

Goal 3

2020

We will live in communities and have access to services and care that optimize health and quality of life.

Californians will live in communities with policies and programs that promote well-being throughout our lifespans.

Californians will have access to quality, affordable, and person-centered health care through delivery systems that are age-friendly, dementia-friendly and disability-friendly.

California Master Plan for Aging: Goal 3- Health and Well Being

GOAL 3: HEALTH AND WELL BEING RECOMMENDATIONS

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Executive Summary

Major Goals for Health and Well-Being of Older Adults and People with Disabilities in California

California's current health system serves older people and people with disabilities poorly. It is expensive, fragmented, and difficult for consumers and families to use. Goal 3 of California's Master Plan for Aging addresses the health and wellbeing of older Californians and people with disabilities. The recommends are as follows:

- 1) Rebrand aging as a positive healthy process and educate all ages about health and well-being throughout the lifespan.
- 2) One leader appointed by the Governor and in charge of delivering fully integrated health and LTSS services to every older and disabled Californian.
- 3) "Call to Action" to eliminate health disparities, racism, and discrimination in health care
- 4) "Call to Action" to reform and offer more alternatives to nursing home care.
- 5) By 2030, increase the number of interdisciplinary providers prepared to deliver person-centered, culturally and linguistically congruent, technology enabled care for older adults and persons with disabilities by 10,000.

The sections below lay out the philosophical underpinnings of our thinking and detailed recommendations for achieving these and other key improvements.

Introduction

Philosophical Underpinnings for Systems Change

Aging is a universal process throughout the lifespan and health shapes this experience, across physical, emotional, social, spiritual, and functional dimensions. Individuals age in the context of their multiple identities, influenced by our communities of belonging and the challenges and opportunities of our social and political world. Healthcare systems, at their best, are equitable, place the person at the center of care, embrace the fullness of each person, integrate care, and advance health goals according to individual preference and priority. Ideal health systems enable people to live their lives to the fullest and achieve the highest level of health possible. Healthcare should be shaped around the journey of life and the needs that naturally and commonly arise on that journey, rather than the priorities and convenience of the business of healthcare.

Current health systems fall short of the ideal, offering care that is fundamentally inequitable, institution and provider-centric, poorly coordinated, and often of low value. Existing services and supports for older adults and persons with disability are too often siloed. Failure to address social determinants of health and structural racism guarantees ongoing health inequality. Lack of coordination among providers and agencies serving older adults assures that people fall through the cracks and face negative outcomes as a result of system neglect. Maldistribution of expertise, favoring urban and wealthier neighborhoods,

exacerbates disparities in access. Lack of workforce preparation for the complexity of care for older adults and persons with disabilities limits the capacity of the healthcare system to deliver high quality and high value care.

Mahatma Gandhi famously stated that 'the true measure of any society can be found in how it treats its most vulnerable members.' Older adults and persons with disabilities deserve systems that anticipate and address their needs and systems that integrate services and supports so that when the individual is least prepared to coordinate their own care, the system takes care of that essential function. The third goal of the Master Plan for Aging envisions transformative change in how we view aging and disability and how we design healthcare systems to advance health for aging Californians across all communities, regardless of income, race, ethnicity, disability, gender and sexual identity, immigration status, education, or religion. We aspire to systems that recognize individual goals for health and afford dignity, grace, security and comfort.

Optimal wellness and health are salient for all people, regardless of age and disability, and are relevant across domains of health promotion, chronic disease management, acute illness and end-of-life. Negative stereotypes and fears of aging and disability have historically pushed aging and disability issues to the background and created a separation between those who deny their own aging and functional limitations and those who are dismissed as aged or disabled. Ageism, ableism, racism and sexism undermine health and promote structural inequality. The recommendations by this committee seek to dismantle these sources of disparity and promote healthier systems of care. While there are many things wrong with the health system for older adults and persons with disabilities, this goal focuses on areas with the greatest potential for state action and system integration. These priorities reflect the expertise and experience of the committee, with several topics heightened in the context of the pandemic. We also acknowledge that another Governor appointed entity, the Healthy California for All Commission, is addressing overarching issues like universal health care and how to pay for it.

Cross-cutting Issues

Equity

California is one of the most racially, ethnically and linguistically diverse states in the nation. Equity issues impact access to health care and related services for older adults and people with disabilities in under-represented, under-served and under-recognized communities. More recently, the COVID-19 crisis has dramatically revealed and exacerbated the shortcomings in California's health care delivery system. It has laid bare tremendous system inequities and health disparities that directly result in racial and ethnic populations being at disproportionate risk to contract, to be hospitalized and to die from COVID-19. It has also highlighted the widespread ageism and ableism that infiltrate societal views of older adults and people with disabilities and diminishes their value. To ensure an equitable system, we must address health disparities and social determinants of health while fighting

discrimination, xenophobia and marginalization. Collectively, we affirm the critical importance of equity in addressing the health care needs of older adults and people with disabilities, thereby eliminating disparities caused by systemic barriers.

Leadership

Our hope for the Master Plan for Aging lies in the potential for broad system change, and in the opportunity to fundamentally reframe the way we collectively view and serve California's older adults and people with disabilities. System change requires engagement and collaboration between the Governor, state and local agencies, the Legislature, and the private sector. And, as noted in the Long-Term Services and Supports Subcommittee Report, "Bold leadership starts at the top with elected and appointed officials who are willing to invest in and prioritize the needs of this growing segment of our state's population... Without strong leadership, nothing can be realized -- but with it, everything can be accomplished." Improving health and LTSS care for older and disabled Californians will require the appropriate structural configuration and leadership to provide the vision for (in partnership with older and disabled stakeholders) and implementation of this plan, integrating and administering all health and LTSS services provided to older and disabled Californians.

Integration: People First

Older adults and people with disabilities should have access to health and LTSS systems that are responsive to the individual as a whole—not idiosyncratic silos based on funding source, administering agency, or local oversight entity. A successful Master Plan will outline an approach that ensures individuals can readily access the information and services they need, when they need it—regardless of eligibility distinction, income level, or place of residence. The recommendations all call out the need for integration, reflecting the notion of building systems around the needs of the person, rather than forcing the person to adjust to the needs of the system.

Goal 3--Health and Well Being

California's Master Plan for Aging has the potential to reimagine aging—influencing how our communities across California think about, plan for, and respond to life's changes with age. Because aging is a lifespan issue, the topic is not limited to individuals over a certain age, but impacts young people, families, and communities alike. We aim to reframe how we perceive both age and disability to support health and function throughout the lifespan. Thus, we seek changes in current approaches to aging and disability by recognizing that effective healthcare systems benefit all ages. Embracing the strength of our diversity and transforming systems to be culturally and linguistically congruent and integrated will yield a healthier California, making us a national leader in addressing the demographic and social trends affecting the entire nation. To accomplish this goal, cross-system reform is needed at the population-level, system-level and provider level.

Goal 3--Health and Well Being is intended to address a disparate set of issues which together amplify shortcomings in the state's current approach to serving older adults and persons with disabilities and providing general and specific recommendations for reassessing the gaps in services, reframing how we view aging in California and transforming our system of care to better serve the needs of growing populations of communities of color, older persons and persons with disabilities. Therefore, this report examines a litany of issues: healthy aging, the workforce, care transitions, behavioral health, Alzheimer's, telehealth, palliative care, skilled nursing facilities and oral health. These issues may appear disparate but they are connected by the values inherent in this document; values of a more accessible, comprehensive, welcoming and effective set of programs, services and benefits that together, make it possible to age in this state, regardless of one's circumstances and to enjoy the longevity dividend of expanding life spans.

Person-level: Healthy Aging, Wellness and Prevention

Key Objective: Redefine healthy aging as the process of developing and maintaining wellbeing as we age. This objective focuses on advancing population health, honoring the voice and preferences of the person and their health-related behavior, and relying on system transformation to address disparities (e.g. racial, ethnic, gender, sexual orientation, geographic and income). Recommendations:

- Rebrand Aging in California to create a positive narrative about aging;
- Promote intergenerational healthy aging and wellness initiatives;
- Recognize and address social determinants of health including racism and climate change; and
- Enhance prevention and wellness

System-level: Health Care and Integrated Systems of Care.

Key objective: Develop integrated, coordinated quality health care and LTSS systems that addresses the whole needs of the person including preventive care, well-person care, and acute care coupled with access to long-term services and supports. Recommendations:

- *Leadership*: Provide leadership in system integration and eliminating disparities and racism: Focus on leading at the state level and across sectors to implement integrated and equitable service delivery across all California counties and for all older Californians and people with disabilities;
- *Skilled Nursing Facilities*: Re-imagine nursing home care and improve quality and safety; provide more alternatives to nursing homes; stabilize the work force; consolidate state leadership; and strengthen nursing home oversight and transparency.
- *Behavioral health*: Address issues related to system integration, access, planning, and workforce.
- *Oral health*: Focus on system integration, data and enhancing access to oral health services by expanding Medi-Cal and Medicare coverage.
- *Telehealth*: Expand access, institute payment parity for tele-video and telephonic services while aligning broadband funding, engage consumers, and address oversight issues.

- *Alzheimer's Disease*: Build out systems for screening, detection/diagnosis, documentation, care planning and care coordination. Implement care standards for plans and providers.
- *Palliative Care*: Expand access to palliative care services, grow the workforce, incorporate best practices and operationalize Advanced Care Planning

Provider-level: Professional Health Care Workforce Development.

Key objective: Prepare and grow California's health care workforce to meet the demands of an Aging California with high quality care and support. Recommendations:

- *Vision*: Adopt an organizing framework and strategy to grow the geriatric and gerontological work force.
- *Supply*: Increase the number of qualified providers in primary care and behavioral health
- *Training*: Prepare the workforce to provide person-centered, culturally-congruent, team-based and technology enabled care
- *Oversight*: Align regulations to support optimal access to geriatric care
- *Recruitment*: Incentivize geriatric workforce preparation

The recommendations in this report reflect the variety of issues affecting older adults and persons with disabilities and each are equally important. We do, however, provide in this report a few overarching areas that reflect our values and highlight areas that can provide momentum for all issues in this report (e.g. leadership, reframing, investing in a workforce, cross-sector). In an ideal world, we would have universal and coordinated systems of services and benefits that would integrate our various concerns but until then, we compartmentalize our assessment and recommendations on each of these issues and build from a person to system levels.

Person-Level

Wellness and Prevention Across the Lifespan

Wellness and Prevention Background:

The benefits of integrating healthy aging in all aspects of state programs and initiatives can lead, in time, to a healthier population of older adults and persons with disabilities. California's racially and ethnically vulnerable communities, in particular, have great need for best practices given the social economic and racial inequities they face. Our objectives in this section are to redefine healthy aging as the process of developing and maintaining the functional ability that enables well-being in older adults and includes the role of health and behavioral health systems, individual responsibility, improvement in data and metrics for measuring outcomes, addressing racial, ethnic and income disparities and educating society to integrate best practices.

Wellness and Prevention Recommendations:

Goal 1. Implement a branding campaign that reframes the public narratives about getting old and about the value of engaging in practices to promote healthy aging, prevention, and wellness in early life. Most people are afraid to get old and view aging in negative terms and remain in denial until too late. This initiative will include the media (social, print, technology --Silicon Valley), entertainment (Hollywood), public agencies (DPH, CDA) and advocacy groups (AARP) that can make healthy aging trendy and "sexy" and can encourage younger groups to plan for a long life.

- A. Implement a state level commission (or advisory group) to examine how we can educate, inform and otherwise convince Californians that they can expect (especially if they practice healthy lifestyles) to live up to 100 years of age and thus plan accordingly.** It will have valuable partners from the private and corporate sectors (e.g. Kaiser, Blue Cross, Aetna): insurers, payors and providers already understand the cost-benefit of motivating their consumers to engage in wellness and prevention practices to avoid higher costs.
- B. Particular focus must be given to diverse communities, including those with lower life expectancies (African American and Native Americans) and those with higher life expectancies (Hispanic and Asian).** This would be a precedent-setting initiative having California show the nation how to "socialize" society to plan for a longer life beginning early in life to practice healthy and wellness norms.

Goal 2. Promote Intergenerational Educational Healthy Aging and Wellness Initiatives.

Drawing on the life span perspective we recommend "drilling down" to the K-12 level and all younger age groups to educate and inform about healthy aging practices. This goal is about reintegrating all ages through intergenerational connections but also to mitigate potential generational tensions (e.g. older voters opposed to school bond measures, younger voters opposed to nursing homes and senior programs in their neighborhoods). These include a variety of examples:

- A. Co-locate childcare and adult facilities to promote intergenerational experiences beginning in infancy.**
- B. Promote intergenerational programs beginning in elementary school.** Programs such as “Adopt a nursing home” or volunteer home visits that allow elementary student to engage with elders in both community and institutional settings; and engage in social and supportive activities
- C. Teach Disability Sensitivity beginning in Middle School.** Promote empathy and support for persons with disabilities through experiential learning (e.g. navigating with a wheelchair, hearing with cotton in ears, using glasses with limited vision) and valuing aging with a disability.
- D. Conduct “Healthy Practice” classes beginning in High School.** Incorporate learning targeted to longevity planning to include advanced directives, understanding mobility limitations, examining role of transportation and accessibility, assessing impact of unhealthy food and beverages on long-term health. Incorporate learnings on the important role of safe, stable and nurturing relationships and environments in reducing harmful effects of trauma on health.
- E. Orient college students to high risk behaviors.** Include education about unhealthy sexual, substance use, adversity and trauma, and diet and the consequences they may have in later life. Include education about positive social engagement, peer support, end-of-Life preparations (for older family members).
- F. Support and expand existing financial literacy and retirement reparation for young adults and families.** Income is a key aspect of acting on best practices. Most adults have not planned for retirement security (savings, investments, long term care) and thus enter older years dependent on public support (SSI, Medicaid, Social Security, IHHS). The CAL SAVERS is a national model for promoting savings among low income workers and can be a foundation for a state level financial and retirement efforts, especially among racially and ethnically vulnerable communities most likely to be financially insecure.

Goal 3. Recognize and address the Social Determinants of Health: Healthy aging and wellness is not just a medical or health issue; it is heavily impacted by broader issues of poverty, climate change, social isolation, housing affordability, poor nutrition, transportation barriers, educational disparities, racism and nativism and by geography (zip codes). The existing social and economic disparities of diverse, vulnerable populations (especially Black and Brown) forecasts a much larger population of older persons in 20-30 years facing poverty, poor health, vulnerability and greater dependence on the State and Federal government. Thus, it is to our cost-benefit advantage to address these disparities early on to lessen the public dependency later on.

- A. Promote funding to California Universities and Colleges to examine and test approaches for remediating the various dynamics of social determinants as they impact the aging of California's population.** Pay particular attention to the future of our State when it becomes majority -minority and its elder population faces the risks of greater social and economic vulnerability. Findings and recommendations can be made to the state legislature and Governor's office

and be part of the Public Narrative Rebranding and Intergenerational educational initiatives.

