**STATE OF CALIFORNIA – DEPARTMENT OF AGING: Master Plan For Aging Meeting**

December 17, 2019/3:00 p.m. CST

## PRESENTATION

Moderator

Ladies and gentlemen, thank you for standing by, and welcome to the Master Plan for Aging Meeting. At this time all participants are in a listen-only mode. Later we will conduct a question-answer period. Instructions will be given at that time. [Operator instructions]. Also, today's conference call is being recorded.

I would now like to turn the conference over to your host, Ellen Goodwin. Please go ahead. Your line is open, Ms. Goodwin. Please go ahead.

Ellen

Good afternoon. Welcome to the Master Plan for Aging, Long-Term Services and Support Subcommittee meeting number four. I'm Kim McCoy Wade here at the California Department of Aging.

The purpose of today's meeting is, we have a twofold purpose, and I want to thank our stakeholder members who have been instrumental, more so than ever, in designing and redesigning our meetings. This meeting we're going to do two things; one, continue our—can I call them deep dives when we do them in two or three hours—deep dive on one topic in LTSS

[ph]. Today is going to be IHSS, In-Home Supportive Services part one. And we're also going to take time today to take a pause—we're about halfway through our deep-dive sprint—and spend time on process, because this subcommittee uniquely has the opportunity and obligation of delivering a report to the stakeholder committee and to the administration in March, which I'm not sure if you know it's December. March feels very close, very close.

We're going to do those two things today, start the IHSS conversation and do a process check, how are we going to do all the deep and broad and collaborative work we want to do together.

So, in order to do that, we are tweaking format a little bit. I'm thrilled. We're going to have, can I say less presentation and more discussion, which we're so excited, and that's only made possible because of the work of the planning committee and CDSS hitting the road and having a roadshow with many, many, many stakeholders on IHSS. So, I'm very excited for the meeting.

We are going to make one change in the agenda if there's no objection. Hear me out. We're going to lose the ten-minute break, because we don't

need it for technical reasons, but we'd like to add some public comments for IHSS right there, so that public comment on—excuse me, not right there, but at the end of the fourth topic, after topic four, other IHSS assessment issues, add a few minutes of public comment on IHSS, particularly for stakeholders who aren't able to stay to the scheduled time we will still need to move to our process discussion around three as planned, and we will still have the agenda as public comment beginning at 4:20, but we wanted to try to provide some IHSS public comment close to the IHSS agenda if we can.

Seeing no objection, hearing no objection, that's the friendly amendment to the agenda.

Any other meeting logistics to review before we go around and do introductions and then hand off to CDSS? Any information for people on the phone, Nelson, or captionings happening? Accommodations and [indiscernible], all right. Let's do introductions.

To my left, start us off. I believe the mic needs to go with you.

Carrie — Hi, everyone, I'm Carrie Graham. I'm from University of California, and [audio muffled] as a policy consultant to CDA.

Debbie — Debbie Thompson. I'm the Deputy over Adult Programs at the Department of Social Services.

Kim — Kim Rutledge. I am the Adult Protective Services Liaison/Acting IHSS Policy Chief for CDS Adult Programs.

Ellen — I'm Ellen Schmeding. I'm here representing St. Paul's Senior Services and the California Commission on Aging.

Susan — I'm Susan DeMorris representing the Alzheimer's Association.

Sarah — I'm Sarah Steenhausen with The SCAN Foundation.

Julie — I'm Julie [background noise] here as a liaison to the [background noise].

Claire — Claire Ramsey. I'm an attorney at Justice and Aging.

Kristina — Kristina Bas-Hamilton with United Domestic Workers UBW.

Brandi I'm Brandi Wolf with SEIU Local 2015.

Peter I'm Peter Mendez Atkins [ph]. I'm a representative to [audio muffled].

Karen I'm Karen Fies. I'm the Director of Human Services for Sonoma County.

Nina I'm Nina Weiler-Harwell with AARP California.

Jeff I'm Jeff Thom, California Council of the Blind.

Catherine Catherine Blakemore, Disability Rights California.

Ellen Ellen Goodwin, Department of Aging.

Kim And we have members of the subcommittee on the phone. Let's go north to south geographically. Is Patty Burke here?

Pat North to south, that would [background noise]. Pat Berg, former State Assemblywoman and former Executive Director of [indiscernible] Agency on Aging.

Kim Members from the Bay area?

W [Speaker off-mic].

Kim How about all the way south, I heard Donna.

Donna Donna Benton, University of Southern California and Association of California Caregiver Resource Centers.

Kim And is there a fourth subcommittee member on the phone?

Craig Craig Cornett from the California Association of Health Facilities.

Kim Wonderful.

Kim M. Kim Lydia Missaelides, immediate past Executive Director for California Association for Adult Day Services.

Kim Thank you. I think I'm struck by the fact that I've emailed with every single one of you in the last 24 hours it feels like. Thank you for all of your hard work. Great to see you in person and hear you on the phone.

One note I want to just, on the agenda slide, will just show, just as I mentioned, this is part one of IHSS, and to call your attention that part two will take place on January 27th. So, to be continued, as they say.

But unless there are any other announcements, let's get it out of the way and get to business with—

W [Speaker off-mic] January 27th is now a long meeting. It's ten to four. You should [speaker off-mic].

Kim Right, because that's part two and really the report. More to come on that in our process discussion.

Again, thank you so much to our colleagues, Debbie Thompson and Kimberly Rutledge from CDSS, for their leadership and partnership on IHSS.

W Hi, everybody. Because we want this to be mostly a discussion and because most all of you know the IHSS program very well, the beginning part of the slides on IHSS kind of gives just some overview of the program. I'm not going to really spend any time there. I'm going to skip to the slides where we start talking about what's happening in the growth of the program, which looks like this if you're looking at it, where we get to the growth of the older adult population in California over the next 20 years.

That slide tells us that we're going from about 5.7 million to about 10.6 million older adults over the next 20 years. With that, the IHSS program that serves that population largely, as well as the disabled population, also will be growing. Some very rough high-level estimates show our caseload and our program costs both about doubling in the next ten years, so going from where we are now of about 586,000, about 600,000 recipients, to close to a million recipients, and from an annual program cost of about $13.8 billion to about $25 billion. The program is anticipated to grow. Not a surprise to any of us, right?

And so, we really wanted a part of the Master Plan on Aging that was specifically called out in the executive order was taking a look at the IHSS

program, and how do we ensure its sustainability over time, so that we continue to provide these vital services to the folks that we serve. And the thinking of all the people in this room, as well as all of the recipients and the providers that we serve, and every stakeholder that we have, is really important in looking at that conversation and thinking about the best way to move forward with this program.

And so, as a part of that, Kim and I and a number of our staff have been out doing listening sessions to our recipients and providers in particular, and the rest of our stakeholder population in the different regions of the state. We started that actually on Halloween. We had a statewide webinar call that day, and then we have also now traveled to Berkeley and down to Modesto. And the beginning of January we will be up in Chico and down in Los Angeles to continue to hear from folks.

What we want to do today is we're going to spend some time sharing with you the different things that we have been hearing from folks, and because we now want you to start thinking about those things and giving us your thoughts on those things, because I think that that will be a good jumping off point for all of you as you look at the vision and write your report

that's due in March. So, no pressure. And so, that's what we're going to be doing today.

Am I moving right into that first section? Does anybody want any other background before—

Ellen I was just going to say, how do you come up with the growth numbers that you're extrapolating out—

W Ellen asked how we determined the growth numbers. It's a very high-level rough estimate really looking at historical growth and projecting forward.

W In your slide [speaker off-mic], that means non-relatives and relatives.

W So, the total would be both.

W [Speaker off-mic].

W I'm trying to get to, since they're not numbered in my handout. Yes, so of the 53.8% live-in providers, 45.8% of them are relatives.

W [Speaker off-mic].

W No. There's 53.8% of providers live in. Of that 53.8%--sorry. Of the total. I said that wrong, I'm sorry. In my mind it seems correct.

W [Speaker off-mic].

W Almost all of the live-in providers are relatives.

W [Speaker off-mic].

Kim So ends the intro part of the presentation, and now we are going to move to four topic discussions. Each of them will be facilitated by a member of the subcommittee, which we're very grateful for. The first one, Karen Keesler [ph] called in a backup. So, we're very lucky to have Kristina Bas-Hamilton here, because we are a team, and we're going to kick it off, I believe, with CDSS summarizing the feedback they heard from the field in this topic.

But with that, I'm going to bring up that slide and hand the mic to Kristina.

Kristina [Speaker off-mic].

W We have more than one mic. Do these work?

W [Speaker off-mic].

W At each of the listening sessions that we've done so far, we've heard a lot of feedback regarding our recipients who have the highest need. Those recipients that have complex personal care needs, maybe receiving paramedical services; those that may also be receiving waiver services through IHO [ph] and are getting combination of services; but that group of folks, there was a lot of conversation about—I want to raise two things in particular, and then ask Kim to add anything else that I haven't covered.

But one is that, if they don't have a provider show up that day, so if they are in a situation where the provider is out sick or quits unexpectedly, then they are truly at risk of going to the emergency room, having to go to some kind of placement, not being able to get their basic needs met during

that day if they stay at home. So, that's one area that was a lot of what we heard.

Another area in particular was that, if they are not served by family members, recruitment of providers is significantly challenging. A lot of the comments had to do with that providers are paid the same wage across the board no matter who they're serving in their county, and so that providers who are going to work for people other than their family members are kind of comparing, well, I can go provide some domestic services, and maybe a little bit of basic personal care, and get paid the same wages that if I'm doing more complex types of services. And so, it becomes very challenging to get providers. So, those were two of the big things that we heard around that group of individuals and things that they face in trying to navigate the IHSS program.

Kim, if you had anything to add to that.

Kim — I think you covered it actually. Those were the big points.

W — I think those were the two big points that we kind of wanted to open up for discussion. Where did Kristina go?

Kristina I guess if folks want to speak, then do the whole flipping thing of your nametag. I saw Claire, Susan and Brandy.

W [Speaker off-mic].

Kristina Everyone wants to talk. I love it. I'm going to pass to Claire first.

Claire Thanks, and I appreciate all the discussion time we're going to have today.

Two questions. One is, what would have to happen sort of logistically if we were ever to do a tiered wage payment, so that people who were doing more complex care actually got paid at different rates? Is there any actual issues? I assume union issues, but also questions about implementation issues. That was one question.

And then, what are the possibilities for career paths, so that people, if I'm providing paramedical, but ultimately I want to be a nurse, how could I step through a path so that IHSS serves as that pathway and looks appealing in that way for someone who wants to do that career?

Kristina I'll take the opportunity to respond to your first question, Claire. Logistically, that's a great question. Wages and benefits are currently negotiated at the county level. The state actually has very limited availability—I mean, I guess by virtue of raising the minimum wage, they do have some ability to set wages, because that would do that, right? But they can't tell counties what to agree to, and that would actually be a very significant logistical challenge in terms of, if there was a policy decision made that there should be two different wage levels, then how you would make that happen would be unclear.

What I would argue, as a representative who knows very intimately the situation with collective bargaining at the county level, that it points to what we strongly recommend, which is shifting all collective bargaining from counties to the state, because it would allow for policy decisions that are made at the state level to be actually implemented at the state level, versus recommendations that come out of Sacramento, that may or may not be agreed to by policymakers in local government, which is ultimately the folks who make the decisions regarding wages and benefits. If you know anything about it, you know that they may not necessarily hold the program in very high regard.

My suggestion for how we would go about dealing with the logistics of that—and I know that we've talked in the past with the administration and the legislature about this—new governor, hopefully there's more open-mindedness to it, to the idea, but that is certainly one that we, along with our colleagues at SEIU, are advocating for.

And in terms of career path, Claire, actually, Brandi, do you want to take that one, Claire's career path question? Or maybe, Claire, if you want to restate the question.

W [Speaker off-mic].

Brandi So, for folks on the phone, this is Brandi from SEIU. The California Long-Term Care Education Center, which is SEIU's 501(c)3 training center, has explored through a pilot back in 2012 this idea of training home-care providers, and this idea of moving to an enhanced or advanced home-care worker that specializes in providing care to consumers maybe that have cognitive impairments, or whatever the case may be, just more specialized care. And that's serving as a career ladder for those that want to potentially get their CNA, or go into get an LVN, or move through the career ladder.

As we all know, and we'll get more into in this conversation, IHSS is much like an onion. There are a lot of layers to that. There is the issue of the exemption from the Nurse's Practice Act, for IHSS providers who are serving as an extension of the consumer's body; if you are doing a training that results in a certification, are you jeopardizing that exemption. I think from the union perspective, and I welcome other dialogue from folks other than just Kristina and I, but I think from our perspective, there are some providers that want training and some providers that do not. There are some that want to provide to a more complex care need level, but we would strongly advocate, as Kristina said, that there is a tiered-wage schedule for that, and that it is serving to meet the larger need of health care workforce and long-term care workforce demands.

Kristina Next is Susan.

Susan Part of what I wanted to talk about, Brandi touched on, too. When we talk about more skilled work, did training come up as well? So, from the perspective of the Alzheimer's Association, it is the wages, but also the commensurate training for the skilled work. And the California Long-Term Education Center, the work that they've done in LA is evidenced-

based. It's been evaluated, and they've now moved it to the Alameda County Alliance. So, they're doing the same training of IHSS workers in Alameda County, in partnership with the health plan. So, that's something that we want to pin because it's absolutely a best practice in a model.

Also, I wanted to flag, the Future of the California Healthcare Workforce had a recommendation around this stepladder and career pathway where there's, the wages go up, the training goes up, and it's a pathway, not just for Alzheimer's and dementia, but specializing perhaps in autism, or diabetes, or there might be other conditions that people will specialize in. So, training goes hand-in-hand with wages, from our perspective.

Kristina Next is Peter.

Peter [Indiscernible], but it has to be written in such a way [indiscernible], because I have hired people who have had previous training and there's this whole [indiscernible], and it's really challenging because I have to sort of un-teach some of their bad habits, including around how to work with people with disabilities [indiscernible], no, I can't eat in 15 minutes because I'll choke. Even something as minor as mixing meat and potatoes because at the facility they were told to go ahead and mix the food. I hate

that food. I know it's minor, but as we discuss training, there's a lot of concern in the community. Well, it's sometimes often necessary, it has to be more targeted to the consumer's needs. And we're all individuals, and we all have various needs and various styles in how we work.

Also, it would be helpful for me if folks have more training about how to use adaptive equipment, like [indiscernible], because I happen to have one. Those things aren't really taught in the educational setting [indiscernible]. Just remember that like IHSS is consumer-based, so the training has to be consumer-based and consumer-driven.

W Just to that point, I think this issue will probably come up several times as we talk about IHSS today, and again at the part two session. But I think there is a need to talk about self-directing versus non-self-directing consumers as well, and what that means for any training proposal that is put forward.

Local 2015 has been pretty vocal with our membership, and their active consumers as well, that we would not put forward a mandatory across-the-board X-amount of training hours for every single person. We recognize the value of the self-directing component of this program, but also want to

be cognizant of the consumers in the program that are not self-directing, and what a model of mixed training potentially could look like.

I just wanted to raise that up.

Mya — Hello, can you hear me—can I get in line, this is Mya, to speak?

W — Yes, got you in the line.

Donna — Can I get in line after Mya? This is Donna.

W — Yes.

Nina — Nina again, AARP. I just have a couple quick questions and then an observation. The slide that went by really quickly, it seemed like a very high percentage of the paid caregivers are family members of some sort. Did I read it like 90%, or was it not that high?

W — [Speaker off-mic].

Nina Okay, yes, it was pretty high. I know one of the questions I did have about the family caregivers is, do we have any data about, are these individuals who were able to, say, quit a full-time job, to come home, take care of their family member probably for lower wages, but at least they're not losing everything? Do we have any data on that?

And then finally, I just want to thank Brandi for her comments around training requirements and not having these mandatory minimums, because that would be very challenging or many family caregivers. So, how we find that meaningful middle would be great.

Kristina I have next Karen, Catherine, Mya and Donna, but I do want to ask Debbie if she has an answer.

Debbie So, 70% of family members, first slide.

Kristina No, the second question that Nina asked was, does the department have any data on who left employment to become a provider. No, okay. So, that is a no.

