CHHS California Health & Human Services Agency

Together We ENGAGE Master Plan for Aging

California Master Plan for Aging
LTSS Subcommittee Meeting #1
October 28, 2019

Meeting Transcript

Anastasia Dodson
Thank you all so much for coming. We're going to get started soon. We have only a short three-hour window for the meeting. If you don't mind, take your seat. And looks like we've got everybody a chair. We're going to go ahead and tell the operator to start the call.

Operator
This is the operator, whenever you are ready to start, I can get you into the main room.

Anastasia Dodson
Very good. Please go ahead and start. And just a reminder for everyone in the room. We have audience here in the room and then on the phone, we have an operator assisted conference call.

Operator
Thank you for standing by, welcome to the master plan for aging call. At this time, all participants are in a listen-only mode. Later, we will give instruction. Should you acquire assistance, press start and then zero. As a reminder, this conference is being recorded. I will turn the conference over to Anastasia.

Anastasia Dodson
Just a reminder, folks on the phone, if you are not muted, please mute. Otherwise your lines are open. And I think there are a couple folks that situation.

Kim McCoy Wade
Welcome. Good afternoon. I am from the Department of Aging. I want to give a thank you for all who traveled here from home without power, or putting up people or smoke, or those that are worried. The director will not

be with us today. She is on the front lines and thank you to all of you who are doing that work back home and are still with us today. Of course, those who were unable to be here, this is not the only time we will be discussing long-term services and supports, there will be many opportunities. So thank you for coming and giving us your attention and dedication in a very tough time for the communities for the state.

We are excited, even with that backdrop, to be kicking off the long-term services and support conversation. Part of the master plan for aging. We have a packed agenda and today, we are going to get to know each other as a community. We have an incredible group of people so thank you all for your service. We probably should add up the years at some point and it is centuries, no doubt. We also want to take time to organize this work. We have quite a mandate and quite a short time period to do this. And we want to talk a little bit about the scope and how we want to organize it. And we will be proposing deep dives and the first one is the first one on information and referral. In the deep dives, we are trying to get a leader, the state service supporting that leadership and stakeholders on the committee and the general public as well. Before we do that, let me check because I want to start with the introductions. Any housekeeping before we get further?

Anastasia Dodson
Just one for thing, all of you will have to eat the mic so the folks on the phone and in the room can hear us. We have a great audience here in the room as well and there will be time for public comment in the end and also on the phone, we will have time for public comment. And here I'm breaking my own rules about eating the mic. And we were a little short on chairs, we were not sure everybody was coming in person so we're going to rotate out after this first section and Irene and Karol will come to up the table.

Kim McCoy Wade
Introductions. Should we pass it to Karen.

Karen Keeslar
California Association of Public Authorities for IHSS.

José Alberto Arévalo, MD
I'm a family doc and also representing Latino Physicians of California and Sutter Health, I'm the Chief Medical Officer for Sutter Independent Physicians.

Julia Figueira-McDonough
I'm a worker's rights attorney representing low wage workers, including care givers. A government fellow and here also as a liaison for the Secretary of Labor.

Ellen Schmeding
Good afternoon. I'm here from St. Paul's service services also here representing the California Commission on Aging. And I'm from San Diego.

Brandi Wolf
I'm with SEIU local 2015. We represent about 385,000 care workers across the state.

Marty Omoto
Community Actions Network.

Patty Berg
I've been involved in aging since 1985, the founding executive director of areas on aging, serving Humboldt and served in the state assembly and chaired aging and long-term care and I've written 3 master plans and I've been around a lot of people.

Sarah Steenhausen
And I'm with the SCAN foundation.

Lydia Missaelides
I'm here in a role for the California association for adult-based services having formerly served as the executive director for 30 something years.

Jeff Thom
Representing the California Council for the Blind and we serve consumers with vision impairments throughout the state.

Catherine Blakemore
The executive director of Disability Rights California.

Peter Mendoza
I have been active in disability policy around LTSS since I was 16 and I'm in my 50s so that was a long time ago. I worked for the Marin center for

independent living and here in the capacity as a person who is knowledgeable user of LTSS.

Ana Acton
With FREED.

Susan DeMarois
Representing the Alzheimer's association.

Kristina Bas-Hamilton
UWP, United Domestic Workers.

Claire Ramsey
From justice and aging. Sitting in as an older adult advocate.

Maya Altman
Health Plan, San Mateo.

Nina Weiler-Harwell, PhD
AARP California, we're a membership organization for Californians and Americans, 50 and over and we have 3.3 million members in the state.

Shireen McSpadden
The executive director of the San Francisco Department of Aging and Adult Services the president of the California Association Areas on Aging and board member of the National Association on Aging representing California. I'm here to present today, not on the subcommittee.

Kim McCoy Wade
Do we have subcommittees on the telephone who want to introduce themselves?

Anastasia Dodson
Donna Benton, you are on the phone. Hopefully we can hear you. And Monica? We'll work with the operator.

Kim McCoy Wade
So, with that let's get to work. The first item of business is talking about what we are here to do. As you know, the governor issued an executive order calling for a master age and specifically named one issue for a

subcommittee, long-term services and supports. And this is the first meeting and we'd like to spend time talking about the charter. Talking about the scope and purpose.

The slide first is about the objectives. Uniquely, the subcommittee has two; one is the overall advising for the master plan for aging, which includes both the deliverables, the state master plan and local blueprint and data dashboard, best practices. And uniquely, a report from the stakeholders advisory committee by March 1st, 2020.

Which is about to be five months away. Four months. Very soon. So hence, the gathering as quickly as we could. Let me pause and see if there are comments or questions about the objectives piece. The two-part objectives. I do want to lift up something that we have had many conversations about, which is the master plan will be issued by the administration as a product of the administration. This report is the stakeholder advisory committee. We are here to support the assembly and the smoothing and the production of that. But the voice of that will be the stakeholder advisory committee and we'll talk about that in terms of process. Okay.

I'm going to keep moving and we can come back to it. So, here's our attempt to get all the work done in that time period, which really involves 6 deep dive meetings where we would focus on one piece of this topic, again with that mix of local leader, state system, stakeholder discussion and public discussion. The topics that we have laid out here, the second one would be the issues around financing, in particular of potential new public benefits similar to what Washington state, a conversation about that, November 12th. Then we would like to talk about the services themselves and the suggestion is that IHSS would be stand alone as kind of a large program. But we would have another session on the other programs, all home and community-based services we can talk about how to scope that. That has many issues that topic, obviously.

Another one on paid workforce, family care givers and how all that comes together. And another one on residential facilities, including, but not only – and the six would be on residential facilities, including not only the skills nursing. And we would like to have these deep dives. That would be the end of January and that is fast. But by January or February, the reports are being drafted, coming to the full subcommittee, being finalized in March. After that march report deadline, turning to the rest of the master plan

deliverables. Again, the state plan and the local blueprint, dashboard and best practices. That's a proposal. Think about that.

Anastasia Dodson
Before we go into the next level of discussion, I want to flag that on these meeting dates so we're looking at December meeting dates and that is right around the corner. So, what we have been working on is finding venues. That is what is holding up announcing the dates. Right now, we do have venues for this meeting in Natomas, but we know that is hard to get to via public transit. We're looking to see if we can find other public locations downtown in December. CalAIM are going to have stakeholder meetings December as well. We'll keep working on it. But we know that you need to know the dates soon and that is really the tradeoff is public transit versus parking. That is our dilemma at the moment. Flagging that we're making sure that we don't overlap with the CalAIM.

Catherine Blakemore
Disability Rights California has a large conference room on 19th and K. If you wanted to come look at and see if it would meet needs, we can also video conference in from lots of other locations in the state if that became something that was more accessible to people. We can work out the dates.

Patty Berg
Just because we've been here before, I'm serious that we should be meeting at the capitol. We have so many meeting rooms that can hold all of these people and that is exactly where we should look.

Kim McCoy Wade
Great. I wanted to flag on the next slide, work needs to be in coordination with our fellow departments who are holding forums on related topics. For example, the department of social services, kicking off IHSS services. And the department of health care services is kicking off CalAIM, California advancing and innovating Medicaid, tomorrow. With its own five subcommittees work groups and timelines. A third forum is the governor's new task force with former first lady on Alzheimer's and also beginning work in November. Wonderful opportunities for all this work to move forward and to coordinate.

Sarah Steenhausen
I had a question about the long-term care financing where it says the financing for the middle class and I'm familiar with that important issue. But I wonder if there might be opportunity to discuss financing of the long-term care system. In other words, there has been a lot of discussion in the past about how the actual state budget is constructed and the flexibility and the issue of global budgeting. That is a separate issue outside of how people paid for LTSS and it is another consideration related to financing.

Maya Altman
That is a great suggestion, Sarah. I know you have highlights that we have to coordinate with CalAIM. But I do worry about getting – the state just told in November, that they have to cover long-term care. And that is going to be a central part of the LTSS framework. It has to be folded in somehow and maybe it can be, with the health plans and how CalAIM specifically interfaces with the LTSS.

Kim McCoy Wade:
I don't believe DHSS was able to be here today, I'm looking around.

Anastasia Dodson
We are working closely with DHCS on that. Meeting number four, we're thinking to see how many we can put in related to the DHCS programs, trying to be respectful of everybody's time within the administration and stakeholders. That is one of the things we can use feedback on, in that meeting number four, should that just be home and community-based services? Does it make sense to start thinking about the long-term care carve in there? We want to be respectful that it may be already on the agenda somewhere else for a DHCS meeting.

Kim McCoy Wade
Where we left it, we were kicking off today, they are kicking off form. They committed to come at least to the meet and present on that. We call the question is, is another conversation needed and is that a jointly held conversation? Where, when do we structure that? We have had related conversation for those on the advisory committee dl, are three other goals outside of LTSS. One of which is healthy aging. And all this overlaps. I believe the research subcommittee, there was an expression used and I stuck with it. We're trying to figure out how to bracket the conversations and bring them back together. One of the questions we had in the – and

why I'm looking at you, when we have a healthy aging discussion, a coordinated care conversation at the right time and place, thinking would be after – might be January. We have to get through the initial conversations come together with DHCS to do that. TBD, welcome advice about when, how, where and fits in and how to scope that conversation. So we have the right conversation with the right people. Noted, where that needs to happen.

Maya Altman
I would not wait too long, maybe in one of the December meetings, you can touch on that. Just to try and prevent the silos that have been around for years.

Lydia Missaelides
Just as an example of what Maya is saying, so this makes sense to me is just glancing quickly at the CalAIM document, CBAS, which is ingrate and managed care is moving from the 1115 waver to 1915b. We are already in the managed care scope. There is interests intersection there. I assumed we would be under the December 4 meeting just under that conversation, but now I'm not clear if we are or not.

Susan DeMarois
I would put a plug in on meeting number 6 as well because that is a big piece – Medi-Cal is a big piece of that.

