

FINAL DRAFT FOR SUBCOMMITTEE REVIEW 3/10/2020

March 2020

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



# Acknowledgments

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

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## Executive Summary

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

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

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

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

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

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

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

## **OBJECTIVE 1: A SYSTEM THAT ALL CALIFORNIANS CAN EASILY NAVIGATE**

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

## **OBJECTIVE 2: ACCESS TO LTSS IN EVERY COMMUNITY**

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

## **OBJECTIVE 3: AFFORDABLE LTSS CHOICES**

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

## **OBJECTIVE 4: HIGHLY VALUED, HIGH-QUALITY WORKFORCE**

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

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

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

## **OBJECTIVE 5: STREAMLINED STATE AND LOCAL ADMINISTRATIVE STRUCTURES**

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

## **NEXT STEPS AND THE IMPORTANCE OF STATE & LEGISLATIVE LEADERSHIP**

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

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

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

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



## LONG-TERM SERVICES AND SUPPORTS SUBCOMMITTEE STAKEHOLDER REPORT

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

#### Introduction

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

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

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

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

1. The growth and sustainability of state long-term care programs and infrastructure, including In-Home Supportive Services (IHSS).
2. An examination of access to long-term care, financing for long-term care services and the quality of long-term care provided in a variety of settings.



3. An examination of the impact of program instability and other factors on labor supply and retention of the workforce providing long-term care services and supports.
4. Recommendations to stabilize long-term care services, including IHSS, as a foundation for implementing the Master Plan.

### **Scope of Report**

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

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

### **Definition of LTSS**

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

### **LTSS Subcommittee Values and Vision**

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

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

Vision: A strong, shared vision must guide the transformation of how we deliver long-term services and supports for all Californians. The Subcommittee envisions a California where:

- 1) All Californians can easily navigate the LTSS system
- 2) There is access to LTSS in every community
- 3) LTSS choices are affordable
- 4) The workforce is highly valued and of high quality
- 5) State and local governments are organized to enhance access to LTSS

### **Importance of Gubernatorial Leadership**

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

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

### **Leadership**

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

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

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

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

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

### **Equity**

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

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

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

(Robert Wood Johnson Foundation)

## Big Ideas

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

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

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

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

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



## SUMMARY OF SUBCOMMITTEE OBJECTIVES

The LTSS Subcommittee respectfully recommends adoption of five bold objectives.

### OBJECTIVE 1: A SYSTEM THAT ALL CALIFORNIANS CAN EASILY NAVIGATE

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

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

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

### OBJECTIVE 2: ACCESS TO LTSS IN EVERY COMMUNITY

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

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

### **OBJECTIVE 3: AFFORDABLE LTSS CHOICES**

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

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

### **OBJECTIVE 4: HIGHLY VALUED, HIGH-QUALITY WORKFORCE**

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

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

**WHY:** Building a robust network of LTSS options relies heavily on a sufficient supply of both paid and unpaid caregivers. For the paid workforce, Department of Labor statistics show that there are not enough direct care workers to meet

population needs due to low wages, meagre benefits and low respect for demanding jobs requiring difficult physical and emotional work. Additionally, California's LTSS system is heavily dependent on immigrants. It is critical that we protect these workers who are the cornerstone of the paid labor force.

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

## **OBJECTIVE 5: STREAMLINED STATE AND LOCAL ADMINISTRATIVE STRUCTURES**

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

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

# Objectives and Recommendations

## OBJECTIVE 1: A SYSTEM THAT ALL CALIFORNIANS CAN EASILY NAVIGATE

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

Public Comment

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

### **1A: Develop a Comprehensive Statewide Navigation System**

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

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

### **Recommendations:**

- 1A i: Implement a statewide person-centered No Wrong Door approach to navigation at the local level with trusted community partners using common standards for a local information and assistance system that is open to all Californians.
- 1A ii: Fund and implement a web-based portal that would offer a public-facing, trusted source of information for people seeking accurate LTSS information



anywhere in California. The platform should serve as a one-stop source of information and include home and community-based services, as well as residential and institutional care options.

- 1A iii: Build on existing local networks and statewide 24/7 call lines to create a system that offers culturally responsive, multi-lingual, and ADA accessible information and assistance to ensure equitable access.
- 1A iv: Develop and provide adequate resources to implement statewide quality standards for information and assistance services that are linguistically and culturally responsive to ensure consistency and accuracy. Evaluate local information networks such as Area Agencies on Aging, Independent Living Centers, and 211s for compliance and consistency statewide.
- 1A v: Conduct a statewide marketing campaign, using easily understood messaging that is linguistically and culturally responsive, to educate the public about how to connect with aging and disability information and resources.

