MEETING TRANSCRIPT
Master Plan for Aging
Research Subcommittee Meeting
Goal 1: Long-Term Services and Supports (LTSS), and Caregiving
January 24, 2020

Welcome, Introduction, & Meeting Overview

>> We are going to get started. We are a couple of minutes late. Part of that is we are in this new wonderful place. Thank you to the host for welcoming us to this place. We'll talk about where we are. Do you want to do the two-sentence version?

>> Thank you for joining us, Kim and staff. Welcome. This is citrus center for technology research in the interest of society. You are in the -- I can say this and feel proud, the innovation hub for the university of California system working closely with silicon valley, 20-year-old organization one of four throughout the state multi-campus, interdisciplinary. Happy to do more later. I don't want to get in the way of the meeting. If we end with enough time, I would be happy to offer a tour.

>> There's motivation.

>> I'm Kim McCoy wade from the California Department of Aging. Let me confirm that the phone is open and folks can hear. Let's do introductions of the governor's master plan for aging. Carrie, kick us off.

>> I'm Carrie, happy to be here on the road. I am an associate professor university of California.

>> I'm Stacey Moore with AARP California.

>> I'm NARI Rhee at the Berkeley center.

>> Janet Frank, UCLA fielding of public health.

>> Catherine Kietzman.

>> Donna, faculty of the university of Southern California.

>> I'm David. We have a center called safe track for research.

>> Gretchen.

>> Kathy Kelly with care giving.

>> Jennifer Breen from the California association of health facilities.

>> David Lindeman with the health and aging programs here at citrus.

>> Are there other subcommittee members in the room? How about on the zoom?

>> This is Karen Lincoln, Southern university California.

>> Shireen McSpadden from San Francisco, California, department of disability and aging.

>> Sharri Nevins, aging and adult services.

>> Wonderful. Anyone else? Thank you for bearing with us. Welcome. We'll make sure to figure out how to hear your voice. Thank you, Marty. We have a new team member here. Let's make sure we are set for a good meeting. Let's go the other way. I believe both of you on the phone and in the room are coupled with the logistics, materials are on our web page. Here's what we are going to do today. Those at the full stakeholder advisory committee meeting Tuesday heard the pivot, happy New Year. We have been working the last few months, ground the work, began

engagement to learn from each other. We are rolling up our sleeves on the deliverable this year in October. A few short months away. We'll talk you through how we are thinking about the meetings, working meetings. All of you who are in academic life, the work happens between the meetings too. We'll talk about that as well, making sure we are not just striving toward the executive order, dashboard to add state and local and public and private, but the future. What is the data capacity and infrastructure and systems we need in people's lives. I'll do a quick update to hear more from a wonderful leading worker, honored in California to get to work on goal one and hear more from David and his colleagues. Also, public comment, action item and perhaps a bonus tour.

We have borrowed the AARP meeting guidelines. They are on the door. Table toppers to remind us how much we didn't do but will aspire to do. I have a one minute card. We'll speak one person for one minute. That's hard sometimes.

>> I think there are five minute cards too.

>> It's a gesture, a reminder. It will set the tone and good intentions. Any questions we need to add? Look at this impress I have group. I can't thank you enough for the time and trust you are investing in the process to ensure we get it right and not just have visions and goals but metrics and accountability and improvement and gratitude. I'm going to turn it over -- you will take it from here and remind us why we are here and the calendar we are marching down.

>> We meet once a month compared to the subcommittee meeting basically every other day. I found it good to go back to review what our purpose is here. The governor issued an executive order with the purpose -- MPA for local government private sector. The purpose of the stakeholder subcommittee called out in the executive order is to provide advice and input to the stakeholder advisory committee for the MPA. We are charged with advising agency and stakeholder advisory committee to develop relations for measurable indicators at the population system level conveying status moving toward an age friendly state for all Californians. We want to develop clear baseline data and ten year goals and identify disparities to measure progress toward reducing disparities in the California population.

The main deliverable as Kim said is coming up with metrics, core measures, system measures for data dashboard, but the group can also make recommendations to the stakeholder advisory committee about where California should be going in terms of data and how we create a data system to inform the master plan over the next decade and beyond. I think we covered that. Guiding principles, we covered these two, collegial and open environments, support collaboration between members and person centered data

Driven approach. Questions on the subcommittee purpose here? We have had a couple of meetings so far. This tells us where we are going. The entire master plan has four goals. The first one, just to make this manageable, the master plan has been put into buckets. Goal one is care giving. That is what we are here to talk about today. What are the important measures to assess where California is in terms of helping people live where they choose with the support they need? That's what we are talking about today. Our February meeting will focus on goal two, living communities and purpose. In this context, purpose is civic engagement, social engagement. Those type of things. That would be Sacramento. Goal three, we are on the road to La Jolla. We'll see you on the beach. West health is talking about the health and well being goal. It will be a biggy. Think big in terms of data in California. We have a couple meetings to go as we go.

>> This is a work in progress by your discussion today and after.

Data Dashboard Partnerships and Data Gap Analysis Project (G.A.P.)

>> I'm noticing two meetings a week apart. That seems aggressive. There are questions about the forward looking data systems. How does the dashboard become a driver of person-centered work? We think maybe June will be ready for that. I want to thank David for hosting us and building a tour to the day before the meeting. We want toco create this with you and make sure the work drive is scheduled. Give us feedback as you have it. Goal one, to live in the community as we age. There will be caring access. This is how we bucketed it for September. What can we measure, how do we measure, if this isn't right, we need to tweak this. I don't want the words drafted in September to drive what we want to measure. I want to drive it by research expertise. If we have to go back and forth to make them sink, that's part of the process together. One more update. We are thinking there are three pieces of this work right now. We are so thrilled to move toward the center driven approaches and candidly, they have no research and data staff. We have been struggling for the vision. The first one is the designing of the metrics. What are the person-centered outcome and the system drivers we want on the dashboard? That's you all. Helping advise what are the person-centered outcomes and drivers. We talk about that today. We want the concepts, sources, what does that look like? The second thing, someone has to build the dashboard. That's not us. Rest assured. We have been fortunate that our colleagues at the Department of Public Health who have built and maintained the let's get healthy California site are let's get interested. We have another one coming to see how we leverage the let's get healthy staffing and experience to be part of that the design and back end. We are moving to the interest, enthusiasm and more specifics

are coming on that. That's where the site would be living October 20. That's the plan for that. We will not be done by October. We'll be beginning by October.

Particularly, it's come up over and over again that there are many gap in the data world, whether the data isn't available, isn't collective, quality issues, can't be inundated, etc., etc. While we don't want that to stop us from the October dashboard, we don't want that to be the end. We came warm up with data action plan to capture where there are opportunities for improvement. There would be a data gap plan. Terry Shaw has that. Data backgrounds and technology backgrounds, brings the two together to work on covered California, ways and means committee. I'm doing a terrible job. With the resume. Terry has come onboard in the last few days, for the onboarding. She's here to meet all of you and come alongside and she will be helpful about what we have, what we don't have, what are the barriers? Terry's holding the whole thing together, right? The CDH partnership, Terry shaw and Carrie and my deputy mark Beckley will help us internally navigate the department. He's ill today. We have the team together and wanted you to know that's part of what is kicking off this month so we have something to stand by and be proud of in October, educating people and prioritizing to take action. It's the beginning, not the end. That's not quite one minute, but less than five.

>> I think we are ahead of schedule.

>> Questions or comments on the state work to support this?

>> No questions on the dashboard?

>> I have questions.

[Laughter]

>> I have a data force question. It seems you are working with administrative data, health support. That side of things. I'm wondering with home care providers, turnover rates at the client level, and I don't know how much you are looking at other agencies that have the data?

>> Yes, are these publicly available or an agreement and does the agency have one? We have one for wage checks. Whether it covers the use, I don't know. That's part of the assessment with liveable communities. To your point, economic indicators are in

special services. I'm getting ahead of the process. That's back and forth, in a perfect world, where are we now? What do we next that has to do with research advice, reality check and long term, anyone else with questions about building the dashboard?

>> That we can answer at this point.

>> We have a plan that hopefully, at the next meeting, we'll have more details and concrete roles. We'll keep you posted.

>> All right. In the interest of cross pollination, we wanted to give you a quick update on what is happening with the LTSS subcommittee. They are the only goal -- the only one creating a report to sack. We were going to have Lydia here, but she's having training issues. I don't think she's here. Sara Steenhausen is on the line to give us an update. I'm going to put the graphic up of what the LTSS report is beginning to look like.

LTSS Subcommittee Report

>> Can you hear me?

>> Yes.

>> Sara: Great. If Lydia walks in as I'm speaking, she can take over. It's wonderful to be here virtually with all of you. I'll give you a quick report on how the LTSS subcommittee has organized their work. We have a report for the stakeholder advisory committee in March required as part of the governor's executive order. It's to make recommendations on ensuring the sustainability of the LTSS system, address finance issues and it's called out, the in-home supportive services program, one that financing and service delivery structure needed attention as part of this report. Recognizing that there are a number of issues that intersect with long-term services, support and care giving, the meetings have been structured in a way to get a different aspect of system and service delivery. The way we have structured the report, if you can see the graphic is, there are three buckets that we have developed as a way to provide context for the different issues to cover.

Building pathways to care is bucket number one that you can see, which includes how people onramp on to the system, such as how they get information and assistance, how they are screened and assessed for services, transition of care settings, and integration of medical, social and behavioral health services. The second big bucket is the infrastructure, how you act in the access to services. This is where we look at issues involving supporting family caregivers, home and community based services programs such as IHSS and others, building a comprehensive statewide infrastructure, planning and accelerating workforce development and addressing issues related to 24-7 residential care setting. On the final bucket is how we finance all of it. This is looking at individual options, the state and local financing structures as well as financing.

I think what's really important is looking at overarching all of this, cross cutting issues of state leadership, strategy as well as data and analytics, and the importance of public and private investments. One important value will be inserted as a cross cutting issue, the issue of equity and how you can ensure that underrepresented or marginalized committees are able to get services they need. The reason this graphic is so important to the committee is because it puts the person at the center of all of this work with the community and caregiver surrounding the person as you see in the info graphic. While we discuss in the committee a number of wonky policy issues, what is driving -- seeking to drive at is improving the system for the person, for the families that are so critical to the system.

The final note I want to make is that we are trying to emphasize to the broader stakeholder audience that this is a report on LTSS. It by no means reflects all of the issues that should be or will be in the master plan. This is the subset of issues pertaining to LTSS. That's one issue. This report in itself is not the master plan, as you know. This is the recommendation that comes from the stakeholder advisory committee. Even among the stakeholder advisory committee, we are doing a lot of work to come to consensus where we can, how to prioritize and how to ensure a fair reputation where there may not be consensus. I'll pause there. Lydia is here. She can chime in as well. Sara did the overview and Lydia walked in the door. This graphic was done by AARP. Thank you to the AARP folks for donating that time as well. It's a work in progress. Thank you for the hard and complicated work. I tried to give you a minute, Lydia.

>> Lydia: I'm sure Sara did a fantastic job.

Q&A Discussion – Part I

>> I'm Jeannie, president and CEO of leading age California.

>> Perfect.

>> Jeannie: I have a question. Maybe Gretchen will address this later talking about metrics that would be applicable. If this were successful, I would be curious what the committee thought success would look like. This is a great framework. It has so much depth to it. What would success look like in ten years if this was a successful

application. I don't know if you talked about it in committee, Sara, or not. I think it might compel us to evaluation criteria to get to that point.

>> Gretchen: I think it's a really good question and comment overall, Jeannie. In many ways it feels like there is separate work and synergies between the LTSS and developing the March submission and then there's the work we have to do to both look at what measures exist and various goals and objectives and what we might want in that, and the macroon that which is, what does success look like in each of these goals? It would be -- it hasn't come up, Sara and Lydia, at this moment, as a Crystallized success vision one overarching or multiple areas, but it might be helpful if there is a way to draft some of that.

Passing the baton back to us looking at if that is the vision of the LTSS work group, what do we do as the research group to offer considerations of things that connect with that vision or say it doesn't at all with success at that level and what do we offer as a consideration for the state to do next steps. That's what is in my brain as you ask the question. I think about the discussion later today and the things Sara shared with me about how the work groups are coming. Should we think about this in a different perspective?

>> I think the person centered is hardest for this one. There are more person-centered goals around poverty thanks to our partners at AARP. How do we know people are in the home of their choice? Also, we are starting with this one. You have to go first with the hardest one in some ways. I appreciate that, that's the goal. Let's see how far we get. Each of the subject matters have dynamics.

>> We haven't drilled down to the research conversation. It has come up in conversation, but we have been so busy with the census of 200 recommendations and it's a process. We keep drilling down, drilling down. At some point, it's probably going to need to be after we submit the initial draft to the master plan committee. We are on some stiff deadlines here. We have taught, and some of the more formal recommendations that came in on Carrie's format, thankfully have answers to what data supports this? Where can we find data? To the extent that the subcommittee would like our subcommittee to drill into more, we can set aside time to do that. Right now, we are focused on Getting the writing done. I don't know about the timing, Kim or Sara, if you have thoughts on whether we want to wait until the census has happened and take a look at where we are and look into recommended data sources and try to illicit a road map from there. I think that's a fantastic next step. The LTSS subcommittee has been working well together, a lot of expert people giving a great deal of time and energy. I appreciate that.