Marty Omoto
Echo the comments made by everybody. And it is going to be hard to pull all this in because everyone is on different timelines. You have the department of health care and department of developmental services working on a master plan for services. But the stakeholder groups have not been announced. But the master plan because include people with disabilities as they age and families. We need to look at the other master plans, even though it is not technically part of this, but as we mentioned before, there are grandparents, older people who are taking care of younger children, younger children in early start or even as you know, younger children. And I think the other reason why we want to look at the other master plans as they are moving forward, but not get bogged down. There might be good things we want to replicate in terms of research, reporting and monitoring or even pilot programs that another master plan is looking at that we can adapt here.

But it is complicated because a lot of things are happening all at once. The one thing we ask, and the legislature of course, is doing their thing. I just hope that one of the things that will happen with the larger stakeholder group is that there are people talking to each other and that whatever develops and any of the master plans will take the best ideas or – and also as you pointed out, Maya, to remove the silos. Because that is the whole point, I think is the barrier to accessing quality services and also leading to good outcomes. So thank you.

Catherine Blakemore
I guess one of the things that I hope we would get to at some point is a core set of principles or visions about what is going to drive this component of the long-term services support. I understand we have specific tasks. But before you get to specific tasks it is like where are we trying to head? Justice and aging and DRC, we had a chance to think a little bit about that and say the intention of the plan is to keep people in their home and communities for as long as we can. And it seems to us that there are some key elements of our capacity to do that, that should be overarching of all of our discussions. So that everyone has access to long-term services support so that they can achieve that. IHSS is a current backbone of that system and it is what does a great job of keeping many people in their home. There are other services that are a part of that and an importance of the workforce. I hope before we get too much into the weeds, we can focus on some broad principles of what is this all leading to so that the weeds do not consume the broadness of that. And I'm going to pass around the things I quickly went through and Claire has some as well. And I handed out one braille copy, but if you need more, let me know.

Kim McCoy Wade
You raised an excellent point because that came up in the stakeholder advisory committee where we talked about goals and values. That is coming back to the full committee on Monday. That is where we look at the framework and those things are really the purview of the whole committee. I hear that conversation has not happened and we're going to work before that has been landed by the full committee.

Catherine Blakemore
I guess I'm just encouraging us to keep something in mind or we'll just be buried in the information and referral. Information and referral, to what end?

If we don’t know what the end is and we don’t have a common understanding, we do referrals all day long and we can design any number of things. But it has to be towards that commonly understood purpose.

Claire Ramsey
I think the other piece of this, too, is to CalAIM seems like it needs to get to a very detailed level of programmatic complementation and to think careful about whether that is what we need to do about everything. Because we might have a way to structure goals other objectives that lead some of the next steps down, the next piece of the puzzle with these strategies and tactics. As opposed to forgetting we don’t know the higher level pieces. I’m just worried that it is easy for us to jump to all the detailed levels because it might be the first things in our head, but to step back.

Sarah Steenhausen
I love that point and I will get back into the details. I had a thought about the issue of the financing of the system and the issue of integration, I do think it does fit generally, but there are so many other issues related to home and community-based services. If it were possible, I don’t want to add extra work for everybody, but maybe one meeting to focus on the financing of the system and integration. Integration is financing and service delivery kind of mix. That might be one suggestion of a way to approach it.

Kim McCoy Wade
Yes, peter?

Peter Mendoza
I’ve been involved in LTSS for many, many years. And one of the things that we always talked was making it seamless. Services should be seamless, so that a person who, for example, is maybe getting services for DDS and regional center, they often get stuck because the IHSS system works one way and the regional center services work another. So, it is really important to we communicate with each other and we work to develop a program so that because you may get multiple LTSS support from a number of different services or programs. So we really need to develop the communication piece because as we age, we’re all going to need different types of supports that all come under LTSS. And what we are talking about with the wrong door. We need to have that system used so that we remain seamless. So that when a person uses IHSS the regional center services support and they blend in, the consumers and

people use LTSS, don't suffer some of the difficulties with access. Or a confusion between case managers and other departments.

Donna Benton, PhD
I really like the last speaker, what he said. And I also want to remind – I think we already said the family care givers. Statewide and being able to integrate that as part of the LTSS system is also important. [indiscernible] as part of that long-term care system in addition to the care services so that no wrong door approach. Because family care givers are often making decisions for the family around the other systems.

Kim McCoy Wade
Thank you, Donna, we had a little bit of audio trouble, but I think we got it.

Nina Weiler-Harwell, PhD
So I am in support of all that has been said so far about no wrong door, seamless integration. I do hope that we're having a robust conversation about that because right now our system is not user friendly for the person needing care or the care giver. Let's not forget the care giver resource centers when we are having the conversation. I would have liked to have seen them on the agenda. One other thing that we're talking about, how we get to the beginning discussions of universal assessment, but getting there. Because it is ludicrous that folks have to fill out multiplications even in the regional systems center, having some autistic – everything was in the regional centers, but to get IHSS was a different program. And that does not – if we had needed CalFresh or any other services, it would have been a whole other set of assessments. I'm just saying, we're California and we should do better.

Ana Acton
I think having a conversation about what our definition of LTSS is would probably be good because I think sometimes we assume we're talking about the same thing and maybe we're not. And then secondly, really, I don't know if there is an opportunity to kind of do an assessment of all the current providers and systems that are out there in the community. What do we mean by LTSS and who are those on the ground service providers to make sure we're developing a system for the individual and not the system. And leveraging current resources that have the capacity to build off.

Kim McCoy Wade
That is a great segue into the next couple slides. This is your subcommittee to figure out what topics and how to organize. If the topics are not grouped right or sequenced right, if you want five more meetings, we can do that. I'm going to lead us through a couple other pieces of information to put in the puzzle so we can see, is this the right approach or do we need to tweak? We just need something to react to.

To answer a couple things and I will acknowledge, what is scoped for the LTSS is different than what you might see in the master plan and we're trying to do overlapping circles here and not sure if that is helpful.

Moving to the slides, this is what the LTSS report is supposed to cover. We're going to have three slides on this with very small print to give you a sense of the scope as the EO. The master plan can go beyond that and the report is yours too. But here are the things. The growth and sustainability of programs infrastructure. Examination of LTSS, quality in a variety of settings.

[reading] examination of the impact of program… recommendations to strengthen and… calling out IHSS. [reading] a range of information and referral… it stops at age. So it is quite a range. Probably everybody here would have written that differently in a different way. But that is the charge we have. Going to the next slide just to come back to process.

We'd like to see a final report come out of the subcommittee. Ideally that is a consensus so it can be finalized by the end of march. We're here to provide technical assistance and we also will tap our friends at the research subcommittee if there are data needs.

We're suggesting that subcommittee members from the public will come in kind of by the end of the year to start writing. We can bring you a draft in January if we have all the content. And edits are happening and then it is being finalized.

And then to your point, Catherine. Just to give you a sneak preview of the revised goals. We heard from the full stakeholder committee in September, the need to go bigger on mission, vision and goals, but drilling down to policy. We're trying to do a little bit of both. But the four big goals, revised

with your feedback. And this is the goal one subcommittee. We will be able to live where we choose as we age and have the help we need to do so. The other goals do not have a requirement that are planning stakeholder forums to get that input from local leaders stakeholders from the public. Age-friendly.

[reading] goal 4. And I will add that disaster response will be a part of that. Those are intended to be person-centered goals and what does that mean and look like when we achieve that in 2030? That is a sneak preview of the goals that will be reviewed by the full committee on Monday. That is a little look at the timeline and scope. With that, maybe I don't want to put our tech people out too much. We can go back to the proposed topics schedule. And are very open to revision and reconfiguration and help with rooms to make this work.

Patty Berg
One of the big elephants in the room that has not been mentioned since this is supposed to cover the entire state, I'm representing. I see myself as representing rural areas, about the only person here really representing rural areas. Many of the 38 counties representing 80% geographically of the state, we're talking, don't even have an acute hospital. There has to be, when we look at this, and we have do hone in on what services must be in place? It is not just touting service rich like San Francisco, LA, and San Diego. We don't have those options rural areas. But there has to be a certain mix that has to be in place in every county in the state. And that is what is going to cost money. I just want to throw that out because it is not like – I have to tell you, in and every poll I have ever seen and every needs assessment, ranks like at the bottom of the list in terms of what people want.

In part because what we call it. Seniors don't understand, information and referral, what does that mean? And I think that is why. Just saying, the basic step and we need to do a needs assessment in terms of what exists all the counties. Counties who are running poor, there are a lot of them, especially in rural areas; they don't want to have to pay the state for in home supportive services, there is a fee for that. They are interested in putting people in skilled nursing, whether that is in their community or moving them out of the community if they don't have it. It is to their benefit not to send people home. Do you know what I mean? You guys please nod your head.

These are some major, major stumbling blocks and you can't just be thinking of the world out there where we are going to get everything. Trust me, I've done that three times. And gotten nothing from it. When we're looking at California and being a model, we have to look at what is absolutely necessary to have in 58 counties in our state to keep people out of the institutions and at home in terms of their choice?

Marty Omoto
Thank you. Just going back to the topics. Just a small point because actually an important one to extend that. People need to understand ins larger community as they provide comments and become engages in the process of the master plan, they are a part of it. If we don't use terms they can identify with and they won't feel like they are part of it. I strongly suggest that the word developmental services, regional services, something is included. My sister had physical disabilities and she was holder. Everyone identifies with IHSS, but that is about the only abbreviation that people identify here with. LTSS most families don't think what they are getting from the regional center and long-term services. They don't know that it is Medicaid funded, except for IHSS. Those families that access it, they know that is a critical foundation. And the other thing is simply because with the regional center population there is an element, those with down's syndrome are likely to develop Alzheimer's. And the families who are care givers, they are aging and they have all the kinds of issues that other aging Californians have, including Alzheimer's and mental health issues. It is just important to use words that other people will know. And you are doing a great job with this.

Kim McCoy Wade
I appreciate that and I think you are making a couple points, language and acronym. I think the language in the EO is long-term care and there was a discussion about that. I agree with you, that is still not plain talk. If there is a better term for this, we're all ears. I think you are suggesting that regional centers be a part of this conversation?

Marty Omoto
Absolutely. And peter spoke to this earlier. It was part of the governor's order, the access of IHSS and CBAS. My sister was a Medi-Cal recipient. They access CalFresh, but it is kind of lost in the mix. We just have to remind ourselves that this population is includes.

Kim McCoy Wade
You are making a population and system point.

Marty Omoto
Yeah, yeah.

Kim McCoy Wade
We've had this conversation. It is a system, I think – well

Marty Omoto
And the other point is, we talk about IHSS. When we talk about services the home, is IHSS a cornerstone? But for people who are eligible for regional center services, supportive living or other instances of that type of service. Actually it is the same person in that house and it helps us break the silence because that is hard for us, too, as advocates and people with the state. And Karen knows all about this, too.

