CWDA
Advancing Human Services
for the Welfare of *All* Californians

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Dr. Mark Ghaly, Secretary
California Health and Human Services Agency
1600 9th Street, Suite 460
Sacramento, CA 95814

Kim McCoy Wade, Director
California Department of Aging
1300 National Drive, Suite 200
Sacramento, CA 95834

RE: Master Plan on Aging Recommendations

Dear Dr. Ghaly and Director McCoy WAde:

As you know, county human services agencies administer multiple programs serving older adults and persons with disabilities. As the organization representing the county human services agencies who are at the forefront of serving California's growing aging population, the County Welfare Directors Association (CWDA) hereby submits our recommendations for the Master Plan for Aging. CWDA is inspired by the Administration's leadership in initiating this process and engaging a diverse group of stakeholders in an ambitious effort to identify opportunities to strengthen services for older adults, their families, and caregivers.

CWDA strongly supports the vision and values identified by the Master Plan for Aging Advisory Committee in its work to adopt recommendations. These values embrace a person-centered approach to promote consumer choice, equity, inclusion, dignity and accessibility; support innovation and evidence-informed practice; and encourage partnerships among federal, state, and local agencies including philanthropy and private sections. County human services agencies, including the social workers and many other county staff, strive on a daily basis to deliver services in alignment with these core values.

In finalizing the Master Plan on Aging, we urge consideration and prioritization of a number of immediate action steps and investments that can be taken to address increased demand for services already experienced by local agencies. Specifically, in the short term, an investment in the Adult Protective Services (APS) Program is necessary to serve older adults with more complex needs, including persons who are homeless and/or have serious cognitive impairments who come to the attention of the APS system. This, and other short-term action steps, should be coordinated with

CalAIM and Homelessness Council efforts to address an aging homeless population.

We recommend taking other action steps in the near future to increase collaboration across existing programs and establish an integrated Aging and Adult Services System within county human services agencies. These include:

- Place the administration of Area Agencies on Aging (AAA) under the county human services agency to better align AAA services with other county programs and create a full continuum of services, while increasing funding for AAA services.
- Establish a "no wrong door" approach to services through a statewide expansion of the Aging and Disability Resource Connections (ADRCs). We propose unifying ADRCs with county human service agency services in a more intentional way. Where possible, we recommend administering ADRCs within the county human services agency, while recognizing that Independent Living Centers (ILCs) are core partners in administration of ADRCS. This would streamline access to a broad range of services and county programs, including In-Home Supportive Services (IHSS) and APS.
- In partnership with county affiliate associations (CSAC, CBHDA and the CA PA/PG/PC Association), consider options and benefits for consolidating the administration of local Public Administrators/Guardians/Conservators (PA/PG/PC) within county human service agencies to improve services to older adults with diminished capacity to make decisions due to cognitive impairments and severe mental illness. This must be accompanied by an increase in funding for the program. We also suggest consideration of placing oversight of the program withing the California Department of Social Services (CDSS).
- Adopt a data-driven and stakeholder informed Outcomes and Accountability process to improve performance and outcomes across programs serving older adults.
- Prioritize building a full continuum of housing options that can meet the needs of older adults, including but not limited to supportive housing such as board and care homes.
- Address workforce needs in key programs administering services through the use of social workers who are often overburdened. Grow and increase supports to the in-home caregiver workforce.

Within the In-Home Supportive Services (IHSS) Program, notwithstanding the Governor's Executive Order to address growth and sustainability of the program, we urge the Administration to recognize its value as an important prevention program to institutionalization, poverty, abuse and neglect. In our recommendations, CWDA has identified opportunities to improve the program while maintaining its core value as a consumer-directed entitlement program. Although initial recommendations of the larger Master Plan group are due by March 2020, we encourage that all recommendations be vetted with the broader stakeholder community.

As CWDA continues to engage in further conversations on these issues and discuss our recommendations with other key organizations, we welcome any input and questions. Attached to this letter we provide more in-depth discussion of the recommendations listed here.

We look forward to continued collaboration with your agencies as well as all stakeholders in developing the Master Plan on Aging, and hope that our recommendations can provide a basis for a re-envisioned county-based Aging and Adults services System that leverages and builds upon existing programs and partnerships while lifting up innovative ideas and best practices that will ultimately result in a easily accessible continuum of services that allows older adults and persons with disabilities to live with dignity.

Sincerely,

Frank J. Mecca
CWDA Executive Director

cc: Kim Johnson, Director, California Department of Social Services

Attachments

CWDA Aging Master Plan Recommendations

I. BACKROUND

Counties, specifically county human services agencies, administer multiple programs serving older adults and persons with disabilities, and for this reason, play a critical role in addressing the expected needs resulting from the dramatic growth in California's aging population. We are pleased to have this opportunity to participate in the Master Plan for Aging efforts to share county human services agencies' vision for building upon the excellent programs currently serving older adults. Our recommendations acknowledge and embrace the vision and values set forth by the Aging Master Plan Advisory Committee, while also identifying opportunities to improve coordination of care, build seamless access to services, and improve upon existing, effective programs.

County human service agencies operate the State's largest Long-Term Services System (LTSS) Program – the In-Home Supportive Services Program (IHSS). IHSS is a key, foundational strategy to reducing the use of institutional care and hospitalizations, which are more costly to individuals, taxpayers and society. By providing timely, hands-on personal care and assistance with activities of daily living, IHSS ensures that individuals are assisted in their homes and communities. IHSS is also a key strategy to meeting the requirements of the Olmstead Decision that reaffirms federal law to support individuals with disabilities in receiving supports and services necessary to remain in their homes and communities.