Goal 4. Prioritize prevention and wellness: Prevention is about proactive actions that avoid unnecessary problems and wellness is about positive actions that minimize harmful outcomes. Prevention activities at all levels – primary, secondary, and tertiary, are needed for all age groups. A variety of approaches can be considered in this space:

- A. Address the imperatives of social isolation and its connection to depression, dementias and suicides.** Fund Universities to investigating these concerns.
- B. Implement evidence-based initiatives to prevent falls among older adults and people with disabilities.** Falls among the elderly are the leading causes of hospitalizations and institutionalization (and accompany decline and death). Models of effective falls prevention currently exists (such as Ventura County and the USC Falls Prevention Institute) ---support and replicate these effective programs and initiatives.
- C. Recognize the relationship between nutrition security and health outcomes, and address food insecurity by maximizing the reach of services such as Cal Fresh and Commodity Supplemental Food Program.** Food insecurity and its resultant impact on health is a growing concern and food deserts in low-income areas persist. Enjoin the CDA and AAA's to spearhead food security strategies for older adults.
- D. Promote a senior campaign to raise awareness about the risks of prescription drugs, alcohol, and other substances in older age.** Opioid Addictions and overmedication lead to harmful outcomes for older adults and persons with disabilities. This must be done in conjunction with acknowledging the realities of those with chronic pain.
- E. Promote holistic, complementary wellness approaches (e. g. Tai chi, Qigong, meditation, yoga, Pilates, music and pet therapy, massage) to promote healthy aging.** Non-traditional and non-medical forms of exercise, stress reduction and prevention are proven to be effective in wellness improvements for all populations. To reach vulnerable populations, enlist such practitioners to modify these practices for those with cognitive and physical limitations.

Goal 5. State Level Leadership and Coordination: There is currently no state-wide coordination or leadership in facilitating state-wide action in examining the barriers and impediments to promoting healthy aging, prevention and wellness nor working in partnership with others committed to these issues and branding healthy aging as a mainstream public issue. The many different ideas, strategies and recommendations in this report require a "home" that can integrate the big ideas and themes and its application to supporting a healthier diverse California as its ages.

- A. California should institute a state level entity (e.g. commission, advisory group) to evaluate each state agency with a "healthy aging" lens and lead the charge.** This advisory body should coordinate with the California Department of Aging, California Department of Public Health, and California Commission on Aging to

ensure the healthy aging perspective is integrated into the work of all state agencies.

Wellness and Prevention Resources:

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- CalFresh Food. (2019). <http://calfresh.dss.ca.gov/food>
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System Level

Health and Integrated Care

Health Care Integration Background:

Health Services are a key quality of life issue for older adults and people with disabilities. As we age, we have more chronic and acute health conditions and these conditions interact with functional limitations to create greater need for health and other services. People of all ages with disabilities often have similar complex health and social needs. Currently, there is a bewildering array of providers and programs that a consumer and their family must navigate to maintain health and wellbeing. Our health care system often fails to provide the care and services older adults and people with disabilities and their families truly need. Because our multiple systems, both public and private, are difficult to navigate, our most vulnerable populations are left to coordinate their own care and coverage across Medicare, Medi-Cal, and other needed services. Fragmented care also disproportionately disadvantages many distinct populations, especially lower-income people and racial and ethnic minorities who historically have suffered from health disparities and racism.

Health care fragmentation and complexity create real world hardships for people and are especially fraught for individuals as they move from one care setting to another. For older adults and individuals with disabilities, particularly those with complex medical, behavioral, or social needs, such transitions are even more challenging. "Care transitions" involve an individual moving from hospital to home, hospital to a nursing home, or a nursing home to home or another setting. Successful transitions rely on timely access to services across the health and long-term services and supports (LTSS) continuum to meet an individual's health, functional (help with activities of daily living), and social support needs. However, many older adults and people with disabilities are discharged from hospitals or nursing homes without appropriate services and supports, placing them at greater risk for re-hospitalization or long-term stays in a nursing home.

Many of the problems related to care transitions are rooted in the federal/state breakdown between Medicare and Medi-Cal payment and service delivery as well as the fragmentation between medical services and social and LTSS service programs:

- *Medicare/Medi-Cal misalignment:* California's 1.4 million individuals eligible for Medicare and Medi-Cal ("dual eligibles") have high rates of chronic conditions and functional impairments and rely on access to services across health and LTSS programs, particularly during care transitions. Medicare pays for acute hospital care and other medical services (including short nursing home stays), while Medi-Cal covers long term stays in nursing home and other services designed to help people live at home or in other community settings. This fragmented fiscal arrangement disincentivizes providers and payers from investing in services according to individual needs and preferences and complicates or prevents good care transitions.

- *Medicare-only population challenges:* Since Medicare does not pay for LTSS, beneficiaries with complex care needs have great difficulty in affording functional support services (such as personal care services in the home) that are especially needed during times of care transitions, and must instead navigate a fragmented service delivery system without assurance that their needs will be met.
- *Fragmentation in health care and LTSS systems of care:* The lack of coordination across health care and LTSS systems writ large makes it difficult for individuals transitioning home to access health care and LTSS in a coordinated fashion. Sadly, often the default is a nursing home.

The Master Plan proposes a vision for integrated care with seamless access to coordinated services. Health care must be fully integrated across the continuum of care, offering a standard quality of care for all Californians, including preventive care, acute care and chronic disease care and management that is coupled with access to home and community-based services. Services must be person-centered and also include behavioral health (both mental health and substance abuse services); vision, dental, and hearing services; durable medical equipment, physical therapy, palliative and hospice care provided according to the individual needs of people, easily and flexibly accessed through appropriate modalities, including tele-health. Services should bridge transitions and be nimble enough to deliver care to those in need in a variety of settings, including the home.

Integrated Health Care Recommendations:

Goal 1: An integrated system of care requires strong leadership.

- A. *The Governor should appoint a cabinet-level leader with responsibility for all integrated services for older adults and people with disabilities.*** Such services would include but not be limited to health, behavioral health, long term services and supports (LTSS), and oral health. This position will create a vision and call to action for optimized and integrated services and lead implementation of that vision across state, federal, and private systems of care. The integrated care leader will be advised by a stakeholder advisory committee with subcommittees related to specific areas of concern. One of the primary charges for this leader will be the reduction of health disparities through effective integrated care.

Goal 2: The Governor should promote a “Call to Action” to eliminate racism and disparities in health care.

- A. *The Governor should call for explicit annual, five- and ten-year targets for the elimination of health disparities in the Medi-Cal program.*** As said by the newly appointed Director of Health Care Services, the COVID-19 pandemic “has been enabled by a pandemic of racism.” The State should also take a strong stand against discrimination toward older adults and people with disabilities in all health programs, whether privately or publicly funded.

Goal 3: Commit to service and system integration as an explicit vision for the State.

- A. Establish a Medi-Cal/Medicare Innovation and Coordination Office in the Department of Health Care Services to lead all efforts around duals integration in the state.** Older individuals with multiple chronic conditions and/or functional limitations, people with disabilities, and residents of nursing facilities are largely dual eligible and are the most vulnerable in the COVID virus. For these individuals, the need for coordination across physical and behavioral health care, access to LTSS, and programs that address social support needs is more critical now than ever. This is a high priority equity issue since those dually eligible for Medicare and Medi-Cal (called “dual eligibles”) are low-income, sicker, more likely to experience a serious mental illness, and more likely to be from populations systematically and historically disadvantaged. Dual eligibles have also suffered from much worse outcomes in the COVID pandemic.
- B. By 2025, assure that Medicare-Medicaid recipients (i.e., “dual eligibles”) have a fully integrated option wherever they live in the state.** Duals now receive their benefits through up to eleven different delivery systems, depending on their specific conditions and where they live. A fully integrated option means access to health (both Medicare and Medi-Cal funded benefits) and the full range of LTSS, behavioral health, and oral health services in a coordinated and accountable system of care. These integrated options should also include strategies for incorporating social supports such as housing access, food security, and other nonmedical services. Integrated options can be built on existing accountable entity platforms -- Medi-Cal Managed Care, PACE, Dual Eligible Special Needs Plans, and other potential federal demonstrations or programs.
- C. Build off lessons learned from Cal MediConnect.** [Cal MediConnect \(CMC\)](#) combines the delivery of Medi-Cal and Medicare benefits through Medi-Cal managed care plans in seven California counties. CMC was authorized as part of the federal Centers for Medicare & Medicaid Services (CMS) [Financial Alignment Initiative](#) with the goal of developing person-centered care delivery models integrating the full range of medical, behavioral health, and LTSS for dual eligible individuals to the greatest extent possible. We recommend that the lessons learned from CMC [evaluation](#) inform future efforts, by providing a platform to build off integrated service delivery for California's dual eligible population.
- D. Identify best practices and build partnerships across health plans and home and community-based service providers.** Community-based organizations (CBOs) play a central role in delivering daily living support through collaborations with the health care sector. While health care and CBOs have been tackling the issue of care coordination and effective care transitions, they have been doing so in silos. Developing partnerships between health plans and CBOs is critical to realizing the vision of integrated care. The state should engage partners to identify [best practices](#)

such as those that bring together [health care, housing and CBOS](#) to leverage the strengths of each sector in developing integrated, coordinated systems of care.

- E. *Align Medicare/Medi-Cal funding streams through the D-SNP Platform.*** The [Coordinated Care Initiative](#) (CCI) is set to sunset in 2022. We recommend that the state build leadership and develop a strategy for the next phase of the CCI, using the Duals-Special Needs Plan (DSNP) platform to better align and coordinate care or whatever other federal integration vehicles may be available at that time.
- F. *Expand access to PACE.*** PACE is a growing and proven model of integrated care that is well suited to managing care transitions. We recommend that PACE be offered as a Medi-Cal plan choice, in areas where it is available. As with other managed care plan options, PACE would be included in all enrollment and outreach materials for dual eligibles and persons with disabilities, and that it be identified as a Medicare plan choice for dual eligible beneficiaries.
- G. *Pursue federal demonstrations to test new community-based integrated care models.*** Existing federal demonstration authority currently allows CMS to conduct demonstrations of adaptations of the PACE model to serve additional at-risk populations, including persons with serious mental illness, younger adults with physical disabilities, and older adults at risk of nursing home placement. The State should pursue these and other integration opportunities through CMS demonstration authority (see Goal 2 recommendation for an integrated Long Term Care at Home demonstration).
- H. *Ensure that any Medi-Cal reforms include a robust integration vision and strategy for older adults and people with disabilities.*** This includes as a first principle ensuring that any Medicaid reform includes dual eligibles. Duals comprise two-thirds of older adults and younger disabled on Medicaid in California. All Medi-Cal reforms should include an evaluation of impacts on older adults and people with disabilities.

Goal 4: Focus integration efforts on two key areas in Medi-Cal: Behavioral Health and LTSS.

- A. *Behavioral health services, including care for Alzheimer's and other cognitively challenged patients, should be integrated with primary care to avoid stigma and make them easily available.*** The State should end the carve-out of the specialty MH system and break down barriers for older adults and the younger disabled that exist among Medicare, Medi-Cal mild to moderate coverage, specialty mental health, and privately funded care.
- B. *Health care should be integrated with all Medicaid funded LTSS services.*** This includes IHSS, CBAS, and MSSP, including through Medi-Cal managed care health plans, PACE, and other integrated program platforms. Health care should also be

integrated with other LTSS services not currently supported by Medi-Cal funding, e.g., assisted living, adult day health care, and the full range of Area Agency on Aging services.

Goal 5: Incorporate strategies to include social determinants as part of integrated care.

Poor health is largely due to factors outside of health care: poverty; housing and food insecurity; and agism and racism, to name a few. Addressing these issues through health integration strategies can help alleviate health disparities and inequities. Ensuring there are specific goals to reduce disparities and monitor progress are essential for integration efforts.

- A. Encourage health plans to use screening tools to identify social needs, such as food or housing insecurity, and either refer to other services or develop their own interventions to address these needs.**

- B. Incorporate In Lieu of Services (ILOS) into Medi-Cal managed care plans.** As recommended in the State's CalAIM proposal, allow Medi-Cal managed care health plans to provide housing, food, and other non-medical benefits to beneficiaries on an as needed and voluntary basis, and recognize health plan costs for these services through the ILOS mechanism. Current federal law permits states to use ILOS, as long as these are included in health plan contracts with the state. This can be implemented immediately by DHCS.

- C. Within three years, the State should develop a benefit package that includes non-medical services.** Conduct a robust evaluation of the outcomes and cost savings of ILOS and from that evidence, develop a benefit package of ILOS that will be available through managed care plans statewide.

Goal 6: Use Care Coordination and Assessments to improve care across settings during transitions.

- A. Implement a comprehensive pre-discharge and in-home assessment.** Prior to an individual's discharge from the hospital or nursing home, we recommend development of a uniform bio/psycho-social assessment of needs that builds off the individual's goals and preferences, along with a home assessment of falls risk. The assessment should build off the individual's goals and preferences to inform the plan of care.

- B. Implement a caregiver assessment before discharge.** The at-home caregiver is critical to the successful transition and as such, we recommend that their needs should be assessed in a comprehensive manner.

- C. Promote Care Coordination that spans different settings.** Care coordination is a cornerstone of a person-centered system of care, including care transitions, serving

as the lynchpin connecting individuals with a range of needs across the medical and LTSS delivery systems. As such, care coordination should be a critical component of any care transitions program.

Goal 7: Develop better integrated care options for Medicare-only beneficiaries.

A. Expand opportunities for the provision of non-medical benefits (called *Special Supplemental Services*) into Medicare Advantage Plans in California. Federal law through the [CHRONIC Care Act](#) now permits Medicare Advantage plans the flexibility to provide non-medical benefits (e.g., special supplemental benefits for the chronically ill) as part of the plan benefits package. [Guiding Principles](#) have been adopted by a diverse group of stakeholders to help in the development, offering and implementation of non-medical benefits in Medicare Advantage. We recommend the state work with Medicare Advantage plans and Special Needs Plans operating in California to leverage opportunities to access to non-medical benefits. This framework would provide the structure needed to align incentives and improve care transitions for older adults and people with disabilities on Medicare.

- Convene California's Medicare Advantage plans to define a strategy to integrate chronic care benefits into their plans and gain their commitment to a timeline to implement that strategy.
- Evaluate the costs and outcomes of specific non-medical benefits to guide California Medicare Advantage plans to provide the most beneficial services to Medicare beneficiaries.

B. Advocate for the inclusion of non-medical benefits in regular Medicare. Only 40% of California Medicare beneficiaries have chosen to receive their care through Medicare Advantage plans. There should be options for beneficiaries in regular Medicare to also receive certain non-medical benefits, especially if these benefits have been shown to reduce the costs of care in the long term. The [Bipartisan Policy Center](#) conducted actuarial analysis showing that certain non-medical benefits for seniors with chronic conditions could save the program money. Through evaluation and advocacy, California should lead the way in advocating for the inclusion of these benefits in Medicare Part B.

- Advocate with the Federal Government to explore the inclusion of certain non-medical benefits into Medicare Part B that have been shown to reduce Medicare expenditures in the long term.
- Explore opportunities to include Medigap carriers and Medicare Accountable Care Organizations in insurance regulation change that would allow these plans to offer complementary products to cover LTSS services.