Kim McCoy Wade
I want to acknowledge that we are off the agenda, but this is one of the most important conversations. I would like to have it go for another 10 minutes, because there is a nice queue of people in the room.

Kristina Bas-Hamilton
I have a comment, but I do want to ask something based on what Marty said, are the developmental services and regional centers not in this committee? Or it is mentioned here by accident?

Kim McCoy Wade
The population is. I think the question if we want to look at regional center system, we have not initiated that. If that is what we want to do, we should add that to the p list.

Kristina Bas-Hamilton
I think it has to because it is missing people and it is the same worker in most cases. I conceived of LTSS to include regional center. I am glad you raised that. My comment is, a way to structure the discussion, if we're going to talk about a whole person, person centered, look at create almost like a "jane doe" how does jane doe relate to long-term care? There might be services she is paying for out of pocket. I envision it as public and

private financing. Within those buckets, there are a lot of similar issues and we have workforce in both areas. And things like services and how they interact with each other, information and referral, et cetera. But I want to propose that the framework, the distinction is what is publicly funded privately funded and how do those interact and how does the person experience those. And how does the “average” person experience those things?

For example, number 3, a deep dive on IHSS is going to include number 5, which is the discussion about workforce. I don’t want us to be like, okay, we’re on number 4, but that is not until January. But you can’t really talk about it – you have to talk about it if you are talking about that. I’m suggesting a different way to do those things.

Susan DeMarois
Under the report topics, I see on the first one we talk about IHSS eligibility and assessment. I hope that is not the only assessment that we talk about. Eligibility.

Karen Keeslar
I guess it is a process question and it deals with the input from the public to the stakeholders. And I appreciate that the department of social services is doing a listening session on IHSS. After I sent that word out to the IHSS coalition, I was immediately flooded with, why in Sacramento on Halloween, I appreciate the response I got from Kim R. at DSS that said we’re doing one in la are more to follow. Just a recommendation, to the extent that there is going to be anything that is outreach to the public, letting folks know in advance that they are going to be geographically spread across the state is going to be helpful to the community as a whole. And I wonder how as a subcommittee member, that I would obtain the information that you are getting that the relevant to the subcommittee’s work that comes through people posting through the website or attending listening sessions.

Kim McCoy Wade
Two things in process – well, public from the meetings will be captioned, the scripts, summary, posting. The other two things a have been coming in or individual public comments and we had over a thousand and we’re categorizing them. Is it better to do survey results, how do share that back. We’re hearing a lot about housing. And we’re getting organizational letters

comments and those are posting as here is organizational. Individual comments we're trying to collect and organize the masses upgrading our ability to manage that many week by week and posting the organizational. Those are the ways. And there are these IHSS listening sessions, Alzheimer's task force and subcommittees that we will be sharing as well.

Nina Weiler-Harwell, PhD
Just to speak – use using the whole person concept and CalAIM which specifically talked about – I would really like us to remember that particular framework for this. So just really basically the whole person needs to eat, needs to get from point a to point b, needs to get out in the community, a roof over their head and whatever services they need to remain in the community.

Kim McCoy Wade
We could easily flip the meetings do a different persona each meeting, but those are different meetings. We can do a meeting about a person with dementia, a person who is 85 and has no family or friends. We can do that, but could not quite figure out how to structure the meeting. We suggested against my – to go back to programs and acronyms. But it is upon all of us to pull it back and cross the line. But we are open. If we think we can do meetings, person-centered meetings and not have the IHSS competition five times. How do we resolve that?

Patty Berg
I don't have the answer. But from the scan forum, I think it was the gentleman from Colorado and because my question is this; we have to talk about the population that we're trying to develop the master plan for. And what I heard was not just low income, it is taken care of the inn home services population is taken care of by the state. 20 to 30*% of people can take care of their own services. It is the rest that don't know what to do. Our responsibility is not just low income, this plan is not just for low income, but for the middle class individual as well. We have some programs, like all of the CDA programs, essentially, are not – there is no means testing. Anybody that is 60 plus years of age can have a meal. They don't have to pay anything. That is just the way it is. And so that is the administration on aging's program.

And then the other programs are very means tests. It is the population. We have to be clear population we are developing the master plan for. I don't

want it to get stuck in the weeds just low-income individuals. If it is really a state plan.

Brandi Wolf
Just a comment directly to that piece. Yes, IHSS is the cornerstone long-term care program for low income individuals. But the pattern in IHSS currently with case load growth versus funding will enfold on itself in the next few years or so. So, I think that is right, we've got to be thinking about populations outside of just the low-income population. But having a real conversation. And I think SEIU's engagement with the governor around what we were hoping to achieve in the overall master plan really does have to do with why IHSS was called out specifically in some of the charges. We have to figure out how to have a sustainable IHSS program moving forward. If that is gone, the foundation that we all know is gone as well. I would add that.

Kim McCoy Wade
To share some of our thinking, the first meeting we did information referral and the attempt to be referral centered is a start. Then we go to the middle class benefit. Then we go to IHSS. And then we try to go to the other program. We were trying to – to your point, workforce is IHSS, but broader. And we have to figure that out without duplicating. I'm not trying to be defend it, we're open if there are other. We can meet every other Wednesday between now and march through this. We just need some way to wrestle this. Oh, and one other thing, we are happy to get volunteers to be point for each of this. If you think, I will help shape that one, so that we get the right – we did our best here with the local model and the state's INR system and we will need that for all of these. And we will be happy to have members from the subcommittee and help us put together a program. I'm going it say it is coming up on three. Sorry, I'm having trouble with the cards. Let's try to move towards a recommendation. Lydia?

Lydia Missaelides
My heart is with your approach that you articulated, which is the more person-centered, identifying. And looking at barriers, challenges, needs desires. But I don't know have practical that is. I would have to give it more thought. That is my instinct to go that direction. I'm not clear on the public stakeholder and how that is being structured. And it is more my question, maybe in organizing those meetings, activities, that we perhaps don't define those as programmatic gatherings, but more come and talk to us

about your successes, barriers, challenges, hopes, desires needs so we can flush out from the person perspective. We all have our own individual experiences we bring that to our discussion and thinking and to the table. But I'm thinking this aggressive timeline, are we really going to be able to have public meetings during the holiday months?

Kim McCoy Wade
Maybe there is a little confusion. These meetings, including today, have a public comment period and the public is invited to participate.

Lydia Missaelides
There is not separate --?

Kim McCoy Wade
Not through the subcommittee.

Lydia Missaelides
Are there other forums?

Kim McCoy Wade
I will answer that a couple different ways. Yes, the master plan, we are having public forums with different legislators around the state and we will talk about this in the full committee meeting on Monday. But we have one in Bakersfield and one coming up with senior atkins. In November and December we have time. Our partners, CDSS is having IHSS listening sessions. And if we want to have more information from them about that. And CalAIM is having their own stakeholder process. But there are – I think what you were saying, at this moment, although that could emerge.

Lydia Missaelides
Thank you.

Jeff Thom
I just wanted to say, in addition to sort of the non-service element such as housing, we need to look at things such as different types of durable medical equipment that are not covered by any other programs. Such as hearing aids that are partly covered for some people. Low vision aids are not covered at all. There are a lot of other non-service elements that we frequently don't consider when we think about the full spectrum of services supports needed.

Kim McCoy Wade
Thank you, that needs to be included and we'll call that out more clearly.

Claire Ramsey
I just wanted to say that I'm not necessarily weighing in on reorganizing the topic areas. It does not look like we did this on INR, but how much should we be coming into the meeting with a list of recommendations as the starting point? How much easier it is to react instead of coming in with stuff. I think it might provide direction to the conversation and really some framework for moving forward. And I guess because I could see us really driving it in a lot of different ways, and without more framework.

Kim McCoy Wade
For the first meeting, the attempt to do that was to ask Susan and Ana and they are on the subcommittee. And their recommendations are invited. That is part of what I'm asking people, to say yes, I would help assemble that and you help us figure out the local state presentation. And discuss it. What do we call it? Discuss it to help us do that role. That was our attempt at this meeting, I agree. It is good to have content.

Anastasia Dodson
Also we have the engage in box and community members, you can e-mail us with recommendations around these areas. Part of what we were challenged with is get things started. If you have recommendations already for any of the programs, you can send them to us tomorrow, this afternoon, whenever you want. And we can start looking at how would we try scheduling in the topics into the meeting schedule.

Peter Mendoza
One of the things we should talk about too, is long-term services and support in the employment setting. Many with disabilities are living longer and also because of the economic climate, are working longer. Plus we also have care givers working longer, including family care givers. And many care givers don't get retirement, either because they are providing LTSS for free or they don't get paid retirement. If you are a care giver, familiar. We need to talk about that issue. Because LTSS we need to talk about independence and making sure that people can still have economic opportunity and security.

Nina Weiler-Harwell, PhD
I'm going to be really quick because you need to move the agenda. One is when I mentioned the whole person idea before, I wasn't trying to say that we should programmatically structure the meetings. That is going to get us back to where we are now. I was not suggesting that at all. For December 12, I have been talking to Anastasia and we definitely raised out hands out with the agenda. November 12, sorry.

Kim McCoy Wade
We're at 5 after and I don't know that we're going to land and decide this right here. Anyone have a final – I think we're going to give you a day or so to come up with a better way to do this and we're going to keep moving. But we're very open to – Jeff said be sure you call out equipment and workforce we're hearing you about the overlap. We welcome volunteers. We may come to you to ask to help us cohost one of these topics.

Patty Berg
I was going to say, what I was hoping, I don't want somebody to present to me. I know these things, everybody in the room knows these things. Not for today. But, what I was hoping for process is that we would be given homework. We have homework, we have to come prepared to these meetings and there could be a variety of things that you could assign us to do. We would present.

Kim McCoy Wade
Understood.

Patty Berg
And we would discuss.

Kim McCoy Wade
Yes.

Patty Berg
I don't want to come and have presentations, that is a waste of time.

Kim McCoy Wade
Understood. I'm so happy to hear you say that. We did ask Susan and Ana to do work for this time. And that is what we're trying to do. Not everyone

have homework every time, but sometimes. And if patty wants to do it every time, that is great.

Julia Figueira-McDonough
It is just a quick point, I think you said this is going to be going back to the larger committee soon. I think it would be great, if it could be made implicit that we're talking about the whole person and community well-being and health that the care giver is implicitly included in that and not just the recipient of care. Assuming that obviously the better the health and the well-being and the economic stability and all the things mention ds, the better the care received. It is worthwhile making that explicit, if possible.

Kim McCoy Wade
That has come up in many conversations we want to make sure this is clearly defined.

Donna Benton, PhD
Okay, I just want to say I volunteer for number 5.

Kim McCoy Wade
Yes, Donna, thank you.

Donna Benton, PhD
I don't know what else you have besides number 5. That's it.

Maya Altman
When you say the number, can you say the meaning?