Next I have Karen.

Karen Thank you. Karen Fies from County of Sonoma. From a county level, this is very important to us, because in my county only about 50%, maybe 60%, are relative caregivers. The balance in our economy, which we have a 2.5 unemployment rate in Sonoma County, it is incredibly challenging to find non-relative providers. You can work for In-N-Out and get more, and get better wages, and get better benefits than if you work at IHSS.

We do everything we can to entice. We provide training. My department also has our Workforce Investment Board. So, we try to provide some workforce training for anybody who's interested, but many folks are not interested. It continues to be a challenge, and I can see it as these numbers continue to grow, which we are absolutely seeing an increase, probably at least 10%, 12% a year in our IHSS population. Many clients do not have providers, and we can see that gap growing.

Kristina Thank you, Karen. I'm going to take the liberty, I'm going to use executive privilege right now.

What you're saying about In-N-Out Burger is a very serious thing, because we have had leaders, member leaders in our organization, who

have come to us and said, we want to be providers, but I could take this job and get health benefits, and I could easily make $2 more an hour starting. It's a significant crisis that I'm afraid not a lot of policymakers are aware of, to the point that I don't think folks understand that without increasing wages, this is only going to get worse.

I don't want to be beating a dead horse, but I'll keep beating it. Until we bring collective bargaining to the state level at which the state then has an ability to set wages based on what is considered good public policy, we will continue to have this crisis, because you can't convince 58 different boards of what they think is good policy, which I can tell you in majority of the counties is not raising wages for IHSS workers.

This is a fundamental issue. Training, all of this stuff, nothing means anything in IHSS unless you raise the wages, period. It is the number one problem. Until we address it, everything else is superfluous.

I'm going to get off my high horse now and go to Catherine.

Catherine I'll just say a couple of things. I agree about wages. I think in some other systems direct care wages have been raised, such as the development

disability system, and that may be sort of a model for an approach. I think it's a statewide approach, which goes to Kristina's point.

I think a topic we have not talked about with people who have more significant needs is the adequacy of backup systems, and what is the obligation to ensure that there's a backup system so people aren't institutionalized or left in their home at risk and so forth.

And then, I think as we're discussing the topic of people are self-directing and people who aren't, I think there is a grey area in there. I don't think it's your one or the other. And I think there's some training or other discussion about what does the supported decision-making look like, helping people make decisions so they can direct their own care. Who do we rely on to do that and some other models about that. But to get into a box that says you're either one or the other, I think is a not great place for us to end up.

Kristina So, stemming from Catherine's question, back to you, Debbie and Kim, on backup systems. I know there is a lot of history in the department on dealing with backup systems, specifically coming out of the paid sick leave law, that at least I was privy to. So, the concern being that with paid

sick leave, providers won't take it if they are not sure that there's anyone else to do the work when they're sick. And so, we had a lot of discussion around what different counties are doing and not doing. I know that we landed with the department is tracking the rates at which public authorities are getting calls from recipients about needing backup providers, and those rates were, if I recall correctly, not very high. But I would make the argument it's because most consumers aren't calling the public authorities to say I need a back provider, either they don't know to do that, or they've given up because maybe they've tried it in the past and that authority may not have a registry that has a lot of people on it, they've been through all the people on the registry or whatever.

So, I don't know that that's good evidence of people needing backup providers, but I did want to highlight that there's a big history on this, and did you want to speak to that at all?

W Just really briefly, yes, there is a history, and it's also an open, ongoing conversation, and one that we continue to look at and have discussion about, and recognize that the things that you said, that it's hard to get data, because we don't necessarily know how many people didn't call those kinds of things. But I will say that it does seem to be, and it kind of is

what came out of the IHSS listening sessions, it seems to be particular groups of people that are most impacted by that need, individuals with the higher need levels who aren't served by family members and that end up in a position where that is a critical need.

Kristina So, I want to wrap that up really quickly. My understanding—and you don't need to agree with me—but the governor, the previous governor, didn't agree, or finance didn't agree in spending the money or doing anything, mandating backup systems because of cost pressure that it would then create because counties would need to be compensated for doing that.

I would like to raise to this group that we either seriously consider as a recommendation revisiting the idea of mandating county-administered backup systems that are funded, that are robust, that are built on solid foundations, rather than helter-skelter, what we are able to manage to piece together, which I think is essentially what we have right now.

So, the next I have up is Mya.

Mya

Yes, thank you. I want to build on some of the other comments that were made about training and self-direction, and folks that the model might not fit for them.

I recognize what Catherine said, there's a grey area, but I think it's pretty clear that the population of [speaker off-mic] that is a larger proportion of elderly people now, and that's going to grow, is growing population of people with cognitive issues. I think people, a lot of people with mental health issues. But talking about this at the local level in our county, we all really struggle with the folks where the model doesn't really fit them well. We've experimented with the contract mode, which right now, as far as I know, only San Francisco has through Homebridge. And we actually worked with Homebridge for a time when IHSS was under the plan. And there were challenges, but it really is a much better model in terms of training and support for the workers, particularly difficulties with the self-direction.

We just see that as a real need. I'd just like to put a pin in that and say that I think more—the contract mode is expensive. [Audio muffled], I think that's why no other county does it. I would like [audio muffled] really do a lot more thinking about solutions for that group of people.

And then, I just wanted to remind folks that the [indiscernible] in the in lieu of services packages, there is a proposal that allows plans to go ahead and get workers in on an emergency basis for people. And so, it could serve as kind of a backup. Again, that's only a partial solution in terms of its very limited. It's an in lieu of services package, but it is in there. Thank you.

Kristina Next I have Donna.

Donna I just wanted to, I think just following up on what was just said, particularly for our older adult population that have cognitive impairments, I also think that we have to think about what's going to happen in cases for misuse or abuse issues that could come up if we don't have protections in place for those older adults during this time while they're using IHSS. Because I certainly hear about that, not just for older adults, but for other people who may be more susceptible because of mental health problems, where they're not, even though they're considered self-directed, they end up in a relationship of dependency so the person may just say, oh, you know, sign this sheet, but they never

came. And so, we do need to have ways of having that emphasized in the training, but also in how we monitor IHSS workers.

And then, I did want to—and I think everyone else is starting to discuss about the backup systems, because we know for persons with cognitive impairments, they're not going to be able and say my IHSS worker isn't showing up or whatever. So, they may not even know how to make that call for backup systems, so we do have to have really good monitoring in place.

And for family members, I think that one of the things that happens is, you said they aren't using [audio drops], and some of that has to do with the fact that when they are family members, they really are more like 24/7, they may have stopped working, and out of guilt, this is just a little [audio drops] money that's helping them do what they would normally do without any compensation. Wherever we can, we have to think about the legitimacy of having respite for the IHSS families.

Kristina I have Ellen next.

Patty And Patty would like to say something, too.

Kristina Okay. And then, I'm going to have to cut off because we are set to move on.

Ellen Thank you. I'll make it quick. One of the things about IHSS is it's about 12 or 15 different programs, and trying to meet the needs of everybody has always been a challenge within the program. One of the things I think about with a certain segment, which are those that really can self-direct and whose hours are fairly fixed, is advanced pay. It's something that was in the works. It's highly complicated to administer, so it does take some special folks to be able to provide the support, and for the actual recipient to be able to administer it.

But looking at cash and counseling, which is used in a number of other states as a model, and looking at the ability of people who have that type of expedited, they can hire somebody quickly, they can bring in backup providers quickly, and they have the ability to pay them. So, I know there's just a handful of people left on advanced pay, but I think relooking at that model, especially for those that can self-direct and have high hours.

M This has been mentioned to some degree, and I want to follow up on it a little bit. As we live in a more limited resource environment, given the increase in the population that we're going to have to serve, I think we need to look at a few things a lot more carefully. One of them is a more wraparound type of system where, let's say a person with a vision impairment or a cognitive impairment can really do certain things with the proper training, and it's going to require, not a system where, okay, you got your five hours of training, we're going to cut your hours, it's going to need a lot more than that. But I do believe we can really promote both independence, and in many cases fewer hours by a system that provides more services.

The other thing is technology, and I know there's a lot of people who are very concerned with technology. It might be, as technology improves, that we find that certain things like cleaning a house might be able to be partially offset by the type of technology we can provide, and that technology can be a lot cheaper in the long term than hours. So, we have to be thinking outside the box, and not in a bureaucratic way that just says, okay, we're going to give you something and then we're going to take something away, but in a way that really promotes both independence and ensures that the person doesn't become more dependent by losing hours.

Kristina Patty, you're the last on the list.

Patty Okay, just a couple comments. One is that we started a training program for In-Home Supportive Service workers back in the '90s, and we had a 33-hour curriculum that was really put together well, and it also had a clear path leading out of it. However, we offered it voluntarily, so they were not paid. There'd be more motivation if caregivers could be paid in order to attend training. So, it took them away from caregiving, and at the same time, they did it on their own time. That's just something to consider.

Secondly is, you don't have the kind of information that came up before about the caregivers themselves. And one of the things we're pushing for, that [indiscernible] be pushing for, is a universal assessment that would also involve caregivers. I think we need to add questions on that that would deal with the In-Home Supportive Service workers, in terms of, are you leaving a position now, what were you doing before, that kind of thing that you said you have no data on. That's it.

Kristina Do you want me to summarize?

W Yes. What we're going to do is try to have Kristina summarize briefly what we heard, recommendations [audio muffled]. We'll come back again after public comment at the end and do that as a whole. This is so big, let's do it in chunks. Take a crack at it.

Kristina This is what I have written, and if I missed anything let me know. I have self-directing versus non-self-directing IHSS consumers, not one size fits all; perhaps advanced pay for those who can self-direct. Recipients with the highest level of need have particular challenges. For those without family members, worker recruitment is very difficult. Needs to be higher wages for those who do skilled work, and a distinct need for backup systems at the county level. One suggestion is potentially coming out of CalAIM, making that something that maybe is managed by the health plans.

Training is needed in certain cases; needs to be consumer based, paid, and not mandated; needs to be tied to higher wages and career advancement past. Wages are currently set at the local level. The state can develop a good policy, but not necessarily implemented locally. The proposal is to

move all collective bargaining to the state, so that then they can implement good policy decisions regarding wages, training, etc.

We need to look at technology as a way to promote consumer independence. The universal assessment discussion should include questions for caregivers as a way to get the data that we don't currently have, which is how many workers are leaving the paid workforce. Or I should say, the non-IHSS workforce to join the IHSS workforce, because we don't have that data. I think that is actually huge. I love that suggestion of working it into a universal assessment tool, because that is really politically what makes it very hard to argue for a lot of these things, is we don't have the concrete data around the impact on local economy, local family, household income, etc. I think if we can show that people are leading good middle-class jobs, and that the whole family unit is suffering because there's no one else to be serving as a caregiver, that that's a pretty strong political argument. That's my notes.

W Nod [ph] in the room, all right. We are going to move to topic two. I'm going to ask Claire to come up to the front [indiscernible] and turn it back over to CDSS. That was our first round doing it. We had a little extra

time on that one because your introduction was so quick, thank you. But now we are going to be at the kind of 20-minute mode, so go.

W Okay, go. The next topic is children in the IHSS program. Did I do it wrong? Oh, sorry. Out of order on my paper. Protective supervision.

So, protective supervision is challenging service to assess for the IHSS program. Currently we serve about 40,000. Between 40,000 and 45,000 recipients in the IHSS program are receiving protective supervision, which means that they've been identified to have mental status, such that they're unable to make decisions for themselves that they could potentially be at risk. They don't know that wandering off, or running out in the street, or turning on the stove and putting papers on top could create a harmful situation. They have the physical ability to carry out those activities, and that's a static condition for them, that mental health impairment, or that mental impairment, that physical capability, and that there is a need for the provider to do interventions to prevent them from doing those types of dangerous behaviors on a regular basis.

The social workers do that assessment, and they do request information from physicians about the person's mental status. They also may request

information from other sources to make those determinations of the need for protective supervision. We hear on a regular basis that that is still challenging to really feel like they have a good understanding of the person, situation, and need. I think it's an area that we wanted to have some discussion with you all about, and what that will look like ongoingly.

Patty Can I ask a question here? This is Patty.

W Patty, is this a question like a point of order question—

Patty It's a question in regard to the social worker. The social workers in the system, I don't know what kind of training they have, what kind of protocols have been developed, so that everybody's asking the same—they have to be trained in terms of asking these questions. I'm just not sure that they get ample training and the same statewide.

W Debbie's going to answer that and then I'll take over.

Debbie Through the IHSS Training Academy there is training on the protective supervision component of assessing that for IHSS, and then there's the

regulatory guidelines and different direction that's come from the state as well through the forms of ACLs. I think that the social workers still are not always sure that they're getting clear information coming to them, and that they get what they need to actually make that determination. So, it's just an area of challenge.

Patty Yes.

W Thanks, Debbie. So, like before, if you have a question, please flip or raise a hand to show me that you want to get in line for a question. If you're on the phone I'll check in with you in just a second. I just want to put a couple of pieces on top of this from the consumer side.

So, we were just mentioning about non-self-directing consumers, PS consumers are, by definition, non-self-directing, so this conversation we can have more fully right now if people want to.

One of the things on your list is how the caseload is growing. That's obviously not like an individual consumer provider concern, but it is a concern for costs in the program because protective supervision consumers get the limit, the maximum hour limit. So, it means that they

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|---|---|
|  | are some of the most expensive consumers; however, they're also some of the highest need consumers, and the consumers with likely greatest risk of going into institutional care if they do not receive adequate IHSS. |
|  | So, this is one of those places for us to think about cost benefit and to think about, it's easy to look at simply the cost within IHSS and say, wow, that's expensive, but we need to compare it to something else, compared to what exactly. |
|  | Nobody has any questions or comments.  Kristina, Ellen, Susan, okay. Peter.  Anyone on the phone want to get in line? |
| W | Not yet. |
| W | All right, thank you. |
| W | Let's start with you Kristina. |
| Kristina | Thank you.  So, protective supervision is one of the issues that we get a lot of questions and concerns about from our members.  I realize I didn't say this earlier.  UDW represents 116,000 IHSS workers in 21 counties.  One |

of the major issues that we hear about is protective supervision specifically not being properly assessed for in the first place, so parents of children with developmental intellectual disabilities who are getting minimal number of hours, that then upon appeal get retroactive full hours.

And then secondly, strange kind of trends in different counties where people will start getting reassessed and getting their 280 hours reduced without a change in the diagnosis or change in the situation of the client. I want to say we raised this once maybe to you—not to you, Claire, but I want to say I've raised this once to some legal organization, maybe it was DRC, could we show a trend if we had evidence that there was actually a directive in certain areas to actually restrict protective supervision and take people off of it because it is so expensive, and because it was appearing to be done in certain patterns geographically, and because there was no impetus why it was happening. It just seemed to be happening out of the clear blue. So, that is, I think the proper assessment of protective supervision, I would note, as a very urgent need.

W Ellen is next.

Ellen

When you think about the complexities of IHSS, I think protective supervision really takes the cake. It is the hardest to assess from a social worker perspective, it's the hardest for a family to figure out how they're going to solve the 24-hour care issue, and for the individual in question, they're often at a point in time when they're really experiencing dementia or other serious illnesses.

One of the things that we did, I worked with county government for about 20 years in IHSS, and we really prioritized our quality control on checking in on people who were receiving protective supervision and living alone, and so, they had providers coming in. And that was really one of the key groups that we tried to administer.

I'll just say—and I know this won't be particularly popular—but sometimes it is better for a person to receive care outside the home. Having worked with our elder death review for a number of years, the kinds of cases that we saw often times involved people on protective supervision whose family, for whatever reason, was not able to care for them. I think just keeping in mind that solving protective supervision and having it work well is probably one of the biggest challenges in IHSS.

Patty I totally agree, Ellen, with you, totally agree.

Claire All right, Patty has given you a double check on that. Susan, yes.

Susan Debbie has presented to the State Alzheimer's Advisory Committee on this topic previously, and we have long questioned the percentage. When we look at half of the population in IHSS being 65 or older and we apply prevalence data, just for Alzheimer's and dementia alone, it should be far higher than 8.8%. And we think that one of the reasons for that is because many people with Alzheimer's and dementia are not diagnosed. About half do not have a documented diagnosis in their medical record, and so that causes persistent problems when they're looking for X outside resources.

