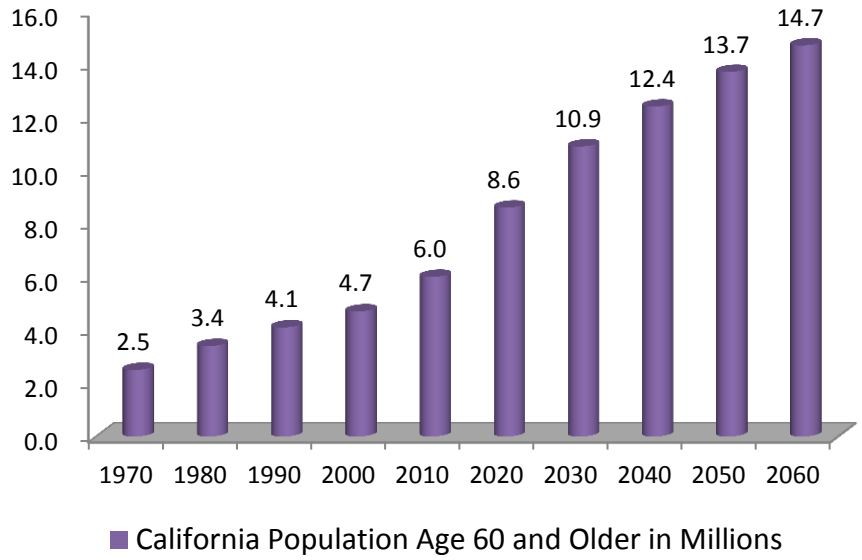
DRAFT – FOR PUBLIC COMMENT

CALIFORNIA STATE PLAN ON AGING 2017 – 2021



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FORWARD

As California's designated State Unit on Aging, the California Department of Aging (CDA) has prepared the *California State Plan on Aging, 2017-2021* with a focus on promoting the independence and well-being of older adults, adults with disabilities, and their families throughout the State. Eligibility for many Older Americans Act (OAA) services begins at age 60 and California is home to more than 7.8 million individuals age 60 and older. By 2030, that number is estimated to increase by 40 percent. However, most individuals accessing OAA services are in their seventies or older. By 2030, the number of Californians age 85 and over is expected to grow by over 37 percent.

In hearings conducted to receive public comments prior to submission of this State Plan, CDA heard directly from older adults, persons with disabilities, family members, advocates, and providers about the unmet needs in their communities related to: _____ **(Update based on input from hearings)**

While the sheer number of Californians who could benefit from the OAA, senior employment, and health insurance counseling programs continues to grow, over the past two decades federal funding has been stagnant, and California's allocation has actually decreased by approximately $10 million annually due to the federal Sequestration cuts.

California continues its implementation of federal health care reform, which has enabled millions of Californians to obtain health care coverage through both public and private plans. Many Californians now have access to affordable, quality health care coverage through Covered California. The state also expanded Medi-Cal (Medicaid in California) to cover childless adults and parent/caretaker relatives with incomes up to 138 percent of the federal poverty level, and expanded Medi-Cal mental health and substance use disorder benefits. Moreover, the state has developed new care delivery and financing models to better serve low income beneficiaries with more complex care needs, including those dually eligible for both Medi-Cal and Medicare. This demonstration program, known as Cal MediConnect, is being implemented in seven of California's largest counties.

CDA, has been and will continue to work closely with the California Department of Health Care Services (DHCS), program providers, consumer representatives, and other key stakeholders in ongoing efforts to further improve coordination between the participating Cal MediConnect health care plans and the long term services and supportive programs to enhance consumer choice and their ability to remain in (or return to) their own home and community with community supports. Several objectives in this State Plan address CDA's continued involvement in activities tied to Cal MediConnect's successful implementation and the Aging Network's active participation in this important endeavor.

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EXECUTIVE SUMMARY

Federal law requires each State Unit on Aging to submit a State Plan to the federal Administration on Aging (AoA) at least every four years. When approved, the State of California receives federal funds to administer the State Plan. These federal funds are matched with State and local funds. The State Plan outlines specific goals and objectives that are achievable within CDA's existing resources.

Beyond the minimum required information, the *California State Plan on Aging, 2017-2021* (State Plan) addresses: key socio-demographic factors that will shape funding needs; priorities, unmet needs and promising practices identified by CDA and Area Agencies on Aging (AAA); and CDA's objectives in working with the AAAs and others to provide cost-effective, high quality services to California's older adults, persons with disabilities, and their caregivers.

California's older adults age 60 and over continue to grow rapidly. Between 1970 and 2016, the number of older adults in this State grew from 2.5 million to 7.8 million, an increase of 212 percent. By 2030, when all of the Baby Boomers have reached age 60, there will be an estimated 10.9 million older Californians. While 604,139 Californians were 85 or older in 2010, projections indicate that by 2030 over 1 million individuals will be in this age group, a 70 percent increase. This rapid aging population can be attributed to two factors: (1) individuals are living longer lives than in previous decades; and (2) the baby boomer cohort is proportionately larger than previous generations. This projected growth has many implications for individuals, families, communities, and government.

In the late 1990s, racial and ethnic minority individuals became the largest segment of California's population. California's older population also continues to grow more racially, ethnically, and culturally diverse. While 57 percent of older adults were White/Non-Hispanic in 2016, it is anticipated that by 2050 the majority of older adults will be from racial, ethnic, and cultural diverse groups. This diversity has enriched California, fostered new innovations, and encouraged an appreciation of the State's multicultural traditions and the values and priorities we hold in common. Nonetheless, because some of these groups have been historically denied opportunities, or are now faced with the challenges of life in a new culture, this diversity can frequently be accompanied by health, social, and economic disparities that must be addressed.

This State Plan outlines goals, objectives, and strategies that are sensitive to this environment and articulates measurable outcomes that can be achieved within CDA's resources. The State Plan seeks to: increase consumer access to health and supportive services; assist people in making informed decisions about available programs and benefits; enable individuals to continue living in their communities in a manner consistent with their abilities and values; expand opportunities for civic engagement; integrate evidence-based practice into OAA programs and services; protect consumer rights; and prevent abuse. Throughout, it focuses on developing and maintaining the ongoing partnerships necessary to support the ability of the Aging

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Network to address local needs. By strengthening the infrastructure for home- and community-based services, the State Plan continues to build toward a future in which every Californian has the opportunity to enjoy wellness, longevity, and quality of life in strong, healthy communities.

Summary of Goals and Objectives

GOAL I: *Empower older Californians, persons with disabilities, and their caregivers to easily access the information they need to make informed decisions.*

A. Make information on health and supportive services accessible to older adults, their caregivers, and others to promote independence and wellness.

B. Provide enhanced beneficiary outreach, counseling, and education to individuals who are dually eligible for Medi-Cal and Medicare to help them make informed decisions about their Cal MediConnect benefit options.

C. Make information and training on person-centered counseling principles and processes available to consumers, transition coordinators, and agencies serving older adults and persons with disabilities.

GOAL II: *Enable older Californians, persons with disabilities, and their caregivers to be active and supported in their homes and communities.*

A. Support successful integration of long-term services and supports into Cal MediConnect.

B. Implement California's Medi-Cal State Transition Plan (STP) to ensure that the Multipurpose Senior Services Program (MSSP) and Community-Based Adult Services (CBAS) programs are in compliance with federal Medicaid Home and Community Based (HCB) Settings regulations.

C. Implement necessary operational changes in the MSSP and CBAS programs to comply with federal rules governing person-centered care, provider screening, and non-discrimination requirements in Medi-Cal health and Long-Term Services and Supports (LTSS) programs.

D. Promote effective delivery of the OAA core services to eligible persons, with particular attention to noted special target groups who often do not access these services for various reasons.

E. Expand opportunities for community involvement and volunteerism to increase the availability of services to older adults, persons with disabilities, and family

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caregivers; promote peer-to-peer support programs; and foster intergenerational service programs.

GOAL III: *Provide older Californians, persons with disabilities, and their caregivers with information and tools to support their health and wellbeing.*

A. Promote healthier living through evidence-based programs targeted to adults with various chronic conditions and family caregivers.

B. Support older adults in increasing their access to nutritious foods and establishing healthy eating habits.

C. Support Cal MediConnect managed care health plans in identifying and implementing tools to better serve members with dementia and their families.

D. Engage Ombudsman representatives in promoting strategies to reduce the risk of health care acquired infections and promote antibiotic stewardship in long-term care facilities.

GOAL IV: *Protect the consumer rights of older Californians and persons with disabilities and assist them to obtain needed benefits.*

A. Evaluate local implementation of California's Legal Services Provider Standards and identify best/promising practices.

B. Improve abuse investigation skills for Adult Protective Services (APS) workers and Ombudsman representatives.

C. Promote awareness of abuse against elders and adults with disabilities and effective prevention strategies.

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SECTION I – STATE PLAN PURPOSE AND VISION

State Plan Purpose

Federal law requires each State Unit on Aging to submit to the federal AoA a State Plan on Aging at least every four years. At a minimum, this State Plan must specify:

- The State's goals and objectives for the planning period;
- Statewide program objectives to implement the requirements under Title III of the OAA of 1965, as amended;
- A resource allocation plan indicating the proposed use and the distribution of Title III funds to each Planning and Service Area (PSA);
- The geographic boundaries of each PSA and the designated AAA;
- The prior federal fiscal year information on low income, minority, and rural older adults; and
- Compliance with assurances currently required by the OAA of 1965, as amended, Title 45, Code of Federal Regulations (CFR) Section 1321.17(f) beginning at (f)(1).

When approved, the State of California receives federal funds to administer the State Plan. These federal funds are matched with State and local funds.

Beyond the federally required information, California's State Plan outlines:

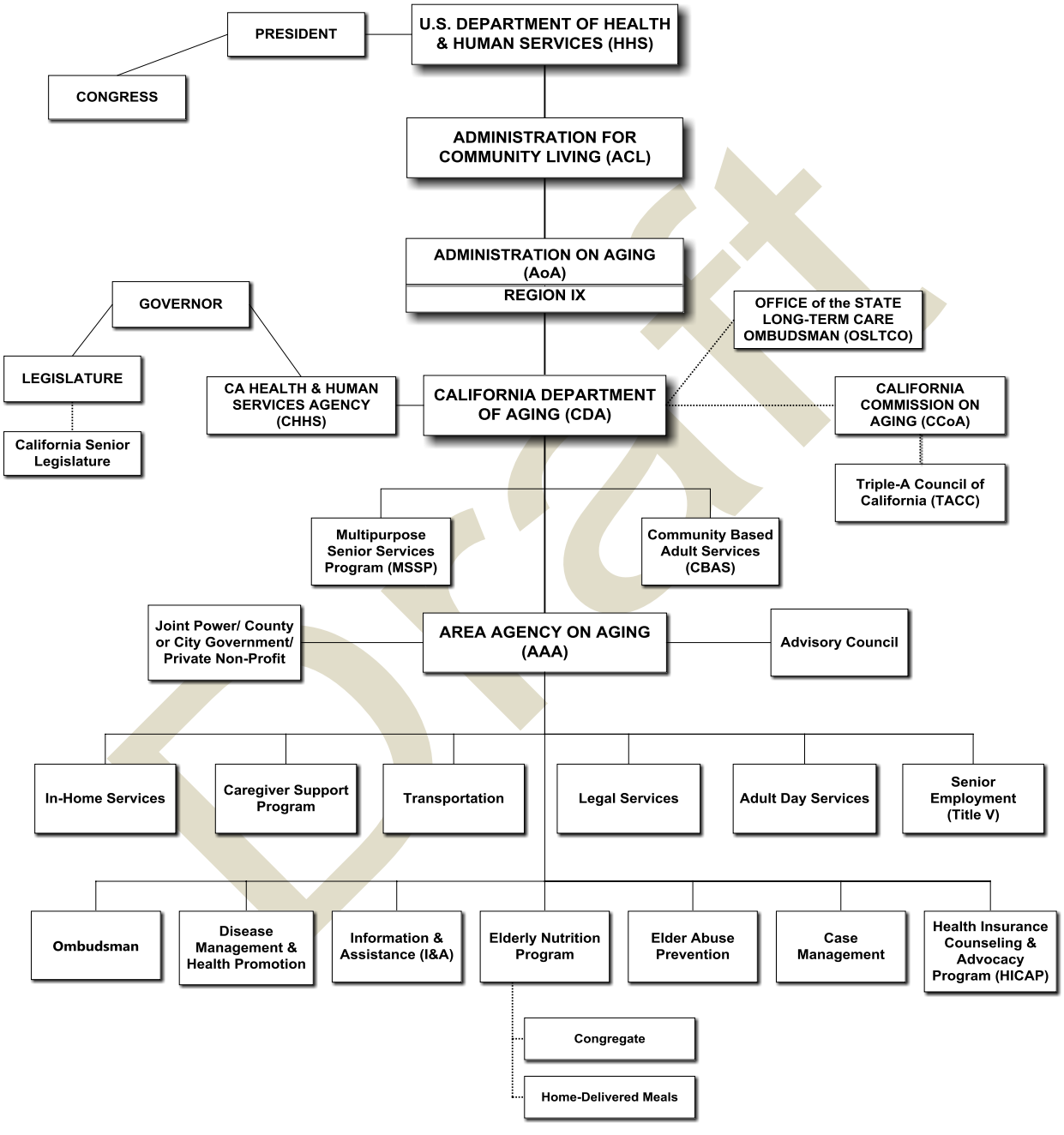
- Key socio-demographic factors that will shape funding needs and priorities;
- Priorities, unmet needs, and promising practices identified by CDA with input from the AAAs, other program providers, and key stakeholders;
- CDA's objectives focused on working with the AAAs to provide cost-effective, high quality services to older adults, persons with disabilities, and their informal caregivers; and
- Additional target populations that CDA, in collaboration with the AAAs, and other program providers, seeks to better serve through more culturally competent outreach and services to these often underserved groups, including, but are not limited to: individuals who are Holocaust survivors; Native Americans; recent refugees; Lesbian, Gay, Bisexual, Transsexual, Queer, Questioning or Intersex (LGBTQI) older adults; adults with disabilities; and family caregivers.

In addition to the OAA home- and community-based services authorized under the OAA, CDA and the AAAs also administer the statewide Health Insurance Counseling and Advocacy Program (HICAP) to assist Medicare beneficiaries in understanding their health and long-term care (LTC) insurance options. CDA also administers the MSSP, the Medi-Cal waiver for older adults at risk of skilled nursing placement, and certifies licensed adult day health care centers for Medi-Cal reimbursement through the CBAS Program. CBAS providers serve adults aged 18 and older who have functional or cognitive challenges that place them at risk of institutionalization without these supportive services. These Medi-Cal programs receive federal and state funding dollars. Medi-Cal is California's Medicaid program (Figure 1)

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FIGURE 1

CALIFORNIA AGING NETWORK



REVISED: MARCH 2017

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Vision, Mission and Values

The Department envisions every Californian having the opportunity to enjoy wellness, longevity, and quality of life in strong healthy communities.

Its Mission is to promote the independence and well-being of older adults, adults with disabilities, and families through:

- Access to information and services to improve the quality of their lives;
- Opportunities for community involvement;
- Support for family members providing care; and
- Collaboration with other state and local agencies.

The Department strives to pursue its Vision and accomplish its Mission in a manner consistent with its Values (Appendix A).

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SECTION II – CONTEXT

Overview of the California Aging Services Network

Local Level: AAAs

The OAA and the Older Californians Act (OCA) provide the legislative context for California's 33 AAAs to fund specific services, identify unmet needs, and engage in systems development activities in their PSA (Appendix B). Systems development is a set of activities and processes used by the AAAs and other organizations to envision, plan, manage, coordinate, integrate, evaluate, refine, and improve the quality of a community's constellation of services.[1]

State Level: CDA

The OAA and the OCA specify that CDA has an important role in helping AAAs and their local communities to develop systems of services. As with AAAs, CDA often does not have the administrative or budgetary authority to "require" other agencies or organizations to participate in systems development efforts. Nonetheless, its expertise on aging, disability, and caregiving issues is important to shaping programs and service systems that are sensitive and responsive to the needs of older adults, adults with disabilities, and their families.

By leveraging its resources through federal grants and collaborative partnerships, CDA continues to strengthen the infrastructure for the home- and community-based services necessary to address local needs. CDA administers a number of grants to support evidence-based health promotion and develop local service partnerships. As an active participant in California's Olmstead Advisory Committee and other policy forums, CDA joins State departments, local agencies and other stakeholders to identify strategies to prevent or delay institutionalization and improve service delivery. Section III of this Plan further describes these efforts. In addition, CDA assists AAAs and communities by:

- Working with other State departments and agencies, AAAs, and other local entities to define roles and responsibilities at both the State and local levels;
- Providing Area Plan guidance that encourages and supports systems development;
- Working to remove State-level barriers. CDA works with sister agencies to resolve implementation issues;
- Developing common program standards, including service unit definitions and reporting requirements;
- Fostering the development and implementation of common intake, screening, and assessment instruments;
- Actively supporting local efforts;
- Helping to improve access to information, resources, and services;
- Providing training and technical assistance to individuals and organizations at the local level as needed;
- Sharing promising practices; and

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- Refining data collection and reporting to improve the information available to decision makers in developing policies that affect older adults.

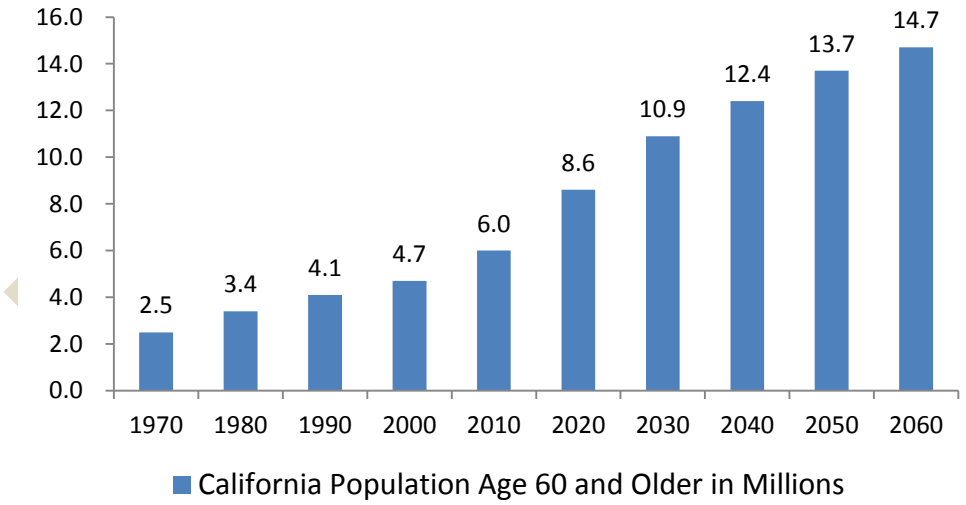
These combined efforts comprise a proactive strategy to make optimal use of limited resources during challenging times.

Aging in California

Overview

Since 2010, California's population age 60 and over has grown rapidly (Figure 2). Between 1970 and 2016, the number of older adults in this State increased from 2.5 million to 7.8 million, an increase of 212 percent. This trend is estimated to continue as the cohort age 60 and over is estimated to grow to 14.7 million by 2060, an increase of 88 percent from 2016.

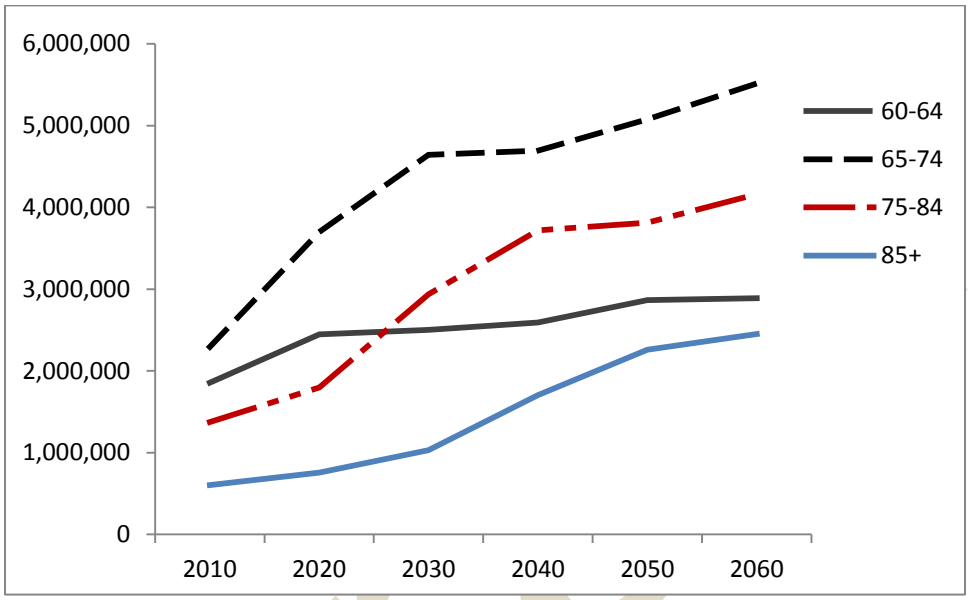
Figure 2
California Population Age 60+ Growth Trends[2]
(in millions, rounded)



While the overall population age 60 and over is growing rapidly, increases within this age group are occurring at different rates (Appendix C). The largest growth will occur during the next 30 years as the Baby Boomers, those born between 1946 and 1964, reach age 60. Between 2010 and 2030, California's 85+ population is estimated to increase by over 70 percent.

An estimated 1.86 million Californians are currently between age 60 and 64. By 2050, this age group is projected to grow to 2.87 million, a 54 percent increase. While 604,139 Californians were age 85 and over in 2010, by 2050, an estimated 2.26 million individuals will be in this age group, a dramatic 274 percent increase (Figure 3).

Figure 3
Age 60+ Population Growth Projections[3]



The current size of the population age 85 and over, and the projected increase in this age group, is notable. Those 85 and older have a significantly higher rate of severe chronic health conditions and functional limitations that result in the need for more health and supportive services. The rapid growth of this age group has many implications for individuals, families, communities, and government.

The impact of an aging population, described by some as an "age wave" and others as an "aging tsunami," will be felt in every aspect of society. The economic, housing, transportation, health, and social support implications of this phenomenon must also be viewed in the context of the State's tremendous population growth, which continues to challenge the State's overall infrastructure planning. Demographers project that California's population, at 38.2 million in January 2016, could reach 51.7 million by 2060.[4]

While Table 1 presents an overview of older Californians today, older adults have never been a heterogeneous group in terms of educational achievement, income level, and health and disability status. In the coming decades, the gap between the "haves" and the "have-nots" among older Californians will grow even wider. Educational and employment opportunities throughout life impact access to health care, retirement savings, and pension benefits in later life. The cumulative effect of all these factors shapes older Californians' prospects for a healthy and secure retirement. Important

differences among the State's older adults are tied to racial, ethnic, and cultural factors; gender and marital status; geographic location; and socio-economic resources.

Table 1
A Snapshot of Older Californians Age 60+

Characteristic	2009-2016
Living in a nursing home[5]	2%
Below poverty level[6]	16.3%
Medi-Cal Eligible[7]	19.1%
Limited English proficiency[8]	23.1%
Poor or near poor (0-149% of poverty)[9]	20.7%
Living alone[10]	25%
Women age 60+ living alone[11]	72%
Percent with any disability[12]	36.2%
Proportion of Californians age 75 and older with a driver's license[13]	61%
Homeowners[14]	77%
With high school diploma or higher[15]	81.8%
Number of grandparents responsible for basic needs of grandchildren[16]	300,000

Geographic Location

The Los Angeles Basin and the San Francisco Bay Area are home to about two-thirds of the State's older population; this likely will continue over the next 40 years (Appendix D). While every region, except the most rural areas of the State, is expected to experience strong growth in its population of persons age 60 and over, the largest increases are predicted for several Central Valley and Southern California counties (Appendices E and F). By 2030, the number of older adults age 65 years of age and over are projected to increase by 117 percent in Central Valley Counties, such as, Kings, Merced, San Benito, San Bernardino, San Joaquin, and Riverside counties.[17]

Race, Ethnicity and Cultural Factors

In the late 1990s, racial and ethnic minority populations became the largest segment of California's population. California's older adults will continue to grow more racially, ethnically, and culturally diverse. While White/Non-Hispanic older adults were a majority in 2016, by 2050 the majority will be from groups formerly considered to be minorities (Appendix G).

Ethnic and cultural diversity has enriched California, fostered new innovations, and encouraged an appreciation of the State's multicultural traditions and the values and

priorities we hold in common. However, because some groups have been historically deprived of opportunities, or are now faced with the challenges of life in a new culture, diversity may translate into health and economic disparities that must be addressed:

- Older adults who are not White report poor or fair health more often than Whites/Non-Hispanics. Older Hispanics and those with limited English abilities have the worst health profiles compared to statewide averages.[18]

- While 88 percent of U.S.-born older Californians have at least 12 years of education, only about 64 percent of older immigrants have this level of education.[19]

- Cultural customs and expectations related to a family's caregiving responsibilities can have a significant negative impact on the primary caregiver's health and future financial resources.[20]

An estimated 38,000 residents age 60 and older migrated to California from other states and 27,000 migrated from abroad.[21] Approximately 1.6 million (30 percent) of California's total older adult population was foreign-born. Of these, 78 percent arrived before 1990, 15 percent in the 1990s, and 7 percent in 2000 or later. The future size and age distribution of the California population will be influenced by both international and domestic migration, each of which is difficult to predict.[22]

Resettlement to a new country and the need to learn a new language can be especially difficult for older refugees.[23] Newly arriving refugees in California are the most ethnically diverse groups in the nation, originating from more than 85 different countries and speaking more than 80 different languages at any given time. Several counties (Alameda, Los Angeles, Orange, Sacramento, San Diego Santa Clara and Stanislaus counties) have drawn the highest number of refugees and other refugee-eligible populations.

The U.S. Department of Health and Human Services (HHS), Office of Refugee Resettlement provides the Service for Older Refugees (SOR) grant through a formulation based on older refugees on aid. This grant provides minimal federal funding to the California Department of Social Services (CDSS), Refugee Programs Bureau, to provide linguistically and culturally appropriate services to newly arrived refugees and other refugee-eligible populations, aged 60 and older. States may provide services to eligible populations who have been in the country up to 60 months (5 years) from the date of entry or asylum application approval, with the exception of referral services, interpretative services, and citizenship and naturalization preparation services, which do not have a time limit.

States receiving SOR funding focus on the following areas:

- Outreach - Establishing and/or expanding relationships with state or local agencies on aging to ensure older refugees are linked to community aging services;

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- Service Enhancement - Providing appropriate services not currently being provided in the community to older refugee populations;

- Independent Living - Creating opportunities that enable older refugees to live independently as long as possible; and

- Naturalization - Developing services that link older refugees to naturalization services, especially individuals who have lost or are at risk of losing Supplemental Security Income (SSI) or other federal benefits.