County human services agencies are also on the frontlines protecting older and dependent adults from abuse, neglect and exploitation through the Adult Protective Services (APS) Program. The trauma of such abuse, once inflicted, can be devastating for older adults. In addition, recovery from abuse is often more difficult for older and dependent adults with complex medical, physical and cognitive issues. Reports to APS -- from law enforcement, doctors, financial institutions, and other mandated reporters and the community -- have steadily increased since the program was created, commensurate to the growing aging population, and will only continue to rise as the state experiences profound growth in its aging and disabled populations. It is imperative that this important safety net program is prepared to meet these demands to protect victims and address their needs.

County human services agencies also administer multiple safety net programs that older adults and persons with disabilities rely upon. All county human services agencies administer CalFresh and Medi-Cal eligibility, two key programs for providing nutritional support and critical access to health care services. The recent expansion of CalFresh to persons receiving Supplemental Security Income (SSI) is an important opportunity to increase food security for this population. And California is currently in process of renewing its Medicaid 1115 and 1915(b) waivers through the CalAIM 2020 initiative, which will increase opportunities for collaboration between county agencies and the managed care systems to support the physical, mental health and substance use disorder issues facing low-income Californians, including older adults.

Many counties operate broad health and human services agencies that directly administer programs such as County Behavioral Health Services, Veterans Services, Public Health, Public Guardians/Conservators/Administrators and Area Agencies on Aging. Counties who do not have these programs under their direct control have close working relationships with the administrators of these programs in order to better meet the needs of the millions of Californians served through county agencies.

Given the increasing concerns of California's housing crisis and lack of affordable housing for our most vulnerable populations, counties are also leading efforts, through partnerships with State agencies, to increase availability of, and access to, affordable housing. County health and human services agencies directly administer housing assistance to individuals and families served by the county agency, including the Housing and Disability Advocacy Program (HDAP, in 39 counties) and the new APS Home Safe Program (in 25 counties). These efforts require intense collaboration and partnership with local housing Continuums of Care, including federal Housing and Urban Development (HUD) agencies.

County agencies partner with community-based agencies through informal and formal means (e.g., contracts) to meet the needs of older adults and persons with disabilities. No single agency can serve all needs, and close working relationships with community-based providers allow services to be more readily available and accessible. This includes partnerships with community agencies serving a broad spectrum of children, youth, families and older adults, including Family Resource Centers, Kinship Caregiver Centers, local Food Banks, Child Care Resource and Referral agencies, and many others.

Lastly, and importantly, aging is a life-long process. Healthy aging requires attention to the social determinants of health across the lifespan. This means ensuring that Californians are economically secure, have access to quality health care, reliable transportation, nutritious food, and safe housing, and that they are socially and emotionally connected to persons who genuinely care for their well-being and are engaged in activities that promote their physical and mental health. County agencies and their diligent staff are working daily to meet these needs for younger generations through our child abuse prevention and intervention programs and through the General Assistance and CalWORKs Programs, the latter of which provides child care, housing, and substance abuse, mental health and employment services to low-income families. County human services agencies are suited to providing wraparound care through a social services lens, while collaborating with health care systems to meet individuals' physical and behavioral health needs.

As such, counties are well-positioned to assist and support the growing population of older adults and persons with disabilities through a re-envisioned, county-based Aging and Older Adults Services System that leverages and builds upon existing programs and partnerships.

II. CWDA SPECIFIC RECOMMENDATIONS

Outcomes and Accountability

Meeting the needs of a growing aging population requires increased accountability to achieving desired outcomes. California's Aging Master Plan should adopt, as a foundational element, a robust outcomes and accountability system that is data-driven and informed by the experiences of stakeholders including those receiving services. We recommend consideration of the framework developed for the Child Welfare Outcomes and Accountability System (also referred to as Child and Family Services Reviews, or CFSR) as one such model. This model includes (1) data-driven performance and outcome measures (2) peer-quality case reviews (3) stakeholder interviews and (4) a self-assessment and system improvement plan with the goal of continuous quality improvement targeted upon areas of need identified by each county in partnership with its community.

As with CFSR, local assessments and system improvements for a more robust Aging and Adult Services System should be overseen by local Boards of Supervisors, and ultimately by the California Department of Social Services (CDSS). CDSS has extensive experience of working with counties to improve performance and outcomes, through the Child Welfare and IHSS programs, and soon through implementation of the California CalWORKs Outcomes and Accountability Review (Cal-OAR) process. Given that many programs that would come under the Aging and Older Adults Services System are also under the purview of the California Department of Health Care Services (DHCS) and California Department of Aging (CDA), we recommend consideration of an agreement across the state agencies to specify the terms and conditions that would enable CDSS to serve as lead agency for the outcomes and accountability process, in partnership with other state agencies.

Importantly, data on performance and outcomes should be transparent and accessible to the public and policy makers in a manner that is easily understood. The measures should be identified through a stakeholder-driven input process. Again, the CWS Outcomes and Accountability System can serve as a model.

Through the outcomes and accountability System, the State can also set expectations for coordination of care and services on behalf of older adults with across service providers, including but not limited to county human service agencies behavioral health agencies, managed care plans, Regional Centers, Independent Living Centers, Veteran's Services, and others as deemed appropriate.

County Aging and Adult Services – System of Care

We recommend that the majority of services for older adults be consolidated within each county human services agency to create an expanded County Aging and Adult Services System. This consolidation is intended to support integration and create more seamless access to a continuum of services for older adults seeking assistance and services. County Aging and Adult Services could serve as the central "hub" for accessing a broad array of local LTSS services, including but not limited to IHSS, APS, and services currently administered through Area Agencies on Aging (AAAs). This would entail the following changes:

1. **Expand AAA services and integrate those services into the Aging and Adult Services System.** AAAs administer many primary prevention and early intervention services to older adults, either directly or indirectly through contracts with local providers. These services, such as home-delivered meals, Senior Companions Programs, and Adult Day/Respite, are critical to preventing or delaying the need for more intensive, and costly, care and interventions for older adults. For this reason, it is critical that the AAA-administered programs are integrated with an Aging and Adult Services System of offer a full continuum of services, from primary prevention to intensive long-term care and support. AAAs operate in all 58 counties through 33 Planning and Service Areas (PSAs), with some like Los Angeles that have two AAA programs (a city and county AAA), and some such as Sacramento AAA, which operates as a single program serves multiple counties.

