California Master Plan for Aging
Research Subcommittee Meeting #1
October 24, 2019

Meeting Transcript

Anastasia Dodson:
Welcome. Before we start, we're going to make sure that the folks on the phone who dialed into the webinar hear us. All right, so you should have on your control panel. If you're dialing in from the web a little hand icon. Please click on that hand icon on your screen. We're looking to see if we have a bunch of hands raised. All right good. It sounds like our audio is working correctly with that. I'll turn it over to Kim.

Kim McCoy Wade :42
Off to a wonderful start. This is Kim McCoy Wade. I am acting director here at California Department of Aging, I am thrilled to welcome both those of you who are in person to our home here at the Department of Aging and those of you who are able to join by phone.

This is our first subcommittee meeting of all the Master Plan for Aging and it is the first subcommittee of the Research subcommittee and we are particularly thrilled to be starting with this as a commitment from our Administration to a person-centered, data-driven approach to the Master Plan for Aging.

We are going to start with introductions. We have an incredibly illustrious group of leaders globally, nationally, and here in California joining us and we are so grateful and so fortunate. So, we will kick it off in the room and then go to the phone.

Anastasia Dodson
Anastasia Dodson, California Department of Aging.

Carrie Graham
Carrie Graham, I'm from the University of California and acting as an external consultant here.

Latesa Stone
I'm Latesa Stone and work with the California Department of Public Health.

Julie Nagasako
Julie Nagasako, also with the California Department of Public Health.

Stacey Moore
Stacey Moore, AARP California.

Jeannee Parker Martin
And I'm Jeannee Parker Martin with LeadingAge California.

Zia Agha, MD
And I'm Zia Agha with West Health.

Jennifer Breen
Jennifer Breen with the California Association of Health Facilities.

Laura Carstensen, PhD
Laura Carstensen, with Stanford University, Stanford Center on Longevity.

Derek Dolfie
Derek Dolfie, League of California Cities.

Kim McCoy Wade
And then do we have the ability to have subcommittee members on the phone to introduce themselves?

Anastasia Dodson 2:09
We have Gretchen Alkema, PhD from The SCAN Foundation, although she may be limited to speak. And we should have Donna Benton, PhD from USC Family Caregiver Support Center, Janet Frank, DrPH from UCLA Fielding School of Public Health, Kathryn Kietzman, PhD from UCLA Center for Health Policy Research, Karen Lincoln, PhD from University of Southern California, David Lindeman, PhD, Center for Information Technology Research in the Interest of Society, and Shireen McSpadden, from San Francisco County Department of Aging and Adult Services.

Nelson Sheya
That's right.

Anastasia Dodson
And they're all dialed in?

Nelson Sheya
Yes.

Kim McCoy Wade 2:50
So, at our first meeting a couple things we need to get organized. The purpose of today, of course, is to really talk at the highest level about what the goal of what this subcommittee is and how it's going to inform the Master Plan for Aging. The role of the subcommittee and the process.

We will spend some time up front getting ourselves organized, but then we will get to work and look at some data dashboard examples and data source examples on some of our key indicators. Just a note on how we are structuring these meetings and of course open to continuous improvement, but the way we are wanting to do a deep dive on topics is to have some presentations from local state and national experts.

Today we have some those on dashboards and data sources and then have a chance for stakeholder subcommittee member discussion to discuss what you're seeing, what you'd like to see more of, suggestions, recommendations, and then as always there will be public comment at the end. We will have time for that both on the phone and in the room. And then we will wrap up with what we're hearing, big themes and next steps.

Of course, just a reminder on process: input is always I'm through the webpage. Rolling process, there are not deadlines or formal mechanisms at this point it's all coming in and being taken in so that we can develop deliverables to come back to you for review and discussion. Are there any questions people have about what we're going to tackle today before we jump right in or any housekeeping additions?

Anastasia Dodson
A couple of members on the phone who wanted to do live introductions.

Kim McCoy Wade
Wonderful. Donna and Sharon, can you introduce yourself?

Sharon Nevins

Hi, this is Sharon Nevins from the County of San Bernardino Department of Aging and Adult Services – Office of the Public Guardian.

Donna Benton, PhD 4:50
I'm Donna Benton, and really glad to be here virtually.

Kim McCoy Wade 5:01
Thank you. Thank you for joining us.

Anastasia Dodson 5:17
Just a couple more housekeeping items. So, folks in the room if you wish to speak if you can put your table tent sideways like this and it Carrie is going to keep track of who's in the queue, and then Nelson will keep track on the phone. So, we'll try to coordinate on that. And anybody who's calling in and looking for the meeting materials they are posted online and they're also going to be shown on the webinar. For folks who are in the room if you need use the restroom or leave and come back, there's some temporary badges over here, but please do leave them before the end of the meeting. And then again members of the public will be able to type in comments and suggestions in the webinar form that we will review at the end of the meeting, and members of the subcommittee can also type things in so if you have a URL or something you want us to look at we won't be able to pull it up on the screen immediately, but we can look at it afterwards.

Kim McCoy Wade 6:20
Okay, any other kind of housekeeping questions or comments before we jump in?

Jeannee Parker Martin
If we could remember to speak up as well.

Kim McCoy Wade 6:20
Yes, and especially be mindful to speak where microphones are. Thank you. And let us know if you have feedback or if things are fading in and out. This is our debut of this room, being used for this purpose. So, we will again continuously improve and do speak up if things are not working.

So, here's where we are, and how we're going to spend our time today. We thought we'd start with that foundational conversation about a charter, why we're here and what are we here to do. Talk about the connection to the

master plan. What is the role of research and data in the master plan? And then, because a dashboard is one of the deliverables here, look at examples of state and local dashboards. There's quite a number from our state government local government partners that can give us some inspiration. And then turn to data sources, we have a some good partners at OHSPD here to share some of the data sources for health and aging.

And again, as I mentioned, we will have discussion throughout each of those items by the subcommittee members, and then public comment, and then we'll be sure and land with where to go from here.

So why are we here? We are here because the governor has announced and made a commitment to a Master Plan for Aging and the executive order released in June 2019.

This is a commitment that comes both from his personal experience that he shared with his own family and the overwhelming data trends showing the rise in the number and the diversity of aging Californians and the opportunity to do more to make sure that we and our families and communities are ready for this major change.

Interestingly in the executive order, although this is an all-encompassing master plan, only two subcommittees are by name. One is long-term care, which kicks off on Monday, and the other is research. And again, I think that's a sign of the commitment to this being a data-driven process and for those of you who have been around tables like this there have been master plans or things like that in this field before and part of what we're trying to do different here is really have those benchmarks, those goals, that annual accountability at the state and local level.

As the charter suggests on this Slide, the purpose of the research subcommittee is to provide advice and input to the Health and Human Service Agency and the full stakeholder committee on research and data.

For those of you who are on the full committee, we've discussed this, but for those of you who may be joining us, the master plan will be released by the administration, so the purpose of these committees is to advise the administration in a continual iterative process, we'll bring back work to you and get your feedback, but the goal ultimately, the deadline is October 1st 2020 now less than a year.

To be a little more specific about what that means. There's a lot of words on this slide but let me just call your attention to a few of them. So again, to advise our agency and the stakeholder advisory committee.

A) Indicators. How are we doing? Indicators at the population and system level which convey how we are moving towards an age-friendly dementia friendly disability friendly State.

B) Baseline data and ten-year goals. Where are we right now? And where do we want to be or need to be? And I would just say including where we don't have that data. I suspect there may be a few places where we want to measure, and part of the recommendation will be to develop the data system or get that data, or analyze that data. And then very important to disparities, both from again, our Governor's vision of California for All and Equity and what we know about disparity across age and race and place and income and sexuality, etc.

Both making sure that we are addressing those disparities that accumulate over the lifespan and really make aging quite different for folks and then reducing them and not certainly not aggravating them. So, making sure our data is broken down and lots of ways that can be useful to make sure we're all, all of us are aging well in California.

So indicators, baseline goals, disparities. Next slide, my favorite word, dashboard. D for dashboard. We want this to be very user-friendly and visual so that any mayor could look at their city or any community group or any interested family member could look and see how we are doing and where are the opportunities? That's been a very quantitative conversation. Well, I like to say there's also qualitative pieces that were interested in because of course when you look at the dashboard and see that your community has room to grow you want to know what to do.

We're wrestling with how do we identify best practices, promising practices, evidence-based practices in a way that we can do realistically and sustainably on every issue affecting aging. We want to be sure that we can point people to the right place. But what's the useful way to do that?
And then again F) more at the emerging, the new, the promising. How do we continue to in California always be advancing the latest and stimulating the latest findings?

And then throughout you are the mega subcommittee, you touch every issue. So, as groups go to work on poverty, or go to work on housing, or go to work on depression and isolation they're going to perhaps need some technical assistance on what are the right indicators in this area. And so, there will be some opportunities for working with those goals specific, program specific conversations as well blend your data expertise.

So that's it. That was A-G. Really that quantitative qualitative lens to make sure we stay person-centered and data-driven.

Next slide. We're all driving towards a couple things. Again, long-term services and supports get called out for a stakeholder report in March. So that subcommittee is kicking off on Monday and I feel like it's meeting every week for about three months. It's going to be the most accelerated subcommittee. But that will be very important and come out in March and look at issues around access, financing, and quality of long-term care across the continuum, but the major products of the master plan process per se are these four: 1) the state roadmap with data indicators, 2) local blueprints so that local communities can take it to enhance their work. We've just been visiting with places like Ventura who have a plan in progress, San Diego that have a plan already, and other cities that are just getting started. 3) The resource tool kit I mentioned; how do we point people to the right evidence-based policies and practices? 4) And the data dashboard. Really if I may say the primary deliverable of this subcommittee is the data dashboard.

Let me pause there and see if my team has anything to add or correct and turn to the stakeholder subcommittee to see if there are any comments or questions.

Jeannee Parker Martin 14:04
One small question is it easy to say that all of the objective should be focused on a 10 year horizon? There was one comment on indicators, the second one, related to recommendations for clear and measurable baseline data and 10 year goals… is that across all of these?

Kim McCoy Wade 14:22

I would say yes and with markers along the way. But the EO does have a 10-year framework 2020 to 2030 kind of vision that we're tracking with. Is that your question? Starting in October 20, so that'll be our Baseline.

Anastasia Dodson 14:53
Just a reminder for folks who are speaking in the room, if you could announce your name right before you speak, for the people on the phone. Thank you.

Kim McCoy Wade
Thank you, Jeannee Parker Martin. Laura Carstensen?

Laura Carstensen, PhD 15:12
A follow up to that, do you plan to measure only indicators that you want to move, or do you also want descriptive data over that 10-year period?

Kim McCoy Wade
Say more. I'd love to have the group address that question. Go ahead.

Laura Carstensen, PhD 15:32
Are you only going to try to identify things like, for example isolation, and then say we want to move isolation from Point A to Point B in 10-years, or do you also want things like family composition where you're not going to try to change it over that 10-year period, but it would be something that would be a covariate with some of these other variables and you might want to monitor.

Kim McCoy Wade
Yes, I will say what I have been thinking and then people can have at it. There would be some demographic data that we will absolutely be tracking and again what level can we go, there's individual population level, but family level, dementia level, various different demographic, probably some program intervention like how many program slots or investments or dollars, and then the outcome piece, which is of course is the hard one, right? What is what's happening with isolation and what's happening with depression so you could measure how many people are in a certain category, how many people you do an intervention with, and then have you moved the needle?

But really, you are the experts and that's what we defer to you and it may vary by may vary by issue. I think we want to be careful. There's always that tension. You want to do what you can count, which is the service you delivered, but you really want to know what the results of that was. So, how do we look at both? And what data do we have available to us?

Carrie Graham 17:03
And I will say, we absolutely want to get these covariates, because some of the indicators will be for specific populations, so for people living alone who have a certain family composition.

Laura Carstensen, PhD
There may also be, say the percent of people who are working is something we might want to track, and might change with effective interventions. As people have more ability to get transportation to various parts of the city, they might be more likely to engage in paid work or volunteer work. And so, some things like that may not be trying to increasing the percentage of people who work, but it would be interesting to say, when we did this intervention, that changed. Or simply to be able to say over the last 10-years more or fewer older Californians are engaged in paid or volunteer work. That's my question, are we trying to characterize the population or only say these are the interventions, so we're going to measure those targets of the interventions, and whether they change over time.

Kim McCoy Wade 17:56
Do other people have response to that question? We've got lots of people with experience.

Zia Agha, MD 18:26
I hope we do a little of both, we can't do one or the other. Identify the problem and gaps and selectively intervene. We can't boil the ocean on the other hand. We will need some key indicators and beacons of success that we can all align on and then hopefully change.