And then I had a second thought that I'll have to come back to. I don't know if there's any auditing or anything that goes on and how it's initiated to get—given that there's 58 different jurisdictions, we hear very uneven—it's working well in some counties, and it's very difficult to get in other counties. Is it usually the consumer that's initiating? How that [speaker off-mic]. People don't know that's even an option to be considered for protective supervision.

Debbie I was just going to respond a little bit. It can be initiated varying ways. It could be the family members; it could be the person themselves; it can be a part of the assessment, the social worker that does look at memory orientation and judgment. If the person's diagnosed, clearly that's an indicator, but diagnosis really doesn't have to be the basis of what's going on. We're really looking at, is there an impairment that's leading to behaviors that is putting that person at risk, so that the providers needing to intervene with is a lot of what's being evaluated for.

So, a part of the conversation with the social worker would be around that, what's happening with the person. Ellen can—she's nodding, but she can certainly share, having been a part of actually operationalizing this for a year, so if she has anything to add there, too.

Ellen Not right now. I had my turn.

Claire Peter was next. Then after Peter will be Sarah.

Peter One of the issues around protective supervision for folks who need it [indiscernible]. I think one of the issues around [indiscernible] who really

needs protective supervision is the amount of documentation it takes. The documentation it takes is even confusing to medical providers and family members, and other people who may be providing the circle of support for the individual who may need the supervision care. And the definition of supervision care is interpreted differently by various counties, and that's a problem, too. As someone who's assisted people navigating the IHSS system, we need to find a balance for getting the documentation that's required so that people [indiscernible] service they need and the support they need, but also put together a document that's easier for families and friends, or even medical providers, so it's clear what's needed, so when you're assisting someone getting a protective supervision, you work with a doctor and the doctor does their work, it doesn't get kicked back. Because when it happens once, it's okay; if it happens twice, the consumer is not getting the service they need, and in many cases, as medically required, but also, doctors don't want to deal with having to reject to. And it's already difficult [indiscernible], if you're a person with a disability, to get doctors to complete detailed forms.

I want to do a shout out for Disability Rights California because their guide for protective supervision makes the process go a lot easier, but it is difficult to get technical assistance from sometimes county staff, or other

folks who should be in the know, when someone's coming to an agency for assistance.

Claire Thanks, Peter. Then Sarah, and then Catherine. And then anybody else on the phone? Because I think then I take the mic back because we're about six minutes—

Patty I just have one comment. That's Patty.

Claire Okay, Patty, great, I got you on the list. Thank you.

Sarah Thank you. Terrific conversation. I really appreciate the wonderful succinct overview and the opportunity for such great discussion. I'm certainly learning a lot. Something that strikes me is this theme of what we hear a lot in the policy world of the problem with the growth in the IHSS program. It was discussed, relative to protective services, about how that's considered such a bad thing, but exactly as was said, when you think about what would the alternative be for many of these people, I think we could pretty certainly say that people who have been assessed for needing protective services would end up in an institution were it not for this.

But what this really gets to, to me, is this bigger system issue of fiscal incentives for the counties. Counties are on the hook for IHSS. They are not on the hook for nursing homes. So, why would a county want to ensure that people in their county know about protective supervision when that's just a cost for them? But if they knew they had a role in both institutional and home and community-based services, their incentives would completely change. So, that's a really tough issue. Obviously it gets to realignment issues. It's obviously something that is really difficult to figure out how you resolve. But I think this issue about cost pressure on IHSS continues to come up in all of the conversations, not just about protective supervision, it was mentioned in the executive order. Like it's a real problem that IHSS costs are growing. I get that it's a really difficult issue and that there needs to be resolution, but we also have a population that's aging. So, what's the cost if we don't meet the needs in the community? So, that's one issue. It's just this larger kind of fiscal incentives.

And the other is, when you think about the assessment issue, I really appreciated, Peter, your comments about the challenges of getting the medical community engaged, and trying to get the paperwork filled out and how complicated it is for everybody. So, if we were to think about an

ideal system, wouldn't it be terrific if there were a more integrated service delivery system where doctors could share information—understanding all the public health information issues, but if there were more team-based approach to care, so that the doctors could flag that this individual might need protective supervision, and have a way to communicate with the counties about it. That was the idea behind coordinated care, but I think we've kind of moved far away from that. Just kind of stuck out to me when you mentioned that. Thank you.

Claire — Thanks. Actually, Patty, if you can give your comment quickly, then Catherine's last, and then I'll wrap up.

Patty — Okay. Well, I was going to say something very similar to what Sarah just said, so put that down as a double check for me, too.

It has to do with the 40,000 or 45,000 people who are currently in protective supervision. How many of those suffer from dementia? Do you have any idea? The reason I'm asking, I mean, is this something that we could pass over to the Alzheimer's Master Plan people?

W I don't have that number off the top of my head, but what we do know—and not off the top of my head again—but what we do know is that quite a number of the protective supervision cases are children, so it would be more the autism or Asperger [ph] types of [overlapping voices], rather than dementia.

Patty [Overlapping voices] who are patients of the regional centers?

W Correct, yes.

Patty And the regional centers don't put any monies into that, they just put it into the care plan or refer to IHSS?

W That's right, Patty. The regional centers do not put any money into IHSS.

Patty I think that has to be looked at.

Catherine I was going to raise a separate question. For one, I agree with the institutionalization. I think to understand protective supervision increases you have to look at who's getting the services. We've closed DD institutions in California. People that previously would've gone into a

developmental center live with their families at home, and to maintain people at home they're going to need supports. And some of those supports come from regional centers. There's a requirement that regional center consumers access generic services. IHSS is a generic service, right, so that's sort of how we get there, and there's an [indiscernible].

The other issue that we have raised, and I think we're working through with the department, is sort of the proration of hours for high-needs people, including protective supervision where there might be two or three children with high needs, and sort of how do you decide how to manage those hours, which is very complicated, and in our experience results in people not having adequate providers to meet all of those needs.

Claire

Thanks, Catherine. I'm just going to do a very quick wrap-up, because I literally have one minute. I'm going to just talk about themes. Heard a lot about county variance, and so question about what's the state's role in preventing county variance, and what are the county roles in preventing that variance. I think that was a major theme.

Another one about county costs, recognizing that it will directly impact negatively a county's budget when they approve protective supervision,

and so some counties seem to not be doing that, or taking it away. Again, what's the state's role? Maybe there is more state money when protective supervision is given, and take some pressure off the counties.

What are our documentation requirements? Are they too complicated? Yes. How do we simplify; how do we streamline? Also, nobody said this exactly, but in paramedical it's the doctors approving, and that is something we could think and talk about, about whether that model is more of a protective supervision model or a bad model, but that's another alternative.

Sort of counties having more time for assessments, and that will lead into our next discussion. And then, last but not least, recognition of sort of balancing of costs and realizing that we have to [ph] institutionalize people for the benefit of those people and all California, but now when the money doesn't look the same, how do we go forward around that.

That's my quick wrap-up. I know I didn't get to every single piece, but thank you for that conversation. I think that gives us a lot of potential for recommendations.

W Okay, great. Well done. Continuing right into topic three, which may be a surprise to some at [ph] your Master Plan on Aging Meeting, but here we go with IHSS and children. And again, Debbie will start us off, and Kristina's back in the facilitator's seat.

Debbie And I'm going to take 30 seconds of executive privilege and [audio muffled] what Kristina did, because I wanted to just kind of reiterate what Claire was saying about protective supervision and the role of the physician in that. I think people are familiar, but in case people aren't, with paramedical, we basically send a document to the physician, and they are the ones who determine the need for the paramedical and authorize the time, and then the social worker puts that into the authorization.

I think what Claire was saying is, would there be any benefit to looking at some kind of model similar to that for protective supervision, and I think that would be a good discussion for this group to have. So, I just wanted to kind of reiterate that since it didn't get a lot of time.

Anyway, now we are moving in to children. And thank you for the intro because it was what I was going to say, which is that our Master Plan on Aging, but still this is a big part of IHSS and a growing population within

the IHSS program, and actually a growing population receiving protective supervision, as Catherine mentioned, within the IHSS program. But again we kind of come to that, what we were hearing is the assessment process for children. And probably second only to protective supervision, children are fairly complex, because in addition to kind of looking at the need area, you're also looking at the need and comparison to a child of that same age without a disability, and what's the difference between the parent responsibility versus eligibility for IHSS services when it's outside of that normal range for children.

Also, the piece of most of the time it is the parent that is providing the service to the child, and then you have that dynamic of the parent becoming the employee of the child, and that dynamic, and the oddities that that can create. We just wanted to open it up for conversations about children within IHSS and what makes sense in how we are providing services to them, and ensuring that they get their needs met as well.

Kristina Claire. Anyone on the phone?

W No.

Kristina

I'm going to reassert my executive privilege here. I'm so privileged. [Background noise my privilege right now.

One of the major issues on children and IHSS—and this speaks to parents as the employee of the child—parents are discriminated against under federal and state law because they are working in the home for a child, and therefore are not eligible for unemployment, Social Security or Medicare. The same exists for spouse providers. This is a major issue that discriminates against largely women, results in poverty after a lifetime of working and having not even the bare minimum of Social Security to land on your feet, or one day stop working. You literally can never stop working. And God forbid you lose your child or your spouse, not only are you grieving their loss, you are also potentially about to lose your home because you lost a paycheck and are not eligible for unemployment.

So, major recommendation that will be coming from me is these loopholes need to be fixed. I can tell you very concretely, we do believe the UI loophole can be fixed at the state level, because federal law does allow state latitude in how they administer the program. We are introducing a bill to do that in January. I hope everybody is on board with that. The Social Security and Medicare issue is significantly more complicated.

That has to be resolved federally. We are also introducing a bill federally with Congresswoman Linda Sanchez that will attempt to resolve all of those things as well. I have spoken with many of you on the advisory committee about that, but I think if it could come out as a recommendation of the advisory committee that the state do what it can to eliminate those loopholes, it would be very significant because it is a real parent penalty and spouse penalty.

Really just terrible public policy that comes out very concretely of the history of when the Social Security Act was first passed. The only way that they could get southern democratic senators to vote on it was by agreeing to exclude domestic workers because they were largely women of color. This is a very racist and sexist history that this is all premised on. And if we in California are not that, then we should be not abiding by those type of policies. That's what I would add to the mix.

And I have Claire.

Claire [Speaker off-mic].

W We can't stop talking.

W I think it should definitely be a recommendation coming out of this committee, definitely.

Claire Thanks. Couple things about kids. So, children are about what, 7%, but they tend to be pretty high need because if a kid needs IHSS it's because they probably have fairly significant needs.

Couple things. One is, I think we make it way too hard for the parent to be the provider. The set of rules around that is so complex, and you can actually get into a situation where even though the kid's eligible, nobody is technically eligible to be the provider, and that cannot possibly what was meant, and I think that's like an error we can fix. I think it speaks to the larger point. If a kid has been eligible, it means they have extraordinary needs, and I don't understand why we have to take the next step of being like, and now, parents, have you made things as hard as possible in your life to do this job. You've quit your other job. Most parents obviously can't do both anyway. If a parent wants to be the provider, I think we should let them if the kid's eligible, and if they don't, and they want to hire a non-parent provider, we should let them. We should assume they're already doing all their parental responsibilities and

fulfilling the family code obligations, and strip all of that away. It's just needlessly complicated.

The other thing I think is the assessment for kids are extremely challenging. I don't know if it's just the training issue, I don't think it is, but because it's trying to compare behaviors and needs across ages, it's very complicated, and because so much of the caseload is adult based, individual social workers may not have that many kids on their actual caseload.

I don't know what the right answer is, but some sort of specialization within counties for people who carry the child caseload, but just more thinking about how to make child assessments work well and actually meet the needs of the family so it's not such an uphill battle. If you have a kid or multiple kids who need IHSS, then you are already struggling to do a lot of care in the home and to do a lot of different things as a parent, and I don't know that we need to make it any more challenging.

W [Overlapping voices], but the regional centers themselves, who have very professional workers, social workers, psychologists, all of that, that help

with the assessment tool. They can design an assessment tool for kids. They know that population.

W — And I don't have an answer. I'm going to pass the mic to Kristina, but I'm going to walk and talk. I do think the question of like kind of what the overlap population is between regional center and IHSS is a good thing for us to know and think about how that informs each other.

Catherine — I'm just picking up on that thread. One of the things that fascinates me around these discussions is these are all Medicaid dollars. It doesn't actually matter whether it's—IHSS, plus there's some county money—or regional center. It's kind of state money generally. But that said, I think there's ways to make this more seamless for the people that are receiving the services.

And so, why wouldn't we want regional centers to be making the assessment for this—

W — [Overlapping voices] if there was a dispute because the county or the state thought regional centers were doing something [audio muffled], have a dispute where the agencies fight it out. Why is this the family who's

trying to maintain the child in the home problem to sort it out between agencies about who's providing what? I think as a state, seamless delivery [audio muffled] you know who your primary agency is that's going to assist you, and if they disagree with another agency let them solve the problem [overlapping voices] five different places.

Patty That's a great recommendation.

Kristina Nina, sorry. Anyone on the line who wants to go on the list? Nina, Karen. Nina.

Nina Since we're having this conversation, I was thinking about IHSS and universal assessment, and how you roll everything in, and I just—think you've heard me say this before. I'm a mother of a child with autism. Thankfully he is high-functioning, but when he was younger, not so much. At one point we did consider applying for IHSS, and it would've been a whole separate thingamabob. And we decided not to do it because we could make do with respite and what he was getting in the school and so forth, and my being able to work from home a few days a week, which was great.

I mean, I don't know where people are on that. Because IHSS, I will just say, this is a best practice—California should be proud of this program for all its challenges. I don't think there's much else like that in other states, maybe Washington, which beat us in a lot of things.

What do we do, again, to make this more seamless for all recipients, whether old or middle-age or younger. How do we wrap IHSS into this without kind of losing its distinctive [audio muffled] system of care?

Kristina Karen, yes.

Karen Thank you. Counties like the idea of team-based assessments with regional centers. We love working with regional centers. When we can get them to play and do it well, we get really good results. I just wanted to say that, that we'd be very supportive of that, because right now, sometimes it's a little challenge. If we had a little bit more legislative guidance or allowance to work better with regional centers that would be great.

I just have to make a plug for a non-executive decision making comment that's basically for the last set of comments. There's a lot of conversations

[audio muffled] social workers trying to save money. Social workers don't try to save anybody money, trust me.

Kristina Anyone else? Sum it up? Okay. This is what I have. Parent, as the employee of the child, raises particular issues. Recommendation to remove the discriminatory exemption of parent and spouse providers for unemployment, Medicare, and Social Security. Rules are so complicated for parents to even become a provider; why is that; needs to be simplified.

Assessments for children very complicated, need to revamp at the county level. Perhaps social workers should only specialize in child recipients. Overlap of regional centers and IHSS, why can't regional centers do assessments. How do we make this more seamless? Counties need legislative guidance. That's what I have.

W Good, good, good. Our fourth topic, and thank you all. Again, we're going to try to do about 20 minutes on this one, and then have about 10-15 minutes of public comment on the discussion so far.

Topic four, I'm going to ask Catherine. Catherine, here you are. You're ready to facilitate. Other IHSS assessment issues. And again, back to Debbie to kick it off.

Debbie

Okay, last one. IHSS assessment and reassessment. We heard a lot about this at the listening sessions, and recipients and providers really wanting to ensure consistency across social workers, across counties, and not wanting a change in moving from one county to the other, or getting a new social worker; impacting their hours and their assessment; how to ensure that consistency and uniformity; brought up training, ensuring there's enough training for folks.

Particularly with reassessments, the question of what is covered at a reassessment when there is no real change to condition or circumstance. So, if the person is living in the same place, condition hasn't changed, circumstances are the same, perhaps the assessment focus is different, or there's a different discussion than the typical traditional assessment process as a part of that was something that was raised. Ensuring that there's an ability to have reassessments done timely and be consistent.

So, that's kind of what we were hearing there. Again, wanted to bring it to this group to hear your thoughts and comments.

Catherine — Okay. What? Ellen, right. We're going to just take people's names. Ellen. Anybody else in the room? Kristina, Claire, and Karen.

