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

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

GOAL 2: LIVABLE COMMUNITIES RECOMMENDATIONS

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Table of Contents

MPA GOAL 2: LIVABLE COMMUNITIES – EXECUTIVE SUMMARY

Overview

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

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

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

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

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

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

Report Framework

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

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

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

Guiding Principles

This report is designed with the following guiding principles:

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

Recommendations

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

1. **Housing**
    - Increase the supply of affordable housing, using reliable data based on thorough measurement and assessment of the problem.
    - Prevent homelessness by keeping people housed with rental and mortgage assistance, and home modification.
    - Create and expand innovative solutions to housing older adults, such as shared housing programs, intergenerational housing, and service-enriched housing models.
2. **Accessible Transportation**
    - Expand and Improve Accessible Coordinated Transportation.
    - Implement Sound Planning and Policy Agenda.
    - Enhance Rural Services and Volunteer Programs.
3. **Parks and Public Spaces**
    - Address access by protecting and preserving funding for parks as part of our critical health infrastructure, and improve funding adequacy by creating new state-level grants, inclusive of age and equity in criteria.
    - Ensure state, county and local parks and recreation departments apply an age-friendly and culturally inclusive lens in park planning and programming.
    - Examine and adopt new methodologies in planning to improve quality, equity, and leverage parks innovations, informed by research and insights gleaned from ongoing monitoring.

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

4. **Social Participation**
    - Spearhead Action: Appoint and fund an "Engagement Czar" who is experienced in aging services.
    - Fight Ageism and Engage Talent: Strengthen the deployment of anti-ageism campaigns and capitalize on the sub-optimized treasure of age, experience, time and wisdom represented in workers, leaders, and volunteers.
    - Ensure Access and Honor Diversity: Enhance digital and physical accessibility in all counties in California, while honoring the tremendous variability in preferences for the amount and the type of social engagement individuals desire.
5. **Leadership**
    - Establish an interagency process similar to the Strategic Growth Council to prioritize and implement all Master Plan for Aging components.
    - Appoint a Cabinet member tasked with over all coordination, along with an Interagency Task Force on Aging and Disability with set goals.
    - California joins the Network of Age-Friendly States and Communities (NAFSC) and develops a statewide partnership for age-friendly communities and organizations to collaborate, exchange local best practices, and help the state ensure policies are appropriate and relate to community as well as state need.

Conclusion

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

> **Housing** provides the basic infrastructure that allows Californians to thrive, for older adults to live in and be engaged in communities that are race, gender and disability **equitable, age-friendly, dementia-friendly, and disability friendly**. Paired with affordable housing, accessible and affordable **transportation** allows community access at all stages of life.
>
> Every Californian must be able to actively participate in their communities through **civic and social engagement.** Paired with full access to health care, **parks and public spaces**, and work opportunities, we can advance the promise of a Livable California for All.

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

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

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

Background

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

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

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

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

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

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

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

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

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

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

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

Domains of Livability Framework

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

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

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

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

- Measure and assess the problem with reliable data.
- Increase the supply of affordable housing.
- Prevent and end homelessness by keeping people housed and end homelessness by helping people transition into permanent housing.
- Create and expand innovative solutions to housing older adults, such as shared housing programs and intergenerational housing models.
- Develop policy solutions to help redress racially explicit housing policies and their resulting discriminatory systems, and ensure equitable access to housing.
- Create and expand programs that help older adults stay permanently housed and allow them to age in place.

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

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

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

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

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

- Systemic statewide implementation of accessible coordinated transportation and mobility spanning the entire age/ability spectrum (local): Promote driver safety programs; expand the availability of accessible transit; increase community walkability; and improve accessibility to fixed route services, local/regional passenger rail, and other mass transit.
- Policy and Planning Imperatives (statewide): Ensure transportation system reflects the needs of older adults; create a CA coordinated transportation commission; measure impact and outcomes, etc.
- Rural Investments: Expand volunteer driver programs; expand RTAP; provide microtransit and flexible fixed route services.

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

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

- Protect and preserve funding for parks as part of our critical health infrastructure.
- Advance park design, planning, and programming that is culturally inclusive, dementia-friendly, disability-friendly, being diverse across the age and ability spectrum while eliminating disparities in older adult park use.
- Examine and adopt new methodologies in planning to improve quality, equity, and implement innovations.
- Improve parks and public space access and address funding adequacy.

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

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

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

- Intentionally age-integrate and foster intergenerational connections in public space, while increasing access to community colleges and workplace for older adults and people with disabilities.
- Implement a campaign to educate Californians about the diversity, value, and contributions of older people.
- Partner with counties and local partners to develop screening tools and interventions to detect social isolation and develop a coordinated, shared statewide platform mapping hot-spots and emerging needs in real time.

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

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

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

Tying It All Together

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

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

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

MPA GOAL 2: LIVABLE COMMUNITIES – HOUSING

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

Overview

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

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

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

The housing recommendations are designed around the following principles:

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

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

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

1. Background

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

[7] "SSI/SSP Grants Are No Match for California's Housing Costs," Scott Graves, January 2020. California Budget and Policy Center. https://calbudgetcenter.org/resources/ssi-ssp-grants-are-no-match-for-californias-housing-costs/.
[8] "Housing America's Older Adults 2019," Joint Canter for Housing Studies of Harvard University. 2019. https://www.jchs.harvard.edu/sites/default/files/Harvard_JCHS_Housing_Americas_Older_Adults_2019.pdf.

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

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

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

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

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

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

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

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

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[9] "Social Security Fact Sheet," U.S. Social Security Administration, 2019. https://www.ssa.gov/news/press/factsheets/basicfact-alt.pdf.
[10] "Out of Reach 2020: California," National Low Income Housing Coalition. https://reports.nlihc.org/oor/california.
[11] "Housing America's Older Adults 2019," Joint Canter for Housing Studies of Harvard University. 2019. https://www.jchs.harvard.edu/sites/default/files/Harvard_JCHS_Housing_Americas_Older_Adults_2019.pdf.
[12] "Housing America's Older Adults 2019: Data," Joint Canter for Housing Studies of Harvard University. 2019. https://www.jchs.harvard.edu/housing-americas-older-adults-2019.
[13] Ibid.
[14] "Housing America's Older Adults 2019," Joint Canter for Housing Studies of Harvard University. 2019. https://www.jchs.harvard.edu/sites/default/files/Harvard_JCHS_Housing_Americas_Older_Adults_2019.pdf.
[15] Ibid.
[16] Ibid.
[17] Ibid.
[18] Rothstein, Richard. The Color of Law: A Forgotten History of How Our Government Segregated America
[19] Taylor, Keeanga-Yamahtta. Race for Profit (Justice, Power, and Politics) The University of North Carolina Press.
[20] HOLC "Redlining" Maps: The Persistent Structure of Segregation and Economic Inequality
By Bruce Mitchell PhD., Senior Research Analyst and Juan Franco, Senior GIS Specialist, NCRC / March 20, 2018 / Research. https://ncrc.org/holc/.
[21] Ibid.

