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BAY AREA ADULT & AGING SERVICES

Strategic Planning

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Methods

This report incorporates information from an array of sources, including 31 key informant interviews with Bay Area leaders in Adult and Aging Services, county administrative data, and publicly available data sets. Interviews were conducted between March and July 2022. Data were analyzed to highlight current issues in Adult and Aging Services and to illustrate key accomplishments, challenges, and strategic priorities identified in this report.

The BASSC research team conducted interviews, analyzed available data (Appendix I), and drafted the report and case studies (Appendix II). Adult and Aging Services directors developed the case vignettes (Appendix III) to illustrate the experiences of elderly and disabled clients receiving services and supports. Case studies were reviewed by interview participants for accuracy. BASSC Adult Services Committee members reviewed and provided input on the full report.

Key terms

- AAA = Area Agency on Aging
- AAS = Adult and Aging Services
- ADRC = Aging and Disability Resource Connection
- APS = Adult Protective Services
- ASC = Adult Services Committee
- BASSC = Bay Area Social Services Consortium
- CalAIM = California Advancing and Innovating Medi-Cal
- CS = Community Supports
- ECM = Enhanced Care Management
- IHSS = In-Home Supportive Services
- MSW = Master of Social Work
- PA = Public Administrator
- PC = Public Conservator
- PG = Public Guardian

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INTRODUCTION: THE LANDSCAPE OF ADULT AND AGING SERVICES IS CHANGING

County Adult and Aging Services (AAS) departments play a critical role in caring for older and disabled adults. In the Bay Area, rapid growth in the number of people seeking county AAS services, coupled with increased complexity of service needs, has placed tremendous pressure on county AAS to expand capacity. Additionally, recent policy changes at the federal and state level present unique challenges and opportunities to county AAS as they work towards creating a Bay Area where people of all ages and abilities can thrive. This report summarizes key findings from a year-long strategic planning process by the Bay Area Social Services Consortium Adult Services Committee and makes seven recommendations for strengthening AAS in the region.

CALIFORNIA'S POPULATION IS AGING AND DISABILITY IS BECOMING MORE COMMON.

California is undergoing a historic demographic change. Older adults are the fastest growing age group in the state (see Appendix 1). Between 2010 and 2040, the number of adults 60 years or older will more than double (from 6.1 million to 12.6 million); by contrast, the overall state population is projected to increase only 16%. This trend is mirrored in the Bay Area, where the fastest population growth is concentrated among the oldest adults, 75 and older (Figure 1). The number of adults with disabilities is also increasing: In California, almost 1 in 4 adults has a disability, and this number is projected to grow.[1] Finally, California is already one of the most diverse states in the country and will only become more so in the future.[2] All of these changes will have a significant impact on county services in the region.

MORE OLDER ADULTS AND PEOPLE WITH DISABILITIES WILL RELY ON COUNTY ADULT AND AGING SERVICES FOR SUPPORT.

County Adult and Aging Services (AAS) play a critical role in caring for socioeconomically vulnerable older adults and people with disabilities. Current trends indicate that a growing number of people will rely on county programs for support as they age. Caseloads for county AAS programs have been growing for decades, particularly In-Home Supportive Services (IHSS)[3] and Adult Protective Services (APS).[4] Research from the Public Policy Institute of California finds that the number of Californians who will have difficulty caring for themselves will nearly double from 548,700 people in 2012 to 1,010,100 people in 2030.[5] It is also becoming more common for older people to be single, childless, or living alone. Without family close by to support them day-to-day, more older adults and people with disabilities will rely on county programs for support in the coming years.

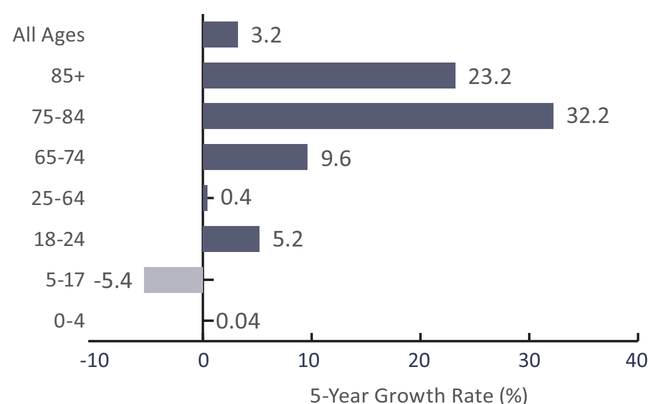

Figure 1 | Bay Area 2022-2027 population growth rate by age group

Source: California Department of Finance. Demographic Research Unit. Report P-3: Population Projections, California, 2010-2060 (Baseline 2019 Population Projections; Vintage 2020 Release). Sacramento: California. July 2021.

As caseloads grow, it is becoming more difficult for counties to ensure that everyone who qualifies for services can access them. For example, IHSS pays for essential services for low-income older adults and people with disabilities, including housecleaning, meal preparation, personal care services, and accompaniment to medical appointments. However, a 2021 report by the California State Auditor[6] found that tens of thousands of IHSS recipients do not receive the services for which they qualify, and that counties are unprepared for future program growth. Without planning and investment by the state and counties, the gap between service eligibility and access will continue to grow. When people who qualify for IHSS or APS go unserved, the chance they will become injured and need expensive medical services and long-term nursing home care increases.[7]

THE NEEDS OF OLDER PEOPLE ARE GROWING MORE COMPLEX.

The needs of older people are becoming more complex, and gaps in the county services available to meet these emerging needs are growing. Increasing numbers of older adults are experiencing homelessness,[8] substance use disorders,[9] and untreated behavioral health needs.[10] A growing number of older people also struggle to afford the basics[11]—healthy food, safe housing, and reliable transportation—but do not qualify for means-tested government support through Medi-Cal, California's Medicaid program. On average, cost of living for older adults is much higher in the Bay Area than in California as a whole—$41,275/year or $3,440/month in the Bay Area compared to $34,008/year or $2,834/month in California. Affording the cost of living in the Bay Area is especially challenging for people over 65, who often rely almost entirely on their Social Security benefits.[12] As a result, Bay Area counties are seeing more "property rich, cash poor"[13] older adults who seek support from the county through programs that have less strict eligibility requirements than Medi-Cal, indicating a growing need for programs that serve middle-income older adults.[14] There is also a notable shortage of services for older adults who are cognitively impaired, particularly those with dementia.[15] To respond to changing needs, county adult and aging services are adapting existing services and creating new programs.