While approximately 15 percent of older Californians have limited English proficiency, in Alameda, San Francisco, San Mateo, Santa Clara, Merced, San Benito, Tulare, Los Angeles, Orange, and Imperial counties, between 22 and 48 percent of older adults have difficulty communicating in English (Appendix H).

Providing culturally appropriate outreach and assistance is essential to overcoming disparities in accessing health and social services. However, addressing these linguistic and cultural issues adds to the complexity and costs involved in serving these older adults.

During the past decade, the unique issues experienced by California's LGBTQI older adults have been increasingly recognized and addressed. Older LGBTQI adults are as diverse as their heterosexual counterparts. Lifelong fears or experiences of discrimination have caused some of these older adults to remain invisible, preferring to go without much-needed social, health, and mental health services. It is difficult to estimate the number of LGBTQI older adults in the population, but studies indicate that between 5 to 10 percent of the entire U.S. population is LGBTQI.[24] Although this estimate may be low, applying this percentage to California's population of older adults suggests that there are approximately 380,282 to 760,565 older LGBTQI Californians. By 2030, this number is expected to nearly double.[25]

Gender and Marital Status

On average, women live 4.8 years longer than men.[26] Among Californians ages 60 to 84, 55 percent are women. Beyond age 85, 65 percent are women. Owing to their longer life expectancy and their tendency to marry men who are two or three years older than they are, women have a much higher probability to be widowed and to live alone in old age. More than 40 percent of women age 65 and older in California are widowed, compared to 10 percent of men.[27] Women become more vulnerable as they grow older, because they are more likely than men to live alone, be (or become) poor, and have multiple chronic health conditions.

In retirement, older women are at greater economic risk than men due to income disparities. Non-married women and minorities had the highest poverty rates ranging from 18 percent to 19.2 percent. Of the total adults receiving monthly Social Security benefits, 45 percent were men and 55 percent were women, of which 13 percent of the

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women received survivor benefits.[28] Among retired and disabled workers who received benefits based on their own work records, men received a higher average monthly benefit than did women. For example, women received an average Social Security benefit of $1,182 per month or 79 percent of men who received an average Social Security benefit of $1,500 per month.[29] Not only are women's average Social Security benefits less than men's, such payments are also more likely to be their only source of income. However, for those with benefits based on another person's work record (spouse and survivors), women had higher average Social Security benefits of $1,291 per month or 15 percent higher than the average monthly benefit of $1,126 for men.[30] The proportion of women with dual entitlement (that is, paid on the basis of both their earnings record and those of their spouses) increased from 5 percent in 1960 to 26 percent in 2015.[31]

Income Resources

According to the California Retirement Security for All report, *Aging California's Retirement Crisis (October 2015)*, about 29 percent of older Californians age 60 and older live below 200 percent of the Federal Poverty Level (FPL) based on a 2015 equivalent of $23,540 for a one-person household and $31,860 for two people.[32]

In 2016, 85 percent of married couples and 84 percent of non-married persons aged 65 or older received Social Security benefits.[33] Social Security benefits were the major source of income (providing at least 50 percent of total income) for 48% of aged beneficiary couples and 71 percent of aged non-married beneficiaries. Social Security benefits were over 90 percent or more of the income for 21 percent of the aged beneficiary couples and 43 percent of aged non-married beneficiaries.[34]

Less than half of the older Californians have a retirement income (e.g. pension, 401(k), or IRA) in addition to Social Security benefits, and 28 percent are estimated to have incomes that are below the amount an older adult would need to meet their basic needs.[35] With the high cost of living in California, older adults may be more adversely impacted by the cost of basic necessities (e.g. food, health care, shelter, transportation, utilities, etc.). In particular, the need for affordable and accessible housing continues to grow for older Californians, where about 26 percent of the seniors face a housing cost burden, spend more than 30 percent of their income on housing expenses.[36] UCLA's Center for Health Policy Research develops and updates the California Economic Security Standard Index to demonstrate the actual cost of living for older adults in each PSA (Appendix L).

Households of various racial groups are more likely to reach retirement with significantly less wealth than older white adults due to lower access to workplace retirement plans, less secure employment, and lower Social Security benefits. Latino older adults are the fastest growing segment of the senior population and are 44 percent more likely to live in poverty with incomes below 200 percent FPL than older white adults. Asian and African-Americans are 32 percent and 23 percent, respectively, more likely to live in poverty than older white adults.[37]

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For very poor older Californians, SSI can be an added source of income. SSI provides a minimum guaranteed monthly income for all qualified individuals who are age 65 and over, blind, or disabled. The State of California supplements the federal benefit substantially through the State Supplementary Payment (SSP). In 2016, the combined SSI/SSP annual benefit was $10,673 for an older individual and $17,954 for an older couple living independently.[38] However, SSI recipients' accumulated assets must fall below certain limits, and recipients cannot earn income that exceeds their SSI benefit without reducing their monthly payment. Many poor older adults are not eligible for SSI because their assets exceed the maximum allowed. Many others do not apply for the benefit because they do not know they are eligible or do not want to receive public assistance.

Health Status

The dramatic gains in life expectancy that occurred during the twentieth century were due primarily to advances in sanitation, medical care, and the use of preventive health services. These factors also account for a major shift over the past century in the leading causes of death—from infectious diseases and acute illnesses to chronic diseases and degenerative illnesses.

The State of Aging and Health in America 2013 report provides good indicators of where to focus attention to improve the health of older Californians. In 2013, the top five leading causes of death for individuals over the age of 65 were: cardiovascular (27.7 percent); cancer (22.1 percent); chronic lower respiratory diseases (6.5 percent); stroke (6.4 percent); and Alzheimer's disease (4.4 percent). These five causes accounted for 67 percent of all deaths among adults age 65 and older.[39] Although the risk of disease and disability increases with age, poor health is not an inevitable consequence of aging. Three behaviors—smoking, poor diet, and physical inactivity are the major contributors to death.[40] These behaviors are often associated with the leading chronic disease killers such as heart disease, cancer, and stroke. Adopting healthier behaviors (e.g. regular physical activity, a healthy diet, a smoke free lifestyle, etc.) and getting regular health screenings (e.g. mammograms, colonoscopies, cholesterol checks, bone density tests, etc.) can dramatically reduce the risk for most chronic diseases.[41]

The burden of chronic diseases encompasses a much broader spectrum of negative health consequences than death alone. People living with one or more chronic diseases tend to experience a diminished quality of life and generally reflected by a long period of decline and disability associated with their disease. Chronic diseases can affect a person's ability to perform important and essential activities, both inside and outside of the home, such as managing money, shopping, preparing meals, and/or taking medications as prescribed. Also, as functional ability further declines, people may lose the ability to perform basic activities of daily living (ADLs), such as taking care of personal hygiene, feeding themselves, getting dressed, etc.

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State Plan Development

This State Plan was developed with input from the AAAs, the California Commission on Aging, and other key stakeholders. These organizations reviewed and provided input to the draft Plan. The Department consulted with these organizations to identify shared priorities and opportunities for collaboration in achieving these objectives during the next four years. In partnership with these organizations, CDA conducted three public hearings on the draft State Plan in Sacramento, Los Angeles, and Fresno on May 10, 18, and 22, 2017, respectively. CDA also posted the draft State Plan on its web site. Public input was taken into consideration in the final version of the State Plan.

In addition to considering information gathered at public hearings, CDA reviewed the goals and objectives outlined in 33 local Area Plans to identify local priorities and strategies that could inform State level activities. CDA supplemented this information from additional feedback from the AAAs, the California Commission on Aging, and other stakeholder groups when providing State Plan updates.

Our Challenges and Future Priorities

During the next four years, CDA and the State's Aging Network will continue to face a number of challenges tied to the growing population in need of these services, severe and ongoing fiscal constraints, and increasing federal requirements for these programs and services.

This State Plan outlines goals, objectives, and strategies that are sensitive to this environment, and articulates measurable outcomes that can be achieved within CDA's existing means. CDA will leverage its resources by partnering with AAAs and other stakeholders to provide technical assistance and share promising practices to enhance services related to volunteerism, better serving target populations, and enhance evidence-based health promotion activities. Through ongoing communication and collaboration with the AAAs and other collaborating agencies, CDA will apply and share promising practices and lessons learned both at the state and local level in implementing these activities.

CDA believes this State Plan sets a course that will contribute to building the infrastructure needed to support a statewide system of home- and community-based services. The Plan includes strategies to increase the availability of consumer information, support intergenerational opportunities for volunteerism and civic engagement, promote health, protect consumer rights, prevent fraud and abuse, and assist people with obtaining needed benefits. Throughout, the Plan focuses on developing and maintaining the ongoing partnerships necessary to support the ability of the Aging Network to address local needs. By strengthening the infrastructure for home- and community-based services, the State Plan continues to build the foundation for a future in which every Californian has the opportunity to enjoy wellness, longevity, and quality of life in strong, healthy communities.

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SECTION III – GOALS AND OBJECTIVES

GOAL I: *Empower older Californians, persons with disabilities, and their caregivers to easily access the information they need to make informed decisions.*

Easy Access to Information (Objective 1A)
Information empowers people to make informed decisions about their future and promotes self-sufficiency and independence. AAAs fund Information and Assistance (I&A) as a priority access service in their Area Plans. CDA supports local I&A services by sponsoring a statewide toll-free telephone number (1-800-510-2020) to link callers directly to their local AAAs. This Senior Information Line is a component of the AoA's national Elder Care Locator (ECL) system.

CDA also administers the statewide toll-free HICAP Information Line (1-800-434-0222) to assist Medicare beneficiaries and others in accessing information about Medicare benefits and related insurance options. Through the Office of the State Long-Term Care (LTC) Ombudsman, residents of LTC facilities and their family members can call the toll-free CRISISline (1-800-231-4024) 24 hours a day, 7 days a week to access information and submit complaints.

Increasingly consumers and their families are turning to the Internet for information on aging and caregiving issues. CDA is involved in efforts to increase access to these resources through the Aging and Disability Resource Connection (ADRC) and in collaboration with the AAAs local I&A programs. CDA also continues its efforts to add to and keep resources on its website up to date and user-friendly.

- ***Senior Medicare Patrol***
  To assist with identifying, reporting and preventing suspected Medicare fraud and abuse, the State HICAP Office and local HICAPs collaborate closely with the California Senior Medicare Patrol (SMP). SMP is a federal program administered through the Administration for Community Living (ACL). SMP services are available at all of California's 26 local HICAPs where many registered HICAP counselors serve as SMP volunteers. Each SMP volunteer receives specialized training on working with Medicare beneficiaries to detect and report Medicare fraud and abuse. In addition, HICAP and the California SMP host joint statewide trainings each year for HICAP and SMP staff and volunteers on subjects such as identity theft, fraudulent billing practices, and health insurance scams. SMP volunteers serve as key resources on issues related to Medicare fraud and abuse to Medicare beneficiaries and other HICAP counselors by conducting educational presentations, providing one-on-one counseling, and delivering helpline assistance.

- ***Aging and Disability Resource Connections***
  In seven regional areas, the local AAAs and the Independent Living Centers (ILCs) have established a formal partnership, in collaboration with other key local

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agencies, to create more effective strategies focused on helping individuals and families searching for community based long term services and supports in accessing these services.

At the state level, CDA, in partnership with the DHCS and the Department of Rehabilitation (DoR), oversees California's ADRC efforts by providing technical assistance and oversight of the existing and developing ADRCs; managing California's ADRC designation process and criteria; and staffing the ADRC Advisory Committee. CDA provides AAAs, ILCs, and other ADRC Advisory Committee members with on-going technical assistance, information, and tools necessary to sustain the administrative infrastructure necessary to support successful ADRCs. In addition, CDA continues to explore how ADRCs can have an active role in assisting individuals enrolled in the Cal MediConnect health plans in being able to remain in or return to an independent living situation.

CDA staff will continue their efforts to secure person centered care training for the existing and emerging California ADRCs. This training is a core federal ADRC program requirement. However, federal funding for this training was limited to a core set of pilot states to provide this training. CDA will also continue to increase access to much-needed consumer information on aging and LTSS on its website and also expand the CDA website to include ADRC resources and materials.

Cal MediConnect (Objective I.B)

Since 2012, California has been actively involved in implementing innovative managed care approaches to better coordinate and fund the full range of health and long term services and supports for dually eligible adults in the seven demonstration counties (Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara). While enrollment in Cal MedConnect—a managed care plan that includes all Medicare and Medi-Cal benefits and services-- is an option for Medicare services, most adult Medi-Cal beneficiaries in these seven counties must enroll in one of the participating managed care health plans for their wrap around Medicare and Medi-Cal benefits.

CDA, has been and will continue to work closely with DHCS, program providers, consumer representatives, and other key stakeholders in ongoing efforts to further improve coordination between the health care plans and long term services and supportive service providers to prevent avoidable acute care episodes, enhance consumer choice, and assist plan members in being able to remain in (or return to) their own home and community. Several objectives in this State Plan address CDA's continued involvement in activities tied to Cal MediConnect's successful implementation and the aging network's active participation in this important endeavor.

Through a Financial Alignment grant from the federal Centers for Medicare and Medicaid Services (CMS), CDA will continue to provide additional resources to the AAAs in the Cal MediConnect counties to support HICAP outreach, education, and one-

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on-one counseling services to dual-eligible beneficiaries in these seven counties so they can make informed choices in considering their health care coverage options.

In the Cal MediConnect counties, the health plans directly reimburse the CBAS programs, the MSSP sites, and skilled nursing/sub-acute facilities for services to their plan members. However, through its interagency agreement with DHCS, CDA continues to certify CBAS centers for participation in the Medi-Cal program and also continues to administer California's MSSP 1915(c) home- community-based waiver throughout the State.

Aging and Disability Resource Connection (Objective I.C)
CDA will continue providing consumers, AAAs, ILCs, and other service providers with information about the array of LTSS services. CDA will also continue to provide technical assistance to existing and emerging regional ADRCs on person-centered care management techniques that are responsive to the individual support needs and preference of older adults and persons with disabilities. During the next four (4) years, CDA will provide AAAs, ILCs, and the California Community Transitions (CCT) lead agencies with access to person-centered counseling training. In addition, as part of new federal requirements for a person-centered complaint resolution, the Office of the State LTC Ombudsman will also work closely with the ADRC network in providing this type of training to the local LTC Ombudsman staff and volunteers.

Objective I.A: Make information on health and supportive services accessible to older adults, their caregivers, and others to promote independence and wellness.

Strategies:

1. Continue to support and maintain the toll-free 800 telephone numbers that connect the public to their local AAA, HICAP and Ombudsman programs.

2. Ensure AAAs and their providers have the technical assistance and training necessary to support responsive and effective local I&A programs.

3. Provide AAAs, ILCs, ADRCs and other stakeholders with the information, technical assistance, and tools necessary to establish and sustain successful local ADRC partnerships.

Objective I.B: Provide enhanced beneficiary outreach, counseling, and education to individuals who are dually eligible for Medi-Cal and Medicare to help them make informed decisions about their Cal MediConnect benefit options.

Strategies:

1. Enhance local HICAPs' capacity to provide impartial information to beneficiaries about their benefit options in the Cal MediConnect counties.

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2. Develop beneficiary outreach and HICAP Counselor training materials specific to the needs of beneficiaries to assist them in understanding the difference between traditional Medicare, Medicare Advantage, and the Cal MediConnect health plans.

3. Provide outreach, education and counseling to dual-eligible beneficiaries in the Cal MediConnect duals demonstration counties.

Objective I.C: Make information and training on person-centered counseling principles and processes available to consumers, transition coordinators, and agencies serving older adults and persons with disabilities.

Strategies:

1. Provide consumers with information about California's array of LTSS and how to engage in developing a person-centered service plan that address their individual support needs and preferences.

2. Provide AAAs, ILCs, other ADRC partners, and CCT lead agencies with person-centered counseling information and training.

3. Support implementation of new federal requirements for person-centered complaint resolution in the Office of the State LTC Ombudsman Program through additional training.

GOAL I – Performance Measures

Objective	Performance Measure	Target Date
I.A.1	Conduct an analysis of calls to CDA's toll-free Senior Information Line, HICAP Information Line, and Ombudsman CRISISline to identify calls inappropriately answered or re-routed by local AAAs, HICAPs, and Ombudsman programs.	July 2018 and ongoing
I.A.2	Ensure at least one CDA staff member completes Alliance of Information and Referral Systems (AIRS) certification training.	December 2017
	Survey local AAAs, HICAPs and Ombudsman programs to identify the core components of their I&A programs and potential training and technical assistance needs.	May 2018
	Compile an analysis of the I&A survey results for dissemination to CDA, AAA, HICAP, and Ombudsman program staff.	September 2018
	Establish a workgroup comprising of CDA, AAA, HICAP and Ombudsman program representatives to develop recommendations for delivering I&A services and related training.	January 2019
	Issue recommendations to the AAA network for the delivery of I&A services and provide in-person and online training and technical assistance to support local AAAs, HICAPs and Ombudsman programs providing I&A services.	November 2019 and ongoing
	Conduct a survey of AAAs to identify the number of AAA I&A staff that are AIRS certified.	February 2018

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Objective	Performance Measure	Target Date
	Coordinate with AAAs to increase by five percent the number of AAA or AAA service provider staff who have completed AIRS certification training.	December 2019
I.A.3	Convene and staff meetings of California's ADRC Advisory Committee.	November 2017 and ongoing
	Maintain current information on CDA's website about ADRC designation standards, training and technical assistance resources, and the potential sources of funding to support and sustain ADRC partnerships.	November 2017 and ongoing
	Provide ongoing technical assistance to developing ADRC partnerships throughout California.	November 2017 and ongoing
	In partnership with the DoR, convene periodic meetings of the California ADRC Designation Committee to review applications for ADRC designation.	November 2017 and thereafter
I.B.1	Continue allocating CMS HICAP Financial Alignment funding to the AAAs in the Cal MediConnect counties that administer HICAP to provide additional HICAP counseling to Medicare beneficiaries considering their health care coverage options.	October 2017 and ongoing
I.B.2	Convene meetings with key stakeholders to evaluate the efficacy of Cal MediConnect outreach and educational materials and referral procedures and recommend any necessary revisions.	February 2018 and semi-annually thereafter
I.B.3	Collaborate with the DHCS to revise and distribute new and updated Cal MediConnect beneficiary outreach and education materials to local HICAPs.	February 2018 and ongoing
	Publish new and updated Cal MediConnect beneficiary outreach and education materials to CDA's HICAP E-Clearinghouse.	February 2018 and ongoing
	Provide technical assistance and additional training as needed to local AAAs and HICAPs in the Cal MediConnect counties on providing outreach and counseling to Medicare beneficiaries about their health care coverage options.	February 2018 and ongoing
	Coordinate the dissemination of Cal MediConnect training, education, and outreach materials among local HICAPs in the seven duals demonstration counties.	April 2018 and ongoing
I.C.1	Develop web-based consumer information and resources on CDA's ADRC website on LTSS.	November 2017 and ongoing
I.C.2	Train ADRC Option Counselors and CCT Coordinators in Person-Centered Counseling.	December 2017 and ongoing
I.C.3	Provide training on person-centered complaint resolution in long-term care facilities to local Ombudsman coordinators at the Ombudsman Fall Conference.	October 2017
	Conduct annual training on person-centered complaint resolution in long-term care facilities to new Ombudsman coordinators.	March 2018 and ongoing

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GOAL II: *Enable older Californians, persons with disabilities, and their caregivers to be active and supported in their homes and communities.*

Cal MediConnect (Objective II.A)
Cal MediConnect requires participating managed care health plans (plans) to enter into agreements with MSSP waiver sites, CBAS providers, and nursing facilities to deliver coordinated LTSS to their eligible enrollees. These plans also contract with MSSP organizations in their covered zip code areas to provide MSSP case management and waiver services to MSSP waiver participants. Similarly, demonstration plans contract with the licensed and certified CBAS centers in their covered zip code areas and adjacent zip code areas to provide CBAS services.

Cal MediConnect also requires DHCS, CDA, and the health plans to focus on person-centered approaches to care based on individual consumer needs and preferences, with a focus on maintaining plan members in the community, or diverting/transitioning individuals already in a nursing facility to care in a community based setting.

Home and Community-Based Settings Requirements (Objectives IIB and IIC)
In 2014, CMS issued final regulations articulating the characteristics and qualities that home- and community-based LTSS must comply with to continue receiving Medicaid funding.[42] In clarifying the characteristics of HCB Settings, these regulations seek to maximize beneficiaries' opportunities to participate in community living in the most integrated setting possible by incorporating person-centered planning approaches to identify beneficiaries' goals, preferences, and experience(s).

States were required to submit a transition plan to CMS specifying the processes and changes that would be conducted to comply with these requirements. DHCS, in close collaboration with the other Health and Human Services departments that directly oversee Medi-Cal HCB Settings waiver programs, prepared and submitted California's STP to CMS in November 2016. This transition plan included assessment tools that would be used by providers to self-assess their compliance; consumer assessment tools, and documentation delineating the settings assessment process, key milestones and the timeline to achieve full compliance by March 2019.

Through Interagency Agreements (IA) with DHCS, CDA administers the MSSP and CBAS programs. For MSSP, CDA oversees the MSSP operations through contracts with 38 local entities that directly provide MSSP services to approximately 12,000 clients. For CBAS, CDA certifies CBAS centers to provide therapies and other services focused on restoring or maintaining the participants' optimal self-care capacity to delay or prevent institutionalization. Currently, there are over 240 certified CBAS centers who serve over 34,500 seniors and adults with various types of functional, cognitive, behavioral and/or developmental disabilities. In both programs, all participants live in a non-institutional setting.

CDA has worked closely with DHCS in developing the components of the STP related to the MSSP and CBAS programs and the processes that will occur to achieve

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compliance with these regulations by March 2019. CDA will continue to partner with key provider organizations, such as, the California Association of Adult Day Services (CAADS) and the MSSP Site Association (MSA) to understand the HCB Settings requirements by developing and disseminating provider educational materials via CDA's website; provider newsletters; local training events, and statewide association conferences. Both programs have already conducted webinars educating providers and centers on the new federal regulations and have provided them with instructions on how to complete the new CBAS Provider Self-Assessment tool. CDA designed this tool, which will be completed by the program providers and submitted to CDA, to assist the Department in determining whether MSSP sites and CBAS providers meet all of the new requirements. Validation of the provider self-assessments will occur when CDA staff conduct on-site MSSP utilization reviews or during CBAS certification visits. Validation and remediation will be ongoing with an anticipated completion by March 2019.

Stakeholder engagement in developing these tools and the monitoring processes has been vital and will be ongoing. MSSP and CBAS will continue to collaborate with key partners to solicit their input, through webinars, conference calls and other opportunities.

Older Americans Act (OAA) Core Services (**Objective II.D)**
CDA contracts with 33 AAAs to provide OAA programs and services to older adults, persons with disabilities, and family caregivers throughout the State. The OAA specifically emphasizes that these services should be targeted to older adults with the greatest economic or social needs, with particular attention to low-income minority individuals. The OAA defines "greatest economic need" as a need due to an income at or below the poverty level. "Greatest social need" is defined as a need caused by non-economic factors which include physical and mental disabilities, language barriers, and cultural, social or geographic isolation caused by racial or ethnic status.

In the aggregate, California's AAAs are highly successful in meeting these targeting requirements, but in certain geographic areas, this can be more challenging. CDA will provide technical assistance to these AAAs and share strategies other similar AAAs have found to be effective in establishing relationships within these target groups who are either in greatest economic need or social need of assistance.

Over the next four years, CDA will convene discussions with the AAAs and other key stakeholder groups to identify outreach and service delivery strategies that they have found effective in engaging older adults who are often hard to reach due to social isolation, prior experiences (or fear) of discrimination, limited English proficiency or other factors that may create a barrier to participating in needed services. CDA will gather these recommendations and additional resources to share with all the AAAs via webinars, conference presentations and other forums.

CDA will particularly focus on developing guidance, identifying promising practices, and providing technical assistance on effective strategies to better serve specific groups that

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have historically been underserved, including older adults who are Holocaust survivors, Native American, recent refugees, or LGBTQI.

California enacted the *Lesbian, Gay, Bisexual, and Transgender (LGBT) Disparities Reduction Act of 2016 (Chiu, Chapter 565, Statutes of 2015).* This legislation requires that specific state departments and offices that provide/collect sociodemographic data on participants in major health and social services programs add data on sexual orientation and gender identity to the data they currently collect by July 2018. As one of the departments included in this legislation, CDA will establish a workgroup that includes AAA representatives to: provide input on the changes CDA will need to make in its current data reporting system so that AAAs and their local subcontractors can input this additional data; help develop training for AAA and subcontractor staff so they understand the data changes, understand why these changes are being made, and why it is important to collect this information (although providing this information is always optional for consumers); and show how this new data might be helpful in conducting successful future outreach and services.

Volunteerism (Objective II.E)

The Aging Network relies heavily on volunteers to provide services and leverage resources. CDA has had a long-standing objective to recruit individuals of all ages into community involvement and volunteerism. Among the concerns that CDA has highlighted over the years are: difficulty recruiting volunteers of all ages; and high volunteer turnover rates. During the next four years, CDA will focus on showcasing local program volunteers in CDA administered programs on the CDA website to recognize the personal rewards and community benefits from volunteerism. CDA will also pursue strategies that encourage older adults and adults with disabilities to share their skills, talents, and experiences with people of all ages in their communities to promote and foster intergenerational coordination of services.

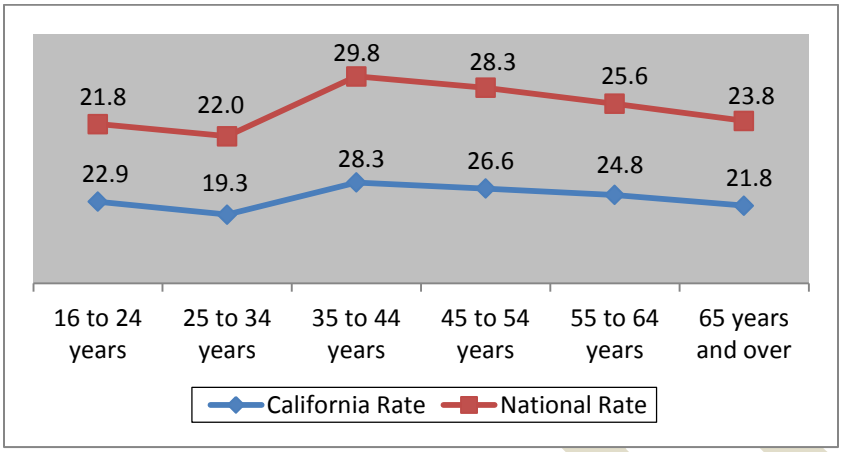
Despite having the largest number of volunteers of any other state (7.4 million), California has one of the lowest rankings for volunteerism in the country. California ranks below 38 other states on a number of key indicators (e.g. volunteer hours, retention rates, volunteer rates among different age groups, overall civic life engagement, etc.).[43]

Most volunteer activity is in faith-based (33.1 percent) or in educational/youth services (25.2 percent), while volunteering in social or community services ranks third (14.6 percent). This is of concern since social and community services frequently serve older adults and persons with disabilities.