Kim McCoy Wade
Slide 5, it says topic 1 today is deep dive and referral. Going forward, Nina volunteered for number 2. IHSS, I think I have ideas around the table who might want to volunteer. Kristina, Brandi and Karen may have thoughts and we invite others. And Claire. And we'll do that in partnership with CDSS. Nothing about without us. We will have that whole circle. And I just heard Donna on topic 5.

Susan DeMarois
I will join Donna on topic 5.

Peter Mendoza
I will do topic 5 as well.

Kim McCoy Wade
Workforce, okay.

Karen Keeslar
Will you send out the notes.

Kristina Bas-Hamilton
Should we in the IHSS include work force issues?

Kim McCoy Wade
Help us figure that out.

Kristina Bas-Hamilton
Why don't you say for number 5, deep dive on – let's just leave it open.

Kim McCoy Wade
We'll figure out how to do that.

Nina Weiler-Harwell, PhD
Add me for number 5.

Kim McCoy Wade
There is no one for 4 or 6.

Lydia Missaelides
I was going to say that. 4.

Marty Omoto
Me, too, 4.

Kristina Bas-Hamilton
That should be including regional centers then.

Marty Omoto
Oh it will. [laughter]

Kim McCoy Wade
Excellent.

Ellen Schmeding
I can assist with number 6.

Kim McCoy Wade
I think we caught this, but we will go back around.

Maya Altman
If nobody is saying number 6, I will take it.

Kim McCoy Wade
You and Ellen are going to. And I think Craig.

Sarah Steenhausen
To me it sounds like just in summary, there have been three themes raised. There was the issue broad setting the context of does this group want to have some sort of goal statement for specify to LTSS and if that is something the group wants to pull together to bring to the next meeting. I think it would help us all feel grounded in the work as general. From that, the report structure that you outlined on number 3, I think everything in there would be included. But it could be revisited according to the goal statement of the subcommittee. And as well, most of these meetings would probably stay the same, but one or two that evolve. I hear what you are saying, you need this committee to provide the feedback. You have done a great job of outlining your suggestions. If we have an alternative approach, I don't think we're going to come to consensus on that right now. One thing as an example that we did not come to resolution on is the issue of the financing of the system and how it is financed and crossed over with the other issue being integration, that is not here.

Kim McCoy Wade
The middle-class financing conversation is stand alone. Is the IHSS financing conversation happens at IHSS or is it separate alone financing outside?

Sarah Steenhausen
I think so because we have to look at as a whole, the whole system. Every program is funded differently and has different streams. In that, you have a

lot of issues about planning because of the separate funding streams. And will are ways to look at it and other approaches that some other states have made. And also, you have the issue of – that can be done through the health plan and that could be a place to engage.

Kim McCoy Wade
There could be a topic on that.

Claire Ramsey
You are seconding more of a broad financing discussion?

Kristina Bas-Hamilton
Public financing. How the state pays for all of the services and how the budget is structured and planned. It ties in to so many different issues. For example, the way our – the budget process plays into a lot of this. And why are they housed – entitlement to LTSS.

Maya Altman
We're not going to get to the level of detail, but it is important to set a vision around that and this group is really equipped to do that. It might not be immediate fixes, but where do we want the system to go?

Kristina Bas-Hamilton
Won't that be the 4 principles that are going to be presented?

Kim McCoy Wade
Maybe I can lean those of you who are on the full committee just to bring this to Monday's conversation and see how far it gets us. If an ad hoc group is needed to push or stretch that.

Kristina Bas-Hamilton
I think the way you wrote it, if I recall, number one is I want the services – we will be able to choose where we live and have the help we need to do so. That sounds like a pretty profound, broad mission goal, statement, whatever, for this committee. Or do you think it is something different, Sarah?

Sarah Steenhausen
I think that is what we're saying, but you can take it further beyond that one sentence. And that can be something the group can flush out in 3 sentences, just to help guide.

Kim McCoy Wade
Okay. So. Three next steps I'm hearing, I'm going to move us forward. The goal statement will be discussed at the full committee meeting on Monday and then some folks here may take that and do more adding on. We will work on this topic list a little more. Sounds like a 7 has been added around public finance and we will ask for 2 to 4 volunteers to help structure the meetings. And we'll send that around and share that back with the full committee on Monday. That was two things, sorry.

Sarah Steenhausen
I think the report structure can be maybe a little bit tweaked to reflect broader categories rather than individual programs specific issues. That could be something that flows from the goal statement. The feedback provided by the committee, we can all somehow provide input on that.

Kim McCoy Wade
Absolutely. Okay. We are going to take a pause, mentally. Close that conversation. We're adult learners and folks can take breaks as they need. We are going to switch to – we thought we ought to start in the beginning, which is how do people find out about the systems? Information and referral and we wanted to start with on the ground reality as well as local leadership and innovation. And we were very, very grateful – let me tell you on the agenda so you can see how we are going to tackle the topic. Shed some light on the state network behind it. The aging disability resource connection that California develop of aging. We have asked members of the subcommittee. And we will open it up for the full subcommittee. This is our first time doing this. If we come up with recommendations in the end, that is fabulous. The intent is to get them out on the table, and more will come. It is pushing towards that draft in January. Susan just left. Just kidding. Shireen. We're honored and delighted to have you here to be the first presenter. You are on.

Shireen McSpadden: I have a question about the slides. Hi everybody. I'm going make this and dedicate this presentation to patty. [laughter]

Patty Berg
Thank you. I hear you have a great reputation.

Shireen McSpadden
I'm here today, executive director of the San Francisco development of adult aging and services. And I'm here to talk about the benefits and resource hub.

I just wanted to basically say that our department – I'm going to lay out the agenda. Our department talk about it in the background and talk about the various pieces of the benefits and resource hub and talk about the creation and structure. Integrated intake and referral, community connections lessons learned and hopefully time for discussion.

So, vision, mission and values. San Francisco is a city where people with disables older adults are valued and engaged and living can dignity is our vision. Our mission is that we support the well-being, safety and independence of adults with disabilities, older people and veterans. And values are compassion, accountability, inclusion, equity and innovation.

The San Francisco department of aging adult services has a budget of 370 million annually. Most of that funds in home supportive services, wages health care for the providers. 75 million goes to community-based services provided by non-profits. We have 370 staff across the direct services programs and administrative support. IHSS, 170 staff. Adult protective services, 64 staff and legal and guardianship, 66 FTEs. We partner with 62 community-based organizations. Much more.

Our department is split in two divisions, department programs. Mostly the direct services, protective services resources for people who need extra support to live safely and with stability in the community. And then we have community services. Those services are focused on connection, community engagement and other programs offered through nonprofit organizations. We do have direct client facing services in our division and I will talk about the benefits resource hub that helps people connect with services.

This is just another way that we think of – that the range of services that we have. Which I personally think is helpful. Unfortunately, this is so tiny that I can't see it. We go from – going from engagement and wellness services. If

we look at services, we look at population needs. Thinking about people who are independent and active individuals. And then on this spectrum, all the way to individuals unable to manage their own needs. And the services range from engagement and wellness services to community stability services, crisis intervention to guardianship services and we have that whole network of services.

Moving on to the hub specifically.
I think it was about 5 or 6 years ago, has not been that long. Actually, this came from our IHSS director who said we should have a service center. In San Francisco we have what is known as a service center model. More in our human services agency programs. And we thought it might be helpful to have a service center model for people with disabilities and older adults. Motivation was really to create an inverse service center for aging and disability. And our parent agency, the human services agency had several service centers already.

We went about this in the same way that our human services partners had done where we brought in a consultant to really look at modeling need, usage. And to try to help us decide what our staffing should look like and how we should model that staffing. We really had no idea at the time how many people would really use the service center. And I was concerned a bit about trying to develop something and then not having anybody come.

We wanted to make sure it was going to be useful for people. We did a lot of community engagement, brought in people with disabilities older people who might use the services. And reached out to the community-based organizations to have them for help in designing this.

Ultimately, I think we did a soft launch in December of 2015 and then a bigger launch in March of 2016. What we really did when we started this was cobble together funding. We brought in eligibility workers from the IHSS world and adult protective services workers who previously had done intake and had information and referral assistance staff. And we launched it that way. There are some lessons learned around that. But we did not have another way to fund this and how do we integrate the front-facing staff people into one system?

So, our hub structure is intended to be a one-stop shop for services. This includes the services provided by the department, but also services beyond

our immediate scope. We refer people and services provided by community organizations, other city agencies and more. For example. We referral for assisted living placement, we refer to our homeless department and other places like that.

The on-site services provided at the hub are county veteran services. We have about 3400 clients, about 450 visitors. The DAAS eligibility, primary focus on people applying for IHSS. We feel this provides us with efficiency gains and centralize work within DAAS. Our staff have a specialty of working with people with disabilities older adults and we feel that gives a better experience for people who need our support.

And the depth of knowledge. Understanding the Medi-Cal roles specifically related to older people and those with disabilities and they can provide better guidance on the most advantageous ways to enroll in IHSS and Medi-Cal. We get about 800 new application per year there.

Information and referral. We do integrated intake and referral and that leaves the referral services for the county. And I will talk about that piece a few minutes.

IHSS provider support. We moved the enrollment services for IHSS providers. So, providers recipients are seen in the same place. Of course, probably most of you know, that makes a lot of sense because a lot of times people are living together and family members. It seems to make more sense. And it helps, I think, in giving more visibility to this site.

So, in 2007, we created an integrated intake unit. Currently, this is staffed with about 30 FTE, that includes a manager and 3 supervisors who oversee. Most of the staff are BSW and some are MSW. And those are the ones that manage the aps referrals. In the early 2000s, we had two staff doing all this work and that was not very successful. By 2012, the unit had staffed was staffed 12 FTEs. Part of the reason we've grown it a lot is really bringing these things together and thinking about the eligibility piece in particular, but also because we're fortunate in San Francisco to have the d. Fund and we've been able to add a few staff because of that.

Our workload for this entire unit is about 28,000 incoming calls per year. We have about 15,000 program applications a year and about 4,000 information and referral sessions, individual.

So, our services provided, just to go into a little bit more detail. We have information and referral and obviously we provide information about all the relevant services and resources. We process applications and intakes for several department programs. You can see the list on the slide. We have adult protective services, case management referrals. We have what is called the community living fund in San Francisco. Which is more intensive case management with purchase of service dollars attached many home delivered meals in home supportive services.

Patty Berg
You are a county run organization and that is altogether different in terms of non-profit.

Shireen McSpadden
Very different, yes, that is true. For us, I think that the use of the integrated intake in our system database allows us to really collaborate with the community organizations, our non-profits. It allows us to skip asking and repopulating the same basic information. Once they have applied for one service, we have the basic information and we can – when they come back and want something different, we already know what they have and it is helpful from that perspective in order for us to provide really good customer service.