   AAA programs and services are a highly valued, vital component of the continuum of services for older adults, their families and caregivers. However, the AAA programs and services are not always aligned with county-operated older adult services. For the 19 AAAs that operate under a county umbrella, those counties typically report a higher level of service coordination and more opportunities to leverage other funding sources, including county funds, to improve services to older adults. For this reason, CWDA recommends that a governance structure for all AAAs shift to operate under the umbrella of the county human service agency. This would entail potentially expanding the number of PSAs to align with county boundaries, with options for smaller or more rural counties to operate through joint management agreements.

   By shifting the governance for all AAAs, county human service agencies would also assume responsibility for local plan development. Currently, AAAs are required to submit an Area Plan, typically every four years, that reflects future activities of the AAA to best serve the needs identified by older adults, adults with disabilities, and caregivers in their designated PSAs. Shifting responsibility to the County would promote increased coordination with county aging programs (IHSS, APS and others), leverage efforts with the proposed Outcomes and Accountability System noted in Recommendation 1 above, and align disaster response planning, which is currently a responsibility of the County and its local departments but also a function of the AAA.

Together, these changes would enable counties to tailor services to meet the unique needs of their county residents, allow leveraging of the county's infrastructure and existing resources, and encourage investments of county resources to better meet the needs of older adults and persons with disabilities. This also creates improved connection to the broader County local planning process for transportation, housing and other infrastructure and services to better meet the needs of older adults and persons with disabilities.

Additional Considerations:

- Even with the AAA governance structure embedded within the County Adult Services System, counties would continue to have the ability, and are likely, to administer Older Americans Act Programs and services through contracts with local community agencies and providers.
- Additional investment of State General Funds would be necessary to "hold harmless" local services and supports as the services and administration are spread to additional counties and providers.
- Many of the services administered by AAAs are underfunded yet are critical in preventing the onset of more serious, debilitating conditions, and therefore additional investments should be considered.

2. Grow the Aging and Disability Resource Connection (ADRC) Program statewide.

Stakeholders in the Aging Master Planning process have expressed broad support for improving access to a continuum of services for older adults, their family members and caregivers through a statewide information and assistance (aka "no wrong door") approach. ADRCs fill this need and are a best practice that should be expanded statewide. ADRCs are also an important prevention strategy, offering options counseling and short–term support for care transitions to avoid more costly institutional care or hospitalization.

Our recommendation is to expand the ADRC model statewide and, where possible, to house the ADRCs within the county human services agency. Given that the ADRCs are administered in partnership with Independent Living Centers and local Area Agencies on Aging, with oversight by the CA Department of Aging (CDA), we recognize that further conversation will be necessary to determine how best to unify and leverage these existing partnerships and expand this effective model.

We believe that by more intentionally unifying ADRCs with county human service agency infrastructures, persons seeking assistance can access a broader array of services to meet their needs. For example, best practices in San Francisco and San Diego Counties demonstrate the benefits of leveraging ADRC services with the APS 24/7 response system, IHSS Intake, and other county–based services. As of October 2019, California has nine State–designated ADRCs serving Alameda, Marin, Nevada, Orange, Placer, Riverside, San Diego, San Francisco, and Ventura counties. With the recent passage of SB 453 (Statutes of 2019), and contingent on adequate funding, California has an important opportunity to promote an ADRC model that embraces best practices and true integration of services, with staff

who are trained across disciplines. This can serve as the central point of entry to the LTSS system and services that support basic needs for housing, food, and other essential needs that support healthy aging.

Additional Considerations:

- If the State (i.e. CDA) also implements a State–level information and referral hotline, the State and county agencies can coordinate "warm hand–offs" similar to what is currently being developed under the Family Urgent Response System for foster children and families. CWDA was a sponsor of the legislation in 2019 that led to the Family Urgent Response system and can offer valuable insight in terms of linking state–level and county–level hotlines.

- The State (i.e. CDA, CDSS) can play a role in establishing statewide standards for ADRC so that information and services are aligned statewide, while allowing for customization in services based on local service capacity. This can include standardized training of staff who can identify potential needs for prevention and safety net programs including APS, IHSS, AAAs, and other services.

- Special consideration may be needed for rural counties to better leverage scarce lcoal resources, such as implementing regional ADRCs through a Joint Powers Agreement (JPA).

3. Common Intake and Screening Tool/Universal Assessment. To promote a "no wrong door" approach while ensuring some standardization across agencies, we recommend use of a universal intake tool to collect baseline information through the ADRC. The intake should include a brief screen that allows just enough information to track requests for services and supports, with the "deeper dive" left to other programs and services to collect additional information through their assessments. This tool should be developed through a stakeholder–driven process.

   After the initial intake process is complete and a referral made to appropriate services, we recommend consideration of a bio–psycho–social strengths and needs assessment tailored to older adults, such as the Adult Strengths and Needs Assessment (ANSA) by the Praed Foundation, or other similar tools used by other states, for use a the local level by county staff and other local agencies serving older adults. The ANSA or an ANSA–like tool should be customized for California's older adult population to assess older adults, and their caregivers, in a more holistic way of their strengths and areas of need, which can allow programs to better tailor services to a more directly and effectively address areas of unmet need. Additionally, the tool can be used to share information across older adult services agencies, track improvements or declines in strengths and needs of older adults, support better service planning, and track performance and outcomes over time that inform the overarching outcomes and accountability system.