Marty Omoto 18:39
Towards those points you both made, everyone refers to outcomes or indicators that the Administration has and the legislature has, and one of the issues I think that we're going to struggle with and I'm not sure we're going to drill down on is what is an outcome that can be measured that is

actually meaningful? And one of the issues that I've raised, and some of the other advocates we've raised, in the legislature and with the administration in previous meetings outside the master plan is that the outcomes when people speak about them are always terms of utilization or dates or duration or mostly about spending. And somehow then someone extrapolates from that if the number of ER visits for instance have gone down that means it's a good thing the assumption being that someone is not requiring that use, but that's not necessarily true. And if we are talking about person-centered approaches to solving and approaching and identifying solutions to the master plan, then we're going to have to do better than that. And the problem though is it is not easy, right? Because if you start drilling down on outcomes that are individually based, that makes it really hard to do something in the aggregate. But just because it's hard doesn't mean that we should not try to find a way to identify real outcomes that are meaningful for the individual. And maybe it is that we do an audit, over several programs. I mean you have your experience with CalFresh, the expansion and X number of people now have received food stamps that didn't, but what does that actually mean? Does that mean that food insecurity is lessened or actually, hopefully it's not actually increased? Or what does that mean for that individual with disabilities who lives in Ventura? And I think we somehow we got to struggle that we're truly interested in getting good information about how solutions are being implemented and afford this either on a pilot level or on a systemic level that is meant to be permanent. We're going to have to come up with better outcome measurements.

Again, I don't have the answer to that, but I do have questions. My own sister, she had developmental disabilities, she had several visits to the ER and the Urgent Care or acute care hospital, and when that stopped, I know the assumed that her health was better, but she died, she ended up dying. So, it's just, I don't want to belabor this but I just think it's something that we're going to have to kind of work on together.

Kim McCoy Wade 21:19
I really appreciate that. I mean, it's issue of more older adults working could be both a good thing and a bad thing depending on that individual.

Marty Omoto
We don't know, do they have to work because there's no other choice? Like my father. He is 81 and had to go back to work when his daughter my sister

died and she left her 12 year old son, and he wasn't prepared to do that. And so that outcome or that result would be much different than someone else. Like anybody running for president would have a different reason why they're still working.

Kim McCoy Wade 21:51
We have three of our members on the phone who wants a comment. So Karen Lincoln, doctor Lincoln?

Karen Lincoln, PhD 21:59
I'm unmuted. Can you all hear me? Yeah. Hi. Very good. Thank you. So yes, I wanted to speak and thank you for the speaker. I'm sorry. I didn't catch your name. I completely agree with everything you said in terms of being a quantitative researcher as well as partly qualitative.

I think it's important for us to get a sense of what's being measured currently and then what's missing. Because if we're going to monitor, address, attend to disparities we obviously need some characteristics and demographic data and it may go so far as you know, neighborhood and zip code and other kinds of resources. So I think it's really important for us to when we think about Baseline to go beyond the characteristics of the individual and really think about, you know, the wider community where people are living to better understand, what are the gaps in terms of services and access etc. And so, I just wanted to throw that out in terms of our task in terms of data.

One, what is currently being measured. Two, what's missing? And then three, how do we measure disparities? How do we measure something beyond differences? But actual disparities which are more systemic. So, I think we have to think about what are those kinds of data that will need that will go beyond an individual person and perhaps an individual family.

Kim McCoy Wade 23:24
Thank you. Dr. Benton?

Donna Benton, PhD 23:42
Thank you. I just wanted to say that I did agree with everyone and I think that what I'm hearing is that we are going to need that combination of both qualitative and quantitative analysis to get us in the right direction.

And as we look at the dashboard, I think it is going to be really important that the dashboard be consumer-friendly also and not just a dashboard that's going to look great for a researchers, but for the general public to be able to easily understand what we're trying to do and move the needle in our aging research here.

Kim McCoy Wade 24:09
Thank you. And Nari Rhee you were next in the queue. Dr. Rhee?

Nari Rhee, PhD 24:16
I think I missed the beginning few minutes, but I just want to make sure I can be heard. I want to add a little bit in terms of whether it's for person-centered or more aggregate data. Just given the kinds of demographic changes that we're going to see in the senior population over the next 10 to 15 years. And also, in terms of the resources that they're going to have is going to be really different from the resources of current seniors in terms of retirement income and assets. So I do think that that's something that needs to be taken into consideration and it's a little bit of figuring out what the baseline is and understanding that it's a moving target based on the kinds of changes are going to happen to the senior population.

Kim McCoy Wade 25:11
Follow up question, when I was with Yolo County Aging Alliance they are presenting their data in 3 bands, 45-65, 65-85, and 85 and above, to get a little at the moving target, the baseline for who is aging in 2030. I don't know if that is similar to the point you are making or something broader.

Nari Rhee, PhD 25:31
Yes, that's pretty similar. And the main point being that you have to look at this generationally, so there were some national studies put out very recently by various organizations, including one that I co-authored looking at specifically Baby Boomers and what's happening in terms of financial and their assets and perspective retirement income, and then if you look further on down the line, it looks even worse so there's every indication that that's going to polarization is going to worsen over time. So the age spans, what you're going to see is these ripple effects across those age spans over time, as you know, specifically as Baby Boomers age.

Kim McCoy Wade 26:20
We have two in the room, I believe. Thank you.

Jeannee Parker Martin 26:33
Thank you. A follow up to the various comments that have been made. A few things came to mind that I think we should keep in mind and also consider as key indicators. One, income is highly correlated with housing, and I'd like us to consider some indicators of correlate with senior affordable housing and for people who have disabilities, and in addition, I think we should also think about the per capita income, for the per capita cost changes. So, what are we spending now? And if we invest a certain amount in this particular activity that's been identified, we may be spending a little bit more now, but the cost might decline over time per capita. So, it gives back to, you can't measure an individual, but across the aggregate if the per capita cost decreases over time, if we invest in a certain area that improves quality of life for the spectrum of aging needs, then that would be an indicator of potential success, if the costs were to decline over time.

I think as we consider any of our indicators, we should keep that in mind, because there are examples now, where the two year projections showed that we had to spend money, so we're not approved from a budget standpoint. But if we had invested in the first couple of years, cost over time would have declined. So, I'd like to see us keep the per capita cost in mind as we look at various interventions and indicators as we move forward.

Kim McCoy Wade 28:14
I think we're going to have Stacy's comment and then move to the next part of the agenda.

Stacey Moore 28:44
Some of my colleagues have said some things on my mind, so I will keep this very brief. I agree with the things everyone has been saying. I think it is also important for us to consider in addition to discreet aspects or discreet indicators pertaining to housing or financial or economic security or whatever that might be. As we look at shifts in demographics over time, the existing disparities in line with the demographic shifts between now and 2030 and really taking that into account. Because across the varied ways that we can look at disparities there will be some areas that will really be exacerbated when it comes to economic or housing security standpoint or other domains, for some populations versus others, so it is really important for us to consider not only the range of them, but to have a framework for how, once we get to a point of making recommendations we'll be looking at prioritization, again we can't boil the sea. So, what will be the framework we

look at for prioritizing certain interventions or certain indicators for tracking and elevation to dashboard.

Derek Dolfie 29:50
I think it is indicative of a great meeting when you have a robust discussion and you're not even off the title slide. I think that means we are all going to gel well together. A quick comment and a question, coming with my local government hat on, I want to ask a little about where you imagine the education and outreach component to the local elected officials and their communities on this. We've talked a lot about measurements and metrics and data. I am coming at this, looking at it with a little more how we get that story or messages out to the community. One thing I hear time and time again, talking to local officials, not everything bubbles up to the local elected level. You might have your city staff working on it, but maybe the council is not aware of it, because they have everything they have to think of. So, just want to make sure that we're keeping in mind, any comments let me know, about how we can market this or tell these stories. We gather data and learn the stories about what is happening, the trends, and then how do we communicate that, and show those best practices and programs that are working to those local elected officials, to make sure they know.

Kim McCoy Wade 31:08
Absolutely. We are, in this year, very focused on hearing the ideas from City and local experts to engage, "Together We Engage" is our banner, to get as much input in the development of the plan, but we joke here at CDA that actually our work begins October 2020, because then it's just what you said. It's the now we have to then roll that out and work with the County Association, City Association, the AAAs and all of the networks that actually make the work happen and help shape that plan.

We're also having lots of conversations with other committees about that kind of broader public engagement with aging. You think about how First Five has really shaped the conversation around the first five years of life and what could there be, and so there's also some interesting, beginning to think about what would a public aging, and lots of people are on the room, ARP and other folks have good advice on that to so more to come for sure.

Okay, so now we're going to try to boil the ocean together and go to the next slide, and I believe Anastasia and Carrie are going to lead us through our attempt to do that. And as you're looking at these think about, you can

begin to see, to foreshadow, the indicators that we're going to be working with you and the qualitative and the disparity work we're going to want to work out with you.

Anastasia Dodson 32:25
As we transition into this next part of the slides in the presentation today, I want to also mention that we have been thinking about the meeting frequency for this group and how future meetings might be structured around working on segments within these goal areas. So just putting that in the beginning, so we can think about it as we go through the goal areas.

What we're thinking is that is that for future meetings we would have a deep dive in one of these goal areas, and then sort of a discussion and update on progress for the other goal areas, and then also on the dashboard progress. Because we think we need to start working on the dashboard as soon as we can and have it be in development as we're going through each of these goal areas.

So, a little more framing. Some of you are already on our stakeholder advisory committee already, so you participated in the discussion that we had in September about a draft framework for the master plan and thinking about how do we look at all the aspirations that we and the state have for the master plan? And we thought about the framework in these statements that a month ago they started with the word "I" and then we revised them to start with the word "We" and will continue to revise them. At our next full stakeholder advisory committee meeting on November 4th will have a little more discussion about this. So these goal statements here are still draft, but they're the latest draft. What we'd like to do is talk to you about these goal areas and start getting your input on what data and what indicators might be helpful in the priority areas within these goal areas, but then understanding that throughout the next few months we will continue revising the goals, but that they're good enough for now for us to start discussing.

Some of you may have seen this, some of you this may be a little bit new, but the first goal area we'll be looking at is, "We will be able to live where we choose as we age." And has it helped we and our families need to do so is related to long-term services and supports primarily.

And so, we have these goal areas, this number one goal is particularly aligned with our subcommittee for LTSS.

The second goal area, “We will live in and be engaged in age-friendly communities,” is about housing, transportation, and reducing isolation. We will go through these in detail on the slides.

Goal 3 is maintaining our health and well-being as we age, and we know there's some crossover with goal one, but again just for having a rational way to divide up the areas.

Goal 4 is about economic security and being safe from abuse, neglect, and exploitation.

Just staying at the big picture level, we have these goals, and then we think about as you'll see on the next few slides priority areas within the goals. And then for each of those priority areas, we want to have indicators, and we are just shamelessly copying from the Let’s Get Healthy effort that used some of those same words. And it was successful for our colleagues at the Department of Public Health and for the State, the “Let’s Get Health” so we think those words are helpful for us today and in this effort.

Now we're going to go into the more detailed version of these goal areas and think about, this is hot off the press, thinking about as we go through these detailed versions of these goal areas looking for you all, on the subcommittee and the public as well, to identify which of these areas do you have expertise in and what feedback do you think the group ought to have around the data? And specific data, it doesn’t have to be right now, it can be by email or other ways we can get your feedback. But we really we do want to be inundated by you with everything that you would suggest. Then Carrie and I will sort it out and come back at our next meeting and kind of tell you, this is what we've gathered from the group and all these different things like data around number of people or data around indicators that show we're moving the needle in the right way, anything, datasets. And then, what suggestions do you have for future meetings? Are there topics, such as a dashboard discussion, or state discussion something from a local organization or another statewide effort that should be presented here at this group. We would love your suggestions on that.

These are the discussion questions and we could have had the whole meeting on this, but we're going to have other parts of the meeting as well. We're trying to spend a little bit of time on each of these goal areas. What's the data or evidence for older Californians that we should be looking at in this goal area? What are the promising practices and innovations? Trying to think about how will this get launched on the ground. And then what measure or indicators should we look at for the short-term or long-term? I know that's ambitious.

Carrie Graham 38:31
We don't have to answer all these questions today. This is trying to throw out a framework of as we go through the goals and objectives and get more in the weeds on each of these goals, the kinds of feedback we will also be seeking from you between meetings. We don't need to get all these answered today, but we wanted to put these questions in your mind.

Anastasia Dodson 38:37
Okay, so we're going to dive right in with goal one, which as we said is really about our long-term services and supports, and even all of your knowledge, we think that you're all pretty familiar with long-term services and supports, the array of services that are offered at the state and county level. Of course, in-home supportive services, skilled nursing care, residential care facilities for the elderly as well as all the different medical waiver programs and AAA information and referral systems. That's what we consider our long-term services and supports.

So you can see these priority areas. And again, we're just making our best stab at this point in thinking about how do we, for information and referral systems, is there a way that we ought to think about measuring those systems? We can talk in more detail any of these areas.