As staff speak with a caller or visitor about what program, they get a sense of the individual's need. And we're working with staff to make sure that they are thinking about the whole person and about the needs that might go beyond the initial ask. They may say I want IHSS and we realize there is a protective issue and we can get into that. We've noticed that many times when people need meals that they actually – it is a protection issue. And I think in addition to that, if we're looking at case management, we may identify that the person has a personal care need. It is really a good place for our staff to be when they are speaking with somebody or with a care giver and start sussing out what the other issues might be that people don't know about. When people are calling, they don't know about other services, they barely know about the service they are calling about. This has been a good move in the right direction.

With case management and home delivery meals, we do more than take the application. For both of the services, we have a clearinghouse and

we've moved initially, I think we were just – when I started at the department 16 years ago, we were still referring out to the meal sites we to would get a call and give everybody the laundry list of meal sites. We do the same thing with case management. Of course, people have different needs and different needs in terms of language and specialty. With our meals programs, we have specialty meals. Very specific ethnic meals and the other things that other counties have.
We have developed two databases so that we can keep the clearinghouse within the hub so that when somebody applies for meals, for instance, we know what their preferences are. And we know what the priority is. We use an algorithm so we can decide what the acuity level is. If somebody is at high emergency level, we can get the meal to them right away. So, the system prioritized all of that.

With our centralized case management wait list, we centralized this in 2016 because we heard from the providers that they lacked the capacity and we thought that did not jive with what we were seeing. We went out and started paying attention to the different programs realized part of it was, nobody knew where the openings were. If there was an opening with one program with a specific language, we were saying to everybody, here is the case management and call around. This really made a difference. We have 12 agencies providing case management. We got rid of all of the duplication around wait list and we screen for emergencies there. Referral people to aps if they need to be referred immediately or assign them to the provider agencies.

One of the things that has been important with both of these, with the home-delivered meals and case management clearinghouse, we noticed the importance of the information with the staff and working with the community providers. It is a dynamic relationship and we need people to come together and discuss what is working and not work and moving forward together to kind of tweak the system. I think it is working really well at this point.

In terms of leveraging the hub, we do all of our community outreach from the hub. So, our staff in the DAAS unit, host information tables, and given their role and responsibilities, they are well equipped to lead for the agency. And right now, we're in the middle of an end ageism campaign in San Francisco and they are helping with that. Helping to socialize by going out and talking to people about what it is and how it works and distributing

posters and buttons telling people how to take advantage of the social media campaigns.

Patty Berg
This is something that need to be added to the master plan and they talked it so you will be brought in.

Shireen McSpadden
We have the opportunity to leverage space and promote across program connections. We have a computer lab, a drop in with staff to help. Getting on to benefits, searching the web, if people want to do that. We have para transit coming in and the MTA has regular hours for people to come in. And then one of the things that we do there that I actually am proud of, we thought a lot of about the site and how to make it comfortable for people with disabilities and older adults. We wanted to have clear signage and comfortable chairs and we had community members help tell what the seating should be like and making sure it is accessible for people with disabilities. And one of the things that people really wanted from the community was to have people who looked like them be there. So, we have a community liaison program where people with disabilities, older adults veterans who are there to greet customers when they come in the door so that people feel comfortable when they see somebody who is a peer.

And then the department also funds community-based organizations to have information and assistance specialists at site throughout the city. And this helps maximize the impact and extend assistance. We think of this as the hub and then the hub with spokes out. We have aging and disability resource centers throughout the city. And it is what we call INR like. If somebody really needs something like a heavy adult protective services intervention, that is mostly done at the hub. And the ADRC, it is confusing. The aging disability resource centers, we could refer into the hub and sometimes out. While we have a lot of languages at the hub, it is really nice for people to be able to connect in their own neighborhood.

So those sites have an information referral function, but they help people in assisting – they assist people in filling out forms, which, of course, is a really important function. We have this facilitated by a centralized coordinator who is a liaison with the department and helps the information and keeps that up to date. I think right now we have 12 spokes. We have

11 different sites, one in each supervisor district. And then we have one that specializes specifically in serving the LGBTQ population.

For instance, our past efforts to increase participation, CalFresh has really been elevated by those sites. They really helped get information out into the communities. The roll out of the collection requirements. Those centers actually do tie into the ADRC system. The centers and the coordinator who work with the centers are part of our ADRC in San Francisco along with our department.

Lessons learned; one is the importance of the community connections. We call it the hub for a reason, as I said, we have spokes out into every neighborhood so that people can disabilities everyone else. And the connections out and back in or really important piece of the model.

The benefits of wait list manage and home delivered meals and case management. It allows us to have a better idea of the need and allows us to have a better idea of what is actually going on in the communicate.

Integrated intake and database. Integrating forms and having a shared database. The ability to ensure that individuals receive all the services they can benefit from. And clear signage is key. We know it is important, but we learned it in a new way from creating the hub. Beyond signage, it is about the atmosphere and space, needing to be warm and welcoming. And the community liaisons, having peer navigators is helpful.

This slide shows the billboard, mockup that is going to be at the site. We had a billboard there before that did not match what was actually there. It was something about foster care and there was an arrow to our site. There is a veteran, senior and a person with a disability on there.

Patty Berg
It says the hub?

Shireen McSpadden
I can’t read it either. It says Department of Aging and Adult Services, Benefits Resource Hub. And shifting the staff perspective to the whole person orientation is obviously really important. That is a work in progress. it is so much better than it was, but we’re still working on it and have a great new program director and I’m excited. She has good ideas about how

to get the staff really there. That is what we're working on now. I think that is a huge lift. Staff have been doing one piece and all of a sudden, they have to know everything. And they are building their expertise and we're working on it, but I'm really excited about what it is going to look like in the near future. I think that's it.

The only other thing I wanted to say because to me this is really important. Our department's name is changing, I believe. Because there is a name change on the ballot. It has to be changed by the voters. It is going to be disability and aging services there is no opposition and I'm sure it is going to change. That is going to be an important message to the community. I'm very excited about that. [applause]

Kim McCoy Wade
I'm going to ask us to have a state and narrative perspective. We have Irene Walela and Karol.

Irene Walela
Thank you all for being here and thank you for that. I know all of you are doing great work in your communities and you've added this. Wow, thank you. We're going to take a look, stepping back a little bit from the local level and looking at the more state level, talking about the idea of a "no wrong door" concept. Specifically, age and disability resource connection and centers here in California.

This concept offers a way for people with disabilities older adults and families and care givers to access long-term services and supports. And a seamless experience. It reflects what Kim said early in the meeting, we will be able to live where we choose and have the help and the family – I'm trying to talk too fast and I will slow down. Having the help, we need to do so. Let's start with a story of a person.

This slide tells a composite story of June Smith. [reading] So, she may be a composite, but not unusual. We know in California we have blended, non-traditional families, families who are intergenerational in terms of being care givers. June hears stories from friends and neighbors about the help that they get, but she does not know how it find that help for herself. She has heard about some of the sales pitches that one can get if you sign up for the complementary steak dinner for long-term health care insurance. But she does not want to participate in being sold or does not want a list of 8

phone numbers to call or more. Or fill out 10 applications, all with the same information. Likely she does not know the names of the places that she needs to contact. She knows if she does be not get help, she is facing poverty.

On the next slide we put forward a picture of what we are calling California's information silos. This is an illustration of what has been talked about here earlier today. It shows individuals inside of the circles, none of which are connected. I did hear something recently that I want to share with the group about reaching and bridging the silos. Which I think Shireen gave us examples us. Organizations are providing the services, but if we are connected with each other, it would take care of the problem of being separated.

There is no shortage of information in California and really, there are a lot of services. But first a person like June Smith has to find by name, and perhaps a name she has not ever heard of. And then she has to go from silo to silo filling out applications and getting additional phone numbers and possibly being delayed when she is in crisis. Possibly health and safety needs fulling through the cracks. Sometimes each of the systems will respond by trying to fit the person into a system. This is not a whole system or approach as mentioned. But with all good intentions, every person in the system is trying to find the right box for that person so they can get the services they are looking for.

We do have a foundation in California with the 33-area agencies on aging. Those 33 triple a's have information and assistance system and provide up to date information on resources and services for older adults. And using those programs to refer for resources the community and follow up on the referrals. Those are programs that are limited to the programs offered through the AAA for the community partnered. It is often an entry point for older Californians, but it is not able to serve people with disables across the life span or program individuals who are having early onset dementia or other situations that require long-term services supports many although many of the AAAs do work with the partners at the local level to provide those additional resources.

They are seen, often identified as a service for older adults. So not known to other groups.

We have many other information and referral resources used in California. And we have a graphic that no one can read up there.

Which is exactly the point. Multiple circles rectangles all connected by overlapping and dotted lines confusing lines.
Some of the many places that offer these services and offer them well are listed on the slide. In addition, there is even more. We have the veterans administration, faith-based organizations and schools and libraries. Of course, all the different service locator programs that are available with the 800 numbers. Independent living centers are an important hub for individuals' disabilities at the local level. 211, local government, county programs. They are all listed here on the slide. I will not read them.

Each of those systems is doing their best, like I said. With all good intention. Trying to provide the services that they know of to the person that comes in. Now we have another graphic that is a little easier to see. This shows a tiny little person facing a giant maze. And that is what our current information referral system feels like to the person like June who is looking for services now. She is not looking to go through a maze to get the services she needs.

Switching to a vision, the aging and disability resource center or connection is a system based on the no wrong door concept. It is a coordinated system with shared protocols, a trusted source for information. It does not duplicate services that are offered, it offers pure navigators through a partnership with the independent living centers and the AAA and areas on aging and a network of local organizations so that the individual seeking services and their families and care givers can make one call and have warm hand offs that are personal-centered, to reach the seamless and streamlined access to services that they need to reach the goals of independence. ADRC serves any individual of any age and income and disability by delivering the right information at the right time. The local ADRCs have four main functions, which are not duplications of services in the community. Offering peer navigators at the AAA and independent living centers to provide a streamline pathway. They offer the enhanced information and referral, short-term service coordination for the services that are critical to help people avoid institutionalization or other health and safety risks.

Person-centered counseling, also called options and transition services. Those seeking to go home or return to the community from a skilled

nursing facility. We've got a few legislative whims. Recently ab1287, requires a master plan to consider universal assessments and no wrong door system. The sb453, signed October 12 and requires the department of aging to develop a core model of best practices. And department of health care services to look into using Medicaid administrative claiming to fund a no wrong door system in California.

Lastly, sb80 part of the budget human services bill, provides funding for the infrastructure grants program for implementing no wrong door through the triple as and the ILC partnerships. What that consists of at this time, we have 9 currently designated ADRCs in California, which covers about a third of the population. That is 9 counties and currently be re-designated so that they can be ready to go when the funding program begins January. The infrastructure grants program will help build capacity by supporting new partnerships that are being developed, of course, the grants program that I mentioned. These local ADRCs have demonstrated the value of state departments working together. The ADRC is housed as department of aging and is in partnership with DOR and receives funding for staff from department of health care services to we can provide that seamless experience for the counties that we have in place right now.