Consistent with the national volunteer profile, the typical volunteer in California is a woman between the ages of 35-54.[44] As identified in Figure 5, older and younger age groups participate less in volunteer activities.

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Figure 5
Volunteerism by Age Group 2015



A number of factors are associated with higher volunteerism rates among individuals age 35 through 54, including larger social networks leading to greater community involvement, better health status, and higher socio-economic status. A number of demographic factors promote and inhibit volunteerism, requiring strategies targeted to specific age groups. CDA plans to collect, identify, and disseminate this type of information about volunteerism so that the AAAs and other aging network organizations can target efforts to increase volunteerism in each of their communities based on their unique demographic characteristics.

Objective II.A: Support successful integration of long-term services and supports into Cal MediConnect.

Strategies:

1. Collaborate with DHCS, the MSSP 1915(c) home- and community-based waiver providers, and participating managed care health plans to incorporate the MSSP waiver care coordination model into the managed care health plan long-term care coordination benefit structure in the seven Cal MediConnect counties.

2. Collaborate with DHCS, MSSP 1915(c) home- and community-based waiver providers, and participating managed care health plans to ensure the seamless transition of MSSP participants into the managed care health plan long-term care coordination benefit in the seven Cal MediConnect counties.

3. Ensure coordinated and effective beneficiary education and outreach in the Cal MediConnect counties.

Objective II.B: Implement California's Medi-Cal STP to ensure that the MSSP and CBAS programs are in compliance with federal Medicaid HCB Settings regulations.

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Strategies:

1. Provide educational materials, training and technical assistance to CBAS providers and MSSP sites to promote their understanding of and compliance with the federal HCB Settings requirements.

2. Conduct monitoring and oversight activities to ensure CBAS providers and MSSP sites comply with the federal HCB Settings requirements.

Objective II.C: Implement necessary operational changes in the MSSP and CBAS programs to comply with federal rules governing person-centered care, provider screening, and non-discrimination requirements in Medi-Cal health and LTSS programs.

Strategies:

1. Provide CBAS providers and MSSP sites with educational materials, training, and technical assistance to assist them in understanding these new federal requirements.

2. Engage stakeholders in developing monitoring and oversight processes and tools needed to comply with these new federal requirements.

3. Conduct monitoring and oversight activities to ensure that CBAS providers and MSSP sites meet these federal requirements.

Objective II.D: Promote effective delivery of the OAA core services to eligible persons, with particular attention to noted special target groups who often do not access these services for various reasons.

Strategies:

1. Develop and provide guidance, training, and technical assistance on effective Title IIIB and Title IIIE care management practices.

2. Develop and provide guidance, training, and technical assistance on effective approaches for delivering OAA core services to target populations including older Holocaust survivors, Native Americans, recent refugees, and LGBTQI individuals.

3. Develop and provide guidance, training, and technical assistance on effective approaches for identifying and addressing nutritional risk among Title IIIC program participants.

Objective II.E: Expand opportunities for community involvement and volunteerism to increase the availability of services to older adults, persons with disabilities, and family

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caregivers; promote peer-to-peer support programs; and foster intergenerational service programs.

Strategies:

1. Showcase local program volunteers in CDA-administered programs on the Department's website to recognize the personal rewards and community benefit from volunteerism.

2. Identify, collect, and disseminate information on the characteristics of program volunteers and promising practices for volunteer recruitment and retention.

3. Share information through presentations and webinars with local agencies and service providers.

GOAL II – Performance Measures

Objective	Performance Measure	Target Date
II.A.1	Provide information, training and technical assistance to DHCS, Cal MediConnect health plans, and other stakeholders to assist them in understanding the characteristics of MSSP participants, the core components of the MSSP waiver's care coordination model, and address ongoing operational issues.	October 2017 through December 2019
II.A.2	With DHCS, participating health plans, MSSP sites, and other stakeholders, develop and implement a plan to integrate the MSSP waiver's care coordination model into the managed care health plan long-term care management benefit in the Cal MediConnect counties.	January 2018 through December 2019
	With DHCS, participating health plans, MSSP sites, and other stakeholders, develop and implement criteria for determining the health plans' readiness to assume responsibility for the long-term care coordination of MSSP waiver participants in the Cal MediConnect counties.	January 2018 through December 2019
	Coordinate with DHCS in monitoring the impact to MSSP participants of transitioning responsibility for long-term care management from MSSP waiver providers to health plans in the Cal MediConnect counties.	January 2020 and ongoing
II.A.3	Collaborate with DHCS in revising and distributing new and updated beneficiary outreach and education materials to local HICAPs in the Cal MediConnect counties.	March 2018 and ongoing
II.B.1	Develop and distribute informational materials on HCB Settings requirements to CBAS providers, MSSP sites, program participants and other interested parties.	December 2017 and ongoing
	Post HCB Settings informational materials and references on the CDA website.	March 2018 and ongoing
	Provide in-person training and technical assistance on the HCB Settings requirements to CBAS providers and MSSP sites at periodic CAADS and MSA meetings.	March 2018 and ongoing

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Objective	Performance Measure	Target Date
	Provide periodic training webinars to CBAS providers and MSSP sites on HCB Settings requirements and compliance expectations.	May 2018 and ongoing
II.B.2	Modify CBAS and MSSP monitoring and corrective action processes and tools to incorporate the new HCB Settings compliance requirements.	February 2018
	Conduct onsite reviews of CBAS providers and MSSP sites to determine compliance with HCB Settings requirements and implement corrective action plans if necessary.	October 2017 through January 2019
	Establish and ensure ongoing compliance with HCB Settings requirements in CBAS and MSSP.	March 2019 and ongoing
II.C.1	Develop and distribute informational materials on federal rules governing person-centered care, provider screening, and non-discrimination in Medi-Cal programs to CBAS providers, MSSP sites, program participants, and other interested parties.	October 2017 and ongoing
	Provide training and technical assistance about federal requirements to CBAS providers and MSSP sites.	February 2018 and ongoing
II.C.2	Engage CBAS providers and MSSP sites via workgroups, meetings, and webinars in modifying CBAS and MSSP monitoring processes and tools to comply with federal provider requirements.	October 2017 through March 2018
II.C.3	Conduct onsite monitoring reviews of CBAS providers and MSSP sites to determine compliance with the federal provider requirements.	March 2018 through January 2019
II.D.1	Survey local AAAs to identify the core components of their local Title IIIB and Title IIIE care management programs and potential areas for training and technical assistance.	February 2018
	Compile an analysis of the care management survey results for review by CDA and the AAAs.	April 2018
	Establish a workgroup that includes CDA and AAA representatives to develop recommended best practices and develop training for delivering Title IIIB and Title IIIE care management services.	June 2018
	Issue recommended AAA best practices and conduct training for delivering Title IIIB and Title IIIE care management services.	November 2019 and ongoing
II.D.2	Survey local AAAs to identify the core components of their local service targeting efforts and potential areas for training and technical assistance.	January 2018
	Compile an analysis of the targeting survey results for CDA and the AAAs to review and discuss.	April 2018
	Establish a CDA workgroup that includes AAA representatives to address the operational and training issues involved in adding sexual orientation and gender identity to the data that CDA collects from the AAAs on OAA Title III participants.	June 2018
	Participate in quarterly meetings of the Governor's State Agency and Department Tribal Liaison workgroup and share information	January 2018 and

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Objective	Performance Measure	Target Date
	relevant to OAA Title III service coordination and delivery with the Tribal Liaisons, CDA staff and AAAs.	ongoing
II.D.3	Survey local AAAs to identify the core components of their local Title IIIC nutrition risk assessment efforts.	January 2018
	Compile an analysis of the Title IIIC nutrition risk assessment survey results for dissemination to AAAs.	March 2018
	Issue recommended promising practices for conducting nutrition risk assessments in the Title IIIC program and provide in-person and on-line training on these recommendations.	November 2018
II.E.1	Coordinate with AAAs to solicit nominations of local program volunteers for special recognition by CDA. Recognize a different local program volunteer every six months on CDA's website.	January 2018 and periodically thereafter
II.E.2	Compile information on the characteristics of older adult volunteers and promising volunteer recruitment and retention strategies and post it to CDA's website.	December 2017 and ongoing
	Compile aggregate data on HICAP and Ombudsman program volunteers and post it to the California Health and Human Services Agency's Open Data portal.	November 2018
II.E.3	Present information on promising volunteer recruitment and retention practices at annual HICAP and Office of the State LTC Ombudsman training conferences.	January 2018 and ongoing
	Disseminate information related to community involvement, intergenerational programs, and volunteerism to AAAs, state agencies, tribal organizations and other stakeholders through training conferences and postings to CDA's website and through social media.	December 2018 and ongoing

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GOAL III: ***Provide older Californians, persons with disabilities, and their caregivers with information and tools to support their health and wellbeing.***

Evidence-Based Interventions (Objective III.A)
According to the federal Centers for Disease Control and Prevention (CDCP), chronic diseases disproportionately affect older adults and are associated with increased disability, diminished quality of life, and increased health and long-term care costs. Approximately 92 percent of older adults have at least one chronic condition and 77 percent have at least two. However, research over the past decade has led to the development of evidence-based health promotion and disease prevention education programs that empower older adults to avoid chronic physical and mental health conditions and/or better manage them to prevent further disability.

Health trends among older Californians over the past four years reveal some good news in terms of increased use of several preventive health screening services. These services can lead to earlier diagnosis and treatment of several types of life-threatening diseases. However, California's large and diverse population continues to grow older and significant racial and health disparities persist in the rate and treatment of chronic health conditions.

- ***Chronic Disease Self-Management Education***
  Between 2012 and 2015, CDA had a three year $1.4 million dollar Chronic Disease Self-Management Education (CDSME) Grant from the federal ACL to further expand the availability of the CDSME programs. California applied for but was not successful in securing subsequent federal CDSME demonstration grant funds.

  However, CDA continues its partnership with the California Department of Public Health (CDPH) in leveraging the OAA Title IIID resources to sustain access to these programs (including those focused on Fall Prevention). Both departments also continue to provide leadership to the *CA Healthier Living Coalition* that sponsors www.cahealthierliving.org. This website provides technical assistance to local agencies and other partnering organizations offering these programs; resources and materials for workshop leaders; and a searchable database that the public and/or referring agencies/providers can use to find and enroll in these evidences based programs in their area.

- ***Caregiver Support***
  Alzheimer's disease and other forms of dementia are debilitating conditions that not only impact the lives of individuals who have the disease but also the family members caring for them. By 2020, approximately 690,000 older Californians will have Alzheimer's disease and will be cared for by over 1.5 million Californians. In 2016, California caregivers provided over 1.8 million hours of unpaid care per year, with an approximate value of more than $23 billion.[45] Numerous studies have demonstrated the significant negative physical and emotional impact involved in

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caring for a person with mental illness or dementia. Access to Alzheimer's caregiver services are very limited or non-existent in many ethnic communities throughout the State.

Over the past 15 years, California has pioneered efforts to increase and provide culturally competent services for individuals and families dealing with Alzheimer's disease. In partnership with the Alzheimer's/Greater Los Angeles and the Alzheimer's Association of Northern California/Nevada, CDA completed a three-year Dementia Cal MediConnect Project in 2016. This effort was funded through an ACL Alzheimer's Disease Supportive Services Program (ADSSP) Demonstration Grant and provided training and technical assistance to the health plans participating in the Cal MediConnect demonstration program for dually eligible Medi-Cal beneficiaries to enhance their care managers' capacity to:

- Identify and diagnose plan members who may have Alzheimer's Disease or a related dementia; and
- Providing care coordination to these individuals and their family caregivers, including referrals to services and supports in the community, including caregiver supportive and respite services.

When this original grant ended in 2016: 319 health plan care managers had received basic dementia training; 44 care managers had received Dementia Care Specialist training; and 550 family members had attended caregiver training. Web training for care managers was also developed and implemented.

In FFY 2016, CDA applied for and received a $323,493, 18-month ADSSP grant from ACL to expand this project to include the Cal MediConnect health plans and family caregivers in Riverside, San Bernardino and San Diego counties (and to continue assisting the health plans already participating in the other counties). Work with the health plans in these new counties is already underway and will continue into 2018.

Nutrition Support (Objective III.B)

Over twenty-percent of Californians over age 60 are eligible for Medi-Cal and over thirty-three percent of the eligible older adults served have high nutrition risk. One in twenty have poor diet quality due, in part, to limited funds to buy food. For older adults, there is a significant relationship between food insecurity and poor health.[46] Given these facts, the importance of nutritional safety nets like the OAA Title IIIC Elderly Nutrition Program (ENP) and the Supplemental Nutrition Assistance Program (SNAP) to older adults' health and well-being cannot be overestimated.

- ***CalFresh***

  SNAP (CalFresh in California), formerly known as the federal Food Stamp Program, provides monthly assistance to purchase food for human consumption or seeds and

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plants to grow food for household use. When compared to other age groups, older Californians have a very low CalFresh participation rate. Misinformation, challenging regulatory requirements, and the stigma associated with applying for public benefits are among some of the barriers to older adults' participation in CalFresh. To be eligible for CalFresh, adults age 60 and older must have a net income at or below 100 percent of the Federal Poverty Guidelines. While low income older Californians who are under age 65 may be eligible for CalFresh, they often do not know they are eligible.

To increase program eligibility awareness, CDA, CDPH–Network for a Healthy California (the Network) and CDSS have collaborated in developing a variety of CalFresh outreach and SNAP Education (SNAP-Ed) strategies to encourage eligible individuals to apply for CalFresh benefits and make other healthy food and lifestyle choices. CDA plans to continue this partnership through the existing contracts with 16 AAAs and will encourage additional AAAs to participate if more funding becomes available.

- ***SNAP-Ed***

  The Healthy, Hunger-Free Kids Act of 2010 restructured the evidence-based SNAP-Ed Program to expand nutrition education and obesity prevention programs to eligible low-income individuals.[47] With the encouragement of the United States Department of Agriculture (USDA), CDA has secured funds through CDSS to provide targeted SNAP-Ed nutrition education and obesity prevention programs to low-income older adults. In addition to educating eligible low-income older adults about the importance of nutrition, the SNAP-Ed Program also provides an evidence based teaching and demonstration component where participants learn about healthy cooking, low impact exercises, and/or other techniques to help older adults stay healthy and prevent obesity. As an outgrowth of SNAP-Ed, some participants have continued their community walking clubs, exercise classes, etc. CDA will continue to contract with its statewide network of AAAs to provide SNAP-Ed services to eligible ENP participants.

- ***Congregate Meals and Home Delivered Meals***

  CDA will continue to contract with its statewide network of 33 AAAs to provide older adults and persons with disabilities with access to nutritious congregate meals or home delivered meals. In addition, CDA will continue to encourage the 33 AAAs to target access to congregate meals and home delivered meals to other special need groups, including older adult Holocaust survivors, Native Americans, recent refugees, and LGBTQI individuals. CDA will also provide the AAAs with additional technical assistance and training if additional funding becomes available to expand the congregate and/or home delivered meal programs.

Long-Term Care Facilities (Objective III.D)

OAA Title VII authorizes vulnerable elder rights protection activities. Through its designated local programs, the Office of the State LTC Ombudsman works to improve the quality of life of residents in skilled nursing facilities and residential care facilities for

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the elderly by acting as their independent advocate. Local Ombudsman staff and volunteers visit LTC residents, monitor conditions, investigate and resolve resident complaints, advocate for needed change, and provide education on LTC issues.

The Office of the State LTC Ombudsman will continue to work to support training for local Ombudsman representatives so they can in turn, educate LTC facility staff, residents, and families in developing strategies to reduce the risk of health care acquired infections and that promote antibiotic stewardship in LTC facilities. Access to strategies shall also be provided to LTC resident and family councils to further prevent incidents and promote safety for residents. As well, as part of the on-going training provided by the Office of the State LTC Ombudsman to LTC Ombudsman representatives, the intent would be to incorporate these strategies and techniques into the regular trainings provided by the Office of the State LTC Ombudsman.

Objective III.A: Promote healthier living through evidence-based programs targeted to adults with various chronic conditions and family caregivers.

Strategies:

1. Expand access to and sustain availability of evidence-based programs through the use of Title IIID funds, other funding sources, and in collaboration with public health departments, healthcare entities and other partnering organizations.

2. Compile and disseminate data on select risk factors to support local efforts to deliver and fund evidence-based programs.

3. Conduct outreach to federally recognized tribes and other organizations serving Native Americans to encourage participation in evidence–based programs.

Objective III.B: Support older adults in increasing their access to nutritious foods and establishing healthy eating habits.

Strategies:

1. Continue to implement a statewide SNAP-Ed project to promote healthy food and lifestyle choices among low-income older adults.

2. Develop new partnerships to expand collaboration and coordination with non-OAA funded partners to improve food security among California's older adults.

Objective III.C: Support Cal MediConnect managed care health plans in identifying and implementing tools to better serve members with dementia and their families.

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Strategies:

1. CDA, in collaboration with regional Alzheimer's organizations, will continue to provide technical assistance to Cal MediConnect health plans and training to their care managers to increase their capacity to better identify and serve plan members with dementia and support their family caregivers.

2. CDA will solicit stakeholder input on strategies to more broadly disseminate across the programs CDA administers for family caregiver resources and materials developed through the Cal MediConnect dementia project.

Objective III.D: Engage Ombudsman representatives in promoting strategies to reduce the risk of health care acquired infections and promote antibiotic stewardship in long-term care facilities.

Strategies:

1. The Office of the State LTC Ombudsman will continue to work to support training for local Ombudsman representatives on strategies to reduce the risk of health care acquired infections and promote antibiotic stewardship in long-term care facilities.

2. The Office of the State LTC Ombudsman will conduct statewide training for local Ombudsman representatives and other key partners on these strategies.

3. Local Ombudsman representatives will educate long-term care facility resident and family councils on these strategies.

GOAL III – Performance Measures

Objective	Performance Measure	Target Date
III.A.1	Survey AAAs and review AAA budget data to identify the evidence-based programs that AAAs offer through Title IIID and other fund sources and the amount of funding directed to these programs.	January 2018
	Disseminate the analysis of evidence-based program delivery and funding to AAAs.	March 2018
	Establish mechanisms for CDA and AAAs to share information and discuss strategies for leveraging evidence-based program training opportunities to maintain and expand AAAs' evidence-based program offerings.	May 2018 and ongoing
III.A.2	Post to CDA's website and social media county-level data on chronic diseases and fall rates among older adults and information about the associated risk factors.	December 2017 and ongoing
III.A.3	Participate in annual Native American Day event at the California State Capital and share information about evidence-based disease prevention programs with tribal organizations and members to promote opportunities for collaboration and coordination.	September 2018 and annually thereafter
III.B.1	Engage additional AAAs, who are not currently participating in	April 2018

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Objective	Performance Measure	Target Date
	SNAP-Ed, in referring eligible older adults to other SNAP-Ed programs in their service area.	
	If additional SNAP-Ed funding becomes available, solicit the participation of additional AAAs.	July 2018 and thereafter
III.B.2	Establish a new partnership with at least one non-OAA funded agency to collaborate on identifying and implementing strategies to improve food security among older Californians.	December 2019
	In collaboration with the new partner agency, develop an implementation plan to improve food security among older Californians.	December 2020
	In collaboration with the new partner agency, implement the plan to improve food security among older Californians.	June 2021
III.C.1	In collaboration with regional Alzheimer's organizations, provide technical assistance to Cal MediConnect health plans, dementia training to 100 care managers, and educate and support 170 family care givers in participating counties.	June 2018
III.C.2	Engage representatives from the California Association of AAAs (C4A), MSA, and CAADS and the California Caregiver Resource Centers to identify promising strategies for disseminating the new dementia caregiver support materials and resources developed through the Cal MediConnect project with these networks.	October 2019
III.D.1	Support Ombudsman representative training on antibiotic stewardship and healthcare acquired infections.	December 2017
III.D.2	Conduct training for LTC Ombudsman representatives, LTC facility surveyors, and facility staff.	March 2018
III.D.3	Train local Ombudsman representatives on how residents and families can help reduce the incidence of healthcare acquired infections and promote antibiotic stewardship by providing information and consultation to individuals and presentations at facility resident and family councils.	June 2018 and ongoing

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GOAL IV: *Protect the consumer rights of older Californians and persons with disabilities and assist them to obtain needed benefits.*

Legal Services Providers (LSPs) (Objective IV.A)
As California's population ages, an increasing numbers of older people are at risk of abuse, neglect and exploitation. CDA recognizes the need for strong advocacy to protect the basic rights and benefits of older adults. CDA supports a coordinated system that ensures that relevant legal services networks work together to protect elder rights, particularly for those who are socially and economically vulnerable.

CDA plans to convene meetings of representatives of the LSPs and AAAs to discuss strategies and best practices for preventing and protecting abuse, neglect and/or exploitation of older adults or persons with disabilities. Existing, as well as, any new information would continue to be made available on CDA's website to provide the greatest access to this information. In addition, on-going technical assistance will continue to be provided to LSPs and other involved organizations throughout California.

Adult Protective Services and Ombudsman Investigations (Objective IV.B)
The Office of the State LTC Ombudsman regularly collaborates with CDSS, who administers the APS Program. During the next four years, the Office of the State LTC Ombudsman will work closely with CDSS to develop training materials to assist local APS social workers and Ombudsman representatives that enhance their investigative skills. In addition, since coordination between APS and Ombudsman representatives is vital for the safety of older adults and persons with disabilities, the Office of the State LTC Ombudsman will continue to work closely with CDSS on cross-reporting, coordination, and co-partnering on investigations.

Elder Abuse Awareness (Objective IV.C)
CDA regularly coordinates with C4A related to Elder Abuse Awareness efforts. CDA will continue to collaborate with C4A to publicize and support World Elder Abuse Awareness Month. CDA will also collaborate with CDSS APS and other key stakeholders to promote and coordinate efforts to observe annual World Elder Abuse Awareness Day event. Elder Abuse Awareness materials related to preventing, identifying, and reporting abuse against older adults and persons with disabilities will continue to be made available on CDA's website.

Objective IV.A: Evaluate local implementation of California's Legal Services Provider Standards and identify best/promising practices.

Strategies:

1. CDA's Office of Legal Services will establish a workgroup comprising of representative California Legal Services Providers and the AAAs to develop a methodology for evaluating California's Legal Services Provider Standards.

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2. CDA's Office of Legal Services will work with the workgroup to analyze the evaluation findings and identify best/promising practices and/or areas for improvement.

3. CDA's Office of Legal Services will consult with the evaluation workgroup to draft and disseminate a report summarizing the evaluation findings and identifying next steps.

Objective IV.B: Improve abuse investigation skills for APS workers and Ombudsman representatives.

Strategies:

1. The Office of the State LTC Ombudsman will collaborate with CDSS APS staff to develop training materials to assist local county APS workers and Ombudsman representatives to enhance their abuse investigation skills.

2. The Office of the State LTC Ombudsman will collaborate with CDSS APS to provide abuse investigation training to local county APS workers and Ombudsman representatives.

Objective IV.C: Promote awareness of abuse against elders and adults with disabilities and effective prevention strategies.

Strategies:

1. Collaborate with CDSS APS and other key stakeholders to coordinate efforts to observe and publicize a World Elder Abuse Awareness Day event.

2. Collaborate with C4A to coordinate efforts to observe and publicize World Elder Abuse Awareness Month.

3. Identify and post to CDA's website resource materials related to preventing, identifying and reporting abuse against older adults and adults with disabilities.

GOAL IV – Performance Measures

Objective	Performance Measure	Target Date
IV.A.1	Convene meetings of representatives of the LSPs and AAAs.	October 2017 and ongoing
	Maintain existing and new information on CDA's website about evaluation tools for OAA legal services providers in California.	October 2017 and ongoing
	Provide ongoing technical assistance to legal services providers throughout California.	October 2017 and

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Objective	Performance Measure	Target Date
		ongoing
IV.A.2	Share best practices for provision of OAA legal services with LSPs and AAAs.	October 2017 and ongoing
	Maintain current information on CDA's website about best practices for legal service providers in California.	October 2017 and ongoing
IV.A.3	Identify members of the workgroup and establish meeting dates.	February 2018 and ongoing
	Survey legal providers and AAAs about their evaluation tools.	April 2018 and ongoing
	Draft and disseminate report summarizing evaluation findings.	September 2018
	Finalize and distribute report.	December 2018
IV.B.1	The Office of the State LTC Ombudsman will work with CDSS APS and the Academy for Professional Excellence at San Diego State University to develop an online mandated reporter training. This training will address abuse in the community and in long-term care facilities.	December 2017
IV.B.2	The Office of the State LTC Ombudsman and CDSS APS will promote use of the new on-line mandated reporter training. In addition, local Ombudsman representatives will be invited to participate in APS core competency trainings.	January 2018 and ongoing
IV.C.1	The Office of the State LTC Ombudsman will continue to partner will CDSS APS on coordinating a World Elder Abuse Awareness Day event.	June 2018 and annually thereafter
IV.C.2	The Office of the State LTC Ombudsman will continue to partner with C4A and other key partners on observing and publicizing World Elder Abuse Awareness Month activities.	June 2018 and annually thereafter
IV.C.3	The Office of the State LTC Ombudsman will identify appropriate resource materials about preventing, identifying, and reporting abuse of residents of long-term care facilities for posting to the CDA website.	June 2018 and ongoing.

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SECTION IV – QUALITY MANAGEMENT

CDA manages the quality of service programs through on-site monitoring reviews and desk reviews, performance data validation, policy guidance, technical assistance and training. CDA conducts periodic on-site monitoring reviews of each of California's 33 AAAs. The purpose of this onsite monitoring is to determine each AAA's compliance with all pertinent federal and State requirements related to the administrative, program, fiscal, data collection and reporting components of their direct and contracted HICAPs and OAA programs.

On-site monitoring reviews focus on the AAA's program compliance, procurement, internal controls and fiscal processes, and other AAA administrative functions. Following the on-site review, CDA provides the AAA with a report detailing any monitoring findings. When there are findings, the AAA then submits a corrective action plan to CDA documenting how the findings have been addressed. CDA continues to work with the AAA to ensure all findings are resolved.

In addition to monitoring program compliance and performance, CDA conducts retrospective audits of AAAs to determine the accuracy of financial closeout reports, adequacy of internal accounting and administrative controls, and compliance with applicable laws, regulations, and contract requirements.