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

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

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

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

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

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

[22] "Examining the Black-white wealth gap." Kriston McIntosh, Emily Moss, Ryan Nunn, and Jay Shambaugh, February 27, 2020. https://www.brookings.edu/blog/up-front/2020/02/27/examining-the-black-white-wealth-gap/.
[23] Systematic Inequality: How America's Structural Racism Helped Create the Black-White Wealth Gap" By Angela Hanks, Danyelle Solomon, and Christian E. Weller February 21, 2018. https://www.americanprogress.org/issues/race/reports/2018/02/21/447051/systematic-inequality/
[24] "Racial Disparities Among Extremely Low-Income Renters," National Low-Income Housing Coalition, Apr 15, 2019. https://nlihc.org/resource/racial-disparities-among-extremely-low-income-renters
[25] Matthew Desmond, "Unaffordable America: Poverty, housing, and eviction" (Madison, WI: Institute for Research on Poverty, 2015), http://www.irp.wisc.edu/publications/fastfocus/pdfs/FF22-2015.pdf.
[26] "How Decades of Racist Housing Policy Left Neighborhoods Sweltering," Brad Plumer and Nadja Popovich, New York Times, Aug. 24, 2020. https://www.nytimes.com/interactive/2020/08/24/climate/racism-redlining-cities-global-warming.html.
[27] Ibid.
[28] Ibid.
[29] Ibid.
[30] Ibid.
[31] "2019 Greater Los Angeles Homeless Count Results," Los Angeles Homeless Services Authority, 2019. https://www.lahsa.org/news?article=557-2019-greater-los-angeles-homeless-count-results.
[32] Ibid.

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

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

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

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

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

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

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

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

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

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

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

[38] Ibid.

[39] Ibid.

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

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

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

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

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

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

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

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

Recommendations

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

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

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

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

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

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

[47] Ibid.

[48] Ibid.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

*Report to be completed Fall 2020.

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

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

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

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[59] Examples of programs include:
Los Angeles County Program 20: Ownership Housing Rehabilitation Assistance: http://planning.lacounty.gov/housing/program20
CAPABLE Program: https://nursing.jhu.edu/faculty_research/research/projects/capable/capable-faqs.html
Area Agencies on Aging Older Americans Act Title III B Funding: https://www.n4a.org/Files/DataReport-Home-mod-508.pdf

[60] California Roadmap HOME 2030. https://roadmaphomeca.org/.

[61] Federal Rental Assistance Fact Sheets. Center on Budget and Policy Priorities. December 2019. https://www.cbpp.org/research/housing/federal-rental-assistance-fact-sheets#CA.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[72] "Digital gap between rural and nonrural America persists," Pew Research Center, May 31, 2019. https://www.pewresearch.org/fact-tank/2019/05/31/digital-gap-between-rural-and-nonrural-america-persists/

[73] Examples of public and private partnerships:
https://www.caregiver.org/internet-services-low-income-adults
https://corporate.comcast.com/covid-19
https://www.abc10.com/article/news/health/coronavirus/free-wifi-hotspots/103-8002bb36-b9f8-4c32-8801-7da31bfb8449

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

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

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

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

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

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

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

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

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

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

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

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

[74] "SASH Vermont Overview" https://sashvt.org/learn/.
[75] "Research Summary: Support and Services at Home (SASH) Evaluation: Highlights from the First Four Years," HHS Office of the Assistant Secretary for Planning and Evaluation, Office of Disability, Aging and Long-Term Care Policy, July 2017. https://aspe.hhs.gov/system/files/pdf/257926/SASH4hl-rs.pdf.
[76] Ibid.
[77] Ibid.
[78] Ibid.
[79] Ibid.
[80] Ibid.
[81] Ibid.
[82] "Vermont All-Payer ACO Model," Centers for Medicare and Medicaid Services. https://innovation.cms.gov/innovation-models/vermont-all-payer-aco-model.
[83] Support and Services at Home (SASH) Evaluation: Highlights from the Evaluation of Program Outcomes from 2010 to 2016," HHS Office of the Assistant Secretary for Planning and Evaluation, Office of Disability, Aging and Long-Term Care Policy, July 2019. https://aspe.hhs.gov/system/files/pdf/262061/SASH5hl-rs.pdf.
[84] Ibid.
[85] Ibid.
[86] Ibid.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3.5.3. Benefits of an Integrated Care at Home Demonstration:

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

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

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

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

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

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

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

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

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

[102] Ibid.

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

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

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

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

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

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

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

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

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

4.1.5. Total number of shared housing units.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MPA GOAL 2: LIVABLE COMMUNITIES – ACCESSIBLE TRANSPORTATION

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

Overview

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

Accessible transportation recommendations fall into the following key areas:

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

Adoption of these recommendations will:

- Transform and create a transportation system that is accessible and designed around the rider, not designed for the ease of the system
- Mitigate decades of underinvestment and unfulfilled policies in transportation/services for the population of older persons and those with disabilities, particularly minority populations
- Increase safety and support health
- Address identified needs statewide
- Bring an end to accessible transportation issues being regarded separately and unequally relative to every other mode of transportation
- Increase cost effectiveness and other systemic improvements

Background

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- Mitigate decades of underinvestment
- Increase safety (i.e., health and well-being)
- Address identified needs statewide
- Bring an end to accessible transportation issues being regarded separately and unequally relative to every other mode of transportation
- Increase cost effectiveness and other systemic improvements implementation of increased coordination through the Consolidated Transportation Services Agencies (CTSA) model will produce[116]:
    1. Significant reductions in service costs
    2. Greater amount of available transportation
    3. Higher quality service by improvements in coordination and safety
    4. Access to increased funding by reducing duplication and silos
    5. Creation of a one-stop shop for finding local transportation options

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

Recommendations

1. Expand and Improve Accessible Coordinated Transportation

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

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

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

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

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

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

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

a. Promote Driver Safety Programs

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

- Create a Referral Program Between DMV & California Highway Patrol & Transportation Ambassadors. Using the options counseling approach, a locally designated Transportation Ambassador can work with individuals and family members to review transportation options available in the community, and develop a training program or referral process that best fits the needs of the individual transitioning from driving their own car to accessing other options.
- Promote driver participation in safety programs like CHP "Car-Fit" and AARP Driver Safety Program, and other similar courses designed to enable older adults to retain their ability to drive safely in their own vehicles.

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

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

b. Improve Community Walkability

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

- Install pedestrian islands at intersections.
- Remove artificial barriers between businesses, housing & services, designed to discourage easily moving from one vendor to another.
- Amend the Government Code to require local jurisdictions to 1) circulate capital improvement plans, or other lists of significant public works to the local CTSA, 2) circulate general/specific plans to the local CTSA, and 3) respond to comments from the CTSA whose goal it is to ensure that local planning infrastructure investment incorporate accessible transportation issues.
- Establish a Vulnerable Road User (VRU) Law[119]: VRU laws provide legal protection to older adults walking on roads and sidewalks.
- Increase funding to the California Active Transportation Program (CATP) and provide legislative direction and support to more efficiently and equitably administer the program: State agencies, such as Caltrans, are charged with fulfilling the ATP objectives of N-19-19, have concerns with adequate staffing and resources. Legislation providing additional funding and direction can assist.
- Give cities and local transportation agencies the ability to lower speed limits on roads within their jurisdiction and direct the California Department of Transportation (Caltrans) to eliminate the 85th percentile rule in speed-limit setting: The 2019 Zero Fatalities Task Force Report contains further details on these two specific proposals, including extensive research on the ineffectiveness of the 85th percentile rule.

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

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

- Provide free rides for older adults and people with disabilities during off-peak hours.
- Provide safe and comfortable places to wait for the bus - benches, shelters to protect from rain and sun.
- Design transit stops in front of stores, rather than bordered by large parking lots. Or, as an alternative within existing malls, parking lots, etc., create driverless shuttles to take shoppers from the front door to bus stops. These systems solve the challenge of navigating a large parking lot between the store and the main roadway where buses are boarded.
- Adjust transit design to match changes in the shopping habits and evolution of shopping technologies
- Commission a California Vehicle Economy study: Conducted via a collaboration of research universities and state agencies, with the goal of providing a clearer financial assessment of the direct and indirect costs that California taxpayers pay per year to subsidize car-centric transportation infrastructure.