Patty — And on the phone it'll be Patty.

W — Lydia [ph] and Donna.

Catherine — Why don't we just start with Ellen, and we'll just go around that room that way, and if there's something you want to say, then you can say it. We'll save Ellen from running around.

Ellen — This is really a question more for you all, Debbie and Kim. Does the data back up the contention that the assessments are wildly varying across counties? I know with hourly test guidelines there was really a move underfoot to try to do a lot more about standardizing and putting together ranges of service hours. This is what you're hearing, but is this what the data shows?

W It's not so much data-driven as what folks are telling us is happening. We don't really look at intercountry transfer cases for changes in hours from a data collection perspective, so I don't have that.

Susan In the prior topics I wanted to talk about assessment, but I waited until now. This is really key, because it lifts all boats or sinks ships. To Catherine's point about it's all Medi-Cal dollars, we're looking at the CalAIM proposal where there's a whole risk assessment and stratification process, and then we talk about assessment here. If somebody's participating in the assisted living waiver, there's a whole other care coordination entity and assessment that takes place.

And so, individuals are being moved around, asking different questions, not being asked the right questions in some cases. We have a scarcity of RNs and social workers, and so the very specialized positions are being used in all of these places to do redundant work.

I would just advocate, again, for a universal assessment where the data can be shared across counties, with the state, whether it's a nurse; we talked about physicians with protective supervision, try to get paperwork, as Peter said, from a physician to get things signed. We should avoid going

to them unless we have to. And if nurses and social workers in similar settings can do the same assessment, or do interdisciplinary assessments using a common dataset, that's very important.

Sarah Yes, ditto to what Susan just said. One question I have is, I recall several years ago when there was a lot of discussion in the Alzheimer's Disease Advisory Committee about the issue of IHSS assessments in nursing homes, and I think at Olmstead as well, for people who indicated an interest to transition back to the community. And there was a real challenge getting the IHSS assessments conducted in the nursing homes, despite the fact that the state [cough] clarifying letters to the county saying, yes indeed, you can and should do IHSS assessments in nursing homes, but my understanding was it's a resource issue.

But again, if you think back to the fiscal incentives for counties, they really wouldn't have a huge reason to want to conduct assessments in nursing homes for that reason. Not that they are these evil people that are trying to keep people in institutions, but if there were a fiscal incentive for them to transition people into the community, that might help alleviate the problem.

I don't know if anybody else any feedback on that, but I would be curious to hear how that issue has evolved.

Ana [Background noise] this is Ana, can you hear me?

W Yes. Ana, did you want to get in line [cough]?

Ana Oh, yes, thank you.

W Sorry, Catherine, do you want to let her go or—

Catherine No. Claire goes, and then we'll go to Ana, and then we'll go on this side of the table.

W I'll be brief. I do want to say that I think we have really burdened the counties, in terms of fiscally, with how much their proportion of IHSS is. And so, one of the things is, I think they do—I just want to say, I think counties want to have the time to do good assessments, and we make it so challenging because we give them such caseloads and we put so much pressure on them to do so much.

I really like the idea of going to some sort of tiered assessment process. I keep thinking of it in my head as almost presumptive eligibility. Like what Debbie said, if your condition hasn't changed, your living situation hasn't changed, why can't be an annual phone check-in of ten minutes, and then that gives the county more time for protective supervision, children, new assessments, etc., and so you can get things get going on the right foot, and then hopefully things just move forward.

I just want to say though, I do think that another place where things kind of can get messed up is in intercountry transfer. I do think having some sense of like, when things move from county to county, how do we not end up starting over in every county with totally different assessments and people looking back and being like, well, they were wrong and we were right, so therefore, that's what you get going forward, to have that consistency going forward.

Catherine Ana and then Kristina.

Ana I just want to piggyback off of what servicing, there needs to be a better process for the assessment of individuals prior to transition. We've had certain counties really work collaboratively and do those IHSS

assessments in the nursing home, which makes for a much smoother, transition to community living, versus other counties. They do say it's a resource issue as to why they're not able to get into those nursing homes in a timely manner to assess, but it really makes for a bumpier transition to community living. And then we are like scrambling to find dollars to pay for caregiver resources until the assessment is done and the IHSS provider is put into place. Thank you.

Kristina — Piggybacking off of that, I think that it's been said a couple of times, they're all Medicaid dollars, but we have to be very clear that there is a difference of the county paying into a portion of IHSS, and not paying into a portion of other Medicaid programs. That doesn't create the fiscal incentive to transition people from one into the other. It creates very much that whole siloed budget thing, which means that there's no—it's actually not logical at all if you think about it.

I would say that that begs the question of just how the whole thing is funded is bizarre hieroglyphics that probably five people in the State of California truly understand, and I can say I'm not one of them. The whole thing was created in 1991. It's time to look at it again. It's Frankenstein. It's just been added on to over the years as legislature makes policy, and

the formula just keeps kind of evolving like a cellular structure that just keeps evolving and multiplying. It doesn't make any more sense. It's not logical. It's not reasonable, rational. It needs to be reevaluated because of these very issues that we're talking about.

And then I think, also, like what folks are saying, it's not that people at the county level are wanting to keep people in institutions. There is the resource question of, there's no reason why social workers should be carrying caseloads of 300 and 400. I don't understand why that exists. And I don't know within the push and pull of county admin funding what the state gives them; it's not enough, it is enough. I don't know who's right and wrong with that, but there is a serious problem when social workers have more people on their caseload. If they did an assessment every day, they still wouldn't get to everybody on their caseload. So, that should be another recommendation coming out of here, which is they should have reasonable caseloads so that you can actually have them do what they're supposed to do, which is all of these other things, like go to nursing homes and etc.

I'm writing that down as another recommendation.

Brandi

I would echo the comments of both Kristina and Claire, and won't be repetitive on that. This is a little bit more of a feel-good recommendation, but I think is actually something that can be very fruitful. We have explored within SEIU this concept, but it is our anecdotal experience that there is this like unnecessary battle and push in pull between social workers and IHSS providers and consumers. It is us-against-them mentality when I think a vast majority of social workers don't go into the profession to screw over the consumer or the provider.

And so, is there a way that the state could encourage or convene some sort of body that is made up of the various players in the IHSS system, mainly consumers, providers, and social workers, to talk through some of the major issues. We have seen such a breakdown in communication amongst providers and consumers and the counties and social workers when it comes to policies like FLSA or EVV. I can't tell you how many times we've gotten emails, both at UDW and SEIU, that's like the union told me this on FLSA and the county's telling me this, and they're completely different, and there's just no effective way of sort of getting everyone on the same page to implement program changes in a way that are addressing caseload for the social workers, but also is not to the detriment of the consumers and their providers.

I don't know that that's a big formal recommendation, it's just something we've been toying around with internally at SEIU. I think if we can do it where there's representation statewide, it could be a really good thing for program changes within IHSS.

Peter I was going to mention a lot of things that were mentioned, but this comes down to coordination and only managing the SSN [ph] process. [Indiscernible] was on IHSS for about 30 plus years. I'm now getting my support for home care through the regional [indiscernible], and I still, for my work life, work with folks who are providers and people who are on IHSS. The assessment process varies depending on where you are, and even for the social worker. So, there has to be more consistency.

Also, I support doing the assessments based on need [indiscernible] person's disability doesn't change, then the assessment probably doesn't need to happen as often as they do. One county I lived in, they did one every year like clockwork. I had it on the calendar. It was pretty easy for me, but we didn't have much to talk about. In another county I lived in, when I moved I had my original assessment, and I realized I hadn't seen anybody in three years. I thought I better call them because I'm sure I'm

going to be the one getting in trouble. So, I called them and they said, we have too many people, you're fine, anything going on, no, don't call us, we'll call you. But there has to be something in the middle that works for everybody. And also, going from one county to another is really problematic, whether it's the IHSS system or most of our other systems, you have to start from square one. And as I probably said before, people with disabilities have many facets to our lives. We're active in our community, we work, we live independently, but sometimes you almost need a second person to manage the disability piece because there's so much to do in order to just maintain your independence there isn't always a lot of support for.

Catherine Thanks, Peter.

Karen I like the concept of presumptive eligibility. I think with the [indiscernible] task guidelines, I think social workers are much more likely to be as consistent as possible. People are human though. There are variances. But I also wanted to say, even though there's an annual assessment process, frankly, social workers contact their clients much more often than just the assessment. Frankly, with all the power outages, PSPSs [ph], we've been in contact with our IHSS clients every week it

seems like, at least in the fall. So, there's a lot of contact. It's not all about the hourly assessments. Bottom line is they're big caseloads, and we would love to see more dollars flowing into IHSS.

Nina My remarks earlier about exploring universal assessment, or however we're going to do it [indiscernible], along with my kudos about IHSS, and the important role it plays in this state, best practice. I'm hearing a lot today really about what counts at utilization controls, I think is the proper term. But remembering what the goals program is, it's to keep people in their homes where they want to be, but also for that 60% or so that are the family caregiver, they're already going to lose hundreds of thousands of dollars in wages, never mind the lost Social Security income. That at least makes up some of it. So, yes, all the other issues, they don't pay into Social Security.

Finally, I just have just like quarter big thought, because I'm kind of hearing little strands of ACA coming in, like rebalancing. Just, again, I'm not a provider, so forgive my ignorance, but is there a way to create rebalancing incentives between counties? Right now, the way it sounds like it's set up, is counties are responsible for something like IHSS, but not for who ends up in an institution. So, what kind of incentive could be

created to allow more folks the ability to access a [indiscernible]? They service like IHSS is.

W [Speaker off-mic].

M I don't think that Brandi's comment is a feel-good one, because unless we happen to come up with some potential changes that really save some dollars and enable the program to continue to flourish, if they can be described in those terms, it's going to happen anyway because the legislature's going to force us to get together and come up with something.

Whether we can perhaps show that some type of presumptive eligibility saves money, whether we can put more money into employment programs to get those who are employable off IHSS sooner, those who can do without that program, whatever it's going to be, there's going to have to be, and some things are going to be items that consumers won't like, just because that's part of a process of compromise and that always is. So, we're going to have come up with some sort of modifications pretty quickly, or they're going to be forced down our throat.

W That's very true.

Catherine Exactly. So, the takeaways that I heard [overlapping voices]. Patty, you want to say something?

Patty I do, I do. Just in regard to this particular issue, I know that [background noise], the majority of them—it used to be 17, I don't know how much it is now—were county triple A's. Of those, several of them run the In-Home Supportive Service programs, as well as the Area Agency on Aging programs. I was a private nonprofit, but we were available to the In-Home Supportive Services program to provide all kinds of resources to those In-Home Supportive clients, which was a cost saving to the county, but it just showed the kind of cooperation that we were able to provide, and it helped people get off In-Home Supportive Services earlier. But I don't know that that's still happening, and that happened in our area, I don't know if it's still happening now. But there are all the resources in the community that can be used, other than just having a provider.

Kim And, Patty, just to put a pin on that, absolutely, the [indiscernible] majority, I think it's all but 7 of the 33 are counties that—Karen is here from Sonoma, but there are counties who absolutely are blending their IHSS and Older Americans Act. San Diego, Ellen could speak to—

Patty — I know they were one of the first ones, and Sonoma I know does as well. I'm just saying all of us should be doing that throughout the state.

Catherine — Thank you for that. I'm going to just do a quick summary, and then I think we're on to public comment [overlapping voices]. Sorry, one more comment?

Lydia — Yes, I think I was in the queue. This is Lydia. Sorry.

Catherine — Hi, Lydia.

Lydia — I'm sorry I'm not there today. I just wanted to very quickly just put a marker down for, I've been really interested in all the discussion around assessment. That's an area [audio muffled] very interested in for a long time. I want to put a marker down for figuring out some best practices that I know are going on in the community today where there is some good communication and coordination going on between managed care plans, adult day health care, IHSS, [audio muffled] where people are coordinating and communicating really well around not only assessment, but also needs of people and making adjustments as situations change, and

particularly for the high-need folks who are not able to effectively or safely self-direct their care, and really do need that assistance.

I'm just wondering, too, just as a question, I'm kind of thinking short, medium, and longer term goals around IHSS, if there is an opportunity to kind of talk about that a little more in-depth at some point and map that out for the Master Plan. But also, is there any compilation right now of good practices happening at the community level, whether it's around assessment, triaging? Kind of Peter mentioned being in a county where they were prioritizing the caseload, which makes a ton of sense to me [audio muffled] people's condition aren't going to substantively change over time.

Those are just some of the thoughts I wanted to share on piggyback on what others have said. I think this is really a great discussion.

Catherine Thanks, Lydia. Not hearing anyone else, I'm going to do a quick summary. We should look at the reassessment process, modify the process for those whose needs haven't changed or consider doing that. Look at presumptive eligibility; universal assessment across providers and systems with data sharing; and look, as Lydia's just said, at models that

work and coordinate between adult day health care, IHSS, and other systems.

Eliminate disincentives [ph] for counties to do assessments in nursing homes, as moving people to the community is more cost effective and probably has better outcomes for them. Assessment should be consistent across the counties and timely. Social workers should have reasonable caseloads, and look at good models and get some data about what is happening in counties that we might learn and make recommendations from.

Patty And better coordination with their agencies on aging.

Catherine Noted.

Kim Thank you very much to the planning committee for that. We'd like to open the floor now. The additional suggestion was to have some public comment on IHSS right now. I want to remind you we're going to have the scheduled public comment again at the end of the meeting. We have the half hour then. We're going to continue the IHSS conversation at our January meeting, and comments are always, always welcome through our

engage. We're still counting how many came in on Friday, over 200. So, please keep it coming.

But for now, we'd like to do ten bonus minutes of public comment on IHSS. Nelson, will tell me who's on the phone, and if there's anyone in the room. We have a few. Can we start in the room and then go to the phone? Okay.

W [Speaker off-mic].

Moderator [Operator instructions].

Kim As always, we ask people to aim for two minutes and do your best. It's hard. It's a complicated topic. Should we start here?

Julia Hi, my name is Julia Harold. I coordinate Marin [ph] County's ADRC. I just want to make a couple of quick points under two minutes. I just wanted to say that for Marin County, I'm just coming from actually, we're modeling how we function to other emerging ADRCs [ph], so I'm really amped to be coming from a meeting where we're talking about how I, as the coordinator, meet weekly with IHSS, APS and [indiscernible]

supervisors to ensure best practices and wraparound services because we've noted it really takes a village. I say it all the time, team work makes the dream work.

By working together, for example, we had one woman who we just saved from eviction literally four hours ago, because the IHSS social worker was able to reengage this woman and get her hooked up to 250% working disabled because she wasn't being—anyways, I'm getting off track.

The point I really want to make is that for the successes that we need to see to make a difference and reach the outcomes and the deliverables that we're talking about, we really need the support across agencies, and support IHSS from every level. I think it's really important that we push CalAIM to develop more extensive billing codes around IHSS and enhance care management and in lieu of services. This is definitely an important topic to be discussed.

I think, also, I want to echo something that Jeff [indiscernible] I'm on the state ADRC Advisory Committee, and Joe Xavier, the Director of Department of Rehabilitation, recently did a wonderful presentation for us. Really, I think, he made a very important point that Jeff spoke to, in that

we're not talking about employment and reengaging people. We do not have enough of IHSS caregivers currently in California to meet the needs. But, for example, in Marin, with my clients what I've been seeing a lot of are people who have the ability to provide some of the IHSS caregiving, and then they need a second one, but if someone is receiving IHSS they cannot provide IHSS, and that, in and of itself, is limiting, because people with disabilities are still important contributing members of society. We are doing ourselves, our families, and our communities wrong by not recognizing that.

W [Speaker off-mic].

W I just want to say that there isn't anything that prohibits an IHSS recipient from being a provider.

Justin Justin Garrett with the California State Association of Counties. Really appreciate the robust discussion on ways to strengthen and stabilize this important program. Counties that are proud to partner on the IHSS program and work towards, we're incentivized by the improved outcomes that are seen by the program and helping individuals remain safely in their home.