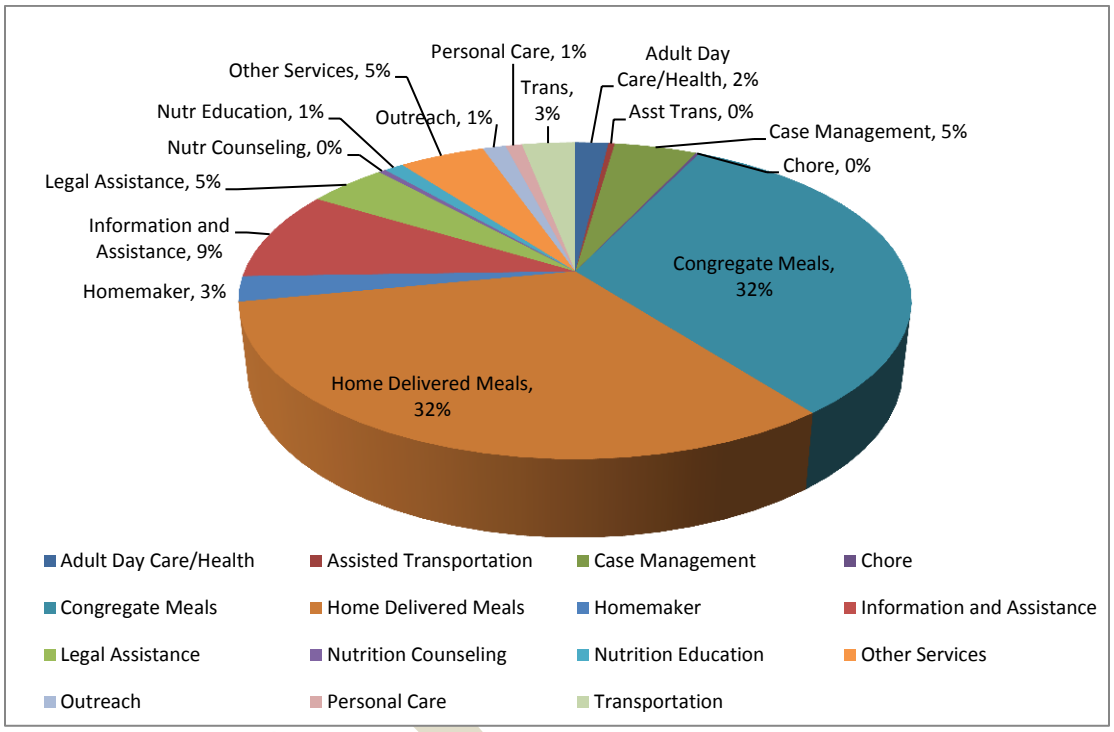
CDA also conducts ongoing desk monitoring of AAA budgets, expenditures, and performance data. CDA reviews AAA performance data quarterly and at year-end, providing each AAA with reports detailing all questionable and missing performance data. These reports assist AAAs to resolve or explain discrepancies in their data submissions. CDA provides AAAs with ongoing technical assistance to ensure complete and accurate data are entered into California's National Aging Program Information Systems (NAPIS) State Program Report (SPR). CDA analyzes both fiscal and performance data to identify patterns that may indicate the need for further attention.

To support improved program compliance and performance, CDA provides AAAs with written guidance, and ongoing technical assistance and training via webinars, conference calls, and on-site visits. CDA targets these efforts as necessary to address emerging issues.

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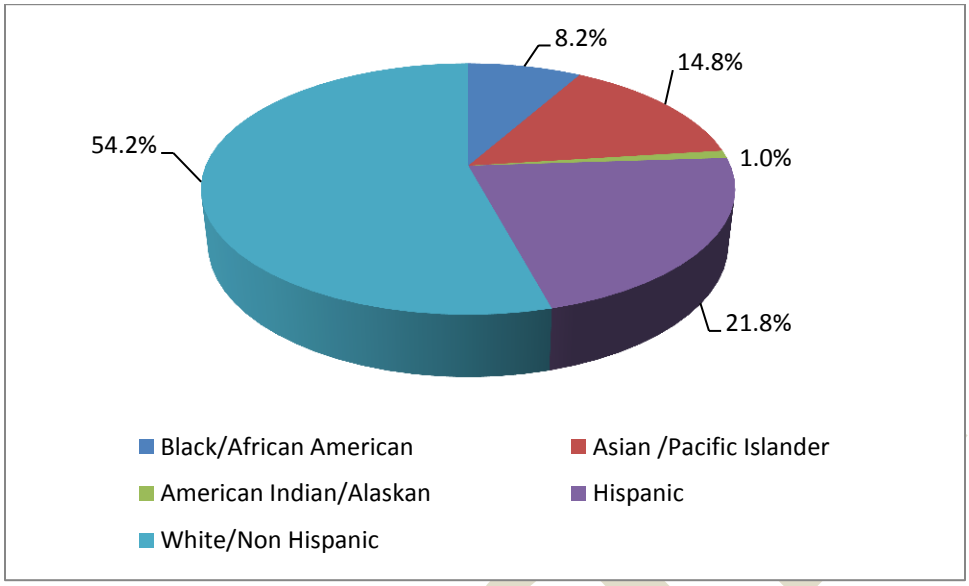
RESOURCE ALLOCATIONS AND FEDERAL ASSURANCES

2013-2014
Older Americans Act
Title III Services by Total Expenditures [48]

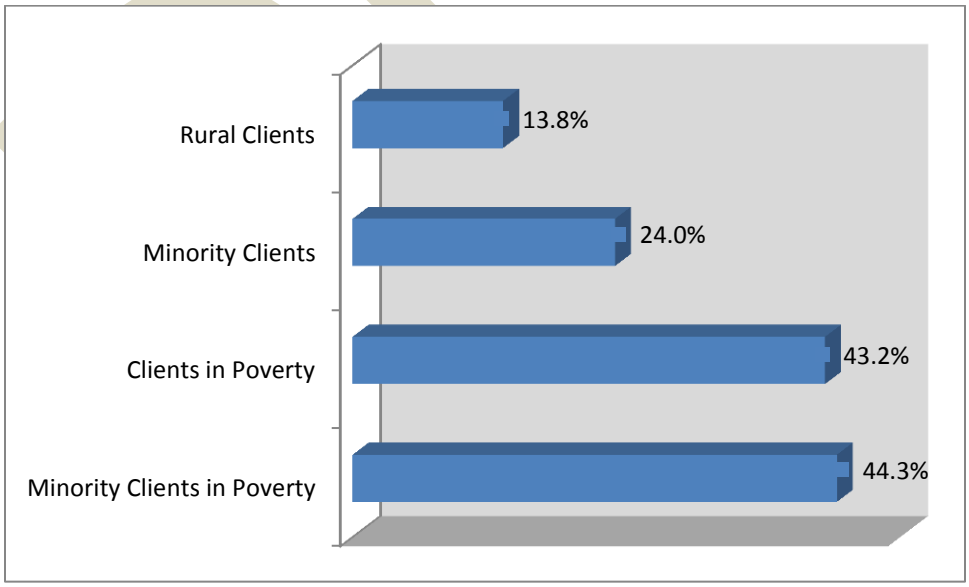


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2014 State Program Report
Registered Clients by Minority Status[49]



2014 State Program Report
Registered Clients by Targeting Status[50]



Approved Minimum Title IIIB Expenditures For Priority Services: Access, In-Home Services, and Legal Services[51] FY 2016/17

PSA #	Access	In-Home	Legal
1	40.0%	3.0%	10.0%
2	30.0%	1.0%	10.0%
3	20.0%	10.0%	10.0%
4	30.0%	15.0%	8.0%
5	33.0%	19.0%	11.0%
6	45.0%	5.0%	45.0%
7	20.0%	8.0%	11.0%
8	20.0%	25.0%	5.0%
9	15.0%	15.0%	10.0%
10	60.0%	5.0%	10.0%
11	35.0%	35.0%	8.0%
12	65.0%	7.5%	2.0%
13	27.5%	1.0%	15.0%
14	40.0%	8.0%	2.0%
15	20.0%	2.0%	15.0%
16	50.0%	5.0%	10.0%
17	7.0%	20.0%	5.0%
18	5.0%	5.0%	5.0%
19	30.0%	17.0%	5.0%
20	40.0%	1.0%	10.0%
21	25.9%	6.0%	3.5%
22	42.0%	11.0%	10.0%
23	40.0%	17.0%	3.0%
24	30.0%	8.0%	10.0%
25	58.5%	15.5%	5.5%
26	45.0%	10.0%	20.0%
27	40.0%	30.0%	10.0%
28	31.8%	10.5%	10.5%
29	18.0%	1.3%	30.0%
30	33.0%	20.5%	22.0%
31	40.0%	2.8%	20.0%
32	30.0%	0.0%	25.0%
33	32.0%	26.0%	22.0%

CALIFORNIA DEPARTMENT OF AGING
INTRASTATE FUNDING FORMULA (IFF) REQUIREMENTS

Each State IFF submittal must demonstrate that the requirements in Sections 305(a)(2)(C) have been met:

> OAA, Sec. 305(a)(2)
> *"States shall,*
> *(C) in consultation with area agencies, in accordance with guidelines issues by the Assistant Secretary, and using the best available data, develop and publish for review and comment a formula for distribution within the State of funds received under this title that takes into account --*
> *(i) the geographical distribution of older individuals in the State; and*
> *(ii) the distribution among planning and service areas of older individuals with greatest economic need and older individuals with greatest social need, with particular attention to low-income minority older individuals."*

- For purposes of the IFF, "best available data" is the most recent census data (year 2010). More recent data of equivalent quality available in the State may be considered.

- As required by Section 305(d) of the OAA, the IFF revision request includes: a descriptive Statement; a numerical Statement; and a list of the data used (by planning and service area).

- The request also includes information on how the proposed formula will affect funding to each planning and service area.

- States may use a base amount in their IFFs to ensure viable funding across the entire state.

Response:

DESCRIPTIVE STATEMENT OF FORMULA
CDA is required under Title III of the federal OAA to develop a formula for the distribution of funds within the State under this title. This formula is to take into account, to the maximum extent feasible, the best available statistics on the geographical distribution of individuals aged 60 and older in the State and publish such formula for review and comment. The IFF allocates funds to PSAs to serve persons aged 60 and older (60+).

While the OAA is concerned with the provision of services to all older persons, it requires assurance that preference is given to older individuals with greatest economic or social needs, with particular attention to low-income minority individuals. Under the OAA, the term "greatest economic need" means the need resulting from an income level

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at or below the poverty level established by the Office of Management and Budget. The term "greatest social need" means the need caused by non-economic factors that include physical and mental disabilities, language barriers, and cultural, social, or geographical isolation including that caused by racial or ethnic status which restricts an individual's ability to perform normal daily tasks or which threatens such individuals' capacity to live independently.

CDA's IFF was developed: to support the provision of needed services to older persons; to reflect the relative emphasis required by the OAA; to provide consistent emphasis to individuals with certain characteristics, regardless of their area of residence; and to be responsive to California's diversity.

The requirement to give "preference" and "particular attention" to older individuals with certain characteristics recognizes that other older individuals with needs also are served under the OAA. The CDA takes this into account by assigning a weight of one (1.0), the least weight, to the population factor of 60+ Non-Minority, identified here as "other individuals."

CDA then applied the definitions of greatest economic need and greatest social need in selecting the three remaining factors listed below, and assigned weights to develop a weighted population and to achieve the relative emphasis required by the OAA.

INDIVIDUALS	FACTORS	WEIGHTS
Greatest Economic Need:	60+ Low Income	2.0
Greatest Social Need:	60+ Minority	2.0
	60+ Geographical Isolation (Rural)	1.5
Other Individuals	60+ Non Minority	1.0
Medical underserved (IIID only)	60+ Medi-Cal Eligibles	1.0

When combined, these population factors and weights result in an allocation of Title III funds which is consistent with the OAA and which is based on the relative degree of emphasis (from 5.5 to 1.0) for the individuals noted below.

	RELATIVE EMPHASIS	
	RURAL AREAS	OTHER AREAS
Low Income Minority Individuals	5.5	4.0
Low Income Individuals (not Minority)	4.5	3.0
Minority Individuals (not Low Income)	3.5	2.0
Other Individuals	2.5	1.0

CDA assumes that the IFF must: be equitable for all PSAs, and reflect consistent application among PSAs of greatest economic or social need, with particular attention to low-income minority individuals; include factors which are mutually exclusive whenever possible; utilize data that are available, dependable, and comparable statewide, and

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that are updated periodically to reflect current status; reflect changes in population characteristics among PSAs; and be as easy as possible to understand.

NUMERICAL STATEMENT OF THE FORMULA

The following is a description of the Intrastate Funding Formula (IFF used for allocating OAA Title III and VII funds in accordance with Section 45 CFR 1321.37

1. The process begins by identifying:
   a. Total Federal and State matching funds available for allocation to PSAs for each Title III and VII program. (Total in Demonstration Column O)
   b. Population data, updated no more than annually as information is available, by county and arraying these data by PSA. (Population Data Columns A-F on Demonstration)
2. The Statewide total amount for the administration allocation is calculated by taking ten percent (10%) of the Federal funds. (The Total in Demonstration Total Column G)
3. The Statewide total amount for the program allocation is calculated by subtracting the administration allocation from the total for State and federal funds. (The Total in Demonstration Column M and N)
4. Administrative funds are allocated as follows:
   a. Each PSA receives a fifty thousand dollar ($50,000) base.
   b. The balance of total administrative funds identified in 2. above is allocated to PSAs based on each PSA's proportion of California's total persons aged 60 and older.
   c. Each PSA's total administration allocation is distributed among its qualifying Title III programs based on total qualifying administrative funds available.
5. Program funds are allocated based on weighted population figures. Weighted population totals are determined for each PSA by combining the following factors:
   a. The number of non-minority persons aged 60 and older in each PSA is multiplied by a weight of 1.0 (Demonstration Column H).
   b. The number of minority persons aged 60 and older in each PSA is multiplied by a weight of 2.0 (Demonstration Column I).
   c. The number of low-income persons aged 60 and older in each PSA is multiplied by a weight of 2.0 (Demonstration Column J).
   d. The number of geographically isolated persons aged 60 and older in each PSA is multiplied by a weight of 1.5 (Demonstration Column K).
   e. The number of Medi-Cal eligible persons aged 60 and older in each PSA is multiplied by a weight of 1.0 (Demonstration Column L) for Title IIID only).
6. The total weighted population for each PSA is converted into a proportion of the total weighted population for all PSAs.
7. Each PSA's program allotments are determined in the following manner:

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a. For Title IIIB, C-1, and C-2 programs,
    i. Total State and federal program funds available are distributed to each PSA by multiplying each PSA's proportion or total weighted population by total statewide program allocation for Title III B, C and E.
    ii. Each PSA's program allotment is compared to its 1979 allotment level. If a PSA is under its 1979 level, it receives an allotment equal to its 1979 level in lieu of the computed allotment in 7.a.1.
    iii. The statewide program allocation is reduced by the total amount allocated to those PSAs receiving allotments equal to their 1979 level. The remaining statewide program allocation is then distributed to the remaining PSAs according to the formula to determine their adjusted total Title III B, C-1 and C-2 program allotments.
    iv. Total program funds for each PSA are then distributed to each Title III program as follows:
        1. Federal funds are distributed based on the proportion of funds received by the Department of the latest Notice of Grant Award from the Federal Government.
        2. State funds are distributed based upon the statewide totals included in the most recent Budget Act, or Budget bill if allocations impact the next budget year, or other relevant legislation.
b. For Title IIIE and VII program funds are allocated by multiplying each PSA's proportion of the total weighted population by the total statewide program allocation for each program, then distributing to fund sources as in 7.A.4.
c. For Title IIID program funds are allocated by multiplying each PSA's proportion of the total weighted population, including Medi-Cal eligible, by the total statewide program allocation for each program, then distributing to fund sources as in 7.A.4.

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CALIFORNIA DEPARTMENT OF AGING
POPULATION DATA AND DEMONSTRATION OF AN ALLOCATION
FOR DISPLAY PURPOSES ONLY (NOT ACTUAL ALLOCATIONS)

	Population Data (Number of Persons) b/							Demonstration of IFF Allocation									
									Weighted Population = Weight x Number of Persons								
		c/	d/	e/	f/	g/			1.0	2.0	2.0	1.5	1.0	Title IIIB, C, E	Title IIID	Total	
a/		60+	60+	60+	60+	60+	a/	Area			Low	Geo	Med-Cal	Weighted	Weighted	Federal	a/
				Low	Geo.	Medi-Cal		Admin									
PSA	Pop 60 +	Non-Min.	Minority	Income	Isolation	Eligibles	PSA	Allocation	Non-Min	Minority	Income	Isolation	Eligibles	Total	Total	Allocation	PSA
Col>	A	B	C	D	E	F		G	H	I	J	K	L	M	N	O	
1	41,653	36,008	5,645	5,070	11,725	6,267	1	$100,022	36,008	11,290	10,140	17,588	6,267	75,026	81,293	$535,472	1
2	82,276	72,424	9,852	9,480	33,482	11,387	2	148,807	72,424	19,704	18,960	50,223	11,387	161,311	172,698	1,151,042	2
3	95,815	81,208	14,607	11,570	27,986	15,113	3	165,066	81,208	29,214	23,140	41,979	15,113	175,541	190,654	1,252,931	3
4	502,292	352,100	150,192	53,275	41,636	84,721	4	653,214	352,100	300,384	106,550	62,454	84,721	821,488	906,209	5,865,212	4
5	75,221	65,055	10,166	5,160	5,180	5,915	5	140,335	65,055	20,332	10,320	7,770	5,915	103,477	109,392	738,185	5
6	190,922	73,687	117,235	32,850	0	58,544	6	279,283	73,687	234,470	65,700	0	58,544	373,857	432,401	2,671,823	6
7	250,018	156,901	93,117	19,570	1,769	34,004	7	350,252	156,901	186,234	39,140	2,654	34,004	384,929	418,933	2,747,556	7
8	177,112	98,176	78,936	13,115	3,580	24,818	8	262,698	98,176	157,872	26,230	5,370	24,818	287,648	312,466	2,053,108	8
9	331,034	155,148	175,886	33,765	1,320	71,850	9	447,546	155,148	351,772	67,530	1,980	71,850	576,430	648,280	4,117,163	9
10	375,672	188,480	187,192	34,305	4,347	78,385	10	501,153	188,480	374,384	68,610	6,521	78,385	637,995	716,380	4,556,740	10
11	132,451	70,763	61,688	15,870	11,455	28,594	11	209,063	70,763	123,376	31,740	17,183	28,594	243,062	271,656	1,735,853	11
12	56,431	49,882	6,549	5,379	31,924	4,900	12	117,769	49,882	13,098	10,758	47,886	4,900	121,624	126,524	867,379	12
13	74,540	55,583	18,957	6,970	9,588	10,088	13	139,517	55,583	37,914	13,940	14,382	10,088	121,819	131,907	869,437	13
14	202,119	109,576	92,543	29,195	30,224	49,825	14	292,729	109,576	185,086	58,390	45,336	49,825	398,388	448,213	2,845,517	14
15	99,842	54,825	45,017	15,825	14,653	25,984	15	169,903	54,825	90,034	31,650	21,980	25,984	198,489	224,473	1,417,868	15
16	9,480	7,860	1,620	1,085	3,869	745	16	61,385	7,860	3,240	2,170	5,804	745	19,074	19,819	339,702	16
17	165,131	127,102	38,029	14,660	16,116	18,904	17	248,310	127,102	76,058	29,320	24,174	18,904	256,654	275,558	1,831,467	17
18	180,702	120,855	59,847	15,340	5,252	24,383	18	267,009	120,855	119,694	30,680	7,878	24,383	279,107	303,490	1,992,183	18
19	1,227,216	477,432	749,784	157,891	10,719	368,978	19	1,523,792	477,432	1,499,568	315,782	16,079	368,978	2,308,861	2,677,839	16,501,557	19
20	362,499	186,975	175,524	47,795	21,182	77,710	20	485,333	186,975	351,048	95,590	31,773	77,710	665,386	743,096	4,751,858	20
21	461,839	289,613	172,226	53,930	21,442	76,510	21	604,633	289,613	344,452	107,860	32,163	76,510	774,088	850,598	5,526,359	21
22	645,061	387,520	257,541	59,975	827	120,870	22	824,669	387,520	515,082	119,950	1,241	120,870	1,023,793	1,144,663	7,311,589	22
23	645,410	415,896	229,514	68,095	22,757	109,547	23	825,088	415,896	459,028	136,190	34,136	109,547	1,045,250	1,154,797	7,463,037	23
24	35,075	8,197	26,878	6,990	4,789	14,530	24	92,122	8,197	53,756	13,980	7,184	14,530	83,117	97,647	594,200	24
25	725,297	292,642	432,655	130,889	723	218,069	25	921,026	292,642	865,310	261,778	1,085	218,069	1,420,815	1,638,884	10,153,483	25
26	46,838	39,689	7,149	6,630	17,199	8,690	26	106,249	39,689	14,298	13,260	25,799	8,690	93,046	101,736	664,205	26
27	127,448	106,523	20,925	10,445	17,953	14,324	27	203,055	106,523	41,850	20,890	26,930	14,324	196,193	210,517	1,400,001	27
28	131,562	78,061	53,501	10,710	8,942	17,271	28	207,996	78,061	107,002	21,420	13,413	17,271	219,896	237,167	1,569,304	28
29	53,891	47,519	6,372	3,425	16,600	4,164	29	114,719	47,519	12,744	6,850	24,900	4,164	92,013	96,177	656,263	29
30	100,842	65,913	34,929	13,065	8,100	22,711	30	171,103	65,913	69,858	26,130	12,150	22,711	174,051	196,762	1,243,294	30
31	43,934	23,020	20,914	6,780	5,905	11,708	31	102,761	23,020	41,828	13,560	8,858	11,708	87,266	98,974	623,403	31
32	80,073	46,324	33,749	8,465	10,445	14,025	32	146,161	46,324	67,498	16,930	15,668	14,025	146,420	160,445	1,045,257	32
33	145,285	85,945	59,340	20,120	17,295	31,816	33	224,476	85,945	118,680	40,240	25,943	31,816	270,808	302,624	1,933,997	33
	7,874,981	4,426,902	3,448,079	927,689	438,984	1,665,350		$11,107,244	4,426,902	6,896,158	1,855,378	658,476	1,665,350	13,836,914	15,502,264	$99,026,445	

Notes for Population Data and Demonstration of Allocation:

a. PSA means a geographical area, the boundaries of which are determined CDA pursuant to federal law and regulation. CDA allocates funds to an AAA to provide services to older individuals residing within a specific PSA (Appendix B).

b. 60+ Pop[52]: The number of individuals 60 years of age and older residing within the PSA.

c. 60+ Non-Min[53]: The number of individuals age 60 years and older residing within the PSA that self-identify as White (alone).

d. 60+ Minority[54]: The number of individuals age 60 years and older residing within the PSA that self-identify as American Indian/Alaska Native, Asian, Black/African American, Native Hawaiian/Other Pacific Islander, or Two or More Races.

e. 60+ Low Income[55]: The number of individuals age 60 years and older residing within the PSA with annual income below 125 percent of the federal poverty level.

f. 60+ Geo. Isolation[56]: The number of individuals age 60 years and older throughout the PSA residing in a rural area. According to the 2010 census, a rural area encompasses all population, housing, and territory not included in an urban area. (An urban area is comprised of a densely settled core of census tracts and/or census blocks that meet minimum population requirements, along with adjacent territory containing non-residential urban land uses as well as territory with low population density included to link outlying densely settled territory with the densely settled core. To qualify as an urban area, the territory must encompass at least 2,500 people, at least 1,500 of which reside outside institutional group quarters.)

g. 60+ Medi-Cal Eligibles[57]: The number of Medi-Cal-eligible individuals, age 60 years and above, residing within the PSA. Alpine County (PSA 12), Mono County (PSA 16) and Sierra County (PSA 4) are not included in the population counts. The Medi-Cal population in these counties was excluded to avoid identification of particular individuals.

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ATTACHMENT A

STATE PLAN ASSURANCES AND REQUIRED ACTIVITIES
Older Americans Act, As Amended in 2016

By signing this document, the authorized official commits the State Agency on Aging to performing all listed assurances and activities as stipulated in the Older Americans Act, as amended in 2016.

ASSURANCES

Sec. 305, ORGANIZATION

(a) In order for a State to be eligible to participate in programs of grants to States from allotments under this title--
(2)The State agency shall-- except as provided in subsection (b)(5), designate for each such area (planning and service area) after consideration of the views offered by the unit or units of general purpose local government in such area, a public or private nonprofit agency or organization as the area agency on aging for such area.

(B) provide assurances, satisfactory to the Assistant Secretary, that the State agency will take into account, in connection with matters of general policy arising in the development and administration of the State plan for any fiscal year, the views of recipients of supportive services or nutrition services, or individuals using multipurpose senior centers provided under such plan.

(E) provide assurance that preference will be given to providing services to older individuals with greatest economic need and older individuals with greatest social need, (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas) and include proposed methods of carrying out the preference in the State plan;

(F) provide assurances that the State agency will require use of outreach efforts described in section 307(a)(16); and…

(G)(ii) provide an assurance that the State agency will undertake specific program development, advocacy, and outreach efforts focused on the needs of low-income minority older individuals.

(c) An area agency on aging designated under subsection (a) shall be--…

(5) in the case of a State specified in subsection (b) (5), the State agency; and shall provide assurance, determined adequate by the State agency, that the area agency on aging will have the ability to develop an area plan and to carry out, directly or through

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contractual or other arrangements, a program in accordance with the plan within the planning and service area. In designating an area agency on aging within the planning and service area or within any unit of general purpose local government designated as a planning and service area the State shall give preference to an established office on aging, unless the State agency finds that no such office within the planning and service area will have the capacity to carry out the area plan.

States must ensure that the following assurances (Section 306) will be met by its designated area agencies on agencies, or by the State in the case of single planning and service area states.

Sec. 306(a), AREA PLANS

(a) Each area agency on aging…Each such plan shall--
(2) provide assurances that an adequate proportion, as required under section 307(a)(2), of the amount allotted for part B to the planning and service area will be expended for the delivery of each of the following categories of services-
(A) services associated with access to services (transportation, health services (including mental and behavioral health services), outreach, information and assistance (which may include information and assistance to consumers on availability of services under part B and how to receive benefits under and participate in publicly supported programs for which the consumer may be eligible) and case management services);
(B) in-home services, including supportive services for families of older individuals who are victims of Alzheimer's disease and related disorders with neurological and organic brain dysfunction; and
(C) legal assistance; and assurances that the area agency on aging will report annually to the State agency in detail the amount of funds expended for each such category during the fiscal year most recently concluded.