### **1B: Streamline Access through Standardized Screening and Assessment**

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

#### **Recommendations:**

- 1B i: Work with stakeholders to identify the common standard questions that are linguistically and culturally responsive, and a set of data-informed public domain screening tools to identify functional, health, cognitive and social support needs and risk factors, while documenting the individual’s goals and preferences. As appropriate, these questions should identify who is serving in the role of caregiver to determine if additional supports are needed.
- 1B ii: Adopt a common baseline of data elements across all LTSS programs that can be shared securely and quickly among LTSS partners.
- 1B iii: Pursue development of comprehensive assessment questions, to include physical, oral, cognitive and mental health, that are linguistically and culturally responsive, to be utilized across health and LTSS settings, with the necessary data, funding, and infrastructure to support its system-wide implementation.
- 1B iv: Ensure Californians with cognitive impairment are identified through a culturally and linguistically responsive intake process and assessed for risk. Currently, one in five persons with dementia lives alone and is at-risk.

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

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

### **Recommendations:**

- 1C i: Empower consumers to make informed decisions about LTSS by funding ADRC Options Counseling statewide for anyone, across age, disability and income level, who requests information and/or services because of a disability, chronic condition or status as a family caregiver. Options Counseling includes a person-centered interview, decision-support, action plan development, referral to and navigation of services, and follow-up.
- 1C ii: Provide ongoing infrastructure funding to incentivize ADRC development and implementation statewide.
- 1C iii: Provide the California Department of Aging (CDA) with resources to support the ADRC initiative (e.g., training; technical assistance; policy and program guidance; monitoring and evaluation) to ensure consistency and quality of services statewide.
- 1C iv: Coordinate ADRC services closely with county Health and Human Services agencies and core partners including Area Agencies on Aging, Independent Living Centers, and Regional Centers.
- 1C v: Enable seamless access to public benefits and programs with the state taking the lead in partnering with local entities.

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

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

### **Recommendations:**

- 1D i: Outline a five-year Medi-Cal/Medicare integration plan that commits the state to the highest level of integration possible. The plan must:
  - a. Ensure people who qualify have access to an integrated Medi-Cal/Medicare health plan and that those plans are federally defined Fully Integrated Duals Special Needs Plans; Highly Integrated Special Needs Plans; and the Program for All Inclusive Care for the Elderly (PACE).

- b. Incorporate best practices from California’s past integration efforts, such as requiring health plans to train staff on Alzheimer’s and dementia, improve quality of care in nursing facilities, provide institutional long-term care diversion and transition services, ensure all Health Risk Assessments include standardized LTSS screening questions developed through a stakeholder process, and coordinate with programs and services that are not offered through Medi-Cal managed care.
- c. Require strong consumer protections, improved access to home and community-based services, stakeholder engagement, ongoing evaluation, and provide incentives for contracting with local, trusted and linguistically and culturally responsive community-based organizations.
- d. Ensure Medi-Cal/Medicare (dual eligible) recipients are included in all components of the Medi-Cal CalAIM proposed programs and services.
- e. Implement a comprehensive set of Home and Community-Based Services (HCBS) as covered benefits in Medi-Cal, building on the voluntary services (federally defined “in lieu of services”) proposed in Medi-Cal CalAIM.
- f. Include these comprehensive services in all home and community-based services to help an individual avoid institutionalization, including adult day care, residential care facilities, and a purchased services model like that used in the Multipurpose Senior Services Program (MSSP) and PACE programs.
- g. Establish incentives for health plans to build and provide or contract for these supplemental services.  
Establish a policy and specific targets for reducing avoidable institutionalization.

## **1E - Establish a Statewide Integration Oversight Council**

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

### **Recommendation:**

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

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

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

### **Recommendations:**

- 1F i: Establish an office in the Department of Health Care Services to design and implement innovative strategies that are linguistically and culturally responsive to serve individuals and families from diverse backgrounds and experiences who are eligible for Medi-Cal/Medicare with a goal of improving how services are delivered at the local level across the health and LTSS systems. The office would explore new models in partnership with state and federal partners, while also overseeing implementation of related elements of Medi-Cal CalAIM initiative.
- 1F ii: Explore targeted demonstration programs intended to reach special populations with complex care needs (e.g. evidence-based interventions for Medi-Cal beneficiaries with Alzheimer's disease) whose Medicaid costs are currently 23 times higher than costs for older adults without a cognitive impairment.