- C. Explore development of new community based integrated care models for Medicare beneficiaries through federal Medicare waivers and demonstrations through which PACE, Federally Qualified Health Centers, and other provider based risk bearing entities would provide integrated services to those not on Medi-Cal and middle income seniors and persons with disabilities**, partially financed through income-adjusted premiums. DHCS should work with stakeholders and CMS to identify Medicare waivers and demonstration authorities that can be used for this purpose and support and advocate on behalf of promising demonstrations with CMS.

Health Care Integration Resources:

- Medicaid and CHIP Payment and Access Commission: June 2020 Report to Congress, Chapter 1, Integrating Care for Dually Eligible Beneficiaries: Background and Context; Chapter 2, Integrating Care for Dually Eligible Beneficiaries: Policy Issues and Options. Accessed on July 27, 2020 at:
- Aging and Disability Business Institute: *Integrating Care to Improve the Nation's Health*. Accessed July 5, 2020 at: <https://www.aginganddisabilitybusinessinstitute.org/resources/integrating-health-and-social-care-to-improve-the-nations-health/>
- Centers for Medicare and Medicaid Services: *Community-Based Care Transitions Program Fact Sheet*. Access on July 5, 2020 at: <https://innovation.cms.gov/files/fact-sheet/cctp-fact-sheet.pdf>
- Centers for Medicare and Medicaid Services: *Community-Based Care Transitions Evaluation*. Accessed on July 5, 2020 at: <https://downloads.cms.gov/files/cmms/cctp-final-eval-rpt.pdf>
- *Partners in Care Foundation: A Change Agent in Community-Based Care*. Generations Magazine. Spring 2019. Accessed July 5, 2020 at: <https://online.flippingbook.com/view/21895/34/>
- Graham, Carrie, PhD: *The Impact of Cal MediConnect on Transitions to Community-Based Settings*. May 2017. Accessed on July 5, 2020 at: https://www.thescanfoundation.org/media/2019/08/the_impact_of_cal_medicconnect_on_transitions_from_institutional_to_community-based_settings_may_2017.pdf
- Center for Health Care Strategies: *Facilitating Community Transitions for Dually Eligible Beneficiaries, Health Plan of San Mateo's Community Care Settings Program and Inland Empire Health Plan's Housing initiative*, December 2019. Accessed July 27, 2020 at: <https://www.chcs.org/resource/facilitating-community-transitions-for-dually-eligible-beneficiaries/>
- Centers for Medicare and Medicaid Services: *Preliminary Medicare COVID-19 Data Snapshot*, July 2020. <https://www.cms.gov/newsroom/press-releases/cms-updates-data-covid-19-impacts-medicare-beneficiaries#:~:text=The%20updated%20data%20on%20COVID,1%20to%20June%20>

[20%2C%202020.&text=Black%20beneficiaries%20continue%20to%20be,670%20hospita
lizations%20per%20100%2C000%20beneficiaries.](#)

- [Bipartisan Policy Center. Next Steps in Chronic Care: July 2019.](#) Expanding Innovative Medicare Benefits. <https://bipartisanpolicy.org/wp-content/uploads/2019/07/Next-Steps-in-Chronic-Care.pdf>

Skilled Nursing Facilities

Skilled Nursing Facility Background¹:

Nearly one in four Californians will be aged 65 and older by 2060.² The number of California older adults with one or more limitations in activities of daily living (ADL) is projected to increase from one million in 2015 to 2.7 million in 2060.³ As the population ages and adults with ADL limitations grow in number, the need for long term care will only increase.

Most individuals needing long term care prefer to live in their own homes or smaller residential care settings, not in restricted environments such as a long stay in a nursing home. While a myriad of programs has sought to create more long-term care options at home and community settings, the need for alternatives to living in congregate settings is greater than ever. We need a housing program that plans for and finances residential care and assisted living beds as well as independent living units in California. Such a program should focus on housing for low-income individuals who are aging or have disabilities, including homeless people, to avoid unnecessary nursing home use. The housing recommendations in this Master Plan, included under Goal 2, address these substantial housing issues. In the meantime, however, there will always be a need for some level of skilled nursing facility capacity throughout the State.⁴

At the same time, we need to “re-imagine” nursing home care in California. There has been a shift from nursing homes to home and community-based care over the past several years, although that shift has not occurred quickly enough. In fact, total nursing facility beds declined slightly from 2010 to 2016 in California, while use of home health, hospice, and other home or community-based services has grown.⁵ A ten-year roadmap calls for nursing homes to be smaller, more home-like, and focused on those patients who absolutely require this level of care.

The COVID-19 crisis has had a devastating impact on nursing home residents and staff. As of this writing, more than 32% of COVID deaths in California have been among NH residents; yet individuals admitted to NHs represent less than one percent of the state’s population. Infections and deaths have had a disproportionate impact on racial and ethnically diverse residents and workers, highlighting the disparities in the long-term care system and the society at large. In response to COVID and to the longer-term challenges in NHs, California needs to develop a strategy for ensuring quality services through a combination of

¹ SNFs are a discreet licensing category and are generally short stay (more than 80% of nursing home patients have less than a three-months stay). SNFs also have long stay patients. Intermediate Care Facilities (ICFs) generally serve long stay developmentally disabled patients. Residential Care Facilities for the Elderly (RCFEs) are also touched on in this section. These are non-medical congregate living facilities and are often referred to as “Assisted Living.”

² CHCF, *Long-Term and End-of-Life Care in California: Is California Meeting the Need?* (June 2020).

³ Ibid

⁴ Skilled Nursing Facilities will be referred to as “Nursing Homes” throughout this section.

⁵ Ibid

leadership, workforce development, appropriate payment incentives and regulatory oversight.

Also, Intermediate Care Facilities (ICFs) for the Developmentally Disabled in California serve an important population that is often overlooked in discussions about the long-term care needs of Californians. Like nursing homes, some are supported by the State's fee for service system, while others operate in counties where managed care organizations have payment responsibility. These are generally small operations owned by families and need a great deal of support as well. Many of their residents transferred from recently closed State operated Developmental Centers (e.g., Agnew, Sonoma, Porterville). All NHs and ICFs are scheduled to operate under managed care within the next two years.

Finally, this section only touches on congregate living facilities such as Residential Care Facilities for the Elderly and other assisted living options which do not generally provide medical support. However, RCFE's are a critical resource for older adults and people with disabilities. RCFEs and the services they offer can provide alternative living options for individuals who might otherwise have to move to a nursing home.

Skilled Nursing Facility Recommendations:

Goal 1: Immediately stabilize the nursing home workforce in the face of the pandemic.

Many nursing facility staff, particularly part-time workers, reportedly do not have health insurance or adequate paid sick leave, which exacerbates long-standing staffing issues in a time of COVID. Black and Latino workers make up nearly half of the U.S. LTSS direct workforce⁶, including many workers in nursing facilities. These staff are also most at risk of COVID infection and poor outcomes. Low pay and lack of benefits result in racial and ethnic disparities and income inequities. Nursing facilities have seen temporary increased reimbursement from Medi-Cal, Medicare, and the Federal Cares Act during the pandemic. The State should ensure facilities use this increased funding for the following:⁷

- A. Health insurance and adequate paid sick leave (two weeks) during the pandemic. This will prevent workers from coming to work sick, reduce the need for workers to work multiple jobs and address racial/ethnic disparities and income inequities;**
- B. Hazard pay for workers in SNFs with COVID outbreaks, regular testing of staff, and adequate PPE provision; and**
- C. Adequate infection preventionist coverage.⁸**

⁶ Chernof, Bruce and Mann, Cindy, *Building the Long-Term System of the Future: Will the COVID-19 Nursing Home Tragedies Lead to Real Reform?* *Health Affairs* (July 31, 2020).

⁷ The State and CMS have indicated they will audit nursing home financial reports to ensure the additional reimbursement is being used for COVID related expenses.

⁸ AB 2644 would require this: https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200AB2644. It is enrolled, but not chaptered as of this writing.

Goal 2: Establish immediate support for facilities to improve staff engagement and quality of care through comprehensive performance improvement. The Department of Health Care Services often partners with outside entities such as foundations and consultants, managed care plans, physician groups and consumers in quality improvement initiatives for physician providers and to increase the overall quality of health care available to California's Medi-Cal population. However, the current Quality Assurance Fee program is not adequately addressing improvement in quality. Although facilities are required to have quality improvement policies and programs, current data from surveys and complaints, as well as experience in the COVID crisis, does not demonstrate adequate quality in many nursing homes.

- A. Immediately explore and implement models such as that provided by the State of Oregon, which developed a foundational program for quality assurance and performance improvement in long-term care settings, using long term care facility fines and license fees to pay for the program.⁹ The State should also explore the use of Quality Assurance Fund dollars for this purpose. DHCS and CDPH should be charged with leading this exploration collaboratively.**

Goal 3. Consolidate state leadership responsible for all aspects of NH and other congregate care. Currently there are several different departments involved in regulation and oversight of SNFs and Residential Care Facilities for the Elderly (RCFEs), resulting in a lack of accountability. These facilities share similar challenges although they also differ in important ways. While RCFE's typically do not include medical care, they need medical support both in emergency situations such as this pandemic and in normal times to ensure their residents can age in place.

- A. The State should create one leadership position in Health and Human Services to be accountable for and ensure coordinated NH, RCFE, and ICF oversight, and SNF and ICF payment.**

Goal 4: Promote a “Call to Action” to offer services in community-based settings instead of nursing homes. In 1999, the U.S. Supreme Court ruled in the case of *Olmstead v. L.C.*, finding that the unnecessary institutionalization of people with disabilities is a violation of the Americans with Disabilities Act of 1990 (ADA), thereby establishing the right of individuals with disabilities to receive services in the most integrated setting. To meet the intent of the *Olmstead* decision, it is the State's obligation to ensure that individuals have access to an array of supportive services that meet each person's needs and preferences, regardless of age or degree of disability. According to the [2017 Long-Term Services and Supports Scorecard](#), almost eleven percent of California's 101,000 nursing home residents—or 11,000 individuals--- are identified as having low-care needs. These individuals could be cared for in the community, as an alternative to skilled nursing care. But for many such individuals, the opportunities to transition either do not exist or they are unaware of the alternatives.

⁹ See description at LiveWell Program website, <https://www.livewell-oregon.com/>

- A. Continue developing urgent responses to the COVID pandemic to help people avoid nursing home care.** The State is implementing several actions but needs to do more. The State should mobilize all tools available, including mobilizing Medi-Cal managed care health plans, PACE organizations, LTSS providers, hospitals, nursing homes, home health providers, community-based organizations, and housing providers to help with transitions and alternatives to nursing home care.
- B. Develop goals and a plan for nursing home transitions.** The State should set annual and five- and ten-year goals for nursing home transitions to community settings. The State should also develop specific plans for how to meet these goals, including specifying which services are needed and how each type of organization can contribute to meeting these goals. Possible metrics might include rate of nursing home admissions, rate of nursing home transitions to the community, and longevity in the community post nursing home discharge. The plan should include incentives and goals for managed care health plans and PACE organizations, either as convenors or as direct service providers. Any proposed program must be part of a coordinated strategy for reducing the population being cared for in nursing homes through integrated services. Finally, the State's plan should include evaluations of why some programs and approaches work better than others in achieving successful nursing home transitions.¹⁰

Goal 5: Begin now to create the NH workforce of the future through higher pay and training to improve employee skills. Education, training, and pay and benefits are all key for improved recruitment and retention for NH staff. The average California nursing home had over 53 percent nursing staff turnover and over 50 percent turnover for all employees, according to an analysis of 2018 cost reports.¹¹ Pay for staff in nursing homes is low relative to many other health settings, resulting in income inequities and racial and ethnic disparities in the NH workforce, and the need for workers to work multiple jobs in different facilities.

- Refer to MPA LTSS Subcommittee Report (May 2020) for recommendations for expanding LTSS workforce supply and improving working conditions; ameliorating staffing issues in residential settings; and investment in LTSS workforce education and training.
- Develop strategies to improve conditions for NH clinical staff, through incentives to encourage NHs to increase wages and benefits for nurses, and to encourage NHs to employ and consult with physicians and other clinical staff with expertise in geriatrics, chronic care management, dementia, and mental health. Refer to recommendations in "Assuring the Workforce to Care for Older Adults" chapter under Goal 3.

¹⁰See for example, H. Stephen Kaye, *Evidence for the Impact of the Money Follows the Person Program*, UCSF (July 2019), which notes that California ranks 38th among all states in the rate of transitions per 100,000 population. <https://clpc.ucsf.edu/publications/evidence-impact-money-follows-person-program>

¹¹ See Charlene Harrington recommendations write-up.

Goal 6: Improve collaboration and coordination among state and local organizations responsible for oversight, payment, and quality in nursing homes.

Since the establishment of the Coordinated Care Initiative in 2014, most NH care is now paid for by managed care organizations, including all NH care in LA County. County Organized Health System managed care organizations (MCOs) have long been payers for NHs. Despite this, and the planned shift of payment responsibilities to MCOs in all counties in the next one to two years, the State's overall strategy for ensuring quality in nursing homes through payment incentives, regulatory oversight, and close alignment with managed care plans is lacking. Even when payment responsibility is held by DHCS, there is little evidence of collaboration and shared strategic approaches among DHCS, CDPH, and DDS (responsible for some oversight of ICF-DD homes).

In addition, health care payers in general have increased reliance on payment arrangements that shape provider behavior (called value-based payments) to ensure cost-effective and high-quality health care. CMS has encouraged and incentivized this trend for all Medicare funded services. However, the use of these payment tools has lagged in Medi-Cal nursing home reimbursement strategies. Several Medi-Cal managed care plans have implemented value-based payments with nursing facilities prior to the COVID pandemic and with additional reimbursement to reward quality and safety during the pandemic.¹² The State has begun some work in this area with the AB1629 program; however, coordination with DHCS and Medi-Cal managed care plans that are responsible for payments to nursing homes is lacking.

- A. Establish a consortium including state officials from CDPH, DHCS, DDS, health plans, and NH representatives to investigate strategies for improving quality through payment.** The consortium should be tasked with developing value-based payment arrangements that can be used by health plans and the State to incentivize improved quality care and staffing in nursing homes.¹³

Goal 7: Strengthen oversight and ensure adequate staff staffing to conduct oversight.

According to the California State Auditor,¹⁴ the State had a backlog of roughly 10,000 nursing home complaint investigations and incidents to investigate in 2014 which is still ongoing. In 2018 and 2020, the State Auditor found that the State was still unable to complete its required inspections and is not providing effective State oversight of NHs. In the year prior to the COVID outbreak, over 60 percent of California nursing homes were

¹² See for example Inland Empire Health Plan, Partnership Health Plan, and Health Plan of San Mateo.

¹³ We understand that 2020 Budget Trailer Language required DHCS to convene a stakeholder process by September 1, 2021 to develop a successor supplemental payment or similar quality-based payment methodology to replace the current program. This process should include Medi-Cal managed care plans.