We hope the partners are an example of a way to provide a no wrong door system in California to apply a set of principles in California to the long-term services and supports. Lastly, we have a better graphic, which is a circle of ten hands, each holding on to the wrist of another hand. And the representation here is the idea that they are working together so that the person like Ms. Smith, when she opens any door, any door at all, she will be able to find the services she needs without having to attempt to find services through all kinds of doors. So no longer a maze, but rather a way to come into the system and get the supports she and her family needs to be independent in their communities. Karol is going to talk about what other states are doing.

Karol Swartzlander
I'm going to provide you with a quick overview, Washington, Wisconsin and Minnesota. I'm going it highlight the features or gold standards of each model.

First, starting with the state of Washington, they use a mini door approach and brand their no wrong door model as the community living connections

or CLCS, which are basically an area agency on aging who has contracts with partner organizations, including the regional Medicaid office.

They are promoted on a state website that includes a state staff information 800 line and online chat feature. The portal offers a self-guided assessment for consumers and care givers. And have allocated funding through the tailor care protocol and support platform. And the organizations are funded by the state Medicaid agency. The next slide is just a screen shot of the website.

Moving to Wisconsin. Wisconsin uses the ADRC for branding and they are a resource connection center. They can be stand alone, human service departments or county aging units. The state has contracted for ADRCs in every one of the counties and they have a required set of services that include INR and benefits counseling. They have to be free from conflict and provide standardized data across the state. They offer an online portal that includes referral resources.

The next slide is for Minnesota health. It is a broad resource that provides full access to health care, social services other supports, either online, in person or by phone. It is really much broader than any of the other websites. They go into all kinds of services, but they have their brand of Minnesota health. They can go into a topic or specialized portal for seniors, veterans or disability. And they offer an additional feature, which is the long-term health care navigator.

The next one is the navigator forum. To summarize the key features that I see in the three states, first each one has a standard logo and branding. Each one has a statewide web portal that links individuals to local organizations for in person support. Washington and Minnesota both have statewide 800 and online chat features and provide guided searches. And Washington state is unique because their CLCS are funded to conduct the prescreening and they have the universal assessment for long-term services supports. And I have Washington envy, I really do. If you want to learn more about each of the states, the links are embedded in the slides. [applause]

Kim McCoy Wade
Great. Thank you. We did want to have the subcommittee helps structure and kick off the conversation.

Susan DeMarois
How many minutes would you like me to spend being a discussant?

Kim McCoy Wade
Less than 5.

Susan DeMarois
Here is my personal philosophy on system navigation. If you have been a parent and ever gone to the state fair and your child has tickets coming back saying I want to go on this ride and this ride. And you end up spending more at the end of the day than if you buy a bracelet or arm band. We're talking about this. To fund the programs that we will need for the growing population, we need to realize new efficiencies. You have slides and I hope you will look through and I hope you will visit the ALD website to see the self-guided features and community resource. We have a national partner, which is AARP on the community resource finder.

A few things, we, the Alzheimer's association is a non-profit agency. We are not the fifth largest economy in the world. Who is? We've invested technology. And often we talk about devices or apps for the consumer. But the back endospore for something like our 800 number that is available 24/7 in all 50 states, was a huge investment in technology. So, we would urge the state to make a similar investment. It is also an investment in staffing. We found and I loved how Shireen talked about the hub and spoke.

We had part-time people pieced together in offices around the country trying to do the same thing and we realized if we invested in master's level clinicians provided them the training, they could help everybody, 24/7, no matter where they lived help people access information. In my case I lived in Sacramento and my mom with Alzheimer's lived in lake county. Many people don't live where the services or information is needed and we're able to provide that.

We're able to invest in continuous quality improvement. So, we can improve our systems and training as needed.

We have invested data and Analytics. And I want to thank Kim, she had been appointed for maybe 18 hours and she was on a personal trip to

Chicago and toured where our hub is located. We can tell how long somebody has waited, what language and can tell if somebody called us daily for a month. And we reduced redundancies in the network and created – for example, several of our offices today are without power. Because we have this back up, we can assist families throughout California who are able to call the 800 number and get live assistance. In a state of our size having that back up redundancies can really help the consumer in the end.

If there is a small office and they are going out for a long birthday lunch and nobody can reach them for 2 hours, we've overcome that. I like the words centralized. That is what we found. And also, that we've been able to offer extended hours. Through model, we were able not just 8 to 5. So many people – people work, especially in the case of Alzheimer's, so many families have questions late at night, overnight and they can reach a live person to help them in their time of need. We find that family care givers do not work 8 to 5 and they are not able to get the help they need. This way we can extend hours offer assistance during the holidays which are difficult for families living with Alzheimer's.

Those would be the features. Look at the slides. If you haven't visited our community resource finder, I encourage you on your own time, put in your zip code and walk through and see how much information is there for free and can be available statewide. Alz.org is the website. If you click on help, I think it is on your slides. I will send you the exact link. You can enter your mom in Atlanta Georgia. During the day, the 800 number and this is a feature we hope California will adopt, it identifies where you are calling from and connects you to the nearest local office, which is a feature that technology can provide. Thank you.

Ana Acton
Executive director of FREED and core partner of the Aging and Disability Connection in Nevada county. I need to bring up the fact that I do not have a presentation because we've been dealing with the public safety power shut off. I'm going to read you two INR pieces that came in.

Identified as a woman in a rural part of Yuba county, in a hospital that has not have power for days. 65-year-old gentleman who came to the ER, he is too cold to care for himself properly and has not eating in 2 or 3 days. These are the things we are dealing with and why I don't have a prepared

presentation. With that, in Nevada county, we have been working collaboratively for many years aging and disability organizations. For us, we mentioned there are some key organizations doing information and referral. And that is the independent living centers, freed is one of 28. And also, the triple as that do the senior INA.
We have the benefit in Nevada county of having a 211. This is a 211 that happens to operate the IHSS regional public authority. This is an organization that is deeply engaged understands disability and aging issues and becomes a critical partner in the system. And other counties as well, we don’t have a 211. We don’t have the connecting point that we have in Nevada county in all other counties. But those end up being the key trusted referral resources that we can say call 211, 24/7 and you will get connected. We do hand to hand pass offs.

I wanted to mention a few things that we find; one is we have to make sure when people connect, they actually touch down and land. And so, what we hear too often is that I got referred here and there and no one can actually help me. I was not eligible. Really ensuring that the referral and training, make sure regardless of which organization they go to, they actually get to where they need to go. And looking at other more calls coming in by the minute.

Kim McCoy Wade
That is another presentation we can make.

Ana Acton
Making sure people connect and look at how it assess the needs. How many of you were part of the state process? We really need – we really need to come up with a universal way to assess need and get people connected.

Aging and disability, these are the same services people need regardless of age. It allows us – another key partner is adult services. We don’t have an aging and disability services yet. But this allows us to identify the gap. A lot of times provide funding for home modification because you are under the age and don’t fall under the act. And it allows us to coordinate services. It is a major culture shift that we’re going through, through the no wrong door and personal-centered ways of providing services. It is new to some organizations some of us have been doing it for years others it is a culture shift. What do we mean by person-centered and individualized services?

That is something we need to look at. And shared databases and release of information. How many of you are familiar with the HMIS, homeless management information system? There is an example, not always used to its full potential. Consumer control, and confidentiality. They will be able to coordinate that in a real way that ensures confidentiality. With that, our partners 20, are very rural in Nevada county. Which is a benefit, and also means we don't have as many robust services, but we have deep relationships that help us coordinate the services that help make a difference for that individual.

Kim McCoy Wade
Thank you. And Ana, I want to thank you and all the independent living centers. And the network and services have been largely pushed out by the health and human services agency. Causing a lot of relief. So, thank you all for all you are doing and we are all committed to doing better and more. More to come on another day about disaster response. Let me open it up to the stakeholder community.

Lydia Missaelides
Question that as I was listening to these excellent presentations came to mind. In some cases, as we all think about thousand improve systems today, there are likely some federal barriers that come to mind. I'm wondering, is there an opportunity to identify what some of the federal regulations laws are? While we don't independently have the influence, I wonder, do you have thoughts about that and how much energy we might want to spend as we gather thoughts?

Kim McCoy Wade
First one, yes, the second one is for the group to prioritize.

Karen Keeslar
I appreciate the lessons learned from the other states, but I want to make sure that we're building on our investments what we have in place in California and our county-based welfare departments that run IHSS, that work with state and IHSS. The public authorities a work with the state on IHSS. Our system that is built on partnership with local government is very, very different from Washington and Wisconsin and the other states that were highlighted here. So, whether we're building a universal assessment, no wrong door, whatever the topic is, I think we really need to be building

on both the differences and the similarities in a county-based partnership and administration.

Kim McCoy Wade
Yes, one thing that Susan, in my rushing you, my understanding, if anyone calls the national 800, they are logged in the contact management database and the local is pinged and has to get back to that person within 48 hours. There is a customer service standard, but the local will handle in their own way with their own local resources. You all spent many years working out how you leveraged the best of local services with the national network and systems. That centralized, decentralized balance.

Susan DeMarois
And there is a hierarchy. If it is an emergency situation, there will be a personal call and a connection as soon as that next office opens. Otherwise it is a computer referral and then they have to follow up as well. And report in the system that it has been followed up. Since I have the mic phone, I forgot to talk about the ability to offer services in so many additional languages through a centralized approach and we have a bilingual staff with over 200 languages we provide.

Ellen Schmeding
Thank you, that was so interesting, and I appreciated all the presentations. One thing that occurs to me, the ADRC is the basic level one on one integration and Shireen and what happened in other areas, takes to an extreme integration model. And I wish we could dream big that every county and region could go with the full integrated model. But starting with this would be a huge step forward. With only 9 regions so far looking to have at a basic entry. We spent many, many years in San Diego, branding the call center and services and how challenging that was for people to get to know what is available and offered. I only wish that every region could have all of the programs integrated. But to start with ADRC is huge.

Kristina Bas-Hamilton
So, I'm curious from a nuts and bolts perspective. Why is there not a requirement that ADRCs exist all over the state? Is this a browning era where they used to be, and all got cut?

Irene Walela
It was started with a federal program that then the monies were discontinued. In California there were federal moneys and some state support and probably Karol knows more about this because she was a part of that. That is what happened and now we're back to getting resources again. Is that fair?

Karol Swartzlander
The previous efforts were fully federal funded. Only with this last bit of legislation is the first money that we have gotten from the state general fund. Before it was all voluntarily and people had to come to the table. But there was no way to mandate with no funding.

Kristina Bas-Hamilton
Were there attempts to get funding? That is a loaded question and I will leave that alone.

Irene Walela
The short answer is yes.

Kristina Bas-Hamilton
That could be a very simple recommendation coming out of this advisory committee. This is a best practice and we should fund such a thing. Okay.

Marty Omoto
Okay, all in favor?