(4)(A)(i)(I) provide assurances that the area agency on aging will—

(aa) set specific objectives, consistent with State policy, for providing services to older individuals with greatest economic need, older individuals with greatest social need, and older individuals at risk for institutional placement;
(bb) include specific objectives for providing services to low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas; and

(II) include proposed methods to achieve the objectives described in items (aa) and (bb) of sub-clause (I);

(ii) provide assurances that the area agency on aging will include in each agreement made with a provider of any service under this title, a requirement that such provider will—

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(I) specify how the provider intends to satisfy the service needs of low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in the area served by the provider;
(II) to the maximum extent feasible, provide services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in accordance with their need for such services; and
(III) meet specific objectives established by the area agency on aging, for providing services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas within the planning and service area; and
(iii) with respect to the fiscal year preceding the fiscal year for which such plan is prepared,
(I) identify the number of low-income minority older individuals in the planning and service area;
(II) describe the methods used to satisfy the service needs of such minority older individuals; and
(III) provide information on the extent to which the area agency on aging met the objectives described in clause (i).

(B) provide assurances that the area agency on aging will use outreach efforts that will—
(i) identify individuals eligible for assistance under this Act, with special emphasis on--
(I) older individuals residing in rural areas;
(II) older individuals with greatest economic need (with particular attention to low-income minority individuals and older individuals residing in rural areas);
(III) older individuals with greatest social need (with particular attention to low-income minority individuals and older individuals residing in rural areas);
(IV) older individuals with severe disabilities;
(V) older individuals with limited English proficiency;
(VI) older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and
(VII) older individuals at risk for institutional placement; and
(ii) inform the older individuals referred to in sub-clauses (I) through (VII) of clause (i), and the caretakers of such individuals, of the availability of such assistance; and
(C) contain an assurance that the area agency on aging will ensure that each activity undertaken by the agency, including planning, advocacy, and systems development, will include a focus on the needs of low-income minority older individuals and older individuals residing in rural areas.

(5) provide assurances that the area agency on aging will coordinate planning, identification, assessment of needs, and provision of services for older individuals with disabilities, with particular attention to individuals with severe disabilities, and individuals at risk for institutional placement, with agencies that develop or provide services for individuals with disabilities;

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(9) assurances that the area agency on aging, in carrying out the State Long-Term Care Ombudsman program under section 307(a)(9), will expend not less than the total amount of funds appropriated under this Act and expended by the agency in fiscal year 2000 in carrying out such a program under this title;

(11) provide information and assurances concerning services to older individuals who are Native Americans (referred to in this paragraph as "older Native Americans"), including-
(A) information concerning whether there is a significant population of older Native Americans in the planning and service area and if so, an assurance that the area agency on aging will pursue activities, including outreach, to increase access of those older Native Americans to programs and benefits provided under this title;
(B) an assurance that the area agency on aging will, to the maximum extent practicable, coordinate the services the agency provides under this title with services provided under title VI; and
(C) an assurance that the area agency on aging will make services under the area plan available, to the same extent as such services are available to older individuals within the planning and service area, to older Native Americans.

(13) provide assurances that the area agency on aging will—
(A) maintain the integrity and public purpose of services provided, and service providers, under this title in all contractual and commercial relationships;

(B) disclose to the Assistant Secretary and the State agency--
(i) the identity of each nongovernmental entity with which such agency has a contract or commercial relationship relating to providing any service to older individuals; and
(ii) the nature of such contract or such relationship;

(C) demonstrate that a loss or diminution in the quantity or quality of the services provided, or to be provided, under this title by such agency has not resulted and will not result from such contract or such relationship;

(D) demonstrate that the quantity or quality of the services to be provided under this title by such agency will be enhanced as a result of such contract or such relationship;

(E) on the request of the Assistant Secretary or the State, for the purpose of monitoring compliance with this Act (including conducting an audit), disclose all sources and expenditures of funds such agency receives or expends to provide services to older individuals.

(14) provide assurances that preference in receiving services under this title will not be given by the area agency on aging to particular older individuals as a result of a contract or commercial relationship that is not carried out to implement this title;

(15) provide assurances that funds received under this title will be used-

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(A) to provide benefits and services to older individuals, giving priority to older individuals identified in paragraph (4)(A)(i); and
(B) in compliance with the assurances specified in paragraph (13) and the limitations specified in section 212;

Sec. 307, STATE PLANS

(a) Each such plans shall comply with all of the following requirements:…
(3) The plan shall…
(B) with respect to services for older individuals residing in rural areas—
(i) provide assurances that the State agency will spend for each fiscal year, not less than the amount expended for such services for fiscal year 2000…

(7)(A) The plan shall provide satisfactory assurance that such fiscal control and fund accounting procedures will be adopted as may be necessary to assure proper disbursement of, and accounting for, Federal funds paid under this title to the State, including any such funds paid to the recipients of a grant or contract.

(B) The plan shall provide assurances that--
(i) no individual (appointed or otherwise) involved in the designation of the State agency or an area agency on aging, or in the designation of the head of any subdivision of the State agency or of an area agency on aging, is subject to a conflict of interest prohibited under this Act;
(ii) no officer, employee, or other representative of the State agency or an area agency on aging is subject to a conflict of interest prohibited under this Act; and
(iii) mechanisms are in place to identify and remove conflicts of interest prohibited under this Act…

(9) The plan shall provide assurances that the State agency will carry out, through the Office of the State Long-Term Care Ombudsman, a State Long-Term Care Ombudsman program in accordance with section 712 and this title, and will expend for such purpose an amount that is not less than an amount expended by the State agency with funds received under this title for fiscal year 2000, and an amount that is not less than the amount expended by the State agency with funds received under title VII for fiscal year 2000.

(10) The plan shall provide assurance that the special needs of older individuals residing in rural areas will be taken into consideration and shall describe how those needs have been met and describe how funds have been allocated to meet those needs.

(11) The plan shall provide that with respect to legal assistance --
(A) contains assurances that area agencies on aging will--

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(i) enter into contracts with providers of legal assistance which can demonstrate the experience or capacity to deliver legal assistance;
(ii) include in any such contract provisions to assure that any recipient of funds under division (i) will be subject to specific restrictions and regulations promulgated under the Legal Services Corporation Act (other than restrictions and regulations governing eligibility for legal assistance under such Act and governing membership of local governing boards) as determined appropriate by the Assistant Secretary; and
(iii) attempt to involve the private bar in legal assistance activities authorized under this title, including groups within the private bar furnishing services to older individuals on a pro bono and reduced fee basis.

(B) the plan contains assurances that no legal assistance will be furnished unless the grantee administers a program designed to provide legal assistance to older individuals with social or economic need and has agreed, if the grantee is not a Legal Services Corporation project grantee, to coordinate its services with existing Legal Services Corporation projects in the planning and service area in order to concentrate the use of funds provided under this title on individuals with the greatest such need; and the area agency on aging makes a finding, after assessment, pursuant to standards for service promulgated by the Assistant Secretary, that any grantee selected is the entity best able to provide the particular services.

(D) the plan contains assurances, to the extent practicable, that legal assistance furnished under the plan will be in addition to any legal assistance for older individuals being furnished with funds from sources other than this Act and that reasonable efforts will be made to maintain existing levels of legal assistance for older individuals; and

(E) the plan contains assurances that area agencies on aging will give priority to legal assistance related to income, health care, long-term care, nutrition, housing, utilities, protective services, defense of guardianship, abuse, neglect, and age discrimination.

(12) The plan shall provide, whenever the State desires to provide for a fiscal year for services for the prevention of abuse of older individuals --
(A) the plan contains assurances that any area agency on aging carrying out such services will conduct a program consistent with relevant State law and coordinated with existing State adult protective service activities for--
(i) public education to identify and prevent abuse of older individuals;
(ii) receipt of reports of abuse of older individuals;
(iii) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance where appropriate and consented to by the parties to be referred; and
(iv) referral of complaints to law enforcement or public protective service agencies where appropriate;…

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(13) The plan shall provide assurances that each State will assign personnel (one of whom shall be known as a legal assistance developer) to provide State leadership in developing legal assistance programs for older individuals throughout the State…

(15) The plan shall provide assurances that, if a substantial number of the older individuals residing in any planning and service area in the State are of limited English-speaking ability, then the State will require the area agency on aging for each such planning and service area—
(A) to utilize in the delivery of outreach services under section 306(a)(2)(A), the services of workers who are fluent in the language spoken by a predominant number of such older individuals who are of limited English-speaking ability; and
(B) to designate an individual employed by the area agency on aging, or available to such area agency on aging on a full-time basis, whose responsibilities will include--
(i) taking such action as may be appropriate to assure that counseling assistance is made available to such older individuals who are of limited English-speaking ability in order to assist such older individuals in participating in programs and receiving assistance under this Act; and
(ii) providing guidance to individuals engaged in the delivery of supportive services under the area plan involved to enable such individuals to be aware of cultural sensitivities and to take into account effectively linguistic and cultural differences.

(16) The plan shall provide assurances that the State agency will require outreach efforts that will—
(A) identify individuals eligible for assistance under this Act, with special emphasis on—
(i) older individuals residing in rural areas;
(ii) older individuals with greatest economic need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas;
(iii) older individuals with greatest social need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas;
(iv) older individuals with severe disabilities;
(v) older individuals with limited English-speaking ability; and
(vi) older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and
(B) inform the older individuals referred to in clauses (i) through (vi) of subparagraph (A), and the caretakers of such individuals, of the availability of such assistance.

(17) The plan shall provide, with respect to the needs of older individuals with severe disabilities, assurances that the State will coordinate planning, identification, assessment of needs, and service for older individuals with disabilities with particular attention to individuals with severe disabilities with the State agencies with primary responsibility for individuals with disabilities, including severe disabilities, to enhance services and develop collaborative programs, where appropriate, to meet the needs of older individuals with disabilities.

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(18) The plan shall provide assurances that area agencies on aging will conduct efforts to facilitate the coordination of community-based, long-term care services, pursuant to section 306(a)(7), for older individuals who--
(A) reside at home and are at risk of institutionalization because of limitations on their ability to function independently;
(B) are patients in hospitals and are at risk of prolonged institutionalization; or
(C) are patients in long-term care facilities, but who can return to their homes if community-based services are provided to them.

(19) The plan shall include the assurances and description required by section 705(a).

(20) The plan shall provide assurances that special efforts will be made to provide technical assistance to minority providers of services.

(21) The plan shall--
(A) provide an assurance that the State agency will coordinate programs under this title and programs under title VI, if applicable; and
(B) provide an assurance that the State agency will pursue activities to increase access by older individuals who are Native Americans to all aging programs and benefits provided by the agency, including programs and benefits provided under this title, if applicable, and specify the ways in which the State agency intends to implement the activities.

(23) The plan shall provide assurances that demonstrable efforts will be made--
(A) to coordinate services provided under this Act with other State services that benefit older individuals; and
(B) to provide multigenerational activities, such as opportunities for older individuals to serve as mentors or advisers in child care, youth day care, educational assistance, at-risk youth intervention, juvenile delinquency treatment, and family support programs.

(24) The plan shall provide assurances that the State will coordinate public services within the State to assist older individuals to obtain transportation services associated with access to services provided under this title, to services under title VI, to comprehensive counseling services, and to legal assistance.

(25) The plan shall include assurances that the State has in effect a mechanism to provide for quality in the provision of in-home services under this title.

(26) The plan shall provide assurances that funds received under this title will not be used to pay any part of a cost (including an administrative cost) incurred by the State agency or an area agency on aging to carry out a contract or commercial relationship that is not carried out to implement this title.

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(27) The plan shall provide assurances that area agencies on aging will provide, to the extent feasible, for the furnishing of services under this Act, consistent with self-directed care.

Sec. 308, PLANNING, COORDINATION, EVALUATION, AND ADMINISTRATION OF STATE PLANS

(b)(3)(E) No application by a State under subparagraph (A) shall be approved unless it contains assurances that no amounts received by the State under this paragraph will be used to hire any individual to fill a job opening created by the action of the State in laying off or terminating the employment of any regular employee not supported under this Act in anticipation of filling the vacancy so created by hiring an employee to be supported through use of amounts received under this paragraph.

Sec. 705, ADDITIONAL STATE PLAN REQUIREMENTS (as numbered in statute)

(a) ELIGIBILITY.—In order to be eligible to receive an allotment under this subtitle, a State shall include in the state plan submitted under section 307--

(1) an assurance that the State, in carrying out any chapter of this subtitle for which the State receives funding under this subtitle, will establish programs in accordance with the requirements of the chapter and this chapter.

(2) an assurance that the State will hold public hearings, and use other means, to obtain the views of older individuals, area agencies on aging, recipients of grants under title VI, and other interested persons and entities regarding programs carried out under this subtitle;

(3) an assurance that the State, in consultation with area agencies on aging, will identify and prioritize statewide activities aimed at ensuring that older individuals have access to, and assistance in securing and maintaining, benefits and rights.

(4) an assurance that the State will use funds made available under this subtitle for a chapter in addition to, and will not supplant, any funds that are expended under any Federal or State law in existence on the day before the date of the enactment of this subtitle, to carry out each of the vulnerable elder rights protection activities described in the chapter.

(5) an assurance that the State will place no restrictions, other than the requirements referred to in clauses (i) through (iv) of section 712(a)(5)(C), on the eligibility of entities for designation as local Ombudsman entities under section 712(a)(5).

(6) an assurance that, with respect to programs for the prevention of elder abuse, neglect, and exploitation under chapter 3—

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(A) in carrying out such programs the State agency will conduct a program of services consistent with relevant State law and coordinated with existing State adult protective service activities for--
(i) public education to identify and prevent elder abuse;
(ii) receipt of reports of elder abuse;
(iii) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance if appropriate and if the individuals to be referred consent; and
(iv) referral of complaints to law enforcement or public protective service agencies if appropriate;
(B) the State will not permit involuntary or coerced participation in the program of services described in subparagraph (A) by alleged victims, abusers, or their households; and
(C) all information gathered in the course of receiving reports and making referrals shall remain confidential except--
(i) if all parties to such complaint consent in writing to the release of such information;
(ii) if the release of such information is to a law enforcement agency, public protective service agency, licensing or certification agency, ombudsman program, or protection or advocacy system; or
(iii) upon court order…

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State Plan Guidance
Attachment A (Continued)

REQUIRED ACTIVITIES

Sec. 305 ORGANIZATION
(a) In order for a State to be eligible to participate in programs of grants to States from allotments under this title—. . .
(2) the State agency shall—
(G)(i) set specific objectives, in consultation with area agencies on aging, for each planning and service area for providing services funded under this title to low-income minority older individuals and older individuals residing in rural areas; . . .
(ii) provide an assurance that the State agency will undertake specific program development, advocacy, and outreach efforts focused on the needs of low-income minority older individuals; and
(iii) provide a description of the efforts described in clause (ii) that will be undertaken by the State agency; . . .

Sec. 306 – AREA PLANS
(a) Each area agency will:
(6)(F) in coordination with the State agency and with the State agency responsible for mental and behavioral health services, increase public awareness of mental health disorders, remove barriers to diagnosis and treatment, and coordinate mental health services (including mental health screenings) provided with funds expended by the area agency on aging with mental health services provided by community health centers and by other public agencies and nonprofit private organizations;

(6)(H) in coordination with the State agency and with the State agency responsible for elder abuse prevention services, increase public awareness of elder abuse, neglect, and exploitation, and remove barriers to education, prevention, investigation, and treatment of elder abuse, neglect, and exploitation, as appropriate;"

Sec. 307(a) STATE PLANS

(1) The plan shall—

(A) require each area agency on aging designated under section 305(a)(2)(A) to develop and submit to the State agency for approval, in accordance with a uniform format developed by the State agency, an area plan meeting the requirements of section 306; and (B) be based on such area plans.

Note: THIS SUBSECTION OF STATUTE DOES <u>NOT</u> REQUIRE THAT AREA PLANS BE DEVELOPED PRIOR TO STATE PLANS AND/OR THAT STATE PLANS DEVELOP AS A COMPILATION OF AREA PLANS.

(2) The plan shall provide that the State agency will --
(A) evaluate, using uniform procedures described in section 202(a)(26), the need for supportive services (including legal assistance pursuant to 307(a)(11), information and

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assistance, and transportation services), nutrition services, and multipurpose senior centers within the State;

(B) develop a standardized process to determine the extent to which public or private programs and resources (including volunteers and programs and services of voluntary organizations) that have the capacity and actually meet such need; …

(4) The plan shall provide that the State agency will conduct periodic evaluations of, and public hearings on, activities and projects carried out in the State under this title and title VII, including evaluations of the effectiveness of services provided to individuals with greatest economic need, greatest social need, or disabilities (with particular attention to low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas). Note**:** "Periodic" (defined in 45CFR Part 1321.3) means, at a minimum, once each fiscal year.

(5) The plan shall provide that the State agency will:
(A) afford an opportunity for a hearing upon request, in accordance with published procedures, to any area agency on aging submitting a plan under this title, to any provider of (or applicant to provide) services;
(B) issue guidelines applicable to grievance procedures required by section 306(a)(10); and

(C) afford an opportunity for a public hearing, upon request, by an area agency on aging, by a provider of (or applicant to provide) services, or by any recipient of services under this title regarding any waiver request, including those under Section 316.

(6) The plan shall provide that the State agency will make such reports, in such form, and containing such information, as the Assistant Secretary may require, and comply with such requirements as the Assistant Secretary may impose to insure the correctness of such reports.

(8)(A) The plan shall provide that no supportive services, nutrition services, or in-home services will be directly provided by the State agency or an area agency on aging in the State, unless, in the judgment of the State agency--
(i) provision of such services by the State agency or the area agency on aging is necessary to assure an adequate supply of such services;
(ii) such services are directly related to such State agency's or area agency on aging's administrative functions; or
(iii) such services can be provided more economically, and with comparable quality, by such State agency or area agency on aging.

(22) If case management services are offered to provide access to supportive services, the plan shall provide that the State agency shall ensure compliance with the requirements specified in section 306(a)(8).

June **XX**, 2017

Signature and Title of Authorized Official *Date*

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ATTACHMENT B

INFORMATION REQUIREMENTS

IMPORTANT: States must provide all applicable information following each OAA citation listed below. Please note that italics indicate emphasis added to highlight specific information to include. The completed attachment must be included with your State Plan submission.

Section 305(a)(2)(E)
Describe the mechanism(s) for assuring that preference will be given to providing services to older individuals with greatest economic need and older individuals with greatest social need, (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas) and include proposed methods of carrying out the preference in the State plan;

Response:
CDA employs three primary mechanisms to assure preference is given to older individuals with greatest economic and social need; CDA uses an IFF to distribute federal and state funds to AAAs. The IFF is based on a combination of factors, including: age; income; geographic isolation; racial or ethnic status; social isolation; and English language proficiency.

The AAA's four-year Area Plan and annual Area Plan Update must assess and describe the target population within the AAA's PSA. The AAA must also develop service goals and objectives that meet the needs of targeted populations and reduce barriers to services. CDA also assures every AAA targets high-risk populations through annual contract requirements stipulating that the AAA and its subcontractors must serve all eligible persons, especially targeted populations.

Section 306(a)(17)
Describe the mechanism(s) for assuring that each Area Plan will include information detailing how the Area Agency will coordinate activities and develop long-range emergency preparedness plans with local and State emergency response agencies, relief organizations, local and State governments and other institutions that have responsibility for disaster relief service delivery.

Response:
California regulations, CDA's Area Plan Guidance, and CDA's Standard Agreement require AAAs to describe in their Area Plans how they identify their local Office of Emergency Services contact persons and AAA disaster response coordinator and coordinate their disaster preparedness plans. In addition, AAAs must describe how they identify vulnerable populations and plan to follow up with them in the event of a disaster.

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CDA's *Disaster Assistance Handbook for Area Agencies on Aging* (*Disaster Assistance Handbook*) describes what AAAs are required to do before, during, and after an emergency event to address the needs of the populations they serve.

Section 307(a)(2)
The plan shall provide that the State agency will:
(C*) specify a minimum proportion* of the funds received by each area agency on aging in the State to carry out part B that will be expended (in the absence of a waiver under sections 306 (c) or 316) by such area agency on aging to provide each of the categories of services specified in section 306(a)(2). *(Note: those categories are access, in-home, and legal assistance. Provide specific minimum proportion determined for each category of service.)*

Response:
CDA's Area Plan Guidance requires AAAs to describe in their Area Plans how the AAA establishes priorities for the planning cycle, the factors influencing the AAA's priorities, and its plans for managing increased or decreased resources. The Area Plan must include the AAA's process for establishing an adequate proportion of funding for Title III access, in-home and legal assistance, in keeping with federal and state requirements. Changes to adequate proportion must be reflected in the Area Plan Update.

California regulations and CDA's Standard Agreement specifically require that AAAs meet the adequate proportion requirements for priority services. Please refer to page 39 for a display of approved Title IIIB minimum proportion expenditure levels for California's 33 AAAs.

Section 307(a)(3)
The plan shall--
...
(B) with respect to services for older individuals residing in rural areas:

(i) provide assurances the State agency will spend for each fiscal year not less than the amount expended for such services for fiscal year 2000.

(ii) *identify, for each fiscal year to which the plan applies, the projected costs of providing such services (including the cost of providing access to such services).*

Response:
Thirty-one of California's 33 AAAs have some rural (geographically isolated) population. To ensure a baseline level of funding, each PSA receives annually at least as much funding in total as it received in 2000. The IFF allocates funds in part based on the number of persons aged 60 and older who are geographically isolated. Demographic data used in the formula are updated annually with the best available data. In addition,

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the IFF acknowledges the cost of serving rural individuals by assigning greater weight when allocating funds to individuals who are geographically isolated.

(iii) *describe the methods used to meet the needs for such services in the fiscal year preceding the first year to which such plan applies.*

Response:
CDA's and AAAs' data collection and analysis assists with determining the size and location of the rural population(s) in each PSA and supports targeted outreach and service delivery. AAAs target services for older individuals residing in rural areas through their requests for proposals and contracts. AAAs monitor contractors who provide service to rural individuals to ensure they meet program and performance requirements. AAAs use nutrition sites, health fairs, and other rural venues to link older individuals to the services. AAAs collaborate with community-based organizations in rural areas to assess needs and develop responsive services and service systems. AAAs also make extensive efforts to educate elected officials, private foundations, and the general public about the needs of older individuals residing in rural areas.

Section 307(a)(10)
The plan shall provide assurance that the special needs of older individuals residing in rural areas are taken into consideration and shall *describe how those needs have been met and describe how funds have been allocated to meet those needs.*

Response:
California's IFF provides greater weight to individuals who are age 60 and older and geographically isolated (e.g. rural) than those who are not. The formula assigns a weight of 1.5 to this factor. Within rural areas, low-income minority individuals receive the highest relative emphasis. Older individuals residing in rural areas are among those individuals to whom AAAs target services through their RFP and contracting processes.

Section 307(a)(14)
(14) The plan shall, with respect to the fiscal year preceding the fiscal year for which such plan is prepared—

(A) *identify the number of low-income minority older individuals in the State, including the number of low income minority older individuals with limited English proficiency*; and

(B) *describe the methods used to satisfy the service needs* of the low-income minority older individuals described in subparagraph (A), including the plan to meet the needs of low-income minority older individuals with limited English proficiency.

Response:
CDA's and AAAs' data collection and analysis assists with determining the population and location of low-income, minority older individuals and those with limited English proficiency in each PSA and supports targeted outreach and service delivery. CDA retrieves updated data for individuals with these and other characteristics annually from

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recognized sources. CDA uses the best available data to allocate funds to the AAAs, with the number of low-income minority individuals receiving the highest emphasis in the funding formula. Data on the number of low-income and minority individuals is displayed on page 46 of this State Plan. Data on the distribution of older individuals with limited English proficiency is displayed in Appendix H. CDA also publishes this data on its website.

AAAs conduct focus groups with multicultural older adults in their respective languages and survey service providers to identify service gaps. This helps them to target services to low-income minority older individuals with limited English proficiency through their requests for proposals and contracts. AAAs monitor contractors to ensure they meet program and performance objectives for serving targeted individuals. AAAs employ bilingual staff and culturally competent non-bilingual staff to support responsiveness to the service needs of the low-income, minority individuals with limited English proficiency. They also devote considerable effort to educating the community about the service needs of older adults, especially those for service under the OAA. AAAs use community fairs, other special events and community education publications translated into a variety of languages to reach low-income, minority individuals with limited English proficiency.

AAAs also seek to address service needs by engaging low-income minority individuals with limited English proficiency as members of their AAA Advisory Councils and other advisory committees. Doing so supports outreach, needs assessment, planning and service delivery that are sensitive and responsive to the needs of targeted individuals.

Section 307(a)(21)
The plan shall --

(B) provide an assurance that the State agency will pursue activities to increase access by older individuals who are Native Americans to all aging programs and benefits provided by the agency, including programs and benefits provided under this title *(title III),* if applicable, *and specify the ways in which the State agency intends to implement the activities .*

Response:
Coordination is essential to increasing access to aging programs and benefits by older individuals who are Native Americans. CDA will continue to work with AAAs and state tribal organizations to identify opportunities and strategies to improve coordination between Titles III and VI, and involve recognized tribes in implementing evidence-based CDSME programs. CDA's Medicare Improvements for Patients and Providers Act (MIPPA) grant activities includes requirements for AAAs to increase the enrollment of Native American Medicare beneficiaries in the Prescription Drug Assistance Program, Low Income Subsidy, and Medicare Savings Program.

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At the local level, AAAs continue to conduct a range of activities focused on increasing service access to older individuals who are Native Americans. These will include data collection, analysis and planning efforts to identify the particular needs of older Native Americans and target services appropriately. AAAs are encouraged to establish Title III/VI activities, such as congregate meal sites, providing nutrition education and delivering meals to older individuals who are Native Americans, and providing technical assistance and food safety training to Native American program staff. Activities to increase access also will include engaging Native American individuals as AAA advisory council members, conducting outreach to tribal communities, and making referrals to community-based programs, including evidence-based CDSME programs.

Section 307(a)(28)

(A) The plan shall include, at the election of the State, an assessment of how prepared the State is, under the State's statewide service delivery model, for any anticipated change in the number of older individuals during the 10-year period following the fiscal year for which the plan is submitted.

(B) Such assessment may include—

(i) the projected change in the number of older individuals in the State;

(ii) an analysis of how such change may affect such individuals, including individuals with low incomes, individuals with greatest economic need, minority older individuals, older individuals residing in rural areas, and older individuals with limited English proficiency;

(iii) an analysis of how the programs, policies, and services provided by the State can be improved, including coordinating with area agencies on aging, and how resource levels can be adjusted to meet the needs of the changing population of older individuals in the State; and

(iv) an analysis of how the change in the number of individuals age 85 and older in the State is expected to affect the need for supportive.