>> I think we, at the last subcommittee meeting, you got familiar with the recommendation form that we encouraged people to use. Anybody could submit a relation on goal one to the committee. Some people used the form. Some didn't. There is a field saying how do you know this is successful and what are the data sources that have this, what are they? That's meant to be a resource for the research committee.

>> On the access piece, number two, there is going to be a recommendation coming forth about developing standards that don't exist at this point. I think that's the starting point that there is a lot of consensus around. We'll keep plugging around.

>> We have benchmarks, all over the map in how information came to us.

>> It feels like we'll keep following in. We have discussion today. You have ideas from the center, and things the group is putting forward, what are the metrics with that and comes back to us, I think it's a process. Kim gets to make sense of it all for or team.

[Laughter]

>> I'm happy to stay connected to research subcommittee. I like the stuff. Helped with Sara. Did you bring the data book? We have to show that.

>> We have that as part of it.

>> Show and tell. Thank you for pinch hitting. Thank you for persevering.

>> Anytime.

>> Any other questions or thoughts?

>> I want to add to Jeannie's point. Person-centered outcomes will be difficult to identify and track in populations. The drivers are equally important, system level. Which ones we track and which ones we demonstrate change is valuable. The drivers

demonstrate better improvement, like smoking cessation you cannot show how many lung cancers were prevented that year.

>> The drivers are important. I like person-centered core measure, but they are not actionable. This many people are not living many the home they chose. Why? What can we do about it? You are right. The system drivers are the place they might point to more action.

>> That's what the state person -- if you all say this is the Uber metric, to get there, we need to see statewide assistance center statewide standard of care, five system things we can measure. If you do that, that becomes the agenda, administrative budget as well. How the logic model too.

>> It's important to assess whether they are satisfied with the services. That's a huge thing there.

>> This comes up all the time in information assistance. How many calls you answered is not the same as how many people you helped.

>> David?

>> David: Quick comment. Less than a minute. It's interesting to look at this from the point of view of the people using it. Starting with me right now, going forward. I think we all recognize there is a complexity of insurance systems where you have to feel your way through it. Maybe that's under information. That can be more emphasized. What does this look like for the people that use these different service sets, and make sure they are not so complex that they are not sure where to go and who to call and stuff like that.

>> There is a subtlety that came up in the housing conversation a while ago about the complexities, maybe a subtlety to this point about who is eligible when. You may not know to access the service. One thing we might want to consider, maybe a sub mentoring, or guideline, we establish a common baseline for all service eligibility timing. 55 v. 62 v. 65 on some of these issues. That's come up in the housing conversation.

>> You can't access services certain ones at 62, and others at 65. There might be more of a sense of expectation that I need to check into this. Do I have access? An example, social security. If you are getting close to 65, you probably thought about it.

>> The older you wish –

>> It's like kindergarten. The conversation we have had about kindergarten. We know at age five or so, we start kindergarten and until 18, you are taken care of. If we have a parameter we think about around age. Are we going to set an expectation at all so information and access becomes an understandable expectation, then?

>> Are you making a data dashboard point that the age set in the indicator should match the program, the source, or are you saying, no, we should go the other way? 50 is the beginning of AARP? I think there is an important role in defining and educating if we do it right, if we are successful. How do you reconcile the norm and communicating and educating and prayer against the program rules and data sets that are different? Is that the question you are opposing to the group?

>> It's the question I'm posing. I can't say I thought this through, but it's come up so many times that you become eligible for X, Y or Z, that you have to have a threshold. It's the expectation at 45 or 40, we need people to think about what they need in 20 or 30 or 40 years. We have to set the expectations in dashboard. That becomes information and referral and therefore access point, right?

>> What is the dashboard for? Will it have a use for people that need access? Those are quite different.

>> Right. They are. It's envisioned as user friendly so it's helpful in community planning, but it's not the user portal people want. One stop services, it is not thought of as the same thing. Maybe they want to talk to each other, but –

>> If you think about the information referral, discussion -- if we started measurement at age 50 and said, we don't have a baseline now, right? We don't have a common system so we don't have a baseline. If we want people to enter the referral system, that's a measurable time system to say we are hitting people at 50, not 72. As the graphics show, you will see, maybe that's the data point we have to tag to every element. Snot saying we have to, but maybe.

>> This, this may be valid to circle back to. I think some of the chip questions are not age, but experience. You can relate them by age in terms of the macromessaging point Kim was going to.

>> Do you want to introduce yourself?

>> Sorry, Berkeley parking and my own problems. I'm Laura Christensen member of the research committee.

LGBTQ Seniors in California

>> We are going to move on to a segment of research meetings where we call smart people using data in interesting ways to the master plan. Otherwise known as partner research. I have Jason Flatt on the phone from UCFF, just moved from Las Vegas. He is one of the foremost researchers on aging issues in LGBTQ community. Part of, as you saw, and purpose of the dashboard is to lift up issues of equity and how we can -- you know, we can have recommendations for the communities, but we can also use the dashboard to track this population. Jason, are you on the phone?

>> Jason: I am. Hi, everyone.

>> Hello.

>> You have the floor.

>> Jason: Okay. Thank you for letting me talk with everyone today. I'm going to give you a bit of an overview of some of the work we have been doing, and as mentioned, I recently moved to Las Vegas. I still have an adjunct position at UCSS. Still doing work there. The big piece with my work, just to highlight, I have Federal funding to support this work. I'm looking at dementia risk among LGBTQ seniors using Northern Colorado data from Kaiser. I'll talk about some of those findings today, as well as national data I have been accessing in the behavioral risk factor surveillance system data from the CDC. I'll also highlight work that comes out of the William's institute at UCLA, some of the work done by Elon Meyer and the California health interview survey to give you an understanding of the health and long-term care needs of LGBTQ seniors. Then, last

piece, I have been fortunate to partner with open house in San Francisco on several initiatives. We have been looking at affordable housing for low income seniors, thinking about inclusive services as well as we recently finished a needs assessment where we looked at the needs for adult day programs for LGBTQ seniors and their caregivers.

I'll highlight a bit of what we found from that. The next slide shows, really, some of the research and press that we have been getting, just from the work that we have been doing, so again, what we were trying to answer from California and specifically in San Francisco was understanding why aren't LGBTQ seniors accessing aging services as much as their peers, their heterosexual peers, non-trans people. What we are finding is they are not finding the services welcoming. They experience economic challenges that are unique. Many consider being sandwiched where they are on a fixed income and not eligible for subsidies but they can't afford to pay out of pocket, especially given the rent in some of the urban locations in California for housing. That came out a lot as well as experiencing discrimination or accessing services or being treated poorly accessing care.

I'll give examples of that in a moment. On the next slide, I wanted to share just a bit more about our research and what we have been finding. One of the unique pieces, and I think this is the first to look at this is thinking about how often LGBTQ seniors are considering concerns with memory, possibly dementia. We looked at 24 states, 2015-2018. Interestingly, California didn't participate in the module that looked at memory. What we found nationally was that LGBTQ seniors were more likely to report problems with memory or report that it's gotten worst in the past year compared to one in ten for non-LGBTQ seniors. When we looked at subgroups, it's important to understand the community may face additional challenges, due to social economic or discrimination in society. We found that lesbian, bisexual and trans were having more problems with memory than gay men.

Gay men, 11% reported, 18% for lesbian, and trans people. We found and looked at memory challenges, did you have other problems? What we found was that LGBTQ seniors compared to non-LGBTQ, if they had subjective cognitive decline, memory issues, they were giving up day-to-day activities, as well as their memory impairment problems with daily lives, work or volunteering. Suggesting that they are seeing that the memory problems are creating a burden to them and limiting their ability to engage in everyday activities. This is an area that we feel would be important for the master plan and aging to consider. Looking at the next slide, I wanted to share with you just a little bit -- what does it look like for LGBTQ seniors in California? I heard others talking about the age of entitlement. We were having to look at the data as well, and give you an estimate.

There are over 400,000 LGBTQ seniors in California who are age 50 and older, and much like the demographic shift we see the population grow older and older, we are seeing this for LGBTQ seniors, a major concern when we think about long-term care needs has to do with the ability of caregivers for this group. They are more likely to live alone. Looking at, this is from the California health interview survey 2016, you see a third of LGBTQ seniors lived alone compared to a quarter of straight seniors who are age 65 and older. Showing you right there that living alone can be a challenge for care giving and we know from other work done, LGBTQ seniors are less likely to be married or have children. Many report no care giving support. We know the challenges are also increased for members of the community.

Tran seniors find more challenges in care giving support. We estimate around 29,000 tran seniors currently in California are age 65 and older. Big challenges for the community is they are experiencing stigma, discrimination and trauma from accessing Medicare, aging services and many of the service providers that have a religious affiliation may not welcome them. They are reluctant to seek outaging services often as well as medical care. Major challenges for this community that should be considered. I wanted, on the next slide to really emphasize the importance of understanding the social economic concerns for the community. We know one third of LGBTQ seniors nationally are living at or below the 200% Federal poverty level. What is unique is we are finding major challenges for other groups within the community.

From the survey, they found bisexual Californians age 65 plus, twice as likely to live at the 200% below poverty level compared to gay and lesbians. Again, seeing major economic challenges for this group when it comes to aging in place, accessing aging services and their ability to care for themselves. On the next slide I highlight some of what CHIZ has found. Here are some of the top health concerns we are seeing for LGBTQ seniors. Overhalf report a diagnosis of hypertension. Nearly half report being disabled. We see disabilities, actually are much higher for LGBTQ seniors than their heterosexual peers. Many report -- over one in four report fair to poor health. We see cognitive difficulties being reported. Asthma, heart disease and diabetes. Another group often left out of this, and it's not listed here, but our long-term survivors of HIV and aids. This group is also facing unique challenges in our urban settings around being able to afford housing.

Many of them were on disability, and when they reach entitlement for social security, they see huge changes in their income. The entitlements don't -- they see a huge reduction in their monthly income, and this has caused major challenges around risk for homelessness, ability to access medications and healthcare. It's another group within the community that deserves attention. On the next slide, it's something we should consider for California, look at it as why LGBTQ seniors are not accessing aging services. We explored this in San Francisco, trying to understand why they were four times less likely to access services. We conducted -- surveys for those 60 and over. We found the reasons they were not accessing services was that one in five felt unsafe or unwelcome in accessing the aging services.

Examples they shared were not receiving discrimination or treated in an unkind way by the staff, but it was the other seniors that were at the services that often were not respectful. We saw mobility limitations as a challenge for them accessing services. One in four reported challenges with accessing transportation. Whether, you know, it was public transportation or being eligible for entitlements to access subsidized costs for transport. We found those seniors were living alone and needed care giving, but they weren't able to access that. They didn't have the resources. There has been a huge concern in San Francisco, and I anticipate this is also happening in Los Angeles where we are seeing those that can afford to leave the city, are moving, and seniors are losing their support networks.

Those limited financially are aging in place and those better off are moving to get services they need. A huge challenge and something to consider. I wanted to Sharon the next slide, words from LGBTQ senior, just so you can hear a bit about what they are actually saying. The first one, I wanted to point out was just that this is an example of a senior who talks about -- you know, the challenges of their income, right? They are not eligible for entitlements because of the current finances, but after having to pay for most of their care out of pocket, they are now living in poverty. They basically had to use all of their savings to take care of themselves. A piece that I wanted you to consider is our gender minorities are trans communities. Here, a trans senior talked about how their views and needs are different from others. It's different from the needs of lesbian, gay and bisexual community. They feel organizations need to better understand and think about, you know, having a more person-centered focus when designing focuses, so they are designed with trans people in mind as well as making sure you have an environment that's not only welcoming, but you are also hiring LGBTQ people to work there.

That's been a big piece of what seniors were saying a lot about, making sure you have staff that are transgender, that you have staff that identify as a member of the community. Carrie had also on the next slide asked me to give you a little advice on the type of data you might want to consider. Much of my work, with my training and epidemiology, as well as community research, these are the top sources right now, that I recommend that have information on LGBTQ people. The William's institute, if you don't know about them, they are at UCLA. They have done a really great job of coordinating data from across the nation so we can understand estimates of the population, unique needs. It's not specifically focused to seniors, but there is information there that has estimates on the population by age as well as sexual orientation and gender identity.

Another source that I would recommend that you check out and I presented on this today is the California health interview survey. You can access that at UCLA. They have been asking questions about sexual orientation and gender identity for a while. There can be unique data I think can answer questions about the needs of this community as well as others using that data. Finally, every state participants in the CDC's bur face, annual survey. There could be an opportunity to influence what is collected or access some of the information that's there that you could use it. I encourage you to check those out. I was excited to see an upcoming presentation by

HealthNet. I briefly mentioned the data I'm using at Kaiser. What I'm utilizing there, there is a unique study called the research program for genes and health started in 2017 -- maybe 2007 -- not 2017. What they had asked was sexual orientation baseline.