For long-term services and supports financing and we think of that as being financing not just for individuals who are low-income qualify and qualify for MediCal but middle income and the struggles that middle-income families have as far as affordability, and then for home and community-based service options thinking about IHSS and the other array of services, home community based services, MSSP, TBS, long-term services and supports workforce, of course a very important issue both for institutional and community-based care, paid caregivers, family, friends, caregivers and then coordination with healthcare community supports transportation. It is

very ambitious for us to be thinking about all this and how do we think about data and indicators for this area?

In some ways this is maybe the most familiar area to some of you, but then also it's a very challenging area because you know, if something like this was easy it would have been done before, it's not, so we welcome your feedback on this slide. Any thoughts that you all have? There may be some no-brainers, of course such and such and such put that put that in the mix, you know, that should definitely be on the dashboard.

Jeannee Parker Martin 41:09
Have you done any research to the to date, on the information on all of these items, or the data that's already available? And do we have a starting point to think about what we might want to hone in on? I'm sure all of us have a specific opinion about each of these including the other three goals, but is there a starting point for us to start to crack the nut?

Anastasia Dodson
Yeah, so we definitely have administrative data, so we can provide the number of individuals who are served through IHSS or MediCal waiver programs or information and referral systems, I think that's a little trickier because there's a variety of services there. And how do we get an unduplicated number? Administrative data that we can certainly work on and of course, how much does it cost or what is the cost per capita? That for sure we can get and we can work on.

Kim McCoy Wade 42:32
A big piece where we don't really have are the linked data sets. Right? The linked data sets particularly the individual level. We might have an aggregate Meals on Wheels count. But how many of those folks are also on IHSS are also on CalFresh, there's a lot of challenges there in terms of do we have individualized datasets? Do we have permission? Do we have the operational ability to match them and tell a story with that?

Back to an earlier point, at one of our meetings we will do this. We will have the pre-work to say here's the data we have, here's what we can do with it, what we can't do with it, here's the gaps. And to your point some characteristics, some programs, potentially some outcomes depending on the piece. The workforce data sets a whole different data set, right?

For each of those we would like to have an informed conversation about what we have currently, and what we might want to have to in order to measure our progress. So there's nine of these slides.

This is one of the toughest although there's a couple tough ones. But each of those is this question of how do we put data indicators around something as broad and diverse as this?

Anastasia Dodson 43:35
Oh good. Look at all these people with their hands up. Who's next?

Carrie Graham 43:44
That would be Gretchen on the phone.

Gretchen Alkema, PhD 44:06
Great discussion so far. I was thinking a lot about the long-term services and supports scorecard that while it's a scorecard across states, there are a number of data points that are driven directly from California data relative to California's rankings. So, I just wanted to throw that out there. Happy to follow up with Carrie on that.

Carrie Graham 44:30
So, we have Laura next.

Laura Carstensen, PhD 45:16
Could we get a long list of all the variables that are possible across the different subsections? It would help me think about what is just completely not available.

Kim McCoy Wade 45:36
We anticipated that would be a homework assignment coming out of the meeting, to start that spreadsheet. If this is the framework and these are the goals and these priorities what the--yes.

Laura Carstensen, PhD
And what's linkable.

Kim McCoy Wade
What is individual and what's linkable, yeah.

Carrie Graham
Doctor Agha.

Zia Agha, MD 45:45
Following up on the comment made on the phone, I think it's equally important to understand what are the benchmarks? What are we measuring ourselves against? And if there are certain other validated benchmarks out there, that other states are using or even the whole country using, I would say that would help us. And benchmarks would also help us prioritize, so in some things states maybe are better than others, so I think understanding benchmarks is important.

Kim McCoy Wade 46:15
And to echo what Anastasia said earlier, we are very much not wanting to reinvent the wheel or invent the wheel. This is part of why we need your expertise on this is the benchmark. This is already, thank you Gretchen for lifting up a scorecard. That's when we can just leverage and link to what's already there.

Jennifer Breen 46:30
I just wanted to support the LTSS workforce as one of the key areas, because we need to have those boots on the ground available and able to assist and take care of people as they age. And I think that that's one of those areas where no matter where that entry point is, even if it's the lower levels. A lot of times our workforce initiatives look more at the PhDs than the people who would be the home help aides in those regards.

Kim McCoy Wade
This is an excellent point, and this is another area where some conversations about the role of technology and how technology will help family caregivers and the workforce. And again, what's the measurement for that? What's our goal? What's our benchmark? What's our outcome? So again, measuring in a changing world.

Carrie Graham
Marty Omoto.

Marty Omoto 47:15
I agree with all the comments that were made, and adding to that, on these data indicators, as we try to identify what those are, so you're talking about

a long list that you'll give us, could be a short list too, are we just assuming that if you get it indicator from in some agency or some system that that is valid that, that is enough? Because obviously all the systems through the state budget have their ways of reporting certain things, and advocates often, we may say those don't necessary reflect reality, or the Department of Finance has their take on things which is primarily how much money is attached to that number. And so, how do we make sure that the indicators are credible, so that it's not just credible to the state, but credible to the advocates, credible to those who need the help, credible to all of us. That's really what data should be, right?

And then secondly is what's missing? What is it be measured against ? I think that is really important. Because we talk about the workforce, we talk about the services, but what's layered in that and what's probably driving this is unmet need or underserved people which then are not showing up in any indicators at all, and eligibility. Eligibility is a tool to shut out people, and you know, sometimes it's for good reasons due to financing is due to cost, but if we if you just go on the eligible population, and that's our benchmark, then we're not measuring the right things.

And the governor's executive order, which I really like the broad scope of it, went beyond systems and services of eligibility, it really addressed the entire population of older Californians. And I think we're going to have to struggle with the data, because you know, there's one track why is used, and so we I think we're going to have to pivot and say what is this information? Well, actually someone else raised that, is it for the public or is it for the state? And how is this going to be used? What is it driving? And we know what the executive order says, we know what it's meant to, but what is this really meant to? Because data has been used that way, sporadically, when the legislature wants to make a point, but dropped and really decisions are not necessarily linked to that. It is complicated. I am not saying I have the answer, they have the answer there, make them come up with an answer.

By the way, one thing to throw in the mix, you mentioned IHSS which is critical, there's other systems or services, we know that regional center funded services are in there too, and so that complicates how you identify the services and eligible population. Also, your point about the workforce, how do you identify across system lines, and never mind private insurance.

Anastasia Dodson 50:29
Right. Well speaking of, we'll go to the next slide. And again, we're thinking about caregiver support here, but workforce blaring in both of these areas, and this is something that as we look at, it's well-known to many of you that comes it's not just the individual who needs care, but it's their family that is greatly affected by what services are available and can really get a great benefit from caregiver resource centers and caregiver supports. So, this is all part of the long term services and supports category. But is there anything else particular to this area that you all want to flag for us?

Laura Carstensen, PhD 51:11
Yes. One data point that would be very useful for this and for family support would be absentee workforce days for the caregiving family members. Especially if we are going to look at cost effectiveness indicators, of investment and different kinds of resources, and how that saves. We should be able to factor in savings from those kinds of ripple effects.

Marty Omoto 51:47
Does this also refer to aging Californians being required in circumstances to actually take care of the grandchild or something?

Kim McCoy Wade 52:33
Yes, we hear a lot of my colleague who directs department of developmental disabilities and aging caregivers and concerns around that, excellent addition.

Anastasia Dodson
We have Donna Benton on the phone with a comment.

Donna Benton, PhD 52:47
I just wanted to say that or this area we want to look at generational impacts on overall savings toward retirement, and interruptions and work over a lifetime. If we're looking at 10 years, we need to be able to look at younger caregivers,18 and up and how that impacts their overall lifetime savings. I think that that's going to be a little hard, but it does make a difference for when they retire later. So, in some way I think we need to have a general measure on that.

Anastasia Dodson 53:17

Great point. Okay, so we're about to transition and we know this is kind of a rush.

Carrie Graham
This is an overview, to start thinking in these areas.

Anastasia Dodson 53:48
Now we're going to, like a different world. Engaging in age-friendly communities. So, thinking about, obviously housing and transportation, but then also engagement, reducing isolation, parks and recreation, libraries, other community anchors. We have a subcommittee member here Dr. David Ragland. We're so glad to have you joining us today, an expert in transportation, and Stacey great, you have your tent card up. Stacey?

Stacey Moore 54:10
When it comes to age-friendly communities, one thing that I would offer is looking at the livability index, the AARP livability index, which has a variety of categories, including housing, transportation, civil engagement and economic factors in there as far as employment and cross section of things, but I would offer that as one model to look at that has a variety of publicly available data sources embedded in it.

Kim McCoy Wade 54:23
And we have also been in contact with the Governor's Strategic Growth Council in the Office of Planning and Research and other folks with ambitious housing and transportation goals. And again, we would want to linking and leveraging to those not deviating or replicating. Dr. Ragland?

David Ragland, PhD
I was late for transportation related reason, there was a brush fire along I-80 you probably heard about it. Small but anyway. Glad to be here sorry I am late.

Anastasia Dodson 55:20
Thank you, welcome. You know any time during this meeting and again for people who are on the phone or webinar, you can type in suggestions in this area. And then after the meeting send us emails.

Kim McCoy Wade 55:43
Again, the Department of Transportation does has shared with us DMV numbers and initiatives around people. Their efforts to transition people from driving to not driving and things like that. So, there's again we'll be gathering. How do you count? How do you collect from them?

Marty Omoto 55:51
On the priority 2C, it refers to accessible paks and recreational areas, libraries, and other community anchors, is anchors referring to other public accommodations, that is seen as normally an issue among the disability community in terms of restaurants shopping centers and things like that?

It has always meant to include people who are older that require certain accessible things in a store or whatever, but just want to make sure that would be an important thing to include here, because obviously going to a restaurant or going to a store is just as important as going to a library.

Kim McCoy Wade
So, you're just saying the private sector?

Marty Omoto
Yes, and also as we all know it's been very controversial in how you come up with solutions. So obviously this is not the place for that at this point, but it is a factor. As long as we maintain our credibility with everyone to show that that is important too. You can't just have an accessible park and library, but the store that you want to buy food and the aisles are blocked. I mean my friend here Connie knows about those kinds of things, but it's just it's just one of the things just they show that they see me.

Stacey Moore 57:21
A few specific things for consideration, things like housing under the category of housing affordability, so how many folks are extremely housing burdened? Some things we may want to look at. The availability of affordable housing units and/or their disappearance in certain parts of

California and the trends. When it comes to parks and open spaces, disparities within that, how many people have a park within a ten minute walking distance from home, and there is some data available around park disparities across the state. I think those are some specific points of data and indicators we might be able to look at.

Anastasia Dodson 58:13
And are those in, I know AARP has a lot of measures in these areas, is there a set that we should right away look at?

Stacey Moore
Absolutely, the Livability Index has a lot of that built within it. If you click in an individual domain it will give you a subset of data point and data sets, where the scores are derived from, and policies that may or may not be in place that influence a particular score.

Anastasia Dodson
Great, and we have several people waiting to speak. We'll start with Derek Dolfie, then go to the phone.

Derek Dolfie 59:13
I think the community begs the question, what are challenges communities face in making age friendly communities, for example I know a lot of cities in rescission in 2008 were hit hard and one of the first things that went was a lot of park and recreation programs that a lot of seniors used. Some of those have rebounded and some have not, while we talk about the need for some of these things we also should think about the challenges that local government and city and county face when it comes to providing some of these services. I want to make sure we throw that out there as well.

Anastasia Dodson
So we have three on the phone right now. Dr. Frank?

Janet C. Frank, DrPH 59:43
Thanks. I just want to mention as far as available data, there are a number of cities and communities that have been working in the states and I think that for sure you will be able to be in touch with if you haven't been to find out what kinds of indicators and measures should been used for LA.

Kim McCoy Wade

Yes, a sneak preview. The full stakeholder committee will hear from San Diego county November 4, and then we have LA teed up for January, because these are basically states within California that have master plans with indicators, so we are looking and learning from LA's work, thank you. Donna Benton?

Donna Benton, PhD 1:00:28
Two quick points. There's also, besides the age-friendly communities, there are some age-friendly universities. We have that here at USC. That might be something we want to look at for higher education and making sure the campuses where people want to go back to school across the board could be age friendly. And then the other thing is I think we do want to make sure and make it explicit that we also besides older adults' family dementia friendly component usually within the age friendly plans, but call it out.

Kim McCoy Wade 1:01:01
Great, wrote the same note down. Thank you. Dr. Lincoln?

Karen D. Lincoln, PhD 1:01:39
I want to speak to priority 2c, I'm thinking about engaging in a new line of research for me, I am looking at dynamic exposure, following the cancer research where they are considering static measures of the local environment, zip code, is there a park or library there, but they are also focusing on are people *using* those spaces? The assumption that these things are there doesn't necessarily mean that people are using them. So, adding a dynamic exposure, meaning going beyond the infrastructure, how we measure place, to get a better sense of who and why people are using them. If they would use them and who is using them. Speaking about widening disparities or reducing the gap, having a better sense of if we build it they will come, but some people will not come. So additional measures to get an assessment of access, not defined by if it is present. But are people actually using them.