¹⁴ California State Auditor. Skilled Nursing Facilities: Absent Effective State Oversight, Substandard Quality of Care Has Continued. 2017-2018. <https://www.auditor.ca.gov/pdfs/reports/2017-109.pdf>

found to have inadequate infection control plans by the federal HHS Office of the Inspector General (2019).¹⁵

- A. Use multi-disciplinary state survey teams and ensure penalties are commensurate with the severity of the violation, especially for non-compliance with staffing, life safety, emergency preparedness, and infection control requirements.**
- B. Explore elimination of state surveyor conflict of interest.**
- C. Deploy state survey teams that are capable of coaching NHs to comply with standards and use penalties for NHs that are not cooperative.**
- D. Increase transparency from survey results, e.g., by using a five-star rating system.**
- E. Develop improved and transparent criteria for use of holds on admissions and temporary managers to force immediate compliance whenever resident safety is threatened.**
- F. Explore consolidation of state and federal survey tools so that surveyors only need to survey once for similar issues.**

Goal 8: Stop inappropriate discharge and transfer of NH residents. Inappropriate discharge is the number one complaint ombudsmen receive from long term care residents. Two recent New York Times investigations reported on the extent of this problem nationwide.¹⁶ This is a critical reform needed for responding to the current pandemic.

- A. The State should enforce current requirements for thirty-day notice of discharge, consent signed by the patient or responsible family member, appeal rights, and assistance in finding an appropriate living arrangement and services. Enforcement should include appropriate fines and disciplinary action, including placing payment holds for future admissions if necessary.**
- B. The State should work with local stakeholders to develop strategies for more residential options for patients with behavioral health and cognitive issues, since nursing homes are often not the best alternative for these individuals. However, finding appropriately staffed and high-quality community placements is exceedingly difficult and a payment source is mostly lacking.**

Goal 9: Ensure appropriate staffing levels. Multiple research studies and professional associations have identified minimum staffing levels needed to protect the health and safety of residents, recommending 4.1 total nursing hours per resident day (hprd) including 0.75 RN hprd and 2.8 CNA hprd.¹⁷ Research shows that 75 percent of California nursing

¹⁵ Office of the Inspector General, U.S. Health and Human Services. <https://oig.hhs.gov/reports-and-publications/workplan/summary/wp-summary-0000471.asp>

¹⁶ [New York Times](#): “‘They Just Dumped Him Like Trash’: Nursing Homes Evict Vulnerable Residents,” July 23, 2020; “Nursing Homes Oust Unwanted Patients with Claims of Psychosis,” September 19, 2020.

¹⁷ See for example: Harrington, C., Ross, L., Chapman, S., Halifax, E., Spurlock, B., & Bakerjian, D. (2020). Nurse Staffing and Coronavirus Infections in California Nursing Homes. Policy, Politics, & Nursing Practice. <https://doi.org/10.1177/1527154420938707>

homes did not meet the 0.75 RN hprd and 55 percent did not meet the 4.1 total nursing hours per resident day.

- A. Increase nurse staffing levels over an appropriate time-period to meet the higher standards.**
- B. Eliminate waivers of the minimum staffing level requirements for nurses and explore funding to cover actual direct labor costs.**
- C. Conduct study on outcomes based on staffing levels to assure the ratio of FTEs to discipline is appropriate (i.e., what are outcomes if more CNAs or more LVN's are working in a facility?)**

Goal 10. Increase transparency associated with nursing home for-profit ownership and third-party transactions. In California, 89 percent of nursing homes are for-profit, and 75 percent of nursing homes are part of a nursing home chain. It is difficult to determine who owns many nursing homes and the related companies they hire for services. Some nursing homes have as many as eight or ten layers of parent companies and dozens of related companies that provide services to the nursing home. Also, by engaging in "self-dealing" or paying other companies that they own (related party individuals and organizations) for services that include management, nursing, and therapies, and lease arrangements and loans, nursing homes often siphon money out of the facilities as expenses and hide profits through these third party contractors.

- A. Require a consolidated cost report for the owner/operator of every nursing home chain and/or parent company that includes every nursing home and related party companies and individuals they contract with to reveal self-dealing profits and losses.** Require that the consolidated cost report be certified by a CPA.
- B. Enforce the current requirement that all nursing homes owned or operated by individuals or corporations fully report all their parent companies and all related party companies along with an organizational chart for the complete chain to CDPH and OSHPD.**

Goal 11: Enforce minimum criteria for the purchase or management of NHs.

- A. While prior approval of applications for ownership and management changes is required within 90 days of when a change is requested, regular enforcement is lacking.**

Goal 12: Provide easily accessible information for consumers

- A. Support CalQualityCare.com which provides comprehensive quality information about skilled nursing, assisted living, ICF-DD, and other LTSS services.**

Goal 13: Create a long-term care strategy that allows for an individual to be cared for in the least restrictive setting. Despite projections for significant growth in the numbers of older people and people with disabilities in California, the number of nursing home facilities has declined in the state in recent years.¹⁸ There is also a maldistribution of nursing home beds and facilities. Some communities, where land is limited and expensive, rural areas, and inner-city urban areas, have more limited access to nursing homes and residential care, while there is excess bed capacity in other regions. Nursing home bed availability in the San Francisco Bay Area has declined markedly in recent years, creating placement difficulties for mainly Medi-Cal patients, especially those who experience behavioral challenges.¹⁹ While the State should rightly focus on reducing reliance on NHs and providing alternatives to NH care, there will always be a need for some NH care that is high quality and culturally appropriate.

- A. Develop a statewide benefit for long term care delivery in the community, whether it be in an individual's home, independent affordable housing, residential care facilities, or other community settings. As many people as possible should be diverted for NH level of care to these community alternatives.**
- B. Ensure an adequate supply of residential care/assisted living beds and independent living units in California, with a special focus on meeting the housing and services needs of individuals with behavioral health or cognitive difficulties, to facilitate moving nursing home residents to more home like and less restrictive settings and to avoid inappropriate nursing home stays.²⁰**
- C. Commission a study to determine projected need for NH beds, assuming NH alternatives are implemented and will be available. This study should consider differences in need by geography.**

Goal 14: Refashion architectural models of facilities to modernize and promote smaller, home like models that are recommended for infection control, staff satisfaction, and resident quality of care. Most nursing home buildings in California are old, outdated, and poorly configured, and often do not meet contemporary seismic standards. There have been many models, like The GreenHouse Project,²¹ that are architectural designs that use single occupancy rooms and group living spaces. These models have been studied and shown to improve the well-being of residents, improve job satisfaction of workers, and are well designed for infection prevention.

¹⁸ CHCF, *Long-Term and End-of-Life Care in California: Is California Meeting the Need?* (June 2020).

¹⁹ County of Santa Clara, *Santa Clara Gap Analysis on Care Facilities and Transitional Housing*, November 2016.

²⁰ See housing recommendations under Goal 2 for more information.

²¹ <https://www.rwjf.org/en/how-we-work/grants-explorer/featured-programs/the-green-house-project.html>

- A. Establish a state commission to reimagine the nursing home of the future.** This commission should also direct the remodeling, refinancing, and replacement of outdated CA nursing homes and residential care facilities and replace them with models that are more home like and help prevent the spread of infection.
- B. Expand existing financing programs that incentivize remodeling nursing facilities and residential care facilities.**
- C. Set new minimum standards and establish financial mechanisms for remodeling or replacing non-conforming nursing homes and residential care facilities within the next ten years.**

Goal 15: Evaluate progress. The State should evaluate the progress it has made under these recommendations by examining trends in data at regular intervals. All metrics should require analysis of the data by the equity dimensions of race/ethnicity, income, age, and ability to prevent disparities.

- Quality metrics in NHs
- Number and frequencies of complaints and violations
- Rates of staff turnover in facilities (nursing and all staff)
- Extent of value-based payment arrangements implemented by managed care organizations and the State
- Rate of NH admissions from community-based settings
- Rate of NH transitions to community-based settings
- Longevity in the community of those individuals transitioned from NHs to community settings
- Satisfaction ratings among SNF residents and SNF residents transitioned to the community, trended over time.
- Satisfaction ratings among staff in NHs, trended over time

Skilled Nursing Facility Resources:

- CHCF, *Long-Term and End-of-Life Care in California: Is California Meeting the Need?* (June 2020).
- CHCF, *COVID-19 Tracking Poll: Most Front-Line Staff at California Nursing Homes See Infections at Work, July 16, 2020.* <https://www.chcf.org/blog/covid-19-tracking-poll-most-frontline-staff-nursing-homes-see-infections-work/>
- Harrington, C., Ross, L., Chapman, S., Halifax, E., Spurlock, B., & Bakerjian, D. (2020). Nurse Staffing and Coronavirus Infections in California Nursing Homes. *Policy, Politics, & Nursing Practice.* <https://doi.org/10.1177/1527154420938707>
- <https://www.rwjf.org/en/how-we-work/grants-explorer/featured-programs/the-green-house-project.html>
- LiveWell Program. Accessed on July 27, 2020 at: <https://www.livewell-oregon.com/what-we-do>
- [Manatt, Recommendations to Strengthen the Resilience of New Jersey's Nursing Homes in the Wake of COVID-19, June 2, 2020](#)

- County of Santa Clara, *Santa Clara Gap Analysis on Care Facilities and Transitional Housing*, November 2016. Access on July 27, 2020 at: <https://sccgov.iam2.com/Citizens/FileOpen.aspx?Type=1&ID=7735&Inline=True>
- Chernof, Bruce and Mann, Cindy, *Building the Long-Term System of the Future: Will the COVID-19 Nursing Home Tragedies Lead to Real Reform?* Health Affairs (July 31, 2020).
- California Association of Health Facilities, *2020 Quality Report*. This and other quality related materials can be found at: <https://www.cahf.org/Reports>.

Behavioral Health

Behavioral Health Background:

Older adults in California with behavioral health problems, which include both mental health and/or substance abuse issues, are unserved and underserved relative to their needs²². For example, adults age 65 and above were 16.0 % of the adult Medi-Cal population, but only 1.7% received one or more specialty mental health services (SMHS) during the year (FY 2016-2017). Priority concerns include the need for more systematic data collection, shortages in geriatrically-prepared behavioral health workforce, geographic and racial disparities in service availability, and a lack of state guidance and leadership to promote an older adult system of care for behavioral health services. Older adults with behavioral health needs, coupled with common physical health issues, are best served with integrated health models that increase access and convenience to meet their needs.

Geographic disparities in access to behavioral health care remains a pressing issue for older adults. Even in counties that offer innovative programs that are tailored to meet the needs of older adults, their reach is usually limited to a small proportion of older adults with need who are located in a specific geographical area of the county or, in some cases, are members of a special population group. In some counties, specialized mental health programs for older adults are only available in certain geographic areas, typically the cities or more densely populated areas. In other counties, even basic services are not available in certain geographic pockets. These geographic barriers are seen as especially challenging for older adults who are more likely to have mobility limitations and are at heightened risk due to social isolation.

Integrated care can address geographic barriers to receiving care, an issue especially relevant in rural counties and in rural pockets of large counties where there is little or no service delivery infrastructure. Co-location of behavioral health services with primary care improves access to care, especially for older adults who are more likely to have multiple chronic conditions.

The deleterious impact on substance abuse and addictions, depression, and mental illness shortens the life span and leads to an assortment of debilitating illness, diseases and morbidities. Other components of the Master Plan address these issues in great deal but we draw on several that are pertinent to this Goal. We specifically applaud those recommendations that designate a new older adult administrative unit within HCS and we recommend drawing on innovative early intervention and prevention programs. Geriatric/gerontology behavioral expertise and standardized geriatric training is crucial given the rising needs of an older population including culturally and racially appropriate services for racially and ethnically vulnerable older populations. The UC System can play an

²² <https://www.ncbi.nlm.nih.gov/books/NBK201404/>, https://www.calbhbc.com/uploads/5/8/5/3/58536227/2017_18_statewide_summary_of_all_2017_data_notebooks_12.31.2018_fi nal.pdf and <http://healthpolicy.ucla.edu/publications/search/pages/detail.aspx?PubID=1710>.

important role through its graduate programs in medicine, public health, nursing and social work by incentivizing them to address geriatric/gerontology education, training and best practices. We suggest financial support to encourage members of racial, ethnic and immigrant groups to seek advanced degrees in these areas. Proposition 63 provides crucial resources for behavioral health services and we recommend accountability and oversight of how these funds target and benefit older adults

Behavioral Health Recommendations:

Goal 1. Document and address the scope of behavioral health needs and unmet needs among older adults and people with disabilities in California.

- A. *Institute mandatory and standardized data reporting requirements at state and local (county) levels.*** Counties should systematically investigate and document the unmet needs and measure and monitor their progress in serving the behavioral health care needs of older adults. *(Note: The UCLA Center for Health Policy Research has developed and published a recommended essential set of data elements to measure older adult outcomes in the public mental health system [see <http://healthpolicy.ucla.edu/publications/search/pages/detail.aspx?PubID=1559>]).*
- B. *Conduct dedicated outreach and document unmet need among older adults with mental illness and behavioral health issues.*** Outreach strategies must be specific to older adults, take into account where and how best to identify those in need.
- C. *Ensure geographic equity in access to behavioral health services.*** Older adults and people with disabilities who live in rural counties and communities often do not have access to needed services due to small networks of providers, large geographic distances to travel and lack of providers who are linguistically appropriate for population needs. The cost of delivering services and the need for incentives to recruit the necessary providers needed is not being accounted for in the current funding formula. The funding formula should be increased to assure that rural counties are provided the necessary funding needed to address critical geographic disparities in service delivery.

Goal 2. Increase access and service delivery to older adults and people with disabilities to address unmet need.

- A. *Designate a new older adult administrative unit (administrator with geriatrics/gerontology expertise and support staff) within the California Department of Health Care Services, Behavioral Health unit.*** This new unit will provide leadership to improve older adult service delivery and work collaboratively across state departments and with county mental health and aging units. *Note: AB 480 (Salas) is a model legislative effort that was not approved in 2019 awaiting the development of the Master Plan on Aging (see http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200AB480).*

- B. Include engagement with stakeholders and consumers in Behavioral Health Planning.** For service planning, consumer advocates and/or people with geriatric/gerontology behavioral expertise should be “at the table” within important statewide agencies and professional organizations, with designated slots or committees organized around the issues of older adult behavioral health.

Goal 3. Increase service integration, especially the integration of medical, behavioral health, aging, and substance use services. To effectively integrate services at the point of service delivery, the funding sources, health plans and administrative agencies must first align. This requires coordination across the relevant state and county administrative agencies, health plans, and funding sources. At the point of service delivery, this type of systems integration would support more opportunities for physical co-location and service integration.

- A. Task the new Behavioral Health services administrator (see Goal 1. A. above) to establish a system of care collaborative across relevant departments and units at the state level.** This will include building functional bridges and agreements with health services, aging services, health equity, OSHPD, county mental/behavioral health departments and other departments/units to assure a seamless continuum of care for behavioral health services.