Jerry's Experience: Client Vignette, IHSS

For over two decades Jerry worked construction jobs and lived independently. A back injury left him unable to work and his expenses quickly depleted his savings. At the age of 59 Jerry was evicted from his apartment and started living on the streets of San Francisco. To cope with the difficulties of living on the street, Jerry started to use heroin and quickly became addicted. Though he had access to some resources through various services for people experiencing homelessness in San Francisco, Jerry regularly used the emergency room in order to manage medical situations stemming from his diabetes and hypertension. Jerry's substance use disorder and chronic care needs made it hard for him to remain housed. For Jerry and many others like him, new types of programs are needed to address the range of difficulties making it hard for him to thrive. See Appendix III for details on how the county stepped in to support Jerry during the COVID-19 pandemic. His story highlights the emerging need for "contract mode" or agency-managed IHSS to support recipients who struggle to direct their own care. Contract mode IHSS is currently only available in San Francisco, but multiple directors have expressed the need for similar support in their counties.

EMERGING POLICY REFORMS ARE DIRECTING NEW ATTENTION AND ENERGY TO ISSUES IMPACTING OLDER AND DISABLED CALIFORNIANS.

Today, counties face the unique opportunities, challenges, and realities of an aging population. New statewide initiatives such as the California Master Plan for Aging and California Advancing and Innovating Medi-Cal (CalAIM) provide tremendous opportunities for innovation in aging services, yet also place new demands on an already lean service system. Meanwhile, the COVID-19 pandemic highlighted the critical shortage of home care workers (also referred to as "caregivers") and revealed the vulnerability of older adults to sudden economic downturns, evidenced by the rise in food insecurity during the pandemic.[16] The Home Safe pilot program—a 2018 to 2021 initiative designed to improve county capacity to support APS clients who are homeless or at risk of becoming homeless—has resulted in new partnerships with local homelessness service providers and new staff expertise and capabilities in housing navigation.[17] In the coming years, more older adults will require assistance with self-care, placing even greater demands on a safety net already approaching the limits of its capacity.[18]

TO CREATE A BAY AREA WHERE PEOPLE OF ALL AGES AND ABILITIES CAN THRIVE, COUNTIES WILL NEED TO DEVELOP NEW PROGRAMS AND REFINE HOW EXISTING ONES ARE DELIVERED.

As communities across the state adapt to become more inclusive to people of all ages and abilities, county governments will play an important role as funders, conveners, and direct providers of support. Expanding the capacity of county AAS will be necessary to ensure Bay Area residents have the support they need in the coming years.

In 2021-22, the Bay Area Social Services Consortium Adult Services Committee (BASSC-ASC) engaged in a year-long data gathering and strategic planning process in order to: identify current and emerging needs among older and disabled adults; describe key accomplishments and challenges in service provision; and develop strategies to expand service capacity. This report summarizes findings, outlines seven strategies to strengthen AAS, and describes how Bay Area counties are already taking action to improve the lives of older adults and people with disabilities in their communities. The seven strategies are:

1. Grow the adult and aging services workforce
2. Adopt new policies, procedures, and approaches to management
3. Build partnerships
4. Integrate services and use a client-centered approach
5. Seek new and more flexible funding
6. Develop equitable and responsive programs and workplaces
7. Educate about ageism

GROW THE ADULT AND AGING SERVICES WORKFORCE

An expanded workforce is needed to serve the growing population of older and disabled adults and ensure service access and quality. As counties plan for the future, they seek staff with new capabilities and expertise, including bilingual staff and staff with skills to address homelessness, behavioral health, and substance use. However, recruiting and retaining social workers for AAS is challenging[19] due to salary competition, the limited number of Master of Social Work (MSW) program applicants interested in gerontology, limited training in gerontology within schools of social work,[20] slow and bureaucratic county hiring processes, and other county-specific issues.

A LARGER WORKFORCE IS NEEDED TO MEET THE NEEDS OF THE GROWING AGING POPULATION.

County AAS departments operate with a lean workforce and are grappling with how to serve the growing number of clients. AAS leaders report that if they are unable to hire more staff, they expect service quality and access will suffer in the coming years as their client population grows. Although county AAS departments may administer a range of programs,[21] this section of the report focuses primarily on core county programs for which AAS directors report unique workforce challenges: In-Home Supportive Services, Adult Protective Services, Public Conservator, and Public Guardian.

> "I don't know that the work is sustainable without the department growing. It just has to grow, it's necessary."

In-Home Supportive Services (IHSS)

The IHSS program serves more than 591,000 individuals statewide, helping recipients live independently in their own homes and avoid long-term care arrangements that would be much more costly to the state.[22] Historically, the state's IHSS caseloads have grown by approximately 7% each year, from just over 200,000 clients in 1999 to just over 500,000 clients in 2018.[23] Bay Area AAS directors report that their departments have grown considerably over that same period but not enough to keep up with the growth in demand for IHSS services. From January 2015 through December 2019, the number of recipients statewide who lacked care grew from 33,000 to more than 40,000 on average each month.[24] In addition, although counties must generally make an initial determination of an applicant's eligibility for IHSS within 30 days, applicants in 2019 waited more than 72 days on average.[25]

IHSS faces two distinct workforce challenges. First, IHSS relies on caregivers to work with older adults and people with disabilities in their homes. However, there is a statewide caregiver shortage, which is expected to worsen. Currently, a large share of IHSS caregivers are family members of IHSS recipients. However, as the number of divorced, single, or childless older adults increases, IHSS will increasingly rely on non-family professional caregivers.[26] The low wages that counties pay to caregivers also makes recruitment difficult. In 2021, no county in California paid its IHSS workers a living wage,[27] and many IHSS caregivers had sufficiently low income to qualify for county social services themselves.[28] County directors are concerned that the increasing population of older people, changing family caregiving norms, low wages for IHSS caregivers, and existing caregiver shortage will make IHSS very difficult to operate in the coming years.

"In IHSS you've got the combination of really low wages and hard work. Caregivers are not being paid living wages. So people are leaving the caregiving field and I don't blame them, I would too. Who can survive with the wages that are provided? … Some of our clients have such severe needs, and there's no way for us to compensate caregivers for more intense work. Whether you're having to clean somebody's body or you're having to vacuum someone's house you get the same amount of pay. There's just no fair way to compensate people for the work that they do. And so the number of providers is dwindling."