## **1G - Simplify IHSS Program Administration**

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

### **Recommendations:**

- 1G i: Evaluate which administrative rules are necessary and work with stakeholders to allow greater flexibility and simplify administration of the IHSS program, where possible.
- 1G ii: Simplify and improve the functional needs assessments while ensuring individual need is reflected and allow for simple re-determinations for recipients with stable conditions.
- 1G iii: Change the parent-provider rules to allow for a choice of providers.
- 1G iv: Streamline provider rules to ensure it is easy to hire and pay providers as quickly as possible.
- 1G v: Improve the coordination between the IHSS program and institutional settings to ensure there are no gaps in services for those being discharged.

## **1H - Enhance IHSS Public Authority Practices and Training**

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

### **Recommendations:**

- 1H i: Identify and apply best screening and matching practices to improve consumer experiences.
- 1H ii: Increase and expand caregiver training delivered through multiple avenues.
- 1H iii: Provide IHSS provider training stipends. To achieve this goal, the state may need to work to eliminate state and federal rules prohibiting financial incentives.

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

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

### **Recommendations:**

- 1I i: Improve care coordination between the IHSS program and other LTSS and health providers including formal authorization for secure information sharing with managed care providers of health and LTSS services.
- 1I ii: Require the state to collect data and report on beneficiary access to services, including referrals and receipt of services, transitions and care coordination.

## OBJECTIVE 2: ACCESS TO LTSS IN EVERY COMMUNITY

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



Gwen Boozé, (Alameda County)

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California will have the country’s most comprehensive LTSS system where people and their caregivers can find and afford the services they choose, where and when they need them. To do this, California must act urgently to fund statewide access to LTSS to ensure enough supply exists to meet the growing demand by older adults and people with disabilities.

### **2A - Remove Barriers to Community Living**

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

## **Recommendations:**

- 2A i: Develop a statewide institutional diversion and transition strategy including:
- a. Establish a California Community Living Fund as a “bridge” program that expedites the provision of goods or services – including rent – not available through other means to individuals either transitioning to the community or at-risk of institutionalization.
  - b. Require that person-centered assessments and transition planning is conducted in institutional settings to support an individual’s return to the community.
  - c. Expand California’s Pre-admission Screening and Resident Review Program (PASRR) to all older adults and people with disabilities using Oregon’s experience as a model. Currently, in California this program is only available to individuals with serious mental illness and individuals with intellectual or developmental disabilities.
  - d. Authorize the California Community Transitions (CCT) program permanently. Streamline and improve its operation to more effectively provide transition services.
  - e. Provide incentives for Medi-Cal managed care plans to participate in an institutional diversion and transition strategy.

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

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

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

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

## **Recommendations:**

- 2B i: Adopt the following minimum core of services to serve as a local blueprint for LTSS infrastructure (alphabetical order):
- Adult Day Services (Adult Day Health Care and Adult Day Programs)
  - Aging & Disability Resource Centers (ADRCs)
  - Caregiver Resource Centers (CRCs)
  - Care management
  - Independent Living Center services

- Information and Assistance
  - In-home care
  - Nutrition services
  - Older Americans Act Programs
  - Older Californians Act Programs
  - Program for All Inclusive Care for the Elderly (PACE)
  - Residential housing options, including RCFEs and SNFs
  - Transportation and mobility services
- 2B ii: Develop minimum standards for how easily Californians can access these core LTSS, including the time and distance it takes to get to a service outside of the home.
- 2B iii: Create and maintain a web-based database of LTSS programs to enable the state and local communities to assess current LTSS availability, identify gaps, support development of new resources, and measure progress.
- 2B iv: Include in the state budget immediate investments to build an equitable core LTSS system infrastructure at the local level:
- a. Fund expansion of services provided by Caregiver Resource Centers, including administering high-quality caregiver assessments by trained professionals, providing information and referral services using up-to-date resource lists, providing evidence-based/data-informed education and training programs, raising caregiver awareness, and supporting innovative programs, including digital and online programs, to meet the evolving needs of family caregivers.
  - b. Invest in and enhance the state’s contribution to the federal Title III E Family Caregiver Support program.
  - c. Modernize the Multipurpose Senior Services Program (MSSP) by increasing total “slots,” expanding to all counties, and changing eligibility to lower the eligibility age from 65 to 60.
  - d. Use one-time state grants to spur development of non-profits interested in starting Adult Day Health Care (ADHC), Adult Day Programs, and Centers of Alzheimer’s disease Excellence to support the person experiencing Alzheimer’s disease or related dementia and their caregivers. Concurrently, amend Health and Safety Code 1579 to provide for more flexibility in how ADHC is delivered in rural communities (33 counties are currently without adult day services) and reimbursed under Medi-Cal Managed Care.
  - e. Encourage expansion of PACE, especially in underserved regions of the state.
  - f. Encourage Medi-Cal managed care plans to use incentive funding available through CalAIM to fund LTSS capacity in every community.
  - g. Develop a plan and funding stream to make Traumatic Brain Services available throughout the state as outlined by SB 398 of 2018.
  - h. Provide fall prevention programs through the Area Agencies on Aging (AAAs) to prevent primary and secondary falls and keep people safe in their homes.