Behavioral Health Resources:

- *Geographic disparities (excerpted from the California Mental Health and Older Adult Study Deliverable 3 report (access at: <http://www.healthpolicy.ucla.edu/Older-Adult-Mental-Health>)*
- <http://healthpolicy.ucla.edu/publications/search/pages/detail.aspx?PubID=1559>].
- AB 480 (Salas) is a model legislative effort that was not approved in 2019 awaiting the development of the Master Plan on Aging (see http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200AB480).
- <https://www.ncbi.nlm.nih.gov/books/NBK201404/>.
- https://www.calbhbc.com/uploads/5/8/5/3/58536227/2017_18_statewide_summary_of_all_2017_data_notebooks_12.31.2018_final.pdf and
- <http://healthpolicy.ucla.edu/publications/search/pages/detail.aspx?PubID=1710>)

Alzheimer's and Dementia Care

Alzheimer's and Dementia Care Background:

California leads the nation with the largest and most diverse population directly impacted by Alzheimer's and related dementias: currently 690,000 individuals are affected and 1.6 million family members provide hands-on, direct care and support to a loved one with the disease. These numbers are slated to grow by 22 percent by 2025. In its February 2019 *Measuring Public Health Status Report*, the California Department of Public Health documented Alzheimer's as the second leading cause of death in California. For the most recent period evaluated, there were nearly 1 million annual emergency room visits in California by patients with dementia.

The burden of Alzheimer's is large and growing, especially among women and people of color. The impact of the disease on individuals, families, communities and health systems is significant. Costs, to the public Medicaid program where costs are 23 times higher for beneficiaries with dementia than those without – and to families, who spend in excess of \$50,000 annually for assisted living or more than \$100,000 annually for skilled nursing care, are unsustainable at nearly \$350,000 per person over the average 7-10 year course of the disease.

Alzheimer's and Dementia Care Recommendations:

Goal 1. Improve care for older adults and people with disabilities who have Alzheimer's and related Dementias.

- A. *Improve screening and detection*** – All managed care health risk assessments and service provider initial intakes/functional assessments should include validated screening questions to detect cognitive impairment. Medicare, through the annual wellness visit, covers a brief, validated structured cognitive assessment tool.
- B. *Increase the number of Californians who are aware of their diagnosis*** – When an individual self-reports symptoms or concerns, or when a screening tool warrants, or upon referral, the patient should receive a comprehensive assessment. The California Alzheimer's Disease Centers have produced a toolkit for primary care physicians to guide in this process. Healthy People 2020 Goal DIA-1 calls on the nation to improve the percentage of all people aware of their diagnosis from just 62 percent.
- C. *Improve systematic documentation of Alzheimer's and related dementia diagnoses*** – If a patient is diagnosed with Alzheimer's disease, mild cognitive impairment, dementia, or related condition, the diagnosis should, first, be disclosed to the patient, and then documented in the medical record and made available through the electronic health record.

Goal 2: Ensure Californians with Alzheimer’s and related dementia receive care coordination and care plans.

- A. *Provide Care Planning to patients and families with Alzheimer’s and related dementias*** – California pioneered the Alzheimer’s Disease Clinical Care Guideline for post-diagnostic treatment and, since January 2017, Medicare has covered a comprehensive dementia care planning benefit. Yet, only about one percent of beneficiaries have been provided with a care plan.

- B. *Improve Care Coordination***– Without a diagnosis or a care plan, care coordination is unattainable. Nearly all persons with dementia have at least one co-occurring chronic condition and, increasingly, many live alone (estimates are one in five). Several groundbreaking CMS Innovation projects have been successfully piloted in California, including UCSF Dementia EcoSystem and UCLA Coordinated Alzheimer’s and Dementia Care, as well as ongoing Administration on Community Living (ACL) Dementia Care Management grants to California Department of Aging.

Goal 3. Integrate care for Californians with Alzheimer’s and related dementias.

- A. *Invest in home- and community-based services.*** Because age is the greatest risk factor for Alzheimer’s, the vast majority of people affected are Medicare beneficiaries and many are dually eligible for Medi-Cal. With this population, the need to integrate the two funding streams – and invest savings in home and community-based supports – is paramount.

- B. *Improve hospitalizations for people with Alzheimer’s and related dementias.*** With nearly 1 million high cost emergency room visits recorded each year in California. Healthy People 2020 Goal DIA-2 calls for a reduction in avoidable hospitalizations. West Health has set the national standard for Geriatric Emergency Departments and many Californians with Alzheimer’s and dementia have directly benefited from the model, most notably with reductions in hospital readmissions.

- C. *Improve care transitions.*** An area where lack of integration is pronounced and costly is care transitions; persons with dementia who cycle between residential care or skilled nursing and hospitals, driving costs up in both the Medi-Cal and Medicare programs with little benefit to the resident; in fact, often to the resident’s detriment with transfer trauma.

Goal 4. Address the needs of California caregivers

- A. *Caregiver Identification and Assessment.*** Because of the progressive, degenerative nature of Alzheimer’s disease, it’s imperative to establish a care team early. Physicians, health plans and community-based service providers are encouraged to identify and document a family caregiver, assess caregiver strain, and develop care plans for the caregiver. The Family Caregiver Alliance and the 11 Caregiver Resource Centers are national leaders in this work.

Goal 5. Create a dementia capable workforce in California

- A. Workforce** – Persons with Alzheimer's, over the long course of the disease, rely on the full array of health professionals, from direct care workers to specialty physicians and every level of job category in between. It's challenging to promote dementia training across such a wide spectrum of educational backgrounds, licensure categories and employment models. Models exist, including the California Long-Term Care Education Center training IHSS workers, statutorily required dementia training in all RCFEs, and training of care managers in health plans under the ACL grant noted above.

Alzheimer's and Dementia Care Resources:

- California's statewide network of Alzheimer's disease centers <https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/CDCB/Pages/CaliforniaAlzheimersDiseaseCenters.aspx>
- California Primary Care Physician Toolkit for Dementia Diagnosis <https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/CDCB/CDPH%20Document%20Library/Alzheimers%20Disease%20Program/ACCT-AD%20Toolkit%2012%2027%2018.pdf>
- California post-diagnostic Alzheimer's clinical care guideline <https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/CDCB/CDPH%20Document%20Library/Alzheimers%20Disease%20Program/ALZ-CareGuidelines.pdf>
- Stanford's Geriatric Dementia and Depression Scale <http://med.stanford.edu/svalz/apps.html>
- Centers for Disease Control Healthy Brain Initiative <https://www.cdc.gov/aging/healthybrain/index.htm>
- UCSF Dementia Care Ecosystem <https://memory.ucsf.edu/research-trials/professional/care-ecosystem>
- UCLA Alzheimer's and Dementia Care Management Program <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3889469/#:~:text=The%20UCLA%20ADC%20program%2C%20which,centered%20care%20for%20patients%20with>
- Alzheimer's Association <https://www.alz.org/professionals>
- National Institutes of Health <https://www.nia.nih.gov/health/alzheimers>

Telehealth

Telehealth Background:

California was one of the first states to pass a telehealth law with the [Telemedicine Development Act of 1996](#). At the time, the bill was considered progressive legislation and provided model language for other states. However, in the almost two decades that followed, telehealth law in California essentially remained unchanged, even as technology and its penetration rapidly evolved. Progress was made with the [California's Telehealth Advancement Act of 2011 \(AB 415\)](#) which went into effect in January of 2012 and in recent years, the language put in place by AB 415 has been amended, with the most significant change occurring with the passage of AB 744 in 2019.

With his signature, Governor Gavin Newsom positioned California back to the forefront of telehealth policy. One of the most substantial revisions, which applies to health plans issued, amended or renewed on or after Jan. 1, 2021, requires payers to reimburse for telehealth services on the same basis and to the same extent, as well as at the same rate as an equivalent service when delivered in person. With this law, California became one of roughly a dozen states to require payment parity. Newsom also signed into law [AB 1264](#). The bill adds California to the growing list of states and government entities embracing asynchronous (or store-and-forward) telehealth, which allows patients to submit questions or answers and provide data that providers can review at their discretion.

Although California is ahead of many if not most for patient and provider friendly telehealth legislation, there is still significant room to enhance our state's leadership to better serve the population, particularly the aging and disabled. The Covid19 pandemic has brought to light the importance of telehealth enabled care. Telehealth is one of the few subjects that has achieved bipartisan support. This is exemplified in the June 17th, 2020 [letter](#) to Senate leadership signed by at least 30 senators from both sides of the aisle calling on Congress to "expand access to telehealth services on a permanent basis so that telehealth remains an option for all Medicare beneficiaries both now and after the pandemic. Doing so would assure patients that their care will not be interrupted when the pandemic ends.

Particularly with California's and the rest of the nation's experience with Covid-19; the ongoing vulnerability and increasing isolation among frail seniors, as well as the rapid rise of the aging population in California over the coming decade, telehealth is an imperative that not only can be used to improve patient experience and health outcomes but also be a lifeline to seniors and other high-risk individuals who are not able to seek care in doctor's offices or clinics amid COVID-19 and after.

Today, with waivers in place that allow reimbursement at parity, verbal consent and cross state practice, challenges still exist. Public awareness of what telehealth is and how telehealth can be accessed through their providers and health plans is still lacking. Overall visits for chronic care are down and as noted by national media, people are avoiding getting the care they need and in turn, their conditions are becoming increasingly worse.

Robust education and public awareness campaigns geared towards seniors and the disabled are needed to help stem this trend.

Concerns are that as the national emergency ends and the waivers are rescinded that many of the restrictive telehealth policies will be put back into effect. Requiring an additional telehealth specific consent when consent for treatment has already been signed or the lack of payment parity for Medi-Cal are examples of operational and reimbursement restrictions. These restrictions have been barriers to adoption and threaten to leave citizens without appropriate access to care if put back into effect. Recommendations ensuring that California continues to lead nationally will help all citizens, particularly the aging and disabled, receive the right care at the right time and at the right location.

Telehealth Recommendations:

Goal 1: California should expand coverage of telehealth services:

- A. *Statutory definition of telehealth should be inclusive of telephonic services that are important for low-income communities that lack internet/broadband access and also easier to use with seniors.*** California should permanently remove any geographic restrictions to ensure that patients can receive telehealth services regardless of their location. Expand coverage to include behavioral health, remote patient monitoring, advance care planning and goals of care conversations, dental care and technologies that address social isolation.

Goal 2: Ensure Telehealth payment parity for Medi-Cal managed care and Denti-Cal:

- A. *State plans should also guarantee payment parity for telehealth services.*** While AB 744 guarantees payment parity for commercial plans, many seniors and disabled Californians rely on Medi-Cal managed care and Denti-Cal plans.

Goal 3: Reduce Licensing Board and practice restrictions:

- A. *Ensure that Licensing Boards do not unnecessarily make the use of telehealth onerous or burdensome (i.e., extra credentialing or registration).*** As long as meeting standard of care, the practitioner should be able to provide care via telehealth.

Goal 4: Improve coverage and reimbursement:

- A. *Ensure Medi-Cal allows use and reimbursement of all modalities of telehealth.*** Medi-Cal should cover services provided via remote patient monitoring which has been shown to improve health outcomes and reduce costs, particularly patients with chronic conditions.

Goal 5: Provider education and awareness.

- A. *Resources should be expanded or devoted to provider education on not only how to use telehealth in their practices, but also what are the existing policies and how to***

bill for services. COVID-19 showed that providers need technical assistance not only in starting and ramping up telehealth programs, but also understanding the myriad of telehealth policies, some of which they are unaware of.

B. Ensure the language used by commercial and state plans clearly identifies reimbursable codes and services that are covered.

C. Ensure consistency in how to bill and what is covered. Lack of consistency on what is covered and how to bill across different payers creates confusion and frustration for many providers. While clarity on policies will help, more consistency will alleviate this burden on providers and make it more attractive to utilize telehealth in their practices.

Goal 6: Bridge the digital divide by expanding telehealth.

A. Expand telehealth access to low income families by aligning funding to improve internet access to underserved and rural communities.

Goal 7: Improve Consumer education and awareness of Telehealth availability:

A. Initiate public awareness campaign to educate seniors about telehealth and provide robust training resources to seniors and family caregivers to support them in their use of technology. Create public awareness by informing consumers on what telehealth is and how telehealth can be accessed through their providers and health plans.

Goal 8: Create consistency across the state

A. Create a state telehealth coordinator to ensure state agencies are aware and familiar with the different telehealth policies and who will also engage with outside stakeholders on a regular basis.

Telehealth Resources:

Patient and Provider Educational/Training Resource Links

1. CHHS website on telehealth for consumers - <https://covid19.ca.gov/telehealth/#top>
2. UC Davis - <https://health.ucdavis.edu/cht/clinic/index.html>
3. CHCF videos on consumer and patient perspective - https://www.youtube.com/watch?v=wwVOebpljCI&feature=emb_title
4. DHCS: <https://www.dhcs.ca.gov/provgovpart/Pages/Telehealth.aspx>
5. HHS Telehealth Website - <https://telehealth.hhs.gov/>
6. AARP: Telehealth & the Coronavirus - <https://www.aarp.org/health/conditions-treatments/info-2020/telehealth-faq.html>
7. AARP: New Patients Share Their Telehealth Experiences - <https://www.aarp.org/health/conditions-treatments/info-2020/telehealth-benefits-for-patients.html>

8. Mid-Atlantic TRC "Helping A Patient/Client Understand Telehealth"-
<https://www.matrc.org/matrc-telehealth-resources-for-covid-19/>
9. West Health resources for senior focused telehealth -
<https://www.westhealth.org/telehealth/>

References and resources used for MPA recommendations

1. Letter to Senate Leaders CONNECT for Health Act 06.12.20.docx:
https://www.schatz.senate.gov/imo/media/doc/Letter%20to%20leadership_CONNECT%20for%20Health%20Act_06.12.20.pdf
2. Center for Connected Health Policy, The National Telehealth Policy Resource Center:
<https://www.cchpca.org/>
3. California Telehealth Policy Coalition:
<https://www.cchpca.org/about/projects/california-telehealth-policy-coalition>, West Health Institute is a member of the coalition and its Education Subcommittee
4. Morning Consult, Shelley Lyford, Congress Should Act Swiftly to Make Telehealth Expansion Permanent: <https://morningconsult.com/opinions/congress-should-act-swiftly-to-make-telehealth-expansion-permanent/>

Palliative Care

Palliative Care Background:

Palliative care is specialized medical care for people living with a serious illness. This type of care is focused on providing relief from the symptoms and stress of the illness. The goal is to improve quality of life for both the patient and the family. Serious illness is [defined](#) as a health condition that carries a high risk of mortality and either negatively impacts a person's daily function or quality of life or excessively strains their caregiver.

Palliative care is provided by a specially trained team of doctors, nurses and other specialists who work together with a patient's other doctors to provide an extra layer of support. Palliative care is based on the needs of the patient, not on the patient's prognosis. It addresses and relieves suffering across all aspects of the person: mind, body, spiritual, and relationships. It is appropriate at any age and at any stage in a serious illness, though it should start at the point of diagnosis, and it can be provided along with curative treatment. Palliative care improves health care value by both improving quality and reducing costs of care for the sickest and most complex patients. [Learn more about palliative care.](#)

Advance care planning is the process by which people think about, document and communicate their preferences for medical care should they become unable to speak for themselves. It can improve the quality of care and the patient and family experience during serious illness by aligning medical treatment with patient preferences. Thoughtful conversations are a key element of advance care planning. But to ensure people's wishes are known and honored, it's important to have documentation in the form of an advance healthcare directive (AHCD) or the Physician Orders for Life-Sustaining Treatment (POLST) form. Each form has a different purpose and should be used in the correct situation. [Learn more about AHCDs.](#) [Learn more about POLST.](#)

Palliative care is not routinely made available to patients who would benefit from receiving the services. For example, fewer than 1 in 20 hospitalized patients who could benefit from palliative care actually receive it.²³ Palliative care is often [misunderstood](#) by both health care providers and the general public. The barriers posed by race, ethnicity, culture and language sometimes interfere with people getting the best care possible. In addition, palliative care access can be limited by a lack of providers trained in the specialty, especially in rural areas and in smaller hospitals. According to a 2017 California Health Care Foundation [report](#), inpatient palliative care capacity for the entire state was estimated to be sufficient to meet 43% to 66% of need, and community-based capacity was estimated to be sufficient to meet between 33% and 51% of need.