Sarah Steenhausen
That is a perfect segue. Thank you, all of the presentations were illuminating. Even the Alzheimer's association, which I had the pleasure of visit and seeing the call center. They are trying to get more people to find out about this system and service and it is hard to connect people. One of the themes that has come up a lot in other conversations is the disconnect with the medical community. And Jose Alberto Arevalo, I'm looking at you. How can we form better connections so there is that way to line up people to the resources? That is one thought.

The other thing I was thinking about from the presentations was in San Francisco, the benefit of the collocation with the Medi-Cal, most ADRCs don't have that and you really can't help people if they can't apply inform

Medi-Cal and not connected to a separate system. That is a really effective model. And also, you have the benefit of resources from the community and dignity fund. I love, if I could just throw out my own recommendation, it would be why can’t we create a statewide community living fund? There used to be a special circumstances fund in DSS funded through SSI/SSP, where people with emergent needs and different range of issues, it was only a million dollars, but still, more than we have now. You would get some special need met. That is what San Francisco has. And what are the little programs we can squeeze you into? Finally, won’t it be great, not to hammer on this again, a whole person approach can only be taken if you have a way of assessing a person for a whole need. I know it was hard and a tough conversation. I would argue that the universal assessment was not really a universal assessment. They were trying to make something based on three programs. And there was not a lot of will to make it happen and it was a difficult conversation. And I do agree what Karen said. We have to build off the systems. How can we build off that, obviously it is really hard? But if we can dream big, that would be great.

Kristina Bas-Hamilton
Are we noting as we come along, that’s it, draft recommendation?

Kim McCoy Wade
We are. Let me do a process note. At 4:20, it is public comment. I would like to finish the stakeholders we will stay as long as takes to finish. I’ve got 8 stakeholder members. 9, hopefully you can be a minute. And to give the public who has been with us a long time. 10 minutes and then I want to open the phone.

Peter Mendoza
ADRCs are really important in emergencies. Center for independent living just got state designation. And our coordinator deserves credit. What ADRC came through for us, our office does not have power and there was a PSPS that were impacted by this and people were evacuating. And working with one of our ADRC partners, aging and adult services, we were able to utilize the information and referral line, which they were going to man 24 hours. And they were in direct communication with us and were part of a team with another that was assisting with needs, both within the system. The emergency operations systems and through aging and adult services. We published that number on our social media so people with

disabilities and other people who needed assistance, seniors and others, had a way to community with MCIL and health and human services.

Because of the relationship with their ADRC, we were able to set that up fairly quickly. And a few short phone conversations, we have strong relationships our partners and the ADRC system came through and it was a benefit for our community.

Kim McCoy Wade
That's right. You can't build that on the fly.

Nina Weiler-Harwell, PhD
I have lots of ideas, but I will be really quick. First of all, I want to make a comment, San Francisco aging and adult services I just want to say the fact that you all called out as putting your population, people who are independent and active is really important. There has been – I was at the research subcommittee meeting the other day and it seems like all the data that was being pulled up painted this picture that all seniors and all Californians are frail. We want to make sure we are taking care of all of the populations, including our older Californians that are still active, working, wanting to get out in the community, can't get from point a to b for whatever reason, while still being active. That is one thing.

I agree with the comments about every county, so in my ideal world, ADRCs would be in every county, including the rural counties.

Patty Berg
First is the information and referral is what I say.

Nina Weiler-Harwell, PhD
However, it may set itself up. So, we certainly were deeply concerned about that. Seeing the 800 number, AARP does put together a care giver resource guide. When the national office said, can't you do a statewide guide? No, you gave us 9 pages because we have a different number for all the services. Having that first step, that no wrong door would be the single site or the 800 number. But we are going to do it, and this is high level recommendations. Emergency services are integral to all of this and it is becoming so apparent. And again, the rural communities, largely increasingly older individuals and persons with disabilities, the stories Ana was telling broke my heart and we are hearing about this all the time.

My understanding on the ADRCs, yes, we have funding from the feds through the aca, however, the state was not willing to match that up. I think things have – the tide has turned.

Claire Ramsey
Thanks, I have three points. I just want to say that we need to make sure we have the resource there is to back up any information and referral. While we can have the best system in the world to tell people where to go – and it leads to break down in trust about the system because the system does not really help you. Someone mentioned this, we have to think about regional approach because counties are great. If I live in one part of the county and want to get to another, I should be able to.

Last about the data sharing piece, the whole person care pilot had a complicated data sharing component to it. I don't know all the details of how they worked it out. I do want to say there are a lot of examples of how this is worked out in other programs and other parts of the universe we're talking about. Borrowing through what already exists, we need to be on alert for that.

Kim McCoy Wade
Thanks.

José Alberto Arévalo, MD
Thank you. I think Sarah and I are on the same page about the issue of getting the information out. Especially when there are new challenges. One of the things I wanted to appreciate, the presentations were excellent. The Alzheimer's organization to have language capabilities. Along with it, the cultural pieces that are necessary just because it is more than language, it is cultural barriers a need to be part of that process. Getting that information out to the communities. I'm from the LatinX community and we definitely need to know, and I know that is a big gap, how do we get that information out to the community?

I'm in an integrated system, I can't speak for rural counties. One of the things is that integrated health systems are moving to understand population health because they are taking risk. This is important from the integrated health system approach that now we need to get out there and create the referral systems and know what is happening, but it is still a big

gap. And we need to figure out especially the integrated systems themselves, we are going to want to create the conduits of communication and how do we find out about this information and have it available to the clinicians skilled nursing facilities and other partners because now we are taking on more and more risk.

There is an organization which I'm sure everybody has heard of, the California care organization. Which brings together community clinics under the state of California and they are working to provide information to the providers and the care givers and their ancillary or partner organizations. So CPCA is a huge and wonderful organization that I think we need to kind of think about as a part of this conduit of communication.

Marty Omoto
Thanks for the presentations. Toward that, on the pilots, and I actually tried the Alzheimer's call center and it works, at least for me. I tried other versions of those, again it was for personal use for people that I know of family members, IHSS and LA County. And some of those don't work. It depends on the person, and I don't necessarily fault the individuals who are trying to provide that service. But either they are overwhelmed or there is misinformation. To your point, credibility is important to people that we serve. But Alzheimer's did seem to work. And why does it work? And I have heard countless presentations on pilots and the pilots always seem to work, but it does not work if you try to apply it anywhere else.

One of the things as a subcommittee and master plan, why does it work? What are the elements in this and makes it work versus something else that does not work? We need to solve this on a scale that is much larger and there is something as to why that works. It is not just the funding or accountability; it might be a factor of all the things. The issue of no wrong door and again, my family has been pushed into a door and then you end up in a closet and then you are in a back door that leads right back outside. And Ana, you mentioned following up on referrals. I don't know exactly how you did that, and you don't need to answer that now.

That is so crucial, when you refer someone to another type of service, did they land somewhere or are they still in the air? Lastly going back to the other points on the structure of what we have, there is some parameters of what we do here in the master plan, meaning there is some big gorillas or elephants out there, what have you call them and it has to do with money

and the sustainability of IHSS and it is scary. And we got to make sure as we're talking about the ideas that we are strengthening the foundation of what we have and building on it. IHSS, that is 7% reduction is still there and the need is expanding, and we have to do other things it. I love the presentations we need to pick it apart as to why it works. I just put her thing their because I assumed, she wanted to talk. I forget she is not working in the assembly anymore.

Patty Berg
I will just say a couple things. I tried last year to use the state Alzheimer's association and it did not work for me. I did get down to Santa Barbara and that was not helpful. That was my experience. But just from a historical point of view, information and referral, 45 years ago, ladies and gentlemen, you had to write the first grant in order to become an area on age. First you had to write an information and referral program. The second grant, you went after the big money and that was the nutrition program. You had to have an information and referral service in your area. Just because you had to have it 45 years ago, what makes more sense to me in terms of this discussion is ADRCs. It is broader and it deals with real issues. Because where people start cutting dollars in terms of services. In the services that they offer, is INA. That is what they cut.

A lot of them just have volunteers that do it. And this is not something I would give necessarily to area agencies on aging. At least in the state of California. We have good and some shitty ones to be perfectly frank, truly. So, you have to look at that. You have to look at structure and the structure issue is really, to me, the structure is like restructure. Is what has got to be part of this in order for it to work. I mean, a master plan, it can't just be aging.

Kim McCoy Wade
We have four folks left and I am watching the clock and the public audience. Ana, Kristina and Donna and Susan. And then we'll do public.

Ana Acton
So, as brief as I possibly can. I think the ADRC model is a great place to start because we have the infrastructure and starting point, foundation. It is not just information and referral. That is where I think what we're honing in with on this model. The person looking at the individual, assessing them for the individual needs strengths, and the short-term, which is diversion.

And then the transition piece, what we find, this can be expanded on even, that the transition, people get tripped up during major life transitions. That is where we need to come in and really provide that wrap around coordination of services supports, when they are getting out of the hospital, when a family member dies and in nursing homes want to come home. It sets the stage for the packages of services.

The department of rehab has a transition fund, it is $400,000 for the state this year. We just increased it and it nothing. But again, there is a model, it is agile, and we use it and we can get people out of nursing homes and help divert people from going in. Let’s look at those. Lastly, there are other programs we have to look at, MSSP, CBAS, assisted living waiver. We know it exists and it works, it just all takes money. But these are proven programs.

Patty Berg
And don’t forget PACE.

Donna Benton, PhD
Thank you. I agree with everything everyone has said. So that makes really easy. I have four points, I will cut it down to one. I think one of the things as we begin to build this system, we need to look at the staffing that has appropriate compensation and training in the competencies that we want on the INR lines. I think when you were talking about Minnesota health information, and also the Alzheimer’s line, many times we do have volunteers at INR lines and not to say that volunteers – they may not be competent, but I think sometimes we do need a professional level. But it turns in to not just navigating people, but people who have to listen to somebody who is irate or depressed and they can’t quite get to the point right away. I just want to throw that out there. And that second point, finally would be that we – we have to address the continuum of all ages. Like the Minnesota help line, full access and support. It does not jump out as a specific age group, but we know the majority of people using it might be older adults, but it tracks everyone across the bridge.

Maya Altman
I’ve mainly been listening but building on comments. The disconnect from the health system. We want to get at not just people calling in, but you want to be more proactive. And health plans health systems have a wealth of

information about people. An example, during the power outages, we mine the data and find out who are the people that are most dependent on the devices. And we work with the county to do proactive outreach. We need to think about how to use the data exists to cross sectors. Again, I worry again and again about the silos and disconnects.

Kim McCoy Wade
Thank you all for condensing a very rich discussion into a quick reaction. More are welcome in writing.

Anastasia Dodson
We're going do cue up the operator.

Kim McCoy Wade
We will do the full 30 minutes. Can you give us a sense of how many people on the phone? If we have 300 for example. Do we know how many in the room would like to make comments? Wonderful. Let's start in the room. Ellen thank you for the microphone assist.