In addition, more county social workers are needed to process applications for the program, guide applicants through the application process, and conduct annual reassessments. In some counties, large caseloads prevent social workers from offering clients adequate, timely support, and as a result, a growing number of clients are enrolled in IHSS but not connected with caregivers. The challenges navigating the IHSS application process and hiring a caregiver experienced by some clients (e.g., people living in shelters) compound the problem. As caseloads grow more complex, social workers experience decreased bandwidth, focusing attention on clients with the greatest needs, leaving higher-functioning clients with less support. County directors are concerned that quality and timeliness of IHSS services will suffer if counties fail to increase the number of IHSS social worker positions in their AAS departments.

Adult Protective Services (APS)

County APS programs provide a critical safety net to protect older adults and dependent adults from abuse, neglect, and financial exploitation. County APS staff respond to reports of abuse and neglect and conduct case investigations. Similar to IHSS, the size and complexity of APS caseloads are increasing. Santa Clara county, for instance, reports that since 2013, the overall APS volume of reports and active cases has increased approximately 14% each year.[29] Other Bay Area counties report similar growth, yet growth in the APS workforce has not kept up with increased demand.

Another challenge for APS relates to providing ongoing case management to meet the growing need for more extensive support. This is particularly true for clients experiencing homelessness and those with dementia. Given limited state or federal funding, counties often struggle to offer ongoing case management to APS clients. Many communities also lack the specific resources that clients need (e.g., memory care, affordable housing). In response, county AAS directors report efforts to create new programs to address service gaps within the community (e.g., for case management and other supportive services).

"An increasing number of our clients are coming in with severe mental health issues, homelessness, substance use, which requires a lot more intensive work."

Public Conservators and Public Guardians

In California, Public Conservator and Public Guardian (PC/PG) programs play a critical role in caring for individuals who do not have capacity to do so themselves. Public conservators arrange mental health treatment and placement for people who are unable to provide for their food, clothing, shelter, and treatment needs, as a result of a mental health disorder.[30] Public guardians assist adults who are substantially unable to provide for their own basic needs like food, clothing, and shelter, (e.g., older adults with severe limitations or individuals with serious cognitive impairments). In over half of California counties, AAS departments are responsible for administering these two programs.[31] Counties do not receive any targeted state funding to support PC/PG operations, which hinders their ability to adequately staff these programs. Upcoming implementation of California's new CARE Court system[32] is expected to increase referrals to PC programs, placing further strain on their ability to meet client needs.

RECRUITING AND RETAINING SOCIAL WORKERS FOR ADULT AND AGING PROGRAMS HAS PROVEN CHALLENGING.

All counties report facing barriers to recruiting and retaining social workers. Findings from the BASSC 2021 AAS workforce survey and interviews with county AAS leaders, presented below, identify the primary recruitment and retention challenges faced by counties, and the strategies they are using to overcome them.

> "I've had to do two rounds of recruitment to try to fill a position—8 months—and that really hurts. It takes a long time to get people in, if you even can."

Directors experience broad, structural challenges to hiring such as a shortage of social workers graduating from Bay Area universities with interest or training in gerontology, and recruitment has become even more difficult as counties seek to hire bilingual social workers to provide culturally and linguistically appropriate services. In the 2021 survey, eight of the eleven Bay Area counties noted language proficiency as a recruitment criterion that was difficult to fulfill.

The low pay social workers in AAS receive relative to other social work specialty areas is a common issue across counties. For example, in most Bay Area counties, compensation for social workers with comparable training and experience is higher in children's services than in AAS.[33] Directors also note that AAS departments compete with other public sector organizations and private employers, both within their county and in neighboring counties, to attract social workers. Some directors report hiring and training staff only to see them move to another department, county, or non-county organization for higher pay or better benefits.

Other challenges are county-specific. For example, counties with a high cost of living experience difficulties attracting applicants who are willing to move to their county for relatively low-paying jobs, or commute from distant, low-cost counties. Counties that border higher-paying counties lose applicants to counties that offer better pay or benefits. Rural counties report challenges attracting social workers to live and work in their communities, citing the distance from Bay Area schools of social work. Finally, slow county hiring processes can also hinder recruitment efforts.

STRATEGIES TO EXPAND AND STRENGTHEN THE WORKFORCE.

County AAS directors highlight the importance of state support for workforce development, particularly investment in stipend programs and other pipeline programs to make careers in Adult and Aging Services more compelling to social workers while they are still in graduate school. Directors note that to be effective, local schools of social work might also need to enhance available training in gerontological social work practice. Directors report developing an array of strategies to expand the AAS workforce and make their positions more attractive to potential applicants. Key strategies include succession planning, professional development opportunities, and flexible work arrangements (e.g., telework). Retention is supported by creating pathways for professional growth (e.g., career ladders), while recruitment is aided by offering field placements to current students or opportunities for clinical supervision to recent graduates.

> "When they come to the interview people are asking, 'Do you offer clinical supervision?' Because it's so important. A lot of them are coming in halfway through getting their clinical hours, and so we need to support that. About 80% of the staff we hired in the last three years came in wanting clinical supervision. It can make or break someone's decision to come to the county."

Counties are working to build new capabilities to serve more older people who are experiencing homelessness, have behavioral health needs,[34] or seek care in a language other than English. Hiring staff with necessary expertise (e.g., staff who are bilingual or reflect the demographics of the clients they serve) is another priority for AAS directors. Serving older people experiencing homelessness represents a new role for AAS departments.

> "One challenge is the growing homeless older adult population and all the issues around that. We do not have the expertise. We're not housing experts. We're not mental health experts. [But] we're trying to do better."

Case Study: The Santa Cruz Design Team

In 2016, Santa Cruz AAS leadership created the Design Team within Santa Cruz County's Division of Adult and Long-Term Care in response to a staff survey that found limited trust and lack of communication between management and line staff. The Design Team works to build trust and improve communication by facilitating collaborative decision making—bringing staff and leadership together to develop new initiatives and projects. The Design Team improved staff morale by creating a work environment where staff feel that their perspectives and experiences are valued.

ADOPT NEW POLICIES, PROCEDURES, AND APPROACHES TO MANAGEMENT

All BASSC-ASC directors report adopting new policies, procedures, and approaches to management. These changes are designed to improve staff recruitment and retention or the access, quality, and efficiency of services. Key changes to improve staff recruitment and retention include implementing flexible work arrangements, offering more supervisory support and professional development activities, and changing workplace culture to encourage bottom-up communication from staff. To improve access, quality, or efficiency of services, directors are implementing new approaches to performance management, redesigning how services are provided, and investing in new data / IT infrastructure or other technology to support meaningful use of data to inform decision-making and practice.

RECRUITMENT AND RETENTION.