What's unique is that we are able to link that information to the medical record and be able to look at disparities compared to non-LGBTQ people. I encourage data from the local health plan especially those collecting information on LGBTQ identity.

Using Data to Incentivize Quality in Skilled Nursing Facilities

>> Thank you so much, Jason. We appreciate your time. If you have time, stay on the phone. We'll take questions at the end. Next up in our smart people working with data series is Ed Mariscal from HealthNet.

>> Ed: Hey, everyone. Hi, Lydia. We talk on the phone quite a bit.

>> I want to be sure people can hear on the phone?

>> Ed: I have a speaker in front of me.

>> What I wanted to talk to you about today briefly. I know we are a little behind schedule is -- what I came to HealthNet, I'm the long-term services support and programs. I have been in the nursing home field almost all of my career. I was tasked with a couple of things. I was tasked with quality in long-term care population, those that live in nursing homes that are institutionalized. I was tasked with creating a dashboard that obtained and received data from a lot of different sources putting it together and using it to inform decisions around targeted outreach for case management, targeted quality improvements, and ultimately, helping our MediCal population make better decisions around nursing home placement. I'm going to go very quickly, but ultimately, what we started to do with this particular incentive program, I can go to nursing facilities and talk to them, promise to put them on preferred programs, send patients their way, but how am I going to get nursing homes to improve quality.

Everyone's focus is part A reimbursed member, resources and services are focused there. I want to focus on the other 75% in the nursing facility, those that live there, that are at a much lower rate. How can I help nursing facilities serve that population better? I looked at data we are collecting. I looked at our nursing facilities, and my focus was essentially on 75 facilities whose metrics told me -- informed me, that they have room for improvement. What does that mean ultimately? The readmission rates were higher. Emergency room utilization was higher. Also, their inpatient admissions and preventible conditions was higher. I think that's -- a really important point to focus on with the research that we did and the data we collected. That bucket alone, that preventible bucket alone was significant for our population. My focus is on Los Angeles and San Diego counties where we are contracted with 402 nursing facilities.

We have 10,000 members in long-term care in those two counties alone. What can I do? What can I focus on? I focused on nine quality metrics, things I can leverage from CMS and the state and my own internal claims data. If one of my members goes from the nursing facility to the hospital, I will know about it because we paid the bill. Nursing facilities say to me, once the patient leaves the door, I don't know what happens. That may be true. They are still your patient. Your responsibility didn't end. I'm not changing the way I'm looking at this program. What did I look at? I looked at completion of the post forum, physician's order for life sustaining treatment. I don't care what the pulse form says. I want the discussion to take place. 100% completion is one of the metrics. You can expect me to hit 100%. I'm not expecting 100 people to check the box that says measures. Have the conversation. That's all I'm asking.

Staffing requirement, at the time of the program, when we were rolling it out, they increased staffing for nursing homes in California. That was great but at the same time they accepted waivers to not have to meet the increased staffing requirement. I don't remember where we are today. I think a little over 300 facilities were approved for the waiver. Some have expired. As part of our quality program, we stuck with the higher rating. Sepsis, our data at HealthNet tells us 31% of our members from a nursing facility to hospital are admitted under a sepsis diagnosis. I wanted to be sure it was a quality metric. Pressure ulcers are on there, flu and pneumonia vaccines, we want our members receiving those. UTI is second largest hospitalization for member, 13%. Catheter left in bladder falls with major injuries. Those are the metrics we are looking at.

There are a lot more to incorporate 2020 into the study, but for this roll out, those were the nine metrics we looked at, data showed improvements there will result in reduced acute bed days, reduced preventable readmissions, reduced utilization and reduction for 1,000 member days. The four performance measures you see up there, that funded this particular pilot we did. If we saw a reduction, if we saw a reduction in acute days or the utilization of the emergency department, that's where the bucket came from we would then share in the savings with the nursing facilities. Those nine quality measures you see on the top left, we tiered into four tiers. Eight or nine shared 50% of the savings. When we rolled this out, when we looked at the first group we wanted to target, 51 were tier one. Lots of opportunities for improvements.

I looked at DHS data, quality supplemental ability payment. I looked at their metrics. When I added what would happen if one less member became sick. That was my baseline. The number of facilities showing worse than the target, we can see the group of 75, 60 were staffing less than the target. 50 were -- metric was -- worse than your baseline for pressure ulcers. UTI32 didn't meet the metric catheter, falls, 28. The pulse, because that information doesn't come from one particular source, I have a team that goes to facilities. They go chart by chart to the proper post. They report to me if they see a big stack at the corner to report to the ombudsman's office.

You are seeing my version, interactive or using the platform tableau. We can look at each metric as it compares to all of the data sources we are using, claims of state of California, national, cause and target we have set for this program. What we are doing also, we are collecting as much information as we can and putting it on one page so we get the star rating. It's a public visual out there, thing. It's important that we take it into account. A lot of things come out since we have drafted this to incorporate. Incorporating abuse, the special focus candidate list separate from the focus list we incorporate here as well. We have the one page on the bottom left there that will give the facility a one page view on how they did on all of their metrics. On the right-hand side, the chart there, on the performance metrics that helps fund the program that is listed there.

We have a long claims run out period of about three months. We have another couple of months for validation of all of the data. The information I'm sharing with you, excuse me! Is for Q2 -- 2019. Q2-2019, I was telling Carrie earlier today, today is the day my first set of incentive payments went out.

[Applause]

>> How much did I save the state of California, and how much did I pay? Before I say that –

[Laughter]

>> Ed: Leaving you wanting a little more. We wanted to make it interactive and actionable, but we wanted the facilities to use the information we are going to share with them to be proud of and share with their staff, but also, when you go into the community and market your facilities, I can give you data that says maybe you are better than your neighbor. We created these charts that will say where you rank overall. What I also did was created dashboards specific to the parent organization of the nursing facilities so the larger chains can see how they are doing over all. The larger chains are spread throughout different counties, they can take a look. Actionable for them. When cost came out, they hired people to focus on cause so develop incentives and bring in revenue for the facilities. We are doing the pilot in L.A. and San Diego, I broke up L.A. and San Diego. San Diego is one region, much smaller and L.A. is five regions. City center, the valley, this valley, the west side. It

wasn't scientific at all. I got a map and drew a circle. So I can go where I live and say this is how you are doing against your neighbors. You are not doing well. Or I can say, here's your sheet. Go to the Arcadia Methodist, Huntington and mark it yourself. You are doing well with your members.

You can look at region and metric together and see where you rank. So how did the facilities do? At the beginning I said we targeted 75 facilities. We did not contract with 75 for the initial rollout. We did 40. One thing I forgot to focus on when rolling this out is change of ownership. There is so much change of ownership with nursing facilities that they couldn't contract with us until the change of ownership was complete. The data wouldn't be coming in accurately, different PIs, tax IDs, it wasn't actionable data for them. 40 contracted with us. Q2, we saw a million dollars savings in reduced emergency department visits and reduced inpatient visits. Higher than what my target was, my target is to save $3 million in one year. I saved one million one quarter. I'm on my way. $213,000 in incentive payments, so we are proud of that.

I didn't include the facility names on there, but provider one in L.A. county, $97,000 in savings, but they only made it to eligibility tier two, meeting four or five of the quality metrics. Today they received a check for $14,000. Provider number two saw a lot of savings, 65,000. They didn't meet quality metrics. Provider number three saved $45,000, but they met eight of their quality metrics. They were tier four, 50% of their savings, getting a $22,000 check today. Some facilities didn't reduce their visits, but they have the information. We have the information. We as a health plan go to the facilities to work on contracting and referrals, we have actionable information that's specific to our members. Eight of the facilities were in tier one, 17 facilities, tier two, 13 in tier three and 13 in tier four. If you remember one of the first slides, 51% of the facilities, tier one category. We did significant improvement here.

We saw improvements in the metrics, without all of them seeing a reduction in hospitalization. I think a conversation down the line is hospitals get penalized for readmissions, nursing facilities don't.

>> That's not true.

>> Oh, they are being penalized now. Are physicians being penalized for readmissions?

>> No.

>> The physicians tell us at times -- they call us on the phone and don't have a lot of information to we send them back to the acute. Some things we can target later on.

>> Because it's readmissions, it's all payer sources, but it's readmission within 30 days of the hospital discharge. The long-term hospital visits, long-term ED visits, not right now.

>> Ed: That's it for me.

>> Thank you so much. One quick comment. It would be so awesome for the L.A. county data to be broken up by supervisor district. That may be something that supervisors may be interested in, in terms of quality of care facilities.

>> Ed: Thank you.

Linking Information on Area Agencies on Aging with Data on Health Care & Nursing Home Utilization in Their Planning & Service Areas

>> Thank you. Amanda Brewster from UC Berkeley to look at outcomes from functioning.

>> Amanda: Hi, everyone. I'm down the hill at the UC Berkeley health. This afternoon -- I'll just stand over here. You won't see me sitting in the corner. I study healthcare organizations and management. Looking from the healthcare outcome side, and my work focuses on source of organizational arrangements and management strategies in the healthcare sector and beyond the healthcare sector can lead to better outcomes for patients and population health. Lately, my focus has been on trying to understand how innovative arrangements and cross sector partnerships appreciate the social determinants of health, people's life experiences outside of their exposure and benefits of healthcare, how they come together to influence health outcomes and how we might leverage strengths in the social service networks, social service provider outcome in the communities and sets of providers we have for people of all ages, older adults and social services side.

I study partnerships and collaboration. I like to acknowledge my research partners. I'll focus on what we can learn from area agencies on aging which many of you are probably familiar with, but I want to highlight, I have been working for a number of years now with colleagues at the national association of area agencies on aging as well as the scripts gerontology center at the university of Ohio to get national data to look at what the AAAs do, health sectors do in budgeting outcomes and healthcare.

>> Just so you know, the chair of the San Francisco board is in the room.

>> Amanda: Fantastic. Most of you probably are well aware of the contributions that the AAAs make. From a research perspective, I'm going to highlight the way we can leverage the opportunity to do research and evaluation. The real attraction of AAA besides the work they do in the community, they are serving older adults in defined service areas across the country, which makes this a great opportunity for national or state scale research to understand what is going on with the population inside a given geographical area, community and how cross sectors might improve the outcomes.

The bottom funds are designated to provide and coordinating services for older adults, supporting health and supporting the important types of services that aren't directly medical care and support social determinants of health. There are recent efforts to link up patients identified in healthcare settings as needing assistance with nutrition or housing and factors that can improve health but are not in the wheelhouse of healthcare organizations. This is -- I won't go into this, but I can talk about the network map. My interest comes from impure call work looking at communities across the U.S., networks of organizations that support the health of older adults from the healthcare side and social services and aging services side. When you map out the collaboration network, who is working with who, collaborating with who, committees on aging are in the middle, which won't come to surprise in an audience like this, but the top web bar is the area agencies on aging showing you the numbers, dramatically more central to the collaboration networks than any other organization that we tend to see.

The study I'll tell you about now, is the effort to consistency areas across the country and survey data collected over the course of ten years now by the scripts gerontology center in Ohio in collaboration with 4A, to document what they are doing from their perspective. They are in the center. They know what's happening in terms of the collaborative relationships, cross sector partnerships that collaborate health and valued measures of potentially avoidable healthcare youth and spending we get from Medicare data. That way you map, we took advantage of the data to map what the AAAs are doing to the medical outcomes and service areas are, is by getting information on the community living on what the boundaries of service areas are.

We got that and we were able to assign counties to AAA. This could be done at a state scale. The challenge of power is lower. Considerably lower but can be do that. Most are defined by county boundaries, so that makes it seamless to use Medicare claims data available at the county level. Go on the website now. We are more involved to get it at the individual been officiary level. We use the county level, straightforward to map the counties to the Medicare beneficiaries in the counties and look at what the AAAs were doing change over time, how the health outcome -- health related outcome measured by utilization changed over time and see what happened. We focused in on two measures of what was going on in terms of multi-seconder collaboration. One was community initiative, multisigh sector efforts to plan for supports of well being and health and for older adults.

Second, we looked at partnerships established between AAA and healthcare organizations. I'm happy to talk more about the details if you have questions about that.

>> He's in the room too.

>> Amanda: I'm used to talking to healthcare audiences. The initiatives are a great indicator of the multi-sector sort of activities that are starting to emerge. I know what comes next. What happens, the only thing you don't have on the slide is the results.

[Laughter]

>> We are able to look over the course of three years. We have measurements from 2008, 2010 and 2013. They ask AAAs about the partnership arrangements and how they changed over the time periods. We are able to look at change in Medicare utilization and avoidable nursing home utilization which we define as a low-care nursing home metric. I usually have to complain all of that. We look at exchange in those two measures over time and find that when we look at livable community issues, we can see the numbers budging in a significant way. We find that when AAA starts in the year AAAs start to report that they are doing funded involvement in a livable community initiative, we see the low care nursing home rate in their counties go down in a significant way. It's about a one percentage point drop. A significant change we can see there. When we look at particular partnerships AAA is utilizing with healthcare, we can see in the year when AAAs report establishing a partnership with a mental health organization, we see nursing home use going down in a significant way.