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

2. Implement Sound Planning and Policy Agenda

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

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

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

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

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

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

2.6. Evaluate effectiveness and adjust:

- CTSA statutes: Ensure the creation, effectiveness, pervasiveness, and stability of CTSAs.
- Funding levels and policies: Funding, disbursement formulas, eligible activities, maintenance of effort, should be continually analyzed for effectiveness and to ensure service deficiencies are addressed with an unrelenting focus on issues of equity, age, race, cultural, etc.
- Oversight structure: Internal/External meta-review of oversight effectiveness.

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

3. Enhance Rural Services and Volunteer Programs

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

3.1. Expand Volunteer Driver Programs: Volunteer driver programs can be extremely effective in meeting the needs of older adults, especially in rural areas where service needs are episodic. To meet these needs, fund the Senior Volunteer Program121 described in Older Californians Act (OCA), which would also augment volunteer-based programs like Health Insurance Counseling and Advocacy Program, Ombudsman, TCE/VITA, Meals on Wheels, etc. Provide a baseline level of funding so that rural communities receive enough of an allocation to provide adequate program infrastructure and produce successful services.

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

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

Summary

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

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

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

MPA GOAL 2: LIVABLE COMMUNITIES - PARKS AND PUBLIC SPACES

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

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

1. Overview

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

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

Benefits of Parks and Open Spaces

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

1.1. Parks for ALL

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

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

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

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

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

1.2. Park and Public Space Access

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

1.3. Park Equity

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

1.4. Park Design, Planning, and Programming

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

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

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

Recommendations

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[133] Urban green spaces: a brief for action. World Health Organization, Regional Office for Europe. 2017.; Greater London Authority, European Federation of Green Roof and Green Wall Associations, and Livingroofs.org. Living Roofs and Walls, from policy to practice. 10 years or urban greening in London and beyond. 2019

MPA GOAL 2: LIVABLE COMMUNITIES – ENGAGEMENT, SOCIAL ISOLATION, SOCIAL INCLUSION

Overview

As longevity reshapes the distribution of age in the population, California is changing irrevocably. More generations than ever in history are alive at the same time. Families *routinely* include four and five generations. Workforces include workers spanning five and six birth cohorts, all the while the ethnic, racial, and religious diversity of the population grows ever richer[134].

Viewed through the lens of social resources, diverse multigenerational societies can be better societies than we have ever known.[135] The challenge is to optimize the complementarity of strengths and vulnerabilities at different life stages and across segments of society with the aim of improving quality of life for all. While the current state of the state falls short, the potential to bring all Californians together as a vibrant and compassionate community is enormous.

At the same time California becomes an aging society, it will become a minority/majority state. Evolving models of social strength stand to benefit from the diversity of California's population, the practices of immigrant populations, lessons from affinity communities, and wide-ranging cultural norms. The richness of a population that includes Hispanics, Asian/Pacific Islanders, African-Americans, immigrants, and refugees has much to teach about filial piety, traditions, customs, and languages, as well as households that include multiple generations where younger people help elders and elders care for grandchildren. These traditions give elders a role in supporting their families and being cared for. Just as sure, the pandemic has revealed vulnerabilities in multigenerational families and the risk of social isolation. We must examine and understand the impact of the pandemic and how we can strengthen traditional intergenerational ties post-pandemic.

With sustained attention and deliberative planning, we can intentionally create and elevate environments where older people are valued, contributing, and socially connected as family members, employees, volunteers, mentors, and life-long learners of all abilities, races, religions, ages, and identities. Proximity is a powerful predictor of friendships, shared values, and collective actions.[136] Age segregation contributes to stereotyping, competition, and isolation. [137]Thus, whether in homes, workplaces, recreational areas, neighborhoods, or civic centers, Californians must be fully integrated into the social fabric of life. Age-integration must be achieved in all realms of life and age-discrimination must be eliminated.

[134] Gonzales E, Matz-Costa C and Morrow-Howell N (2015) Increasing opportunities for the productive engagement of older adults: a response to population aging. *The Gerontologist* 55(2): 252-261.

[135] Carr DC, Fried LP and Rowe JW (2015) Productivity & Engagement in an Aging America: The Role of Volunteerism. *Daedalus* 144(2): 55-67, Morrow-Howell N and Greenfield EA (2016) Productive engagement in later life. *Handbook of aging and the social sciences*. Elsevier, pp.293-313.

[136] Borgatti SP, Mehra A, Brass DJ, et al. (2009) Network analysis in the social sciences. *Science* 323(5916): 892-895, Eagle N, Pentland AS and Lazer D (2009) Inferring friendship network structure by using mobile phone data. *Proceedings of the National Academy of Sciences of the United States of America* 106(36): 15274-15278, Festinger L, Schachter S and Back K (1950) *Social pressures in informal groups; a study of human factors in housing.* Oxford, England: Harper.

[137] Hagestad GO and Uhlenberg P (2006) Should We Be Concerned About Age Segregation?:Some Theoretical and Empirical Explorations. *Research on Aging* 28(6): 638-653, Portacolone E and Halpern J (2016) "Move or Suffer": Is Age-Segregation the New Norm for Older Americans Living Alone? *Journal of Applied Gerontology* 35(8): 836-856.

Today's older Americans remain a largely untapped resource. Age-related increases in practical knowledge about life,[138] emotional resilience, [139] and prosocial inclinations,[140] point to the potential for improving society by actively integrating older people into communities and deploying their talents to help others and address broad societal challenges. Despite scores of effective programs such as the AARP Experience Corps[141], the Foster Grandparent program(Corps)[142], RSVP[143], EnCorps STEM Teachers Program[144], and Encore.org's Encore Fellowship program[145], such programs operate largely independently, face persistent funding challenges, and are subsequently constrained in their reach. Most older people do not participate in the paid workforce[146] and only a minority of older people volunteer.[147] All the while, many older people report feeling underutilized,[148] most perceive discrimination,[149] and a significant minority are extremely socially isolated.[150]

A substantial number of older people also lag behind in the adoption of technology that can promote connection and engagement. A recent Pew study found that only 73 percent of people over 65 use the Internet[151]. Internet use, access to home broadband and smart phone ownership is even more limited among those ages 75 and up[152]. Expanding digital access and literacy is critical to reducing social isolation and giving older people access to services that will increasingly be made available primarily online.

The ways that older people are viewed and engaged has well-documented effects on physical health, cognitive functioning, and well-being. Studies show that ageism has negative effects on cognitive performance.[153]Social isolation

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[138] Grossmann I, Na J, Varnum ME, et al. (2013) A route to well-being: intelligence versus wise reasoning. *Journal of Experimental Psychology: General* 142(3): 944-953.

[139] Carstensen LL, Turan B, Scheibe S, et al. (2011) Emotional experience improves with age: Evidence based on over 10 years of experience sampling. *Psychology and Aging* 26: 21-33, Charles ST and Carstensen LL (2010) Social and emotional aging. *Annual Review Psychology* 61: 383-409.

[140] Beadle JN, Sheehan AH, Dahlben B, et al. (2015) Aging, empathy, and prosociality. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences* 70(2): 215-224, Raposo S, Hogan CL, Barnes JT, et al. (2020) Leveraging goals to incentivize healthful behaviors across adulthood. *Psychology and Aging*. Epub ahead of print 2020/07/07. DOI: 10.1037/pag0000428, Sze JA, Gyurak A, Goodkind MS, et al. (2012) Greater emotional empathy and prosocial behavior in late life. *Emotion* 12(5): 1129-1140.

[141] AARP Foundation *A Triple Win for Students, Volunteers and Schools*. Available at: https://www.aarp.org/experience-corps/.

[142] Corps AS *Foster Grandparents*. Available at: https://www.nationalservice.gov/programs/senior-corps/senior-corps-programs/fostergrandparents.