The kind of county fiscal implications have come up a couple times today, so I just wanted to respond to a few things there. First, we went through a pretty extensive process over the last couple years in partnership with the administration, the legislature, the provider unions, and all stakeholders on finding a more sustainable fiscal structure for counties that was enacted, and SB80, and it came from the governor's proposal to revise the county [indiscernible], as well as the 1991 realignment report, which essentially found that realignment can no longer provide for county realignment funding, provide for the cost of the programs that are realigned, particularly IHSS, and particularly because of programs changes that occur, many of them outside of county's control, such as federal [indiscernible] and statement and wage increase.

And so, the recommendations of the report and the governor's proposal were so that IHSS costs could fit within county realignment funding, and that more significant funding wouldn't be taken away from the other important and mental health programs that counties operate. I just think that should be a guiding principle as we look at any changes that are being made to the program, and that's been suggested a couple times as we look at statewide collective bargaining or backup providers that there are new

mandates on counties that the appropriate state funding would be provided. So, I really appreciate those comments and that discussion.

The last one, and I think Karen said it more eloquently than I will, but counties aren't really incentivized to cut hours or to reduce protective supervision. Counties have an MLE [ph], we have a set cost amount that's going to grow by 4% every year. And so, reducing [indiscernible] save county's funding, so we don't need an additional share of cost with some other program as an incentive to help change practice there. We would oppose kind of that suggestion, but also [cough] if the problem is more social workers being needed, or more additional county administration funding, then that's the better way to approach issue and we'd support that. Thank you.

W I think we have six on the phone and Connie [ph]. If they all do 2 minutes that is 14 minutes. Can we do that? There's our challenge.

Connie Connie Arnold here, Disability Rights Advocate, 30 plus years. I would first say I disagree with the fact that the counties want to state that they don't cut hours. The truth is, is social workers do come out, some of them come out with predetermined where they're going to cut the hours of the

recipient. I had that. I experienced that myself as a long-time person at 283 hours, and the person knew I was an advocate. So, that is a problem.

There is no incentive for them not to have people end up in a nursing home. I had a call since this Friday of somebody in a nursing home, who the nursing home would not help them with the CCT waiver. He's been there. He's an advocate in Long Beach. He's been in the nursing home for over 90 days.

I'm going to jump down and just give you headers. Blaine Beckwith [ph] in Berkeley has not been able to find a caregiver that he needs for three years. He says he may end up in a nursing home. Home health care agency vouchers for IHSS recipients in [indiscernible] participants in emergency backup services is important to consider in programs like Easy Does It, IHSS recipient and IHO waiver participant, new prospective provider, individual training budgets, or stipends for training, and it could be individualized for the recipient.

When they tried mandatory training in Washington, that reduced the pool of community providers significantly. I'm concerned about that. The public authority registries are not very useful referrals, and they lack

competent, skilled, experiences care providers, and there's no real contract for them to go out and do outreach.

I'm writing this up for you. Ongoing search for care providers. Sources of searches often don't involve public authorities. Can you hold that microphone down because I can't see? Let me wrap it up because this is important. Can you move it up? That's better.

We have the fire issue, we have disincentives for counties to promote community living. IHO waiver program denies parent providers payment, and that came up in a discussion yesterday. Things like housekeeping and food service opportunity being missed because in the modern age you can have groceries delivered to your home, restaurants deliver hot meals through Uber Eats, DoorDash and Grubhub, and housekeeping services for seniors and persons with disabilities exist, so you might want to rethink some of those things.

The working disabled program needs to have retroactive eligibility for working disabled, and eliminate [indiscernible] cost or raise the income threshold. I think that's critical. There are people out there with disabilities who are not participating on that program, and wondering how

they're going to survive once they retire, because they can't pay all of their care needs out of their retirement.

And so, thank you very much. I'll send this in later.

W On the phone.

Moderator Our first question comes from Kelly Kent. Please go ahead.

Kelly My name is Kelly Kent and I am the Senior Program Officer with the May and Stanley Smith Charitable Trust based in the Bay Area. I oversee our elders work, and my background is 20 years of supportive housing background working in community settings.

My question is, thank you very much for holding and the ability to provide public comment today. I really appreciate it. I was curious about the conversations that have taken place, either in the listening sessions or within this group at other points in time, around the growing numbers of older adults experiencing homelessness with double digits in most every major community across California. I wanted to ask if there is recommendation around greater intersectional work between departments

like HCD and the Department of Aging. In speaking with several colleagues that work in the supportive housing field, they have buildings that are predominantly older adults, and they often lack the additional services that could really keep those individuals stably housed in communities that they've grown to love. I'm wondering if something exists that there is a better mechanism to create education for those kind of nontraditional partners, or if there is programs like—I know there's a pilot going called Home Safe to try and prevent homelessness for at-risk older adults—but if there's something that's being discussed for formerly homeless individuals that may be in permanent supporting housing communities, or entering those communities, just given the high vulnerability of those individuals, and typically lack of family interaction.

W That was precisely two minutes. You get a—

Kelly I do my best.

Kim I'm not sure if anyone wanted to do a short response to it, but the subcommittee is saying that will be part of IHSS part two on January 27$^{th}$. I can tell [overlapping voices] homeless conversation. So, yes, it is on the agenda, it wasn't today.

Kelly Perfect. Thank you very much.

Patty [Overlapping voices] Secretary of Housing involved.

W Yes, as recently as yesterday we had our cabinet meeting with housing and transportation talking about both the housing supply and homelessness issues. That is, I think by all accounts, the top issue that's come up in every Master Plan on Aging [indiscernible] and homelessness.

Next Nelson.

W On the phone, who's next?

Moderator Our next question is from Cheryl Browne. Please go ahead.

Cheryl Hi, everyone, it's good to hear this discussion. It gives me a lot of information to take back to my community, as well as to the Master Plan on Aging.

The couple of things that I wanted to ask about is, one, are we going to run into a scope of practice issue with the doctors and the social workers, and when you're talking about changing what they do? That's number one.

Number two, you know whenever you have, if you have baseline with the utility companies, whenever they reassess you, they send you a piece of paper that says a check-off, and you check it off and send it right back. That might be an idea for your reassessment. The other is, I don't know if we're using the [indiscernible] program for any of the assessments, and how we might be able to do that.

Lastly, who's carrying the legislation that you spoke about? That's it.

Kim — Was that a question for Kristina, who's carrying the state legislation on—I think that's the only bill we mentioned.

Cheryl — Yes.

Kim — Are you prepared to share the author of the state bill on IHSS and state unemployment?

Kristina Not yet.

Kim Stay tuned is the answer. Still in progress.

Cheryl Okay, no problem.

Kim Thank you. Operator, next.

Moderator Our next question comes from Maureen Donahue. Please go ahead.

Maureen I'm a family member provider. I left my career about 20 years ago to care for my daughter with special needs, and unfortunately she was not able to utilize the school systems as much as we would've liked. I was not able to go back to work. I was not able to continue any professional development, or just minimally if anything. I just want to speak to some of the issues in several of the categories.

I live in Marin [ph] County, and I had to apply for a fair hearing this past year. It was the most eye-opening experience just of IHSS and of the law. I had to become a paralegal just to be able to interface with the county and to be able to do the work I needed to do to advocate for my daughter.

There were no resources, practically zero resources. I used DRC [ph], I used GGRC [ph], Disability Rights as a resource, but there were no avenues for me, other than using a hearing, to be able to engage with the county, and for me to be able to get information about how the county was supposed to be assessing my daughter. She's been on protective supervision since 2012. She has an incurable static genetic condition. She's not going to change. There are heavy cognitive impairments that are part of this disability. She was pretty consistent up until 2018. I was told by a lot of people in my discussions that because of the pay raise for IHSS, Marin County actually started targeting all the high number, maximum number of our clients and recipients, and that's exactly what happened.

When one of the SEIU workers in this call had addressed that, that there seemed to be a geographical, or like some kind of a directive that had been given to IHSS social workers to go after protective supervision cases, I am a recipient of that. We were targeted, and we are still engaged in that discussion. I'm supposed to be in a hearing on Thursday that I was actually told to cancel. Because we have maximum hours, I shouldn't bring up any of these other issues, and there's no other place to bring up all those other issues.

During the hearing in August, the county officials were blatantly ignorant about the NPP [ph], the ICIN letters, the ACL letters. I had done more work and had more documentation, and citing directly from those letters, than the county did. They blatantly misrepresented the judge's order. I can't even go back and do anything with that, because unless I file a hearing, and I was told don't go back for another hearing, because then the judges are going to get mad at you for using that judicial time to cover some of these other issues.

Again, across the board, this is statewide, this is advocates from all different parts of the state, they all knew that Marin County was one of number one—and this is their words—the most corrupt county with IHSS, that they were the most ignorant of the actual law, and that they were pro county, not pro recipient, and that I was going to be in for a battle all the time with them now because of the way the changes had been made.

So, as a full-time provider with a child with disability, she's 20 now, and so we're going through adult transition issues, which are very, very challenging for her. I am now having to, like I said, become a paralegal so that I can deal with all these things too. And the burden is that I have to

drop it, and then if I don't fight for her, who's going to fight for her? She can't do it on her own. And if I'm not [overlapping voices] here—let me just finish my thought. If I'm not here and I don't have—this is something else that was said that needs to be addressed with the state also. I am power of attorney and health proxy for my daughter. I was told this week if I don't have a conservatorship, then IHSS does not even listen to anything I say, as a provider or as a parent, and that [audio drops].

W Oh, we didn't do that, just to be clear. We don't know what happened, but just to be clear, it seems like the call was dropped. There was not cutoff from our end. I was trying to break in to thank the commenter for her advocacy and her voice for her family and for clients, and try to move us on to the—many people in the room heard your story and thank you for it. We are going to move on to the next people on the phone. I'm assuming the line is still on. Are they still there?

Moderator Our next question comes from Bill Pelter. Please go ahead.

W I'm going to respectfully remind folks of our two-minute target.

Moderator Bill, your line is open.

Bill I'll try to keep it brief. I'm Bill Pelter. I work at Ability Now Bay Area's community-based nonprofit serving adults with intellectual and development disabilities. I really do appreciate the earlier discussion and the focus on this constituency. I'm also on a group called Caregiver Crunch. It's a group of local community-based nonprofit stakeholders who are trying to address [indiscernible] shortage of paid caregivers. I don't remember the person who mentioned it earlier in the meeting, but I second everything that she said about the wages. It is very expensive, as everybody knows, to provide services in the Bay Area, as it is other parts of California, and we are losing caregivers, along with direct care staff in other programs. Day programs are challenged, group homes, nursing homes, skilled nursing facilities. The direct care worker wages have to come up or we don't have a system.

And so, I appreciate us looking at all the issues that are talked about today and they are important, but the bedrock issue is we have to have a trained, reliable workforce for all of this to happen. I would say to the state, were they to ask me, well, jeez, well, we want to save money, and I would say, well, do the numbers, what's it going to cost you to do in-home care

versus institutional care. We all know there's a significant difference in that.

Lastly, I would say that Keiser in our area has a home health aide program, and the state has a home health aide cert. Home health aides are making between $24 to $28 an hour. They are doing some med administration and some other support issues, but they also are doing some hygiene issues there.

Lastly, I would say I do have lived experience with my 94-year-old mother who lives in a senior-only apartment building. My brother, sister, and I, because she doesn't qualify for Medi-Cal, have pitched in for her to get in-home care. Thankfully we were able to fight the VA. My dad was a veteran of two wars, and we were able to get her some home and assistance so it's not a financial burden for us. But I will say that we need to take a look at [background noise] what was in place when I was a young intern in the 70s, and that's wraparound care.

And so, I want to circle back to the person who mentioned about the Frankenstein system, meaning that it's been pieced together over time, that we're trying to make a system that is a quilt of all these different ideas

work when I think we need to revert back to a more wraparound service model.

Lastly, I would like to add that every [overlapping voices] resource center.

W Thank you very much. I will mention that our next deep dive on January 6th is exactly about workforce across the system. So, stay tuned. Last two comments at this public comment break, please.

Moderator Our next question comes from Nicki Diaz. Please go ahead.

Nicki Hi, everyone. Thank you for this opportunity. I am Nicki Diaz. I've been [audio muffled] disability advocate for about three years. [Audio muffled] four points I have to make here. I believe some of these pretty much blend one into the other. Let's see if I could do this as fast as possible.

Number one, I'm an IHSS recipient, and I am calling about the hourly rate. It's critical. It's bottom line. The caregiver crisis I believe completely blends into this. I can vouch and advocate for all of their jobs all they want, but the bottom, bottom line, the low rate affects my life. They can go out and find a job wherever they want. They have all the

opportunity to look for themselves the American dream. They don't need me to do it. So, when it boils down to that, I am left without someone to go potty, without someone to help me eat, without someone to help me get out of bed, without someone to help me dress. This is not about my advocacy for employees that need a better job or better pay for their life. This is about me. And they don't have the right kind of pay for someone with a severe, a disability of my own, they're going to go, and they go.

I've gone through 35 caregivers in one year, and I've gone 5 weeks without finding people to cover me for an entire weekend. This is not okay. I don't know what you people are doing at your jobs, but this is not okay. I am struggling and I'm sacrificing. I'm doing everything in my power to be able to go to school online, to be able to find a way to employ myself, and I can't do that because I'm spending seven days a week on the phone finding caregivers. You can call and check. I've had seven sheets of provider lists given to me in three weeks' time, and I can't find one. So, that's my first point.

I believe it's not just due to hourly rates. I believe there's a severe mismanagement in the workforce area of this job. [Audio drops]. Hello?

W — We're still here.

Nicki — Okay, I heard music in the background.

W — Is that Nicki Diaz? Just a reminder, we are at two minutes, so if you could tell us your other three issues. We very much appreciate hearing from you.

Nicki — There is no overtime financial provision for waiver providers [overlapping voices]. Hello?

W — Thank you for patience, sorry. We're hearing you, but we also are hearing that interference. Thank you for your patience. Keep going. We heard the overtime issue and the other—

Nicki — The other issue really is just one more. There's an 838 page that has to get submitted every time my providers work extra hours outside of my allotment. That's becoming a major issue, because these people are not consistent, and they don't come to work on time, or they don't come to work at all, or they miss a shift, or something happens in their life. I am consistently trading one shift for another, and sometimes one works more

than the other one, and it goes over what they're allotted. I can't control that. I'm literally driving to my [indiscernible] office like once a week submitting 838 sheets that have—

W So, in actuality, you get to make the decision as to whether or not you want to assign hours to your providers. If you need the flexibility to move hours from one provider to the other, you don't have to assign hours to your provider; however, you are responsible for ensuring that providers are paid accurately based on what they worked, what's in the hours that you are authorized.

Nicki Okay. Why isn't anybody telling me this from my office?

W What county are you in so we could—

Nicki Burbank, Los Angeles.

W We can follow up with them, but that is the policy. So, you are the employer and you direct the service. And you have the option to have hours assigned to providers if that works for you, but if it's not working

for you, you have the ability to not assign those hours and redirect them as needed.

Nicki — Okay. Each time submit an 838 or not?

W — I'm going to ask that we do follow up with you. I'm so grateful for your voice.

Nicki — That would be great.

W — If we could go to the last comment at this bonus public comment, and then we'll do it again at the end of the meeting as well. One more, operator.

Moderator — We have a question from Maxine Hayden. Please go ahead.

Maxine — Hello. I absolutely agree with all of the problems that people are having and struggling to get [background noise]. Our providers are being notified by all of these private agencies that there are jobs available. There's many, many recruitment articles on the internet.

The main thing I called about is, there was a notice given to everyone by the Consortium for Social Science Association, COSSA, on December 10th, entitled members of congress request feedback on [indiscernible] 2.0 legislation. My question to you on that is, did you receive that notice that the representatives, Diana DeGette and Fred Upton, are asking for feedback on [background noise] legislation? Do you know of this statement that was provided November 22nd by Representative DeGette and Fred Upton—

W — We don't in the room, but we can certainly follow up.

Maxine — Yes, but I want to tell you that we didn't get notice of the November 22nd request for feedback [indiscernible] 2.0 legislation which they are revisiting until December 10th. They asked for a deadline of December 16th that was unsustainable because this notice was given too late, but—

W — I'm going to ask if you have any comments about IHSS at his moment. That's what we're taking—

Maxine — Yes. Because in that statement, these are the people that gave us the 21st Century [background noise]. Finally they're saying, we would to improve

the ability of families and caregivers to support their loved ones. Tackling this goal could involve increasing family and caregiver health literacy that are training caregivers in some [audio drops].