Meredith
Meredith from live steps. We provide affordable house and I appreciate the wonderful conversation today. One of the things we notice is that when seniors call in for information and referral, the person answering the phone does not solicit information about their budget and they are given referrals that are not qualified for them. The income is a little too high and they can't apply and that is frustrating. For example, if the income is $1500 a month and the referral is a thousand, it is a long process. And the hard truth is there really is not a service available for them. Being honest so that people – and using the information to identify gaps in services as we are planning right now, it is really important.

Peter G.
Peter G. with CalPACE with the programs of all-inclusive care. I think the pace would like to see the resources information and referral. Pace is a program that is hard to find for people and they come in a high state of need. Many of them in crisis. And many of the concepts a have been expressed, I think we wholeheartedly support a comprehensive array of options for people to consider using trained staff. Several comments went to the conflict free and so forth. We're supportive of the direction that we're hearing. Thank you very much.

Julia Hills

hi, I'm Julia Hills, ADRC coordinator, CA Independent Living Centers here for CFILC to advocate for the serious consideration of implementing the no wrong door approach with your approach here if this work group. So many wonderful things are said today. But really one thing I want to emphasize with the approach of enhancing and expanding ADRCs across the state, that guarantees for information referral. All are partnership with the independent living center and triple a and right away there is opportunity with funding to increase the information and referral systems. I love what Marty said. As a -- on the ground, interacting with whole person care. There has been duplication of services along with whole person care and people exploring ADRCs across the state. Accountability is one of the barriers. It is important to build on the foundation and there are so many providers here at that table and it is the communication that will make this master plan work.

I wanted to touch on how wonderful Shireen, thank you for your presentation, because I love that you have the Medi-Cal eligibility works on site. I want to share that truly is an example of a no wrong door system in operation. No wrong door approach on the federal level includes streamlined eligibility into public benefits and programs. Really, that is a best practice for all us to be looking at.

And also, I can't read my own handwriting, I want to touch on still active seniors and give my mom a shout out. She is turning 70 and is the healthiest person in the family. She was my care giver and I have been my dads for the past six years and it is hell to find resources. And I acquired quite a bit of debt to be a family care giver. And I love what someone said about fair pay. According to my master's degrees, I should be earning about $30,000 more. Staff retention, it is going to be tough because I'm a care giver who has had my own disabling condition. Really, it could have made a world of difference for my family. I think that moving forward, I just want to share that I will be on the CalAIM enhanced care management work group and plan on attending all of these work group sessions. I would be happy to report back because I think liaison between the two is crucial. Especially because there are so many opportunities through a no long door approach. Medicaid has billing codes and potential in place. Is going to be important to see what Medi-Cal does moving forward. It looks like Marin county won't be able to bill for whole care services. There is a lot of

opportunity both for increasing funding through Medicaid and strengthening services through partnerships.

Kim McCoy Wade
Two on the phone. We have a question from Lindsay.

Lindsay
Hi. Good afternoon. I'm Lindsay, with hand in hand and the California domestic worker's coalition. I wanted to make a comment more geared towards the beginning discussion. I was glad to hear there was going to be a session focused on the LTSS workforce and I wanted to encourage the subcommittee to include in that conversation in the private industry. Care givers who are working in private homes. Overwhelming immigrant women of color and vulnerable to tax exploitation in the home. I wanted to encourage the committee to think about a recommendation to the larger master plan stakeholder advisory committee to add a goal that speaks specifically to supporting the LTSS workforce so that they experience – both through the purposes of recruitment and retention but also because it is the right thing to do.

And they themselves are going have their own LTSS needs. Those are my comments and I really appreciate the commitment of this committee to tackle one of the most important issues in the state. And I hope to be able to listen in on as many of the conversations as possible. Thanks again.

Kim McCoy Wade
Thank you. Next will be Nicky Diaz.

Nicky Diaz
Hi everyone. I'm Nicky Diaz, living here in Los Angeles California. I will try to be as brief as I can. I am part of the national community for the – I used to be on the board, directors hear in downtown Los Angeles. I was born with muscular atrophy. Living on my own since I was 19, I lost my husband in 2017 who was my primary care giver. This sent me into a whirlwind of strife. I wanted to address how I unfortunately, came across how every – my life and my crisis for these 3 and a half years has hit every failure that our system throws at my community of people as a disabled person. Everything from in home supportive services, having to do with low grade employees, that is what it comes down to. People who are trying to pay rent or put food in the mouths of their children, are coming in, one job to

another. Not able to commit to a job because they find something with better pay. I require 24-hour care. Being held up for 23 months, going up on 24 months this November. Homelessness, lack of housing accessibility. You name it. I hit every wall in this situation. And I'm thankful for the mercy of some great people I had luck stumbling upon. Care givers, the pay rate needs to go up, especially like those for myself who do not have care givers to lean on. My mother is almost 71 years old, does not want to live with me and does not have an interest. It is a difficult part of her life and I don't know why. As far as everything else, enduring care givers on drugs that I could not fight off because I'm weak. I've never walked a day in my life. No one was there to come to my rescue. Care givers were scared, I was shut out of the house. Finally, I was landing on my feet and I would love to know where and who I can help. And who is going to put a program together to keep those of us with no family care givers, safe in their homes, who are severely disabled, who is going to keep us together for our lives. And how these systems have stopped me from my person-centered plans and goals many I'm a model, song writer, I created my own albums. I'm a writer. I'm in school right now to better and improve my life. All of these circumstances, care givers running out, on drugs, that have their own strife and problems that don't allow them to come here because they don't have enough finances to maintain their life and come to work every day. I'm enduring that, not the care giver. So are the other people in my community that live on their own with no family.

I don't have family care givers as a network. So many incredible obstacles for somebody who is incapable of even scratching my nose by myself. I would like to know what kind of plan is going to be put together. That is all I have to say.

Kim McCoy Wade
That was very, valuable. Thank you for bearing with our schedule to bring us back to where we started and need to focus is on peoples' experience. And we are very glad to hear that you are getting back and on your feet. But we're all here because it should not be a matter of luck and mercy, but a matter of justice for all of us. Any other comments?

Connie Arnold
Connie Arnold, disability rights advocate for 30 plus years, here to support what Nicky has said and I appreciate her being on the phone and speaking her mind about what is going on. This is going on all around the state of

California because I get all the calls, I get the calls get requested to help people. And the pay rate is so low that all of us are struggling to find any competent IHSS providers or workers. It is very difficult, and the system is completely broken. There is no back up providers for any of us if you don't have a family member or friend that can help. You are really struggling and going without. And I think Ana Acton mentioned some of those people as well that are struggling because of the fire.
The wildfire, there is no residential battery backup system to power medical devices right now for people. And that is what is going on. There are people on ventilators in crisis wondering where to go. And hospitals can't take people because the beds are full and the local charging stations are not supportive of the medical needs of people. That is a whole another issue that is being addressed by advocates because there is not funding and PG&E and all the large public utilities have been let off the hook to tell all of us with disabilities to go find your own electricity and there is no transportation to get people there.

I went to the SMUD hearing to advocate on that issue about their wildfire mitigation plan. We are not likely to have power outages Sacramento, yet there are power outages in Sacramento because I get their e-mails. Although my power did not go out, other peoples' power has gone out. These are critical times. And we need residual systems for individuals in high risk areas or individuals with certain specific high risk lie sustaining medical needs. When it comes to IHSS, I don't see that population being addressed of getting calls or anything like that. That only operates by the time they open for business hours. As far as back up emergency services, there is nothing for anybody to call. In Sacramento, if you can find the urgent care numbers, you might get free services, no cost to our hours that is it. You can't make it from a Friday night to Monday morning.

When it comes to LA, I asked for a friend of mine about their back up services. They said, well, if the person does not have a family member or regular provider, we won't provide services to them. It has to be for an unplanned event like somebody got sick, the provider got sick or went to the hospital. And then even getting what information was like digging needles out of a haystack. There is a lot of secret information. Also, when it comes to the waivers, there is a long waiting list. There is now a priority for youth and not seniors. And I think that needs to be addressed. The waivers need to be branded immediately. Why is there student with a scholarship going to Stanford who is having to have a fundraiser for the additional

$2,000 she needs a month for care even though DRC advocated for her and got her on the waiver, she did not get enough hours. And I hear from the underground from some advocacy that I did, that the local entities that are supposed to be processing the waivers don't have a timeline for processing the waivers, why is that? Why are the waivers, the alternative services waivers, those hours you get don't apply to the provider's health insurance? They can't get their hours applied to the waiver. These are just like critical issues that need to be addressed.

Why is it that DSS has an emergency regulations on consumer protection act and yet, it is not all posted how to provide comments online on the post?

Kim McCoy Wade
Can you make one or two more points and then –

Connie Arnold
There are many of us that have a long list of issues that we would like to see addressed. While you are talking about getting people information to get into the system, you need to fix what is broken about the system now. And that is the pay rate for people with severe disabilities, the providers will cherry pick the easy people. They just want to do house keep and cook a meal, not wipe somebody and take them to the bathroom and have to shower them, hands on, everything.

So those back up emergency services, and the provider pay rate, those are very critical issues as well as people on advanced people who are afraid of the EDD coming that we're going to lose our providers. Thank you.

Kim McCoy Wade
Thank you. Thank you very much. I will now try to do in one minute, what I believe the next steps are. First, I want to make sure that every knows who Carrie Graham is, a consultant. Thank you, Carrie.

We have the goal statement that will go before the stakeholder committee and be further developed and come back to folks here to make sure we have the big picture in front of us. We will have meeting summary and transcripts, good meeting hygiene to go with the materials all posted. We will work on the meeting schedule for December and January. Fine tuning the scope of those meetings take you all up on your offers of locations to

we can get those done in December and I’m not supposed to say January. But we have to do that, we have to multi-task. We’re going to get ready for the November 12 meeting, it is on middle class benefit and we got some of you to volunteer and we have a room and we’ll work on the prep and develop that model of having a couple of you prep and getting the presenters and responders.
The fifth and big thing is the recommendations, pulling that out of the summary, capturing and doing our best to serve and bring that up. Each meeting if we want to review the ones from before. We’ll do process thinking about that and open to your suggestions about that. We’re going to try to get them down while they are fresh and think about how to keep iterating with you all. What else?

Patty Berg
I just want an assignment. I don’t want to sit around and just have everybody talk.

Kim McCoy Wade
Great. I will write that down. Give patty an assignment.

Karen Keeslar
Can Patty send the master plans from the past and get those circulated?

Kim McCoy Wade
We have a grid summarizing. We can post links to previous runs and we have a grid that talks no wrong doors.

Nina Weiler-Harwell, PhD
You said there were upcoming listening sessions?

Kim McCoy Wade
Those will all be shared. The legislative sessions, got it. Other ideas? Thank you so much for your attention. Thank you.