[143] Retired Senior Volunteer Program (RSVP) Available at: https://local.aarp.org/volunteer-detail/rsvp-retired-senior-volunteer-program-volunteer-wa-131867.html

[144] EnCorps Available at: https://www.encorps.org/about.

[145] Encore.org Available at: https://encore.org/

[146] Bureau of Labor Statistics U.S. Department of Labor (2019) *Labor force participation rate for workers age 75 and older projected to be over 10 percent by 2026*. Available at: https://www.bls.gov/opub/ted/2019/labor-force-participation-rate-for-workers-age-75-and-older-projected-to-be-over-10-percent-by-2026.htm.

[147] Bureau of Labor Statistics U.S Department of Labor (2015, February 25) *Volunteering in the United States-2014*.

[148] Anderson GO, AARP Research (2020, January) Underemployment in Midlife and Older Workers. DOI: 10.26419/res.00344.001, Dixon AL (2007) Mattering in the Later Years: Older Adults' Experiences of Mattering to Others, Purpose in Life, Depression, and Wellness. *Adultspan Journal* 6(2): 83-95.

[149] Kita J, AARP (2019, December 30) *Workplace Age Discrimination Still Flourishes in America* Available at: https://www.aarp.org/work/working-at-50-plus/info-2019/age-discrimination-in-america.html , Wilson DM, Errasti-Ibarrondo B and Low G (2019) Where are we now in relation to determining the prevalence of ageism in this era of escalating population ageing? *Ageing Res Rev* 51: 78-84.

[150] Cudjoe TKM, Roth DL, Szanton SL, et al. (2020) The Epidemiology of Social Isolation: National Health and Aging Trends Study. *The Journals of Gerontology: Series B* 75(1): 107-113.

[151] Pew Research Center (2019, June 12) *Internet Broadband Fact Sheet*. Available at: https://www.pewresearch.org/internet/fact-sheet/internet-broadband/.

[152] Center PR (2017, May 17) *Technology Adoption Climbs Among Older Adults*. Available at: https://www.pewresearch.org/internet/2017/05/17/tech-adoption-climbs-among-older-adults/.

[153] Barber SJ, Hamel K, Ketcham C, et al. (2020) The effects of stereotype threat on older adults' walking performance as a function of task difficulty and resource evaluations. *Psychology and Aging* 35(2): 250-266, Barber SJ and Mather M (2013) Stereotype threat

heightens the risk of morbidity and premature death.[154] On the other hand, research on intergenerational connectivity attests to benefits for young and old alike.[155]). Nearly three decades ago, Johns Hopkins conducted a multiyear program that was rigorously implemented and studied to evaluate the impact of cross generational programming to see both the impact on the well-being of older adults living on modest resources and elementary school aged children. The results were impressive. Older volunteers displayed improved well-being, physical strength, and cognitive performance while academic and behavioral performance improved in the children.

An intergenerational theme of social activity, connectedness, interaction and interdependency is a likely antidote to undesired isolation and loneliness.[156] Although in many cultures intergenerational homes are more the norm, in California supporting communities to increase intergenerational connection has not been a part of policy, design, funding or programming. Yet the possibilities are great. Taking a strength-based approach to support healthy and desired interconnectedness rather than age silos can help reweave the fabric of a multifaceted community to manifest social reciprocity, human connectivity, visibility, and personhood. Increasing connections among the generations can not only improve the lives of individuals but also strengthen the community overall and increase its resiliency.

The existing narrative of older adults as economic drains is not only ageist, it fails to recognize that older adults are huge drivers of the economy. In 2018, nationwide economic and societal contributions of adults age 50 plus was worth over $9 trillion, and 44% of all jobs were held or created by people age 50 plus. The nationwide economic value of the contributions of adults age 50 and older through unpaid activities like adult caregiving, child caregiving, and volunteering was $744.6 Billion. Recognizing the economic and societal value of older adults should be part of efforts to reframe the aging conversation to support efforts combating ageism.[157]

We maintain that California stands to gain from activating the rich resource represented in aging populations and supporting those who are vulnerable. Optimizing social determinants of health leads to higher functioning, improved communities, and longer lives. Importantly, it also entails cost savings. Ignoring them is costly. One program called "Togetherness" created by CareMore for Medicare beneficiaries evaluated the impact of a 2017 program of 1000 enrolled participants[158]. The study showed a 3.3% reduction in emergency department use over 12 months as well as a 20.8% lower experience in hospitalizations in the enrolled population. Because many of those enrolled were eligible for both state and federal medical coverage it is clear there would be outright savings accrued to both levels of government if further focus and programming were extended to larger populations.

Indeed, California could serve as a model for other states around the country facing the challenges and opportunities of

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can both enhance and impair older adults' memory. *Psychological Science* 24(12): 2522-2529, Tan SC and Barber SJ (2020) Confucian Values as a Buffer Against Age-Based Stereotype Threat for Chinese Older Adults. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences* 75(3): 504-512.

[154] Berkman LF and Syme SL (1979) Social networks, host resistance, and mortality: A nine-year follow-up study of alameda county residents. *American Journal of Epidemiology* 109(2): 186-204, Pantell M, Rehkopf D, Jutte D, et al. (2013) Social Isolation: A Predictor of Mortality Comparable to Traditional Clinical Risk Factors. *American Journal of Public Health* 103(11): 2056-2062, Steptoe A, Shankar A, Demakakos P, et al. (2013) Social isolation, loneliness, and all-cause mortality in older men and women. *Proceedings of the National Academy of Sciences of the United States of America* 110(15): 5797-5801.

[155] Newman S and Hatton-Yeo A (2008) Intergenerational learning and the contributions of older people. *Ageing horizons* 8(10): 31-39, Parisi JM, Rebok GW, Carlson MC, et al. (2009) Can the Wisdom of Aging be Activated and Make a Difference Societally? *Educ Gerontol* 35(10): 867-879, Young TL and Janke MC (2013) Perceived Benefits and Concerns of Older Adults in a Community Intergenerational Program: Does Race Matter? *Activities, Adaptation & Aging* 37(2): 121-140.

[156] Riley MW and Riley JW, Jr. (2000) Age integration: conceptual and historical background. *The Gerontologist* 40(3): 266-270.

[157] *AARP specific report on the economic impact of age discrimination*. Available at: https://www.aarp.org/content/dam/aarp/research/surveys_statistics/econ/2020/impact-of-age-discrimination.doi.10.26419-2Fint.00042.003.pdf, reference LORf Available at: https://www.aarp.org/content/dam/aarp/research/surveys_statistics/econ/2019/longevity-economy-outlook.doi.10.26419-2Fint.00042.001.pdfhttps://www.aarp.org/content/dam/aarp/research/surveys_statistics/econ/2019/longevity-economy-outlook.doi.10.26419-2Fint.00042.001.pdf.

[158] AJMC Available at: https://www.ajmc.com/view/efforts-to-target-loneliness-reap-health-benefits-caremore-finds

growing longevity and profound demographic shifts. Achieving this aim, however, will require a commitment to full inclusion and participation of older people into communities, neighborhoods, and local and state leadership positions. Key barriers to realizing a high functioning multigenerational society include age segregation, ageism, and challenges in effectively reaching older people, especially in low-income and rural areas.

Recommendations

We endeavor to mold a multigenerational society that maximizes strengths and builds resilience and capacity that is also able to support and care for those with vulnerabilities when they emerge. We recommend the following:

Recommendation for Immediate and Short-Term (0-3 Years) Action:

1. **Spearhead Action:** Appoint and fund an "Engagement Czar" (EC) who is experienced in aging services, knowledgeable about strengths and vulnerabilities related to aging, deeply connected to related communities, and passionate about dismantling ageism and promoting the inclusion of older Californians in all domains of life. The overarching charge is to create ways to encourage organic multigenerational integration and support and encourage social innovations, private and public partnerships, while creating opportunities for culture change.