The COVID-19 pandemic placed immense strain on local health and social safety net providers,[35] and fundamentally altered the nature of work in the U.S.[36] To protect employee health and safety, Bay Area human services agencies instituted new or revised remote work policies. As the pandemic abates, in order to improve recruitment and retention, most counties have extended remote work policies to permanently allow staff to work remotely at least 1-2 days per week.[37] Implementing telework and other flexible work arrangements can require lengthy negotiations with labor unions, investment in technology, and development of new supervisory practices and organizational workflows; equitable implementation can also be a challenge, as some adult and aging services can only be provided in person. However, multiple directors describe flexible work arrangements as critical to their ability to successfully recruit and retain staff.

> "That's a question staff ask at interviews, 'Do you offer alternative work schedules?' … COVID has really changed the way people look at work and balance and we need to meet them where they're at."

AAS directors also describe efforts to improve staff retention by strengthening the quality of supervisory support, offering more professional development opportunities (e.g., "on the job" field placements for social work degree programs or clinical supervision towards licensure[38]), and changing workplace culture to encourage more bottom-up communication. For example, Santa Cruz created the Design Team (see Appendix II) to allow for greater staff input in decision-making while Alameda established new processes for regular, bi-directional communication between leadership and staff. To mitigate impacts of pandemic-related administrative turnover, several directors report engaging in more purposeful succession planning.

> "We've had so many changes in managers and supervisors, I implemented a policy where if you are leaving your management position, you must write a detailed transition document so the person coming into your position has a good lay of the land. It's been a good way to capture knowledge for new people entering."

SERVICE IMPROVEMENTS.

All county AAS directors describe changing organizational policies, practices, and management approaches to improve access, quality, and efficiency of services. Key strategies include redesigning services, implementing new approaches to performance management, and investing in new data and IT infrastructure or other technology to

support meaningful use of data to inform decision-making and practice. With regard to service redesign, several counties report cross-training staff from different programs to facilitate more holistic, client-centered approaches to care. Other counties describe restructuring their units or redesigning care processes to improve quality and efficiency of care provided. For example, to improve timeliness of the IHSS intake process, Contra Costa changed existing workflows, including timing of case assignments and responsibility for intake assessments (see Appendix II).

Multiple counties also emphasize the importance of collecting and meaningfully using data to identify community needs, guide performance management and performance improvement efforts, demonstrate program impact, and support advocacy efforts. For example, Sonoma is one of several counties that use Results-Based Accountability to inform how they describe, measure, and report on program performance. In San Mateo, use of a new data analysis and visualization software, PowerBI, is helping the leadership team rapidly review data on changing community needs and identify where targeted program improvements might be needed.

"During COVID, we really ramped up our data collection. We worked closely with our AAA and our community-based organizations to really make sure we were meeting community needs. For example, with Great Plates Delivered, we learned there was a full cohort of middle income older adults we didn't know about, who wouldn't have thought to reach out to the government for assistance. Working with the data helped us really identify who had food insecurity needs."

Case Study: Transforming In-Home Supportive Services (Contra Costa)

In FY 2020/21, Contra Costa's IHSS intake assessment performance was among the worst in the state. In 2021/22, the Adult & Aging Services leadership team made significant changes to how the program was administered, including changes to how intake cases were assigned and to staff responsibilities. These changes resulted in significant improvement in intake performance, from 22.78% of cases with timely assessment to over 90%.

Case Study: Meals on Wheels San Francisco

Meals on Wheels San Francisco (MOWSF) is a home-delivered meal assistance program that serves over 4,000 people daily, including older adults and people with disabilities in the community. Over a four-year period, MOWSF shifted from a paper-based client tracking system to a Salesforce-based customer relationship management platform and staff-facing mobile application. Developing and implementing the platform was described as resource-intensive but transformative for the organization. The platform is used to track active clients, inform routing and mapping logistics for drivers, and provide real-time updates on delivery, client condition monitoring, and visit follow-up. Data from the platform are also used to support management decision-making, quality improvement efforts, and to demonstrate program impact to funders.

BUILD PARTNERSHIPS

Maintaining strong ties with local organizations, other county departments, and at the state level is a priority for AAS leaders in the Bay Area. Partnerships keep directors informed about changing community needs, allowing them to respond with new programs and services. Partnerships also enable counties to respond more quickly and effectively to natural disasters, successfully advocate for new funding or programs to support older and disabled adults, and better integrate care for the people they serve.

County AAS departments rely on strong ties with community partners to stay informed about and respond to emerging needs or natural disasters, and to successfully advocate policy and practice change. Counties responsible for administering local Area Agencies on Aging (AAAs) often report relying closely on the AAAs to stay connected to key stakeholders in the community and help advocate for the needs of older adults. Many counties also describe using advisory boards, councils, or collaboratives to engage community partners.

AREA AGENCIES ON AGING.

Since the 1970s, AAAs have served as local leaders that plan, coordinate and deliver services and programs that enable older adults to live at home and in the community with dignity and independence. AAAs can be private nonprofit organizations or administered by local government; in most Bay Area counties, the AAA is located within the county AAS department. In these counties, AAS directors say the AAA plays an important role in partnership development. In all counties, AAAs provide core services such as congregate and home-delivered meals, transportation, case management, benefits/health insurance counseling, and family caregiver support programs.[39] AAAs also play an important role in advocating for the needs of older adults, and in many counties, work with community partners to help identify and address gaps in services.

"AAAs can be purely administrative or they can be very involved. Our AAA takes leadership on aging issues like getting our county designated age-friendly… Our AAA can be a leader because our community is involved, we have staff who are driven to carry out a vision, and elected officials that support that. The key ingredient is having a community that gets involved."

COMMUNITY ENGAGEMENT.

Many Bay Area counties also report relying on advisory boards, councils, and collaboratives to help elevate the concerns of community members and support community engagement in the creation of age- and disability-friendly programs and policies. For example, Alameda's Age-Friendly Council provides a platform for the county and the community to come together on issues impacting older adults and was responsible for drafting the county's Age-Friendly Workplan (Appendix II, Case Study A). Similarly, Marin's Aging Action Initiative leveraged a strong network of organizations from different sectors to support policy and program change through advocacy, education, and service innovation.

"The intention of the Age-Friendly Council is for the agency to partner with community-based organizations to make policies and procedures… focused on the older population."

EMERGENCY RESPONSE.