In the current health care environment, there is too often a substantial misalignment between the medical care people want during serious illness and the care they actually receive. People are often not empowered to speak up for the kind of care they want, and

²³ National Palliative Care Registry. [Accessed March 12, 2020]; Palliative Care Service Penetration by Hospital Size. 2015.

clinicians are often not trained to have conversations with patients about their values, goals over time, treatment options and preferences. When it does happen, the documents that record these preferences are not readily available in the medical record or through an electronic registry to guide treatment during a medical emergency.

Palliative Care Recommendations:

Goal 1. Expand Access to Palliative Care Services: Develop and implement strategies that make palliative care available to all seriously ill Californians across settings, including hospitals, clinics, nursing facilities, residential care, and home-based care.

- A. *The state should incentivize health plans financially to expand the availability of palliative care in their geographic areas.***
- B. *Require hospitals to have a palliative care consult service as a part of licensing.***
- C. *Develop and implement strategies to support the sustainability of interdisciplinary home-based palliative care, such as adequate value-based payment, [consensus standards](#) for payer/provider contracts, and programs to support referrals.***
- D. *Provide information to social service providers to increase their understanding of palliative care and engage them in identifying and referring appropriate consumers for palliative care services.***

Goal 2. Incorporate Palliative Care Best Practices: Identify and incorporate current best practices into care delivery, for example those put forth in the [Clinical Practice Guidelines for Quality Palliative Care \(4th edition\)](#), developed by the National Consensus Project for Quality Palliative Care and the National Coalition for Hospice and Palliative Care.

- A. *Regulate minimum standards for healthcare providers offering a “palliative care” service to patients and survey to ensure compliance.***
- B. *Institute pay-for-performance add-ons to Medi-Cal reimbursements, as well as Medicare and commercial reimbursement, for superior palliative care as demonstrated by OASIS scores or other existing measurements.***

Goal 3. Grow Palliative Care Workforce: Require the Office of Statewide Health Planning and Development and the California Health Care Workforce Policy Commission to assess the general and specialty palliative care workforce needs in the state, and to take steps to mitigate shortages.

- A. *Provide incentives to encourage a more culturally-diverse and culturally-sensitive palliative care workforce.***

Goal 4. Educate the Healthcare Workforce in Principles and Practices of Palliative Care: Implement strategies around workforce education in palliative care across disciplines.

- A. Require a minimum level of exposure to primary palliative care in pre-professional/pre-licensure education for physicians, physician assistants, nurse practitioners, nurses, and social workers.**
- B. Conduct a healthcare provider awareness campaign through a public-private partnership to increase accurate understanding of palliative care as care during serious illness.**
- C. Incentivize continuing education in specialty-level palliative care.**
- D. Subsidize palliative care training for Medi-Cal providers.**
- E. Require skilled nursing facility staff to be trained in palliative care principles and practices using the [CARE Recommendations](#) as the foundation for the training.**

Goal 5. Empower Persons' Decision Making: Empower older adults to engage in conversations with family members and healthcare providers about serious illness and end of life, and optimize their ability to make and record their decisions about their own care.

- A. Conduct a statewide communications campaign through a public-private partnership to increase awareness of advance care planning and encourage all adults to complete an advance directive with an emphasis on naming a surrogate decision maker.**
- B. Review and update California laws regarding the requirements for making an advance directive or POLST form legally valid in light of COVID-19, electronic completion, and current thinking.**

Goal 6. Operationalize ACP: Engage large healthcare providers (e.g., integrated healthcare systems, medical groups, hospitals, and payers) in establishing systems within their organizations for consistently and reliably soliciting, documenting, retrieving and honoring patient treatment preferences.

- A. Require electronic health record software to include one-click access to advance care planning documents, including advance directives and POLST forms.**

Goal 7. Honor wishes of Californians at the end of life: Create a statewide system for making information about patients' specific treatment preferences available to healthcare providers whenever and wherever it is needed, with advance healthcare directives and POLST that are incorporated into electronic systems so that this information is prominent and readily available and can be honored.

A. Implement a statewide registry for electronic exchange of POLST.

Palliative Care Resources:

- [Consensus Standards for Community-Based Palliative Care in California.](https://coalitionccc.org/wp-content/uploads/2017/11/CAIC-Standards-for-CBPC-Oct-2017.pdf) <https://coalitionccc.org/wp-content/uploads/2017/11/CAIC-Standards-for-CBPC-Oct-2017.pdf>
- About Palliative Care. <https://www.capc.org/about/palliative-care/>
- Advanced Care Planning Resources. <https://coalitionccc.org/tools-resources/advance-care-planning-resources/>
- POLST Forms <https://capolst.org>
- CHCF Report on Palliative Care. <https://www.chcf.org/publication/palliative-care-california-narrowing-gap/>
- CARE Recommendations. https://coalitionccc.org/wp-content/uploads/2015/08/2015_CARErecs_web_final.pdf

Oral Health

Oral Health Background:

The oral health status of older adults and people with disabilities is of critical importance to their overall health. Unfortunately, the attention to the oral health needs of older adults and people with disabilities has been inadequate. Consequently, older adults have significant unmet oral health needs impacting their overall health and emotional and social wellbeing. For example, 50 percent of older adults living in nursing facilities and 33 percent in the community have untreated tooth decay. We also know that poor oral health disproportionately impacts older adults of color, individuals with disabilities, and those residing in institutional settings and rural areas. Nationally, for example, 31 percent of Black older adults have complete tooth loss compared to 15 percent of white older adults.²⁴

Untreated oral health needs complicate chronic conditions like diabetes and heart disease, increase the likelihood for infection, and have significant impact on emotional and overall wellbeing. Seniors and persons with disabilities frequently have more difficulty accessing dental care because their health conditions result in dental procedures taking more time, being performed over multiple rather than a single visit, or requiring adaptations that involve additional costs besides time. Denti-Cal procedure payments are based on "typical" patients and have not recognized these additional costs. Legislative interest in 2018-19 led DHCS to initiate a single flat supplemental payment for seniors and persons with disabilities whose care was more costly.²⁵ The supplemental payment was a positive development. Recognizing the variation in additional costs for different dental procedures and persons with different conditions is, however, essential to equitably assuring better dental care access for seniors and persons with disabilities.

Oral Health Recommendations:

Goal 1. Improve research and evidence around oral health care for older Californians and people with disabilities. Today, there is a nearly complete absence of data on the oral health status of older adults and people with disabilities, their treatment needs, insurance

²⁴ Centers for Disease Control and Prevention, "Oral Health Surveillance Report 2019, Trends in Dental Caries and Sealants, Tooth Retention, and Edentulism, United States, 1999-2004 to 2011 to 2016" (2019)(herein after "Oral Health Surveillance Report"), available at https://www.cdc.gov/oralhealth/pdfs_and_other_files/Oral-Health-Surveillance-Report-2019-h.pdf.

²⁵ SB 1464 in 2018 with Sen. Weiner as first sponsor and Sens. Mitchell, Nguyen, Nielson and Pan as co-sponsors and AB316 in 2019 with Asm. Ramos and Robert Rivas as co-sponsors.

coverage, and utilization of services.²⁶ This makes it particularly difficult to assess the extent of need, develop solutions, and target resources. This is especially true for measuring disparities. Available California and national data demonstrate significant disparities in oral health outcomes based on race, but California data is not disaggregated for older adults and is outdated. Data based on disability and by residential setting (e.g home, residential congregate setting, rural, urban) is non-existent.

- A. Collect Oral Health Data on Older Californians and People with Disabilities.** It is especially important to collect oral health data by age, disability, race, and setting.

Goal 2. Include Older Adults and People with Disabilities in Oral Health Statewide Plan and Local Oral Health Plans. California has developed a statewide oral health plan, but the plan contains few objectives aimed specifically at improving oral health outcomes for older adults or individuals with disabilities.²⁷ With funding from Proposition 56, counties have also developed local oral health plans under the leadership of the statewide Office of Oral Health. Unfortunately, most of these local plans also omit older adults and people with disabilities or include few objectives to improve their oral health.

- A. The Office of Oral Health should develop objectives specific to older adults and people with disabilities to implement statewide and to guide local oral health planning.** At a minimum, such planning objectives would include:

- Expansion of teledentistry, the virtual dental home, and co-location of services to better connect older adults and people with disabilities to oral health services in their homes and communities.
- increase in number of providers trained and able to provide care to individuals with complex and chronic health care conditions.
- Better integration of oral health into medical care.
- Addressing oral health disparities based on race, ethnicity, disability, and residential setting.

Goal 3. Improve access to Dental Coverage for older adults and people with disabilities on Medi-Cal. Federal rules do not require states to include dental coverage for adult Medicaid recipients. Consequently, California has eliminated adult dental coverage in the past during times of budget shortfalls and threatened such cuts in the 2020-21 budget. Such cuts are short sighted. Cutting oral health coverage increases other costs to Medi-Cal, such as emergency room use costs for oral health problems that could be treated elsewhere and costs associated with chronic conditions. Such cuts also disproportionately impact communities of color. Of those who lose coverage, 73% are from communities of color: 48%

²⁶ California Department of Public Health, "Status of Oral Health in California: Oral Disease Burden and Prevention 2017," available at

https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/CDCB/CDPH%20Document%20Library/Oral%20Health%20Program/Status%20of%20Oral%20Health%20in%20California_FINAL_04.20.2017_ADA.pdf

²⁷ California Department of Public Health, "California Oral Health Plan, 2018-2028," Jan. 2018, available at

<https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/CDCB/CDPH%20Document%20Library/Oral%20Health%20Program/FINAL%20REDESIGNED%20COHP-Oral-Health-Plan-ADA.pdf>

are Latinx, 8% are black, and 15% are Asian American/Pacific Islander American.²⁸ California should make adult Medicaid dental coverage a permanent benefit.

- A. Commit to Continued Medi-Cal Dental Coverage.** California must commit to continued Medi-Cal dental coverage, treating this benefit as mandatory, not optional.

Goal 4. Develop Statewide Medi-Cal Dental Advisory Board and Set Utilization Targets for Older Adults and People with Disabilities. The most recent Medi-Cal dental utilization data indicates that fewer than 1 in 4 older adults had an annual dental visit in 2018, and just over 1 in 10 accessed a preventive service.²⁹ There is no utilization data for people with disabilities. The Department of Health Care Services has established statewide Medi-Cal utilization targets for children. Unfortunately, no such utilization targets are in place for older adults and people with disabilities. With the known impact untreated oral health needs have on chronic conditions like diabetes and heart disease and the increased risk for infection, it is critical that older adults and individuals with disabilities are connected to oral health treatment.

- A. California should create an evidence-based advisory group for the Medi-Cal dental program to guide decisions and make sure they are based on the best evidence and science and not merely on cost.**³⁰ This advisory board could also establish Medi-Cal utilization targets for older adults and people with disabilities.
- B. California must put in place utilization targets for older adults and people with disabilities and ensure that such targets are also being met based on race, ethnicity, and residential setting.**

Goal 5. Integrate Dental and Physical Health Care in the Medi-Cal Program. A growing body of evidence shows that investing in the maintenance of a person's oral health has benefits for their overall health and well-being. Gum disease has been associated with respiratory disease, cardiovascular disease, and diabetes; poor oral health is associated with chronic pain and inappropriate use of the emergency department³¹; and for diabetics, oral health and properly controlled blood sugar go hand-in-hand. People with diabetes are twice as likely to develop gum disease, and in turn, infected gums make it harder to control blood sugar. Infections can cause gums to bleed, feel swollen and tender, and can lead to tooth

²⁸ Families USA analysis of American Community Survey (ACS) data for 2018. IPUMS USA, Minnesota Population Center, University of Minnesota, <https://usa.ipums.org/usa/www.ipums.org>.

²⁹ Department of Health Care Services, Adult Dental Utilization CY 2017 and CY 2018, available at <https://www.dhcs.ca.gov/services/Pages/DentalReports.aspx>.

³⁰ Little Hoover Commission, "Fixing Denti-Cal," April 2016, available at <https://lhc.ca.gov/sites/lhc.ca.gov/files/Reports/230/Report230.pdf>

³¹ Improving Access to Oral Health Care for Vulnerable and Underserved Populations. Washington, D.C.: Institute of Medicine and National Research Council; 2011.

loss. Nearly 14% of Californians have been diagnosed with diabetes, and the numbers are rising rapidly³². Diabetes costs in this state exceed \$24 billion each year³³.

Despite the link between dental health and overall health, dental and medical services have traditionally been delivered by separate systems. The Medi-Cal program reflects this, with enrollees enrolled in managed care for medical benefits and the fee for service Denti-Cal system for their dental care. Patients access dental care largely on their own and little supporting infrastructure exists to allow the medical and dental systems to make connections when needed for a patient's overall health. Under the current model, it is difficult to coordinate care to improve patient health or measure outcomes and achieve cost-savings for the overall system. The State has approved two pieces of legislation to address these issues. In 2019, the State approved a dental integration program in San Mateo County, to be administered by the Health Plan of San Mateo. The program is set to begin in 2022. In 2016, the State approved AB 2207 requiring Medi-Cal managed care plans to connect their members to oral health care, i.e., provide a dental screening for every enrolled member as part of the initial health assessment; refer members who have oral health needs to a Medi-Cal dental provider; and identify health plan liaisons to establish relationships with dental providers to assist referrals from dental providers to the health plans for health plan covered services. However, the Department of Health Care Services has yet to issue guidance to health plans on these requirements.

A. Develop an integrated dental and physical health program in Med-Cal by 2030.

CalAIM proposed the development of pilot programs to include, among other services, the integration of oral health in Medi-Cal managed care. These pilot programs should be pursued, with the long-range goal of integrating all dental services in Medi-Cal managed care. The State should establish objectives for improving access to oral health care through managed care, including access to dental prevention services, and measure the cost impact of integrating dental care, such as reductions in emergency room visits due to dental pain and dental procedures performed in a hospital setting.

B. Immediately, the State should issue guidance to health plans and enforce current Medi-Cal managed care plan responsibilities to connect members to oral health care.

Goal 6. Support Federal Medicare Coverage for Dental Care. Today, traditional Medicare does not include dental coverage. As a result, nearly 37 million older Americans have no dental coverage. Efforts are underway to expand Medicare to include coverage for routine and preventive oral health care. A Medicare oral health benefit would provide coverage to all 6.2 million Medicare enrollees in California, including the 1.4 million Medicare beneficiaries dually enrolled in Medi-Cal.