Response:

CDA's and AAAs data collection and analysis shall continue to assist in determining demographic changes to areas where low-income older individuals have the greatest economic needs, including minority older individuals, older individuals residing in rural areas, the number of individuals age 85 and older, and older individuals with limited English proficiency. CDA retrieves updated data for individuals with these and other characteristics annually from recognized sources and funds are allocated to the AAAs with the number of low-income minority older individuals receiving the highest emphasis in the funding formula. Data on projected changes of individuals 60 years of age and older is displayed in Appendix C and this data is displayed by each AAA in Appendix E. In addition, data on the number of low-income and minority individuals is displayed in Appendix I and data on the distribution of older individuals with limited English proficiency is displayed in Appendix H.

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CDA posts demographic data on its website and regularly provides AAAs with access to these types of demographic updates. In addition, CDA provides guidance related to programs, policies, and service priorities so that AAAs can enhance service levels as demographics change. This encourages AAAs to conduct additional focus groups with multicultural older adults in their respective languages and to survey their service providers to identify any potential service gaps.

This Plan also includes data on projected changes of individuals 85 years of age and older displayed in Appendix F. This data is also updated regularly and will be updated as part of the development of the next State Plan due in 2021 so that targeted services can best meet the needs of the individuals 85 years of age and older.

Section 307(a)(29)
The plan shall include information detailing how the State will coordinate activities, and develop long-range emergency preparedness plans, with area agencies on aging, local emergency response agencies, relief organizations, local governments, State agencies responsible for emergency preparedness, and any other institutions that have responsibility for disaster relief service delivery.

Response:
To ensure compliance with this requirement, CDA (1) maintains a *Disaster Assistance Handbook* for AAAs; (2) provides guidance and training to the AAAs to assist them in fulfilling their contractual responsibilities in emergency/disaster preparedness, coordination, response and recovery, including a disaster preparedness webpage; (3) during on-site AAA monitoring, reviews compliance with these requirements; (4) has designated a specific lead staff disaster coordinator at CDA to provide emergency preparedness technical assistance and serve as the main contact for the AAAs and Region IX on these issues; and (5) maintains contact information for each AAA Emergency Coordinator with afterhours phone information to communicate with these organizations in an emergency situation.

The Department also maintains a Continuity of Operations and Continuity of Government Plan to ensure that critical functions and core leadership are maintained during a potential emergency that impacts its headquarters or leadership capacity.

Section 307(a)(30)
The plan shall include information describing the involvement of the head of the State agency in the development, revision, and implementation of emergency preparedness plans, including the State Public Health Emergency Preparedness and Response Plan.

Response:
CDA's Director serves as a member of the California Health and Human Services Agency Disaster Council. This Council, chaired by the Agency Secretary who also serves on the Governor's Cabinet, has a lead role in preparing for and responding to

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emergency/disaster events. The Council serves as a forum for interdepartmental collaboration in planning, response and recovery activities, including those that involve the Cal EMA and the American Red Cross.

The Director receives daily Cal EMA emergency situation reports and, in the event of a major event, would receive ongoing updates and participate in daily situational conference calls/meetings. The Director is also on the California Health Alert Network to receive phone and email notification and messages from the California Department of Public Health in an emergency situation. These response systems are tested at least annually. The Director has been actively involved in the development of the California Emergency Plan, specifically in the sections addressing Emergency Function (EF) 6 – Mass Care and Shelter and EF 8 – Public Health and Medical Emergency.

Section 705(a) ELIGIBILITY
In order to be eligible to receive an allotment under this subtitle, a State shall *include in the State plan submitted under section 307--*

(7) a description of the manner in which the State agency will carry out this title in accordance with the assurances described in paragraphs (1) through (6).
(Note: Paragraphs (1) of through (6) of this section are listed below)

In order to be eligible to receive an allotment under this subtitle, a State shall include in the State plan submitted under section 307--
(1) an assurance that the State, in carrying out any chapter of this subtitle for which the State receives funding under this subtitle, will establish programs in accordance with the requirements of the chapter and this chapter;
(2) an assurance that the State will hold public hearings, and use other means, to obtain the views of older individuals, area agencies on aging, recipients of grants under title VI, and other interested persons and entities regarding programs carried out under this subtitle;
(3) an assurance that the State, in consultation with area agencies on aging, will identify and prioritize statewide activities aimed at ensuring that older individuals have access to, and assistance in securing and maintaining, benefits and rights;
(4) an assurance that the State will use funds made available under this subtitle for a chapter in addition to, and will not supplant, any funds that are expended under any Federal or State law in existence on the day before the date of the enactment of this subtitle, to carry out each of the vulnerable elder rights protection activities described in the chapter;
(5) an assurance that the State will place no restrictions, other than the requirements referred to in clauses (i) through (iv) of section 712(a)(5)(C), on the eligibility of entities for designation as local Ombudsman entities under section 712(a)(5);
(6) an assurance that, with respect to programs for the prevention of elder abuse, neglect, and exploitation under chapter 3--

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(A) in carrying out such programs the State agency will conduct a program of services consistent with relevant State law and coordinated with existing State adult protective service activities for-

(i) public education to identify and prevent elder abuse;

(ii) receipt of reports of elder abuse;

(iii) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance if appropriate and if the individuals to be referred consent; and

(iv) referral of complaints to law enforcement or public protective service agencies if appropriate;

(B) the State will not permit involuntary or coerced participation in the program of services described in subparagraph (A) by alleged victims, abusers, or their households; and

(C) all information gathered in the course of receiving reports and making referrals shall remain confidential except--

(i) if all parties to such complaint consent in writing to the release of such information;

(ii) if the release of such information is to a law enforcement agency, public protective service agency, licensing or certification agency, ombudsman program, or protection or advocacy system; or

(iii) upon court order.

Response:

1) The Office of the State LTC Ombudsman is located within CDA and provides oversight to 35 local Long-Term Care Ombudsman Programs. AAAs provide these programs directly or by subcontract. As advocates for residents of LTC facilities, the Office of the State LTC Ombudsman and the local Ombudsman representatives promote residents' rights and provide assurances to protect these rights. Statewide, approximately 900 state-certified Ombudsman volunteers and paid local LTCOP staff identify, investigate, and resolve complaints and concerns on behalf of approximately 298,000 residents in nearly 1,400 Skilled Nursing Facilities (SNFs), including Distinct Part SNFs and Intermediate Care Facilities, and approximately 7,500 Residential Care Facilities for the Elderly.

   AAAs, directly or by subcontract, provide Programs for Prevention of Elder Abuse, Neglect and Exploitation under Title VII, Chapter 3. These services include public education sessions, distributing educational materials, training sessions for professionals and family caregivers served by Title III E and developing a coordinated system to respond to elder abuse.

2) The State holds public hearings to obtain stakeholder input on these programs during the State Plan review and development process.

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3) The State reviews AAA Area Plans and Area Plan Updates to determine how Title VII funds are used to establish a coordinated system to respond to elder abuse. The State also monitors AAAs and their compliance with the provisions of Title VII, Chapter 3.

4) The State reviews funds expended under this Title and certifies these expenditures to AoA**.**

5) The State imposes no restrictions, other than the requirements referred to in clauses (i) through (iv) of section 712(a)(5)(C) on entities seeking designation as local Ombudsman programs.

6) The State, through the AAAs, coordinates services locally with funds expended under Title VII, Chapter 3, and maintains the confidentiality of any reports of abuse or neglect.

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APPENDIX A
CALIFORNIA DEPARTMENT OF AGING VALUES

The Department strives to pursue its Vision and accomplish its Mission in a manner consistent with the Values outlined below.

Leadership: We set the direction for ensuring that strategies, systems, and methods for achieving excellence are created; and for building the knowledge and capabilities of our employees and others who work with our customers.

Diversity: We work in an inclusive environment that respects the rights of all people, their equal opportunity to succeed, and the contributions they make to accomplish our Mission.

Advocacy: We speak in support of individuals and issues that promote the overall well-being of our customers.

Accountability: We assume responsibility – individually, and in teams – for our behaviors, actions, and results and for serving our customers in the manner in which they want to be served.

Quality: Our performance demonstrates a commitment to, and recognition of, excellence, which is the balance of efficiency and effectiveness.

Innovation: We take initiative by being open and receptive to experimenting with new and creative ideas.

Collaboration: We foster partnerships and cooperation with our stakeholders, business partners, and customers in planning, delivering, and evaluating programs and services.

Integrity: We are open, honest, trustworthy, and professional in the performance of our duties and in our dealings with our customers, business partners, and stakeholders.

Empowerment: We enable individuals to make informed choices that can enrich their lives and support their ability to effectively participate in their communities.

Respect: We hold our stakeholders, business partners, and customers in the highest esteem, and show due consideration and appreciation in our interactions for their ideas, programs, and services.

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APPENDIX B
2017 CALIFORNIA PLANNING AND SERVICE AREAS (PSAS)

The State is divided geographically into 33 PSAs. Within each PSA is an Area Agency on Aging (AAA) responsible for planning and administering services for seniors.



PSA by County

*TYPE**	*PSA #*	*County(ies) Served*
*1	PSA 1	Del Norte, Humboldt
*3	PSA 2	Lassen, Modoc, Shasta, Siskiyou, Trinity
*2	PSA 3	Butte, Colusa, Glenn, Plumas, Tehama
*3	PSA 4	Nevada, Placer, Sierra, Sacramento, Sutter, Yolo, Yuba
*	PSA 5	Marin
*	PSA 6	City and County of San Francisco
*	PSA 7	Contra Costa
*	PSA 8	San Mateo
*	PSA 9	Alameda
*1	PSA 10	Santa Clara
*	PSA 11	San Joaquin
*3	PSA 12	Alpine, Amador, Calaveras, Mariposa, Tuolumne
*1	PSA 13	San Benito, Santa Cruz
*3	PSA 14	Fresno, Madera
*3	PSA 15	Kings, Tulare
*3	PSA 16	Inyo, Mono
*1	PSA 17	Santa Barbara, San Luis Obispo
*	PSA 18	Ventura
*	PSA 19	Los Angeles County
*	PSA 20	San Bernardino
*	PSA 21	Riverside
*	PSA 22	Orange
*	PSA 23	San Diego
*	PSA 24	Imperial
*4	PSA 25	Los Angeles City
*3	PSA 26	Lake, Mendocino
*	PSA 27	Sonoma
*1	PSA 28	Napa, Solano
*	PSA 29	El Dorado
*	PSA 30	Stanislaus
*	PSA 31	Merced
*	PSA 32	Monterey
*	PSA 33	Kern

** AAA Entity: * – County AAA(19) ; *1-Non-profit (5);*
**2 –University Foundation (1); *3 – Joint Powers Agreement (7); *4 – City AAA (1)*

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CALIFORNIA AREA AGENCIES ON AGING♦

PSA 1	**Area 1 Agency on Aging**	**Type *1**
County(ies) Served: Del Norte, Humboldt Maggie Kraft, Executive Director	434 7th Street Eureka, California 95501 Phone: (707) 442-3763 Fax: (707) 442-3714 Home page address: www.a1aa.org	
PSA 2	**Planning and Service Area II Area Agency on Aging**	**Type *3**
County(ies) Served: Lassen, Modoc, Shasta, Siskiyou, Trinity Teri Gabriel, Executive Director	208 West Center St. P.O. Box 1400 Yreka, California 96097 Phone: (530) 842-1687 Fax: (530) 842-4804 Home page address: www.psa2.org	
PSA 3	**PASSAGES Area 3 Agency on Aging**	**Type *2**
County(ies) Served: Butte, Colusa, Glenn, Plumas, Tehama Joe Cobery, Executive Director	25 Main Street, Room 202 Chico, California 95929 Phone: (530) 898-5923 Fax: (530) 898-4870 Home page address: www.passagescenter.org	

♦ ORGANIZATIONAL TYPES:
* = County AAA
*1 = Private Non-Profit
*2 = University Foundation
*3 = Joint Powers Agreement
*4 = City AAA

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PSA 4	**Area 4 Agency on Aging**	**Type *3**
County(ies) Served: Nevada, Placer Sacramento, Sierra, Sutter, Yolo, Yuba, Pam Miller Executive Director	1401 El Camino Avenue, Suite 400 Sacramento, California 95815 Phone: (916) 486-1876 Fax: (916) 486-9454 Home page address: www.a4aa.com	
PSA 5	**Division of Aging and Adult Services** **Marin County Department of Health and Human Services**	**Type ***
County(ies) Served: Marin Lee Pullen, Director	10 North San Pedro Road, Suite 1013 San Rafael, California 94903 Phone: (415) 499-7396 Fax: (415) 499-5055 Home Page Address: www.marin.org	
PSA 6	**Department of Aging and Adult Services** **Area Agency on Aging**	**Type ***
County(ies) Served: City and County of San Francisco Shireen McSpadden, Executive Director	1650 Mission Street, 5th Floor San Francisco, California 94103 Phone: (415) 355-3555 Fax: (415) 355-6785 Home Page Address: www.sfgov.org/coaging	
PSA 7	**Aging and Adult Services** **Contra Costa County Department of Human Services**	**Type ***
County(ies) Served: Contra Costa Victoria Tolbert, Director	40 Douglas Drive Martinez, California 94553 Phone: (925) 229-8434 Fax: (925) 335-8717 Home Page Address: www.ca-contracostacounty.civicplus.com	

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PSA 8	**San Mateo County Area Agency on Aging**	**Type ***
County(ies) Served: San Mateo Lisa Mancini, Director	225 37th Avenue San Mateo, California 94403 Phone: (650) 573-2700 Fax: (650) 573-2310 Home page address: www.sanmateonetworkofcare.org	
PSA 9	**Alameda County Area Agency on Aging Department of Adult and Aging Services**	**Type ***
County(ies) Served: Alameda Tracy Murray, Director	6955 Foothill Boulevard, Suite 300 Oakland, California 94605-1907 Phone: (510) 577-1900 Fax: (510) 577-1965 Home page address: www.co.alamedasocialservices.org	
PSA 10	**Sourcewise Community Resource Solutions**	**Type *1**
County(ies) Served: Santa Clara Stephen Schmoll, Executive Director	2115 The Alameda San Jose, California 95126-1141 Phone: (408) 296-8290 Fax: (408) 249-8918 Home page address: www.mysourcewise.com	
PSA 11	**San Joaquin County Department of Aging and Community**	**Type ***
County(ies) Served: San Joaquin Elise Vigil, Interim Director	P.O. Box 201056 Stockton, California 95201 102 South San Joaquin Street Stockton, California 95201 Phone: (209) 468-2202 Fax: (209) 468-2207 Home page address: www.co.san-joaquin.ca.us/hsa/aging/elderly/safer.htm	

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PSA 12	**Area 12 Agency on Aging**	**Type *3**
County(ies) Served: Alpine, Amador, Calaveras, Mariposa, Tuolumne	19074 Standard Road, Suite A Sonora, California 95370-7542 Phone: (209) 532-6272 Fax: (209) 532-6501 Home page address: www.area12.org	
Kristin Millhoff, Executive Director		
PSA 13	**Seniors Council of Santa Cruz and San Benito Counties, Inc.**	**Type *1**
County(ies) Served: Santa Benito, San Cruz	234 Santa Cruz Avenue Aptos, California 95003 Phone: (831) 688-0400 Fax: (831) 688-1225	
Clay Kempf, Executive Director	Home page address: http://www.seniorscouncil.org/	
PSA 14	**Fresno-Madera Area Agency on Aging**	**Type *3**
County(ies) Served: Fresno, Madera	3837 N. Clark Street Fresno, California 93726 Phone: (559) 600-4405	
Jean Robinson, Executive Director	Fax: (559) 453-5111 Home page address: www.fmaaa.org	
PSA 15	**Kings-Tulare Area Agency on Aging**	**Type *3**
County(ies) Served: Kings, Tulare	5957 South Mooney Boulevard Visalia, California 93277 Phone: (559) 624-8060	
Juliet Webb, Director	Fax: (559) 737-4694 Home page address: www.ktaaa.org	

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PSA 16	**Eastern Sierra Area Agency on Aging**	**Type *3**
County(ies) Served: Inyo, Mono Jean Turner, Director	P.O. Box 1799 Bishop, California 93514 Phone: (760) 872-4245 Fax: (760) 873-5103 Home page address: www.countyofinyo.org/imaaa	
PSA 17	**Area Agency on Aging** **Central Coast Commission for Senior Citizens**	**Type *1**
County(ies) Served: Santa Barbara, San Luis Obispo Joyce Ellen Lippman, Executive Director	528 South Broadway Santa Maria, California 93454 Phone: (805) 925-9554 Fax: (805) 925-9555 Home page address: www.centralcoastseniors.org	
PSA 18	**Ventura County Area Agency on Aging**	**Type ***
County(ies) Served: Ventura Victoria Jump, Director	646 County Square Drive, Suite 100 Ventura, California 93003 Phone: (805) 477-7300 Fax: (805) 477-7312 Home page address: http://aaa.countyofventura.org	
PSA 19	**Community and Senior Services Area Agency on Aging Los Angeles County**	**Type ***
County(ies) Served: County of Los Angeles Cynthia Banks, Director	3175 West 6th Street, Room 302 Los Angeles, California 90020 Phone: (213) 738-2600 Fax: (213) 380-8275 Home page address: www.dcss.co.la.ca.us/aaa/aaa.htm	

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PSA 20	**San Bernardino County Department of Aging and Adult Services**	**Type ***
County(ies) Served: San Bernardino Sharon Nevins Interim Director	686 East Mill Street San Bernardino, California 92415 Phone: (909) 891-3917 Fax: (909) 891-9077 Home page address: http://hss.sbcounty.gov/daas/	
PSA 21	**County of Riverside Office on Aging**	**Type ***
County(ies) Served: Riverside Anna Martinez, Director	6296 River Crest Drive, Suite K Riverside, California 92507 Phone: (951) 867-3800 Fax: (951) 867-3830 Home page address: www.rcaging.org	
PSA 22	**Orange County Office on Aging**	**Type ***
County(ies) Served: Orange Renee Ramirez, Interim Director	1300 South Grand Avenue, Bldg. B, 2nd Floor Santa Ana, California 92705 Phone: (714) 567-7500 Fax: (714) 567-7550 Home page address: www.officeonaging.ocgov.com	
PSA 23	**County of San Diego Aging & Independence Services**	**Type ***
County(ies) Served: San Diego Mark Sellers, Interim Director	5560 Overland Ave. Suite 300 San Diego, California 92123 Phone: (858) 495-5885 Fax: (858) 495-5080 Home page address: www.sdcounty.ca.gov/ais	
PSA 24	**Imperial County Area Agency on Aging**	**Type ***
County(ies) Served: Imperial Norma Saikhon, Director	778 W. State Street El Centro, California 92243 Phone: (442) 265-7030 Fax: (442) 265-7034 Home page address: www.aaa24.org/	

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PSA 25	**City of Los Angeles Department of Aging**	**Type *4**
County(ies) Served: Los Angeles City Laura Trejo, General Manager	221 N. Figueroa St. Suite 500 Los Angeles, California 90012 Phone: (213) 252-4000 Fax: (213) 252-4020 Home page address: http://aging.lacity.org/	
PSA 26	**Area Agency on Aging Mendocino County Department of Social Services**	**Type *3**
County(ies) Served: Lake, Mendocino Vacant, Director	P.O. Box 9000 Lower Lake, CA 95457 Phone: (707) 262-4517 Fax: (707) 263-3112	
PSA 27	**Sonoma County Area Agency on Aging**	**Type ***
County(ies) Served: Sonoma Diane Kaljian, Director	P.O. Box 4059 3725 Westwind Boulevard Santa Rosa, CA 95403 Phone: (707) 565-5950 Fax: (707) 565-5957 Home page address: www.socoaaa.org/	
PSA 28	**Area Agency on Aging – Serving Napa and Solano**	**Type *1**
County(ies) Served: Napa, Solano Leanne Martinsen, Executive Director	400 Contra Costa St. P.O. Box 3069 Vallejo, California 94590-5950 Phone: (707) 644-6612 Fax: (707) 644-7905 Home page address: www.aaans.org	
PSA 29	**El Dorado County Area Agency on Aging**	**Type ***
County(ies) Served: El Dorado Janet Walker- Conroy, Director	937 Spring Street Placerville, California 95667 Phone: (530) 642-7300 Fax: (530) 295-2669 Home page address: www.co.el-dorado.ca.us/humanservices/seniorservices.html	

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PSA 30	**Stanislaus County Department of Aging and Veterans Services**	**Type ***
County(ies) Served: Stanislaus Margie Palomino, Director	121 Downey Avenue, Suite 102 Modesto, California 95354-1201 Phone: (209) 558-7825 Fax: (209) 558-8648 Home page address: www.agingservices.info	
PSA 31	**Area Agency on Aging Merced County Senior Service Center**	**Type ***
County(ies) Served: Merced Alexandra Pierce, Deputy Director	851 West 23rd Street Merced, California 95341-0112 Phone: (209) 385-3000 Fax: (209) 725-3836 Home page address: www.co.merced.ca.us	
PSA 32	**Area Agency on Aging Division Department of Social Services County of Monterey**	**Type ***
County(ies) Served: Monterey Margaret Huffman, Director	1000 South Main Street, Suites 301 Salinas, California 93901 Phone: (831) 755-4466 Fax: (831) 755-8477 Home page address: www.co.monterey.ca.us/aaa	
PSA 33	**Kern County Aging & Adult Services**	**Type ***
County(ies) Served: Kern Lito Morillo, Director	5357 Truxtun Avenue Bakersfield, California 93309 Phone (661) 868-1000 Fax (661) 868-1001 Home page address: www.co.kern.ca.us/aas/	

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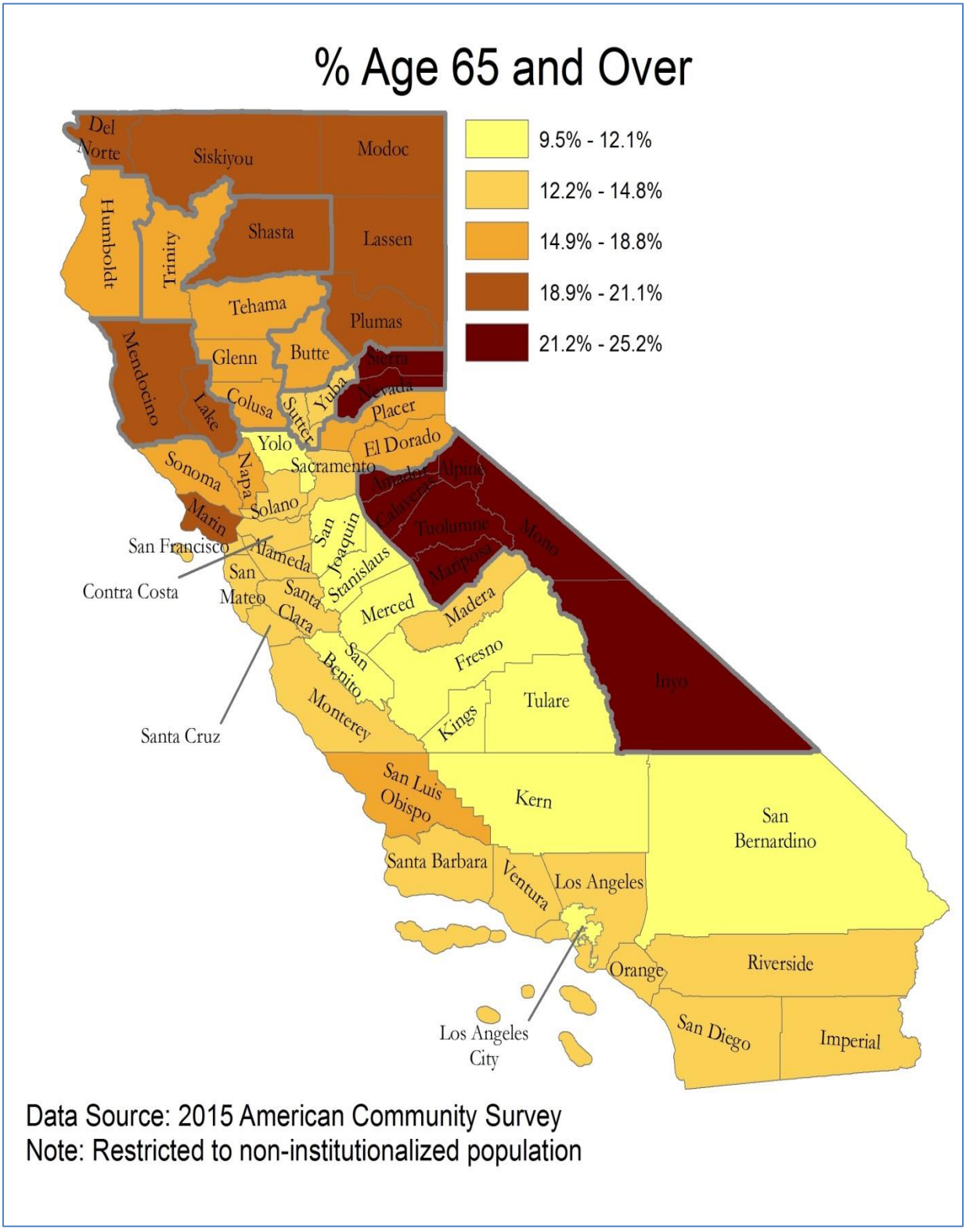
APPENDIX C

Projected Population 60+ Change between 2010 and 2050 (By Age Group)[58]

Age Range	Actual Population 2010	Projected Population 2030	Projected Population 2050	Population Change 2010 - 2030	Percent Change	Population Change 2030 - 2050	Percent Change
60 - 64	1,855,998	2,500,396	2,866,958	644,398	35%	366,562	15%
65 – 69	1,316,782	2,444,952	2,714,392	1,128,170	86%	269,440	11%
70 – 74	979,375	2,197,252	2,364,287	1,217,877	124%	167,035	8%
75 – 79	768,873	1,720,717	2,069,350	951,844	124%	348,633	20%
80 – 84	605,581	1,217,020	1,744,688	611,439	101%	527,668	43%
85+	604,139	1,028,557	2,257,696	424418	70%	1,229,139	120%
Totals	**6,130,748**	**11,108,894**	**14,017,371**	**4,978,146**	**81%**	**2,908,477**	**26%**

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APPENDIX D[59]



APPENDIX E
California Actual/Projected Population Age 60+
Percentage Change between 2010 and 2030
[By Planning and Service Area (PSA) and County][60]