Additional Considerations:

- A "Universal Assessment Tool" was attempted several years ago with the goal of collecting information and establishing eligibility across multiple programs. Based on several meetings, the tool became lengthy and potentially cumbersome to administer. We recommend shifting to a universal intake and screening tool with a limited amount of questions and information collected through the ADRC (or by other agencies, who can then share such tool with the ADRC as appropriate). The primary goal should be to quickly identify and prioritize the support needs for the individual, while also allowing some basic information to be collected for use in the outcomes and accountability system.

- The Aging Master Plan should consider how information collected by various agencies can be shared across these agencies, and how to facilitate information sharing, referral, and "warm hand offs" with other programs. This would help facilitate a "no wrong door" approach. This can be achieved through information–sharing agreements across agencies, data exchanges, and streamlining the application processes across programs. Such an effort should be led by the California Department of Social Services, working in collaboration with other relevant state agencies.

- Note that the State will need to assist local agencies in facilitating the ability for such information exchanges, through options such as Memorandums of Understanding across state and county agencies and providers and clarifying the application of laws including HIPPA.

- The State would also need to determine how automation can facilitate information sharing and data exchanges. Data exchanges may need to be developed across local agencies, and between local agencies and the State for the proposed Outcomes and Accountability System.

4. Coordination with Key Service Providers including Managed Care. CWDA is also part of the current California Advancing and Innovating Medi–Cal (CalAIM) initiative by DHCS to improve the quality of life and health outcomes of persons served by the Medi–Cal Program. CalAIM goals align with the Aging Master Plan in many ways, including its effort to identify and manage member risk through Whole Person Care approaches and addressing the social determinants of health, creating a more consistent and seamless system of care by reducing complexity and increasing flexibility, and improving quality outcomes. The CalAIM seeks to achieve these goals through maximizing opportunities through managed care organizations (MCOs) as well as changes in the payment and delivery systems operated by county behavioral health agencies.

   According to DHCS, more than 80 percent of Medi–Cal beneficiaries are served through the managed care system. Under the CalAIM proposal, MCOs will receive value–based, capitated payments intended to allow flexibility in service planning and delivery to achieve desired outcomes, including and increased focus on preventative and wellness services, identifying and mitigating social determinants of health and reducing health disparities. For

this reason, we believe it is critical for social services and health service agencies to partner and collaborate in a more deliberate way to serve the children, youth and families in our programs.

To this end, CWDA recommends that all county human service agencies and managed care organizations (MCOs) have memorandums of understanding (MOUs) in place for data/information sharing and service coordination for the consumers jointly served by our programs. Such agreements would help to address the social services needs of individuals and align with meeting the physical and behavioral health care needs of older adults and persons with disabilities, which are largely delivered by managed care plans. The MOUs should specifically address multi-disciplinary team participation, and the ability to share health records between the MCO and county social services systems. The MOUs should also include a component of community outreach and engagement, coordinated between MCOs and county social service agencies, to connect individuals to the broader array of services and supports.

To facilitate these MOUs, we recommend that the State develop a master agreement for adoption by counties and MCO that includes a set of expectations for working collaboratively (similar to agreements between MCOs and county behavioral health plans).

5. **Strengthen Role of Public Authorities (PA).** Public Authorities currently perform a number of critical activities in support of the IHSS Program to enable older adults and their caregivers to remain in least restrictive settings. We recommend the Aging Master Plan strengthen PAs' capacity to recruit in-home providers for IHSS and other in-home caregivers, by increasing and expanding caregiver training to cover additional topics, delivered through multiple avenues (in-home, classroom-based, and virtual), in coordination with the County Adult Services System. Training would be tailored to the needs of the consumer.

   Public authorities, in collaboration with county IHSS, should also establish emergency back-up systems of in-home providers across the state for when a caregiver is ill, on leave, or in other emergencies not only for the IHSS Program but for other older adults and persons with disabilities not on the IHSS Program. A handful of counties have emergency backup systems but these are not currently mandated. As noted in the IHSS Listening Sessions, caregivers are critically needed and difficult to find for consumers with more complex needs who are not utilizing relative caregivers.

6. **Consider aligning the governance of Public Administrators/ Guardians/Conservators (PA/PG/PCs) within the county human service agency.** The PA/PG/PC plays a critical role in the overall LTSS structure by protecting adults with diminished capacity and assuming decision-making for critical activities of daily living. County APS Programs rely on their County PA/PG/PC to meet state mandates in serving older and dependent adults who are abused, neglected or exploited. County PA/PG/PC also serves a growing number of homeless adults and adults with severe mental impairments, working with county

behavioral health agencies and law enforcement, providing life-saving interventions and making critical decisions in daily living for conserved individuals. Currently, the PA/PG/PCs are under-funded for the growing demands of an aging population, including a growing number of homeless adults.

In order to meet the exponential growth in the aging population, CWDA recommends that the Aging Master Plan give consideration to (1) moving the PA/PG/PC administration to the county human service agency in all counties, with potential exceptions as determined by local Boards of Supervisors based on local needs, (2) increasing State General Fund investment in PA/PG/PCs to address increased demands on the program, and (3) shifting oversight of the PA/PG/PC Program to CDSS.

APS and the PG often work together to protect older adults and persons with disabilities from abuse, neglect and exploitation. Shifting governance under a county social services system could also increase access to other services including housing, food/nutrition, in-home care, and other important social determinants of health. Locally, the PA/PG/PC program may be housed in a single department or split between agencies. In the majority of counties, some combination of the PA/PG/PC function is embedded in 41 human service agencies, with some functions split to various other agencies in 21 counties (ex. behavioral health, health departments, treasurer/tax collector, district attorney, or as a stand alone department). We believe that housing this program locally in the county human service agency, with oversight and guidance from a single state agency (CDSS), can improve service coordination and outcomes for persons with diminished cognitive capacity who currently come to the attention of APS. Being sure to maintain (and ideally, expand) the staff expertise already housed in the PA/PG/PC entities would be an important consideration in this move.