The last thing we pick up, a significant change is in the year when AAA starts partnering with a hospital. We see that Medicare spending for beneficiaries goes down by a significant -- not enormous, but specifically significant reduction in that year. That's just a taste of how I have been using this data to look at cross sector partnerships and how they flow through to impact utilization and spending on the healthcare side for older adults.

>> We apologize for losing your last two slides. We'll be sure everyone gets those. I want to thank all of our speakers.

[Applause]

Q&A Discussion – Part II

>> Using data to drive policy. We are a little over time. We are breaking our rule, so if there is one question -- we can also get contact information. Any questions?

>> One quick question. This is for -- Jason, are you on the phone?

>> Jason: I'm on mute. Yes, I'm here. Hi.

>> Great. Thank you so much for your presentation. Quick question. In the data you indicated, I was wondering if there is an ability to look not only at the gender identity, but also at ratio or ethnic disposition or identity? One of the things we have looked at was that there is come pounded discrimination, concerns when it comes to healthcare and long-term care settings for those that are LGBTQ and also Latino or black. I wonder if you have insight with regard to that as well?

>> Jason: Yeah, we did look at that. Some of our work with open house, when we recruited, we oversampled for people of color so we could understand the needs for everybody. You are absolutely correct that our black and Latin communities are facing unique challenges as well.

We can find some of those are cultural, less acceptance even within the same cultural group in terms of sexual or gender identity. There are those challenges. There are social economic concerns with historical discrimination against our minority communities. I definitely, in these groups we are looking at our groups of color to see about disparities, sort of this idea of, we have talked about it as being a double minority, right? Where you may experience -- we know some of our people or color have higher risks of dementia, chronic conditions, a lot of that is linked to discrimination. We anticipate seeing those challenges if you are also an LGBTQ person of color.

>> Thank you. For the equity work group, compounding lens is something to examine.

>> Jason: Yes, that's a great suggestion.

>> One more question.

>> Jason, interesting and important data you presented. Do you look at geographical differences and well being? What I was thinking, it would be better to live in San Francisco and L.A.

>> Than the central valley –

>> Not just -- I don't mean to say something negative necessarily, but if you had to be relocated, you might have a supportive group and you can make the same case by race, right? Does the geographical location of your support network and surrounding services make a greater difference for some groups than others, and that's really the –

>> Jason: That's a good point, Laura.

>> Do you have geography on it?

>> Jason: We are going to be looking at that. We were going to be looking at that nationally, where you live, how that would impact urban, rural, sub urban. We have not looked at it within California. That would be an interesting piece to look at.

>> Thank you.

>> All right. I think we are moving on. Thank you again to the speakers. Really, really useful. If you want to stick around, maybe people can curb side you at the break.

>> It's a concrete thing we are doing, but there are so many pieces we are working on, I work with the state and we are thinking about AAA partnerships and how to strengthen them. This is right on time. Nursing home, feature about the LSS recently. These are all on time. Our equity work group master plan meeting in February. We are just so grateful for all of the work, all of the ways we'll put it to immediate use. Thank you for sharing your expertise.

[Applause]

Goal 1 Overview: Person-Level Core & System Driver Measures

>> All right. Gretchen. You are up. We are going to talk about dashboard measures now. Everybody get ready.

>> Gretchen: Before that, everybody stand up, arms up to get 15 seconds, blood flow through your body. We are going to dive way down into the weeds. All right, wonderful, thank you. There's coffee and sugary snacks. You are welcome, Stacey. I know I needed that. While you are getting refreshments, getting a bit of glucose back into your system, I'll start with framing. I'm going to keep on talking. This is kind of a big idea, concept that's going to drive the next hour's discussion. I wanted to lay it out on to the table. It's been really a pleasure to be a collaborative thought partner with Kim and the TA team about lots of pieces of the master plan, most particularly, what are considerations to address the big research charge we have as a subcommittee? One of the things, a dialogue point at previous meeting, we had such great dialogue about measures and they live at different levels.

Some were person focused. I mean the micro person focus, does this person have accessibility needs that are not being met? That's a particular measure with a lot of context around it. There were measurement discussions about do we have enough plots in the MMSP process to meet gate management people in areas where that service was available? We are tugging at lots of levels and interacting points. One of the things -- it's one of those things you offer a facade and Carrie says, great. One of the things we did internally at the scan foundation over time, as we were looking at what our work had been other bodies of time amend years, we thought about measures that were about changing people's actual lives in the direction that we wanted. Then we were thinking, what are the system drivers that facilitate the change? Janet is here. She's smiling at me across the table. When Kim talked about logic models, Jan and I looked at logic models over time. That's how my brain works. What is the person level impact measure we are trying to effect?

Are the system drivers, outcome measures and logic model universe, what are they going to do about it? What is the state going to do? What is the university sector going to do about it? How do we contribute? What are we contributing and where on the master plan for aging? More particularly, goal one, two, three, four. You have heard about -- and we can play around with the language. The language we used inside the foundation for our own purposes was the person level core measure and what was the system driver measure? We can talk about language in a minute. What the next three discussions are going to offer to you are various ways of thinking about person level core measures given that we wanted a master plan for aging and what are the system drivers to have information about how well the information is responding, serving, accessing so people have a flow through to get what they need. Sometimes, two to three system drivers are at play for one person level core measure.

It's not always one-to-one. Thinking about those in context. That gives us a little bit of background in terms of how the discussion is being set for the afternoon. What I would love for you to do for just a moment, and that moment will last about 30 minutes, is suspend judgment about whether you like system core or the language or you think there is another way of Ruebecks cubing this? What's available, we have moderated discussion. I will say what I would love to do today is to try to get a sense of comfort with whatever the frame is to think about the measures today. We would like to do this same thing for goal two next time, three the next time and goal four the next time after that. It's a little bit of both with a hard goal and a lot of information to say, how will we separate the structure of the measures, and here are thoughts to do the next thing on goal two, three and four moving forward.

So that is a little bit of setup. I want to look back to Carrie and Kim to make sure I didn't say anything really important to you? No -- I see shaking heads. This is a really complicated -- the subcommittee had ten meetings on different topics related to LTSS that this committee needs to see a little bit of that in previous meetings. Let's do our best today. We'll start with what David calls a straw man. Jeannie?

>> Can you clarify one thing? Can you give a simple example of what you mean by a person level core measure and system driver?

>> Jeannie: I'm going to use one important to the scan foundation over the last six or seven years. How many Medicare, MediCal beneficiaries were enrolled in integrated care model plans could be MMP, could be PACE -- could be all sorts of things, four stars and up. That's a person level -- how many people got this thing?

We had a value of integrated care is better. That's taken out of this, something that the scan foundation cares about. The system driver, things like what's available, and how many plans are available in various communities, you have to have that in order for people to enroll. What we are going to hear today are variations of what could be person level core and system driver to get to that space.

>> Can I ask a clarification? Would you not include measures like -- when you said person driver -- I'm thinking ability capability, happiness.

>> Absolutely. We thought about -- you know, could you have a measure that is about people feeling safe and happy and fulfilled in the place that they call home. What percentage of Californians over age 50, to Jeannie's earlier question. What matters to me v. is there a place I can go to get help in my community? I may not need that.

>> I would think person enrolled in an integrated care plan would be a driver.

>> We put it as a person-level measure. People would have to make a choice for that.

>> It's enrolling.

>> Availability being a system driver and me getting a plan that meets my needs being more about I'm getting that from me.

>> I think it's important to be in a person reported measure. Talking about happiness or person centered measure at an integrated level. It's a level of access or care.

>> Sure. If I were to think about taking it back to the step back, staff member for the governor, and the governor is rolling out the master plan for aging dashboard that the governor has something to say, we are going to be tracking -- we have an early measure on how many people over 65 have support -- feel they are supported in their community. That's the person level. Then we can say how many community supports are available for family caregivers in term of access points for them to get care. That's a bit of the difference. Some of the things are going to be squishy, right in the middle. That's the spirit of two buckets.

The last thing, I didn't say earlier but I wanted to say, we were going to start this discussion and try to save for today what exists as opposed to what we would like to see. All sorts of things. We know the scorecard with AARP, around a ton of stuff weld love to measure. We have to get back to what we have to measure. That's that purpose today. I wish we could measure this stuff, but California doesn't do it. Have your own parking lot. We are going to capture that later, but not today. Everybody good?

>> I want to bring people's attention to handouts. We have some handouts for the workforce and a handout on domain. I'll turn it over to Lydia Missaelides to tell us about the resource developed –

2002 LTSS County Databook

>> Lydia: In the olden days. Hi, everyone. This is, I believe, the only surviving copy known to woman kind and mankind of the data book. I shared it with Kim and Carrie. We started rapping on what this could be. As I looked at it and I was participating in the LTTS subcommittee, and I was like, they were smart in 2002. We designed this through a grant from Department of Aging when governor Davis had a surplus in the budget, and they were giving money away, if you remember that. A colleague of mine had this vision for a long time. She came to me and said, Lydia, I'll help you write the grant. What do you think? Great. Do it.

This really is developed through a policy and adequacy lens that we wanted to be able to display county by county the array of services, sort of what is the service landscape that existed in 2002. The census data had just come out and was being chunked out at the Federal level, kind of an evolving thing. We had the census data. We were partnering with the data wonks on that. We developed this with a hundred thousand dollars with little technology. Today I think a lot could be done with that amount of money far better than this, but looking back, we wanted to look at the workforce. We found data on workforce wages, medical, housing transportation and special programs. There was a demographics bucket, population growth and second page -- actually, on the first page of the data, I forget how this went. Page one, page two --

We had the landscape of LTSS services. Then the innovation for this, I believe was doing the county comparisons. We were inspired, and I have to give credit to the healthcare foundation, used to put out a medical book that looks similar to this. I don't know if you remember that? That was the inspiration doing this for LTSS. We didn't come up with the design on our own. County comparison is cool. We thought we can use this for adequacy because a legislator would look at this for their county. Why am I bottom on X, Y, Z, good for county income, beds per thousand, okay, fine. We thought that was a way to get a snapshot and see the have and have not counties. There is so much disparity around us. We are different around the state and L.A. county is so different. So that's really all I wanted to share with you, this idea that I think it's possible now with the ability to geomap and technology advanced and data sources you are familiar with, that we could assemble them into the dashboard you are focused on.

If there was a way we could use for county supervisors and legislators. We have been discussing on the LTSS subcommittee, we have access recommendation and infrastructure recommendation among many. How do we rebuild and build up infrastructure? What are the core services to be replicated throughout the state. That's the other point I wanted to make. This would be cool, not for all of the measures, but I leave it to you all, we have a 2002 snapshot of California, and then we could look at today, and as you develop your measures going forward, we can have a change over time 2002 as a starting point. I have all of the data sources on a word document. Anything you guys want, it's Department of Aging funded stuff.

I think that was -- those were the key points I wanted to make. We are going to be bringing infrastructure and access standard recommendations that feed into some of this work -- I think. Let me see, I think that's it.

>> Lydia, one question, when you look at the sheet, page two side, would it be safe to say this is more in the system driver accounts for accounting? When you explained it? Yes. When you explained it the way you did, that's where my mind went right away. It's looking at the system that exists in that region for people to access.

>> Another inspirational resource could be –

>> Dartmouth?

>> Yeah. They have been mapping outcome access data county by county and state by state for decades now. It doesn't have the health data.

>> That's why we are going to innovate all of this. You have to have an inspiration. We are going to be the leaders on that, Kim. Nation awaits.

>> I have a question. Is there any chance that the roll out of whatever the changes are made by the governor, could be county by county in some way –

>> It needs to be. All California data to have value –

>> The staggering, then you would be able to get it. You put in place some new program in L.A. and San Francisco counties and three months later implement that in San Diego county so you can -- if that could be randomly assigned -- you would really have powerful data. You would be able to have causal –

>> LTSS is rolled out. In this we have that already with the waiver or pick your program.

>> It would have to be -- you would have to avoid the selection of the county that got the waiver or less interested in doing something. There is such potential to measure

what works and what doesn't. Particularly in the realm of equity. So many programs seem to work well for people that have a lot. They get access. They fair better, and they miss the neighborhoods, counties, groups that are not doing as well to begin with.

>> I think there are natural programs that roll out in phases and regions. We can think about the Bay Area first and valley. That's possible.

>> What's coming to my mind, an important space, the parking lot space we need to get to as a research subcommittee some time later in the spring that gets to one of the things we wish we could measure, and how do we ensure that any intervention through the master plan next ten years has a built in evaluative framework. What do we learn that both impact measures on the dashboard itself and helps us do a good concept over all in terms of the master plan, look back once we get to the place. The evaluation.

>> Summer meeting.

>> It is a summer meeting but how do we frame that? With that, thank you so much, Lydia.

>> Lydia: You are welcome. I have PDFs of everything in here.

>> It has to go back to the vault.

[Laughter]

>> Lydia: For posterity. I have other documents like that if you are interested in them that I have not scanned. I have a long-term care report that is probably 30 -- some years old.