Strong partnerships also enable county AAS departments to respond more quickly and effectively to natural disasters. For example, Marin's strong ties with partner organizations in the Aging Action Initiative allowed the county to quickly launch its "Great Plates Delivered" meal delivery service for older adults during the COVID-19 pandemic: "[During COVID] we needed to infuse much, much more than we normally had into the system… Delivering groceries is not something we had done before. But there were so many organizations working together and we were all very well connected. We had good relations with local organizations, we had worked with each other before. Even if I didn't have a contract with them, I knew them from this collaboration." Several counties report that recent natural disasters (e.g., wildfires and the COVID-19 pandemic) exposed areas for improvement in existing emergency preparedness and response systems, particularly by highlighting the need for appropriate outreach and access to services for individuals with functional disabilities.

SERVICE INTEGRATION.

Finally, many AAS directors report partnering with other departments or with organizations outside of their agency to better integrate care. Older and disabled clients of county services are often served by multiple programs or could benefit from additional services if they were offered. Integrating services is a key strategy for overcoming system fragmentation. Care integration and client-centeredness are often discussed together by county directors, who emphasize the need to ensure that services are easy to access, well-coordinated to support data-sharing and avoid duplication, and responsive to individual needs. The next section of this report details the steps county AAS directors are taking to integrate programs.

Case Study: Santa Clara's Seniors' Agenda Program

In Santa Clara, the Seniors' Agenda program helps ensure that the county maintains a leadership role in meeting the needs of older adults within the community. Dedicated funds for a full-time project manager allows for focused attention on building relationships needed to enact change. Key accomplishments include helping all 15 cities in the county join the World Health Organization's Global Network of Age-friendly Cities and Communities and participating in the Dementia Friends Initiative.

Case Study: Napa's Healthy Aging Population Initiative

The Healthy Aging Population Initiative (HAPI) is a collaborative network of public and nonprofit agencies serving older adults in Napa. HAPI's purpose is to assess and identify priorities for older adults in the community, develop and implement community-appropriate plans and programs for addressing these priorities, and advocate for age-friendly policies. It facilitates concrete support and inter-agency information sharing among members. HAPI has helped expand the capacity of AAS services to address mental health challenges by securing MHSA funding to develop and implement Napa's Healthy Minds, Healthy Aging Program, a prevention/early intervention program for older adults who show early signs of depression or cognitive decline. HAPI members have raised over $2.5 million in grants to support development of new initiatives, many of which have been sustained by member organizations. HAPI advocacy efforts have supported community, institutional, and governmental policies to make Napa County more age- and disability-friendly.

INTEGRATE SERVICES AND USE A CLIENT-CENTERED APPROACH

Integrated services provide a more comprehensive, client-centered experience of care. County AAS departments are partnering with organizations from a range of service sectors to integrate services, including housing, other human service departments, behavioral health, healthcare, and law enforcement. Overarching strategies being implemented in Bay Area counties to support service integration involve improving care coordination, cross-training staff or creating blended staff roles, and creating single entry points for care.

County directors report integrating services to provide a more comprehensive, client-centered experience of care. The three most prevalent strategies for service integration include providing care coordination, cross-training staff, and creating single entry points for care. In implementing these strategies, county AAS directors report partnering with organizations from a range of service sectors to integrate services, including housing, other human service departments, behavioral health, healthcare, and law enforcement.

Care coordination

Multiple directors report providing care coordination or care management services to older adults and adults with disabilities to help connect them with needed care. For example, Sonoma AAS administers three different care management programs focused on helping eligible clients find and manage services needed to remain safely and independently in their homes. To help fund these services, several counties are considering or have developed contracts with health care payers. For example, Sonoma is in the process of developing a community integrated health network that could contract with health plans to provide care management and other services (Appendix II, Case Study L). In 2022, San Mateo began contracting with the local Medicaid managed care plan to provide eligible Medi-Cal beneficiaries with health and social services case management and other supportive services (Appendix II, Case Study H).

Cross-training staff or creating blended staff roles

Several directors report cross-training staff or creating "blended" roles to help reduce silos in care between different county human services departments. For example, in one of its offices,

Monterey cross-trains frontline staff in AAS and CalWorks Employment Services. Cross-trained staff have a more comprehensive understanding of different resources available within-county and are better equipped to direct clients to appropriate services (Appendix II, Case Study E). In San Mateo, social workers are trained to serve clients in both Medi-Cal IHSS and Enhanced Care Management (ECM) services, thereby reducing risk of care fragmentation or service delays for clients eligible for both programs (Appendix II, Case Study H).

Creating single entry-points for care

Finally, multiple directors report partnering with external organizations to create single entry points for care. For example, Marin's One Door initiative aims to provide a "one stop shop" to help clients navigate the array of services and supports available to older adults, adults with disabilities and family caregivers within the county. Services are provided through the county's Aging and Disability Resource Connection (ADRC), a joint effort between county Adult & Aging Services and the Marin Center for Independent Living, and include enhanced information and assistance, options planning, 90-day short-term service coordination, and support to help clients living in residential care facilities return to live in their own homes (Appendix II, Case Study D).

To implement these strategies, directors report partnering with public and private partners in a range of sectors, particularly housing, behavioral health, healthcare, and law enforcement.

Housing

As the state begins to increase support for older people experiencing homelessness through programs like Home Safe, AAS departments are increasingly partnering with housing providers to address needs of older adults experiencing or at-risk of homelessness.

> "Home Safe funding… has allowed us to partner in a very meaningful way. We have started working more closely with our Department of Public Health. They identify clients for us who are the most at risk, enabling us to focus our efforts on transitioning those clients into board and care facilities."

Behavioral health

Several AAS departments are working with mental health providers and other partners to extend their ability to identify and address behavioral health needs in older adults, particularly dementia. For example, Napa's Healthy Minds-Healthy Aging Program works to address mental health and cognitive impairment issues among older adults and their caregivers,[40] while Santa Clara's "Connections" program provides mental health services to ethnically diverse elder and dependent adults who have been referred to APS and may be exhibiting signs and symptoms of mental health issues.[41] Monterey is exploring the possibility of piloting a new program modeled after San Bernardino's Age Wise, which offers mental health services for high-risk and underserved older adults, including in-home behavioral health and case management services, counseling services, peer and family advocacy.

> "Mental health services are critical for any age. Three years ago San Bernardino was seeing what we're seeing today: a high-risk older adult population with unmet mental health needs costing the county a lot of money through various services. So they established a unit called Age Wise… Age Wise therapists became their support system, their advocates. It was a very successful approach. I want to bring that to our county."

Healthcare

Multiple directors report efforts to improve coordination of care between county Health and Human Services departments or with clinics and hospitals in the community. Several directors also describe partnering to explore feasibility of securing new funding for care management and other supportive services from health care payers. For example, Sonoma AAS used pilot grant funding to embed a social worker on-site at a local health clinic to provide depression screening and county

service information and referrals to older adults and is currently exploring the possibility of funding through CalAIM to sustain and expand the program.