Kim McCoy Wade 1:03:01
That is a great segue to our next slide where we are trying to distinguish, and maybe we don't have this broken out right, but from built environment to true engagement. And what are the true measurements of everything, this is a big one, everything from the prejudice and agism and age discrimination and isolation. I'm increasingly having conversations about depression and suicide rates among older Californians.

To your point, I love that dynamic exposure that actual engagement, so we would like to somehow name both those things separately. To your point, the physical environment from the true human engagement. And these are just some attempts to pull that apart. And again, welcome your feedback. All right. Thank you.

Laura Carstensen, PhD 1:03:53
Sorry now a little old, maybe relates to this too, I was thinking when in response to Derek's comment about communities and cities, and we evaluate them and rank them, but maybe have cities as intervention, target and measure what they need to change over time. How can states support cities to get better, incentives to resources soft and financial, so that one can build a better city support for older Californians over time.

Kim McCoy Wade
I think that is absolutely part of the dashboard, both an end in itself and the means to that, right? So then you can see these are being utilized or have funding or zoning or other challenges, that then tee up those policy and programmatic priorities whether they are administration or budget or bill, that is where we hope to help shine the light.

Laura Carstensen, PhD
But are we thinking with the same kind of intentionality as we think of how do you improve the well-being as an older person? How do you improve the well-being of a city?

Kim McCoy Wade 1:04:52
That is a great question for this group. Right? You heard somebody say earlier, I think it was you Donna, about who is this dashboard for? The public or a researcher? You could imagine for a city, right? Show me my city and it wouldn't just be individual indicators, it would be that the livability domains. So that is part of our design question, is exactly that.

Laura Carstensen, PhD 1:05:23
But I think I'm saying something a little different. If a city is not doing well, really try to understand why. And develop interventions for cities at the city level in the same way we might do that for individuals. Is that?

Kim McCoy Wade

I think I was trying to answer it too narrowly in the dashboard context and sorry, but Derek do you have a response to that?

Derek Dolfie 1:06:05
I think it is an interesting concept. Absolutely. I mean we could explore kind of what that would look like. I mean, obviously I don't think cities would like some sort of corrective action plan with fines.

I completely understand what you are saying, evaluate and say, this city is in trouble but why, how can we help that city, I think that is fascinating and I would love to you know open that up and doesn't have to be today, I know we are not solving all of the questions today, but in the course of the work, looking at cities as one of those healthy indicator units, be able to say, okay, this city as you mentioned earlier, from point a to b, are we simply going to evaluate and say there's x amount of people have access to parks within is certain mile radius of their house, that is good thing, or are we saying are they actually using it, etc., I think that is interesting way of framing conversation as a unit itself or kind of collection of individuals.

Kim McCoy Wade
It's a good question for the plan too, in the local blueprint, things for state government, things for county government, things for private sector, there's sort of, how do you, the matrix questions are looming. Mindful that we're halfway through.

David Ragland, PhD 1:07:08
So, would this be the place where we would also talk about opportunities for people? I mean listing the kinds of opportunities that folks have I think is a good way to measure how much engagement they can happen how meaningful their lives could be. Is that a metric that would put here under goal two?

Kim McCoy Wade 1:07:35
You mean like participation in a volunteer program?

David Ragland, PhD
Things that they can do, ways that they can be of help, actions that they could take around helping their communities have better lives.

Anastasia Dodson

So, are there volunteer programs that are active in a community?

David Ragland, PhD
Yeah.

Kim McCoy Wade 1:07:49
It's probably not a narrow dashboard answer, but I am fascinated by the idea of we are thinking about the Together We Engage campaign and we are thinking about resource kits and activating the dashboard. So now that you've seen this number, here's how you can engage, here's how you could learn more. I think that's a really interesting idea.

Anastasia Dodson 1:08:18
So, I think we could probably expand the time on this topic just a little bit. We still have time for public health and OSHPD, but we will keep going and try to keep moving.

Zia Agha, MD 1:08:45
I want to echo your comment on the city council, that has a lot of value, in my feeling, medicine, when we started measuring doctor performance, with no interventions they improved just by knowing where they rank, there is value to that, in terms of intervention. I hope it is not our role to tell what the cities to do. Use their own best resources and be aware in their own ways to help close the gaps, but measuring as a unit has value.

Stacey Moore 1:09:21
Just a quick comment about the separation of the built in social environment, I understand the need for that, but consider where those may be intrinsically linked, think about social isolation and things to help reduce it. Built in structure, say broad band plays a role in that, where are the places we need to think of them as tied versus separate.

Kim McCoy Wade 1:09:33
We're going to be asking that question, and some of its breaking it up just to get a handle on it and then we'll pull it back together. And so, keep asking, that's really important.

Goal 3, health and well-being.

Anastasia Dodson 1:10:32

We know health and long term services and supports are closely related, but some topics fall into health category around nutrition, physical activity, falls prevention, support for Alzheimer's, mental health supports, so thinking about all of these and the whole person. And how the different interventions that we have at the state and local level can help. Some are not necessarily a government program, maybe with Medicare health plan or provider, a lot ways these types of services are available through cities in some cases, is there something we ought to take a look at? We know the Department of Public Health has aging initiatives, they have data already in this area to look at, but if there is other pieces you think right off the bat. If you think of--?

Jeannee Parker Martin 1:11:31
I think because of a lot of work has been done in these areas, in particular, unlike other areas, we got data but not as much research and analysis and evidence based outcomes, what really worked and what we see with outcomes to the population, but these areas, we should partner with the researchers and universities and others who have done such critical research in all of these areas to say this particular intervention has helped. We may not have done it in California but New York look at what's happened. We know that mental health supports Ohio has done the best job in the nation, what are they doing that helped intervene and then goes to all of the other goals and improvements and qualify of life in the other areas. So in this area, I would rather not have anecdotal discussions but really look at what exists and what has worked from an outcome based, otherwise I have clear opinions, but I want to know what is evidence based to integrate into our master plan.

Carrie Graham
I think that really has brings up this point about the dual role of this committee, which is both to inform the overall committee and CDA to make sure the actual master plan and recommendations within the master plan are evidence based, and the second big task which is to help come up with indicators and evaluate the master plan.

Jeannee Parker Martin
Where there is evidence, we should be able to integrate it, where there's not then we come up with other measures as well. I know that's not exactly what you were saying.

Anastasia Dodson
Okay. We'll keep going to the next slide. Oh, one more on the line. Kathryn Kietzman, your line is open.

Kathryn Kietzman 1:13:08
I was just looking at this list and to your point that these programs happen in so many different settings. Just wanted to add the comment that perhaps one of the metrics we need to consider is how there's cross-sectoral collaboration or not or how linkages are made between community social service programs and health centers, and perhaps between other untapped providers, faith-based community providers and so forth, because these programs happen in so many different places. So just wanted to put that out there as a consideration.

Anastasia Dodson 1:13:52
We're going to go to the next slide which is the other part of health and well-being and that's related to health coverage and access to high-quality coordinated integrated healthcare across medical, dental, behavioral health, and prescription drugs, and then reducing health disparities, and then coordination with LTSS and community support. So gigantic area, so Jeannee your point is well made about existing evidence-based measures and indicators. Anything else anybody wants to add on this area? It really does speak to the work that Let's Get Healthy has done and from a public health as well.

Okay, so I know there's a lot to say about this, but we'll just keep going to goal number four, security and safety. So, this is an area that has two major pieces, one is around economic security (employment opportunities, retirement savings, and reducing homelessness) and see on the next half is safety issues. Any initial thoughts on this?

Jeannee Parker Martin 1:14:49
I have one comment on reduce homelessness. I think reduce homelessness impacts the first several goals, livability of communities, access, using available resources like parks and neighborhood community centers. I don't know the right answer, however I think that this particular issue links in ways that we have not measured at this point. And that may be impacting certain communities to a greater degree and limiting the people going out and using certain available resources.

Kim McCoy Wade 1:15:38
Yes, we are trying to follow the lead and coordinate with our housing colleagues and of course the homelessness task force, in having two halves of an integrated conversation. So one is supply, building affordable and accessible housing, so we put that in the built environment conversation. And then this is often around a person-centered support, preventing that person from falling into homelessness, addressing any behavioral or other mental health or trauma issues, but they will of course have to link back to each other. It is called because it is a crisis right now, but it goes across so many domains.

Ramon Castellblanch, PhD 1:16:14
You don't really need to start planning when you turn 65, but long before, so the idea here is going into earlier generations to start explaining to folks you've got choices to make at 35.

Kim McCoy Wade 1:16:35
For sure.

Carrie Graham
It's very likely the plan will have something around that in terms of recommendations.

Anastasia Dodson 1:16:45
So we have Laura, then Stacey.

Laura Carstensen, PhD
Just very quickly, can we explicitly add financial fraud?

Kim McCoy Wade
Yep. It's coming in the next one. You're ahead of us. It's come up a lot.

Stacey Moore 1:17:15
This crosses over priority areas, under objectives, but when it comes to employment opportunities and retirement readiness, so they are going beyond the jobs per worker discussion and really looking at, both for older workforce who want to be working and maybe are not or are, but perhaps not working enough. We need to look at, in combination with not just only retirement readiness, but the lens of what the younger generations that will be aging, to the comment that was earlier, as well as the current older

generations, because there is very distinct needs there between people who perhaps have access to a traditional pension fund or retirement benefits, and those who are not saving enough, and so going beyond the anecdotal and taking a look at not only retirement readiness for those who are younger, but also those who are or very close to retirement or in retirement age but not able to retire, because they cannot afford to retire, and looking at the factors there.

David Ragland, PhD 1:18:35
Maybe this is sort of redundant following the last two comments, but my grandkids are from age 5 and 13. And I know this sounds awful, but I am already talking to them about necessity for saving. And coming up in terms of changing economy and so forth, so they actually have savings accounts and credit cards that they can use every now and then. And some of them save, and some don't. You see patterns, it is clear all these things have implications all through your life from birth on, that is not our aim exactly but to plan for retirement you have to plan early, especially in the current conditions and what is likely coming up.

Kim McCoy Wade 1:19:19
No, that's right on. We very much see this as a whole family, whole community, and whole life span conversation and figuring out those how we do that is absolutely part of our big vision.

Stacey Moore
Sorry, quick question. Will we be considering the role of innovation in displacing different sectors of the workforce and retraining and programs available for that, will we consider those as part of retirement and work perspective?

Kim McCoy Wade 1:19:50
I think the Future of Work, Secretary Su's commission will be intersecting, they had that conversation this week about the role of technology and the changing nature work and job replacement and redesign and potential of that. And how that fits in. Again, what's the measurement of that? All fair game. Alright onto the next slide. Dr. Agha, go ahead.

Zia Agha, MD 1:20:19
So, this is something that is really very important to the work we do around the security and safety to financial aspect. Medical bankruptcies. A lot of

people save all throughout their lives and do everything right and one hip fracture away from going bankrupt. Is there a way to measure, we have done surveys on that, and know seniors are affected by it and make tough choices between housing or medical bills? Can we measure the impact of high costs of health care on seniors and their retirements and often ended up on the street or bankrupt because of the medical bills?

Kim McCoy Wade 1:21:23
I don't know, let's capture it and figure it out.

Zia Agha, MD
Also ties in with healthcare and well-being.

Ramon Castellblanch, PhD
Given how central medical bankruptcy seems to be in the stories of bankruptcy these days, and how much more vulnerable seniors will be, I think it is an important thing to keep an eye on.

Kim McCoy Wade
Yes, fascinating.

Marty Omoto
I just have a quick one. Marty Omoto, CDCAN. Does that savings and planning for retirement, does that also include capturing data on things like trust, Special Needs Trust, able accounts. California Able is just starting out, but that will be a larger piece or way that people can access money.

And then the other thing about employment opportunity, was wondering and I know--the thing for us grasp, and it is not easy for us, because this is different because we are looking at things crossing system lines. A lot of us are in silos in whatever system we primarily come from, I work across several system lines. My sister had developmental disabilities and accessed a lot of different things, Medi-Cal, Department of Health, Public Health, county programs, and so employment, we're talking about employment for seniors, but are we also talking about competitive integrated employment for a person with disabilities and how that works and how do we track that.

And then the other thing is the state has several master plans moving all at the same time, on early childhood, developmental services, foster care, so

a lot of things are transforming in services being provided, but also in the data. And so, are we trying to keep ahead of that too? Because things are changing as we're saying that's a good data indicator, but actually it's no longer, it's changed.

Kim McCoy Wade 1:23:16
Well the answer is yes, but the "we" is everybody at the table and on the phone. So we are counting on all of you who are in these multiple domains to help us make those connections. That is absolutely right.

Marty Omoto
Yeah, and every one of these things I just mentioned does have some measurement, it's just maybe at some point we have to determine is that the right level?