CWDA encourages the Master Plan for Aging to consider the important role of the PA/PG/PC in the continuum of services for aging and adults with disabilities, and we welcome further discussion and consideration of this specific proposal with our county partner agencies, including CSAC, CBHDA and the CA PA/PG/PC Association.

7. **Build upon the successful IHSS Program to better meet the needs of those served.** The IHSS Program is an essential component of California's LTSS system. Currently the program supports approximately 608,000 persons who are aged, blind, and disabled to live in their homes and communities. IHSS consumers retain full control as the employer of their care providers and are responsible for hiring, firing and directing their care providers. IHSS is an important prevention program and should be embraced as a model to build upon. IHSS enables individuals with disabilities to remain in their homes and communities and reduces the likelihood of costly hospitalization and institutional care. IHSS helps persons with mental illness maintain a quality of life, including those at risk of homelessness. It allows persons with disabilities to retain employment and contribute to our local economies. The IHSS Program makes it possible for thousands of Californians to live with dignity, lead productive lives, continue to make their own choices, and to maintain a quality of life they would not

have without such services.

IHSS is also an employment program, with approximately 494,000 providers who receive varying amounts of wages, benefits and training depending upon the county in which they reside. Public Authorities serve as the employer of record for collective bargaining while the state retains responsibility for payroll and taxes. However, the role of the county as employer-of-record has been increasingly tenuous over the last few years due to a number of court rulings that have found counties increasingly responsible for various aspects of employment of IHSS workers.

The IHSS Program began in the 1950s to support family members and friends who provided care mostly to aging seniors. Since then, the program has evolved and expanded to meet the more complex needs of a broader population, including children with developmental disabilities, persons with mental illness, and severely disabled adult populations with service needs that are outside of the scope of IHSS. IHSS now serves a much more diverse population of consumers and care providers have varying degrees of knowledge, experience and abilities to meet the needs of this population. The IHSS Listening Sessions, hosted by the California Department of Aging as part of its Aging Master Plan development, illustrated the challenges in serving a diverse population, and the need to address concerns shared by IHSS consumers, their family members, caregivers, and the broader stakeholder community.

CWDA acknowledges that the Governor's Executive Order specifically requires that the Aging Master Plan/Long-Term Care Subcommittee address the growth and sustainability of state long-term care programs and infrastructure, including IHSS. This includes consideration of issues around access, financing, quality, the labor supply and retention of workforce. We believe that improvements to the program are necessary to better meet the needs of consumers and support caregivers, and that this can be accomplished in ways that will both meet the Governor's objectives to sustain the program while retaining the entitlement-based, person-centered, and consumer-driven nature of the program. By identifying needs in a more holistic way, and tailoring services to individual needs up-front during the assessment process, this can reduce costs in the long run. However, we caution against making dramatic changes in a rushed manner, and urge the Administration to engage all stakeholders, including the county agencies that administer the program on behalf of the State, in a thoughtful process to determine how best to implement any changes while maintaining the core values of the program.

In recognition of the concerns raised through the IHSS Listening Sessions, and to strengthen the effectiveness of IHSS services and prepare for the expected growth in both the aging and disabled populations, we recommend the following IHSS program enhancements:

Simplify the functional assessment and incorporate an assessment of other aspects critical to the consumer's safety and well-being, including the ability to remain safely in their own home, with improved linkage to other services.

Consumers, family members and providers expressed concerns at the IHSS Listening Sessions regarding assessments, including concerns on the variability of assessments from county–to–county, from year–to–year, and worker–to–worker. Social workers follow a state–required process known as the Hourly Task Guidelines (HTGs) to perform assessments. This process was developed pursuant to legislation passed in 2004 and intended to reduce variability in the assessment process. Yet, the HTG remains a complex tool and process ——— difficult for social workers to administer. As a result, hours may be assessed differently across counties even when using the same tool. For consumers and providers, the process may not be easily understood and may lead to frustration over how need is assessed.

To address these concerns, we recommend a new, and simplified, functional assessment process to assess for functional needs. A new tool is also necessary to assess for other critical activities that support healthy aging, such as transportation to community–based services, assistance with reading medications or bills, more comprehensive medication management, etc. Such a tool can be developed based on lessons learned in California through a stakeholder–driven process, with consideration of tools used in other states. A simplified functional assessment then allows for a more holistic look of the consumers (and their care providers), which can be accomplished through the use of a broader assessment tool such as the ANSA or similar tools as mentioned above, with subsequent connections made to other services that can support the individual and their providers.

a) **Simplify the service allotment process for consumers and providers to give consumers greater flexibility in directing their care.** The complexity of the assessment process can result in variation in authorized service hours which understandably is frustrating and concerning for consumers and their caregivers. This is due to the fact that hours can be increased or decreased above or below the Hourly Task Guidelines based on relative need of the consumer.

   To align with our recommendation for a new assessment process, we also recommend simplifying the allotment of hours so that it is more intuitive to consumers and providers and allows a greater degree of flexibility to meet consumer's needs. Some of our ideas, which could be discussed and fleshed out via a stakeholder process, include:

   - Allot hours along four categories of services such as: domestic and related services, personal care, protective supervision, and paramedical services.

   - Protective supervision for persons with cognitive disabilities (i.e. dementia, Alzheimer's disease) and/or mental health needs can be authorized based on a physician's certification of need without an additional assessment for functional need (although the ANSA and other tools should still be used to identify other potential needs). The IHSS Listening Sessions suggested a need to simplify re–assessment for person with cognitive disabilities and "presumptive eligibility" when needs have not changed from year to year, which we also support.