>> Hand it off to Kathryn Kietzman. Shell talk about things of interest that we have opportunities to think about the system driver pieces. Take it away.

LTSS Measures & Data Sources

>> And a bit beyond. I talked at length last meeting. There are slides at the end of the presentation I won't talk to now. Timeline for the data for the 2020 survey and repeat 2023 and 2024 we are talking about data that should be available 2022. It's a population household survey. We are getting this information from sequel. I'm going to move through quickly because I touched on some of this before. Just to maybe walkthrough person centered measures in the near future and point to some of the systems drivers and data sources other members of the committee have contributed through the handouts you have that's goal number one, services and reports. This is what we are focusing on in the media presentation. Following this, Kathy Kelly will talk about objective 1.2 care giving. On the first slide, this is looking at potential outcome in chips, extensive needs met, how people receive care according to how they prefer it, whether or not people are involved in planning and organizing their care.

These are specific questions in the survey. Also, how people feel if they are involved in deciding what to do in their day and when to do what they do. This is in terms of people's experience as a result of getting their needs met or not. I just shut it off. Moving along to -- there is a lot of descriptive data that we'll generate, statewide estimates about the number of percentage of people that report difficulty. This is the screener to get to the fallen survey, IDL, IADL, importance in decision making, the work group and many in the room part of the process. We wanted these three needs and difficulties represented. This is looking at who actually reports needing help. Having difficulty can be different than saying I need help with these difficulties. More specifically, we ask questions about help with bathing, showering, those measures. In terms of service and support needs, the reason they need help. Are they needing help of emotional decisions or because of needing help to make the decisions.

Those reporting rue tone care needs, or those with unmet personal care needs, we hope to generate the estimates as well. Feels like I'm on the same slide. Okay. It's doing magic. We also have questions about equipment needs, who has the types of equipment, who has certain home modifications and importantly, who needs some sort of equipment or home modification they don't have and there is an open ended answer for what they are missing to generate the numbers. We have measures about who is receiving regular health with self-care and why they are not getting help, too expensive, can't get reliable help. There are open ended to report another reason they are not getting help they need. Sources of help, are they getting help from an unpaid worker, a paid family member or friend or another source. Those who are receiving paid help with self-care, how those services are being paid for, whether they are paying for them out of pocket, paid through a public program or private insurance or another source, it's able to give estimates on that. Important information and assistance maps on to the system driver. We are asking at the individual level, how do you find out about the services available to you, through family and friends, disability provider and so forth. We are able to get numbers on that.

This maps on to outcome data. Person centered. These are questions about adverse consequences of not having needs met. We'll be able to get numbers on people unable to get out of their home because they don't have means. Are they going without personal items? Are they not bathing as often as they would like? Are they not changing clothing.

>> Do you do follow ups on that?

>> We don't. We were constrained to 15 minutes, so we had to make decisions about it. We would love to have that as well. Going without eating because of difficulty -- no one is there to help them or they can't feed themselves, having to stay in bed due to difficulty, unable to get out of bed, not getting to the bathroom as often as needed. These are a number of adverse consequences to tally and report on. More outcome data, this is about the interpersonal relationship with the person helping them, people treated with respect and a frequency scale of whether they feel safe around the people who help them and whether their care provider is sensitive to the conditions of their culture or background. Those are other examples of person-centered measures. Descriptive data, we are asking for those that do access services, what types of services are they accessing? They are getting information about the preferred language. That's one question. In terms of types of services, are they getting skilled nursing home services, home health, and so on, transportation, benefits assistance. Then, this chart is starting to look more -- assistance drivers from the LTSS subgroup, how to map on various data sources, beyond shifts, program data, information from the AAA about information and assistance. The handout has a lot of information about data sources.

We have one question on the LTSS survey, how they get their services. Looking at administrative data, getting information about utilization of in home services and trends for other home based services, program data availability to look at the organization numbers, and pointing to the handout, we have a lot of good sources there.

Caregiving Measures & Data Sources

>>Care giving, I'll turn over to Kathy Kelly to talk about that. There is a module in the general shift a set of care giving questions.

>> I didn't bring that with me.

>> I can do that. We have a slide. I'll scoot over to it. The workforce, LWDA handout from the California work development team. A number of personal measures, others pointed out and details and the handout. Employment statistics, pipeline statistics, statistics from the bureau of labor and consumer affairs and so forth. LTSS integration

with health services. There is one question in the general chip question. They are funded by different sources. In this one they are looking at a subgroup, people with diabetes, cardiovascular disease or asthma. For those folks, are they getting coordinated care. There is high prevalence in our population.

>> Can I ask a question? What does this do at the county level? I feel we are going to heavily depend on that measure.

>> It will depend on the sample sizes. 2,000 over the two year cycle. In some cases, depending on the county, we may not have large enough. There are ways of generating small area estimates. There are ways to combine counties or look and extrapolate the data we have.

>> It can be reached in a way -- how are we going to L.A.?

>> The country of Los Angeles?

>> The nation.

>> There are ways to look at county level data. There are some limitations with cross tabs and things like that. We'll be able to look at statewide and county estimates for descriptives, certainly. How far we can go with that story.

>> One other question I have in terms of taking a big step back, I recall that chip has self-rated health and you can put all sorts of age groupings, and thinking, are there other well being measures that you could cut by age that may not be LTSS goal one specific but live above that in terms of if you thought the master plan at the highest level, what is the well being of California's population?

>> We have a lot of measures on behavioral health, health conditions, so we can cut them by age and look at the folks that bring into this follow on survey and the data will be emerged. We'll look at them by disease condition, health and we'll being measures. We have an isolation scale -- loneliness scale, 65 plus in that case. Another example of a subgroup funded. Obviously relevant for our purposes here. There are a lot of opportunities -- I think in the later slides I list some of those by domain areas. It's 45 minutes of questions depending.

>> Do you remember how many were in the 60 or above age range?

>> 2000, it will be adults for this LTSS.

>> So you will be able to use the full sample not just 60 or above?

>> Right.

>> There are specific questions for the older age.

>> Right. It's going to depend on the age categorization and the geographic question at a county level and so forth.

>> Janet?

>> Janet: I don't know if this goes into the data for a future decision, but looking at the workforce data, I'm not away or data sources that talk about the preparation to work with older adults, whether they have had a class about older adults or aging in the health and human services, whether the current workforce has training, that sort of thing. We have a lot of data about workforce but nothing about Geriatrics.

>> This is how we organize it and develop the discussion. The LTSS is about direct care workforce in the conversation coming in goal three.

>> Okay.

>> The questions, what goes together? What's separate?

>> Okay. Thanks.

>> Clarifying questions, Jamie and then Kathy.

>> We'll do one more round. You're up.

>> Okay, I'm going to talk about -- and Donna, we have been here. Talk about family care giving. Before I start out the door, this is going to be a different kind of conversation than the kind of metrics we are talking about -- prior. It's an interesting one. Caregivers -- family caregivers are 80% of the long-term workforce. They are not really a workforce because they are not paid. They provide many of the services including personal care assistance and everything in between. It's an interesting question because family Caroline through the caregiver resources across the state consider the caregiver to be the client first and care recipient second. We collect information on both of them. It's a little bit different viewpoint about how the data -- why we have the kind of data we do, and sometimes it doesn't resonate with what you have been hearing. Given that, there are a number of different benchmarks and metrics and data collected. I'm going to talk about the scorecard. It's a composite score. I'm going to talk about caregiver information we are collecting through the caregiver resource system or are starting to collect now. We have received $30 million, three year project to expand access to services, and also put in play interactive client record and utilize services throughout the state. In that, we have rebooted our caregiver assessment. The project will be evaluated at university of Davis, and Heather young and Candice are principle on that. We are selecting a lot of data. It's robust. It can be many different ways because it's all identified with a zip code to it. When you talk about getting down to the county, yes, it's at the county level. It's robust data. We expect once we are up and running in the necks year, fiscal year, two years, we'll have at least 8,000 records per year. It's a significant sample.

I'm going to turn it back to talk about the California health information, interview survey.

>> The questions sound familiar.

>> Yeah, I was on the advisory committee. Many, many advisory meetings. Anyway, I want to talk about the scorecard of which the scan foundation is one of the funders along with the commonwealth club and funds, it's a centric, anyway, this is an interesting credit. Susan Reinhart, she wanted to have family care giving for LTSS, finding ways in which you can measure that has not proven to be easy and many of the things we are talking about is not collected consistently across the state to be a measure. There are a few things. Composites, weighted scores. If you want to see the methodology, it's in the full report. There are four components to the measure. One is, when you are thinking about what it means to support family caregivers, 60% are in the workforce. The other part is that the caregiver may not be the older adult depending on where you define older. I'm in every category at my age, but the pro line keeps getting moved back and forth. Older adult, 50. At any rate, it helps to think about these things as generation.

25% of care gives are millennial, least likely to be approached as caregiver through any type of setting. These are composites. Does the state in question have family medical leave that goes beyond Federal guidelines, or does it have paid family leave and sick days available. In California, we are the first 12 years ago to have family leave. We have a lot of scoring on the particular metric. Unemployment insurance, most don't know you can quit your job and get unemployment insurance if you have care giving responsibilities. I think the utilization is low. State quality protecting caregivers from discrimination currently in California, that's not the case. That's being worked on now through many coalitions. That's one -- sorry. Person and family centered care. Most seek financial counseling too late and find they could have sheltered more and didn't. We do have universal assessments. We don't have universal screening. Assessment tools across all programs, that's yet to come. The enactment of the care act, it's to advise -- to be able to identify family caregiver the admission to the hospital and have the person part of the discharge. What we found further studies, 50% of the time that happens if even if the care act passed. Nurse delegation is a big issue because in California, we don't have it. A home health aid can come in to do this. IHSS being exempt. They can do other things. Family caregivers can do brain surgery because they are not under a scope of importance. It's a conundrum when you have a paid aide come in and you can't give them medication. This is a big issue for family caregivers. Transportation, I think it's covered in another area. They put it into the care giving realm.

I'm going to skip over that. We have a lot of random and panel dial surveys at the national level. We extrapolate that down to the state level. Is it useable? Good for estimates, probably not the best. I think California, the data is more reliable in terms of understanding where people are in terms of how many family caregivers we might have in the state. We say now it's 1.8 million -- family caregivers, but we -- we don't really know. Any rate, the kinship and residents and gender, they are all national. When we look at respite expenditures as one of the other issues that came up, we know what the Federal sources are. We can trace it back to title 3E expenditures. We can survey departments on aging for other sources of respite. Respite is a squirrely thing. I'm going to turn to David Lindeman and ask him, when did we do that respite?

It must have been 1980 something?

>> David: 1937?

>> There is still not a working definition of respite. To be able to bite the bullet and get a common definition in eligibility for this, but we know on the expenditure side, it is part of the Federal dollars coming down. It's part of the caregiver resource centers. Those are, I would say, stable numbers. We can always use those. It's hard to collect the rest of it. These are pieces of information that we get -- this is the expanded caregiver profile, caregiver screening and assessment. It would be great if we could get a

baseline on what LTSS service and providers are actually asking. When I looked at the number of years ago, what are the eligibility or assessments for a Medicaid waiver program, there were states that did a caregiver assessment. There were about seven of them. In California, the question is, are you willing and able? Is there a compare giver available? It's not really a caregiver assessment. I think this is actually -- it probably is a working piece or park on the side piece, but we just don't have enough of this information available. Once they have it, we don't know what they do with it.

I'm going to ask you -- I'll stop now.

>> While Kathryn is bringing that up, there were responses about people aging from family caregivers. The intersection of care giving, knowledge information, supports engagement has an intersected level.

>> There is a missing slide. We skipped over our data. Here. Let me look. Complexity of tasks should come up. I don't see it. Here we go. Thank you. Okay.

>> The clicker is weird.

>> Yeah, this is our data. I don't want to talk about that. We are collecting a lot of data on the assessment. These are pieces that are going to stay in. We might have play when we start working with the evaluators, but we collect all of the demographic information you might expect along with, we are looking at complexity of care. We are not really capturing that. Vis-à-vis the kind of medical tasks. We are asking what medical tasks are you performing in the home? The number of hours spent in care giving, including the hours in supervision. Can you leave the care recipient alone for more than an hour gives us an indication of while there is not transaction all the time, you are on the job 24-7. Do they live or not live with the care recipient? All of the self-reported health, emotional health, stress questions, we ask PHQ9 depression, we are also switching over. We are asking loneliness questions. We looked at social isolation. Looking at financial impact, of all of the kinds of things we don't talk about dealing with middle income, we don't talk about finance. The finance on the family, and when you talk about this with family care givers, it's like a game of whack mole. They are going to roll into retirement as a lower level, typically women. These are the kind of questions we are asking that are needy.

>> I think in planning, we ask if you have power of attorney, all of the financial polls for yourself and for the person? Also the one for themselves. That gets to the next generation. They move up. We have to look at that area too. That's planning.

>> Yeah. This will be a rich contextual database and also representative of the state. You will get an urban rule split, ethnicity, diverse population. Donna and I have been looking at our data for the past two years.