   The appointee will oversee the implementation of Recommendations 2 through 5 and coordinate new efforts with ongoing community, state, and national programs that share compatible aims. The appointee will monitor efforts to influence the social determinants of health throughout the life course (see Goal 3) and will work closely with the Research Subcommittee to monitor the effects of changes put in place and estimate cost savings that accrue in response to the implementation of the MPA. In particular, the EZ will ensure that all recommended pursuits address equity by race, ethnicity, ability, identity, and religion**.**

   The EZ will support and evaluate the goals outlined below, while coordinating and expanding programs aimed at social engagement; including deploying a statewide social media education campaign to reduce ageism.

2. **Engage Talent:** Capitalize on the sub-optimized treasure of age, experience, time and wisdom represented in workers, leaders, and volunteers.

   2.1. Scale and lift effective organizations like Encore.org[159] to adapt their efforts to California and expand their reach state-wide.[160]

   2.2. Develop programs that will engage older adults to participate in paid and unpaid work through tax incentives, public recognition, and volunteer stipends—such as a statewide intergenerational service corps.[161]

   2.3. Build on employer incentives to recruit and retain older workers.

   2.4. Conduct qualitative and quantitative research in low income neighborhoods to identify needs of and contributions made by older residents**.**

   2.4.1. Establish and make widely available training for formal and informal volunteers.

   2.4.2. Increase educational access for older people through community college courses, university-based programs. Examples include the Distinguished Careers Institute at Stanford[162], and online learning approaches e.g., Getsetup.com[163] Encourage California universities to endorse and adhere to the

[159] Encore.org Available at: https://encore.org/
[160] Halvorsen C and Emerman J (2013) The encore movement: Baby boomers and older adults can be a powerful force to build community. *Generations* 37(4): 33-39.
[161] Gonzales E, Matz-Costa C and Morrow-Howell N (2015) Increasing opportunities for the productive engagement of older adults: a response to population aging. *The Gerontologist* 55(2): 252-261.
[162] Stanford *Distinguished Careers Institute*. Available at: https://dci.stanford.edu/.
[163] GetSetup Available at: https://www.getsetup.io/.

principles of Age Friendly[164] University Global Network.

3. **Alleviate Isolation:** Reduce social isolation through a range of screening tools and grassroots efforts to detect and reduce loneliness.
    - **3.1.** In partnership with counties and designated local partners**, develop a coordinated shared statewide platform** to map hot-spots of needed focus (e.g., rural communities) and tailor interventions to increase engagement and improve mental health.
    - **3.2. Identify and study communities where isolation is uncommon** with the aim of identifying effective prototypes and models of social integration.
    - **3.3. Identify, implement, and elevate grassroots efforts** to engage with and assist elders, such as community members who regularly serve older adults, e.g., barbers and hairstylists, church members. Enlist community members to detect abuse, identify depression, isolation, loneliness, and cognitive decline, as well as distribute information about resources such as information on telehealth and organizations like Front Porch.[165]
    - **3.4.** F**orm partnerships with private sector companies,** such as Wider Circle[166], that connect neighbors to one another through the formation of small groups that encourage neighborhood support and reduce loneliness with the aim of improving health outcomes.
4. **Fight Ageism:** Strengthen the deployment of anti-ageism campaigns**.**
    - **4.1. Because ageism contributes** to essentially all of the barriers to full age integration it demands comprehensive actions across agencies, departments, universities, and organizations.
    - **4.2. Leverage and contribute** to dissemination of Age On, Rage On[167], Disrupt Aging[168] to strengthen collective efforts.
    - **4.3. Model the Older Women's League** (OWL) and the Gray Panthers who fight ageism and sexism by united young and old in advocacy.
5. **Ensure Access:** Enhance digital and physical accessibility in all counties in California.
    - **5.1. Make digital access broadly available** for all older Californians, including statewide broadband, devices that accommodate sensory limitations, and training in digital literacy, and provide special content about topics ranging from fraud detection to app-based transportation services. Partner with nonprofits such as the National Digital Inclusion Alliance169, the California Emerging Technology Fund[170,] Older Adults Technology Services[171] and Televisit[172] to develop digital access and literacy strategies. Work with libraries that serve older adults and with community service programs at schools and universities to provide intergenerational technology tutoring.
    - **5.2. Utilize existing infrastructures** for multigenerational opportunities, studying existing resources from an available time perspective, in addition to envisioning better use of locations. Utilize spaces like schools and

[164] The Gerontological Society of America Available at: https://www.geron.org/programs-services/education-center/age-friendly-university-afu-global-network.
[165] Hollister B (2013, December) *Model e-Health Community for Aging Executive Summary* Available at: http://fpciw.org/wp-content/uploads/sites/15/2016/05/MeHCA-UCSF-Final-Report.pdf.
[166] Wider Circle Available at: https://www.widercircle.com/.
[167] Age On. Rage On. Available at: https://ageonrageon.com/latest-news/.
[168] AARP Disrupt Aging *The End of Anti-Aging with Allure: Beauty for the Ages*. Available at: https://www.aarp.org/disrupt-aging/.
[169] National Digital Inclusion Alliance Available at: https://www.digitalinclusion.org/join/.
[170] California Emerging Technology Fund Available at: http://www.cetfund.org.
[171] Older Adults Technology Services Available at: https://oats.org.
[172] Televisit Available at: http://www.televisit.org.

day programs for evening and weekend activities.

5.3. **Remove legal and regulatory** barriers to allow for more seamless access to multiuse spaces.

6. **Honor Diversity: Honor the tremendous variability in preferences for the amount and the type of social engagement individuals desire.**

6.1. **Acknowledge cultural diversity and tailor opportunities** for social engagement to cultural preferences, values, and traditions.

6.2. **Accommodate the range of physical and mental abilities** represented in the population and ensure access for the full range in programs and opportunities.

6.3. **Provide a wide range of opportunities for activities** that include individual as well as group socialization and virtual as well as in-person contact.

6.4. **Age integrate senior centers** with day care centers along with family resource centers.

6.5. **Reimagine the role of libraries** as community centers that can serve as hubs for community programming so that connections across generations develop organically.[173]

6.6. **Support 55-plus communities**, such as Beacon Hill[174] [175]and the Villages176, as well as other opportunities for older adult gatherings so that a range of preferences for age integration can be honored.[177]

6.7. **Scale and expand programs like PAWS** [178] which provide companionship and support with animals for people who prefer furry friends to other people.

Summary

We are at an inflection point where we have both the opportunity and need to reassess and renew ways to maximize fuller participation of Californians at all stages of life. We must seize the opportunity to uncover and deploy the assets of all persons, especially older adults who have long been invisible for what they can contribute. Integrating older peoples' contributions will strengthen society and increase formal and informal support for older people when needs arise. Preparing for and purposefully building an interdependent society that invests in well-being throughout the life cycle can build reserves in both individuals and communities that can be tapped during periods of need and disability.