- Domestic and related services can also be authorized at six hours per month (the current maximum rate) and provided to all recipients other than parents of minors, given that nearly 100% of IHSS adult consumers now qualify for this benefit.

- Personal care services could be rolled up into a single authorization/allotment of hours based on an average functional ranking for each functional area, and used flexibly across service areas based on the consumer's needs.[1]

- A "special care allotment" of service hours could also be provided, in addition to existing services, based on the outcome of the more holistic assessment, if the individual is relying upon his/her personal caregiver to support other areas of need, such as transportation assistance to community–based supports, etc., to maintain the consumer's health and well–being and prevent declines in health and cognition.

b) **Tailor assessments and case management services to better meet the needs of consumers and providers, based on the complexity of their circumstances.** For some consumers who are able to act as their own employer or who live within a family system that appropriately cares for consumers, the existing IHSS Program is meeting most of their needs. Case management for those individuals may only require an annual check–in from an IHSS social worker and a basic assessment for services and to ensure safety of the consumer. For others, a more focused set of services is needed.

- Create an **IHSS–Minors Program for children**, with the goal of support families in the care of their children, ensuring the safety of children and promoting independence as the child ages into adulthood. Children receiving IHSS typically have complex needs and received services from multiple systems, including Regional Centers, Special Education, and the California Children's Services (CCS). Yet, social workers often feel they lack the information they need to conduct an accurate assessment of the child's needs. The IHSS–Minors Program should incorporate a team–based approach to serving families with partners that include Regional Centers, local education agencies, CCS and health care providers, plus county behavioral health if the child has potential behavioral health care needs. This should be accompanied by either a mandate or state guidance, to increase information sharing across these agencies to improve assessments, services and outcomes.

[1] Functional areas to include: mobility inside, bathing and grooming, dressing, bowel, bladder and menstrual care, transfer, eating and respiration.

- Establish an IHSS–Enhanced Program for individuals with mental health needs and severe impairments who need more direct assistance with care management, including money management, provider recruitment and support, etc. This would be targeted to individuals who are physically or mentally unable or unwilling to perform the duties of directing their own personal care or acting as an employer, who may be isolated due to lack of a support system, or whose in–home provider may also face challenges in serving this consumer either due to their own unmet needs. Under this model, consumers would receive more frequent contact from IHSS social workers, who would lead a team (including regional centers, behavioral health, physical health and others) to stabilize and support the consumer.

  The IHSS–Enhanced Program should also include the ability for the county to designate an authorized representative (in–house or through contract) to assume responsibilities of hiring, scheduling, and directing services as needed, coordinating with providers of physical and behavioral health services, and securing other community–based services including respite care, transportation, etc. To implement this provision, consideration should be given to adopting the "Cash and Counseling" Option under the Medicaid Program.

- We further recommend discussion and consideration of the benefits of consolidating the IHSS–Enhanced Program with the Multipurpose Senior Services Programs (MSSP) into a single program operating through the county human service agency, as this has worked well in the counties that operate under such a model.

c) **Address Provider Workforce Capacity.** The IHSS Listening Sessions also highlighted the difficulty in recruiting providers to serve consumers with higher acuity of needs, the need for respite and emergency back up care, training that varies based on consumers' care needs, and inadequate wages and benefits particularly for providers who are caring for consumers with complex needs. We also heard frustration from providers, particularly parent providers, concerning the paperwork requirements when enrolling to care for children. To this end, CWDA recommends consideration of the following:

  - Consider options for providing a rate supplement and establishing an individualized, cpnsumer–driven training plan for providers who are serving individuals under our proposed IHSS–Enhanced Program. Such training should be coordinated and delivered through the Public Authority.

  - Ensure all providers have access to adequate health care and behavioral health services, as well as sick leave, as their own health and well–being is equally important to their consumer's health and well–being.

  - Provide counties with the tools and ability to address quality of care issues

before they become a health and safety concern that rises to the level of APS attention, through increased support of caregivers, increased case management, training plans, or other non–punitive tools and resources.

- Streamline the provider enrollment process and requirements particularly for providers who are directly related to their consumer.

- Consider options to improve the Advance Pay option for consumers with multiple providers, to reduce the burden on consumers, providers, and county staff in the payment reconciliation process.

d) **Address IHSS Social Worker Workload and Improve Training.** County IHSS social workers currently work with very high caseloads, which limits their ability to attend to the individualized needs and link to other services. This can potentially increase the risk to consumers and result in higher costs borne by other agencies. The IHSS Listening Sessions and subsequent LTSS Subcommittee discussion highlighted frustrations with missed visits by social work staff, poor communication, and inconsistent application of IHSS requirements. To address these concerns, we recommend:

- Reducing social worker caseloads, especially for social workers with consumers requiring a higher level of care coordination. IHSS social workers currently have very little time beyond the assessment to identify potential service needs, link consumers to other services, and to coordinate with other programs.

- Provide increased funding in counties for Public Health Nurses, who are critical in working with county IHSS and APS staff to identify health–related issues, serve as liaisons with medical providers, and help consumers access needed medical devices.