Law enforcement

Finally, a few counties report partnering with law enforcement and other county departments to address increased financial abuse of older adults. For example, San Mateo partnered with the District Attorney's Office and the County Counsel's Office to develop an Elder Dependent Adult Protection Team (EDAPT) that focuses solely on investigating financial abuse of older adults.[42]

Case Study: Medi-Cal Enhanced Care Management and Community Supports in San Mateo

In 2022, San Mateo's Adult and Aging Services (AAS) successfully contracted with the county's Medicaid managed care plan as a CalAIM Enhanced Care Management (ECM) and Community Supports (CS) provider of health and social services case management and other supportive services needed to help older adults and adults with disabilities live safely and independently in the community. Critical success factors included the ability to co-locate managed care plan and AAS staff to streamline communication and collaborative ties, and the location of AAS within county health rather than in a separate human services agency, which allowed for use of social workers to serve both ECM and IHSS beneficiaries. A key lesson learned in early implementation of ECM and CS is the need for careful attention to how to meaningfully engage and enroll eligible beneficiaries in services; "cold calls" were described as less effective than more person-centered forms of outreach and engagement.

Client Story: Charlie Jackson, Sonoma County

Charlie Jackson, 67, is a retired private school teacher who lives alone in rural, wooded West Sonoma County. He was navigating early symptoms of Parkinson's disease until a fall in his home caused a significant change in his disability and mobility. Charlie was struggling to care for himself while living at home when he first came into contact with Adult Protective Services (APS). Sonoma's Linkages case management program played an important role in helping Charlie receive home modifications needed to stay safely in-home, even though his income made him ineligible for certain means-tested programs. (Link to full vignette)

SEEK NEW AND MORE FLEXIBLE FUNDING

Limited federal and state resource support for AAS programs pose challenges to counties' ability to effectively serve vulnerable older adults and people with disabilities. Bay Area counties have responded by seeking new and more flexible sources of funding and advocating for systems change. Multiple counties have successfully secured grants, philanthropic funding, and other funds to strengthen local capacity, create new programs to address existing gaps in care, or extend services to new populations. Increased funding is critical to counties' ability to continue meeting needs of older adults and adults with disabilities in the future.

BACKGROUND ON FUNDING OF COUNTY ADULT AND AGING SERVICES.

In-Home Supportive Services

IHSS is a statewide Medi-Cal program administered by counties under the direction of the California Department of Social Services. As an entitlement program, all eligible applicants are guaranteed to receive benefits, and services are jointly funded by California and the federal government. However, in practice, IHSS applications are often not processed in a timely manner, resulting in long wait times.[43] Many participants also do not receive all authorized hours, either because of difficulties recruiting and retaining IHSS workers or because they lack capacity to direct their own care.[44] There are also many older adults and adults with disabilities who could benefit from IHSS but do not currently qualify. Recent and upcoming changes to asset limit tests for Medi-Cal eligibility[45] are expected to increase the number

of aged, blind, and disabled individuals eligible for IHSS. This Medi-Cal expansion will help improve the safety net for those newly eligible for IHSS, but it will exacerbate the caregiver shortage and place further strain on a program already struggling to meet community demand.

> "A lot of clients don't meet medical criteria for Medi-Cal placement but their income isn't high enough to get them a placement in a decent facility, so they're in a gap where they can't manage in the home setting and don't have people to support them in home but they can't go into placement because they can't afford it."

Other Adult and Aging Services programs

Until recently, federal funding for other AAS programs such as APS and PG/PC/PA has been limited, with state or local governments bearing most of the cost. Historically, the Older Americans Act (OAA) has served as the primary source of federal funding for non-clinical home and community-based services, nutrition assistance for older adults and adults with disabilities, and for local Area Agencies on Aging. However, between federal Fiscal Year (FY) 2011 and FY 2019, total OAA funding levels remained stagnant ($1.81-$2.06 billion/year). In FY 2020 and 2021, supplemental funding issued in response to the COVID-19 pandemic resulted in large but temporary increases in financial support for AAS programs; most of these increases were not sustained in federal FY 2022.[46]

In general, limited federal and state resource support for AAS programs pose challenges to counties' ability to effectively serve vulnerable older adults and adults with disabilities. These challenges are only exacerbated by rising caseloads and increased complexity of needs among older adults and adults with disabilities.

> "We need more and better facilities, especially dementia care facilities. That is a really big gap. It takes a significant amount of staff time to navigate and a lot of times we still don't have solutions for people... And these are things we have no money to help to do."

STRATEGIES.

Counties have responded to these resource challenges by seeking new and more flexible sources of funding and advocating for systems change. At the state level, advocacy efforts have resulted in recent legislative changes that have helped support growth of AAS programs such as APS. For example, the California Budget Act of 2021 changed the definition of "elder adult" eligible for APS investigation or services from aged 65+ years to age 60+ years; funds appropriated to support this program expansion helped create new staff positions within APS.

At the local level, Bay Area counties have successfully secured grants, philanthropic funding, or other funding to strengthen local capacity, create new programs to address existing gaps in care, or extend services to new populations. For example, in San Francisco, local advocacy efforts resulted in establishment of the Dignity Fund in 2016 (see Appendix II), which set aside county funding specifically for older adults and adults with disabilities and helped strengthen and improve access to AAS in the community. In 2019, Bay Area counties also partnered with the California Department of Social Services and with the California Social Work Education Center to fund and pilot a

regional APS MSW stipend program, which in 2022 was expanded statewide to help grow California's AAS workforce.

Within Medi-Cal, changes introduced via CalAIM, including 2022 Enhanced Care Management (ECM) and Community Supports (CS) benefits and the upcoming carve-in of long-term care within Medicaid managed care, raise new possibilities for improving integration of care and funding non-clinical services[47] for older adults and adults with disabilities. To take advantage of this funding, county AAS departments must develop contractual agreements with Medicaid managed care plans and meet reporting and claims requirements, which could require significant and costly systems change, e.g., to develop needed interorganizational relationships, data sharing infrastructure, and administrative expertise. In 2021, Sonoma secured grant funding to develop its capacity as a community integrated health network that could successfully contract with third party payers to deliver care to older adults and adults with disabilities in the community (see Appendix II). In 2022, San Mateo's AAS department was one of the first in the state to successfully contract with Medicaid managed care as an ECM provider (see Appendix II).