- i. Expand the Assisted Living Waiver program to all counties in the state and increase the number of allowable slots to include those in the community on the waiting list and those in nursing homes who could benefit from a transition (approximately 18,500 total slots).
- j. Ensure that the No Wrong Door system includes linguistically and culturally responsive referrals for individuals in all care settings and stages of their life, including end-of-life and palliative care to reduce hospitalization and institutionalization.

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

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

### **Recommendations:**

- 2C i: Analyze wait lists for and evaluate barriers to statewide access to the Home and Community-Based Alternatives Waiver, the Assisted Living Waiver, and the MSSP waivers.
- 2C ii: Expand waiver services into unserved counties with the goal of avoiding and eliminating wait lists for eligible recipients.
- 2C iii: Evaluate current waivers to determine how to improve access for Medi-Cal beneficiaries who are at risk of institutionalization or who are currently institutionalized and in need of transition to the community.

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

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

### **Recommendations:**

- 2D i: Cover all undocumented older adults to ensure all Californians have access to health care.
- 2D ii: Substantially increase asset limits for Aged and Disabled Medi-Cal and eliminate asset tests for the Medicare Savings programs to ensure low-income individuals do not have to live in abject poverty to receive benefits.

- 2D iii: Explore options for “presumptive eligibility” to speed up access to IHSS where urgent need arises.
- 2D iv: Substantially increase the monthly Medi-Cal maintenance need income level for both community Medi-Cal and institutional care to make Medi-Cal affordable.
- 2D v: Make the spousal impoverishment expansion permanent to ensure married individuals can remain living at home.
- 2D vi: Simplify the renewal process for Medi-Cal and enrollment in Medicare Savings Programs to ensure maximum enrollment in the programs and less turnover in the program.
- 2D vii: Index these changes so the changes made as a part of this process continue to improve access, equity, and affordability now and in the future.
- 2D viii: Explore options to support people with disabilities who are employed but unable to access a range of necessary LTSS. These options may include expanding Medi-Cal coverage of assistive technology and other LTSS to people with disabilities who are employed and do not meet the threshold for the Working Disabled Program.
- 2D ix: Expand access to the Medi-Cal Working Disabled Program and increase the income eligibility threshold to meet population need.

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

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

### **Recommendations:**

- 2E i: Develop a statewide, coordinated linguistically and culturally responsive emergency preparedness marketing and education campaign for older adults and people with disabilities.
- 2E ii: Provide funding to counties for outreach and coordination of services for vulnerable populations during times of emergency and disasters.
- 2E iii: Require a mechanism for collaboration (e.g., a Memorandum of Understanding (MOU)) between local agencies, counties, community-based organizations, private LTSS organizations, Red Cross, FEMA and the state to coordinate services during disasters. Require the MOU to include utility companies for coordination activities before and during a declared emergency or PSPS.
- 2E iv: Require county IHSS social workers to develop and review each IHSS recipient’s personal emergency plan annually to update critical data for emergency response.

- 2E v. Establish an emergency back-up system of IHSS providers administered by Public Authorities for when a caregiver is unavailable for IHSS consumers.
- 2E vi: Create a billing/payment category for emergency services that can be used to compensate IHSS providers for additional hours worked during emergencies or natural disasters.
- 2E vii: Mandate county staff attend shelter fundamental training and shelter management training, as appropriate.
- 2E viii: Provide funding for additional training for older adults and people with disabilities, including Access and Functional Needs (AFN) and Functional Assessment Services Team (FAST) training.
- 2E ix: Allow background checks from other entities to suffice for allowing a home care provider to provide care in an emergency shelter.
- 2E x: Expedite enrollment into Community-Based Adult Services (CBAS) programs on emergency basis; waive certain staffing and program requirements to be able to meet immediate shelter, food, health and safety needs of community members; allow for reimbursement during days of operation when requirements are waived.
- 2E xi: Coordinate with licensed care settings, e.g., Residential Care Facilities for the Elderly (RCFEs) and Skilled Nursing Facilities (SNFs), to ensure staffing is in place and transportation is available to assist all residents.