PSA STATE/COUNTY	2010 60+ TOTAL POPULATION	2030 60+ TOTAL POPULATION	DIFFERENCE	% CHANGE
CALIFORNIA	**6,016,871**	**10,879,098**	**4,862,227**	**81%**
PSA 01				
Del Norte	5,569	8,488	2,919	52%
Humboldt	26,610	38,785	12,175	46%
TOTAL	**32,179**	**47,273**	**15,094**	**47%**
PSA 02				
Lassen	5,306	8,768	3,462	65%
Modoc	2,752	3,575	823	30%
Shasta	41,674	63,423	21,749	52%
Siskiyou	12,510	17,632	5,122	41%
Trinity	4,080	6,042	1,962	48%
TOTAL	**66,322**	**99,440**	**33,118**	**50%**
PSA 03				
Butte	46,813	77,469	30,656	65%
Colusa	3,602	6,411	2,809	78%
Glenn	5,149	7,972	2,823	55%
Plumas	6,039	7,281	1,242	21%
Tehama	14,060	20,481	6,421	46%
TOTAL	**75,663**	**119,614**	**43,951**	**58%**
PSA 04				
Nevada	27,801	38,296	10,495	38%
Placer	74,164	129,033	54,869	74%
Sacramento	226,327	413,632	187,305	83%
Sierra	1,048	1,352	304	29%
Sutter	16,519	28,511	11,992	73%
Yolo	28,572	53,322	24,750	87%
Yuba	10,674	21,180	10,506	98%
TOTAL	**385,105**	**685,326**	**300,221**	**78%**
PSA 05				
Marin	61,008	86,644	25,636	42%
PSA 06				
San Francisco	152,741	243,542	90,801	59%
PSA 07				
Contra Costa	188,186	345,629	157,443	84%
PSA 08				
San Mateo	136,115	236,624	100,509	74%

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PSA STATE/COUNTY	2010 60+ TOTAL POPULATION	2030 60+ TOTAL POPULATION	DIFFERENCE	% CHANGE
PSA 09				
Alameda	244,699	464,632	219,933	90%
PSA 10				
Santa Clara	277,700	553,409	275,709	99%
PSA 11				
San Joaquin	101,133	190,787	89,654	89%
PSA 12				
Alpine	293	603	310	106%
Amador	11,117	16,809	5,692	51%
Calaveras	13,706	22,041	8,335	61%
Mariposa	5,392	9,212	3,820	71%
Tuolumne	15,695	21,779	6,084	39%
TOTAL	**46,203**	**70,444**	**24,241**	**52%**
PSA 13				
San Benito	7,951	17,059	9,108	115%
Santa Cruz	45,170	81,193	36,023	80%
TOTAL	**53,121**	**98,252**	**45,131**	**85%**
PSA 14				
Fresno	131,780	237,916	106,136	81%
Madera	24,406	44,674	20,268	83%
TOTAL	**156,186**	**282,590**	**126,404**	**81%**
PSA 15				
Kings	17,526	32,382	14,856	85%
Tulare	59,553	107,026	47,473	80%
TOTAL	**77,079**	**139,408**	**62,329**	**81%**
PSA 16				
Inyo	4,871	7,369	2,498	51%
Mono	2,231	4,863	2,632	118%
TOTAL	**7,102**	**12,232**	**5,130**	**72%**
PSA 17				
San Luis Obispo	57,536	93,532	35,996	63%
Santa Barbara	73,902	111,912	38,010	51%
TOTAL	**131,438**	**205,444**	**74,006**	**56%**
PSA 18				
Ventura	137,376	243,119	105,743	77%
PSA 19				
Los Angeles	915,572	1,647,708	732,136	80%
PSA 20				
San Bernardino	265,699	550,488	284,789	107%
PSA 21				
Riverside	353,225	695,017	341,792	97%
PSA 22				
Orange	491,040	901,350	410,310	84%

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PSA STATE/COUNTY	2010 60+ TOTAL POPULATION	2030 60+ TOTAL POPULATION	DIFFERENCE	% CHANGE
PSA 23				
San Diego	494,327	883,061	388,734	79%
PSA 24				
Imperial	25,275	52,176	26,901	106%
PSA 25				
LA City	585,366	1,053,453	468,087	80%
PSA 26				
Lake	16,474	28,238	11,764	71%
Mendocino	20,581	27,508	6,927	34%
TOTAL	**37,055**	**55,746**	**18,691**	**50%**
PSA 27				
Sonoma	98,674	156,720	58,046	59%
PSA 28				
Napa	28,762	43,571	14,809	51%
Solano	69,582	131,324	61,742	89%
TOTAL	**98,344**	**174,895**	**76,551**	**78%**
PSA 29				
El Dorado	39,429	71,212	31,783	81%
PSA 30				
Stanislaus	77,543	142,096	64,553	83%
PSA 31				
Merced	33,937	63,986	30,049	89%
PSA 32				
Monterey	63,389	101,237	37,848	60%
PSA 33				
Kern	108,639	205,544	96,905	89%

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APPENDIX F

California Actual/Projected Population Age 85+ Percentage Change between 2010 and 2030 [By Planning and Service Area (PSA) and County][61]

PSA STATE/COUNTY	2010 85+ TOTAL POPULATION	2030 85+ TOTAL POPULATION	DIFFERENCE	% CHANGE
CALIFORNIA	**610,440**	**1,047,819**	**437,379**	**72%**
PSA 01				
Del Norte	464	1,074	610	131%
Humboldt	2,596	4,140	1,544	59%
TOTAL	**3,060**	**5,214**	**2,154**	**70%**
PSA 02				
Lassen	458	966	508	111%
Modoc	240	491	251	105%
Shasta	4,016	7,305	3,289	82%
Siskiyou	1,175	2,036	861	73%
Trinity	268	746	478	178%
TOTAL	**6,157**	**11,544**	**5,387**	**87%**
PSA 03				
Butte	5,707	7,655	1,948	34%
Colusa	368	662	294	80%
Glenn	516	964	448	87%
Plumas	434	1,150	716	165%
Tehama	1,198	2,504	1,306	109%
TOTAL	**8,223**	**12,935**	**4,712**	**57%**
PSA 04				
Nevada	2,815	5,026	2,211	79%
Placer	7,397	15,123	7,726	104%
Sacramento	23,321	37,841	14,520	62%
Sierra	79	177	98	124%
Sutter	1,550	3,091	1,541	99%
Yolo	3,037	5,371	2,334	77%
Yuba	791	1,845	1,054	133%
TOTAL	**38,990**	**68,474**	**29,484**	**76%**
PSA 05				
Marin	6,666	9,935	3,269	49%
PSA 06				
San Francisco	17,794	24,509	6,715	38%
PSA 07				
Contra Costa	19,631	32,599	12,968	66%
PSA 08				
San Mateo	15,545	23,525	7,980	51%

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PSA STATE/COUNTY	2010 85+ TOTAL POPULATION	2030 85+ TOTAL POPULATION	DIFFERENCE	% CHANGE
PSA 09				
Alameda	25,162	43,338	18,176	72%
PSA 10				
Santa Clara	28,039	51,772	23,733	85%
PSA 11				
San Joaquin	10,057	17,609	7,552	75%
PSA 12				
Alpine	7	110	103	1471%
Amador	1,024	1,856	832	81%
Calaveras	989	2,147	1,158	117%
Mariposa	402	996	594	148%
Tuolumne	1,502	2,232	730	49%
TOTAL	**3,924**	**7,341**	**3,417**	**87%**
PSA 13				
San Benito	732	1,514	782	107%
Santa Cruz	4,691	7,125	2,434	52%
TOTAL	**5,423**	**8,639**	**3,216**	**59%**
PSA 14				
Fresno	13,758	22,504	8,746	64%
Madera	1,967	4,820	2,853	145%
TOTAL	**15,725**	**27,324**	**11,599**	**74%**
PSA 15				
Kings	1,416	3,004	1,588	112%
Tulare	5,422	10,219	4,797	88%
TOTAL	**6,838**	**13,223**	**6,385**	**93%**
PSA 16				
Inyo	539	869	330	61%
Mono	89	456	367	412%
TOTAL	**628**	**1,325**	**697**	**111%**
PSA 17				
San Luis Obispo	6,411	8,785	2,374	37%
Santa Barbara	9,255	11,887	2,632	28%
TOTAL	**15,666**	**20,672**	**5,006**	**32%**
PSA 18				
Ventura	14,251	23,032	8,781	62%
PSA 19				
Los Angeles	93,993	159,062	65,069	69%
PSA 20				
San Bernardino	21,120	47,398	26,278	124%
PSA 21				
Riverside	32,776	66,655	33,879	103%
PSA 22				
Orange	50,335	86,846	36,511	73%

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PSA STATE/COUNTY	2010 85+ TOTAL POPULATION	2030 85+ TOTAL POPULATION	DIFFERENCE	% CHANGE
PSA 23				
San Diego	54,697	83,922	29,225	53%
PSA 24				
Imperial	2,079	5,819	3,740	180%
PSA 25				
Los Angeles, City of	60,094	101,695	41,601	69%
PSA 26				
Lake	1,408	2,266	858	61%
Mendocino	1,989	3,445	1,456	73%
TOTAL	**3,397**	**5,711**	**2,314**	**68%**
PSA 27				
Sonoma	11,301	15,320	4,019	36%
PSA 28				
Napa	3,538	4,833	1,295	37%
Solano	6,093	12,134	6,041	99%
TOTAL	**9,631**	**16,967**	**7,336**	**76%**
PSA 29				
El Dorado	3,187	6,676	3,489	109%
PSA 30				
Stanislaus	7,491	13,101	5,610	75%
PSA 31				
Merced	3,086	6,224	3,138	102%
PSA 32				
Monterey	6,887	10,234	3,347	49%
PSA 33				
Kern	8,587	19,178	10,591	123%

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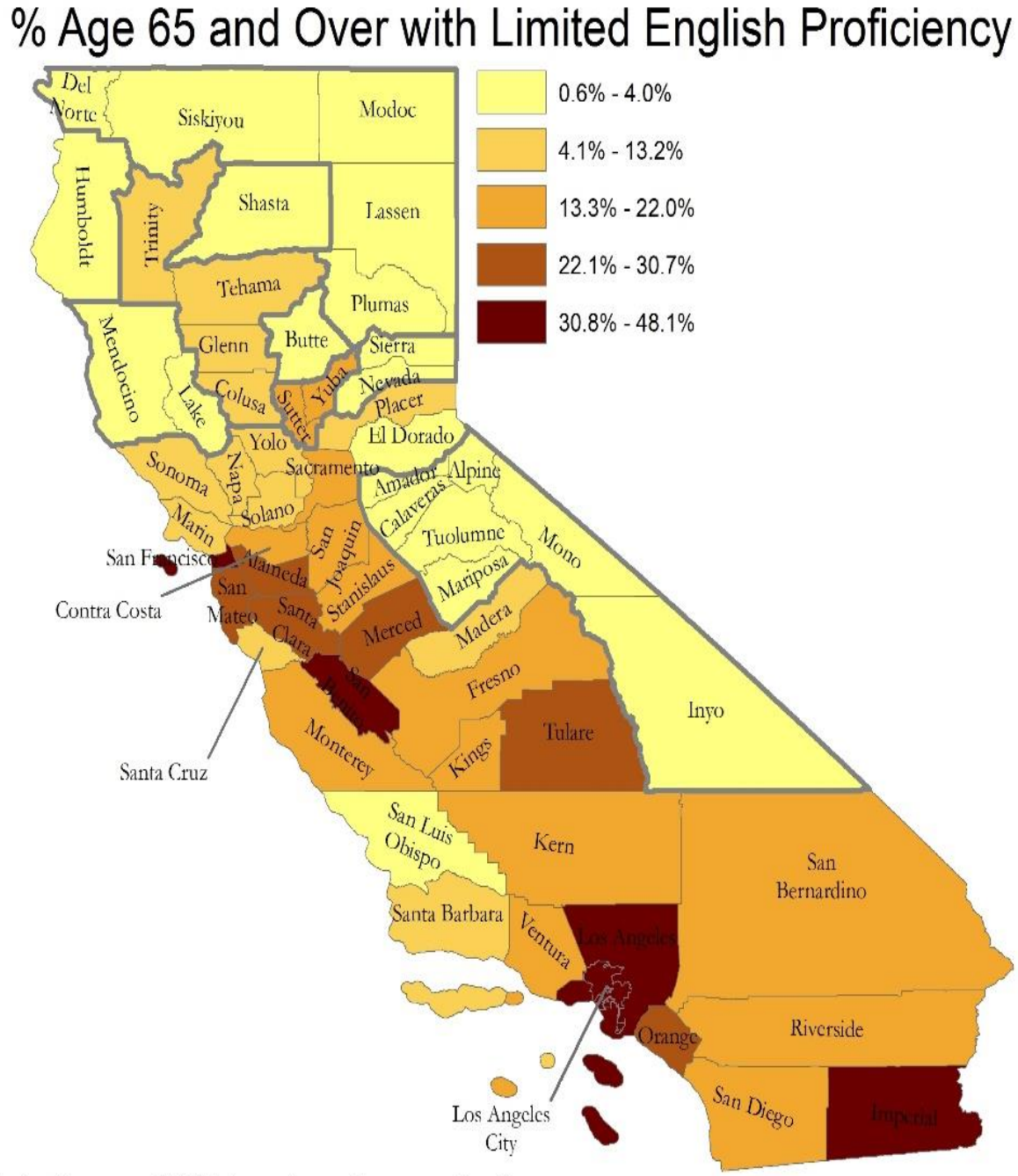
APPENDIX G

California's Projected Population Age 60+ as a Percent of Total Population Age 60+ (by Race and Ethnicity)[62]

Race/Ethnicity	2010	2030	2050
White/Non-Hispanic	60.8%	47.3%	35.3%
Hispanic/Latino	18.5%	28.7%	38.8%
Asian	13.5%	16.0%	18.1%
Black/African American	5.4%	5.5%	4.8%
American Indian/Alaskan Native	0.4%	0.5%	0.4%
Native Hawaiian/Other Pacific Islander	0.2%	0.3%	0.4%
Two or More Races	1.1%	1.6%	2.1%

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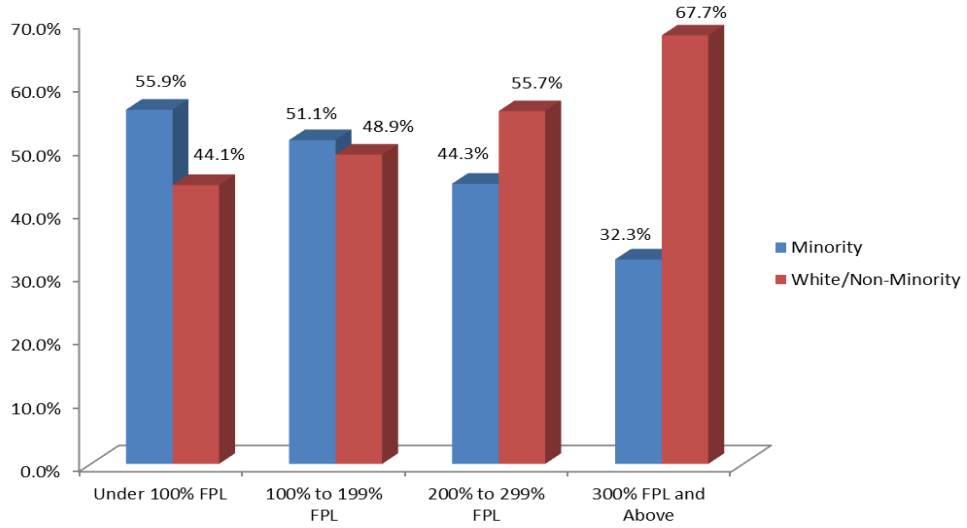
APPENDIX H [63]



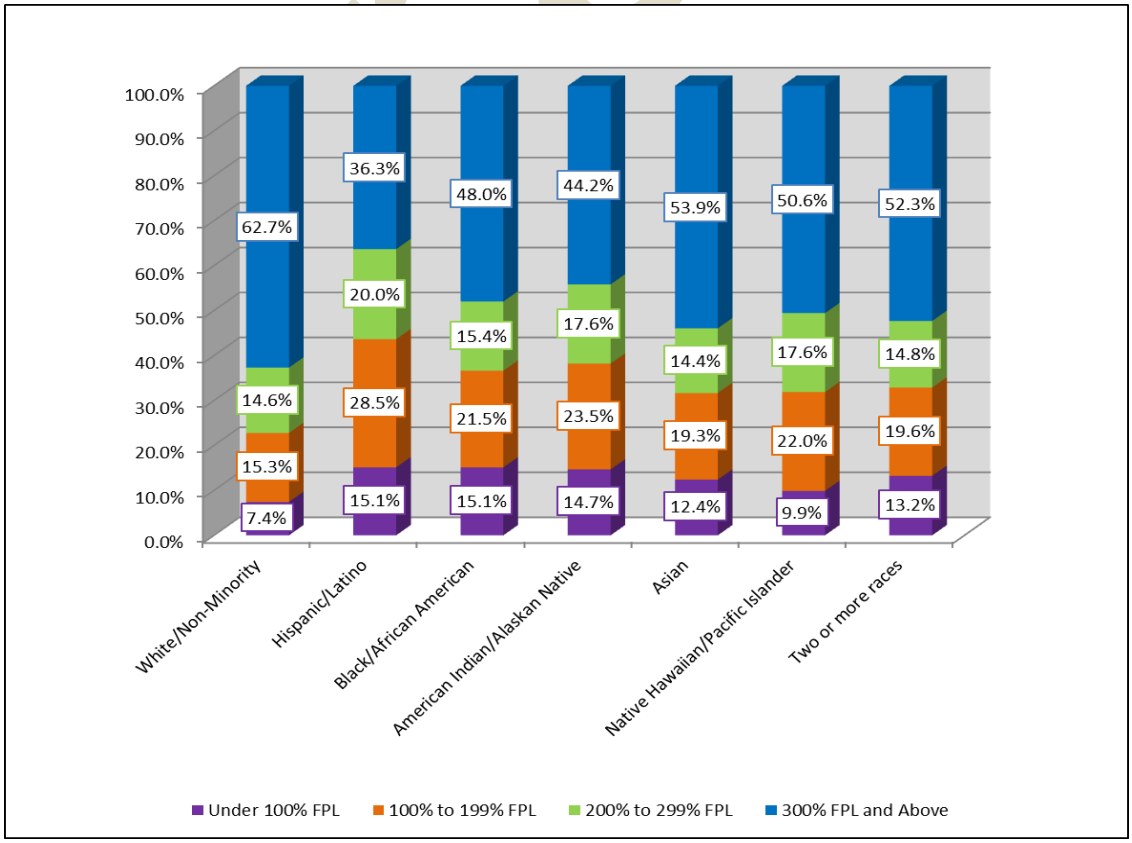
Data Source: 2015 American Community Survey
Note: Limited English Proficiency is defined as those who speak English well, not well, or not at all.
Note: Restricted to non-institutionalized population.

APPENDIX I

Poverty Level of Californians Age 60+ (By Minority/Non-Minority by FPL)[64] 2009-2013



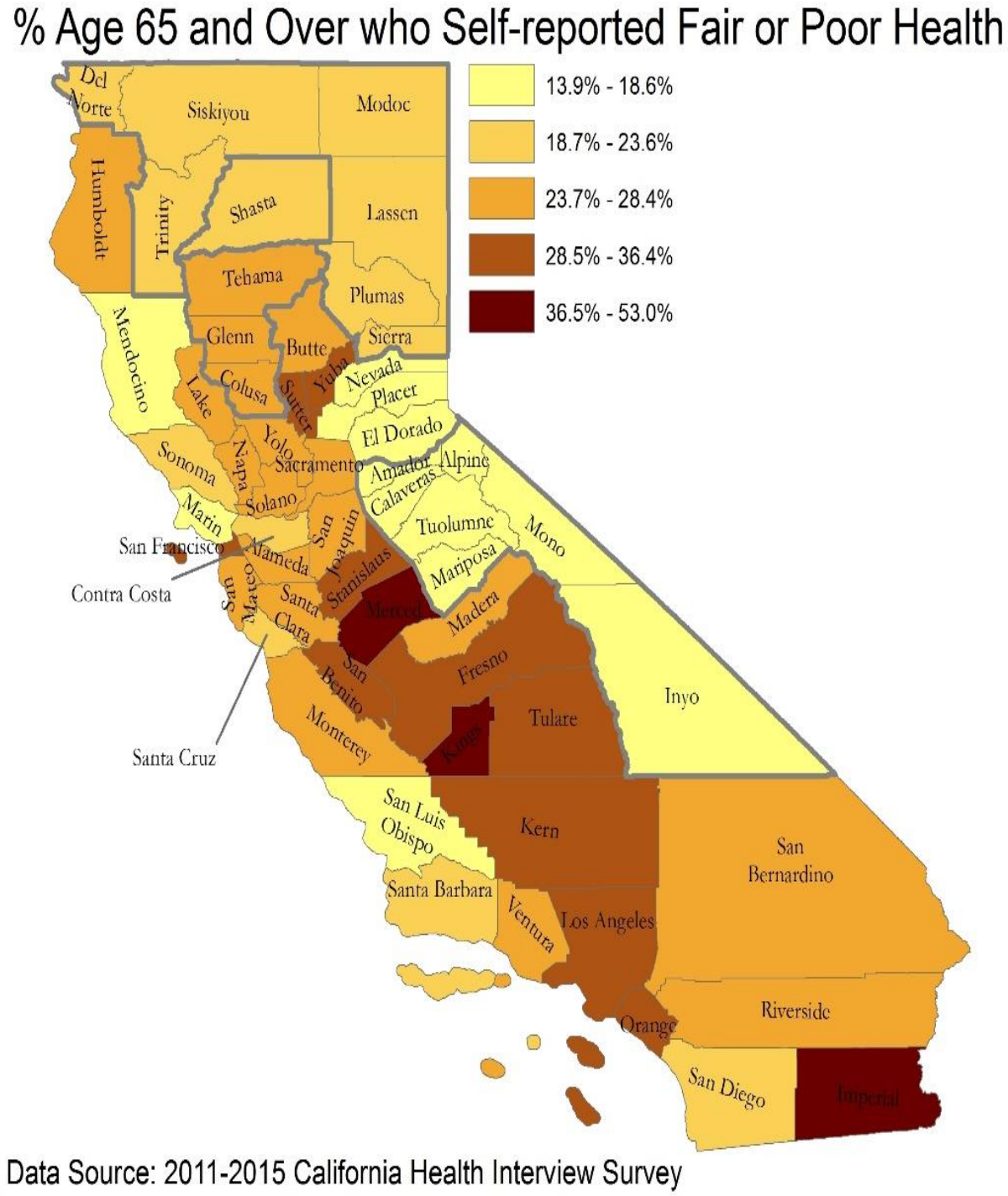
By Ethnicity by FPL



APPENDIX J
California's Health Report on Aging for Individuals 65 +[65]

	Health Indicator	Year data collected	% of adults 65+
	Health Status		
1.	General health status fair to poor	2014	24.0
2.	Frequent mental distress	2013	9.2
3.	Oral health: Lost 5 or fewer teeth	2014	70.0
4.	Disability	2014	38.8
	Health Behaviors		
5.	No leisure-time physical activity within past month	2014	26.2
6.	Eats 2 or more fruits daily	2013	54.5
	Eats 3 or more vegetables daily	2013	30.0
7.	Obesity	2014	24.1
8.	Current smoker	2014	8.0
	Preventive Care & Screenings		
9.	Flu vaccine in past year	2014	58.2
10.	At risk adults (have diabetes, asthma, cardiovascular disease or currently smoke) who ever had a pneumococcal vaccine	2014	70.0
12.	Ever had colorectal cancer screening	2014	79.1
13.	Up-to-date on select preventive services - men	2014	38.5
14.	Up-to-date on select preventive services - women	2014	41.6
15.	Cholesterol screening within the past 5 years	2013	94.4

APPENDIX K[66]



APPENDIX L

2015 California Elder Economic Security Index[67]

Basic Living Costs for Single Older Adult, Owner, No Mortgage

PSA	County	Housing	Food	Health Care	Transportation	Miscellaneous	Monthly Total	Annual Total
01	Del Norte	$257	$262	$431	$228	$236	$1,414	$16,968
	Humboldt	$215	$262	$431	$228	$227	$1,363	$16,356
02	Lassen	$261	$262	$431	$228	$236	$1,418	$17,016
	Modoc	$233	$262	$431	$228	$231	$1,385	$16,620
	Shasta	$246	$262	$431	$228	$233	$1,400	$16,800
	Siskiyou	$263	$262	$431	$228	$237	$1,421	$17,052
	Trinity	$207	$262	$431	$228	$226	$1,354	$16,248
03	Butte	$266	$262	$431	$228	$237	$1,424	$17,088
	Colusa	$224	$262	$431	$228	$229	$1,374	$16,488
	Glenn	$226	$262	$431	$228	$229	$1,376	$16,512
	Plumas	$284	$262	$431	$228	$241	$1,446	$17,352
	Tehama	$193	$262	$431	$228	$223	$1,337	$16,044
04	Nevada	$295	$305	$431	$228	$252	$1,511	$18,132
	Placer	$321	$292	$247	$228	$217	$1,305	$15,660
	Sacramento	$276	$292	$247	$228	$209	$1,252	$15,024
	Sierra	$235	$262	$431	$228	$231	$1,387	$16,644
	Sutter	$250	$262	$431	$228	$234	$1,405	$16,860
	Yolo	$306	$292	$247	$228	$214	$1,287	$15,444
	Yuba	$221	$262	$431	$228	$228	$1,370	$16,440
05	Marin	$424	$262	$256	$228	$234	$1,404	$16,848
06	San Francisco	$296	$318	$239	$228	$216	$1,297	$15,564
07	Contra Costa	$355	$313	$246	$228	$228	$1,370	$16,440
08	San Mateo	$372	$318	$256	$228	$235	$1,409	$16,908
09	Alameda	$320	$313	$239	$228	$220	$1,320	$15,840
10	Santa Clara	$352	$286	$235	$228	$220	$1,321	$15,852
11	San Joaquin	$271	$285	$233	$228	$203	$1,220	$14,640
12	Alpine	$267	$262	$431	$228	$238	$1,426	$17,112
	Amador	$275	$262	$431	$228	$239	$1,435	$17,220
	Calaveras	$293	$262	$431	$228	$243	$1,457	$17,484
	Mariposa	$228	$262	$431	$228	$230	$1,379	$16,548
	Tuolumne	$305	$262	$431	$228	$245	$1,471	$17,652
13	San Benito	$264	$262	$431	$228	$237	$1,422	$17,064
	Santa Cruz	$346	$262	$431	$228	$253	$1,520	$18,240
14	Fresno	$260	$263	$239	$228	$198	$1,188	$14,256
	Madera	$284	$262	$239	$228	$203	$1,216	$14,592
15	Kings	$216	$262	$431	$228	$227	$1,364	$16,368
	Tulare	$222	$262	$431	$228	$229	$1,372	$16,464
16	Inyo	$278	$262	$431	$228	$240	$1,439	$17,268
	Mono	$315	$262	$431	$228	$247	$1,483	$17,796
17	San Luis Obispo	$290	$262	$454	$228	$247	$1,481	$17,772
	Santa Barbara	$332	$262	$454	$228	$255	$1,531	$18,372
18	Ventura	$309	$262	$162	$228	$192	$1,153	$13,836
19	Los Angeles County	$283	$269	$162	$228	$188	$1,130	$13,560
20	San Bernardino	$252	$278	$162	$228	$184	$1,104	$13,248
21	Riverside	$302	$278	$162	$228	$194	$1,164	$13,968
22	Orange	$332	$272	$162	$228	$199	$1,193	$14,316
23	San Diego	$307	$271	$162	$228	$194	$1,162	$13,944
24	Imperial	$204	$262	$474	$228	$234	$1,402	$16,824
25	Los Angeles City	$358	$269	$162	$228	$204	$1,221	$14,652
26	Lake	$271	$262	$454	$228	$243	$1,458	$17,496
	Mendocino	$307	$262	$431	$228	$245	$1,473	$17,676
27	Sonoma	$312	$262	$247	$228	$210	$1,259	$15,108
28	Napa	$371	$262	$239	$228	$220	$1,320	$15,840
	Solano	$258	$262	$245	$228	$199	$1,192	$14,304
29	El Dorado	$347	$262	$247	$228	$217	$1,301	$15,612
30	Stanislaus	$270	$262	$234	$228	$199	$1,193	$14,316
31	Merced	$232	$262	$431	$228	$231	$1,384	$16,608
32	Monterey	$318	$262	$431	$228	$248	$1,487	$17,844
33	Kern	$246	$268	$184	$228	$185	$1,111	$13,332
	California Average	**$300**	**$270**	**$342**	**$228**	**$228**	**$1,368**	**$16,416**

Elder Index is Adults Age 65 and over.

