care

Heretofore, the promulgation of clinical practice guidelines by prominent health care professionals or groups has presaged, rather than constituted, a change in the usual custom and practice of health care professionals in some aspect of patient care. This point is significant because traditionally the standard of care to which physicians or other health care professionals are held is defined and delimited by what other reasonably competent and prudent professionals would do under the same or similar circumstances. There is invariably a lag time between the promulgation of new clinical practice guidelines and their adoption by a majority of health care professionals. Moreover, the mere issuance of clinical practice guidelines, regardless of how much they may be needed or how prestigious the group that develops them, does not necessarily result in changes in professional practice (Lomas, et al., *New England Journal of Medicine* 1989; 321: 1306-1311). Similarly, studies indicate that merely exposing health care professionals to continuing education programs (such as the EPEC seminars or programs offered in response to California Assembly Bill 487) may not consistently result in dramatic changes in practice patterns (Max, et al., *Annals of Internal Medicine* 1990; 113: 885-889).

The problematic nature of motivating health professionals to improve their quality of care in a particular aspect of professional practice has caused courts in an increasing number of jurisdictions to cease to allow the usual custom and practice of health care professionals to define and rigidly set the standard of care. Rather, the usual custom and practice becomes *prima facie* evidence of the standard of care, but that rebuttable presumption can be overcome by evidence, such as national clinical practice guidelines, indicating that the usual custom and practice is inadequate, out of date, and actually detrimental to patient welfare. In other words, the standard of care (when defined as the usual custom and practice) can be shown through such clinical practice guidelines to be substandard. This is arguably what took place in the recent California case of *Bergman v. Chin*, which challenged the quality of pain management provided to a patient with lung cancer. There was expert testimony offered on behalf of the defendant physician that the pain management he provided to the patient was consistent with the usual custom and practice of similar physicians in California when caring for such patients. However, the jury found more persuasive the expert testimony on behalf of the plaintiff that the AHCPR cancer pain guidelines should constitute the minimal standard of acceptable care and, if they had been followed, would

have insured that the patient did not suffer. On this basis, the jury found that the failure of the defendant physician to provide palliative care consistent with those guidelines constituted not simply medical malpractice, but elder abuse.

Ultimately, what is necessary to improve the quality of pain management and palliative care for Californians is the widespread adoption of one or more of the national guidelines and protocols discussed above in a wide range of practice settings, including acute care hospitals, skilled nursing facilities, home health agencies, and hospice programs. All such agencies should be required to demonstrate that their professional staffs have the requisite knowledge, skills, and attitudes to provide care consistent with those guidelines and protocols, and that reliable monitoring mechanisms assure that such care is actually provided. Moreover, mechanisms should be in place to identify departures from those standards and insure that prompt and appropriate remedial measures are instituted.

Prepared by Ben Rich, PhD.

3. **Realign reimbursement systems to cover individuals with certain chronic diagnoses that are not “terminal” but need palliative care**
4. **Reimbursement systems should consider the projected mortality rates for specific diseases and examine the “six month life expectancy” restriction on hospice reimbursement.**

Many Americans, nearing the end of life, suffer needlessly and die badly. In 1982, when Congress enacted the Medicare Hospice Benefit, the program was designed to address the needs of patients with cancer diagnoses, and political considerations demanded budget neutrality. In order to achieve this, provisions were added that require eligible recipients to give up curative care in order to receive hospice services and limit access to the services to those with a prognosis of six months or less to live. Because of the language in the Social Security Act, Medicaid programs follow the same provisions and are plagued by the same barriers.

Since 1982 advances in medical science have blurred the distinction between living and dying as well as distinctions between life-extending and palliative treatments.¹ In order to address the needs of Americans who are living longer with multiple chronic illnesses, improvements are needed to make the system more accessible, less rigid, more accepted by the dying and their families and less financially draining to the health care system.

The Medicare and Medicaid programs are filled with complexities that prevent beneficiaries from fully benefiting from available options. Like Medicare, Medicaid programs lack an innovative, comprehensive plan for providing cost-effective, high-quality care at the end of life. Public policy makers need to reexamine the

eligibility requirements in light of the advances in medical care and reimbursement limits of the Medicaid hospice benefit. It is important for Medicaid decision-makers to identify ways to fund palliative care beyond the hospice benefit.²

The current health care delivery system is organized in silos: nursing home, hospital, home and doctor's office. Under the usual fee-for-service program, doctors, hospitals, and other service providers are paid for each billed service. This arrangement encourages billable services, not continuity of care.³

Changing care for those at the end of life will require leadership, funding, education and research. In order to substantiate anecdotal evidence that hospice and palliative care services are less costly than mainstream curative medical care, researchers need to look at:

- An analysis of whether a case-mix payment system is feasible.⁴
- Analyses of treatment costs for hospice enrollees of a certain type versus non-hospice patients with the same disease.
- Analyses of varying life spans and related costs.
- Demonstration projects analyzing innovative funding mechanisms.
- Demonstration projects analyzing alternatives to the six-month hospice eligibility requirement.
- Identification of best end-of-life practices in the field and development of practice guidelines.

Prepared by Margaret Clausen

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⁴ Report to the Congress, Medicare Beneficiaries' Access to Hospice, Medicare Payment Advisory Commission, May 2002.