## **2F - Strengthen Quality and Choice in RCFEs and SNFs**

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

### **Recommendations:**

- 2F i: Expand supported residential options and identify and implement other affordable alternatives, e.g., foster adult and adult family home models.
- 2F ii: Integrate Skilled Nursing Facility licensure with other ancillary service (e.g. infusions, dialysis, laboratory services, x-rays, etc.) provider types to allow these services to be offered within the facility so residents do not need to go offsite for these procedures.
- 2F iii: Ensure those who are deaf and hard-of-hearing have access to communication devices, staff who can communicate in American Sign Language, emergency procedures that include methods accessible to persons with hearing impairments, and other modalities for meeting access needs.
- 2F iv: Provide for those with vision loss information on menus, daily activities, among other things, in large print or other formats, orientation and mobility instruction that enables these individuals to navigate the facility successfully, and assistive technology that allows for communication with others outside the facility.

- 2F v: Ensure appropriate oral health care is provided in SNFs.
- 2F vi: Strengthen training and incentives for quality improvement in SNFs.

## **2G - Strengthen Oversight of RCFEs and SNFs**

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

### **Recommendations:**

- 2G i: Fund fully the oversight and monitoring of SNFs by the California Department of Public Health and RCFEs by the California Department of Social Services licensing divisions.
- 2G ii: Fund fully the Long-Term Care Ombudsman program at the California Department of Aging to ensure that there are enough paid and volunteer ombudsmen to fulfill the responsibilities mandated by state and federal requirements.
- 2G iii: Ensure public disclosure of key data elements related to facility ownership, operations and cost reporting to enable consumers to make informed care decisions.

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

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

### **Recommendations:**

- 2H i: The Administration should work with stakeholders to:
  - a: Identify ways to strengthen the public and private enforcement of current laws designed to protect older adults and people with disabilities living in facilities.
  - b: Identify additional public and private remedies to address abuse, neglect, and rights violations of older adults and people with disabilities living in all types of residential facilities.
  - c: Fund current and new public enforcement systems adequately.

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

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

### **Recommendations:**

- 2I i: Conduct an inter-departmental examination of admission, retention and transfer policies within and between levels of care to prevent residents with dementia who have behavioral issues from being improperly displaced from residential settings.
- 2I ii: Explore Medi-Cal rate differentials to adequately reimburse for the cost of care for beneficiaries with complex needs including dementia and behavioral health challenges.

## **2J - Ensure Stability and Sustainability of IHSS Financing**

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

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

### **Recommendations:**

- 2J i: Restore, permanently, the 7% cut to IHSS hours by rescinding the authorizing statutes.
- 2J ii: Establish a time-limited workgroup that includes the state, counties, and key stakeholders and experts in IHSS to create a long-term funding plan to update and simplify the IHSS funding formula, ensure sustainability for county IHSS costs, and identify new, sustainable funding sources dedicated to the program. This should include examining ways in which non-Medicaid eligible individuals may be able to "purchase" or "buy-in" to IHSS services utilizing the existing workforce and administrative systems.

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

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

### **Recommendations:**

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

- a: Improve language access by expanding the threshold languages.
- b: Fund linguistically and culturally responsive IHSS outreach to ensure all communities know about the benefit.
- c: Work with communities across the state to improve cultural responsiveness within the IHSS program.
- d: Include "reading services" and "sign language interpretation" to the list of allowable IHSS tasks.
- e: Improve access to protective supervision hours for persons with dementia.

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

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

### **Recommendations:**

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

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

- a. Expand access to voluntary IHSS contracted agency mode.
- b. Expand the use of supported decision-making including increasing funding for additional care coordination.
- c. Increase access to enhanced case management, including through the Multipurpose Senior Services Program (MSSP).
- d. Identify other methods to expand voluntary enhanced services for those who want and need support managing the IHSS program.