>> We have a baseline from Um teen years ago before the cut.

>> We collected this. We have a baseline. I feel like it's Lydia's but -- 30,000 records of this kind of information.

>> What is your baseline here?

>> When did we start?

>> Six, seven, eight -- somewhere in there.

>> In terms of stopping the old database?
>> This is all coming. You couldn't population something today on these measures.

>> We could. We could through the Bay Area and Los Angeles.

>> At least the beginnings.

>> Start building it.

>> Couple of caregiver related items? We have about ten minutes for this section. I want to open up to comments?

>> This question is going to be asked of all 20,000 households sampled toward the two year cycle. The first question is whether or not someone provided help during the past 12 months. It will be interesting to compare this with the data you are generating. It will be interesting getting CITRIS services. It was the first quarter previous year. Are they currently providing care? We ask about the age of the person they are caring for, relationship to the caregiver, if they live with the caregiver, and we capture that. We wrestle with this a lot. What are the conditions? We can get a long list for care recipients. Which require the caregiver help. These are questions about financial distress or stress as a result of care giving. Whether they have all of the supports and a services they needed to provide care. Looking at caregiver outcomes, suffered physical problems during the care, and whether they experienced a change in the work situation as a result of providing care. Those are response options we came up with changing jobs, taking a second job, paid family leave, Kathy Kelly, thank you for that.

>> The last one, we have that in our database.

>> It's a brief module, but we are hoping to find funding for it in the future years so we can have the data as well.

>> That's great. I want to do a quick time check. We are a bit over as always. Maybe we can cut into the break and people can just take a break as you need to?

>> We have been doing that. Yeah.

>> Just for that last set of points, because you are doing all 20,000 households, you have a robust demographic set on anyone that responds to that if you think about the equity lens on the caregiver side.

>> On the disability screening side too. Without doing the follow on, we know the participation and do this based on conditions. We have heard a lot of information, three buckets of data and measures that exist today, existing in the very near future, that they exist, and this gets back to, I would love to open up conversation across the group to the floor, primarily about the lensing of the concept of talking about person level core measures and system driver measures first. Now you have seen examples of some of these and thinking about them in a big swath and thinking if you were charged, the governor would speak in talking points from, does that resonate with you, or is there another way we could think about harvesting the measures and putting them into buckets discernible populating the dashboard.

>> We are not getting there yet. We'll get to that in the discussion. Thoughts on the bigger framework. Go for it.

>> I think it's critical that we think about how to link both people together. Both education, political power, all of these -- I come from the children's side where there is no concept for a child without a parent. Two generation, look how we talk, we use the words and structure and images here to advance on the aging side. I don't know how we do that. It's not just the high level. There could be an interactive one. These two should travel together.

Something around that, I would say. The other question for you, is there a quantity metric? There shouldn't be this much care giving going on, or we are all happy doing it? What is the right amount of care giving that can be expected?

>> I think it's a societal question. The fact is that most -- when -- this was a question on the home alone study for doing medical tasks. Why have you taken these tasks on? The biggest percentage were, I didn't have a choice. I think there is lots of motivations for people to take on care giving, but not having choice and options is a big driver of that. We have not made that -- we have not caught up with the longevity of individuals and the fact that healthcare has changed significantly driving many of these more complex care into the home with the unsaid expectation that families are going to do it. I want to say one more thing about the home alone study, that for all of the medical tasks, wound care, injections and machines and everything, those medical tasks that were technologically complicated, so in one example, we were starting to push down dialysis into the home.

They are trained on the use and equipment and on the metrics and reporting. For things like wound care and injections and things, families report they receive almost no training on that. So, you know, you go to Dr. Google and pretty much find anything. The issue is they don't receive training. On the tasks that are expected to be done, there is no conscious conversation going on about this at all that I can see. That's -- you know, it's hard to say what's enough care giving. The caregivers can provide care up to the time of death. People technically eligible are in the home. Do they want to? Would they like assistance? Absolutely, they would like assistance. Home care would be the number one thing they would want assistance over everything else.

>> If I could add to that?

>> We'll go around.

Group Discussion of Person-Level Core & System Driver Measures for Dashboard

>> First, I want to go back to Kim's comment about the language of aging. Even know it's different for you and me, we have a different pain scale. Same with happiness. We can look at four goals and have six or eight questions relating to are you living where you want to live, scale of one to ten. Those kind of things. Related to the various conversations, I think all of the data is so rich and valuable and good, and yet I'm left with -- so what? So we have all of this data. Have we used it since 2002? I'm not saying any one individual or person, so don't take it personally. What have we done with it to date? Will we use it going forward? I go back to the point about the Dartmouth atlas –

>> 1970.

>> I didn't realize it was that long. I am over 50, I guess.

[Laughter]

>> The Dartmouth atlas and Hartford joint center study on housing paired with the LTSS -- with this data, may be the right overlay of three resources that already exist in some form, particularly the Dartmouth atlas and Harvard study, those are critical studies and have been used widely. Harvard study came out last year. If we could overlay those, I think we can come up with some very reasonable elements that would help us measure what we are trying to measure across the four goals. That was just a bit of a take away. What are the questions if the top 25 questions, not the top 200, but what are the top 25 questions we need to hone in on as we as a research committee need to come up with a dashboard. You can go deeper and deeper but for what? Is it purposeful, meaningful, is it going to fund something? Will it keep someone out of the hospital? Will it improve quality of life over all?

>> For the point I made earlier about the paid workforce side, I feel the big question for me, the use of some of the data is, what is the work being done to project out how much care needs to be provided? What is the scope of that? That's the million dollars question. There is a policy question about how much we expect from family caregivers, and do we do this on the backs of low age workers that can't afford healthcare, are on food stamps and are untrained? I feel it would be useful to think

about some of the data needs in light of the larger questions in the service of meeting the goals. I know this is a little bit of work done, but there needs to be a lot more. On the workforce side, the people that provide paid care giving, older women, immigrants that do IHHS. Looking at indicators for indicators of workforce quality and supply. That should be used to inform the larger policy questions. I feel Washington state is ahead of us. We would like to move in that direction.

That's just what we want to put out.

>> It's not just the benchmark, but where do we need to be in

>> That's what I was getting at for care giving. We are banking on because of the worker shortage.

>> Just to add to Kathy's earlier comments around care giving, to bang the gavel of the equity lens again is important because we know that there are barriers even to getting help for caregivers based on their ethnicity, race, fact that they don't self-identify the issues. The Asian community, we just do this for family. I think some of the barriers with identification in order to get information, in order to get resources have to be considered, especially given the demographics and changing demographics in our state as we move a decade, two decades, three decades out. That's an important lens to apply and factors to consider as we examine that.

>> I wanted to add to Kathy, when you asked the question, how do we have a choice or what is too much care giving? When they ask that question about where people said, I don't have a choice, there is also a nuance in that, I don't have a choice because it's my mom. We have to understand that when we say choice, is it a positive choice or negative choice? The right amount of care giving is hard. Maybe we can look at, do you understand the options of, if you want to keep your mom in the home, you have enough options to keep her there. If you wanted to move her there, do you have enough to understand assisted living. Can you understand the next level of continuing care. That would give families relief and understand the finances that go with each choice.

>> Thanks.

>> I realize how simple we have it in road safety.

[Laughter]

>> I think we just got the quote of the day.

>> I was just thinking, write that one down.

>> DUI, enforcement, culture, policy and loss. Anyway, seconding the idea of the system driver versus core. Maybe we need to make it that fancy, logic model, perhaps, and the other comment, we'll talk about this next time, I guess, is clearly this has to be simpler. Even really fascinating. I didn't know all of these interesting things. It has to be boiled down to the committee level so the governor can talk about it in the 20 minute press conference. Fascinating stuff.

>> Thank you.

>> Piggybacking on your comment, one way to simplify this is to look at these measures through the lens of, are they measurable? Are they modifiable? Are they meaningful? You ladder down your scope. You can prioritize on different needs. The important thing about that lens of looking at things, you can start to identify -- this is going to be a natural experiment happening. You can identify the bright spots. Which county is doing well on this measure? What are they doing that's driving this? You might not get it from the law data but it can emerge. We hear about areas seniors do well. There is a matter to have a lens to focus.

>> Laura?

>> Laura: I wanted to go back to Jeannie's comments and say, I totally agree. I think it would be really useful to spend time crystallizing what the outcome is. What would success look like? What would the population be? If we have that, we can discard a lot of the data and zero in on those. There is a lot of data that's interesting, but it might not be what we need to predict the ultimate outcome.

>> Future backup.

>> What I'm getting at is, okay, it's the spread of where people are living in ten years, at home, give me the ratios we are aiming for so we can push in that direction. What percent of the population should be doing. What is the ideal? There is no one ideal. I'm working backwards.

>> I would go one further. I agree, but what we might say is, there are three terms you have been working with on a project. Trying to remap the life course. It's not just me saying it. We have been arguing that we should create a world at all life stages, the majority of people have the sense of belonging, purpose and worth. That's -- I think it's had legs. That's what we ultimately want. If it is transportation we need to get there, fine. Maybe it's not. It will be. If that's the outcome, biggest thing in caregiver. How many hours?

>> It depends on can people attain the state of need and feeling of purposes and worth? We might do something subject rejective. Then I think of the data set to see if we can use that as a benchmark to predict at the county level. If you want every Californian, should we develop a kind of model where we think we can get to the same things and make estimates about counties?

>> I think a clear recommendation is that we need to double the sample.

[Laughter]

>> That's the kind of conversation we need to have, what we are trying to achieve.

>> I think that's a good question too, about what level does that framework live as well, Laura? Is that the goal and objective level or the framework at the master plan for aging above all of the goals and objective level that every California has the longing purpose and worth. What are the personal aspects that contribute to that and underneath that, what are the system drivers contributing, linking all the way up. That's another way of adding on to that as a consideration. Kathy?

>> I'm going to go back to your question. That is, unlike what healthcare is able to do to say you need this many doctors for this population, we have never projected what the need for LTSS in the community is. How many daycare programs should we have? We lost a third. Adult day healthcare. We don't have the mechanisms to project that. Those are two halves of the puzzle. How much care giving does a family

member have? They do a lot of it if there are not other services in the area. We have not projected what the services should be and what quantities.

>> That's exactly it. Meetings I'm at, everyone thinks we are doing too much. The driver is to create the day center and quality well paid assistance and other -- otherwise, we are pushing it to families. There is going to be recommendation about access standard. Can that be taken on by somebody?

>> I don't know how we get to a goal if we don't know how to measure it.

>> The metrics.

>> It's good for the master plan discussion at the report level leveling up from the feedback, how far can we get along the path in the research committee with the measures that we have, linking it to where does the LTSS need to go on the standard and here is what we are shooting for ten years out, and what is the role of public, private, independent sector for us to get there? I want to be respectful. I want to hear from David and Chris on the next piece. Unless there is a vital question/comment? How many folks are on the phone right now?

>> 27 people.

>> Couple of research committee members.

>> I feel there is a gap between need and what is provided. It's easy to project out based on demographics. The tricky part is what is the unmet need. That's a policy question, right?

>> Wouldn't you help with that?

>> I would also ask, what is want v. need? I might want more than I actually need, and I want to make sure most of the people are healthy and what we are often talking about are the people in need, so do we think about that at some level as well?

>> I will say with the questions, and I was on the committee for this one. I want to put in a plug for the adverse consequences questions. There is this amount of people self-reported. Of those 57% are in bed and can't get out because they don't have help. They can't get to the bathroom. They have dirty clothes and can't change them. That's more concrete than want.

>> They may say they don't need anything?

>> No, need takes us from I want more to –

>> Bare need.

>> This is a rough conversation. I think it's something for Kim and the team to take back. One consideration as a wrap up on this might be doing a quickie table around the various measures arrayed from the person side and system side. We can do a virtual dot exercise where you have to pick your top five and go back. I didn't hear anyone bring in an overly different framework to think about. I heard person level and system driver pieces seemed to be an okay cut even with an overlay.

>> Figuring out the person and family. It's not individual.

>> Exactly.

>> Just that.

>> The overall sweep of the profession can go forward. Thank you for that. I'm going to turn it back to Carrie.

>> I keep thinking, how do we slide into home on this -- recommendation. I like the idea of coming up with a grid with -- I don't know voting or maybe having people who like Kathy and like Kathryn in the room who are going to lead that effort to solidify if we had to choose our top one what would we choose?

>> Different ways to get to loosely the census. I want to say thank you to all of the presenters.

[Applause]

>> And thank you for being a partner and leader in the process of moving from the big picture and have a framework and put it together for real. Thank you so much. We'll keep doing the cycle.

>> If you talk to me about something, I will make a grid.

>> And ask you for slides.

Advanced Topics in Technology Applications for Caregivers and the Workforce

>> We are moving on to David Lindeman and Christine Cassel. We are so happy to have you here. You can introduce yourself. We are so happy to have you here.

>> I'm okay standing here. Can everyone employees stand one more time? Though we are not taking an official break?

>> Good point. For those of you on the phone, we know you have been on three hours already. Thank you. We are all just getting loose before we jump into the next set of material.