W Oh, my goodness.

Maxine Let me finish. And their families, caregivers and providers to be better informed of their options for treatment and services, as well as associated costs. This needs to be responded to. The federal government is the one that gives us the major amount of money for IHSS, and most of it is being impeded by the money for the unnecessary that should be recalled electronic visit verification for one, but responding to them on their concerns regarding the payment of caregivers training and so forth needs to be addressed, and we need to speak to Representative DeGette and Representative—

W I'm going to take that comment about the follow-up with DeGette and Upton on their legislation [audio muffled], and I think we are going to close down the public comment and transition to—thank you very much for those of you who are able to stay with us on the phone and add that vital feedback from your stories and your lived experience. The diversity

of perspective there, we're grateful for that. I want to thank CDSS as well for just the leadership on this issue, the partnership on the issue, the listening sessions all around the state, the collaborative meeting format.

I'm not sure if you're able to stay for the second half as we delve into report process, but before you do—I know maybe Kim can stay and Debbie has to go, but I do want to just really thank you for the partnership [indiscernible] model. So, thank you very much.

W [Speaker off-mic].

W Oh, please. Let's go back and do that.

Kim R. This is Kim Rutledge from CDSS, and I would like to give a really quick plug for our two remaining listening sessions. The three that we've held so far, obviously we've come away with really good ideas and good talking points to bring back to this group to really facilitate an important conversation that we've been able to have today.

There is a slight change from what we have been informing folks about our next two listening sessions. We've had to change venues, but they're

both in the same cities. We will be having a session on Tuesday, January 7th in Chico from two to four p.m. That's is now going to be at county building, and the exact information—we just secured the building this morning actually. We'll be sending out an exact address and other information here ASAP. I'm planning on getting it over to Marty maybe today or tomorrow, because he gets it out to everyone, of which I am very appreciative.

And then, our Los Angeles session we may also be changing locations as well due to some [indiscernible]. But the Los Angeles session will be held on Friday, January 10th from two to four p.m. Hopefully within the next couple days I'll be able to announce exactly where. We really encourage folks to participate, either in person if it's in your area, or over the phone, and bring your ideas because it's been very helpful. Thank you. And we do all look forward to IHSS part two in January where we'll hear back from Chico and LA, and other conversations. So, thank you all.

W We're going to pivot. At the great feedback and input from this subcommittee, we wanted to take a pause, because we are halfway through our deep dive, and really have a conversation about the process to be sure we hit our goal around the deliverable. What we thought we'd do is just

share some baseline on timeline, roles, structure and prioritization, and then really have a discussion. I believe we still have significant amount of time to have this conversation that many of you are ready to jump in.

All of this week, you'll see on the screen, is—what's the opposite of written in stone? Just typed on the slides. Have at it. Just to remind where we are in this timeline, we launched as quickly as we could in October and began these deep dives. We tried to start at the front door with information assistance, the benefit to help pay for LTSS, and then have been walking through home and community-based services, turning to workforce and group living. We knew we wanted to have this cross-cutting conversation the 14th of financing and integration. Trying to both go deep and wide.

Then January 27th, we want to continue the IHSS and really begin to work on the report—I shouldn't say begin—continue to work on the report. Some of the key dates are that it does need to go to the [indiscernible], and I'm just looking to see if those dates are on here. They are not on here unfortunately. So, there is a SACK [ph] date, I'm going to do it from memory, January 21st, where we want to preview the report for the SACK, so that the full, at least the structure, the direction, the issues, I think it

would be helpful for the SACK, because otherwise they will be seeing it for the first time on March 2nd. And March 2nd is the meeting where they—and some of you are on it—so they and you will be finalizing that report, potentially accepting it as is March 2nd, potentially having some more suggestions for the subcommittee to work through, but the notion would be that Jan 21 is one SACK discussion, March 2nd is the final discussion and the report is finalized, assuming we stick with the timeline.

Just to remind folks, that's the report, there's work to do after that on the Master Plan, and we'll get to that later. Right now we're focused on the plan.

I'll go through all this just to share the information, and then we can go back and forth and tear it up. In terms of report roles, we wanted to really surface the issue of who's writing this thing. Carrie Graham is our fabulous consultant, who has a very long impressive title at University of California, multiple appointments, and is also our consultant working fully confidentially for the state to write the report. We also welcome the suggestion that came at the last meeting that subcommittee members would be—Carrie's already nodding, if you're not in the room—willing, able, eager to do that heavy lift, in part because it is a stakeholder report.

It needs to be your voice, your recommendations. So, we want to provide and technical assistance, but we also believe it should come from stakeholders as directed. And also, it's a big lift, and so, many hands make light work. We want to talk with you all about who's doing what and when.

There's also been suggestion that just because the meetings were structured in a certain way to scope the conversation, that does mean the report needs to be structured in that way at all. Here's a proposal I believe from—is this from Sarah?

W [Speaker off-mic].

W So, this is how recommendations—one structure. We've heard from folks it's helpful to have something to respond to. Again, another not written in stone, but one structure is to talk about these big topics of state administration, leadership, financing, access, service delivery and data. We could talk about it that way. And then you could imagine volunteers from the committee taking sections, working on that. We could have discussion flowing from that.

And then I think the real issue is, we're trying to do two things, be comprehensive and prioritize. And we'll talk about this, also, with the other goals tomorrow at our full stakeholder meeting. But I think there's a way in which we can all do diligent work and be comprehensive, and summarize the recommendations that have come in at these discussions, that have come, as I mentioned, over 200 came in on Friday with our initial recommendations deadline. And Carrie is sorting through and putting the LTSS ones in buckets and trying to digest that. And of course we have hundreds and hundreds and hundreds of public comments as well.

There's the work of making sure we have comprehensively reflected all the input we got, but then also thinking about, are we prioritizing short, medium, long, equities, urgency, how the group would like to prioritize. You see this slide says nothing on it, because it truly is for the group to decide how you want to tackle the issue of prioritization in the report. I wish Karen Keefler [ph] was here for many reasons, but she's very good on this topic in particular, in addition to comprehensiveness.

So, those are the four questions we have for topics – timeline, roles, structure and prioritization. And it really is for us as a group to put our heads together about how to move through the next few weeks effectively.

W I love the way Sarah put this together in terms of a report structure as a proposal. It just makes a lot of sense to me having done three of these plans in the past.

W Catherine, did you want to comment?

Catherine I thought you might provide some guidance to us about just timing. I mean, there's always the mechanics of getting something kind of in final form and proofed and all of that. I don't think I saw any of that on your time question.

W Yes. We are happy to do that. I mean, I think at the highest level, we're going to finish this sprint of weekly, or more than weekly meetings by the end of January. In my mind, an outline should be done, a heavy outline should be done by the end of January. And then February, the writers are writing. I recognize budget hearings and bills and other things are happening, but in my mind there's a couple weeks of writing, and then the drafts are circulating. Maybe this group meets by webinar as opposed to in person. It depends on availability versus the value of being face to face to really go into that draft. And then you have something ready to go

March 2nd to the stakeholder committee, that I'm sure they would like to get a couple days in advance so they can process it. So, by the end of February there's a very solid draft, so that the committee looks at it March 2nd. And then depending on how extensive their feedback, there's a couple weeks in March to polish.

That's the high level, but we are open—let's see—

W The last IHSS meeting, the part two is on January 27th. So, the expectation is that, at that date, there's the outline. It seems like it's over chicken and an egg, right?

W Well, that's what happened when we split [indiscernible], yes. And so, you're absolutely right. We're parallel tracking, and there's going to be blanks and drafts and moving parts. And that's part of why the 27th we think needs to be a full day, to finish that IHSS conversation and to work with the draft.

Ellen, you want to—

Ellen I do. I just really appreciate too, Sarah, that you put some sort of a structure up there to help us try to organize. One thought I had was to looking at short term, medium term, long term, but also things that could happen now without resources, and those that are going to require significant resources. I think to be able to identify some quick ones will be important, and then just spend the time—and I'll use IHSS as an example. I honestly believe a much fuller dialogue is needed on the program over a lengthier period of time. I don't think two half days—it's just a very complex topic, and there's many interested parties with great feedback.

W Susan, Claire, Marty. We'll go around.

Susan I am a big fan of backing into things, and so I would move adoption of this so we, rather than debating, this structure looks like one we can work with. I would volunteer to work on an outline so that we know then where things will go instead of figuring out the outline after the content. Thank you for this.

Sarah I, too, would be willing to work in one of the buckets and help however with writing and compiling and all that stuff. I would think that with the

draft that would be done in January, the outline, it could kind of be what are all of the different issues that fall under that. The first draft written, and then there could be—or the prioritization could happen at the January 27th meeting. So, we could have the outline ready for January 27th meeting, and then prior to that, kind of discussion of the criteria that would go into prioritization. So, what are the criteria that we, as a committee, feel need to play into how the priorities are considered; how do we vote on it, like what are the ways that we come to consensus, is it majority, there could be many ways; and then what are the principles.

This is something I know, Claire, you had raised before, and I know that there are some that were drafted for the full sack, but Kim has made it clear that this subcommittee can draft its own principles as a consensus framework for what are the important values that we all would like to see in the policies that are outlined.

Patty I'll also volunteer to be one of the writers.

Claire Couple things. I will also volunteer to write, although not before January 9th, but after. Sort of to Sarah's point, maybe it's the principles. I do like this framework. I also worry like if you look at this, you're like where is

the consumer, where is the person centeredness of this, and I get that all the recommendations are pinging off of that, but I feel like maybe overarching. I'm not a good design person. But there's a rainbow over this talking about consumers, and maybe partially that's coming out in principles to ground every recommendation in that.

I think we actually should make decisions today, if we can, about how we are coming to consensus, how we are prioritizing like in theory at least, because one of my biggest concerns is, Kim, that is an aggressive timeline, and I get that it's aggressive because it has to be, but it is aggressive, assuming we could all nod our heads and agree on everything, that's hard even if we were all like, yes, that, that that. What's going to happen the second one of us is like, well, I want this, and somebody else is like, that's terrible, I'll never say yes to that, no, and then there's legitimately different perspectives on this.

So, I would love for us to actually have that discussion. It's not just about prioritization though, it's about really how are we as a group agreeing on stuff. I think maybe, also, some discussion about, is this just going to be like 200 things that the state could do, or it going to be like, here are the top, not prioritizations, but here's everything that we talked about, but

here, do this, and really target it down. I don't know if it's right, but tempting.

W [Speaker off-mic]. I just want to encourage outside the box thinking like that, because you could do a stakeholder report that had three things in it, and say, these are the three things that are immediate and urgent in March, and all of the comprehensive, short, medium, and long term we're going to do on the Master Plan timeline and give ourselves the luxury of five, six more months.

We are trying to canvas to get everything on the table, but the report is yours and the March timing is a moment, and there are other moments.

W [Speaker off-mic].

W I also think we need to think about the building blocks that we have for this report, and those building blocks are the recommendations. So, we have 189 recommendations, maybe about half of them at this point are LTSS, a lot of them are not, and I know there's a lot more recommendations related to LTSS coming in.

So, the question is, what do you actually want this report to look like, and how do the recommendations come into the report; is the report a beautifully narrated report on these different topics in this framework with the recommendations as appendices, or is it a compendium of recommendations.

And then, we got a lot of recommendations from different people on the same thing that are slightly different. The other question is, do you need consensus on those, or you're putting this report forward to SACK, do you want to put two recommendations forward that look a little bit different on the same thing and let SACK decide. I know you don't, but I'm throwing that out there. How do we incorporate these recommendations? I'm feeling like there's a lot of service delivery recommendations.

Anyway, just want you guys to think about, really concretely, what does this report look like with these recommendations, and how do we sift through those.

W I'm just going to add here, because I think the most important thing, as a starting point, is the state administration and the leadership. That's the number one thing that has got to get done. That has to be immediate.

Because everything else can happen, but it's not going to happen overnight, but that has to happen overnight.

W Catherine, and then I'm going to come back to—

Catherine I guess my thought is that I think there is agreement about some basic values about the IHSS system that we should lay out at the front, and then we actually have—hadn't really contemplated those recommendations yet because I haven't seen then all, but even from today and the prior meeting, I think we have recommendations. And I think those recommendations can be organized in some buckets which might look like that, or they might not look like that. I don't know yet.

And so, if we are able to bring sort of a value statement about IHSS and the importance of it, and some recommendations that are organized in some buckets to the meeting on the 27th, that would seem to me like a good place to start, and then [overlapping voices] is it this structure or is it another structure, because I don't know if everything—

Patty [Overlapping voices] that's the biggest political thing, that we're spending this many hours on In-Home Supportive Services when it's not even really

the target population. That's the big elephant in the room. [Overlapping voices] first, in terms of this plan, is that you have to have an administration, you have to have what is the department going to look like, and who's going to be the leadership within that department or departments. I mean, that has to be the start of it, and I don't care if you prioritize In-Home Supportive Services, but then, I mean, really.

W Okay. We have a packed queue in the room, so I'm going to do my best to run around. Kristina.

Mya [Overlapping voices] line up on the phone, too. This is Mya.

W Mya, okay, great.

Kristina Going back to the executive order, it is very clear what the long-term care subcommittee report needs to include.

Patty Yes.

Kristina So, I would say it does actually, Patty, say it has to adjust the growth and sustainability of IHSS. It also talks about financing. It also talks about labor supply and retention of the workforce.

Patty Oh, my God, yes.

Kristina And recommendations [overlapping voices] stabilize services. So, I think that the suggestion was made—I think it was Kim, or maybe it was Carrie—that we really just focus on that at this moment in time so we don't get overwhelmed, and just really be precise. We are talking about these things, all of the other things are important, but they will wait for the final plan.

I guess my question at this point is, Carrie, when you said 170 recommendations, do you mean just submitted by everybody?

W Yes.

Carrie Yes, submitted by everybody. Not all of those relate to LTSS [overlapping voices] geriatric emergency department.

Kristina So, just organizational recommendations. And then what about the ones coming out of the subcommittee?

W That's included. The ones that were submitted by the December 13th timeline are included in that number, but we expect more.

Kristina But I don't know that anybody submitted a recommendation on conversations coming out of this subcommittee.

W Not yet, but we hope they come soon.

Kristina So, someone has to take the initiative to do that basically.

W [Overlapping voices] submit those. And we are having our second meeting on January 27th, so a nice thing to do at that meeting would be to have all those ones you guys listed as part of that meeting. On January 13th, we're having a meeting on skilled nursing facilities and residential care facilities. We have more recommendations coming on that, and those will be considered at that meeting.

Kristina So then, Kim, my recommendation is that we stick very precisely to the four bullets that are outlined in the executive order, that we categorize the recommendations according to those bullets. The ones that meet those bullets should come in some sort of paper format for us to review, and then create some sort of voting system. I love the idea of having short term, midterm, long term. I think that's essential. The legislature will want us to be crystal clear with what we want them to do, and they are not going to go sifting through myriad text to figure it out. And we should make it as easy as possible for every other advocate that hasn't been in these discussions to look and say, oh, that's exactly what we need to be working on right now in 2020.

So, that would be my recommendation in order to not get too overwhelmed.

Patty That's a good recommendation.

W Go ahead, Brandi, and then we'll come [speaker off-mic].

Brandi I would just second what Kristina said, and if we could implement the consensus voting model, I think might be what—because not everyone's

going to be in 100% agreement with everything, but if folks are familiar with consensus voting—

W [Speaker off-mic].

Brandi Yes, so everyone has like a set of cards or whatever that's a one to five. A one is love it, two is like it, three is can live with it, four is I would be okay if there are some changes, and five is absolutely not. And as long as the fours are addressed and there are no fives, then the recommendation moves forward.

So, I actually like did a training on consensus voting. I could share it and if people felt comfortable. I'm just trying to think of a way that we can have something move forward that we know everyone isn't going to be a one on.

W Peter, did you want [speaker off-mic]?

Peter I think your doing consensus of voting is the best way, and doing as much as we can [indiscernible]. I think the structure should follow sort of the mandates of the items listed in the governor's executive order, and maybe

the additional headings from the board could be like subsections. We want to create something that the administration can really follow [indiscernible].