A. California should support efforts to expand this federal coverage through its federal lobbying efforts.

³² California Diabetes Program. California Diabetes Fact Sheet, 2012, Technical Notes. www.caldiabetes.org. 2012.

³³ Dall TM, Zhang Y, Chen YJ, Quick WW, Yan WG, Fogli J. The economic burden of diabetes. *Health Affairs*. 2010;29(2): 297-303

Oral Health Resources:

- Centers for Disease Control and Prevention, "Oral Health Surveillance Report 2019, Trends in Dental Caries and Sealants, Tooth Retention, and Edentulism, United States, 1999-2004 to 2011 to 2016" (2019) (herein after "Oral Health Surveillance Report"), available at https://www.cdc.gov/oralhealth/pdfs_and_other_files/Oral-Health-Surveillance-Report-2019-h.pdf
- California Department of Public Health, "California Oral Health Plan, 2018-2028," Jan. 2018, available at <https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/CDCB/CDPH%20Document%20Library/Oral%20Health%20Program/FINAL%20REDESIGNED%20COHP-Oral-Health-Plan-ADA.pdf>
- California Department of Public Health, "Status of Oral Health in California: Oral Disease Burden and Prevention 2017," available at https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/CDCB/CDPH%20Document%20Library/Oral%20Health%20Program/Status%20of%20Oral%20Health%20in%20California_FINAL_04.20.2017_ADA.pdf
- Cabezas, Martita, DDS, MPH, County of Los Angeles Public Health, "Identifying Dental Deserts in the Los Angeles Safety Net Using GIS Maps," (2016), available at <https://www.nationaloralhealthconference.com/docs/presentations/2016/04-19/Maritza%20Cabezas-Dental%20Deserts%20of%20the%20Los%20Angeles%20County%20Safety-Net%20Dental%20Clinics%20Using%20GIS%20Maps.pdf>
- Center for Oral Health, "A Healthy Smile Never Gets Old: A California Report on the Oral Health of Older Adults," Nov. 2018, available at <https://www.centerfororalhealth.org/wp-content/uploads/2018/11/Oral-Health-of-Older-Adults.pdf>
- Little Hoover Commission, "Fixing Denti-Cal," April 2016, available at <https://lhc.ca.gov/sites/lhc.ca.gov/files/Reports/230/Report230.pdf>
- Department of Health Care Services, Adult Dental Utilization CY 2017 and CY 2018, available at <https://www.dhcs.ca.gov/services/Pages/DentalReports.aspx>
- Justice in Aging, "Oral Health in California, What About Older Adults?" July 2016, available at https://www.justiceinaging.org/wp-content/uploads/2016/07/Oral-Health-in-CA_What-About-Older-Adults.pdf
- Oral Health America, "An Oral Health Benefit in Medicare Part B: It's Time to Include Oral Health in Health Care," <https://www.justiceinaging.org/wp-content/uploads/2018/07/Medicare-Dental-White-Paper.pdf>

Provider Level

Assuring the Workforce to Care for Older Adults

Workforce Background:

The Aging sub-committee of the California Future Healthcare Workforce Commission deliberated for over a year on the demands of the future and the requisite make-up and preparation of the workforce to care for all Californians¹. These recommendations draw on the work of the Commission, who envisioned older adults aging in place with dignity and respect in an engaged community and a fully integrated person-centered and technology-enabled team (medical + social + behavioral) to deliver appropriately timed, evidence-based best practices, and culturally and linguistically congruent care. Actualizing that vision requires 1) Adequate supply of health care professionals, distributed equitably across both geography and underserved communities. Importantly, the workforce should mirror the diversity of the population necessitating strong pipeline programs to recruit from under-represented groups, career path and mentorship support and incentives to work with older adults across settings; 2) Appropriate preparation: Nationally, less than 5% of the workforce of health care professionals (nurses, physicians, pharmacists and social workers) are certified in geriatrics, yet almost all health care professionals encounter older adults and persons with disabilities in their practice. Older adults and persons with disabilities need competent health care professionals, prepared with competency in geriatrics, dementia care, palliative care, behavioral health, as well as the ability to work in interdisciplinary teams and use enabling technology²; 3) Optimal regulations to ensure quality and encourage innovation so that all members of the care team practice to the full extent of their education and preparation and are compensated accordingly through value-based reimbursement; and 4) Incentives to attract and retain health care professionals in geriatrics/gerontology across settings.

Enacting the vision requires an organizing framework. Two initiatives provide examples: The Geriatric Emergency Department initiative³ and the Age-Friendly Health Systems initiative⁴. These programs have resulted in fast deployment of improved and well-informed care for older adults, offering a practical and rapid approach to deploy evidence-based geriatrics training. Older adults and persons with disabilities with multiple chronic medical conditions are well managed by an integrated and interdisciplinary workforce. Interdisciplinary teams, exemplified by The Program for the All-Inclusive Care of the Elderly (PACE)^{5,6}, improve outcomes including better survival, improved functional and cognitive outcomes and lower rates of healthcare utilization^{7,8,9}. The recommendations build on the essential elements, increasing supply, competence, regulatory support and incentives to promote the workforce to address the future needs of all Californians.

Workforce Recommendations:

Goal 1: Increase the supply of qualified providers to assure access to person-centered, team-based and technology-enabled care.

A. Expand the number of primary care physician and psychiatry residency positions, yielding an increase of 1,872 primary care physicians and 2,202 psychiatrists by

2030.¹ There is an inadequate supply of primary care and psychiatry providers for the growing population of older adults and persons with disabilities and there are many areas of the state that are underserved, with health disparities based on multiple dimensions including race/ethnicity, geography, LGBTQ status, disability, and economic disadvantage.

- B. *Develop a psychiatric nurse practitioner program that recruits from and trains providers to serve in underserved communities to address access gaps in behavioral health by treating over 350,000 patients over five years.***¹ There is inadequate access to psychiatric and behavioral health care with particular emphasis in rural and urban underserved communities. Lack of integration of behavioral health care exacerbates chronic disease burden and compromises quality of life outcomes.
- C. *Maximize the role of gerontologists (e.g., Master's in Gerontology graduates) and geriatric social workers on care teams and in appropriate roles, such as care coordination.*** Gerontologists and geriatric social workers improve the quality of life and promote the well-being of persons as they age within their families, communities and societies through research, education, and application of interdisciplinary knowledge of the aging process and aging populations. Gerontologists and geriatric social workers perform key roles in care transitions and care coordination and can be reimbursed through Medicaid Waiver programs. Given the shortage of geriatrically-prepared health and social service professionals, gerontologists should be utilized in primary care and team care delivery to older adults.
- D. *Scale the engagement of community health workers, promotores, and peer providers through certification, training, and reimbursement, broadening access to prevention and social support services in communities across the state.***¹ It is vital to increase the capacity of primary care and behavioral health teams to support better outcomes for all and to promote recovery and self-sufficiency for people with mental illness and substance use disorder. Engaging community health workers, *promotores* and peer providers expands access and increases cultural appropriateness of care.
- E. *Develop the pipeline by infusing curricula around health professional careers in high school health academies with priority targets for underrepresented populations, support pipeline programs at colleges and universities to recruit the future workforce.*** The projections of the inadequate supply of health care professionals to care for older adults and persons with disabilities in California extends decades into the future. To achieve health equity and access, recruitment efforts today at the high school level can influence outcomes in a decade. Pipeline programs that target diverse youth across urban and rural communities are essential to assure that the future workforce represents the population of older adults in California and is positioned to provide culturally and linguistically appropriate care. Investment all along the pipeline is required to motivate and support promising health care professionals to achieve their career goals.

Goal 2: Increase the number of providers prepared to deliver person-centered, culturally and linguistically congruent, technology enabled care for older adults and persons with disabilities by 10,000 by 2030

- A. Promote inclusion of competencies to care for older adults and persons with disabilities, work in teams and use enabling technology in health workforce curricula at ALL levels.** Curricula in health professions education vary in the extent of content in geriatrics/gerontology, dementia care, palliative care and behavioral health. The American Geriatrics Society published multi-disciplinary competencies to prepare all entry-level health care professionals at a minimum, addressing health promotion, evaluation and assessment, care planning and coordination, interdisciplinary and team care, caregiver support and healthcare systems and benefits. The American Geriatrics Society competencies reflect consensus on basic preparation². Very few health care professionals are prepared to care for older adults and persons with disabilities, work in teams and use technology to improve access and delivery.
- B. Require physicians, nurse practitioners, physician assistants, nurses, and social workers to obtain 10 hours of continuing education (CE) in geriatric and dementia competencies.** The incumbent workforce is not sufficiently prepared to care for older adults and persons with disabilities and those with dementia.
- C. Encourage development of continuing educational offerings designed for multi-disciplinary audiences by streamlining the CE accreditation application and approval process through standardization across and reciprocity between CE accrediting bodies.** The growth of team-based care calls for rethinking and redesigning our continuing education accreditation process that currently evaluates educational offerings from the perspective of disciplinary silos.
- D. Support state and federal programs and legislation that increases hospice and palliative care workforce and funding (ex. PCHETA, new APM).** Require a minimum level of exposure to primary palliative care in pre-professional/pre-licensure education for physicians, physician assistants, nurse practitioners, nurses, and social workers. Conduct a healthcare provider awareness campaign through a public-private partnership to increase accurate understanding of palliative care as care during serious illness. Incentivize continuing education in specialty-level palliative care. Subsidize palliative care training for Medi-Cal providers. Health care professionals are not sufficiently prepared nor incentivized to provide end-of-life care.
- E. Establish a certification process for behavioral health peer-support specialists, including those trained to provide services to older adults, through future legislation.** All counties should develop peer-training programs that involve people with lived experience to provide culturally appropriate auxiliary or additional behavioral health services for older adults and others with complex medical needs. The behavioral

health peer support workforce is not sufficiently prepared to provide comprehensive care for older adults and persons with disabilities in California.

F. DHCS should direct the California Institute for Behavioral Health Strategies (CIBHS) to utilize its funding to develop and deliver a geriatric curriculum to the existing behavioral health workforce in order to inform and better prepare their work with older adults and persons with disabilities. The incumbent behavioral health peer support workforce is not sufficiently prepared to provide comprehensive care for older adults and persons with disabilities in California.

G. California's higher education programs for the disciplines in the behavioral health workforce should ensure that geriatric topics are included in the core curriculum, and that geriatric behavioral health elective courses for specialization are available and are promoted to students. Community colleges and university extension programs should develop career technical education programs and peer education programs to support the development of paraprofessionals in geriatric behavioral health. The behavioral health workforce is not sufficiently prepared with geriatrics and gerontology content to care for older adults and persons with disabilities.

H. Adopt statewide toolkit for primary care providers, to best practices and facilitate early diagnosis and treatment of dementia as required by Medi-Cal, DMHC, and others. Primary care providers across the state are not sufficiently prepared to identify and manage care for persons with dementia.

Goal 3: Align regulations to support optimal access

A. Maximize the role of advance practice providers (e.g., nurse practitioners and physician assistants) as part of the care team to fill gaps in primary care, helping to increase the number of nurse practitioners to 44,000 by 2028, and providing them with full practice authority¹. There is inadequate access to primary care that is cost-effective, high-quality, person-centered and comprehensive, particularly in underserved communities. Even with expansion of medical school slots, the projected supply is insufficient. Furthermore, the supply of health care professionals who reflect the communities they serve falls short of demand. Nurse practitioners and physician assistants can advance access to high quality care.

B. Maximize the role of gerontologists (e.g., Master's in Gerontology graduates) on care teams and in appropriate roles, such as care coordination. Nationally, there are over 650 programs producing well-trained gerontologists, many of these programs are within California. Gerontologists improve the quality of life and promote the well-being of persons as they age within their families, communities and societies through research, education and application of interdisciplinary knowledge of the aging process and aging populations. There are national examples of gerontologists performing in key roles in care transitions and care coordination and being reimbursed through Medicaid Waiver programs. Given the shortage of geriatrically-

prepared health and social service professionals, gerontologists should be utilized in primary care and team care delivery to older adults.

C. Under OSHPD, conduct Healthcare Workforce pilot demonstration projects of nurse delegation in community to provide oversight to direct care workers in performing medical/nursing tasks¹⁰. Most older adults and persons with disabilities age in place in the community, supported by family caregivers and direct care workers. With increasing complexity of health and social care needs, the direct care workforce has the capacity to manage some tasks previously limited to licensed nursing scope of practice (such as medication administration, wound care, tube feeding) through the mechanism of Nurse Delegation. This evidence-based practice has been adopted in many states, and involves RNs assessing the older adult or person with disability to establish care needs, instructing the direct care worker and assuring their ability to perform the task, and monitoring the situation to assure ongoing safety. Other states (e.g., Washington and New Jersey) have advanced new models of care delivery and have conducted evaluative research to evaluate the implications for safety and access.

Goal 4: Incentivize optimal workforce preparation to care for older adults and persons with disabilities

A. Adopt an organizing framework to inform system change, based on Healthy People 2030 goals for older adults, the Age-Friendly Health Systems initiative and the Geriatric Emergency Department initiative. An organizing framework with strategic incentives can inform system change to optimize care for older adults and persons with disabilities by providing a compelling vision and goals in prioritizing decisions. To optimize addressing complex social and health care needs for vulnerable older adults and persons with disabilities, fundamental changes are required in how care is delivered, such as interdisciplinary teams that include gerontologists, community health workers, peer counselors and promotores. Enabling technology can maximize care access, especially in rural and underserved geographic regions.

B. In its next five-year plan for the Mental Health Service Act's Workforce, Education and Training (WET), The Office of Statewide Health Planning and Development (OSHPD) should include a requirement for counties to designate priority slots in future loan forgiveness and stipend programs for trainees who are interested in geriatric behavioral health services. The percentage of slots so designated should be consistent with each county's prevalence of older adults with behavioral health needs. Data reporting on this requirement should be mandatory¹¹. There is a lack of incentives to increase the geriatric expertise in the public mental health workforce among behavioral health trainees. Several counties (e.g., Los Angeles) are already doing this and have been able to create a better trained geriatric behavioral workforce.

- C. OSHPD should include special considerations in WET funding for promoting the geriatric behavioral health workforce in small and rural counties.** For example, strategies might include adjusting the funding formula, providing designated funding allocations and a streamlined application process. There are significant geographic disparities in availability of behavioral health workforce in the public mental health system.
- D. Accrediting bodies and professional organizations should include geriatric behavioral health competency expectations as a component of curriculum review and set standards for prioritizing this area of expertise within programs.** There is inadequate support and motivation for setting competency standards for the geriatric behavioral health workforce

Workforce Resources:

¹ California Future Health Workforce Commission. <https://futurehealthworkforce.org/>

²American Geriatrics Society, Multidisciplinary Competencies in the Care of Older Adults at the Completion of the Entry-level Health Professional Degree

<https://www.americangeriatrics.org/geriatrics-profession/core-competencies>

³ American College of Emergency Physicians. Geriatric Emergency Department Accreditation Program. <https://www.acep.org/geda/> Accessed July 2020

⁴ The John A. Hartford Foundation. Age-Friendly Health Systems Initiative.