>> David, you want me to just -- introduce myself?

>> David: Let me. I would love to do this first and let you fill it in. Please, more water -- whatever. We are going to change gears a bit here and pick up a little bit different from driving into the weeds with specific data to again, what Kim and we have been asked to do by Carrie and others. We would like to use these meetings to share updates about the innovations coming in technology, innovations in data science and try to present ideas because I think a key issue we haven't talked about, while we are measuring what we have now, what will happen over the next ten years? What are the disrupters we'll be seeing? Laura's longevity center. Kathy with her care journey, and now Jeannie is moving it. We see it in the senior residential areas. We have as this goes forward, trying to anticipate how will these things change the space? Furthermore, we have so much going on in data. We are so fortunate to have Chris Cassel join us because we have personalized data all taking care of the data, but so many new opportunities for machine intelligence, work we have in this building an the

Berkeley research group, 300 factory and post docs, it's mind boggling what we see with the compression and what we can see to all of our benefits is incredible.

>> Again, Heather young, I hope is on the phone right now, we have tag teamed the digital world for campus initiative and bringing information from all of our colleagues about this area. In the next 20 minutes, we would like to do a few things. First, I would like to share, do a reprize of the information we presented to the LTSS committee, some of the technology direction there, we hope to do this for each, if invited, for each of the research meetings, as new technology for each of the area, fin tech privacy and security issues, help dimensions etc. as we go through the sessions. How that can come back and are there opportunities to not only anticipate where this will be but take advantage of the resources and offer the department and state resources for public private partnerships that emerge as well. I'll give you a brief over view and take you back to that. Heather and I have general recommendations and share with you a process we collect data from stakeholders, key informants about ideas to consider the next ten years. I would like to turn it over to Chris who is a master in the area. As many of you know, Dr. Cassel has been in Geriatrics and a champion in the field many years, is currently a scholar for a UC presidential scholar focused on ethics and data. Chris led the presidential council in science and tech under the Obama administration. I was honored to support her work in that where we look at new dimensions in technology and last year she and Heather young championed workforce change for the workforce report. We wanted to end the day with her insights and what we should look for in data sense. With that long winded start, let me zip through this, and I'll turn over to hetter. This is with deference to experts on the phone, those in the room with a lot of experience in the area. Refocus in the LTSS space because we have family care giving and workforce. There are a number of ways we see this. Kathy and leadership alliance and AARP have been leaders in how we support family caregivers. We have seen it emerge, growing, and more robust all the time.

I'm not going to read all of the slides to you. We are looking at everything from how family caregivers deal with health to getting information to being able to respond to the needs of older adults. We have looked at and keep scanning different types of technology solutions. There are a number of them we think are emerging and cutting edge issues that are game changers in the area of family technology. We'll give a few deeper dives on these. They range on everything from how we collect data to impacting older adults, falls, depression, dementia, a huge impact on where people are. A few examples. We have much deeper information. Heather did a wonderful job of laying out bigger goals we have. We are seeing major changes we should be aware of and changing how family caregivers get access to information. Telehealth monitoring, which we anticipate bringing forward, how do we be sure all people throughout the state have access to telehealth? How does it reach rural areas? How do wet get internet access to everyone?

Similarly, major problems in medication adherence. We have moved from manual support. We are seeing major changes on how medication is administered with ingestibles, real time data on what people have, people staying independent on medication management, this will be a massive change as that's rolled out the next ten years. Smart age communities. How do we collect information and how do people function in the areas? We have seen so many company in the smart home space. It will change more and more giving people information from ubiquitous data and censors not from information entered by us as family care givers. A number of everything from robotics to new prevention programs, and I raise safe for you which came out of our shop because it's a way to monitor individuals in their residences and prevent falls and what we have seen an evidence based approach a gold standard with the department of services, reduced emergency room services 70%, falls by 40%. They raised $3 million in the series A. They are now in six states. That has happened in two years. Similarly, as we see changes in different types of technology solutions, how we support family caregivers from programs like it's never too late to LAQ, innovation robotics, predicting needs for family caregivers and individuals. That's a flavor of what is coming.

How do we anticipate and look to see what our goals could be or looking at aspirationally. If you switch to the workforce, again, we have the expert in the room, defer to Chris and colleagues putting that together because it's the entire workforce, everything from recruitment to training to retention. Also, how do we engage older workers to stay in the workforce longer? We see a number of intriguing issues outside of aging and the employment sector, programs able to assess individuals in terms of helping recruit how you identify people for best fits in the workforce space. This is where Chris will talk to us about the ethics there. Also in terms of training. Body labs is a robust training program with awards from AARP, the gates foundation, allowing staff to be trained using virtual programming. Again, we have seen it grow. It's been picked up by many of the senior living community in the state. There is standardized technologies that we are used to, to youth programs. Front line worker, pay active is a company out of the east coast helping people get paid early, many things not in our aging space that are being applied here. Even ways to keep older workers here. Wave is a program out of New York City able to work with women professionals that have gone out of the workforce that can't get back in because of bias, matching them anywhere in the country working virtually.

These are changes impacting where we are going. So, Heather and I presented a few brief general ideas about what we can be doing with technology based recommendations in these areas. Again, how we integrate and deploy the technologies, we see as a major area. How we in terms of family caregivers, use the technologies to massively increase access to information, social connectedness and workforce again from the recruitment to retention. How do we take advantage of these, and finally, how do we use evidence base we pull from the UC system, stand Ford or UFC, how do we use that expertise to be sure we are getting the best and impactful programs? We see a number of technologies that are going to be coming in this area that we also must be anticipating. They aren't here yet but when we see the impact of 5G, transportation colleagues, that could be two years to ten years, but we see the areas that are going to be game changers. Voice technology alone. Predictions are that in three years, 50% of the technology interface will be through voice. That will change what happens to older adults, workforce, caregivers. How do we use technology to benefit individuals.

The biggest thing is data, massive amounts of data we have and the integration of the sources. We are going to be pulling data and data will be pulled for us in an impactful way. What I would like to share again, and this is where I'm going to turn it over to Chris, we have key issues as we look at the data side of the technology, cost and cost of the technology, accessibility, internet accessibility, or people not being able to afford it, inner operability is a huge barrier for using all of these. This is where we see the department and state playing a big role. Are we looking at regulations or what I would argue for, guidelines, maximizing innovation and maintaining that we protect individuals first and foremost. Finally, data privacy, ethics, etc., that I think are fundamental to the lens we look at all of the ideas and the wonderful programs we put forward today. With that, I look at it as this is the wave of the future. I'll turn it over to Chris to share her vision for where we are going -- and with all of the answers.

>> Chris: Is Heather on the phone?

>> David: I would love it. Heather, can you chime in at this point?

>> Heather had to drop off.

>> David: I wasn't at the last meeting. We would like to bring this type of information for even's consideration.

>> Chris: Thank you, David. I appreciate being able to sit in on your meeting today. The whole concept of a master plan on aging is so exciting and -- can I say, "overdue?" But way ahead of most of the rest of the country, so kudos to you and the governor for that. As you think about -- I guess we have been talking today about the next ten years, I actually think it's five years in terms of the kind of that I thinks David is talking about. This technology world is moving very rapidly. You don't know one week to the next what new things are coming both for the better and not so much on the horizon.

My opportunity to comment for you today is not at the end of a long and intense day to start talking high fluting conversation you but it comes from philosophy and moral issues in conflict with one another and a systemic and approach to thinking through the conflicts weigh out, how you set priorities, what you decide to do and how to explain why. That's shorthand for a big part of what we think of as the biometric scholarship world. I think the first thing I want to say is that the promise of all of the data is at least to me, very clear. It's certainly clear to the world of entrepreneurs and innovators out there who combined with the challenges of the aging baby boomers, ahead of us, people see that, and whereas in Washington and the policy world where I spend a lot of time, people think of it as a huge set of problems, these people see it as huge opportunity in the market, if you will. You will see a lot of things developing in this area. At the same time, public concerns about privacy and security are growing, particularly with the Google Mayo hitting the Wall Street Journal, seems like one after the other. Governments are responding. First, we have the European union with the GDPR and many companies understanding that they are instantly global though it doesn't strictly apply to the United States. As of January, the beginning of this year, CCPA, California, similarly a lot of people around the country are saying, that's where it's going. You are seeing that beginning to appear probably on your ap's and your various internet, things you use. That's just to say that the awareness is out there. I don't think regulation is the only or even the right answer to these things, and I think academia and the world of research, which is what you all are about, can really contribute to ways to get it right when we do this, rather than fixing it after the fact, and that's been underused. Just a few months ago, the office of the president released guidance for the use of patient data in big data in artificial intelligence, machine learning applications, and it applies over all UC healthcare campuses. I urge you to go on the website and check it out. It's visionary. It's carefully, ethically framed, and what they posit is let's start with a justice based framework. That's the lens you look through this, which sounds great and everyone will applaud that. You say, how does that work? How do you do it? One of the things we have been doing at UCFS, I pulled together a group, and trying to analyze what would that mean, and how does that work? I will just give you an example, I had to step out for a little bit earlier to be on a call on a team working on social determinants of health, not so much for aging, just broadly. Doing a paper on the ethical issues, there are companies that passively scour everything you can find on the internet and feed your hospital or health system or doctor your -- bank information, your debt, where you live, what you eat -- that data is all out there. It does determine health and risk, so why is that not a good thing? Maybe people don't want that data to be shared with their doctor or hospital. Those are the kinds of issues I think what we need is a model you have ethicists side by side with data scientists and whatever the app is, thinking through the issues in realtime. That's the model we have been trying to apply. It doesn't come with funding, unfortunately, even though the big companies are beginning to realize that they can't do it -- Google has had three full time ethicists none of which have lasted more than a year, two ethic's committees both of which they fired in a few months, one in England and one here. I don't think we can rely on the companies, and I think academia has both the intellectual capability but also the distance and perspective, but has to be seen as a constructive partner.

I think a lot of people are afraid the ethic's police will just say no, and that's not at all, I think, what the reality is. I'm here to tell you, ethics is a friend of organization, and just to give you something to chew on, and what I want to do is open it up for questions and discussion. I think for both of us, that's the best use of the time. The core in biomedical ethics, we think of core values as respect for individual autonomy, priority of patient well being. A special concern for vulnerable people and social justice and you form everything from standard informed consent to who goes into ICU and who gets organ transplants are based on those fundamental values in one way or the other. Applying those issues to privacy consent, big data, it doesn't work to have the individual consent model. The IRBs don't know how to apply. We don't have guidance in the area which is why it's a field that's ripe for intellectual creativity and partnerships. Let me give you a couple of examples. If you take the respect for autonomy principles, that's the basis of the fact that you have to give informed consent before you get medical intervention or participate in research.

That's where that comes from. If we are going to think about respecting individual autonomy at a time the data about you is out there, collected, much of this is retrospective data, it's not going to be possible to ask people. Even what we have forgotten is hard to figure out in that setting. If people understand the value of it, they shouldn't want to be forgotten. They shouldn't be fearful of the use of that. That gets to a more important thing, data acquisition and data use and how much say to over what your data is used for. That's the fire storm Google is running into right now in Facebook two. There are people working on technology applications for how you can embed the ability for people to respond and indicate that level of information, and then that becomes an iterative educational tool that for caregivers can educate them, understand what is happening to their data, why it's not all that scary and why there are safeguards there. A second point I think is interesting is, we were asked, and we had a small paper about this. How do you think about justice in the case of say with the companies that turn the data into commercial applications, and they make the money off of it?

You set up a proposal that -- in the sophisticated data world we live in, you can engineer a way in which the patient can Benefit from the commercial application of the data. It can be a way of establishing the value of the data one level or another. Who knows what it could be because it's never happened. There are start up companies starting to do that now. That's another place in which some of the -- ideas of a virtuous business model around data can be informed by ethic's work. I think I just want to say, we shouldn't be afraid of asking the tough questions. I think everybody that works in this field needs to ask the questions, but at the same time, have a bold vision that engages the ethic scholars in your arenas because they need evidence too. They need data. They need to be educated about the questions you are asking in order to be able to ten help you develop the ethical framework that will best serve the patients and families. This couldn't apply more powerfully anywhere but in this complex area of aging.

Let me stop there, David, and maybe we can open it up for comments and questions?

>> Let's do that, but thank you so much.

[Applause]

>> David: For those on the phone, the floor the open.

>> Committee members in the room on the phone?

Q&A Discussion – Part III

>> Great presentation, board. Thank you so much. The other aspect of the world of technology is, who is going to pay for it? You talk about cost. Traditional models are a company of operation. That's not what you want for seniors, vulnerable people. They don't have money to pay for it themselves. Will healthcare pay for it? That's been tried. Why apart from that, and who is working on that situation?

