**CALIFORNIA COLLABORATIVE FOR LONG TERM SERVICES & SUPPORTS**

# Creating a California Master Plan for Aging

*The California Collaborative for Long Term Services and Supports (the Collaborative) represents 39 organizations that advocate or provide essential services for older Californians, people with disabilities, and caregivers.*

*We support the development of a person-centered Master Plan for Aging that:*

- *Recognizes the vital role of access to long-term services and supports (LTSS);*
- *Incorporates healthy aging and preventive care;*
- *Advances the growth of age- and disability-friendly communities; and*
- *Ensures that no segment of the population is disregarded.*

## A New Way of Thinking and Doing!

It is time for a revolution in how society, government, and providers view aging and people with disabilities and the delivery of aging and disabled care, services, and supports. A new way of thinking will crossover to and benefit other arenas of government concern including education, workforce development, housing, transportation, healthcare, and economic security. The overarching outcome will be improved population wellbeing and quality of life. Incorporating new values and approaches in The Master Plan will lead to a better future for all. We can do this by:

- **Addressing the reality and magnitude of the "Forgotten Middle Class**," i.e., those whose income is not low enough to qualify them for subsidized programs or high enough to pay for in-home care or reside in a care facility. Many do not have families they can turn to for support. Without access to affordable long-term services their options are to suffer without care, spend down their assets to enroll in Medi-Cal, or become homeless.
- **Rethinking retirement and combating ageism and discrimination with new attitudes, policies, and programs** that benefit from the vast knowledge and experience of our aging and disabled adults by enabling those who so desire to remain in the workplace or engage in new full- or part-time careers or activities that support and assist their peers and younger generations. Policies and programs developed, and services delivered by, for, and with the aging and disabled will best serve their needs.
- **Infusing intergenerational opportunities for older adults and people with disabilities** into career development, youth social services, and employment training programs.
- **Dismantling programmatic and artificial barriers** between non-medical services and supports and medical care delivery.

- **Recognizing preventive, naturopathic, and social care as critical elements of healthcare** including regard for nutrition and movement as medicine and fundamental to wellness.
- **Establishing a career path for paid caregivers** that provides them with the income, knowledge, skills, and confidence to excel and advance within their field unrestricted by unnecessary scope of practice limitations.
- **Supporting unpaid family caregivers** through needs assessment, training, access to services and supports, and respite.
- **Analyzing and understanding the return on investment in aging and disabled services and supports** in terms of reduced reliance on government subsidies, growth in the homeless population, and loss of income and adverse health impacts on families and caregivers; and overall improvement in economic security and quality of life for individuals and their families.

## Recommendations

The Collaborative has adopted four main principles we believe should guide development of the Master Plan:

- Design an equitable system of comprehensive care for the whole person,
- Address barriers to access,
- Ensure a collaborative process with Governor, Legislature, stakeholder, and public engagement, and
- Create a comprehensive and sustainable plan.

Elements of the Plan we believe are essential for inclusion and critical issues that must be addressed to align with these principles are summarized below.

(1) **The Plan must address aging and disability needs of the whole person and design a system for delivering comprehensive care that enables adults and people with disabilities to make informed decisions consistent with their values and to live and age with dignity and respect in the setting of their choice**. It must extend beyond current concepts of services, supports, and physical and mental health care to address the social determinants of health. It must also align with the efforts and outcomes of the Caregiver, Alzheimer's, and Homelessness Task Forces. This involves a top down and bottom up approach that includes:

- "No Wrong Door" systems of service delivery and cross-referral at the state, regional, and local levels.
- Centralized, navigable, user-friendly, cross-linked systems providing access to information, resources, services, and programs at the state, regional, and local level.