<https://www.johnahartford.org/age-friendly-health-systems-initiative> Accessed July 2020

⁵Leavitt, M. (2009). Interim report to Congress. The quality and cost of the Program of All-Inclusive Care for the Elderly.

⁶Kane, R. L., Homyak, P., Bershady, B., Flood, S. (2006). Variations on a theme called PACE. *Journal of Gerontology Series A*, 61 (7): 689-93.

⁷ Sommers, L. S., Marton, K. I., Barbaccia, J. C., & Randolph, J., (2000). Physician, nurse, and social worker collaboration in primary care for chronically ill seniors. *Archives of Internal Medicine*, 160, 1825-1833.

⁸ Stuck, A. E., Siu, A. L., Wieland, G. D., Adams, J., & Rubenstein, L. Z., (1993). Comprehensive geriatric assessment: A meta-analysis of controlled trials. *Lancet*, 34, 1032-1036.

⁹ Wieland, D., Stuck, A. E., Siu, A. L., Adams, J., & Rubenstein, L. Z., (1995). Meta-analytic methods for health services research: An example from geriatrics. *Evaluation and the Health Professions*, 18, 252-282.

¹⁰ Young, HM and Siegel, EO. (2016). The Right Person at the Right Time to Ensure High Quality and Value Person-Centered Care for Older Adults: Scope of Practice and Other Systems-Level Factors. *Generations*, 40(1): 47-55.

Additional Workforce Resources:

- U.S. Department of Health and Human Services, Health Resources and Services Administration Bureau of Health Workforce. National and Regional Projections of Supply and Demand for Geriatricians: 2013-2025. Rockville, MD: DHHS; 2017. <https://bhw.hrsa.gov/sites/default/files/bhw/healthworkforce-analysis/research/projections/GeriatricsReport51817.pdf>. Accessed April 29, 2018.
- American Geriatrics Society. State of the Geriatrician Workforce. New York, NY: AGS; 2018. https://www.americangeriatrics.org/sites/default/files/inlinefiles/State%20of%20the%20Geriatrician%20Workforce_10%2001%2018.pdf. Accessed April 29, 2018.
- Health Resources and Services Administration. HHS awards \$35.7 million to improve care for older adults [press release]. July 13, 2015. <https://hrsa.gov/about/news/pressreleases/150713geriatricworkforce.html>. Accessed October 2018
- Frank, J.C., Kietzman, K., Damron-Rodriguez, J., et al. (2017). California Mental Health Older Adult System of Care Project Deliverable 3 Report, <http://www.healthpolicy.ucla.edu/Older-Adult-Mental-Health>
- Damons, J. (2001). Program of All-Inclusive Care for the Elderly (PACE) Year 2 Overview. Long-Term Care, Bureau of TennCare, Tennessee.

APPENDIX

Goal 3 Appendix: Other Health Issues

Health is a broad goal area. We chose to focus on areas that we felt provided the greatest potential improvement for older adults and people with disabilities. There are many other issues and recommendations which could have been considered. We include here several areas where work is being done in the state and that also deserve mention. Groups working with these areas requested that the following recommendations be considered; the Health Team did not have time to review and incorporate them into the body of the report.

Goal 1: Health and Nutrition

A. Define nutrition security as a human right and as a foundational goal to achieving many of the other goals of the Master Plan.

All Californians should have access to affordable and culturally appropriate healthy food to support nutrition security. Nutrition security is defined as a situation that exists when all people, always have physical, social, and economic access to sufficient, safe, and nutritious food that meets their dietary needs and food preferences for an active and healthy life ([USDA, 2017](#)). While food security generally focuses on the availability of *calories* to all people, nutrition security requires the intake of a wide range of foods which provides the essential nutrients that individuals need to maintain or improve their health status, including meeting specific needs related to chronic and other health conditions ([NLM, APLU, 2020](#)).

Nutrition security is not only a human right but is a foundational component of health and well-being for all ages, particularly for older adults and people living with disabilities. Sixty percent of deaths in the United States – from heart disease, diabetes, stroke and cancer – are related to poor eating habits, and research consistently demonstrates that addressing nutrition security improves health outcomes and quality of life while reducing health care utilization and costs.

Nutrition security is critical for chronic disease prevention and treatment. In particular, the home delivery of medically-tailored meal interventions (MTMs) to older adults has been shown to reduce hospitalizations (up to 63%), reduces medical costs (by up to 32%), and improves health outcomes overall (www.fimc.org/resources).

B. Explicitly recognize the relationship between nutrition security and health outcomes.

- Nutrition security is the goal. Eliminating hunger does not ensure nutrition security, and nutrition security is equally important if the broader aims of the Master Plan are to be achieved.
- While CalFresh is a vital part of a nutrition security system, it will not meet the nutrition security needs of many older adults or people living with disabilities. Therefore, other nutrition programs, such as delivery of medically tailored meals

and/or groceries, senior meals programs, and produce prescription programs need to be included in the Master Plan.

C. *Standardize the assessment of nutrition needs and referral to nutrition services across all agencies and programs serving older adults and people living with disabilities.*

To meet nutrition security goals, older adults and people with disabilities should be consistently screened to assess nutritional needs. We recommend the development of a standard food and nutrition screening tool that would be used in all eligibility assessments and care transition assessments across programs and departments. This should include, at a minimum:

- a. The two-question food insecurity screen
- b. Assessment of chronic disease related nutritional needs
- c. Functional capacity to shop and cook a nutritionally appropriate diet

This assessment should lead to a standard set of referrals that encompasses the full range of food and nutrition supports, from CalFresh enrollment to home delivered and medically tailored groceries and meals.

D. *Integrate and fund a comprehensive set of nutrition services that meet the diverse needs of older adults and people living with illnesses or disabilities.*

The Master Plan should integrate and recommend funding for a comprehensive set of food and nutrition services to address diverse needs, from those who are able-bodied to those living with chronic health conditions and who have functional needs that prevent the ability to shop and cook a nutritionally appropriate diet. California's nutrition security system for older adults should include not only simplified access to CalFresh, but also funding for:

- A. Increased availability of fresh fruits and vegetables through produce prescription and market match programs
- B. Food and produce pantries at senior centers
- C. Enhanced support for senior meal programs to improve food quality
- D. Medically tailored meal programs for those living with chronic health conditions who are not able to shop and prepare a nutritionally adequate diet

Goal 2: Village Movement and Community Building

Public health professionals can partner with "Villages," grassroots consumer-driven community-based organizations that aim to promote aging in place by combining services, participant engagement, and peer support. First emerging in the early 2000s, currently there are more than 200 Villages in the United States in operation or development. Studies suggest that Villages are a promising approach to increasing members' social engagement and connecting with a variety of formal and informal community supports (including those offered by public health departments) plays a critical role in their ability to do so.

A. *Articulate the importance of community engagement and partnership with grassroots efforts.*

We know from public health practice, particularly around health equity efforts developed over the past decade, that community engagement and partnership are best and necessary practices. We will never have equity if systems are not engaging with community, including investing resources in grassroots efforts. Solutions lie with the people who are impacted.

B. Village Movement California belongs as a best practice in prevention and wellness.

Villages use an evidence based, grassroots and community driven approach to address social isolation, loneliness, and social determinants of health to help older adults thrive in the places they call home.

Graham, Carrie L., Scharlach, Andrew E., Wolf, Jennifer Price, (5.5.2014). The Impact of the Village Model on Health, Well-Being, Services Access, and Social Engagement of Older Adults. *Health Education and Behavior*. 41 (1) pp 91S- 97S.

Trust for America's Health report, *Creating an Age-Friendly Public Health System: Challenges, Opportunities, and Next Steps*:

Goal 3: Assistance with Medicare, Medi-Cal and other Health Insurance Coverage

California Health Advocates provides quality Medicare and related health care coverage information, education, and policy advocacy. It provides education, training, and technical assistance to local HICAPs and to other groups and advocacy organizations. We are concerned about a lack of focus on how consumers get the information they need to choose appropriate health care coverage and make the best use of the benefits they have.

HICAP is a state and federal funded program to assist Medicare beneficiaries and their families with information on Medicare, supplemental benefits, services, assistance, and insurance benefits for long term care. CHA provides information and resources to the local HICAPS and the public that will help them understand the complexity of some of their health care choices and direct them to the most appropriate resources for their needs.

Many of the clients coming to CHA and local HICAPs come for assistance with health and long term care benefits and services and are in the process of using up their resources paying for care, or paying for insurance to cover the cost of their care, or both. They are not yet low income, but many will become so in their later years.

Consideration of HICAP and the assistance it provides in navigating difficult insurance and coverage options faced by older adults should be included in the next stage of the Master

Plan process. The program is an integral part of the Area Agencies on Aging and has a legislative requirement to educate and counsel the public and their clients on long term care planning, education, and insurance. As insurance companies withdraw from selling free-standing long-term care insurance and convert to high cost financial products, moderate income consumers are left with few options to cover the cost of long term care. In addition, recent premium increases have reduced the ability to pre-fund long term care costs and caused policyholders to reduce existing benefits to offset the increased cost of coverage. HICAPs help these consumers determine the best choices for their economic circumstances and maintain appropriate coverage.

HICAPs help consumers understand complex health care choices based on the services and providers they need to best meet their needs. Their choices may include a Medicare Advantage option or original Medicare. Their preferred providers may or may not be part of a restricted network, their premiums and out of pocket expenses vary with each choice, and their choices will affect their income and resources. Often HICAP clients are low income individuals eligible for Medicare and Medi-Cal who need help understanding eligibility and enrolling in the appropriate programs for their needs. And sometimes older adults are faced with draconian choices about their health care and long-term care coverage following the death of a spouse and the resulting drop in income.

HICAPs provide invaluable counseling and information that allow their clients to make the most cost effective choices about their health and long term care benefits, retain their access to chosen providers, and help delay the need to access public programs and benefits.

- A. *Until we have a single health and LTSS coverage program in California the State must assure that appropriate information and counseling is provided to older adults. HICAPs provide that information.***
- B. *HICAPs are already providing information about integrated care, medical resources, and long-term care insurance. California needs to provide additional support to provide services for the growing numbers of people who are aging in the state.***

Goal 4: Affordable Medications

Millions of Californians rely every day on prescription drugs to maintain their health. The United States pays the highest prices in the world, and the result is that many older adults must choose between filling their prescriptions and buying food.

Drug price increases remain out of control. According to AARP Research, in 2018, brand-name drug price increases occurred at more than twice the rate of inflation.ⁱ The average annual cost of four widely used prescription drugs increased nearly 58 percent between 2012 and 2017, while annual incomes across America increased by just over 13 percent.ⁱⁱ

Meanwhile, the average older American typically takes 4.5 prescriptions regularly on a chronic basis.ⁱⁱⁱ In California, the average annual cost of prescription drug treatment increased 57.8% between 2012 and 2017, while the annual income for Californians only increased 12.5%.^{iv}

California residents of all ages are impacted by high prescription drug costs, especially if they lack insurance or are underinsured. Due to the high cost of Rx drugs, AARP estimates that in 2017, 22% of California Residents stopped taking medication as prescribed due to cost.^v For example, AARP has found that the cost of these three commonly prescribed, brand name medications have increased significantly between 2012 and 2017^{vi}:

- Revlimid, which is used to treat some cancers, increased from \$147,413 a year to \$247,496 a year;
- Lantus, which is used to treat diabetes, increased from \$2,907 to \$4,702 a year;
- Aggrenox, used to treat heart disease, increased from \$3,030 to \$5,930 a year.

There are serious consequences for patients who do not adhere to prescribed medication regimens. According to The Centers for Disease Control and Prevention (CDC), “non-adherence causes 30 to 50 percent of chronic disease treatment failures and 125,000 deaths per year in this country. Twenty-five to 50 percent of patients being treated with statins (cholesterol lowering medications) who stop their therapy within one year have up to a 25 percent increased risk for dying.”^{vii}

The state has already enacted legislation or Executive Orders aimed at lowering the cost of prescription drugs. These steps have included banning Pay for Delay agreements that impede access to lower-cost generic drugs^{viii}, using the significant buying power of California to create a bulk buying program for prescription drugs purchased by state and even county entities^{ix}, and creating transparency by requiring that drug companies give 60 days’ notice to public and private purchasers before raising the wholesale acquisition cost of a prescription drug costing more than \$40, if the wholesale acquisition cost-exceeds 16% over a two year period.^x

However, there are steps that California can take to help reduce prescription drug prices in the aggregate. We recommend that California undertake the following changes:

A. Enact legislation that:

- **Authorizes the CA Health & Human Services Agency to develop a comprehensive importation plan, which, upon approval by the FDA, would enable the state to operate a wholesale drug importation program for state purchases. Such action has already been taken in Florida and Vermont.**
- **Prohibits insurers, during a policy year, from removing a drug from a formulary, moving a drug to a new tier with greater cost-sharing requirements, or adding utilization management restrictions (e.g., prior authorization).**

Goal 5: Explore issues and recommendations in the area of vision, hearing, and podiatry care.

Several individuals noted that Goal 3 Health includes recommendations for oral health but not vision, hearing, and podiatry care. The invisible aspects of healthy aging often have to do with one's feet, ears, and eyes. While the Stakeholder Advisory Committee health team did not have time to explore these issues in depth, we recommend they be considered in the next phase of the Master Plan.

ⁱ Stephen W. Schondelmeyer and Leigh Purvis, “*Rx PriceWatch Reports*. Washington, DC: AARP Public Policy Institute, June 2019. <https://doi.org/10.26419/ppi.00073.000>.

ⁱⁱ Stephen W. Schondelmeyer and Leigh Purvis, “Rx Price Watch Report: Trends in Retail Prices of Brand Name Prescription Drugs Widely Used by Older Americans, 2017 Year-End Update,” AARP Public Policy Institute. Washington, DC, September 2018.

ⁱⁱⁱ Ibid.

^{iv} Based on the price associated with taking four widely used brand name prescription drugs. Income is based on median person-level income.

^v Among 19-64 year old population. State Health Access Data Assistance Center (SHADAC) analysis of National Health Interview Survey data, State Health Compare, SHADAC, University of Minnesota, statehealthcompare.shadac.org, Accessed September 5, 2019

^{vi} Stephen W. Schondelmeyer and Leigh Purvis, “*Rx PriceWatch Reports*. Washington, DC: AARP Public Policy Institute, June 2019. <https://doi.org/10.26419/ppi.00073.000>.

^{vii} Federal Drug Administration. “Why You Need to Take your Medications as Prescribed or Instructed”. February 16, 2016. <https://www.fda.gov/drugs/special-features/why-you-need-to-take-your-medications-prescribed-or-instructed#:~:text=Taking%20your%20medicine%20as%20prescribed%20or%20medication%20adherence%20is%20important,important%20part%20of%20medication%20adherence>. Accessed August 26, 2020

^{viii} AB 824 (Wood), Chapter 531, Statutes of 2019. A Pay for Delay agreement allows drug companies to pay competitors to delay creating and selling less expensive generic equivalents of their brand-name medications.

^{ix} Executive Order N-01-19, dated January 7, 2019. <https://www.gov.ca.gov/wp-content/uploads/2019/01/EO-N-01-19-Attested-01.07.19.pdf>.

^x SB 17 (Hernandez), Chapter 603, Statutes of 2017.