- Increase funding for training and coaching of IHSS social workers and supervisors and revamp the current IHSS Training Academy to align with the recommendations above.

e) **Revisit and redesign the current IHSS Quality Assurance and Program Integrity Processes:** CDSS and County IHSS Programs currently participate in a Quality Assurance process, an annual review process that includes desk reviews, home visits, targeted reviews, and other activities, and which result in county quality improvement plans. In addition, the counties implement program integrity at the direction of CDSS to reduce the incidence of program fraud. These efforts/ activities should be re–examined within the context of a more comprehensive Aging and Adults Services System and potentially embedded within the proposed Outcomes and Accountability System.

f) **Align IHSS and Medi–Cal Redeterminations:** The majority of IHSS consumers are also

served through the Medi-Cal Program. Currently, during the Medi-Cal reassessment process, a consumer could lose their eligibility for IHSS pending their Medi-Cal re-determination. We recommend that DSS and DHCS work with counties to align the Medi-Cal and IHSS re-determinations to the greatest extent possible, in order to avoid disruption in services.

8) **Modernize the Adult Protective Services (APS) Program to an "Adult Services" Program.** APS was established in California as a statewide 24/7 emergency response program in 1998 by the Legislature (AB 2199, Chapter 946). APS serves individuals over 65 and dependent adults ages 18-64 who are disabled, who are unable to meet their own needs or are victims of abuse, neglect and exploitation. Law enforcement, doctors, and other mandated reporters and the community rely on APS services to protect older and dependent adults from further abuse. The APS Program is an effective program, responding to 190,715 reports of abuse in 2017-18, which represents a 131 percent increase in reports since the 2000-01.

   Since its inception, the population that APS serves has grown and changed significantly and will continue to do so at a rapid pace. By 2030, one in five Californians will be age 65 or older. Of those 85 and older, an estimated 32 percent will have Alzheimer's disease. The number of older adults in California with disabilities will increase from 1 million in 2015 to nearly 3 million in 2060. Additionally, California's aging population is also an increasingly homeless population. According to Dr. Margo Kushel, Director of the UCSF Center for Vulnerable Populations, approximately 50 percent of homeless individuals are over age 50, and half of those became homeless after age 50.

   In California and nationally, APS programs are largely supported through state funds, since there is no mandate nor funding at the federal level to operate APS. When the program began, the State provided $55 million in funding. The program, now part of 2011 Realignment, has since grown to $138 million due to increases in Realignment revenues. Last year in recognition of the severe housing crisis, the APS Home Safe pilot was launched with a modest $15 million General Fund (GF) investment to provide housing-related assistance and homelessness prevention to at-risk APS clients.

   Even with increased funding through Realignment, County APS programs continue to struggle to keep pace with the growth in reports to APS and are both understaffed and under-resourced to serve victims with complex needs who require more intensive case management to remain safe from abuse. The lack of adequate funding also stymies efforts to provide more intensive services early to prevent a situation from worsening. Within the current funding structure, APS workers can only focus their efforts on emergency response and short-term case management. This increases the likelihood for re-abuse, onset of health issues that lead to the victim to be hospitalized or placed into nursing home care, homelessness, and pre-mature death.

   Given the dramatic demographic changes and the increased risk of homelessness of this

population, the need to serve vulnerable older older populations that are cognitively impaired, and the need to serve all of these individuals earlier before a crisis point, it is imperative to concomitantly change and grow the APS system to keep older and disabled adults at–risk of abuse, neglect and exploitation safe and housed.

By expanding APS and investing in an Adult Services Program, which includes expanding ADRCs and leveraging AAA programs within the county human service agency as recommended above, counties can be better positioned to prevent abuse, neglect and exploitation of older adults and persons with disabilities, thereby reducing the likelihood for costly institutional care and premature death.

Following are the recommendations for APS:

a) **Invest in prevention efforts:** The current APS Program is reactionary – it intervenes only after an adult has experience abuse, neglect or exploitation. To reduce out–year costs, earlier identification of potential need is critical. We recommend providing State General Fund support for outreach and education to community–based agencies both to recognize the signs of abuse, neglect and exploitation but also to help identify potentially vulnerable adults prior to abuse or neglect and connect them to community–based programs. The state can also leverage the AAA Elder Abuse Prevention Program to support these goals.

b) **Expand the age of persons served under APS to 60 and over.** This would not only allow APS to serve older adults "upstream" in a more preventative way, but it would also align with services available under the Older Americans Act, and eligibility for supportive housing and services for those who need it through Residential Care Facilities for the Elderly (RCFEs).

Invest in the APS Program to provide long–term case management. For some APS clients, shorter–term case management is all that is needed. But for others, including homeless older adults and persons with cognitive impairments, the services of APS may be needed for a longer duration to provide for their more complex needs:

- **Homeless Older Adults:** The aging homeless population over age 65 is expected to triple in the next 10 years. Most older homeless adults have multiple, co–occuring health needs and many have experienced abuse, neglect, exploitation resulting in trauma that impacts their ability to secure and maintain stable housing. APS is uniquely positioned to understand these needs and work with this population to secure stable housing, through a multi–disciplinary approach that must include managed care, behavioral health, PA/PG/PC, IHSS and others. Consideration should also be given to whether APS should have a role in supporting homeless adults aged 50 and older. The CalAIM and Whole Person Care Program also provide important leveraging opportunities.

- **Persons with Severe Cognitive Impairments:** Some persons with severe cognitive issues (i.e. brain, injury, dementia, Alzheimer's or adults with developmental disability diagnosed after age 18) have unmet needs not holistically addressed by one system, yet are often referred to APS as a result

of abuse, neglect or exploitation. As a result, many get bounced around between systems, with their families left on their own to navigate each system. For example, a person with dementia and mental illness but no qualifying health condition is not well-served by the health care or mental health systems. For these individuals who often come to the attention of APS, more intensive case management is needed, through a multi-disciplinary team approach that includes other mandated partner agencies including behavioral health, regional centers, health care plans, and PA/PG/PC as well as community-based services to bring to bear the expertise and resources needed to serve this population.