## **2M - Reduce Barriers to Accessing IHSS for Homeless Individuals**

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

### **Recommendations:**

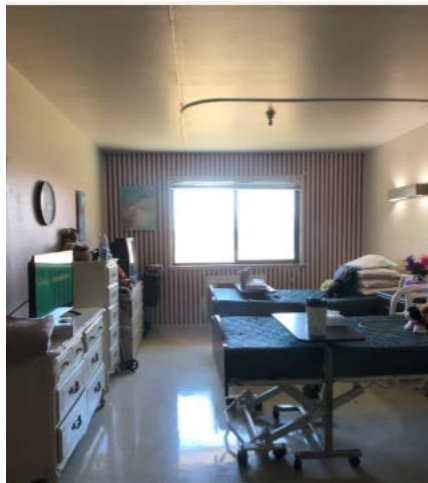
- 2M i: Reduce barriers to eligibility and retention for those experiencing homelessness and housing instability.
- 2M ii: Increase administrative flexibility to meet the needs of this population.
- 2M iii: Invest in innovative solutions.

## OBJECTIVE 3: AFFORDABLE LTSS CHOICES

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

### Public Comment



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

### **3A - Create LTSS Financing Program**

**Issue:** Californians of all ages and disabilities are at-risk of or forced to spend down assets to qualify for Medi-Cal in order to afford and access LTSS when the need arises. Middle income Californians pay out-of-pocket for most services and



supports, and many go without needed assistance for lack of funds. Just one example, the lifetime cost of Alzheimer's disease per person – a condition that impacts 670,000 Californians-- approaches \$350,000, the median home price in Sacramento, the state capitol.

**Recommendations:**

- 3A i: Encourage the California Health and Human Services Agency to partner with the State Treasurer as well as public and private stakeholders including but not limited to the Department of Insurance, the insurance industry, labor unions, advocates and academics to advance a statewide public LTSS benefit to help the “forgotten middle” avoid spending down to poverty when LTSS becomes a need.
- 3A ii: Utilize the actuarial study currently underway at the Department of Health Care Services to assess the feasibility of creating a statewide public LTSS benefit.
- 3A iii: Conduct focus groups to assess the public interest in and need for such a program, following the publication of the actuarial study.
- 3A iv: Codify the program into law, including an oversight and governance board.

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

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

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

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

**Recommendations:**

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

- 3B iii: Ensure statewide access to services in the home and community that meet the identified service and support needs of older adults and persons with disabilities.
- 3B iv: Initiate a top-to-bottom review of regulatory barriers to accessing HCBS. This review would include, but not be limited to, how quickly people can access a needed service, what existing regulatory flexibility exists or is needed to encourage innovation in how services are delivered at the local level, especially in rural communities, and barriers to expansion of services in the community.

### **3C - Explore New Funding Streams for LTSS Through Medicare**

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

#### **Recommendations:**

- 3C i: Work with federal partners to explore broadening the approach to LTSS financing, including mechanisms that promote inclusion of LTSS benefits in Medicare and the private Medicare insurance market.
- 3C ii: Maximize new opportunities to expand access to non-medical Medicare benefits through new opportunities provided by the Chronic Care Act that permit Medicare Advantage plans the flexibility to provide new non-traditional supplemental benefits.

## OBJECTIVE 4: HIGHLY VALUED, HIGH-QUALITY WORKFORCE

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



Maggie Marron-Edwards - Caregiver (Orange County)

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

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

#### **4A - Expand Workforce Supply and Improve Working Conditions**

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

##### **Recommendations:**

- 4A i: Establish a Direct Caregiver Workforce Development Task Force (" Task Force"), to be convened by the Labor & Workforce Development Agency. The Task Force will conduct research, assess public and private caregiver training and workforce development programs, expand apprenticeship programs, explore public-private partnerships and policy incentives for high-road employers, produce a blueprint for creating sustainable jobs, and implement demonstration projects to reach the goal of improving wages, working conditions, training, retention and care.
- 4A ii: Create and enforce comprehensive statewide workforce quality and safety standards for all businesses providing LTSS services in California, to be administered by the state. Quality standards must include wages, training and employee protections.
- 4A iii: Coordinate across state agencies and identify ways to streamline employee licensure, certification and registry,
- 4A iv: Invest in local, regional and statewide workforce development and career ladder training. This could include public education campaigns to attract employees to the field.