Case Study: Enhanced Funding for Social Services Through San Francisco's Dignity Fund

In 2016, San Francisco's Dignity Fund was established through a voter-approved charter amendment to enhance funding for social services for older adults and adults with disabilities in the community. Funding was initially set at a baseline allocation of $38 million and increased by $6 million in FY 2017/18, with additional $3 million increases planned each year through FY 2026/2027 except in years when the city experiences a budget deficit. The certainty and flexibility of funding available through the Dignity Fund has helped stabilize the AAS network in San Francisco and improved equity of services for historically disadvantaged groups and underserved neighborhoods. Strong community advocacy was critical to passing the legislation.

Case Study: Developing a Community Integrated Health Network in Sonoma

In 2021, Sonoma's AAS Division secured funding from the National Council on Aging Network Development Learning Collaborative to work closely with community partners to develop their capacity as a community integrated health network (CIHN). A CIHN refers to a network of partners that work together to deliver services that address health-related social risk factors within a specific geographic area. By creating a single contracting entity with centralized administrative processes, CIHNs allow smaller organizations to more effectively compete for contracts with health plans and other payers. Some key lessons in partnership development have emerged from Sonoma's efforts including the importance of: ensuring adequate time and resources for CIHN development; assessing partners' readiness to engage in a CIHN; ensuring appropriate data sharing infrastructure and business capacity (e.g., to develop Business Associate Agreements with CIHN partners and successfully negotiate with and secure contracts from third-party payers); and the value of securing funding for a business development manager to serve as a neutral lead in moving CIHN activities forward.

DEVELOP EQUITABLE AND RESPONSIVE PROGRAMS AND WORKPLACES

Adult and Aging Services departments in the Bay Area are identifying ways to provide culturally appropriate and responsive services to increasingly diverse communities and clients. Directors also report working to ensure an equitable and inclusive workplace for staff. Important strategies to promote diversity, equity and inclusion (DEI) involve hiring diverse and multilingual staff, creating equity-focused workplace training and supports, implementing trauma-informed practices, engaging in community outreach, and using data to identify and address service gaps.

Older Californians are becoming a more racially and culturally diverse group, mirroring trends in the overall population (Appendix I, Tables 1-3). By 2027, almost 1 in 2 Californians over 60 will identify as a non-white racial or ethnic minority. Similar trends are predicted in the Bay Area (Appendix I, Table 3).[48] Among clients served by AAS programs, the proportion of non-white racial/ethnic minorities and immigrants is high in many counties.

> "About 32% of our county population are not born in the United States and there is no majority ethnic or racial group. We are a diverse county, but our client population is not very diverse. It pretty much consists of Black and Brown individuals living below the poverty level. We have a good number of individuals that speak English as their second language as well."

Among the Bay Area county human services agencies, there is a growing emphasis on providing culturally appropriate and responsive services, and ensuring an equitable and inclusive workplace. Key strategies across the Bay Area include hiring a diverse and multilingual workforce, broader efforts to develop an equitable and inclusive workplace, outreach and engagement efforts, and using data to identify and address service gaps. In support of this work, almost all counties are members of the Government Alliance on Race and Equity (GARE), a national network of government entities working to achieve racial equity.

Agency strategic plans and other guiding documents increasingly highlight principles and strategies focused on racial equity. For example, the Santa Cruz County Human Services Department's 2021-2022 Annual Report highlights strategies including analysis of disaggregated data and targeted training and supports focused on racial equity and inclusion, and notes use of GARE tools in this work. The Alameda County Social Service Agency 2019-2024 Strategic Priorities Report notes the use of racial equity

tools "designed to integrate explicit consideration of racial equity in decisions, including policies, practices, programs, and budgets", and summarizes activities in a number of areas, including advocacy, language accessibility, and immigrant services. In San Francisco, the Human Services Agency's Office of Diversity, Equity, Inclusion, and Belonging (DEIB) supports agency efforts to meet the City's goals for addressing structural and institutional racism in the services it delivers, and developing an equitable workplace, "by building a culture of belonging and inclusion for our employees while also supporting policies that minimize disparities in the workplace".

PROMOTING DEI IN THE WORKPLACE.

Counties are engaged in efforts to ensure hiring, training, and support processes are equitable and responsive to the needs of staff who are Black, Indigenous, and people of color (BIPOC). For example, the San Francisco HSA DEIB 2021 Racial Equity Action Plan Progress Report summarizes progress on workforce related efforts in seven strategic areas (Hiring and Recruitment, Retention and Promotion, Discipline and Separation, Diverse and Equitable Leadership, Mobility and Professional Development, Organizational Culture of Inclusion and Belonging, Boards and Commissions). With respect to hiring, some agencies have instituted an equity and diversity focus at multiple stages of the process as a component of their DEI Strategic Plan. Specific strategies include DEI-focused questions in the application and interview, and blinded review of applications.

"We have an agency commitment to ask DEI questions on all of our recruitments... At every stage of the interview process we include at least one question addressing DEI. And our agency director really pushed to have HR blind the applications, so you can't see names when you're doing the scoring of the supplemental questions, just to address any potential implicit bias based on somebody's name or gender."

DEI training is another common strategy employed to create an equitable and inclusive workplace. Often this training emphasizes a trauma-informed approach. In some agencies, employees play an active role in designing the trainings, through participation in DEI-focused workgroups.

Finally, as mentioned previously, the pandemic highlighted specific equity issues related to opportunities for remote work, as individuals in lower level classifications were less likely to be permitted to work from home; individuals in these positions are more likely to be BIPOC in comparison to managerial positions. A number of counties are updating their remote work policies with a focus on equity, to provide broader access to flexible work arrangements.

"Right now, we, like everybody else, are doing a big DEI review, and what we discovered is it's generally the clerical staff who've had the burden of coming into the office to do the mail, to do the scanning. Those are mostly people of color and we're trying to work around the inequities of that."

DEVELOPING CULTURALLY APPROPRIATE PROGRAMS.

Bay Area AAS leaders report several strategies they are pursuing to design equitable and culturally responsive services, including building a workforce that reflects the community and client population, creating structures and processes to share staff knowledge across the agency, and using assessments and outreach to identify the needs of specific groups within the community. Some smaller counties with lower staffing numbers report challenges to providing accessible services to all racial and ethnic groups. However, even in smaller counties, hiring strategies are in place to promote community representation and language access.

"So the huge challenge we have is that when you're trying to provide equitable services, it can be really difficult because we don't have the infrastructure, if you will, that a large county would."

In Solano County, Caucus to Advance Racial Equity (CARE) groups were developed to facilitate discussion and collaboration among staff focused on the needs and priorities of specific racial and ethnic groups. In addition to providing an opportunity for participants to share experiences and support, the CARE groups have played a central role in developing training and tools for staff.