A Master Plan for Aging that successfully removes barriers to engagement, prevents social isolation, and fosters inclusion can reweave the fabric of increasingly multigenerational society. To do so, we must invest in a cultural shift that intentionally engages and makes more visible the assets of older adults into all aspects of the community. We must engender a sense of belonging, purpose, and worth for all Californians inclusive of all races, ethnicities, identities, ages, and abilities and find ways to organically support those who are vulnerable

[173] James R (2018, October 8) *Libraries as community hubs*. Available at: https://socialhistory.org.uk/shs_exchange/libraries-as-community-hubs/, Ng Y (2020) Finding fertile ground in libraries for intergenerational dance. In: M. Kaplan LLT, M. Sánchez, & J. Hoffman (ed) *Intergenerational Contact Zones: Place-based Strategies for Promoting Social Inclusion and Belonging*. Routledge, Sabo Robin M (2017) Lifelong learning and library programming for third agers. *Library Review* 66(1/2): 39-48.
[174] Beacon Hill Village Available at: https://www.beaconhillvillage.org/content.aspx?page_id=22&club_id=332658&module_id=344865.
[175] McWhinney-Morse S (2009) Beacon hill village. *Generations* 33(2): 85-86.
[176] The Villages Available at: https://www.thevillages.com/about-us.
[177] Poor S, Baldwin, C., & Willet, J. (2012) The Village movement empowers older adults to stay connected to home and community. *Generations* 36(1): 112-117.
[178] Stanford Medicine *Scope 10K*. Available at: https://scopeblog.stanford.edu/2017/09/06/paws-stanford-medicines-therapy-dogs-program-turns-20/, ibid.

MPA GOAL 2: LIVABLE COMMUNITIES – STATEWIDE LEADERSHIP

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

Overview

Simply stated, a Livable California for All cannot be realized without a strong, enduring commitment from statewide leadership at all levels, led by the Governor's Office, with the full support of all state departments and agencies, all elected offices, and the legislature.

In the United States, tens of millions of people in their 50s, 60s, 70s and 80s are leading longer, healthier, more productive lives. Currently, 10,000 people turn 65 each day, and that trend will continue for about 15 years. By 2050, people 65 and over will outnumber children 15 and under for the first time in history.

California's population is also aging rapidly. Today, more than 20% of the population is over 65, or nearly 1 in 5 people. The California Department of Finance projects that in 2030, those over age 50 will be nearly 15.5 million or nearly 37% of the total population projection of 42.2 million. (Source: California Department of Finance).

California must prepare for this new aging reality. Each of its 58 counties and 482 cities must also meet the needs of an increasingly diverse and multigenerational older adult population by taking measurable steps toward becoming more age-friendly and by advancing efforts to create livable communities for all Californians.

A livable community is one that is safe and secure, has affordable and appropriate housing and transportation options, and offers supportive community features and services. Once in place, those resources enhance personal independence, allow residents to age in place, and foster residents' engagement in the community's civic, economic, and social life.

In a Livable California for All, people of all ages and abilities, in all communities, can safely go for a walk, cross the streets, ride a bike, get around without a car, work or volunteer, enjoy public places, socialize, spend time outdoors, be entertained, go shopping, buy healthy food, find the services they need—and make their city, town or neighborhood a lifelong home. [179]

1.1. Gubernatorial Leadership must be front and center in leading the implementation of the MPA.

The Master Plan for Aging provides an historic opportunity to design, develop and deliver a true Livable California for All that will serve as a blueprint for the state and local communities, as called for in the Executive Order that created the Master Plan for Aging. The Governor must be in the forefront, modeling state government commitment and stewardship, and ensuring full implementation of the Master Plan for Aging's recommendations.

California lacks a coordinated, interdisciplinary mechanism to manage and oversee all pieces necessary for the complete implementation of the Master Plan for Aging goals. An intergovernmental process is one way to prioritize Master Plan for Aging recommendations. California already demonstrated its long-term willingness to prioritize critical issues using an intergovernmental process. Two examples are the state's focus on Climate Change (Strategic Growth Council) and Health Equity (Health in All Policies), both of which utilize this intergovernmental process. Similarly, led by the Governor, California can establish a long-term commitment to the Master Plan for Aging that ensures direct oversight by the office of the Governor while also delegating responsibility for implementing the sections of the Master Plan for Aging to the appropriate agency secretaries and department directors.

To accomplish the goals of the Master Plan for Aging, the Governor should appoint a Cabinet member tasked with over-all coordination, along with an Interagency Task Force on Aging and Disability, appointed by the

[179] The AARP Network of Age-Friendly States and Communities. https://www.aarp.org/livable-communities/network-age-friendly-communities/

Governor, with set goals. It should include all departments whose work touches on the Network of Age-Friendly States and Communities' domains of livability[180], including but not limited to the California Health & Human Services Agency (and all departments therein), the Department of Housing and Community Development, Caltrans, and the Department of Consumer Affairs, amongst others. This effort should also include the active engagement of all pertinent elected offices (Education, Insurance, Secretary of State, the Attorney General, State Treasurer and State Comptroller).

1.2. **The Legislature, private entities and private philanthropy must play a role.** All systems and programs examined under the Master Plan for Aging are impacted by much broader issues across the state and local agencies. They require the engagement of the Legislature along with the public and private sectors**.**

Recommendations

2. Recommendations for Immediate and Short-Term Action

2.1. **Establish a cabinet level position.** The Governor will establish a cabinet level position to provide sustained oversight and coordination of the Master Plan for Aging across all sectors and to ensure successful implementation, collaboration and cooperation across departments.

2.2. **Establish an inter-departmental collaboration model.** The Governor and the legislature will work together to establish an inter-departmental collaboration model similar to the Strategic Growth Council. This entity will be tasked with coordinating and working collaboratively with public agencies, communities, private entities, and stakeholders to achieve the goals of the Master Plan for Aging across all domains of livability including the dementia-friendly domains.

2.3. **Appoint an Engagement Czar.** The Director of the Department of Aging will appoint an Engagement Czar who be tasked to coordinate efforts, identify gaps, and advance progress within the social isolation/participation goals described in the Master Plan for Aging. The Minster of Engagement will also be an active player in the interagency process described in this section. The Minister must be knowledgeable about strengths and vulnerabilities related to aging, deeply entrenched in related communities, passionate about social inclusion and have a deep understanding of the intersection between many components of this plan and social inclusion. Lastly, the Minister will actively promote efforts to bridge the digital divide that is far too often present in the lives of older adults.

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

2.4. Join the Network of Age-Friendly States and Communities. By the end of 2020, California joins the Network of Age-Friendly States and Communities (NAFSC) and, in partnership with AARP, coordinates the leadership California's age-friendly communities and organizations 181. California's enrollment in the network would add value to the Master Plan for Aging by offering a unified yet flexible framework for guiding and supporting local jurisdictions in becoming more age-friendly. This is already in use by 50 cities and counties in California who are network members (representing over half of the state's population), along with 6 states and 476 local member jurisdictions nationwide.

2.4.1. By the middle of 2021, California includes the statewide partnership for age-friendly communities into its plan to join the NAFSC. The purpose would be to enhance relationships that encourage the exchange of local best practices, publicize the rich array of resources and tools available to local communities, and help the state ensure their policies are appropriate and relate to community as well as state need. To support this partnership at every level, the state should engage in a series of actions over the short, medium and long-term that are outlined below.

2.4.2. The State actively encourages philanthropic foundations to develop grants to support the work of cities and counties by adding capacity so that they can formulate and implement action plans as part of the NAFSC cycle of continuous improvement.[182]

2.5. Chart a Research Agenda. Work with statewide specialists consisting of academics, private and public sector experts to establish a Research Consortium that will formulate and drive a research agenda to inform continued implementation of the Master Plan for Aging.

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

3.1. State Agencies are required to **consider the impact of policies and procurement on healthy aging**, and on each of the domains of livability including the dementia-friendly domains.

3.2. The Governor's office of Planning and Research includes each of the Domains of Livability into **state general plan guidance**.

3.3. Add valued partners. The Governor's office and appropriate departments bring in additional partners as key players in statewide work, including business groups and for-profit developers.