#### **4B - Strengthen IHSS Workforce Through Statewide Collective Bargaining**

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

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

##### **Recommendations:**

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

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

- 4B ii: Expand eligibility for Unemployment Insurance Benefits (UIB) to IHSS providers who are the spouse or parent of their client. Parent and spouse providers are the only IHSS providers currently carved out of this protection.
- 4B iii: Implement a voluntary certified, standardized, and paid training curriculum for IHSS providers that offers career pathways and opportunities for increased pay for workers, increases their capacities to deliver care for the growing population of clients with complex care needs, addresses retention of the current workforce and attracts the workforce needed to meet future demands.
- 4B iv: Require workforce training to be linguistically and culturally responsive and include topics such as declining cognitive and physical abilities, Alzheimer's and dementia related conditions and social isolation. It should also include a special focus on training people with intellectual/developmental disability (I/DD) to do all or some IHSS tasks.
- 4B v: Ensure that individuals who agree to work as IHSS providers are enrolled into the system and paid in a standardized and timely manner.
- 4B vi: Repeal statutes that require IHSS providers to pay for their criminal background check.
- 4B vii: Establish statewide policies on sexual harassment prevention and workplace violence prevention in the IHSS program.

#### **4C - Address Staffing Issues in Residential Settings**

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

##### **Recommendation:**

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

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

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

**Recommendations:**

- 4D i: Increase funding to reduce social worker caseloads, with additional reductions for social workers with consumers requiring a higher level of care coordination.
- 4D ii: Provide increased funding in counties for Public Health Nurses who are critical in working with county IHSS and Adult Protective Services (APS) staff to identify health-related issues, serve as liaisons with medical, dental and mental health providers, and help consumers access needed medical services and devices.

**4E - Build a Dementia Capable Workforce**

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

**Recommendations:**

- 4E i: Explore certification and career ladder programs to promote dementia specialization.
- 4E ii: Adopt the Dementia Care Practice Recommendations across all licensure categories.
- 4E iii: Restore the Alzheimer's Day Care Resource Center model to augment Adult Day Services expertise and extend it into the community.

**4F - Ensure a Linguistically and Culturally Responsive Workforce**

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

**Recommendation:**

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

**4G - Invest in LTSS Workforce Education & Training Strategies**

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

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

**Recommendations:**

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

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

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

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

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

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

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

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

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

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

**Recommendation:**

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

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

#### **4I - Paid Family Leave for All Working Caregivers**

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

#### **Recommendations:**

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



## OBJECTIVE 5: STREAMLINE STATE AND LOCAL ADMINISTRATIVE STRUCTURES



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

Natalie Franks, Adult Day Services Provider (Orange County)

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

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

**Issue:** Older adults and people with disabilities often struggle to access LTSS due to the fragmented arrangement of state and federally funded programs spanning 22 different departments. There is little data sharing and coordinated policy development focused on the needs, priorities, and experiences of individuals and their circles of support. This results in the inability to identify, plan, and effectively deliver services to Californians who need LTSS.

**Recommendation:**

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

**5B - Re-Organize State Departments**

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

**Recommendation:**

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

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

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

**Recommendation:**

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

## **5D - Explore Cross-Departmental Budgeting**

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

### **Recommendation:**

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

## Appendix - Acronyms and Definitions

AAA	Area Agencies on Aging are a public, joint powers, or private non-profit agency, designated by the state to address the needs and concerns of all older persons at the regional and local levels. AAAs are administered by the California Department of Aging and authorized under the federal Older Americans Act (OAA) and the Older Californians Act (OCA). Most of their funding comes through the OAA but the state contributes funds through the annual budget process. These services are available to individuals aged 60 and older across all income levels.
ADP	Adult Day Programs are licensed by the California Department of Social Services as group settings that are open for less than 24-hours and serve anyone 18 and older. Most funding is private pay but some long-term care insurance plans and local AAAs or Caregiver Resource Centers (CRCs) may also provide funding for out-of-home respite care.
ADRC	Aging and Disability Resource Connections assist individuals with disabilities and/or chronic conditions in accessing health care, medical care, social supports, and other LTSS. ADRCs offer enhanced information and referral, long-term care options counseling (one-on-one decision support across all networks), short-term service coordination (when there is an urgent need for support until a longer -term arrangement can be made), and access to information. ADRCs operate in eight counties.
ALW	The Assisted Living Waiver provides home and community-based services in two settings: Residential Care Facilities for the Elderly or in publicly subsidized housing, with services provided by a Home Health Agency. Eligibility is limited to Medi-Cal beneficiaries over the age of 21. Services include, but are not limited to, assistance with activities of daily living; health related services including skilled nursing; transportation; recreational activities; and housekeeping.
CRC	Caregiver Resource Centers provide information and referral, short-term counseling, respite care, education, training and support to families and caregivers of persons aged 21 and older with Alzheimer's disease, stroke, Parkinson's disease, multiple sclerosis, Traumatic Brain Injury and other disorders at eleven centers throughout the state. CRCs are administered by the Department of Health Care Services.