>> I could give a great example. Shireen, who is on the phone, I'll call out our San Francisco technology council. Folks on aging and disability, it's a public private partnership working with a number of companies, government agencies, academics, number of NGOs part of it. A key issue is equity and access to technology. Their initial data when they did a review of San Francisco, technology rich environment community, 10,000 older adults didn't have access to internet. We started with that. There are a number of efforts by the mayor and certain departments. Again, particularly the agency on aging was extraordinarily impactful there. How do you work with the Kaisers? How do you work with Comcast? Comcast, for a $10 fee they would provide access to the internet and a thousand older adults were put on that in the first year. How do we deal with where many pay privately and others, net is what we have to be concerned about and the department has championed for. How do we look at the state to make sure individuals at risk or can't take advantage do it? When we work with startup companies, it's the business model and payment, but we are also looking at how people afford these and press down so instead of an $800 smartphone, can a jitterbug, user friendly phone be affordable? How do we get those out? As the department considers working with our amazing industry here in California, we look at those models to make sure nobody's left behind. Kathy?

>> Kathy: I think with all of the shift to having home training equipment, the internet and public broadband access will be considered almost a health utility. The system used the most technology in the home is the V.A. system. They have sort of led the way. I think we need to reframe the discussion of the health utility. All of the information is being collected in the home, and that might drive the infrastructure. It's an infrastructure issue more than anything else and partly an access. AT&T has the same $10 program as well.

>> It's a wonderful approach, Kathy. Key stakeholders, could be disruptive and that could be a ten year window to rethink how we look at technology as a benefit.

>> Certainly in the cost of food and transportation and some of these things are cost savers.

>> What do you think about the idea of selling data so that individuals can allow companies to use their data but they have to buy it? I know people in the start up space thinking about setting things up like that. I wonder what you thought ethically about that?

>> You know, you could argue, and it's probably true if there were a robust market for data, that people who are poor would be more likely to take advantage of it. It's like when people talk about selling organs, same problem. Then you have to weigh, is that enough of a detraction that it stops you from what's happening now, that there is no value to data? My personal view is probably not if you structure that in the right way and selling your data shouldn't mean there are no protections set in place. I think those are interesting. The real question, technically, and I have talked with the companies, we should talk offline -- can it happen at enough scale that it really will be useful? But you know, it also has enormous potential globally in under resourced countries, if you think about that. I think that you are going to see more of that kind of thing. It will be interesting to see how the price is set, what it really -- whether it's meaningful or not.

>> There is also a global or geographic issue there. You were saying how Europe and North America are approaching it. Our projects in China right now, we are dealing with a different issue. People don't control their data.

>> Or expect to.

>> We are saying, negotiating and saying we have a 50,000,000 person data set doing deep analytics and AI methodologies. In our love of hospitals, we have 80,000,000 people in hospitals. They can do -- they have real -- not some of the same constraints. This is where the beauty of how do we ensure that we maximize –

>> Then you have India, Africa -- the markets are different there, but not that different. And, you know, that's a much more diverse set of data. We are getting a little off topic from California. One thing you were thinking about technology, thinking about boldly about it, if we look back three year, who had prime delivering their shampoo and medication -- whatever they needed? I think it's hard to imagine what it was like now, and so how do we think forward and think all of this is going to be ubiquitous? In other countries, everyone has a cellphone because they never had landlines, especially rural areas of third world countries. If we think that way, data elements we might want to consider will change over the course of ten years. What we have today is not what we have ten years from now. Ethical questions will be resolved or won't be, and we'll have provided a lot of data that we can somehow use. We have to think about that, and really be bold about the impact of data and analytics and technology that is already accessible.

The technology you described is not ten years out. It's already being used. It's being used in senior settings around California and some instances across the country. I think we can look at what are the impacts of the technologies on aspects we have been talking about today in making life better for families as well as the individuals who are needing care or support. I want to mention what you said, Kathy, about the health utility. There are studies in affordable senior housing in technology use making iPADs available for decreasing isolation and improving socialization. There are technologies that would decrease utilization of other services, so that's something to think about as we move forward as well.

>> Gretchen and then Stacey?

>> I was thinking of the simple measure for the whole spirit of the slide is how many households or individuals, whatever it is, with people over whatever particular age have access to internet pathways, mobile, through their television, whatever the mechanism is, and -- I challenge the two of you to craft or personal measure –

>> That's really important.

>> The two or three things we said are the most evidence-based critical to avoiding calls. We want most households, a part of what utilities are like. That's –

>> That data would be really important for the state.

>> Thinking about the personal level measure, two to three measures that live around that on the dashboard, that's a charge to cities, counties, to many different mechanisms to say, how do we up ramp this, what are all of the touch points that older people use the technology for.

>> Here we go.

>> Failure of mute.

>> We have all been there.

>> My question follows up on Gretchen's comment around access to high speed internet and how many households or internets have that. The key factor in things like access and availability for telecare services and things of that nature and with a business model reducing cost is not necessarily the goal per se, how are there innovations driving cost reductions, technical innovations to make it easier to expand access and are there things to look at as a data perspective around that.

>> David: Great question. Do you want to jump in first?

>> We think of telehealth as a way to serve urban communities. There are families and individuals, it's the same issue, they could get out to see the doctor or nurse. It really is important. I think there have been changes in how Medicare pays for telehealth visits that help drive this. It's not transformational, but it's opened the door. The other -- someone mentioned value purchasing. You have been talking about that for 20 years. It's almost around the corner. If you think about the state Medicaid program or places total cost of care is a metric -- a budget, let's put it that way you have to work within, then I think you can do the value tradeoffs that help that make sense. As more of the country, Medicaid exceeded Medicare two years ago. Maybe those are the places we see the value primarily of this kind of thing. Then, Medicare advantage is growing and showing cost savings and has all of the incentives to cost saving, a lot of challenges, ethical ones among them, of course, but nonetheless is a fundamentally good model to think about. All of those, I think, are going to create an environment where things like telehealth are advantageous. One of the things about

telehealth, mental health services are better received through a remote provider on a screen because there is a kind of intimacy and privacy. You have a real human being sitting there. It's kind of interesting. I don't know if it's true for older people. It might be true for support services for caregivers. It's not like it's always a second best choice. It could be better.

>> I think a key issue that this relates to, as recommendations come forward, what can the members of the master plan adviser committee recommend that are doable and actionable by the state versus in telehealth, we see an FTC issue about more telehealth and broadband into rural communities. It's a Federal issue. Where do we put recommendations in about the state could argue for it at that level. I would like to go back to Jeannie's point and Chris' about how fast this occurs. There are several -- one of the things we like to do, and I'll mention this when we close here, getting more information, doing an environmental assessment from informants. There are technologies breaking each year, many we don't know about. This year alone with Chris' leadership from P cast, the movement with new alternative hearing solutions, for those that don't know, the FDA is supposed to put forward new guidelines later this year so the 70% of people who have not had access, we have affordable solutions in the 200 to $300 range instead 4,000 or 5,000. How do we anticipate that? Then you have a huge health impact. Another one we were talking about, there is a company I don't know -- has anyone looked at social determinants in terms of collecting data? A company out of the east coast has cracked the code on scraping data and pulling this. We are working with major health systems along the east coast. Those in the midwest are engaging them. These are happening now. It's not five or ten years down the road.

As we throw a net out to say what could be happening and where should the state think about it in a ten year plan, there are amazing breakthroughs. We have great experts in the room and committee that can help anticipate those to give the department a chance to how do you get out in front or know where the hockey puck will be.

>> And as we said in many issue, thinking about how we have the conversation and keep it moving so we don't just write it in the plan, we had brilliant thoughts, but what is the loop with public sector helping us to stay -- I don't know ahead of the curve, but at least see it. There is so much to see and do, but I want to do public comment. Looks like one person on the phone and folks in the room that have been here all day.

>> Karen Lincoln is on the committee.

>> Sorry, not yet. Karen Lincoln's comment.

>> Can you all hear me?

>> Yeah, we did.

>> I wanted to follow up with what David mentioned in terms of data we are collecting. It's important for us to get a handle on how many older adults have access. My work, 30%

African-American older adults have access to the internet so 62% do not. If we cut by race, we'll find significant differences. Thinking about access this way, and it's tied to equity. Talking access under the umbrella of equity will help make sure those with low access will be included in the conversation. I think it will be different. If you start with do you have a phone instead of assuming they do. Do you have access to the internet opposed to assuming people do, will change the direction in certain ways, then what are our responses to making sure people have access to people that may not want a phone or will never have the internet or broadband access. I don't know if it means having other people involved that can speak to alternative solutions, but I want to highlight the fact that equity is a part of this, and when we aggregate the data, we miss that some populations have very little access to the things, and to the extent that the dashboard is helpful, I think it's important to remember that.

>> I would empathize. It's not optional that the dashboard have geographic backgrounds and race and ethnic breakdowns. We know there is a lot of length, but that's part of highlighting that. Thank you for underlining and holding us accountable to do the best we can by October and keep going.

Public Comment

>> If I can do public comment, there are people in the room all day. I don't know if there is anyone on the phone? One person has their hand raised.

>> Who is that?

>> Jeffrey.

>> Jeffrey, you are un-muted if you are ready? Is he still with us?

>> Can you hear me?

>> Yeah, I can.

>> Okay. You hit on the subject of internet access, one of the reminders I recently have been reminded beyond our service centers is again, what five years from now Temperaturewise conditions through there. You are doing a lot of data research. Question mark, one of the things I have not heard is how you check up on people. Internet is an effective tool. The reason I bring this up, I have had two people die in the building. It's a reminder. I know you do data checking at a certain point in time to see who has died, but there seems to me a better tool to social communicating with people weekly or monthly with senior citizens.

>> Excellent. Thank you. Comment in the room?

>> Sure. Terry hill. I have a practical condition about how to leverage the database. A couple of years ago there was a database known as healthcare database HBD. We get a draft report to the legislature in a couple of weeks. The legislature specifically asks the focus on cost, quality and equity. It is -- medical claims are very easy to reliably show race and ethnicity through the claims database will have Medicaid, covered California, Medicare and commercial claims, the biggest healthcare claims database in the world -- well, China.

[Laughter]

>> Terry: Medical claims are well and good. The beauty is ling it to other database. Decisions about prioritizing the linkages will take place, you know, over the next couple of years. I would urge this committee to have a little education about the EPCD. Again, the prioritization about the work they do and the release of data is, I think, critical to this community. I have always been a big fan of Amanda's work showing cost savings. Unfortunately, whether we like it or not, a lot of improvement efforts live or die based on whether we can show at least cost mitigation to the legislation.

>> That's a wonderful suggestion. Our health meeting is two from now. That sounds right on time. Thank you for reminding us of that.

>> We have one more person. Bill?

>> I have un-muted you on this end.

>> Can you hear me?

>> Yes.

>> Bill: I want to say thank you for having a robust few hours. I have learned quite a bit and will pass it on at work. Great job, and people need to find out how glamorous data metrics really are.

[laughter]

>> thank you so much. I don't know if you want to follow that?

>> The other thing to look at is community need assessments at the county level. AAA has to do it. That's something to think about. Currently, you are not coordinated across the county. If we can add the key questions. You move to sample size.

[Papers are crinkling and covering chat]

Summary & Action Steps

>> Do you want to do a big finish?

>> Go for it.

>> I wanted to share quickly two items, one, the folks working on technology, we have so many great experts helping to shape these over the next few months. We are reaching out to folks outside of California to get big ideas to put forward and bring back. The research committee and particularly data will be a wonderful place for that to come forward. We know that not all of these recommendations will necessarily go to the secretary or go to them, but they may not come out. We would like to frame the

ideas for people. We would be collecting it. We would love more input. Second, we have a handout here. If we could circulate that? Thank, Laura. Citrus and UC Davis health and colleagues in Europe are sponsoring "aging in a digital world" summit in Sacramento, Wednesday/thursday. We would love everyone to feel welcome to come and password about it for admissions. There is opportunity for posters and publications we'll try to coordinate with people. It's available now. The greatest point is that the Lieutenant Governor agreed to keynote and Kim has graciously offered to have master plan and aging be the first session to promote and get more information. We welcome everyone. We are -- this is being announced now, April 1 and 2nd.

>> And ash rad adequacy day of aging in Sacramento. Maybe we can have technology synergy.

>> This has been a remarkable meeting. Just really, I'm so grateful for the location and hosting. Made an incredible difference and the speakers and presentations were tremendous. In terms of actions, we are going to work on the chart to do the person centered objectives and system deliverables and circulate that to be a living working document. We'll plan the next goal with what we learned from this one. Maybe prework, meaning AARP. I want to think about the location. I think being in the community was nice. We may want to look at back area locations. We won't change cities.

>> Trying to go to standford.

>> My assistant understood you have to have two separate rooms not connected.

>> It has to be ADA. Wired and –

>> Broadband, Laura.

>> Everybody showing up in person was really nice. It might be easier in other locations. Maybe I'm bay centered.

>> Gulf three will be at La Jolla. Excited about that. We'll take that feedback as well. Also, TDD meetings one through four to bring the dashboard together, data systems, technology, we ought to think about dedicating a meeting to that specifically. Parking lot is not meant to be a parking lot. It's meant to be a next, coming soon. Are there things you would like us to be doing or CDA to take back?

>> I want to say thank you to your leadership, Carrie, the whole team, everybody. David, for hosting. Great meeting.

>> Thank you.

[Applause]

>> Thank you so much. That will conclude the meeting.