The other piece I wanted to just ask about is I'm not clear if I've seen—I think I've seen all the recommendations that have come out so far, but we have other comments coming in. So, how is that going to be distilled down so that those of us who are reviewing, making recommendations and helping with the writing can make sure that we have some sort of blueprint?

W Let me answer that. For those of you who are volunteering to write on a topic, Carrie is going to give you all of the content in that area. But for the general public, two things are happening. All recommendations will be posted on the website, and so everybody can see all those 200 documents that have come in. We'll try to post them in a way that's easy to see. And then the public comments that are more the shorter comments are being summarized, and we're kind of doing that in batches. So, we got the wonderful, wonderful deluge on Friday, and we are pulling through it. And we'll be talking about it again tomorrow more on the full stakeholder advisory committee, which everyone's welcome to call in to.

You will get a custom if you are a writer, and everybody else in the public will also see it.

Peter — Wanted to pin an item. We talked about the, at our initial meeting [indiscernible] and getting input from the other entities working on recommendations for the Master Plan [indiscernible]. I don't want to lose that in the discussion. With that, I'm going to take a comfort break and I'll be back shortly.

Marty — First on the structure, or the suggested structure here, I agree with Claire. I was actually looking at that and was looking for the person. It is actually in there if you read it, like in the service delivery. But I think one of the things about this report, or whatever we do, should also help raise awareness and help educate, not only the policymakers, but ourselves, and remind ourselves that we're looking at a different approach. We're looking at providing services and looking at the whole person, looking at that as person-centered. So, something as simple as saying person-centered service delivery just emphasizes that we are looking at how it matters to the individual. Now, you do say that in there. It's just

policymakers are used to looking at something like this, and it's much different that it's about the person and their particular outcomes.

But I like the fact that you offer this up, because, A, the colors are like really mellow, and I just want to smoke something, okay?

And number two, the focus, I agree definitely with Kristina that we definitely need to address the issues that were brought up in the executive order, not that that's the be all, but we can't miss the target. Those programs or those things were mentioned for a specific reason. By the way, you also mentioned regional centers, too. But IHSS was mentioned in a way that could be in a good way or it could be taken in a way that could cause us more anxiety, and we have to address that and be up front.

Catherine, you had raised that earlier, too. That's one thing. So, we have to make sure we're hitting the targets there at least.

And also, going back on the reports, I'm just trying to make sure that, can we look at several reports over the course of the year, which I heard you say that this is like a preliminary one that addresses the immediate issues.

I mean, I know that's not what the executive order says or what the plan says.

And then, because there's a couple of things. One, I think we need to address—I brought this up earlier about the urgent [speaker off-mic]. The battery ran out.

W That's how we tell people they're done.

Marty [Speaker off-mic]. I do think that we need to hit on the urgent things that need to happen in the coming budget year if there are things that we need the stakeholder advisory committee to embrace, and that there's still time to take action before the next budget.

Also, we need to react if there's anything in the governor's proposed budget on January 10th that we think is either advanced [speaker off-mic], some of the issues or concerns that we want, or maybe not, and we should comment or get recommendations on that.

Third, there is a 7% across the board IHSS reduction. I think that is an urgent issue that we need to address probably. I don't think it's longer

term. I think we need to address that. Because if the administration or the state and the legislature's not willing to address that now, it's hardly going to do anything else that we're going to offer up.

Lastly, the third thing is the format. I'm just struggling about the words. We can do a Mueller report, like that's 300 or 400 pages—I know, right—or we can do like the health intelligence—I'm not partisan, but we can do like a bullet point or—I don't think it needs to be a long thing. I just think it needs to hit the target. Kristina, I was totally agreeing with you on the executive order, that we have to hit the targets on there, and maybe some additional urgent items. But I'm just curious, how long does this need to be? I think it should be simple so that stakeholders beyond this room, the people who receive IHSS or other long-term services, the people that we serve, can understand it, too. But policymakers don't want to read a long document.

Patty No, they want to read a one-pager with—

Marty Thank you, Patty. You know, right, because—

Patty I do know.

Marty We used to give stuff to you and you wouldn't read it.

Patty At the same time, you have to say what the problem is, and this is the reason for the solution. I'm thinking even a lot of the things within access workforce, for example. I mean, that's going to take a long time because there has to be a lot of surveying that has to be done. Rural areas, I mean, just in terms of what the baseline service system should look like in any area, that has to be surveyed. A lot of things have to be surveyed. That's going to take time, and that could be done the first year, but you have to have the data available in order to be able to make your case. There's several things going forward.

Karen I agree with the [audio muffled] executive order and making those points, but I think this should be very high level. I don't think we should get into a lot of details immediately, because details take time. We should really focus on principles, values and goals. In terms of data, data buckets kind of scares me, because really in terms of service deliveries [audio muffled] on the ground service provider. To me, it just really depends on how much do we want to do, how well do we want to do it, and are individuals better off.

Those are the important goals. So, don't—

Patty All I can tell you is that I have written—

W [Overlapping voices] talking at will. Do you have a line?

W Yes, we do, thank you. Karen's finished. Patty, hold on one sec, please. We have a line in the room. Nina.

Nina So, one, I do want to help writing this. And I will be really transparent, my focus [audio muffled] LTSS financing piece. We spent two sessions on that, or parts of two sessions. That doesn't mean I won't contribute to others because they're really important.

In terms of the framework, Sarah—she's so brilliant.

Patty She is.

Nina I understand what people were saying about making that person-centered. So, maybe an overarching framework that comes from the framework that

we already have in terms of person and family-centered, so we're making sure we're capturing that.

I think I was grappling with how we would organize all this, because I know I've submitted a couple of recommendations that [audio muffled] executive order [background noise], but I think this really helps us to capture the top line, things that we need to write on. I'm going to make the suggestion that we write this like it is a fact sheet for a bill, each recommendation, two [background noise]. Does that make sense?

Patty No.

M [Speaker off-mic].

W Keep brainstorming. We're hearing lots of ideas [overlapping voices].

Nina What I'm hearing people say is we need to make it short and sweet, get to the point [audio muffled] solution, data, metric. That's where I thought about writing almost like it's a fact sheet for a bill. I'm happy to hear pushback on that. I am not [audio muffled]. I really do think that, again, if we come out with a 300 or 400 page Mueller report, which it [audio

muffled] in that direction, no one's ever going to read it. If I can [overlapping voices]—Patty, please let me finish my thoughts.

Patty Oh, sure I will, honey, sorry.

Nina Thank you. It's something that the legislature or the executive branch can grab and run with, and then they could flush it out from there. We could have appendix with more detail. That's just my topline thought.

W Anybody else in the queue, because I think I want to try to summarize [overlapping voices]—

W I'll be really brief.

Ana This is Ana. Can you put me in the queue, please?

W Mya and Ana. Let's go to the phones since we haven't heard other voices. I'm sorry, this is a lot of chaos here. Jeff, let's do Jeff, then Mya and Ana is next. I'm standing up to mean it's real serious.

Jeff As much as I like the idea of doing a fact sheet sort of thing on each recommendation, using the adage that what is looked at first is the only thing that gets looked at, I think the front should be like an executive summary with bullet pointed recommendations, and then the rest of the report can be problem/solution/ recommendation, or something like that, maybe in a shorter form. But have all the recommendations up front, and we can do it by however the structure we adopt is. I don't care how they're listed, but have them right there. They don't need the problem, they don't need why we're adopting it, just the recommendations themselves at the beginning.

W We have Mya—

W [Overlapping voices] short and sweet.

Patty Put me on the list, too, Kim.

Mya I'll be short and sweet. The only other thing I want to put in was CalAIM. CalAIM has to be wrapped up by June. I agree with what a lot of folks said, that we need to stick to the four elements in the executive order. That's the first order that we need to respond to that. But to the extent

there's any overlap, and there is some overlap, in those areas with CalAIM, we need to put that in this report because of the timing.

W

Ana.

Ana

Thank you very much. So, couple things. I'd like to volunteer to help with any writing. I wanted to mention, I'm not clear on the process. We had made recommendations or discussed programs like CalAIM, like the financing, like the Medi-Cal waivers. Do we really need to do that same recommendation [audio muffled]? Do we need to start there as part of the process, and who's doing those specific ones [audio muffled]?

W

I could just quickly answer that. For each deep-dive meeting, Carrie is still doing a planning group with members of the subcommittee, working on the content, the format, the recommendations, because we still need those for the Master Plan, which is the longer, now seeming luxuriously slow process, to make sure we have all perspectives, all recommendations. So, that work continues and then this is the question, what are we pulling out from where we are at this point in time, and what format to bring forward for you all? Sarah and then Catherine and then Patty, and speak up if I have that wrong.

Sarah Thanks, everybody, for really good suggestions and feedback. I just feel a little concerned right now that we're already getting into the exercise of trying to define what our priorities are. What I've heard, which I think is totally true, we need to make sure we focus on what's in the executive order, but I don't think we have to limit it to just—there might be some issues, as Mya raised, that are cross-cutting, that fall within those general categories, so that's just one thing to notice.

What I think would be great is if the end of today we can get agreement on how we're going to come to consensus, like what was suggested, and also, just a very general structure, and then a workgroup afterwards of all the people who have said they want to help write, can come together and flesh it out further.

W Catherine, I'm bringing you the mic.

Catherine I agree with what Sarah said, which is we should focus on the recommendations, as I understand it, but we should be open if there's something else we need to add. I'm still going to encourage that we have some overarching values like, this is the backbone of California's

Olmstead plan, and we need this program now more than ever kind of thing, or whatever we want to say about that. And I'm fine with Brandi's recommendation for kind of the process, and I'm happy to help write whatever I can help write.

W Raise your hand if you want to help write?

W It's a big list of [overlapping voices].

W Patty, you're going to be next, but hold on one sec. Sarah has volunteered, Patty, Claire, Ana/Kristina, the team of Ana, Nina, Jeff's hand is now up, Katherine, Peter, Ellen [overlapping voices].

W I am a really good editor.

W Susan and Karen are excellent editors. Patty, we're sort of getting to just think about this writing team that Sarah suggested and a process team right now, which is Brandi, and Brandi just left so watch out, but we're going to, in a second here, try to summarize and see where are. But, Patty, yes, please.

Patty Well, I don't see this being any longer than 30, maybe 40 at the most pages, and I think with an appendix. We can put all the data stuff behind in appendixes.

I see an introduction, and in that introduction I think [audio muffled], but we have an introduction, and that really basically gets to what the governor wanted, blah, blah, blah, blah. We can then look at some of the cross-cutting issues. Those are the cross-cutting issues that we've been dealing with. And then some of the policy areas and what those are, and if there are emerging trends that we want to deal with, fine, and then what the recommendations are. That's how I see it. And then with an appendix section.

So, don't have to read tons, but you have to give them something.

W One more comment from Susan, yes.

W In terms of the criteria, I like the consensus model. I envision that this group would probably agree with pretty much everything. I think I would advocate that we also have a prioritization.

Susan — This is Susan with the Alzheimer's Association. That we have consensus and prioritization, because just in IHSS there could be 30 recommendations, and I would prefer that what rises to the top advances.

W — Claire, mic is coming.

Claire — I agree with that prioritization and consensus. I was just going to add, I think one of the things we have to—because the more we get in the weeds, the less—not sure we're all going to agree on things. I think we've been all very nice and open-minded here, but I think when push comes to shove—no, but you know what I mean, right? Like when push comes to shove, I think people will be much more like, no.

One thing we can think about, too, is like, how much of this is like, we're going to get too in the weeds, like what level of thing do we have to land at to actually get people to have consensus. Some of the stuff is too fast, so we can't just—like let us fix IHSS in this report, here you go, we're going to have—some of it's going to have to be like, we have these short-term ideas we think a longer term fix will be around financing. Do these steps to fix financing, but not we told you how to fix financing.

I'm just still worried, how are we getting there?

W [Overlapping voices]. Mindful of the time. It sounds like we have the abundance of people volunteering to write, which is wonderful. And I think that group needs to huddle up and have a deeper conversation about taking all the feedback. There's two structure ideas. One is the graphic we have here on the slide and one is the executive order. I honestly think if you crosswalk them, they're not that far apart. So, there's a little bit of structure work to do to respond to the executive order. There's also the adding the person-centered. There's also the leading with values and principles. There's the staying high level so that we can make sure somebody reads it and acts on it, but deep enough so that we know what we we're saying.

Before people go off and write, you all have to figure out the level and the structure, but I think that's the—we're happy to support, but I think that's the people who volunteered to write circling up and coming up with a proposal and bringing it back to this next meeting, or continuing to iterate that.

There's also the prioritization consensus piece, which I think Brandi's offered, and maybe somebody else could work with her on that, too, so that I think the only way you get to a few pages is if you prioritize.

So, just a couple things I'm trying to reflect back.

W There's really natural groups that have formed throughout this process, right? We have our RCF [indiscernible] group, we have the LTSS financing group who've been planning this meeting, the IHSS group, the information and assistance group, all of that. I would recommend continuing to work with those groups to sort of split this up. We can come together at the meeting, I think it's February meeting—or no, the January 27th meeting where we have half a day to talk about prioritization as a group, but I would make one recommendation to keep these planning groups together to take all these recommendations in pieces, and then maybe bring them back on the 27th of January—

W [Overlapping voices] structure piece back on the 27th with at least an outline fleshed out, I think is what I heard at the beginning. [Overlapping voices].

W I was just saying, I don't disagree with keeping the groups together, but it seems like, for the moment, IHSS is a little fast-tracked, and that we need to set up a separate time to look at the IHSS recommendations particularly as they align with the executive order so that we could have a moment, a nanosecond to think about like what do we present on the 27th that people can look at, that then is going to get fleshed out a bit more. But there's just not—like the 27th is tomorrow. I just think that before we leave we should find a date, those people that want to work on the writing part can actually start doing that.

W Karen has a thought.

Karen I would really recommend if there's one person or just a couple write an outline or a template. We need to make this look like it's written on a common voice, so not everybody has their style of writing. And so, that's my comment.

W Marty.

Marty And just can you remind us again who the—I mean, there's a couple of different audiences, right? The target, obviously, is to respond to the

governor's executive order, but we also need to respond to stakeholders, which is different, but we can't miss what their issues raised because they were raised for a reason. That is just why I really support what you're saying, Catherine, and the others, that we really have to mention the critical importance of IHSS. I mean, it's one of the many services that are critical, but it was mentioned specifically related to costs and sustainability. And so, we just have to address that, and then also the urgent issues. I think as the writers are convening, it's just knowing who the audience is, because it is the administration, but it's also the stakeholders beyond this table, and then I'm assuming the legislature. I'm just not clear on that.

And then lastly, one other thing that we ought to take in, but it's going to come in after the deadline, but we should be aware of it, is the feasibility study. I'm looking at [indiscernible] in the Department of Healthcare Services. We had made an inquiry when we had that briefing. There was supposed to be a draft available sometime in March, and we weren't sure if that would be made available to this subcommittee or to the public.

Patty Can I make a recommendation?

Catherine It's Catherine speaking, and then why don't we go from there. Everybody wants to be involved in the initial, what recommendations that [audio muffled]. That's really what I'm hearing this huddle kind of group being. And then I actually agree with Karen, that having some smaller group of people that can take that huddle information about what might fit where, and come up with an outline that people could look at on the 27th seems much more efficient. It just seems like we kind of need a two-step process.

And so, my question then is, [audio muffled] recommendations that came in on Friday that I don't really—I mean, I know what some of them say, but not—when can the huddle group, the huddle group and the writing group, when can the huddle group have those sometime in January so we can huddle?

W Everybody who's been working on the meeting is getting them as part of that. So, if you're doing the IHSS meeting, you're going to get the IHSS ones. If you were planning the workforce meeting, you're going to get the workforce ones. Note, they came in 48 hours ago.

W [Speaker off-mic].

W But the flow is that, if you volunteered to lead that discussion of that part, you are going to get them.

W Excellent. So, to set a huddle meeting we need to know when we might get them.

W Great question. Are you all realistically thinking you're meeting—

W [Speaker off-mic], but they're not going to be complete because we don't [speaker off-mic].

W When can you do your best work to get us something, knowing that we have to produce something by the 27th and we need two meetings in between them?

W If you don't care what they look like, I can get them to you tomorrow.

W I do care what they look like.

W I guess the point is, I don't think we're meeting—I assume very early January, and then a subsequent meeting in January to get something done for the 27th.