CBAS	Community Based Adult Services are Medi-Cal programs certified by the California Department of Aging and licensed as Adult Day Health Care (ADHC) facilities by the California Department of Public Health. Centers provide interdisciplinary health care and social services in a day-time group setting. Each center's multidisciplinary team of health professionals perform a comprehensive person-centered assessment of each participant to develop an individual plan of care. Required services include professional nursing; physical, occupational and speech therapies; mental health services; therapeutic activities; social services; personal care; nutritious meals and dietary counseling. Transportation is provided or arranged. CBAS is designed to support any adult over the age of 18 who qualifies because of complex chronic conditions that limit physical, cognitive or mental functioning. The goal is to delay or prevent institutionalization. CBAS is offered as a statewide Medi-Cal managed care benefit, although is not available in all communities (approximately 18 of 58 California counties have no CBAS).
HCBS	Home and Community-Based Services refers to services that are provided outside an institutional setting.
IHSS	In Home Supportive Services a federal, state, and locally funded program that provides in-home assistance to low-income adults who are over 65 years of age, blind, or disabled, and to children who are blind or disabled. Qualified recipients receive assistance with activities of daily living, including bathing, dressing, cooking, cleaning, grooming, and feeding. The IHSS program plays a significant role in helping people remain at home and avoid institutionalization and serves as a model of self-directed services. County social workers assess individuals using a standardized assessment to determine the need and then authorize service hours for the recipient. The consumer directs his/her services by deciding how, when, and in what manner IHSS services will be provided. IHSS is administered at the state level by the state Department of Social Services (through an interagency agreement with the Department of Health Care Services), and at the local level through county human services offices.
LTSS	LTSS includes a broad range of services delivered by paid providers and unpaid caregivers to people who have limitations in their ability to care for themselves. These limitations are due to a physical, cognitive, or chronic health condition that is expected to continue for an extended period. LTSS services can be provided in a variety of settings including at home, in the community, in residential care, or in institutional settings.

LTCO	The Long-Term Care Ombudsman Program investigates and endeavors to resolve complaints made by, or on behalf of, residents in long-term care facilities including nursing homes and assisted living facilities. The program seeks to advocate for the rights of all residents of long-term care facilities.
MSSP	Multipurpose Senior Services Program provides care management, adult day care, housing assistance, chore and personal care services (if the individual has used the allocated IHSS service hours), protective supervision, respite, transportation, meal services, social services and communication services for Medi-Cal eligible individuals over the age of 65 who meet clinical qualifications for nursing facility admissions. This waiver is administered by the Department of Aging.
NP	Nurse Practitioners are an advanced practice licensed nurse who is qualified to treat certain medical conditions without the direct supervision of a doctor.
PACE	<p>Program of All Inclusive Care for the Elderly is an integrated managed model providing Medicare and Medi-Cal covered benefits to eligible individuals who are age 55 or older, and who are certified to need nursing home care, but who are able to live safely in the community at the time of enrollment. The program is available in limited areas of the state. Required services include:</p> <ul style="list-style-type: none"> <li>• Medical care provided by a PACE physician</li> <li>• Adult day health care (nursing; meals; nutritional counseling; personal care physical/occupational/recreational therapies)</li> <li>• Home health care and personal care in the home</li> <li>• Prescription drugs</li> <li>• Social services</li> <li>• Medical specialty services, and hospital, plus nursing home care, when necessary</li> </ul>
RCFE	Residential Care Facility for the Elderly provide a special combination of housing, personalized supportive services, and 24-hour staff designed to respond to the individual needs of those aged 60 and above who require help with activities of daily living (ADLs). RCFEs are considered non-medical facilities, and are also referred to as Assisted Living Facilities, Memory Care, board and care homes, and are a component of Life Plan Communities (aka Continuing Care Retirement Communities, CCRCs). These senior housing options are non-institutional, home-like settings that promote maximum independence and dignity for each resident and encourage family

and community involvement. The Department of Social Services licenses and monitors RCFEs.

Regional Center Regional centers are a delivery system comprised of 21 centers covering the entire state with access to comprehensive services in the community by coordinating outreach, intake and assessment, preventive services, and case management/service coordination. In addition, regional centers develop, maintain, monitor, and fund a wide range of community-based services and supports.

SNF Skilled Nursing Facilities are inpatient health care facilities with the staff and equipment to provide skilled nursing care, rehabilitation, and other related health services to patients who have more complex care needs, but do not require hospitalization. The Department of Public Health provides oversight.

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