Anastasia Dodson 1:23:48
We are on the second to last slide looking at the goal areas, goal four the second part of it is to protect from abuse, neglect, and exploitation, (on screen), I am sure you have good ideas, so send it via e-mail.

Kim McCoy Wade
This is one where I am particularly worried about silos and lack of state data systems. It's very different from what I'm more experienced with child welfare, in terms of APS not having a statewide system, guardian and conservator being at the local level. So, this is one we need a lot of work, expertise, interest, thoughts, please, this one is going to be a big one.

Anastasia Dodson 1:24:18
And then the last part of this goal areas is around disaster and emergency planning and response. Obviously today, this week, this month, California we need to be very cognizant of this.

Derek Dolfie 1:24:32
Derek Dolfie, League of California Cities. This is one of the things the league specifically and myself have been focusing on quite a bit, not just for older Californians, but all Californians. I think there is lots of things this committee can think about in regards to notification and our vulnerable populations. I know CalOES is working diligently to make sure there is a system in place to notify. But there are things around privacy as well, you cannot get everyone on a list, because they don't want to be on the list, opt

in systems, but then that poses challenges and people don't know about it or how to opt in, et cetera, notification is one of the big challenges when it comes to helping people understand what is coming and what's here, and how to respond afterwards. I am happy to help talk about that in this context, because it is something that all of our residents frankly, not just older Californians, but all of them are struggling with, especially with large scale wildfires we've had recently. I want to put that out there that cities in general are focusing on and struggling with at the moment.

Kim McCoy Wade 1:25:48
Yes and I want to acknowledge, also here to make a public comment, is our county welfare director of the association, also working hard on this, and certainly the paradise situation, maps of home bound folks and how to make sure they are evacuated. So that is something we are working closely with the local government on. So we solved all that.

Anastasia Dodson 1:26:18
Thank you for being good natured about going through this so quickly, but folks in the room and on the phone, public and committee members, email the engage inbox and we will look at all of it and try to make sure the timing for the next meeting gives enough time to put together thoughtfully and share with you. With that we are going to switch gears to another presentation.

Julie Nagasako 1:26:45
This is Julie Nagasako. I'm with the California Department of Public Health. I'll just start off with some framing comments. A little bit about our role, we're part of Office of Strategic Development and External Relations at Public Health. We're also called the fusion center internally. Part of our scope includes facilitating the State Health Assessment and Improvement Plan, which is Let's Get Healthy, California, and we do that out of Public Health on behalf of California Health and Human Services Agency.

So it is a Statewide plan, which you'll hear a little bit more about. There are also as Anastasia was mentioning earlier a number of initiatives within our department that might also be resources to this team over time. We have a healthy aging initiative which we are very excited about. That team member from our Center for Healthy Communities is here in the room. We also have a number of data dashboards of various types. One that's very well-known is our opioid surveillance dashboard, and we also have an assembly

member from that here in the room as well. And so, those are the resources that we are happy to partner with and serve in different ways.

We're happy to talk to you about Let's Get Healthy, California because there are a lot of really strong parallels between the charge of this plan and the experience of Let's Get Healthy. We are hoping to introduce the conversation in a bit of a broader frame. I know part of it is wanting to check out the dashboard itself. But we also wanted to share some of the experience of the process of how we went up developing the framework the work that goes into maintaining that over time and how we structure that with our wide array of partners and then to share some of what we've learned from that experience. I think that there are a number of ways that our infrastructure might be able to be a support to you and your process and we're really eager to explore that with all of you part of our mission to integrate and elevate work that's happening across sectors. So it seems like a really nice fit. So as your process develops we'll be happy to work together with you on that.

So with that I'm going to turn you over to our expert which is Latesa Stone. She was the lead of the web development team that put together our Let's Get Healthy California dashboard and then several years later became the overall coordinator of our state health assessment improvement plan.

Latesa Stone 1:30:11
I am excited to be part of this discussion and hear some of the inspiring and yet painful questions that come up throughout the process, as this is very familiar to us. We had a similar start to you all. We were initiated through our former governor's executive order to create a six-month task force to develop a ten-year plan with key indicators and a dashboard. And it was to address the problem around the increasing prevalence of preventable disease, widening disparities of health outcomes and the increasing costs of health care. So that's really what it was focused on. In 2014, the Department of Public Health adopted as the State Health Assessment and Improvement Plan as a way to operationalize Let's Get Healthy and resolve into a guiding framework for the way we do our work, it is as Julie said an agency-wide initiative for Health and Human Services Agency coordinated through the Department of Public Health. And we wanted to make sure we were not just reporting on data for data's sake, but actually informing action that moves the dial on the key indicators. As the State Health Assessment and Improvement Plan we target efforts to local

communities, so most of our data is broken down geographically, and demographically so locals can use it in their plans as well.

Two key components that we've been particularly successful in is around data and people. These are also two of the guiding principles from our governing agency.

Data not just in the traditional sense of data, but data with context. And you'll see this when we walk through the website. We really wrap the data in a story so that it's digestible by the public and our local communities. We do collect our data from a broad range of sectors.

So, the people aspect is particularly important to us because it's been an ongoing Statewide collaborative. We leverage what I call a participatory model since we do not own, we own some of the data, but much of the data goes beyond public health. It's really important to invest in the relationships, so we've actually established a model around “data and indicators stewards” so we recognize that folks will be providing the data to us in particular formats to be able to showcase on the website. And then we also need the expertise. We need a partner that's able to put that data into context and provide a different perspective on the analysis of that data.

The original task force and framework outlines six goals around two strategic directions. They actually started with the triple aim as their guiding framework. Better health, better care, and lower costs. And then adding to that this component of promoting health equity for all Californians. They started with a very audacious goal of how can we make California the healthiest state in the nation?

I'm sure you guys are very excited about the audacious goal at you all have as well. But so, the first three goal areas: healthy beginnings, living well, end of life really focuses on health across the lifespan or what it would look like to be the healthiest state in the nation. The last three goals: redesigning the health system, creating healthy communities, and lowering the cost of care is really focused on the pathways to health or what it would take to become the healthiest state in the nation.

All right. So, we've actually evolved quite a bit over time. Like I said, the original task force was a six-month task force. So, you guys have a little extra time. The final report and dashboard was put out in December of

2012. We actually launched our website in January of 2016, but there was a lot of effort in 2015 leading up to that to build the policies and practices around collecting the data at a level that we would need to be able to showcase it on the website in the capacity that we wanted to showcase it in. Also pairing that data with the stories or the evidence-based and promising practices. We launched statewide innovation challenges the first year, we basically challenged the state and said tell us what you're doing within your communities to improve the health in any of our six goal areas. The next year we actually got feedback from participants. And we focused that on social determinants of health. And one key thing around the Innovation challenges was that we didn't particularly have an award or a dollar value to that and yet the first year. We got over 90 submissions in the second year. We got over 80. So it's very exciting. People are really just trying to elevate the community work and get it seen recognized and scaled. We've also participated in community hackathons to really challenge.

We challenged communities in a non-traditional way to use our data to really start to innovate around how we can address some of our toughest challenges. We've brought people together across sectors to really look at what we're doing and how we can better integrate that work and then we've also started building it into our Health and Human Services Agency governance structure as a way of sustaining and grounding it in the work across the agency and the departments and offices.

One of the things that we recognized is that community needs change dramatically over time and so at about the midway point we started to ask ourselves if we needed to do a refresh, if we needed to really assess the needs of the community and reassess what we were measuring, and I'll talk more about that.

Building on the original work done by the task force we did about a year and a half refresh process. The first piece, it was very multifaceted, was really looking at assessing the health status and looking at burden. The way we look at burden is in a multitude of ways looking at top causes of death or disability adjusted life years, looking at the most significant disparities across health outcomes, looking at policy implications or where we have lack of capacity was some of the ways that we look at for burden.

And the next thing we did was we reviewed national and state framework really comparing what others were looking at and prioritizing to what we had reflected within our framework.

But then we also wanted to ground it again in the work of Health and Human Services Agency if they were going to be the one using it as their roadmap and so we actually asked for feedback from the Departments across the agency around what the issues were that they seek to impact and what their top three to five priorities were for the upcoming years. We leveraged that to really ground the framework and the work that we'd be doing in the next few years. From there we wanted to make sure that we were rooted in community needs. So, we leveraged the community health assessment and improvement plans at a local level as an extension to our assessment. We reviewed about 22 of the local Health Department's Community Health Assessment and Improvement plans across California, and we made sure like a true researcher, that our sample was good with a balance of Northern Central Southern and large medium small populations urban-rural etc.

And from there, we actually came up with some common themes and we asked stakeholders to provide feedback on those themes on three scales. One was significance to the population, which aside from your mission and vision of your particular organization, how significant do you think this health or social issue is to the population of California? The second scale was on relevance to their mission and vision. Aside from if they actually had active work happening, how relevant is it to them pursuing and advancing their mission? And the reason for that is we know that some of the social determinants of health areas don't particularly have enough work happening in them, but are particularly meaningful for our partners meet their missions and visions. And then the last piece was around capacity. And that was really if there was active resources and active work happening towards those areas. We tried to look at where there was high significant areas, but low capacity and those we called basically gaps. Those are the areas that we could elevate within our state health improvement plan and say hey we need to drive resources or we need to start working together so we can make a collective impact in these areas. And then we also looked at where there was high capacity and high significance and those were kind of the low-hanging fruits. Maybe we just need to bring people together to see how we can do it better together.

And then from there, we really kept an eye on the governor and our agency secretaries' priorities because we knew that was really where the policy levers were going to be available to be told to make change.

Okay, some of the refresh outcomes. The original taskforce was already pretty heavy in health care and physical health indicators, but the enhancements to the Let's Get Healthy California framework included a stronger emphasis on significant life changes, one of the areas as you saw we have the lifespan, but people said well certain life stages have certain vulnerabilities, and so one of those was maternal and infant health and the other was senior health. So, we've added components around both of those areas to emphasize that the unique needs of those particular life stages. We've also added more emphasis on mental and behavioral health. We already had some indicators around depression and things like that. But we also wanted to add suicide where there's great disparities, and we added substance use which is a great burden for California, and several others. And then social determinants of health is an area we be beefed up quite a bit, and we worked very closely with our office of Health Equity within the Department of Public Health who is legislatively mandated to identify social determinants of health indicators for the state to be able to use.

Anastasia Dodson 1:41:06
I think we're going to try to do a little test drive, right?

Latesa Stone 1:41:10
Yes. Alignment with the draft Master Plan for Aging framework for the second goal area of age-friendly communities we have topics such as housing, transportation, I was getting excited about some of the transportation talk because I just saw our draft visualization around load of commute by commute time. It's really interesting. We've got a great team that is very creative in visualizations. Community cohesion, etc. For good health as I age, or we age, I should have known about that one.

We track several indicators that include senior strata within our indicator areas, and then financially secure and safe. We include poverty, employment, and neighborhood safety indicators. And this is just a snapshot of some of the alignment, we do include several other indicators which would also probably be relevant. Like we work with OSHPD on hospice and several hospital readmissions and things like that.

Okay, so we want to talk a little bit about Let's Get Healthy successes and lessons learned in building out the process of doing all of this. And I actually think that a lot of this conversation already happened, it's like you guys saw my presentation. But the first thing is really being clear on the purpose and intent and using that to inform the selection of your indicators, and the criteria for the data sources you use for those indicators.

As I mentioned the original taskforce was really focused on becoming the healthiest state in the nation, but over time we really realized that it wasn't as important comparing ourselves to the other states across the nation as it was looking within and through California and looking to elevate the communities so that they're all equally empowered. Other areas is about discrete versus aggregate, and timely versus granular.

So, one of our pieces because it's our state health improvement plan we updated annually, so sometimes when you update annually you end up having granularity stability issues. And so, it's trying to figure out what's the most important to you so that you can create your data policy around that.

Julie Nagasako 1:43:54
I think that probably the other pieces on here is around sort of again the intent of the measurement whether it's outcome or performance-based, I think we've struggled with this of measuring population outcomes. But as an initiative that is trying to implement a plan, do you want more targeted information about interventions that are being carried out through that plan and whether or not that's working? That data is probably not going to be same as a statewide population data you have available.

So, trying to think what's that balance look like. I think that our function is around statewide population health assessment. We are typically looking at that broader frame, but I think for your purpose you may want a hybrid of those two and use them in different ways because otherwise we establish a criteria to say yes is has to be able to update it annually, it has to have certain levels of granularity, but that that might not meet the needs of the specific initiative that you're trying to track impact on, even if it's not Statewide, looking at where that intervention is being implemented in a specific community might be helpful to inform the questions around, is this the strategy that works? So, just keeping that in mind when you're laying out the game plan.

Latesa Stone 1:44:54
We really wanted to highlight the them of] ten years is too long, but it's also too short. I think Marty brought up a great point about data really changing over time. And as we look to end around midpoint, we assessed where we were, about a quarter of our indicators were data gaps, because we had lost them. The true intent of a 10-year plan is to be able to measure over time and see the change, but when you're losing data set, it's difficult to do that.