Patty I would be happy to work with Sarah Steenhausen in developing a template on what the report should contain.

W No, I think—

Patty And then send that out since I've done at least two of them already. And just send it out, I can give it to you, Kim, and you could send it out to everybody.

Kim I think we need a couple of things. I think the huddle group is right, and I actually think we need a point from this group to be. That will help us out a lot in terms of subcommittee formality, if I can say it that way. It would help if the people could huddle and give us your best thinking, and we are happy to support you in how to huddle. Patty, if you're on the list of people to do that, but I think it's a broader list of people who want to huddle first—

Patty I just wanted to give something to everybody that they could react to.

Kim Yes, but that's not where we're at right now in the process. We're in a different stage. I guess the question—

Patty I heard somebody saying we needed a template.

Kim Next, yes. First we're going to huddle, then we're going to template. I love these verbs. Are there a couple people want to either nominate your neighbor or yourself to be the quarterback, I'm going with it.

W I have a question. Given the holidays—

Kim Yes, thank you.

W Could the huddle occur on January 6th prior to the meeting? Otherwise, we could do something sooner, but I'm afraid availability and scheduling will be such a problem, that we might want to just plug our nose and do it on January 6th, is a suggestion. I don't know about people's availability over the next two weeks.

Kim It's going to be rough. Thank you, Marty, for naming it. So, a huddle January 6th or potentially the first week of January to—

W Meetings are on January 6th, just as an aside.

W [Overlapping voices], there's the Master Plan meeting, now you want another meeting? I don't know.

M That's a huddle.

Patty Will you explain to me what the huddle is? Tell me again what the huddle is.

W [Overlapping voices].

Kim Is there anyone on the phone who's waiting?

Patty Explain to me what the huddle is.

Kim Patty, hang on. Is there anybody else waiting on the phone? In the room, I see Nina and Claire and Peter. Here's the mic.

Nina I can do that. Susan, thank you for raising that, because I guess we've all committed to this process, but I have family coming in. The next two weeks I'm out. I'm fine reading things, but having a meeting, I'd rather not, but if I had to I would. I appreciate what you said about having that huddle, if not the 6th then the 7th, so that we just [audio muffled] agree. I am happy at that point, or even ahead of time, to pull together folks on the LTSS financing piece and let them know this is coming, at least do some preliminary thinking. I could do that, but I'm not going to be able to produce anything substantial.

W Many people in the room are nodding. Peter.

Peter I can do the 6th, but I could do the 7th remotely, but I can do anything [indiscernible] after the holiday because my family will kill me.

Kim Let me do, another left field thing is we could condense content if we want, and have the whole meeting discuss it to process again, but I think there was some thought that a side conversation would be helpful. So, we're not going to hijack the 6th, but the idea of the first week is still in play.

W I just want to name this, too, because the holidays are basically just about here and people are not going to be around. I'm mostly an optimist, but I also am a pragmatist. Is this actually possible? I mean, I'm sorry, I really have to ask, like are we just—oh, okay, never mind. No, but, I mean, I don't say that to be—I know we have to get something to somebody by some point, but are we really able to do this in a way that's thoughtful and considerate and holistic, and the things we want it to be, and reflects the really great conversations and thinking we're doing? And if the answer is yes, then we'll [overlapping voices] I mean, I'm legitimately saying should we, could we.

W Anything is possible. I mean, I think you're living in that tension of what can we do well by March, and what do you miss by not having done by March. And so, I think that's what the huddle is about, is there's a March opportunity, what is doable in an effective, strategic way by March, and we've all agreed it's not 100-page report, it's not a solution to everything. So, is there something that you want to give the administration in March on these issues? I would encourage you to do so. And there are many other opportunities called the Master Plan for Aging, where we're going to

do a ten-year vision with a comprehensive prioritization, and it will be, again, we'll have a little more time.

So, I think that's the scope question that's so critical, what's doable.

W Then if we all agree that, okay, we do want to meet that deadline because that's meaningful and important, and people are looking to us, then is it like, here are our top ten short-term recommendations? I see shaking heads, I see nodding heads, so I don't know that this is the—maybe long term, short term, but this is not the entire list, but this is our first best thinking to start with.

W A new commenter from the stakeholder committee. You may have as much time as you would like.

W It's not a comment, it's a question. [Overlapping voices]. I haven't been on one of these subcommittees before. You keep saying that there's another opportunity, which is the Master Plan for Aging. And so, what exactly do you mean by that? At what point will we have additional input?

Kim At our March, May, June and August meeting we will be doing a stakeholder process around goal one, goal two, goal three, goal four, reflecting the comprehensive and priorities around all the goals. We're talking about this process tomorrow on the stakeholder advisory committee because it's a different process, different deliverable, different timeline, because then the administration will take all the input from the stakeholder advisory committee, and then go internal and write and develop a plan in the fall that will come out in October. So, there will be another chance when you say, say by August, Anastasia had this great phrase of pencils down. I was going to name check it. Pencils down, here's all the input we have, you have more time to think on goal one, goal two, goal three, goal four for the ten-year plan purpose.

We think that LTSS is the goal one advisory committee. That's how we are thinking. It is also possible you all could say, we are exhausted, we would like to wrap up our business in turning in this report, and goal one can work in different ways. Goal two and three and four are working in different ways. For me, there's so much overlap, it makes sense to continue all the expertise and relationship built here, that you all then become our vehicle to advise and inform on goal one, and deliver us your best thinking on what goal one the Master Plan should be.

W My eighteenth comment. [Overlapping voices].

W Oh, there we go. I'm intrigued by Carrie's suggestion, I believe the structure of our deep dive reflects what our report will look like. We're working on the right topic areas, and we have these ad hoc workgroups working on the deep dive. And I wonder if we could challenge ourselves to say, if there were one recommendation that came out of our INA [ph] workgroup, it would be this; if we got three, it would be this; and if we could have five, it would be this. Just to get like what you're not supposed to do in jury duty. Just to see as the workgroups if we could quickly elevate the top 40 or 50. How many workgroups are there? Seven or eight. So, even if it were 3, that would be 21.

W [Speaker off-mic] here are the seven recommendations on INA that we have, please look at them, and all the comments on INA that we have, and you guys work through those to decide what your higher level recommendations might be. That seems like a logical approach.

W Ease into the process that way.

Ana Can I make a comment?

W You have crosswalk with the executive order and the system look. I'm sorry, was that Ana? Yes, please.

Ana On top of that, I like that idea of a process, keeping the groups together, and then feeding the additional recommendations. But I also am thinking that as part of the priorities, that each group puts forward a state level and a local level kind of recommendation, meaning what administratively on the state level needs to occur to make this happen, but then making sure we have a local level where the people are, where the river [ph] kind of meets the road, where it impacts the individuals to keep it person-centered.

W [Overlapping voices] I think we are really—I'm going to try to mute the phone and [background noise] we're starting to get a little into public comment [background noise] because we had that [background noise], but I think we should not have the huddle. We should set up the huddle. [Background noise].

W No, that's okay. I'm in an airport, it's too busy. I'll write it in.

Kim Oh, I'm so sorry. Safe travels. We've all been there, the conference call in the airport.

W [Speaker off-mic] date for a huddle, a date—

Kim I would like a point person for us to work with. We have a list of half of you, most of you who want to huddle and figure out how to get to this [background noise]. I think Claire almost articulated, right?

W [Speaker off-mic].

Kim There was nodding. Who will be points for huddle with us? Lots of emails. We won't bug you the next two weeks. We know—

W I will.

Kim You said you were an editor, not a writer. You're a huddler, too?

W [Speaker off-mic].

Kim You and Sarah are both doing the if-no-one-else look. What's your deal with each other?

W [Speaker off-mic].

Kim Sarah and Susan are our co-huddlers, co-quarterbacks. We're inventing new sports here as we go. They will get a call calendared on, not the $6^{th}$, but shortly thereafter, to help us crosswalk our content deep dives, our process, trying to make the most of the March, but not do things we're not ready to do yet.

I guess the other question is, at this point, the other thing we need advice from the huddlers, when are we having a process conversation back at the full table? Right now we're kind of getting ready for the SACK on June $21^{st}$ to have a strong presentation to them, having a June $27^{th}$ prioritization.

W [Speaker off-mic].

Kim Absolutely. Did I say June?

W Yes, you did.

Kim January.

W [Speaker off-mic].

Kim Well, a huddle report on January 6th nobody will have talked about yet, I don't think.

W [Speaker off-mic].

Kim If you two think that's a productive use of time, absolutely. If we—

W [Speaker off-mic].

Kim Yes, we're just going to have to do a process at every meeting just to keep us all on track. If you guys can come to that meeting with something to say, we'll absolutely put you on the agenda.

There's a lot of people willing to work on it. There's also a lot of people really saying high-level, action-oriented, short, not jam ourselves on

process, principle, person-centered. Sarah and Susan are nodding as the huddlers, so that's great. And we do thank you for the out of—

W — Timing for the, whatever these magic documents are. From my perspective, it's just hard to huddle if we don't have whatever the other input is on IHSS—

Kim — Okay, so let's try this again. There's two things – our turnaround time from sending them back to the people who are the point is pretty quick. There's a couple days. We don't have IHSS recommendations to send you right now.

W — Oh, you have none?

W — Well, we have a few. [Speaker off-mic].

W — And I do think the open-ended deadline is a slight issue, because you're saying give it to me. So, at some point, you have to say we're ready to go with what—

M — [Speaker off-mic].

W And then your recommendation [speaker off-mic]. They're for you all.

Kim I would say to you it's the end of January, right? That's when the IHSS listening sessions complete, and that's our last content meeting is the 27th.

W [Speaker off-mic] you should have your recommendations on [speaker off-mic] about a week before we have that meeting so they can be considered at the meeting. So, we have a couple more meetings that are deep dive, definitely have those recommendations before those meetings.

W Where I don't think is a good place to get is to have an outline of what our recommendations are for the 27th if we don't have the comments that have been submitted, because then it looks like we're not really paying attention to all the work that you did. I just think in terms of—

Kim Understood. I think it's tricky though because you will heard 80% of the comments, so how you manage that—

W [Speaker off-mic]. I mean, the last session's on the 10th of January, right?

Kim Yes. I think maybe one of the differences we're having is, I don't think the March is only about IHSS. And I know it's essential, it's name checked in the executive order, but the March report is not an IHSS report. We've heard a lot about the public benefits. We've heard a lot about information assistance. We've heard a lot about CalAIM. So, I do think there's ways that things can be written that are responsive to the feedback that's coming in on the website, on the recommendation form, at the community roundtables, at the meetings, at the partner tables, whether it's Alzheimer's or CalAIM, and there will be some holes, because the IHSS preface will not have finished. There'll be listening sessions at CDSS, and there will be the second meeting on the 27th. That's right.

So, how we work with that, what we talk about on the 21st, do we do everything but IHSS, do we do what we know about IHSS, do we—we're huddling.

W I think trying to gather what we do know and going from there as much as possible, and asking people to submit all the ideas that have come up here. Let's see them in writing.

Kim This is [indiscernible]. We were supposed to have the IHSS conversation on December 2nd. We've pushed it to today, and we split it and pushed the second half. We've done this to ourselves for very good reason, to listen and to think and to talk, and so for very good reasons, but it is jamming on the writing side.

M We can say that, too, that there was more information coming through, blame it on—

Kim Blame it on—yes.

W [Speaker off-mic].

Kim You were seeing family, and there's nothing more important than seeing family for the holidays. Right, everybody? Okay. So, with that, anything left? We have a huddle plan, we will adjust as we are doing—I want to just thank everybody. I hope that what we are losing in clarity and black and white we are gaining in effectiveness and [indiscernible].

M [Speaker off-mic].

W Yes, I think so, too.

Kim And it's hard, so thank you for being patient and collaborative, and we'll get there. I mean, I'm still optimistic that what you all are going to say by March is going to be a game-changer.

W I think so, too.

Kim All right. With beautiful colors, right, the whole thing.

M Thank you.

Kim Any other comments from the stakeholder committee, LTSS on this process? Because I would love to hear from the public. Yes, Sarah.

Sarah What is the thinking about when the actual prioritization [speaker off-mic]?

W It's a very general [speaker off-mic].

Kim I think, at this point, we have a ton of time on the calendar in January. [Indiscernible] a lot of work to get speakers ready, but if you think there's time we have to change differently, let us know, but I think it's going to be hard to get more time, given January.

Ellen I would just like to mention that it would be great to have the recommendations and the outline before the meeting, so that we can kind of cast our consensus thoughts before we come together, if that's possible.

W You guys will have all the recommendations that I have. My question is, does everyone want all the recommendations having to do with LTSS, or would you like [overlapping voices] workgroup—

Kim And then they're going on the webpage. If you want to see them all—

W I think if we're [speaker off-mic]. And if we're going to do consensus, we should see them all.

Kim So, part of the huddles is we need a really detailed timeline on what's happening where, when are we getting materials, and we'll work with you on that, huddlers.

W Okay, thank you.

Kim We haven't driven everybody away with an hour of process conversation. I hope not.

W But if it leads to victory—

Kim Thank you, thank you. Public comment on, ideally, IHSS or the process, but welcome on any topic. I see you in the back row. Jackie, Carol. How about on the phone, public comment? One, please.

Moderator We have a question from Thomas Gregory. Please go ahead.

Thomas Hi. I'm with the Center for Independent Living in Berkeley, and I appreciate this opportunity to provide input. I'm hoping that once all of California's Master Plan planning is implemented, no Californian will ever decline employment or promotion due to concerns about how to finance need at LTSS, particularly PAS. People who work can have LTSS needs that unemployed folks don't have, and this is something that I worry could be overlooked in a process that is "for aging". Not that seniors

don't work, of course, but employment isn't as big a factor with seniors as it is with younger adults.

Will this subcommittee consider and address the LTSS needs of young adults, including younger adults who are working and/or seeking employment? Thank you.

Kim Thank you. Consistent with the stakeholder advisory committee framework, yes, we are looking at aging and disability across the lifespan. The vision is a California for all across the lifespan, so those issues are within scope.

Any other comments in the room or on the phone? Connie, yes, please.

Connie One thing I think should happen is that you should consolidate, since you had discussed earlier at one of the meetings I was at, all the different waivers and IHSS, and all the different programs; therefore, to me, you should consolidate all the agencies into an administration on community and independent living. That's ACIL. CIL was the start of it, and we can incorporate that name, and it seems to be inclusive of everybody to say

administration on community and independent living, and you have all kinds of waivers you can put in that.

I mean, why anyone hasn't even thought to, if there are all these different waivers, to make a list of all the variable programs out there so that it's available in one place, I don't know. But anyway, I think that's critical, and I just want to mention that. I have more later.

Kim Thank you, Connie. With that, then maybe we'll give you the gift of some time back. I want to thank the Department of Rehabilitation for hosting us. I want to thank our foundation partners, up to six now I believe, who are providing us snacks. It's certainly not coming from the Department of Aging, so snacks. [Overlapping voices].

Sarah, will you help me appropriately name the six foundations? Sarah, I'm going to start the six foundations. The SCAN Foundation, the Gary and Mary West Foundation, the Art Stone Foundation, the Meta Fund, and newest, San Diego [overlapping voices] Gilbert Foundation as well. So, hear, hear. If you know of any other foundations who—

W [Speaker off-mic].

M [Speaker off-mic].

Kim Yes, all of them get cookie credit.

M [Speaker off-mic].

W [Speaker off-mic].

Kim Yes, as well as our policy staff. [Indiscernible] does not have policy staff, so Carrie Graham and Jennifer Wong are out policy staff funded by the funders. Our new website, which you're going to get a preview of, is funded by the funders as well. Webinar Wednesdays, and all the meeting logistic support is—more is coming starting tomorrow to help us organize the dozens of meetings coming. So, we are just so grateful [background noise]. It's critical for this year, while CDA is looking ahead, that we have this. This is a gap that we couldn't do without the additional resources. And data analysis, [audio muffled] data. More to come. Take your time, I'm taking it. We will follow up with next steps, and I'll talk to many of you tomorrow on the stakeholder advisory committee.

All right. Happy holidays.

Moderator: Ladies and gentlemen, that does conclude our conference for today.

Thank you for your participation. You may now disconnect.