- Seed and supportive funding for expanded community-based infrastructure and resources, including adult day care, systems for social care and mutual support such as the Village Concept, and creation of age-friendly communities.
- Use of functional and cognitive assessment in addition to disability and age to determine eligibility for services.
- Caregiver needs assessment, support, training, and respite.
- Access to:
    - Information and programs supporting healthy aging, including education, recreation, and fall prevention.
    - Affordable, universal/accessible design housing.
    - Home modification and assistive technology.
    - Housing Plus Services.
    - Affordable quality care and services in residential facilities.
    - Transition services among and between hospital, rehabilitation, and nursing facilities to home and community-based services.
    - Affordable transportation and facilitated mobility.
    - Social engagement, quality nutrition, and preventive care.
    - Housing coupled with services for the homeless.
    - Care for those who are unsheltered.

*CRITICAL ISSUES:*

- *Universal Assessment*
- *Caregiver Needs Assessment*
- *Complex acute and chronic condition management*
- *Oral, hearing, and vision care*
- *Medication management and minimization*
- *Hospital/facility discharge and transition planning with patient and caregiver engagement, training, and support*
- *Palliative and end-of-life care*
- *Elder Justice*
- *Oversight, regulation, and inspection, including compliance with Americans with Disabilities Act (ADA) and Title 24 accessibility standards.*

(2) **The Plan must address barriers to accessing information, care, services, and supports**. It must be equitable and reflect the socio-economic, racial, gender, sexual orientation, cultural, ethnic, and geographic diversity of the state. It must also address the high levels of senior poverty, the prevalence of disabilities, and the growing number of people living alone without familial or community support, some of whom have cognitive impairments. The Plan must also recognize that affording long-term care services and supports is beyond the means of many Californians whose incomes are not low enough to qualify them for Medi-Cal. Remedies include:

- A Long-Term Care Services and Supports financing system that meets the needs of the middle class.
- Expanded services and supports in rural and low-income communities.
- Well-paying jobs with benefits and opportunities for professional growth and career advancement for direct care workers.
- Practitioner and workforce development and training that incorporate cultural competency and the ability to effectively communicate complex and sensitive information to patients and their caregivers.
- Early intervention and supports to address declining financial capacity and potential for homelessness.
- Elevated attention to social care services to overcome isolation and accelerated mental and physical decline.

*CRITICAL ISSUES:*

- *Financing Long-Term Care.*
- *Declining parent to child ratios.*
- *Disproportionate impacts on women.*
- *Recruitment and retention of Long-Term Care Services and Supports workers.*
- *Shortage of practitioners, providers, and services in rural and low-income communities.*
- *Shortage of geriatric specialists and declining enrollment in geriatric programs.*
- *Shortage of specialists and services to meet the needs of seniors with sensory and other disabilities.*

(3) **There must be investment and leadership from the Governor's Office and the Legislature and an inclusive stakeholder process involving consumers, providers, practitioners, payers, advocates, academic experts, and policymakers**. This means:

- Ongoing, direct involvement of the Governor's Office.
- Broad and inclusive composition of the Master Plan Advisory Committee and Subcommittees.
- Active engagement by the relevant state agencies, departments, and offices.
- Active engagement of and participation by the Legislature.
- Well publicized public hearings throughout the state with access by phone or computer and accommodations for aging and disabled attendees.
- Stakeholder and public access to the ongoing Master Plan development process through an up-to-date and accessible website and list serve.

(4) **The Plan must be comprehensive, actionable, sustainable, and funded**. It must designate a leader with clear responsibility and ultimate authority for implementation and accountability for progress and results. Priority elements are:

- A designated Cabinet Secretary with ongoing responsibility and accountability for collaboration and coordination throughout the Administration to carry out plan implementation.
- Measurable goals, a timeline for implementation, and a system of specified metrics and data collection methodologies that enables longitudinal and aggregated and disaggregated analysis and comparison of outcomes and results.
- Ongoing evaluation of implementation progress, effectiveness, and evolving and emerging needs.
- Continuous monitoring of best practices and medical and behavioral care and service delivery advancements such as cognitive decline prevention and management, Telecare, and assistive technology.
- A system and timeline for modifying and updating the Plan routinely and as warranted by new developments or the need for course correction.
- Mechanisms for shared learning and funding for initiating and scaling up effective pilot programs.
- Annual reporting to the Legislature.
- Priority funding in the state budget.