d) **Expand use of Forensic Centers and Financial Abuse Specialist Teams in counties.** Elder financial abuse is skyrocketing, and victims who are robbed of their assets face an extremely high risk of homelessness. FAST (Financial Abuse Specialist Teams) and Forensic Centers are considered best practices in APS. They allow for a collaborative and targeted, rapid-response approach to complex cases. Currently, only a few counties have either model, but those that do see great success in interceding and stopping financial abuse, and stabilizing victims. Through a grant-based process, these practices should be promoted in county APS Programs.

e) **Expand the Housing Continuum, including APS Home Safe:** The APS Home Safe Program provides short-term support to prevent homelessness for victims of abuse, neglect and exploitation. This is a 3-year, $15 million State program launched in 25 counties in 2019, but the need exceeds available funding. We recommend expanding the program to additional counties and provide additional funding to meet the existing and future needs.

f) **Make Workforce Training Ongoing:** Permanently authorize the current APS Training Program to ensure the workforce is adequately prepared with the skills, knowledge and best practices in meeting the needs of this population.

g) **Administer Long-Term Care Ombudsman (LTCO) through the County Human Services Agency:** LTCOs are comprised of volunteers trained to investigate and intervene in cases of abuse, neglect and exploitation in institutional settings such as nursing homes. LTCO's are currently administered under the AAA programs and, pursuant to our recommendation for the AAA's, would also come under the county human service umbrella. We believe this would enhance coordination between the LTCO and APS programs, including participation on MDTs as necessary. LTCOs would however retain their independent authority to support residents in long-term care facilities in understanding and exercising their rights including conducting investigations into abuse, neglect and exploitation in these facilities.

III. FOUNDATIONAL ISSUES

The following items are foundational to the success of a comprehensive, person-centered Aging and Adult Services System and should also be considered as part of the Aging Master Plan framework and recommendations:

1) **Housing Continuum:** For older adults including adults with disabilities, California's housing crisis has created additional and unique barriers to retaining affordable, community-based

housing. Addressing this issue will be critical in meeting the overall care needs for older adults:

- CWDA recommends the State convene stakeholders to consider how to develop and support a full continuum of housing options to avoid the use of institutional settings, and identify the regulatory, fiscal, and other barriers and opportunities to expand capacity statewide. Consider how Medicaid or other funding sources can be leveraged to meet the holistic needs of older adults and persons with disabilities. Options can include a statewide expansion of the Assisted Living Waivers, consideration of the Regional Center model, and consideration of best practice models such as those in Washington and Oregon. We recommend CDSS as lead on this effort and include other important State departments (ex: DDS, DHCS, HCD, CDA, etc.).

- One issue gaining recent attention is the significant loss of Board and Care Homes statewide, which has a profound and negative impact on counties' ability to meet the needs of individuals who require more supportive housing with services, including those with mental illness. Since Board and Care operators are prohibited from charging more than the SSI–rate for low–income individuals, few are willing or financially able to care for this most vulnerable population. The result is an increasing homelessness population, and current projections show that the number of persons over age 65 that are homeless is projected to triple by 2030 absent any interventions.

2) **Workforce Issues:** Investment is needed to increase the number of professionals and paraprofessionals working with older adults and persons with disabilities, both at a "systems" level as well as for direct care providers.

- Establish collaborative agreements between the State and California universities to increase the pool of social workers, gerontologists and geriatric specialists. Create incentives for universities to increase their capacity in these fields, and institute a stipend program modeled after the Title IVE Child Welfare Stipend Program to expand the number of credentialed professionals.

- Establish a "rapid response" task force that includes colleges, universities, and aging stakeholders, to identify specific recommendations for pilot programs, or to bring existing promising practices to scale, for increasing the in–home care workforce that includes pathways to other health–or social services–related careers.

- Provide additional support to in–home caregivers. Consider the fact that many individuals providing in–home care are relatives and will have diverse needs; some may have left the workforce in order to care for their family members, others may be working and caregiving, and others may be older and also potentially have their own unmet needs. Supports and services should meet a broad array of potential needs and be readily accessible in communities, including through local Caregiver Resource Centers.

3) **Financial Stabilitiy/Sustainability/Leveraging.** Ensure funding viability for a comprehensive, statewide Aging and Adults Services System, including an LTSS system. In

order to prepare for the growth in our aging population, additional funding will be necessary for the full continuum of services, including prevention, intervention and long-term care.

Additional Considerations:

- We note that on January 1, 2022 or the date that state minimum wage reaches $15 per hour, the county share for any locally negotiated wage and benefit increases for IHSS providers will increase from 35% of the non-federal share to 65% of the non-federal share. This change could result in increased pressures on 1991 Realignment growth, which is the primary source of the county share of cost for the IHSS program. It could also have potential impacts related to the IHSS workforce as it adds challenges in reaching local agreements for wage and benefit increases for IHSS providers.

- We recommend that any considerations of financial viability or sustainability should approach LTSS system costs as a whole, and not in separate parts (i.e. IHSS, AAA programs, etc.). While the IHSS program is clearly a growing program, there are both financial and societal benefits that should be considered. Growth in IHSS should also be considered in the context of the projected growth in State General Fund revenues.

- We recommend looking for opportunities to increase revenues to support enhancements to the LTSS infrastructure, including expanding access to individuals who are middle-income, so that families are not forced to spend down assets in order to meet Medi-Cal eligibility. We recommend seeking additional opportunities to maximize federal funding, including Medicaid (through the CalAIM initiative), Medicare, Older Americans Act, and other fund sources.

- We recommend that the State consider creating new funding streams to invest in "upstream" community-based prevention and early intervention services and supports that align with the Older Adults System of Care and County Adult Service Systems (i.e. similar to the San Francisco "Dignity Fund").

Thank you for this opportunity to submit recommendations and participate in the Aging Master Planning efforts. Please do not hesitate to reach out to CWDA staff with any questions.

County Aging and Adult Services System