Julie Nagasako
And that loss happens either because the data source goes away, if it's a survey, somebody's no longer funding it, or because of a methodology change and you can no longer trend effectively. Those are challenges we encountered.

Latesa Stone 1:45:24
I know Stacy also mentioned a lot about are we measuring for ten years or can we do something else? Community needs and priorities rapidly change and as you start to improve in one area is there may be emphasis of having to look in another area because maybe there's some change that was unexpected, and then the need for both performance measures and accountability as well as the population outcomes for impact.

And then, the other piece is about investing time and establishing infrastructure and promoting distributed ownership. Because we are depending on our partners for much of our data, our success is dependent on the relationships that we build with our partners. And the other piece of it is the strong infrastructure. When we went from a paper dashboard in the report into a dynamic website, we realized that there was a tremendous amount of work that had to be done on the back end around data sharing agreements, partnerships, roles, how we're going to do that collect the data in a standard format and curate that data, and create templates for the metadata for our partners to be able to leverage, as well as standards for how we're going to set our target, and how we're going to measure a statistically significant progress, how we're going to measure progress in addressing disparities, and how we're going to present the data in a way that is digestible to our partners.

So then I'd like to go into the website a little bit.

Anastasia Dodson 1:47:13
So folks who are participating on the webinar, hopefully what you're seeing now is the live site for Let's Get Healthy, California.

Latesa Stone 1:48:12
And our website is actively going through a revamp as we add the new and modified indicators to the website. So, you can click to see the updated framework that includes the new indicators that are being added on the backend right now.

The homepage tells a little spiel about us and highlights our goal areas. We have four key areas in the menu. Our is out about us, our goal areas and within there you can get to the indicators. We also have the progress page which is an overall dashboard. So on the goal areas you can see each goal, and see the indicators in full.

Generally, each indicator has an indicator page and that's to provide context around that data or tell a story. We include an impact statement as well as an introduction to what we're measuring. This is our dashboard piece of it that's included on each individual page, and then there's one comprehensive dashboard on the product page. We highlight community innovation and some fast facts about the area. And then we have indicators or visualization.

The actual website our content management system is on WordPress and we leveraged to have low visualization software to be embedded within the WordPress.

So, you've got your trends and you can break that down by geography. We have a download the data for the raw data for folks as well as visualization help if people need to learn more about how to read the charts. We have bar chart demographic data, and as I mentioned several of our indicators within Living Well has stratification for aging population as well as several other strata. We actually collect every year since we started, and the purpose is to be able to track over time.

Laura Carstensen, PhD 1:49:53
So this is self reported?

Latesa Stone 1:50:21
This particular indicator is self-reported. But our data includes survey data as well as system data, but this one is.

Anastasia Dodson
If you don't mind, we'll go into the discussion part now, because I think there's probably a lot of questions, and we'll try to get through as much as we can.

Laura Carstensen, PhD 1:50:21
Can you cross tab these and look at health by education level and by age?

Julie Nagasako 1:50:24
Not at this time. We are exploring ways to do that. One of the things that we're starting with is also looking at side-by-side presentation of related data, because I think one of the challenges that we mentioned earlier is we either need a deeper dataset that's going to be stable for us to present at that level or linked data across different systems.

Latesa Stone
Some of our enhanced visualizations that we are working on in the backend, we're actually making it so you can look at trends, so you might want to look at age, education, and insurance and see the trend bar chart side-by-side. So that's coming.

Anastasia Dodson 1:51:00
Is there anybody on the phone from the subcommittee you want to ask a question? Click your hand icon.

Zia Agha, MD 1:51:30
I have a question, this is fantastic, you got us really jazzed up. You used actionable and accountable, how do you do that, how do you use the data to hold people accountable to change, and how do you act on it?

Julie Nagasako
I think a big part of that is Let's Get Healthy is interesting because the accountability is universal. I mean it's the state and it's also considered to be a state level plan. Not just a state government plan. So, across our partners we use this to help in our planning process, and then to elevate what are the areas where we are not seeing progress. That's where our

agency secretary would get a briefing on each of those and then with our community stakeholders talk about that and try to bring them together around a shared area of focus.

I think the other place that comes into play is in the structure of community health assessment and improvement plans at the local level, that they can leverage this data in order to identify priorities. And that's one of the reasons is very important for us to provide as geographically granular data as possible. So, they could also say look at my county compared to the rest of the state, look at my community compared to the rest of my county, our outcomes are not where they could be, and being able to use that as a tool that organizations local government and stakeholders could use in that way. But I think that there's a long way to go in terms of initiative and service accountability. And I think that that's something that can be part of an integrated planning process to say if we see that population gap. What are we going to do collectively to help move the dial on that, and then are we going to be able to ensure that impact? But I do think that's where the intermediary performance measures are important to come in to say, what were those service targets or those quality targets that then we're hoping are ultimately moving solution health outcomes.

Kim McCoy Wade 1:52:59
And part of what we're looking at is the Department of Aging is our relationship with our local Triple A's who do go through planning local planning process that is supposed to drive priorities and indicate needs and we've invited our local AAA's, Sharon's on the phone and is one who's with us. But the invited to join us in revamping that process to make it more meaningful and strategic and data-driven. We would hope the master plan does develop does incentivize and excite more local planning, but more formally we would use it and the dashboard to work with our local partners to help them drive local plans that are more effective and more resourced.

Latesa Stone 1:53:49
I have a couple of answers as well. One of the things is as a state health improvement plan, no one entity has full responsibility of moving the dial on any of the indicators, so that coordination between your State Health Improvement Plan and each organization's strategic plan is really important. So, we would be measuring progress in our strategic plan of how we're working to address the population health outcomes. And we also work very closely with several of our foundation partners, Blue Shield of

California Foundation has also aligned their strategic plan with the Let's Get Healthy, California goal areas. So that's an example of the accountability piece of it.

We also report every year, our department particularly, around progress that has or has not been made to the public health accreditation board for our accreditation sustainability. And then we also report to our secretary about progress as well. The actionable areas, a couple of examples, one is the fact that we are using the data to launch innovation challenges or hackathons to help get the community moving towards the data. The other piece is that, this past year, our Director was invited to do a public health status of California legislative testimony, and we leveraged this data to talk about the story of how health has evolved over time, and the importance of is really investing in the social determinants if we're going to make change in some of these areas. So that's another way that it's been actionable.

Marty Omoto 1:55:38
Marty Omoto, CDCAN. This is really very impressive kind of overwhelming too. I have seen pieces of this over the last several years but to see it all like this. And then going to your point of trying not to reinvent wheels, there are a dozen new wheels. But in going back to the indicators, especially those but any indicators, question is how do you monitor to make sure those indicators are credible? That the numbers of what is reported is being credible. Who is doing that, is there ongoing systematic process to check?

Latesa Stone 1:56:29
One of the pieces is that we have a very strict indicator criteria and we have a worksheet we can share if you would like it, basically any time we are looking at data sources we score it, using the worksheet and that includes things like how transparent it is, how granular it is at both the geographic and demographic level, as well as the credibility of the source. We also work closely with partners who are in charge of that data to understand the data, understand the limitations, and we include meta data on the bottom where we talk about limitations and calculation methodology and collection methodology. I think that is some of the key areas how we ensure it is a credible source.

Marty Omoto 1:56:59
I think the fact that this is transparent and consistent, that gets the partners in that community to work together. Because if there is transparency and

accountability and if people are looking at it, someone if it is inaccurate will say something, that is the function of advocacy, community-based organizations, counties, that forces everyone to work together in a way.

Julie Nagasako 1:57:32
I think that's in accordance with processes to revisit measures and gain feedback are important, so people can say we don't think this is one is useful because of whatever factors matter, building into the process, but also I am interested if you find other ways to get at the community representation in validating the data. We would be excited about that too.

Anastasia Dodson
We have three folks in the room and then we're going to have to keep moving to the next part of the agenda.

Stacey Moore 1:58:32
You touched on this a little bit, but about flexibility that you built into your framework and model to account for the changes and loss or naming of data. As we think about concurrent plans developed or task forces that come out with recommendations around domain areas, like transportation which is a consideration within the master plan, just thinking about how you all approached that could inform us as well.

Latesa Stone
I'm so glad you asked that. For a few years it was very difficult because of the fact that that are former Secretary of Health and Human Services Agency who was one of the chairs of the original task force, and as we wanted to honor the integrity of the work that had been put in by the original taskforce, but every year when we reported to the secretary and provided that progress of these ones have moved, these are data gaps these haven't moved. Why aren't these moving? Why is there no statistically significant change? Because we have these data quality issues. It's not stable enough to determine if it's been meaningful progress. We have processes in place as measuring meaningful progress. So that's I think one of the ways we for three years went back and said, hey, there's these issues. Hey, there's these issues and by the way, things are changing. And that started to open up the book to be able to look back at the chapters to see if we needed to add a couple or remove a couple.

Julie Nagasako 1:59:32

And I think that's something that you're at the outset so you could build that into your principles of how you want to approach this data to think about that. We're going to set our best understanding of what the framework needs to be, and we know that part of that is going to be accommodating evolution in the framework and figuring out what that process looks like for you. I think another thing that we've done is at the outside of Let's Get Healthy it was like, oh that's the plan with the 39 indicators, like that was literally the catch phrase that everyone became aware of. It was like 39 indicators. But it's really not about 39 indicators. It's about these broader goals and that it is okay for us to incorporate related data.

We say this is the measure we picked but this is also important to know while you're looking at this, and we've also added featured topics, like maybe this doesn't meet the indicator standard to be able to track over time, but we can hone in on it because we want to bring up the specific intervention or the specific action where the data isn't there yet, but we know there's something to talk about we can use the one shot data we have to at least elevate that problem. So those are tactics that we've used.

Ramon Castellblanch, PhD
You have measures that you just mentioned interventions that relate interventions and outcomes so that we can see what's working, you have sort of a natural experiment and all these different counties doing all these different things with all these different outcomes. So are there some ways that you measure and evaluate interventions in terms of outcomes?

Julie Nagasako 2:01:01
It really hasn't been the primary focus of the work that we've done. Our focus right now has been to establish that framework and make that data available. I think that's part of what the next chapter looks like for us, which is why we're interested in particular initiatives. And initiatives like these are also examples of the interventions happening that are under that larger State Health Improvement Plan trajectory. Anything you'd add to that?

Latesa Stone
Not particularly on program evaluation, but I think a component that got touched during the innovation challenges, where we created the criteria and had a board of panelists that would review community innovations and score them based on their evidence of results and if they're addressing

health equity and disparities and that such, so that's where we're starting to incrementally move towards it.

Ramon Castellblanch, PhD 2:02:02
I agree this is best. We have several website's but not near this scope. We look at the analytics and find out who's using, how much, funders ask for this, and second funders ask for surveys, we have been doing surveys, systematic surveys, not just at the end, out of comments, but surveys of users both with respect to usefulness of data and user friendliness and got a lot of feedback from both of those. Do you have any processes for that?

Latesa Stone 2:02:32
Yes. First, the website was originally developed using user-centered designed process, our sub-contractor did focus groups and got people to provide feedback on other sites and what resonated with them. We also utilize Google analytics and report out to our governing agency around it. Also, an example of how we actualize some of the analytics was after the first innovation challenge we focus on the broad 6 goal areas. We looked at what are pages people are going to, and which stories from the first innovation were they drawn towards, and it was the social determinants of health one, and that is why we ended up targeting the second challenge around that. Because the data was telling us that is what people are most interested in.

Ramon Castellblanch, PhD
So, kind of crowdsourcing to direct future development.

Anastasia Dodson 2:03:37
Great. Well, it's so hard to, every piece of this is so interesting, but we're going to just keep moving. Thank you so much for coming.

Kim McCoy Wade 2:04:07
At the Department of Aging we are just in the baby steps in standing up for research and data shop, and we couldn’t possibly do it without the support of other agencies leading the way. I might follow up with you about if the aging tab is really called End of Life? We’re working hard on our language.

Latesa Stone

It’s in “Living Well” there's a senior health group, we broke each of the goal areas as into groupings of indicators, and so we have a senior health grouping that includes indicators of older adult falls, etc.

Kim McCoy Wade
Yep. Excellent. Thank you so much. Our next state department…

Anastasia Dodson 2:05:07
We’re going to have a brief presentation before the next OSHPD presentation, but we could ask our OSPHD colleagues to come to the table. Going back to the overall, for your information/consideration kind of slides. This first slide “Other Dashboard Examples” shows a number of different dashboards, plus Orange County, CMS, the state department of Managed Health Care, they have dashboards. We don't have time to look at each one. But there sure are a lot of different ways to present a dashboard and even to think about is it comparing different indicators across population? Comparing health plans? Is it comparing States? Many different ways. We'll go to the next slide.

This is just a very scratching the surface this list of local and state initiatives and dashboards – San Diego Orange County Los Angeles Marin County and then something very interesting. Orange County and Marin seemed to use some of the same visualization tools, so one of the things we want to follow up with them is what software or how did that happen?