4. Recommendations for Long-Term Action (5-10 years) – (note that the other sections of Area 2 contain metrics, i.e., housing, transportation, etc.)

4.1. Pass legislation to require that all regional economic development plans include an age-friendly component.

4.2. Evaluate progress made to date. In five years, that state should evaluate the progress it has made under these recommendations.

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[181] Established in April 2012, the **AARP Network of Age-Friendly States and Communities** is the United States-based affiliate program of the World Health Organization's Global Network of Age-Friendly Cities and Communities.

The AARP Network of Age-Friendly States and Communities encourages states, cities, towns and counties to prepare for the rapid aging of the U.S. population by paying increased attention to the environmental, economic and social factors that influence the health and well-being of older adults. By doing so, these communities are better equipped to become great places, and even lifelong homes, for people of all ages.

[182] For example, in San Francisco, the Metta Fund has supported the work of the Long-term Care Coordinating Council by, among other things, providing funding for the Friendship Line along with its anti-ageism initiative. In San Diego, "The **San Diego Foundation** created the **Age-Friendly** Communities Program to address the region's shifting demography and build communities where adults can **age** in place, stay connected to their communities, and remain independent and meaningfully engaged throughout their later years." https://www.sdfoundation.org/programs/programs-and-funds/age-friendly-communities/

MPA GOAL 2: LIVABLE COMMUNITIES – CONCLUSION

Conclusion

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

> **Housing** provides the basic infrastructure that allows Californians to thrive, for older adults to live in and be engaged in communities that are race, gender and disability **equitable, age-friendly, dementia-friendly, and disability friendly**. Paired with affordable housing, accessible and affordable **transportation** allows community access at all stages of life.
>
> Every Californian must be able to actively participate in their communities through **civic and social engagement.** Paired with full access to health care, **parks and public spaces**, and work opportunities, we can advance the promise of a Livable California for All.

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

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

APPENDIX 1: TRANSPORTATION

Appendix 1-A: Evolution of Accessible Transportation via the Americans with Disabilities act of 1990

The 1990 passage of the Americans with Disabilities Act was not only landmark civil rights legislation for people with disabilities, but simultaneously catapulted specialized transportation into the modern world. Service was now mandatory for locations that had fixed route transit, and trip purpose was no longer a restraint to mobility. Unprecedented growth in the industry benefited both older adults and people with disabilities. Service provision became the responsibility of public transit agencies, both large and small, rather the programs often pieced together by underfunded grassroots organization. Public for profit companies proliferated, merged, and became true experts in the field. Smaller, community-based programs with varying operating models gave way to larger, homogenized systems with more service and more consistent service standards.

Not all problems were solved, however. The new “ADA paratransit” systems were often designed to meet ADA minimum standards rather than meet community needs. While many transit agencies exceeded those minimums, financial pressures, especially during economic downturns, often forced reduction in service areas and service models. The ADA paratransit programs were too often seen as the stepchild of traditional fixed-route transit; more costly per ride, more costly for passengers, and were “required” rather than being a primary goal of the public provider. ADA Paratransit is often limited to “where the buses go”, to various operating windows, and to those who can meet the parameters of the service model, including costs, rather than servicing everyone in need, including those who can’t afford ADA Paratransit fares.

Many ADA Paratransit services are now contracted with large for-profit providers whose focus is delivering service dedicated to meeting the requirements outlined in their contracts, rather than community need. While this focused approach to meeting the requirements of the ADA creates greater consistency of service, it shifts the service priority away from meeting the needs of the community to meeting the requirements of the local ADA plan and fixed route provider. Contracted out-of-area providers do NOT have community roots or priorities; instead, their loyalty lies with their contracting agency and corporate homes. This shift has changed the nature of system designs. In the past most specialized transportation programs were locally based and created to respond to community needs and challenges, but were woefully underfunded. Today, ADA Paratransit has replaced many of these agencies with a much better-funded model, but one that is less responsive to existing, to new and to emerging needs, including the inability to pay the required fares.

Thirty years after the passage of the ADA, it’s time to revisit the ADA Paratransit systems if our hope is to insure equitable access to transportation options for these populations. Significant investment and policy changes are necessary. Because accessible transit has been studied extensively, the path to improvement is well established. As described throughout this document, the time is now to make improvements. Leadership and funding will be necessary for implementation, and coordination between ADA Paratransit programs and local communities and community-based and community-driven specialized transportation programs needs to be at the heart of that mix.

Appendix 1-B: Statewide Need: Excerpts from selected Coordinated Public Transit Human Services Transportation Plans, County Unmet Transit Needs Hearings and Short-Range Transit Plans document the need for additional funding throughout the state

- **Butte County:** *"Top-ranked barriers to accessing needed transportation: Funding challenges for directly operating or contracting for transportation…"*
- **Fresno County:** "*Lack of Funding: Funding is insufficient to meet needs for expanding fixed-route service and equivalent paratransit…Duplication and Redundancy: Various sources of funding restrict transportation services to specific populations for specific purposes...results in service duplication and redundancy…*"
- **Inyo-Mono Counties: "***The greatest barrier to coordination for all rural counties is lack of funding. There is simply not enough money available to meet all transportation needs for the target population… particularly in light of the dispersed communities and long travel distance…as such, the various human service agencies piece meal together trips for the most critical needs. Lack of funding/resources contributes to the limited staff time available for all agencies to pursue further coordination efforts*"
- **Kern County:** "*Priorities for the 2007 Coordinated Plan were identified as… Identify and pursue new funding sources…Barriers Identified: insufficient agency funding for Transportation…Very limited transportation funding was reported…difficulty in securing operating dollars to expand or develop new services in both rural communities and Metropolitan Bakersfield…transit systems are operating at their limits of their present funding base is among the most significant of constraints…*"
- **Kings County:** "*Increasing revenue resources: Identified as the core issue…an efficient coordination process must be established…there are many benefits to consolidating on a large scale…there has been no movement towards consolidating transportation entities…The greatest barrier to coordination is lack of funding…There is simply not enough money available to meet all transportation needs for the target population…human service agencies piece meal together trips for the most critical needs.*"
- **Lake County:** *"PRIORITY 1 – Critical: Pursue and secure funding to support, maintain, improve safety and enhance the Lake County public transportation network…" "…Continued priority must be placed on securing new funding sources…"*
- **Los Angeles County:** "*Roadblocks to further coordination. Several were identified, including the following: Funding restrictions; capacity constraints…*"
- **Madera County:** "*The greatest barrier to coordination for many smaller counties is lack of funding. There is simply not enough money available to meet all transportation needs for the target population, particularly in light of the dispersed development pattern and long travel distance in Madera County*"
- **Metropolitan Transportation Commission (San Francisco Bay Area):** "*Current senior-oriented mobility services do not have the capacity to handle the increase in people over 65 years of age…the massive growth among the aging …points to a lack of fiscal and organizational readiness…the closure and consolidation of medical facilities while rates of diabetes and obesity are on the rise will place heavy demands on an already deficient system.*"
- **Riverside County:** *"Securing funding is critical to maintain, enhance and expand transit services…Goal 1: Strategy: Secure Funding, including discretionary sources, to maintain, enhance and expand transit and specialized transportation…The STRATEGIC ASSESSMENT proposes various strategic actions to address system-wide deficiencies…3) Increase Funding…Goal 2 – Connect and Coordinate Services Improve connectivity among public transportation services and coordination with human service transportation…"*
- **Sacramento Area Council of Governments:** *"…gaps in service remain due to geography, limitations in fixed-route/demand responsive services, program/funding constraints, eligibility limitations, knowledge, training…*"
- **San Bernardino:** "*…Coordinated Plan strategies can be supported with 5310 funds …however, this competitive funding source is modest…*" "*…agencies and their transit programs need for assistance continues as they face funding uncertainties* ", "*…First Priority Strategies: Secure funding…to maintain, enhance and expand transit and specialized transportation services…"*