Health Care is actual costs for someone in good health.

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2015 California Elder Economic Security Index

Basic Living Costs for Older Couple, Owner, No Mortgage

PSA	County	Housing	Food	Health Care	Transportation	Miscellaneous	Monthly Total	Annual Total
01	Del Norte	$257	$486	$861	$320	$385	$2,309	$27,708
	Humboldt	$215	$486	$861	$320	$376	$2,258	$27,096
02	Lassen	$261	$486	$861	$320	$386	$2,314	$27,768
	Modoc	$233	$486	$861	$320	$380	$2,280	$27,360
	Shasta	$246	$486	$861	$320	$382	$2,295	$27,540
	Siskiyou	$263	$486	$861	$320	$386	$2,316	$27,792
	Trinity	$207	$486	$861	$320	$375	$2,249	$26,988
03	Butte	$266	$486	$861	$320	$386	$2,319	$27,828
	Colusa	$224	$486	$861	$320	$378	$2,269	$27,228
	Glenn	$226	$486	$861	$320	$378	$2,271	$27,252
	Plumas	$284	$486	$861	$320	$390	$2,341	$28,092
	Tehama	$193	$486	$861	$320	$372	$2,232	$26,784
04	Nevada	$295	$565	$861	$320	$408	$2,449	$29,388
	Placer	$321	$542	$493	$320	$335	$2,011	$24,132
	Sacramento	$276	$542	$493	$320	$326	$1,957	$23,484
	Sierra	$235	$486	$861	$320	$380	$2,282	$27,384
	Sutter	$250	$486	$861	$320	$383	$2,300	$27,600
	Yolo	$306	$542	$493	$320	$332	$1,993	$23,916
	Yuba	$221	$486	$861	$320	$378	$2,266	$27,192
05	Marin	$424	$486	$513	$320	$348	$2,091	$25,092
06	San Francisco	$296	$590	$478	$320	$337	$2,021	$24,252
07	Contra Costa	$355	$581	$491	$320	$349	$2,096	$25,152
08	San Mateo	$372	$590	$513	$320	$359	$2,154	$25,848
09	Alameda	$320	$581	$478	$320	$340	$2,039	$24,468
10	Santa Clara	$352	$530	$470	$320	$334	$2,006	$24,072
11	San Joaquin	$271	$529	$466	$320	$317	$1,903	$22,836
12	Alpine	$267	$486	$861	$320	$387	$2,321	$27,852
	Amador	$275	$486	$861	$320	$388	$2,330	$27,960
	Calaveras	$293	$486	$861	$320	$392	$2,352	$28,224
	Mariposa	$228	$486	$861	$320	$379	$2,274	$27,288
	Tuolumne	$305	$486	$861	$320	$394	$2,366	$28,392
13	San Benito	$264	$486	$861	$320	$386	$2,317	$27,804
	Santa Cruz	$346	$486	$861	$320	$403	$2,416	$28,992
14	Fresno	$260	$489	$478	$320	$309	$1,856	$22,272
	Madera	$284	$486	$478	$320	$313	$1,881	$22,572
15	Kings	$216	$486	$861	$320	$377	$2,260	$27,120
	Tulare	$222	$486	$861	$320	$378	$2,267	$27,204
16	Inyo	$278	$486	$861	$320	$389	$2,334	$28,008
	Mono	$315	$486	$861	$320	$396	$2,378	$28,536
17	San Luis Obispo	$290	$486	$907	$320	$401	$2,404	$28,848
	Santa Barbara	$332	$486	$907	$320	$409	$2,454	$29,448
18	Ventura	$309	$486	$324	$320	$288	$1,727	$20,724
19	Los Angeles County	$283	$499	$324	$320	$285	$1,711	$20,532
20	San Bernardino	$252	$515	$324	$320	$282	$1,693	$20,316
21	Riverside	$302	$515	$324	$320	$292	$1,753	$21,036
22	Orange	$332	$506	$324	$320	$296	$1,778	$21,336
23	San Diego	$307	$503	$324	$320	$291	$1,745	$20,940
24	Imperial	$204	$486	$949	$320	$392	$2,351	$28,212
25	Los Angeles City	$358	$499	$324	$320	$300	$1,801	$21,612
26	Lake	$271	$486	$907	$320	$397	$2,381	$28,572
	Mendocino	$307	$486	$861	$320	$395	$2,369	$28,428
27	Sonoma	$312	$486	$493	$320	$322	$1,933	$23,196
28	Napa	$371	$486	$478	$320	$331	$1,986	$23,832
	Solano	$258	$486	$489	$320	$311	$1,864	$22,368
29	El Dorado	$347	$486	$493	$320	$329	$1,975	$23,700
30	Stanislaus	$270	$486	$468	$320	$309	$1,853	$22,236
31	Merced	$232	$486	$861	$320	$380	$2,279	$27,348
32	Monterey	$318	$486	$861	$320	$397	$2,382	$28,584
33	Kern	$246	$497	$367	$320	$286	$1,716	$20,592
	California Average	**$300**	**$500**	**$685**	**$320**	**$361**	**$2,166**	**$25,992**

Elder Index is Adults Age 65 and over.

Health Care is actual costs for someone in good health.

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2015 California Elder Economic Security Index

Basic Living Costs for Single Older Adult, Owner with a Mortgage

PSA	County	Housing	Food	Health Care	Transportation	Miscellaneous	Monthly Total	Annual Total
01	Del Norte	$705	$262	$431	$228	$236	$1,862	$22,344
	Humboldt	$829	$262	$431	$228	$227	$1,977	$23,724
02	Lassen	$756	$262	$431	$228	$236	$1,913	$22,956
	Modoc	$498	$262	$431	$228	$231	$1,650	$19,800
	Shasta	$793	$262	$431	$228	$233	$1,947	$23,364
	Siskiyou	$658	$262	$431	$228	$237	$1,816	$21,792
	Trinity	$930	$262	$431	$228	$226	$2,077	$24,924
03	Butte	$705	$262	$431	$228	$237	$1,863	$22,356
	Colusa	$925	$262	$431	$228	$229	$2,075	$24,900
	Glenn	$882	$262	$431	$228	$229	$2,032	$24,384
	Plumas	$776	$262	$431	$228	$241	$1,938	$23,256
	Tehama	$828	$262	$431	$228	$223	$1,972	$23,664
04	Nevada	$984	$305	$431	$228	$252	$2,200	$26,400
	Placer	$1,100	$292	$247	$228	$217	$2,084	$25,008
	Sacramento	$897	$292	$247	$228	$209	$1,873	$22,476
	Sierra	$672	$262	$431	$228	$231	$1,824	$21,888
	Sutter	$916	$262	$431	$228	$234	$2,071	$24,852
	Yolo	$1,049	$292	$247	$228	$214	$2,030	$24,360
	Yuba	$914	$262	$431	$228	$228	$2,063	$24,756
05	Marin	$1,487	$262	$256	$228	$234	$2,467	$29,604
06	San Francisco	$1,640	$318	$239	$228	$216	$2,641	$31,692
07	Contra Costa	$1,218	$313	$246	$228	$228	$2,233	$26,796
08	San Mateo	$1,428	$318	$256	$228	$235	$2,465	$29,580
09	Alameda	$1,236	$313	$239	$228	$220	$2,236	$26,832
10	Santa Clara	$1,315	$286	$235	$228	$220	$2,284	$27,408
11	San Joaquin	$877	$285	$233	$228	$203	$1,826	$21,912
12	Alpine	$1,233	$262	$431	$228	$238	$2,392	$28,704
	Amador	$1,017	$262	$431	$228	$239	$2,177	$26,124
	Calaveras	$993	$262	$431	$228	$243	$2,157	$25,884
	Mariposa	$922	$262	$431	$228	$230	$2,073	$24,876
	Tuolumne	$917	$262	$431	$228	$245	$2,083	$24,996
13	Santa Cruz	$1,195	$262	$431	$228	$253	$2,369	$28,428
	San Benito	$1,175	$262	$431	$228	$237	$2,333	$27,996
14	Fresno	$839	$263	$239	$228	$198	$1,767	$21,204
	Madera	$947	$262	$239	$228	$203	$1,879	$22,548
15	Kings	$931	$262	$431	$228	$227	$2,079	$24,948
	Tulare	$750	$262	$431	$228	$229	$1,900	$22,800
16	Inyo	$1,009	$262	$431	$228	$240	$2,170	$26,040
	Mono	$1,157	$262	$431	$228	$247	$2,325	$27,900
17	San Luis Obispo	$1,034	$262	$454	$228	$247	$2,225	$26,700
	Santa Barbara	$1,144	$262	$454	$228	$255	$2,343	$28,116
18	Ventura	$1,150	$262	$162	$228	$192	$1,994	$23,928
19	Los Angeles County	$1,111	$269	$162	$228	$188	$1,958	$23,496
20	San Bernardino	$887	$278	$162	$228	$184	$1,739	$20,868
21	Riverside	$959	$278	$162	$228	$194	$1,821	$21,852
22	Orange	$1,224	$272	$162	$228	$199	$2,085	$25,020
23	San Diego	$1,221	$271	$162	$228	$194	$2,076	$24,912
24	Imperial	$808	$262	$474	$228	$234	$2,006	$24,072
25	Los Angeles City	$1,304	$269	$162	$228	$204	$2,167	$26,004
26	Lake	$796	$262	$454	$228	$243	$1,983	$23,796
	Mendocino	$936	$262	$431	$228	$245	$2,102	$25,224
27	Sonoma	$1,127	$262	$247	$228	$210	$2,074	$24,888
28	Napa	$1,091	$262	$239	$228	$220	$2,040	$24,480
	Solano	$1,031	$262	$245	$228	$199	$1,965	$23,580
29	El Dorado	$1,078	$262	$247	$228	$217	$2,032	$24,384
30	Stanislaus	$839	$262	$234	$228	$199	$1,762	$21,144
31	Merced	$803	$262	$431	$228	$231	$1,955	$23,460
32	Monterey	$1,215	$262	$431	$228	$248	$2,384	$28,608
33	Kern	$751	$268	$184	$228	$185	$1,616	$19,392
	California Average	**$1,090**	**$270**	**$342**	**$228**	**$228**	**$2,158**	**$25,896**

Elder Index is Adults Age 65 and over.

Health Care is actual costs for someone in good health.

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2015 California Elder Economic Security Index

Basic Living Costs for Older Couple, Owner with a Mortgage

PSA	County	Housing	Food	Health Care	Transportation	Miscellaneous	Monthly Total	Annual Total
01	Del Norte	$705	$486	$861	$320	$385	$2,757	$33,084
	Humboldt	$829	$486	$861	$320	$376	$2,872	$34,464
02	Lassen	$756	$486	$861	$320	$386	$2,809	$33,708
	Modoc	$498	$486	$861	$320	$380	$2,545	$30,540
	Shasta	$793	$486	$861	$320	$382	$2,842	$34,104
	Siskiyou	$658	$486	$861	$320	$386	$2,711	$32,532
	Trinity	$930	$486	$861	$320	$375	$2,972	$35,664
03	Butte	$705	$486	$861	$320	$386	$2,758	$33,096
	Colusa	$925	$486	$861	$320	$378	$2,970	$35,640
	Glenn	$882	$486	$861	$320	$378	$2,927	$35,124
	Plumas	$776	$486	$861	$320	$390	$2,833	$33,996
	Tehama	$828	$486	$861	$320	$372	$2,867	$34,404
04	Nevada	$984	$565	$861	$320	$408	$3,138	$37,656
	Placer	$1,100	$542	$493	$320	$335	$2,790	$33,480
	Sacramento	$897	$542	$493	$320	$326	$2,578	$30,936
	Sierra	$672	$486	$861	$320	$380	$2,719	$32,628
	Sutter	$916	$486	$861	$320	$383	$2,966	$35,592
	Yolo	$1,049	$542	$493	$320	$332	$2,736	$32,832
	Yuba	$914	$486	$861	$320	$378	$2,959	$35,508
05	Marin	$1,487	$486	$513	$320	$348	$3,154	$37,848
06	San Francisco	$1,640	$590	$478	$320	$337	$3,365	$40,380
07	Contra Costa	$1,218	$581	$491	$320	$349	$2,959	$35,508
08	San Mateo	$1,428	$590	$513	$320	$359	$3,210	$38,520
09	Alameda	$1,236	$581	$478	$320	$340	$2,955	$35,460
10	Santa Clara	$1,315	$530	$470	$320	$334	$2,969	$35,628
11	San Joaquin	$877	$529	$466	$320	$317	$2,509	$30,108
12	Alpine	$1,233	$486	$861	$320	$387	$3,287	$39,444
	Amador	$1,017	$486	$861	$320	$388	$3,072	$36,864
	Calaveras	$993	$486	$861	$320	$392	$3,052	$36,624
	Mariposa	$922	$486	$861	$320	$379	$2,968	$35,616
	Tuolumne	$917	$486	$861	$320	$394	$2,978	$35,736
13	San Benito	$1,175	$486	$861	$320	$386	$3,228	$38,736
	Santa Cruz	$1,195	$486	$861	$320	$403	$3,265	$39,180
14	Fresno	$839	$489	$478	$320	$309	$2,435	$29,220
	Madera	$947	$486	$478	$320	$313	$2,544	$30,528
15	Kings	$931	$486	$861	$320	$377	$2,975	$35,700
	Tulare	$750	$486	$861	$320	$378	$2,795	$33,540
16	Inyo	$1,009	$486	$861	$320	$389	$3,065	$36,780
	Mono	$1,157	$486	$861	$320	$396	$3,220	$38,640
17	San Luis Obispo	$1,034	$486	$907	$320	$401	$3,148	$37,776
	Santa Barbara	$1,144	$486	$907	$320	$409	$3,266	$39,192
18	Ventura	$1,150	$486	$324	$320	$288	$2,568	$30,816
19	Los Angeles County	$1,111	$499	$324	$320	$285	$2,539	$30,468
20	San Bernardino	$887	$515	$324	$320	$282	$2,328	$27,936
21	Riverside	$959	$515	$324	$320	$292	$2,410	$28,920
22	Orange	$1,224	$506	$324	$320	$296	$2,670	$32,040
23	San Diego	$1,221	$503	$324	$320	$291	$2,659	$31,908
24	Imperial	$808	$486	$949	$320	$392	$2,955	$35,460
25	Los Angeles City	$1,304	$499	$324	$320	$300	$2,747	$32,964
26	Lake	$796	$486	$907	$320	$397	$2,906	$34,872
	Mendocino	$936	$486	$861	$320	$395	$2,998	$35,976
27	Sonoma	$1,127	$486	$493	$320	$322	$2,748	$32,976
28	Napa	$1,091	$486	$478	$320	$331	$2,706	$32,472
	Solano	$1,031	$486	$489	$320	$311	$2,637	$31,644
29	El Dorado	$1,078	$486	$493	$320	$329	$2,706	$32,472
30	Stanislaus	$839	$486	$468	$320	$309	$2,422	$29,064
31	Merced	$803	$486	$861	$320	$380	$2,850	$34,200
32	Monterey	$1,215	$486	$861	$320	$397	$3,279	$39,348
33	Kern	$751	$497	$367	$320	$286	$2,221	$26,652
	California Average	**$1,090**	**$500**	**$685**	**$320**	**$361**	**$2,956**	**$35,472**

Elder Index is Adults Age 65 and over.

Health Care is actual costs for someone in good health.

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2015 California Elder Economic Security Index

Basic Living Costs for Single Older Adult, Renter

PSA	County	Housing	Food	Health Care	Transportation	Miscellaneous	Monthly Total	Annual Total
01	Del Norte	$651	$262	$431	$228	$236	$1,808	$21,696
	Humboldt	$738	$262	$431	$228	$227	$1,886	$22,632
02	Lassen	$730	$262	$431	$228	$236	$1,887	$22,644
	Modoc	$552	$262	$431	$228	$231	$1,704	$20,448
	Shasta	$765	$262	$431	$228	$233	$1,919	$23,028
	Siskiyou	$643	$262	$431	$228	$237	$1,801	$21,612
	Trinity	$635	$262	$431	$228	$226	$1,782	$21,384
03	Butte	$678	$262	$431	$228	$237	$1,836	$22,032
	Colusa	$598	$262	$431	$228	$229	$1,748	$20,976
	Glenn	$604	$262	$431	$228	$229	$1,754	$21,048
	Plumas	$698	$262	$431	$228	$241	$1,860	$22,320
	Tehama	$623	$262	$431	$228	$223	$1,767	$21,204
04	Nevada	$889	$305	$431	$228	$252	$2,105	$25,260
	Placer	$865	$292	$247	$228	$217	$1,849	$22,188
	Sacramento	$865	$292	$247	$228	$209	$1,841	$22,092
	Sierra	$692	$262	$431	$228	$231	$1,844	$22,128
	Sutter	$658	$262	$431	$228	$234	$1,813	$21,756
	Yolo	$837	$292	$247	$228	$214	$1,818	$21,816
	Yuba	$658	$262	$431	$228	$228	$1,807	$21,684
05	Marin	$1,582	$262	$256	$228	$234	$2,562	$30,744
06	San Francisco	$1,582	$318	$239	$228	$216	$2,583	$30,996
07	Contra Costa	$1,235	$313	$246	$228	$228	$2,250	$27,000
08	San Mateo	$1,582	$318	$256	$228	$235	$2,619	$31,428
09	Alameda	$1,235	$313	$239	$228	$220	$2,235	$26,820
10	Santa Clara	$1,365	$286	$235	$228	$220	$2,334	$28,008
11	San Joaquin	$753	$285	$233	$228	$203	$1,702	$20,424
12	Alpine	$672	$262	$431	$228	$238	$1,831	$21,972
	Amador	$793	$262	$431	$228	$239	$1,953	$23,436
	Calaveras	$745	$262	$431	$228	$243	$1,909	$22,908
	Mariposa	$621	$262	$431	$228	$230	$1,772	$21,264
	Tuolumne	$738	$262	$431	$228	$245	$1,904	$22,848
13	San Benito	$927	$262	$431	$228	$237	$2,085	$25,020
	Santa Cruz	$1,254	$262	$431	$228	$253	$2,428	$29,136
14	Fresno	$697	$263	$239	$228	$198	$1,625	$19,500
	Madera	$642	$262	$239	$228	$203	$1,574	$18,888
15	Kings	$628	$262	$431	$228	$227	$1,776	$21,312
	Tulare	$604	$262	$431	$228	$229	$1,754	$21,048
16	Inyo	$780	$262	$431	$228	$240	$1,941	$23,292
	Mono	$1,043	$262	$431	$228	$247	$2,211	$26,532
17	San Luis Obispo	$973	$262	$454	$228	$247	$2,164	$25,968
	Santa Barbara	$1,192	$262	$454	$228	$255	$2,391	$28,692
18	Ventura	$1,160	$262	$162	$228	$192	$2,004	$24,048
19	Los Angeles County	$1,130	$269	$162	$228	$188	$1,977	$23,724
20	San Bernardino	$917	$278	$162	$228	$184	$1,769	$21,228
21	Riverside	$917	$278	$162	$228	$194	$1,779	$21,348
22	Orange	$1,337	$272	$162	$228	$199	$2,198	$26,376
23	San Diego	$1,082	$271	$162	$228	$194	$1,937	$23,244
24	Imperial	$634	$262	$474	$228	$234	$1,832	$21,984
25	Los Angeles City	$1,130	$269	$162	$228	$204	$1,993	$23,916
26	Lake	$663	$262	$454	$228	$243	$1,850	$22,200
	Mendocino	$796	$262	$431	$228	$245	$1,962	$23,544
27	Sonoma	$1,038	$262	$247	$228	$210	$1,985	$23,820
28	Napa	$1,085	$262	$239	$228	$220	$2,034	$24,408
	Solano	$970	$262	$245	$228	$199	$1,904	$22,848
29	El Dorado	$865	$262	$247	$228	$217	$1,819	$21,828
30	Stanislaus	$744	$262	$234	$228	$199	$1,667	$20,004
31	Merced	$608	$262	$431	$228	$231	$1,760	$21,120
32	Monterey	$1,010	$262	$431	$228	$248	$2,179	$26,148
33	Kern	$644	$268	$184	$228	$185	$1,509	$18,108
	California Average	**$877**	**$270**	**$342**	**$228**	**$228**	**$1,945**	**$23,340**

Elder Index is Adults Age 65 and over.

Health Care is actual costs for someone in good health.

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2015 California Elder Economic Security Index

Basic Living Costs for Older Couple, Renter

PSA	County	Housing	Food	Health Care	Transportation	Miscellaneous	Monthly Total	Annual Total
01	Del Norte	$651	$486	$861	$320	$385	$2,703	$32,436
	Humboldt	$738	$486	$861	$320	$376	$2,781	$33,372
02	Lassen	$730	$486	$861	$320	$386	$2,783	$33,396
	Modoc	$552	$486	$861	$320	$380	$2,599	$31,188
	Shasta	$765	$486	$861	$320	$382	$2,814	$33,768
	Siskiyou	$643	$486	$861	$320	$386	$2,696	$32,352
	Trinity	$635	$486	$861	$320	$375	$2,677	$32,124
03	Butte	$678	$486	$861	$320	$386	$2,731	$32,772
	Colusa	$598	$486	$861	$320	$378	$2,643	$31,716
	Glenn	$604	$486	$861	$320	$378	$2,649	$31,788
	Plumas	$698	$486	$861	$320	$390	$2,755	$33,060
	Tehama	$623	$486	$861	$320	$372	$2,662	$31,944
04	Nevada	$889	$565	$861	$320	$408	$3,043	$36,516
	Placer	$865	$542	$493	$320	$335	$2,555	$30,660
	Sacramento	$865	$542	$493	$320	$326	$2,546	$30,552
	Sierra	$692	$486	$861	$320	$380	$2,739	$32,868
	Sutter	$658	$486	$861	$320	$383	$2,708	$32,496
	Yolo	$837	$542	$493	$320	$332	$2,524	$30,288
	Yuba	$658	$486	$861	$320	$378	$2,703	$32,436
05	Marin	$1,582	$486	$513	$320	$348	$3,249	$38,988
06	San Francisco	$1,582	$590	$478	$320	$337	$3,307	$39,684
07	Contra Costa	$1,235	$581	$491	$320	$349	$2,976	$35,712
08	San Mateo	$1,582	$590	$513	$320	$359	$3,364	$40,368
09	Alameda	$1,235	$581	$478	$320	$340	$2,954	$35,448
10	Santa Clara	$1,365	$530	$470	$320	$334	$3,019	$36,228
11	San Joaquin	$753	$529	$466	$320	$317	$2,385	$28,620
12	Alpine	$672	$486	$861	$320	$387	$2,726	$32,712
	Amador	$793	$486	$861	$320	$388	$2,848	$34,176
	Calaveras	$745	$486	$861	$320	$392	$2,804	$33,648
	Mariposa	$621	$486	$861	$320	$379	$2,667	$32,004
	Tuolumne	$738	$486	$861	$320	$394	$2,799	$33,588
13	San Benito	$927	$486	$861	$320	$386	$2,980	$35,760
	Santa Cruz	$1,254	$486	$861	$320	$403	$3,324	$39,888
14	Fresno	$697	$489	$478	$320	$309	$2,293	$27,516
	Madera	$642	$486	$478	$320	$313	$2,239	$26,868
15	Kings	$628	$486	$861	$320	$377	$2,672	$32,064
	Tulare	$604	$486	$861	$320	$378	$2,649	$31,788
16	Inyo	$780	$486	$861	$320	$389	$2,836	$34,032
	Mono	$1,043	$486	$861	$320	$396	$3,106	$37,272
17	San Luis Obispo	$973	$486	$907	$320	$401	$3,087	$37,044
	Santa Barbara	$1,192	$486	$907	$320	$409	$3,314	$39,768
18	Ventura	$1,160	$486	$324	$320	$288	$2,578	$30,936
19	Los Angeles County	$1,130	$499	$324	$320	$285	$2,558	$30,696
20	San Bernardino	$917	$515	$324	$320	$282	$2,358	$28,296
21	Riverside	$917	$515	$324	$320	$292	$2,368	$28,416
22	Orange	$1,337	$506	$324	$320	$296	$2,783	$33,396
23	San Diego	$1,082	$503	$324	$320	$291	$2,520	$30,240
24	Imperial	$634	$486	$949	$320	$392	$2,781	$33,372
25	Los Angeles City	$1,130	$499	$324	$320	$300	$2,573	$30,876
26	Lake	$663	$486	$907	$320	$397	$2,773	$33,276
	Mendocino	$796	$486	$861	$320	$395	$2,858	$34,296
27	Sonoma	$1,038	$486	$493	$320	$322	$2,659	$31,908
28	Napa	$1,085	$486	$478	$320	$331	$2,700	$32,400
	Solano	$970	$486	$489	$320	$311	$2,576	$30,912
29	El Dorado	$865	$486	$493	$320	$329	$2,493	$29,916
30	Stanislaus	$744	$486	$468	$320	$309	$2,327	$27,924
31	Merced	$608	$486	$861	$320	$380	$2,655	$31,860
32	Monterey	$1,010	$486	$861	$320	$397	$3,074	$36,888
33	Kern	$644	$497	$367	$320	$286	$2,114	$25,368
	California Average	**$877**	**$500**	**$685**	**$320**	**$361**	**$2,743**	**$32,916**

Elder Index is Adults Age 65 and over.

Health Care is actual costs for someone in good health.

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