And then last one, we’re talking about dashboards but also data sources, so these are some of the interesting links that we want to highlight for you. One is our California Health and Human Services open data portal. You may already be familiar, but if not we really recommend that. That's a way that right now all state departments can load data sets and anyone from the public can do their own visualization, wonderful wealth there, which is health interview survey you're probably all familiar with as well that you can do your own table development, and then the third bullet, California County Population by Age and Sex 1970 to 2050. If you saw them earlier meeting, that link will take you to a tool that you can look from across the decades every single county by gender looking at all these population going from pyramids to columns, and it's extremely helpful. Dept. of Finance demographic research unit, and then the Dept of Aging we have data on our website as well.

Again, thinking about as we transition to OSHPD and their data that data and dashboards come in so many different forms. So, with that we're going to switch over to the OSHPD presentation.

Kim McCoy Wade 2:07:29
And we've given you a ridiculously short period of time to talk about a lot of complex materials, so thank you in advance.

Mike Tagupa 2:07:42
Good afternoon. My name is Mike Tagupa with the Office of Statewide Health Planning and Development, or OSHPD's healthcare analytics branch. We are the data crunchers and public support group. How many people have heard of OSHPD? How many have used OSHPD data before? How many people have been hospitalized in the last 35 years or to the emergency room or had an outpatient surgery in the last 15 years? Thank you for your contribution.

Today's presentation is briefly going to touch on the roles of OSHPD in the healthcare delivery system, going to spend more time introducing the data collected from California licensed healthcare facilities available and on some data sets that may be most pertinent to the inform the discussion.

The Office of Statewide Health Planning and Development is a department under the California Health and Human Services Agency. Our vision is access to safe quality healthcare environments that meet California's dynamic and diverse needs. Our mission is to advance safe quality healthcare environments through innovative and responsive services and information.

OSHPD's main roles in the health care delivery system are to monitor the construction renovation and seismic safety of hospitals and skilled nursing facilities. Basically, we're the building department of hospitals and long-term care facilities. We provide loan insurance, assist in capital needs, California's not-for-profit health care facilities, we promote an equitably distributed healthcare workforce with loan and scholarship programs and identify health care professional shortage areas. But my focus today is our role to collect data and disseminate information about California Health Care infrastructure and how we publish valuable information about health care outcomes.

OSHPD collects upward of 17 datasets from over 6,000, California licensed health facilities. Seven of those datasets focus on financial related information the hospital financial hospital, annual financial disclosure report contains detailed financial and utilization data, financial data such as the income statement, revenue expenses, net income balance sheet, utilization, such licensed beds and occupancy rates by service and census days, also have financial data by payers such as Medicare and Medical and labor data.

There's about 70 thousand data items on the report is a very detailed report and the number in parentheses that you'll see next to each is the number of reports we expect to receive in a given year. The hospital quarterly financial disclosure report is much more summarized financial report. It includes about a hundred data items and is submitted every three months. The annual financial is about 17 thousand data times. Hospital charge masters are submitted by hospitals and contain the prices of all services goods and procedures for which a separate charge exists. It is used to generate a patient's bill. We have community benefit plans which are required with the passage of SB 697 back in 1994. But that required all private nonprofit hospitals to assume a social obligation to provide community benefits in the public interest in exchange for their tax-exempt status.

Hospitals are required to conduct a community needs assessment every three years and develop a community benefit plan in consultation with the community and annually submitted to OSHPD and that's one of the things that we post on our website. Hospital charity care policies and discount payment policies are submitted to OSHPD every other year and are made available to the public. They consist of those policies, eligibility procedures, the review process, and application form. If you are unable to pay your bill, this may be a good resource for you.

The long-term care annual financial disclosure report consists of financial and utilization data from freestanding long-term care facilities. It includes information such as licensed beds, patient days by payer, income statement balance sheet, and expenses. That is another very detailed report.

We also have data on prescription drug costs that are also reported to us. Prescription drug manufacturers are required to get 60 day notice has specified wholesale acquisition cost increases to purchasers of prescription

drugs to register with OSHPD are required to report quarterly specified wholesale acquisition cost increases of more than 16% and they are required to give three day notices new drugs being introduced to the California market.

Our next five reports, which I'll go over very quickly, we focus on our utilization and services of healthcare facilities. They are the annual utilization report of hospitals, one for long-term care facilities, primary care clinics, specialty clinics which includes a free-standing surgical chronic dialysis, rehabilitation, psychology clinics, and alternative learning centers.

Finally, we have the annual utilization report of home health agencies and hospices. General information included on those reports are patient discharges are in patterns, patient days, licensed beds, and surgical services emergency department data for our hospital report. So limited patient demographics, primary care practitioner staffing, and some limited financial statements such as the income statement. These facilities are all licensed by the California Department of Public Health. And required to report to OSHPD. All this data is summarized and reported at the facility level.

So what data products are available from those sets? Our standard data products include complete data files of all the reported data. Summary files of select data items for those users that only want summary information and not the details, and then we have easy to use Excel pivot profiles also with summary data. Once again, the focus of these data sets and products are at the facility level not individual patient level.

It is it's very hard to carve out a 65 and over specific information from them about any dimension because there there's some detailed information there and it depends really on what direction this group goes.

Okay, so the last five datasets consists of our patient level databases. The last two are specifically used for the respective outcomes reporting programs. The first three though are our best potential contribution to the aging topic.

The inpatient discharge data set consists of approximately 4 million discharge records per year. The emergency department data consists of about 12 million treat and release visits per year. The annual surgery

dataset consists of about 2 million encounters per year and is limited to mostly hospital-based ambulatory surgery, since physician-owned freestanding ambulatory surgery centers do not report to OSHPD.

The last two, the California coronary artery bypass graft outcomes report database and the California percutaneous coronary intervention or PCI also known as stints are use for outcomes reporting specific to those programs. So focus on the first three the inpatient discharge data, the emergency department data, and ambulatory surgery those data sets include demographic data such as age race and sex reported on every record includes some clinical data, diagnosis and conditions, procedures performed, external cause of morbidity, including cause of injuries on every record. Other data that's reported is zip code, physician source, expected payer, and total charges on the inpatient in now the emergency department database and that's on every record.

So, when I Googled healthcare conditions affecting seniors, these are some of the conditions that came up with our patient level data. We can measure inpatient hospitalizations, emergency department visits in ambulatory surgery encounters Statewide by County, by patient zip code, age, race, sex, or payer, or any combination of those. Topics such as heart failure, hip fracture, dehydration, cancer, asthma, COPD, bronchitis, or stroke, diabetes, Alzheimer's disease, mental disorders such as dementia, influenza and substance abuse, example opioid poisonings, are all things that we can measure with our data.

So, the sum of the from the patient level data, we can produce general statistics such a number of seniors hospitalized or the rates the number of seniors going to the emergency department or rates. Would you break it down by their age race sex or payer and generally why they're admitted or treated. We can look at a number of different conditions. In fact the ICD-10 coding manual reports about 70,000 different codes for different conditions.

Standard data products that are available for impatient ED and AD surgery data sets are individual record level data sets. And those are for approved non-public data requesters, which includes hospitals, local health departments, and university, researchers are is easy to use summarize Excel pivot tables by facility and other products. We have our patient origin market share.

I see the ICD-10 code frequency reports and case mix index by hospital for inpatient setting. There are other special health care quality reports which OSHPD creates and I'll discuss in the next slide. We also run ad hoc summary reports focusing on different topics of interest. One day it’s dog bites for the media. Another day is heart failure for a researcher. And this past week, I've had a request for diaper related conditions for a diaper supply nonprofit.

So finally, our special health care quality reports are reports based on health care utilization data to support higher quality more efficient and cost-effective patient care.

The Cabbage, coronary artery bypass graft outcomes shows performance ratings by Hospital in surgeon and are rated better or worse than average or average, the elected PCI outcomes includes 12 hospitals that perform the percutaneous coronary intervention without on-site cardiac surgery. Rates for PCI in-hospital mortality, post-PCI stroke, post-PCI emergency surgery can be compared to the state rate.

Our quality indicators are quality of care measures. They include volume by hospital for procedures such as esophageal and pancreatic islet section A A A repair which is abdominal aortic aneurysm repair, cabbages PCI’s, carotid endarterectomy. The volume of procedures is used as an indicator of performance. More procedures performed by a hospital equals better outcomes.

Utilization rates, over under utilization of C-sections for vaginal birth after c-section, which is probably not as relevant to our population. We also have in patient mortality indicators by hospital which look at heart attack, stroke, GI hemorrhage, heart failure, hip fracture, and pneumonia. The rates of in-hospital mortality for those conditions. Evidence suggests high mortality may be associated with deficiencies of quality of care providers. Hospitals were rated as better or worse than average.

Anastasia Dodson
I'm sorry. We're going to have to go to public comment pretty soon. But you want to just maybe wrap up.

Mike Tagupa 2:22:07

The focus here really is on my side with the patient level data, in patient, ambulatory surgery, really the level of depth that we can look at into those databases for conditions of interest for this group.

Ramon Castellblanch, PhD
So, you could tell us about outcomes by facility, by hospital, where you have a better shot of getting a PCI or whatever, and then also certain kinds of long-term care facilities. Nursing homes I understand, and several other types.

Mike Tagupa
We have nursing home data and not aware of any outcomes reporting that's done for a nursing home.

Ramon Castellblanch, PhD 2:22:35
So you don't track like bed sores or something like that for nursing homes?

Mike Tagupa
I know there's a patient safety indicator for pressure ulcers, but it's not something that we have done in the past.

Jennifer Breen 2:23:08
Just to clarify it's not in the OSHPD reports but the federal government surveys that with the nursing home compare data sets which is on the open data portal from CMS.

Anastasia Dodson
Thank you very much. Maybe just one brief comment and then we'll go to, oh, yes, also Chris on the phone.

Zia Agha, MD
Is there an opportunity as this group comes up with more senior specific indicators that you could add?

Mike Tagupa
There is an opportunity definitely.

Anastasia Dodson 2:23:35
Christopher Langston on the phone.

Christopher Langston
Oh, yes I think I actually was raising my hand to say that I'd used health facility. So never mind. But I did wonder if from the data available we could calculate the admission rate per thousand for people over 65 for ambulatory care for sensitive conditions, things like diabetes, congestive heart failure, etc.

Mike Tagupa 2:24:06
In fact, we do calculate some prevention quality indicators just for those measures, but right now it is calculated using the agency for healthcare research and quality software and it calculates it for the over 18 population right now, but it is something that we can look into doing.

Christopher Langston 2:24:32
Okay, I think that's a pretty good indicator of the quality of the outpatient primary care system, essentially counting the failure of that system leading to an admission for one of those conditions and something we could look at over time.

Anastasia Dodson 2:25:23
What we had talked about in this presentation, Matt has a great number of slides, we don’t have time, so this is a teaser. And then we can talk about what part of this we might want to have Matt come back and present on.

Matt Ortiz
This is going to be a high-level discussion on the what, how, and why of how we identify shortage designations in California. And you're probably wondering what is shortage designation and someone mentioned earlier, how do we identify areas of unmet need across the state? That's exactly what we do at the primary care office. We identified various unmet needs. We designate them and through those designations we prioritize and we steer resources and dollars to those designations. We're a team of about four analysts and two managers and we are the liaison with the federal health resources and services administration. So we're their counterparts and we interface with them in addition to other statewide associations in California, community groups and other County entities.

So I'm going to preface that this is not Medicare Focus for over 65 Focus. This is a general description of our practice and I realized that is the limitation for the purposes of what you're trying to do, but I still think it is

helpful because in terms of figuring out what is a good way to figure out areas of unmet need the across the state. This is one of them. There's probably several others. And you hear them banging about and in my experience, there's no one way to identify areas of unmet need but just want to give you some ideas so you can decide what is best as you go forward.

A big effort for the primary care office is we provide technical assistance to the community clinics and health departments and facilitate the side application process for the National Health Service Corps. They provide loans and scholarships for recipients who are willing to go to these areas of unmet need and work for a predetermined amount of time.

The term you're going to hear throughout this presentation is health professional shortage area, and with there's three types,for the purposes of this discussion, primary care, dental, and mental health and I would ignore medically underserved areas. It's not necessary for this discussion.

The data elements of the health professional shortage area are the medical study service area and a population to provider ratio as well as a contiguous area analysis. What that means is that we have predetermined rational study areas that used to build these HIPSAs and then based on the number of the providers against the population in the surrounding area we can determine whether or not we are going to classify this as a HIPSA.

Kim McCoy Wade 2:28:45
And I think because we do need to stop at for public comment at four, I'm wondering if you want to go to the map and show the whole county in the in the sub-county as an example of again another feature of what folks in terms of data sources the data display.