- Commitment by the state to champion and advocate for changes in federal policies and programs to benefit the aging and disabled population including --
  - Revision and replacement of current program eligibility indicators such as Federal Poverty Level to realistically convey the ability to afford care, services, and supports.
  - Authorization for states to adopt their own eligibility standards such as the California Elder Economic Security Index or the California Poverty Measure.

The challenges of meeting the diverse needs of California's aging population and people with disabilities are great. Overcoming them will require both cultural and structural change internally within the services and supports delivery system and externally among individuals, families, and society as a whole. However, both government and non-government experience delivering aging and disability care, services, and supports have generated a wealth of knowledge about what works and what does not. The Master Plan can capitalize on lessons learned from IHSS, Medicaid Waiver programs, MSSP, PACE, HCBS, CBAS, Senior Centers, Aging and Disability Resource Centers, Independent Living Centers, entities serving the specific needs of seniors with sensory disabilities, Area Agencies on Aging, Managed Care, and Covered California. Many of these are model programs that could and should be scaled up to serve a population far greater than they serve now.

California can also benefit from the experiences and successful (or unsuccessful) programs of other states, such as Hawaii, Wisconsin, and Washington. The Master Plan should also explore the potential for public/private partnerships and opportunities for combining multiple services at senior housing developments; residential care, day care, and health care facilities; and employment sites and educational institutions.

The Collaborative notes that in addition to Master Plan development, other parallel efforts are proposed in currently pending legislation that address long-term care services and supports financing, universal assessment, no-wrong-door system design, workforce development, and expanded benefits and increased reimbursements. The Master Plan process must integrate these critical issues. In addition to pending legislation are implementation of the California Task Force on Family Caregiving Report and the activities of the newly created California Alzheimer's Prevention and Preparedness Task Force and The Homeless and Supportive Housing Advisory Task Force. The Master Plan development process must maintain coordination and alignment with these efforts in order to create an overall integrated system of services and supports.

The Collaborative is primed to serve as a vested resource for the Governor and policymakers as they conduct the Master Plan for Aging development process. The Collaborative and its Master Plan for Aging Workgroup stand ready to provide technical assistance based on decades of collective experience working on the ground and in the Capitol to deliver and improve access to the programs, services, and supports aging and disabled Californians need and deserve.

## *About the California Collaborative for LTSS*

*The California Collaborative advocates for the dignity, health and independence of Californians regardless of age who experience disabilities, functional limitations or chronic conditions and who use long-term services and supports. California needs a system of high-quality, cost-effective long-term services and supports that strengthen the person, his or her family, caregivers, circles of support, and the community at large. That system must promote the person's well-being and social participation, promote economic independence, prevent impoverishment and remove barriers to employment.*

*The Collaborative Endorses a System of Long-Term Services and Supports Based on the following Ten Principles:*

- *Dignity: The services are grounded in respect for the person who uses them and driven by the preferences of that person.*
- *Choice: Access to all types of services is provided on an equal footing.*
- *Flexibility: The services are comprehensive and flexible enough to meet changing needs and incorporate new modes of service and supports.*
- *Quality: Public funding and oversight that values and rewards high-quality care.*
- *Legality: The services are consistent with the legal rights of individuals who use them.*
- *Cultural Competence: The services are appropriate and responsive to the needs of unserved and underserved populations.*
- *Accessibility: The services and information about them are easy to locate and use and are physically and programmatically accessible.*
- *Affordability: The services are cost-effective for the person and the system.*
- *Inclusive: The system recognizes and supports the crucial role of high-quality paid and unpaid caregivers, including family caregivers, and emphasizes the importance of workforce development and training.*
- *Independence: The services support maximum independence, full social integration and quality of life.*