- **San Diego:** "*…gaps in service remain due to geography, limitations in transit service, funding constraints, eligibility, knowledge, and training….*"
- **Shasta County:** "*…limited resources in the form of staff availability, interest, leadership, service and/or capital capacity, funding, and time…*"
- **Stanislaus Council of Governments:** "*While public transportation services do receive Local Transportation Funds…and State Transit Assistance (STA) funds, it is generally not sufficient to address many of the service challenges, such as limited frequencies and longer service hours, which were common themes…*"
- **Tulare County:** "*Activities that better coordinate and consolidate transportation services and resources… Secure funding devoted to maintaining and strategically improving service levels…Secure funding and pursue low-cost, open source Find-a- Ride capabilities…*"
- **Ventura County:** "*…limited funds suggest that it will be critically important to seek other funding sources to address many of the proposed strategies. Such additional funding sources could include but are not limited to…State cap and trade funding…*"

Appendix 1-C: Consolidated Transportation Services Agency (CTSA) Summary Description

Below are excerpts from the California Association for Coordinated Transportation's CTSA eBook[183].

Consolidated Transportation Services Agencies (CTSAs) are designated by county transportation commissions (CTCs), local transportation commissions (LTCs) regional transportation planning agencies (RTPAs), or metropolitan planning agencies (MPOs) under auspices of the Social Services Transportation Improvement Act[184] to achieve the intended transportation coordination goals of that Act.

The Act, sometimes referred to as Assembly Bill 120 (Chapter 1120, Statutes of 1979), added Part 13 (commencing with Section 15950) to Division 3 of Title 2 of the Government Code and amended Sections 99203 and 99233.7 of, and added Section 99204.5 to the Public Utilities Code relating to transportation

Legislative Intent: The purpose of the Act was to improve the quality of transportation services to low mobility groups while achieving cost savings, lowered insurance premiums and more efficient use of vehicles and funding resources. The legislation took the middle course between absolutely mandating and simply facilitating the coordination of transportation services. Designation of CTSAs and implementation of other aspects of the Act were seen as a flexible mechanism to deal with the problem of inefficient and duplicative social service transportation programs that proliferated due to a dramatic increase in the number of social service programs offered by government agencies and private nonprofit organizations to meet their clients' mobility needs.

Who is Eligible to be Designated a CTSA?

Each CTSA shall be an entity other than the transportation planning agency and shall be one of the following: a) a public agency including a city, county, operator, any state department or agency, public corporation, or public district, or a joint powers entity created pursuant to Chapter 5 (commencing with Section 6500) of Division 7, Title 1 of the Government Code. b) A common carrier of persons as defined in Section 211 of the Public Utilities Code engaged in the transportation of persons as defined in Section 208. c) A private entity operating under a franchise or license. d) A nonprofit corporation organized pursuant to Division 2 (commencing with Section 9000) of Title 1 of the Corporations Code.

[183] California Association for Coordinated Transportation: Credit for most of the text in this CTSA eBook goes directly to individuals in the Division of Mass Transportation who created the Final Report to the Legislature (July 1982) related to the Act and specifically to the Project Manager, Ms. Chris Hatfield; and to the individuals who created the follow-up report, SB 157 Action Plan (January 1987), specifically to the Project Manager, Mr. Peter Steinert

[184] Gov Code: Title 2, Div. 3: Part 13: SOCIAL SERVICE TRANSPORTATION [15950 - 15986]

What are CTSAs Required to Do?

Before the Social Service Transportation Improvement Act became law, California had no requirement for the coordination of social service transportation services. It was enacted to promote the consolidation of such transportation services so that the following benefits may accrue:

1. Combined purchasing of necessary equipment so that some cost savings through larger number of unit purchases can be realized.

2. Adequate training of vehicle drivers to insure the safe operation of vehicles. Proper driver training should promote lower insurance costs and encourage use of the

service.

3. Centralized dispatching of vehicles so that efficient use of vehicles results.

4. Centralized maintenance of vehicles so that adequate and routine vehicle maintenance scheduling is possible.

5. Centralized administration of various social service transportation programs so that elimination of numerous duplicative and costly administrative organizations can provide more efficient and cost-effective transportation services permitting social service agencies to respond to specific social needs.

6. Identification and consolidation of all existing sources of funding for social service transportation services can provide more effective and cost-efficient use of scarce resource dollars. Consolidation of categorical program funds can foster eventual elimination of unnecessary and unwarranted program constraints.

The Act did not define social service agency transportation, so an advisory definition was promulgated for purposes of implementing all aspects of the Act. “Social Service agency” was defined as a public or private, nonprofit organization which provides services to any of these four target groups: elderly individuals, individuals with disabilities, youth, and individuals with low-income. The following nine functional areas were identified:

1. Services to children

2. Employment services

3. Provision of food, clothing, and housing

4. Guidance

5. Health services, both mental and physical, including services to individuals with disabilities

6. Recreation

7. Services to special groups, including non-English speaking individuals, individuals with alcoholism, et.

8. Welfare

CTSAs Designees Today and Yesterday

Prior to enactment of the Social Service Transportation Improvement Act, there was no previous requirement or large-scale experience with coordination in California, and as might be expected with such an ambitious undertaking, problems surfaced during implementation and exist even today. While intent of the legislation was to allow for a maximum degree of flexibility, the end result was vagueness in terms of several critical points. The Act:

1. Assumed that some form of coordination would be found feasible in each geographic area.

2. Lacked a clear definition of social service transportation services.

3. Used the terms coordination and consolidation interchangeably.

4. Mandated the creation of CTSAs without defining their function or limitations.

5. Made TDA Article 4.5 funds available to CTSAs at the discretion of the transportation planning agencies, but did not appropriate any additional funding for the purposes of planning or implementation.

6. Did not include a provision for updating either the inventory reports or the Action Plans.

7. Did not include sanctions for noncompliance by either the transportation planning agencies or social service agencies which provided some leeway to avoid fulfilling the coordination mandate.

8. Did not address nor mandate implementation of the Action Plans.

9. Specified that the Secretary of the Business and Transportation Agency (now called Business, Transportation, and Housing Agency) comment on the adequacy of each Action Plan, but did not provide for sanctions if the Action Plans were found to be inadequate.

APPENDIX 2: PARKS AND PUBLIC SPACES – ADDITIONAL RESOURCES

- AARP Network of Age-Friendly States & Communities: https://www.aarp.org/livable-communities/network-age-friendly-communities/
- AARP Livability Index: https://livabilityindex.aarp.org/
- Creating Parks and Public Spaces for People of All Ages, by AARP, 880 Cities, and The Trust for Public Land
- *Park Score Index, The Trust for Public Land:* https://www.tpl.org/parkscore
- Dementia-Friendly America: https://www.dfamerica.org/
- Seattle Dementia-Friendly Recreation: http://www.seattle.gov/parks/find/dementia-friendly-recreation
- Open Streets resources:
    - https://openstreetsproject.org/
    - https://www.ciclavia.org/
- SMART Parks Toolkit: https://innovation.luskin.ucla.edu/sites/default/files/ParksWeb020218.pdf
- 2020 City of San Diego Parks Master Plan , uses a methodology assigning point values for parks that are comprised of factors including park size, features, transit connections, programming and more. The methodology also considers insights from the City of San Diego Climate Equity Index Report in identifying and prioritizing opportunities for improvements to existing infrastructure. Index created by The Energy Policy Initiatives Center (EPIC) at University of San Diego.
- A Challenge to Cities: How Can We Incorporate Green Spaces? Nady, R. Arch 20