Matt Ortiz
Yes. So this is a whole County. MSSA. A medical study surface area. San Benito County, and then if we go to Fresno County you'll see there's a lot of different MSSA's just by virtue of the population. The designations you can look at it from population, and area or facility. For the contiguous area analysis we review the maps of the surrounding areas and determine which ones can be ruled out based on the elect providers, disparities in socio-economic or demographics or geography. So just an easy way to understand it in Fresno County, you have a community of Parlier,

approximately 15,000 people about 98% of it is Hispanic, you go 30 minutes north to Clovis California, seven percent of the population is white. So, you're not reasonably going to expect a community of Latinos to go to providers in a majority white community. So those are one of the things that we look at when we're making those designations because it helps us determine who and where they're going to be able to go to get the best source of care.

Kim McCoy Wade
There's obviously a lot more to say here and I have the terrible job of cutting you off. So I just don't know how to do it. But I'm going to do it. If you could leave us with one thing in this very rich and very deep discussion… advice for the road?

Matt Ortiz 2:30:42
Think of this as sort of gerrymandering honestly that the best way to look at it. We're actually literally drawing the lines across the state to define the areas of unmet needs what we call the HIPSAs, health professional shortage areas, and we update them every 10 years were going to be doing it in 2021 after the census has finished and yeah, so the and they're driving resources to follow.

It's an iterative process, we're constantly engaging our stakeholders and our partners. Happy to answer any questions offline. And yes, thank you.

Kim McCoy Wade2:31:27
Thank you so much. We do want to turn to public comments and have at least 20 minutes for that. I believe we'd like to start in the room if possible and then people on the phone can start raising their hand as we move to that. And we welcome comment on any and all of it the scope of this work, the goal indicator conversation, we had dashboard conversation and sources conversation we had so with that is there a wonderful. Thank you.

Patty Arnold 2:32:16
Hi, Patty Arnold, disability rights advocate 30+ years.

First off I would like to say that next time you have a meeting, if you could have it in an accessible location close to public transportation, would be much better for engagement of stakeholders.

Secondly, when this is kind of a boring subject research, let’s be honest, I would like to say that a list, when you think about the population, you’re talking about people with disabilities, seniors, we're all aging. However, not all of those in that in those communities need services at the beginning of life, midlife or end of life. So, you have to look at that the people that are needing services. Usually are the ones that are impacted by some sort of chronic illness or disability at the same time. If you're a person with a disability who needs public transportation and you need a wheelchair lift, then you need buses with lift or you need platforms that have access or you need tools like the zip pass on your phone to be able to purchase a ticket when you can't reach the ticket machine.

Now when it comes to the Master Plan on Aging in the subject matter the system completely in California for long-term services and supports is absolutely broken.

One thing I'm worried about is not only this one door system to enter and you'll get services that that has adequate funding and support so that the people delivering the services to the people requesting services can actually be served. And as long as it takes until they get services.

When it comes to long-term care services and supports issues. There is no backup services for people with disabilities. I'm sure I'll be restating this at the next meeting I go. So a lot of people with severe disabilities are going to fall through the cracks when they rely on community providers and they don't have family member providers or friends who can provide the support that they need. And oftentimes we don't ask our friends to provide us the support, because we might not have them as friends anymore, because the kind of care that you need is very intimate. So, you've got to consider these issues. So backup services are critical and the higher pay rate when you're talking about workforce.

Well right now we can't from I get calls from everybody asking for services for help. So I help everybody that calls me and I'm not paid for doing any of it. And I do the work of a lot of agencies that they should be doing. However in the subject doesn't really matter so it could be a waiver Services. It could be IHSS. It could be an immigration diversity, it could be Visa Lottery. It really doesn't matter what the subject is.

It's critical to make sure that people have access to the services. When you have waiting lists, that's a barrier. When you have barriers to transportation like PGE saying well get a ride to the hospital when your power is out. That doesn't help you. So, there's a lot of critical issues including disaster planning that have to be considered as part of what you're doing.

One thing that concerns me, when I looked at the one of the points on here is end-of-life care, that had a concern for me because you know, I don't want to see an emphasis on people being terminated because they need services, and I don't want everybody in the community be taxed to death since I got my property tax bill. What are you crazy? How much more can we be taxed? Whether it's our property taxes? And I'm sure everybody feels the same way in the room, or whether its utilities wanting us to pay for the wildfires. And so I just would like to see a listing, I would like to see stakeholder engagement, and I was told by Nancy Becker Kennedy. She wanted me to say basically, "It was important for the success of the master plan on that those of us in the independent living community. Those of us who have served on committees in the past, public authorities, engaged as advocates, seniors and users of the services who have valuable information and feedback to share which is irreplaceable be given the opportunity all along the way to somehow be engaged in the process,and to provide information to you about what services we have now, what the problems are, and what proposed fixes are. I won't go on, but I will be working with community members to consolidate feedback on waivers, on IHSS, on transportation, on housing because things that you don't know. They talk about tiny homes. Okay. Well lot of the communities doesn't it doesn't have access. There's no regulations on tiny homes for accessibility. If you're in a wheelchair, a tiny home is not going to work for you. There's a lot of public barriers to public participation. Walking down the street, you can't reach a crosswalk button without playing chicken.

So, you know, this is our daily life that we live. You can't find restrooms that are accessible when you go somewhere. Yes, all of these are critical pieces and part of the puzzle.

I would just like to say keep working on it, but realize there's a broader community members out there and users who I don't see as any appointees who are IHSS recipients, waiver recipients, like waiver personal care services recipients, like the deaf community, I know the blind community has representation, but some of us feel left out. We want to be

here to tell you what the problems are, with IHSS IHSS advanced pay, waiting lists, waivers, the fact that people can't get the waivers they need, there's not enough waivers, there's people that need assisted living waivers, there's not enough low income housing for seniors. Thank you.

Lisa Coleman 2:39:11
Good afternoon Lisa Coleman with the California Long-Term Care Association. I'm a data geek I love this session. There were a lot of great things and a lot of smart people here. My one caution, when we were talking about the area of planning for retirement, encouraging people to do self-protection, we're going be teaching our grandchildren savings. The fallacy with that people don't know what they don't know and I think for this program to be successful is going to require a very substantial marketing plan to the general population. I look at the DD Community as being so much better off in many ways than our Older Adult Community is if you have a child with a disability you think in terms of five years, ten years, twenty years out. I come across older adults all the time, "My mom is 85 but we never thought she was going to need in-home care. We never thought we were going to have to redo the bathroom." We just don't think about the services until it becomes a crisis. That's the most expensive way for the state to respond. So I think a marketing campaign of what you don't know is crucial to helping people to help themselves.

Anastasia Dodson
I want to encourage folks on the phone on the webinar. If you would like to make a public comment, you can click on the hand icon and then we can add you to the queue. We have one on the phone but anymore in the room.

Terrance Kelly 2:41:03
Hi I'm Terrance Kelly, I am a research scientist with the dashboard. Did see on one of the slides dementia was referred to as mental disorder but it's a neurodegenerative disorder, important to point that out.

Katie Weber 2:42:28
Hi I'm Katie Weber of Health Solutions. Done a lot of research around integrative care communities looking at the top four challenges around housing transportation and socializing etc, one area to think about data is how can it be more preventative? I know we look at indicators around admissions and not looking at how to get further upstream, like around falls. Transportation, if you want to talk about access, it's not just whether

they have insurance, it's whether they can get to the appointment. Also looking at home-bound elderly, where they can't get out of the house. I know a lot of our policies are driven around appointment-based appointments and that can be challenging especially with someone with cognitive limitations. It's a big thing to think about, but I know like around nutrition, if they're malnourished they have a higher risk of falling. So I think that's something as we look at how that integrates into the overall picture. Very critical to changing the cost curve to be more preventative versus reactive.

Kim McCoy Wade 2:42:58
Any other public comment in the room or on the phone? I welcome a change to have a minute to talk about next steps because I think we just laid out the ocean and we need to start swimming.

I heard a couple things. I'm going to try to reflect it back and then I'd like to hear the subcommittee's feedback.

Dr. Carstensen talked about starting to map sources of data and working from the bottom up and what do we have? What do we know? We'll look at our friends at OSHPD and CDPH and other places, universities. I think that we also heard loud and clear the need to do some more work framing the indicators themselves. Doing some work on that with the goals, the indicators, CDPH prompt to ask why, this question about going upstream. What are we measuring?

I think it's okay to start because of our time feels short to me. Although I appreciate CDPH saying we got a whole year to work from both ends to both try to figure out what it is. We know and try to figure out what we want to know from both ends. So, I think those are the two directions we need to work from I think our team suggestion is that we schedule a series of meetings kind of going deep on each topic, but maybe give us a minute to do some homework so that if I don't know when we're thinking the next meeting would be but those kind of three things.

Start mapping the sources we know, doing some more iterations of the indicators back and forth with you all, what are we trying to ask and how does this go down and keep going down levels? And then how do we structure the meetings to make sure each meeting we're bringing something rich for you all to respond and react to?

And that we were taking notes on who knows a lot about what. We're going to work with you in advance to help us develop that before the meeting. Anything you would you like to add?

Anastasia Dodson
Yeah. That the feedback that you provide after the meeting is very welcome. And so as you mull through the next few days what you heard and might see other resources, send that to us. And then December 10th, we have as a date that this room is available and we're all available. We're also trying to schedule a number of other stakeholder meetings like for the LTSS subcommittee, but we were thinking about December 10th. But again, we don't want to just put a meeting on the books if it's too early because maybe we need to do more homework. We want to think about that for another couple days.

But one of the things also is if you have presenters as Kim said, something that is either state agency, local, hospital, researcher or something like that that maybe most people know but not everybody knows or maybe it's some new hidden gem.

Carrie Graham
And I would definitely say we definitely want to get feedback from you in-between meetings. Thinking about ways to do that that isn't a total free-for-all. If something comes to you definitely email us, but we will in the next week or so send out a survey, which is basically just going to be looking at our goals, indicators, and priorities areas and asking you after you've had time to think about it, what data sources should the committee be considering, what kind of evidences are there already in this area, and suggestions for expertise both in this room or other experts we should be talking to in-between meetings. So just a way to structure that feedback. So just watch for that survey from us.

Anastasia Dodson
Okay, one more public comment.

Kim McCoy Wade 2:49:03
Hang on one second. How does that sound? What did we miss? What did we get wrong?

Ramon Castellblanch, PhD

Yes, so will we also be looking at best practices of other states trying to get some examples?

Kim McCoy Wade 2:49:23
Yes. We had Colorado as one of the links in there. We didn't have a time today, but absolutely there's four or five states that have state plans on aging, some more data-driven than others. But yes, that's in the mix.

Ramon Castellblanch, PhD
I think it's important to bring those lessons to this table.

Kim McCoy Wade
Yes, absolutely.

Stacey Moore 2:49:56
Just a quick comment around scoping and terminology. We talked a lot about seniors and the ability to talk about the 65+ demographic, but if this is a Master Plan for Aging, it goes beyond just that demographic, so I'd like to just get some clarity with regards to age range that we're talking about planning throughout the lifespan for aging if that's really what we're looking at here. So just as food for thought.

Kim McCoy Wade
I think the short answer to that longer question is yes, there's not a magic number, whether it's 65 per Medicare Medicaid or 60 older Americans act or other. Or Denny's, 55. Again, we also are looking at aging and an accessibility, aging and disability where appropriate. So that is also part of the work here is what our how are we dividing and measuring appropriately absolutely in scope.

Okay, then we will follow up with survey potential meeting dates and homework and yes public comment?

Nikki Diaz 2:51:09
Thank you. I'm Nikki Diaz, I'm an advocate, thankful for all the ideas. Hope this is our last wall break down for civil rights in our community and campaigns going global right now. I wanted to make a statement first about, I'm noticing here on all the measuring, I don't hear much about a small community of people that is really disability that don't have family care that only use public care providers and wondering where we stand.

That’s my main concern right now. If there are any struggles out there we are the ones that are hit the hardest. We are on our own independently. Main concern is in regards to in-home operations waiver. What is the wait time allowed for this? It seems unbearably long and a lot of pain associated with that impact. All the struggles I have gone through living by myself with a severely disabled woman. All the struggles to services, type of people it attracts, people on drugs and homeless, etc. Don’t want to report that they are getting paid. Pushed into situations don’t want to say yes to. Low pay rates, and fact that most vulnerable in this community. Need to be strongly corralled into a group and given a special focus. Serious consideration. So thank you very much.

Kim McCoy Wade 2:54:18
Thank you very much and yes, absolutely the issue without family caregivers are top of mind. I guess I will take advantage of the last minute to say our colleagues at DHCS are kicking off the Medicaid conversation at Cal IM on Tuesday and our colleagues at CDSS are kicking off the IHSS listening sessions with a statewide conference called next Thursday.

So many forums to share these very important central concerns and make sure we are all hearing them in coordinating on solutions. And all those dates are posted on our Master Plan for Aging web page so that we can all find each other. I think with that we’ve reached the end of public comment. We managed to get through a very deep and wide agenda with all of you experts. Thank you so much for the gift of your time and expertise and commitment. Much more to come very soon. Thank you.