"[CARE Groups] are a way for people to just think and talk, and share what their experiences have been, what some of the challenges are, what can we do to make a difference…. Out of some of those groups have come education to help people understand some of the highlights that we want you to know when you're caring for this population. 'Here are some helpful tools, here are some helpful resources….' We developed a resource manual that allows us to reach the population in a more sensitive way, as well as to access resources in the community for the population."

Agencies emphasize the importance of assessing community and client needs to ensure they appropriately target services to diverse communities. For example, in San Francisco, a community-wide needs assessment is conducted every four years. Data analytics are employed to identify areas of the city that could most benefit from services or resources and the populations affected, so the county can be more targeted in Requests for Proposals put out to the community.

In some instances, AAS directors conduct assessments drawing on existing data from county administrative systems, to track caseload data and examine health disparities for different groups in the community. Finally, directors note that community outreach and engagement is often needed to identify service barriers related to race, ethnicity or culture. For example, one county determined that its pandemic Great Plates program funding restaurant-provided meals was not being used by Spanish speaking clients, and worked to address the issue.

EDUCATE ABOUT AGEISM

Many county AAS directors are concerned that lower levels of funding for AAS relative to other county programs, as well as organizational structures and decision-making processes, may reflect unexamined bias against older people. In order to address potential biases and strengthen programs and services, AAS divisions and departments are engaging in educational and advocacy strategies that include public education campaigns and Age-Friendly initiatives.

The World Health Organization (WHO) defines ageism as: "the stereotypes (how we think), prejudice (how we feel) and discrimination (how we act) towards others or oneself based on age."[49] While ageism can be experienced by members of any age group, negative impacts for older adults are particularly notable: "Ageism is associated with earlier death (by 7.5 years), poorer physical and mental health, and slower recovery from disability in older age."[50] Ageism experienced by older adults is associated with adverse consequences for health care, participation in the labor market, and involvement in community life.[51]

Ageism can be expressed in many ways including through the interactions older people have with care providers and the framing of news stories. For example, research on ageism shows that age-related bias can be expressed toward older adults seeking supportive services when people assume older adults are responsible for their circumstances due to life choices they have made, and they are therefore undeserving of care. A study of narratives about aging in media and advocacy-focused communications concluded that the biggest issue among the dominant patterns of public understanding of aging was:

> "[T]he common assumption that individuals are exclusively responsible for how they age. This idealized vision of aging is rarely achievable in the real world, according to experts. When the media and advocacy organizations fail to link successful aging to policies that actually enable older adults to remain active and socially engaged, they reinforce the public's highly individualistic understandings of the aging process. The result is that people will understand successful aging to be achieved exclusively through lifestyle choices rather than as affected by supports, larger social structures, or public policies. Further, when the ideal is not achieved, many Americans will assume that the reason for the failure lies in poor individual decision-making [by older adults]."[52]

At the county level, when these kinds of beliefs are prevalent among community members and government decision makers, they can act as barriers to effective policy and planning, and contribute to resource disparities for agencies and programs serving older adults.

POLICY AND PLANNING CHALLENGES.

The structure of the Human Services Agency or integrated Health and Human Services Agency creates challenges for policy and planning decision-making related to AAS in some counties. For example, agency structure may not provide the AAS director adequate access to agency leaders who play a critical role in approving policy and planning decisions. This form of structure may reflect a historical lack of attention and priority given to the needs of older adults. In contrast, the AAS division or department in some counties is positioned at a level that ensures participation in relevant executive level meetings and discussions. Difficulties may

also arise where leadership transitions within the agency or among the county Board of Supervisors lead to a reduction in awareness among decision-makers regarding the needs of older adults. In these situations, AAS directors are called upon to provide information to incoming leaders to orient them to AAS programs, services, resources, and challenges.

RESOURCE CHALLENGES.

At the state level, and in some county Human Service Agencies, there may be limited understanding of key issues and policies related to AAS funding, including unfunded mandates.

Directors report working within their counties to strengthen understanding and advocate for investments in addressing the needs of older people. For example, one director recalled a conversation with a colleague about California's FY 2011/2012 realignment of state program responsibilities and revenues to local governments that reflected the belief that protective services revenue realignment related to Child Protective Services only, although APS was included. The director emphasized that even in a supportive collegial county work environment, accidental omission or inattention to the needs of older people can occur.

> "We are so underfunded in Adult and Aging Services. And finally, in the last year, we started getting attention because of the Master Plan for Aging… [But] adding new demands without needed resources is a concern, because we can only do so much. 'What else is going to be added to our plate?' What else will be unfunded or we just have to make it work and stretch?"

In many counties, there are differences in the level of resources allocated to AAS compared to other services and programs. For example, children's services are often a primary focus for funding decisions. The disparity in social worker compensation between APS and Child Protective Services is one illustration of the resource "competition" between children's and adult services. Finally, some AAS directors perceived health departments in their counties as frequently prioritized over AAS in funding allocation decisions.

> "I think that it's the kids, or the vulnerability of kids, that always gets the attention over the vulnerability of adults or people with disabilities. I think that that's changing, but competition for having the attention and getting the services that we need has historically and continues to be a pretty significant challenge."

STRATEGIES TO ADDRESS AGEISM.

To address ageism, counties have begun to develop and participate in educational and advocacy-focused initiatives, in partnership with community organizations and other agencies. In San Francisco, the San Francisco Reframing Aging Campaign represents a "collaborative effort to increase public awareness of ageism, disrupt negative stereotypes of aging, and connect residents with supportive

resources and services," created through a partnership between the San Francisco Department of Disability and Adult Services, the Community Living Campaign, the Metta Fund, and community-based organizations. In Santa Cruz, the Human Services Department was a sponsor of "We're Still Here," an exhibit at the Santa Cruz Museum of Art & History created by a community group of local seniors, advocates, and artists. The exhibit, also sponsored by the Community Foundation of Santa Cruz County, community based-service providers, local businesses, and community members, included artwork focused on loneliness, solutions to build connection, and words of wisdom for future generations.

The WHO/AARP Age Friendly initiative is another strategy being used in counties to change perceptions of older adults and promote services and supports that promote higher quality of life for all community members.[53] For example, Marin is a very active county in the age-friendly community: "There are 11 municipal jurisdictions in the county; nine out of 11 of them are actively part of the World Health Organization and AARP's Global Network of Age-friendly Cities and Communities. The county voted to become a part of that network in 2018; we developed an age-friendly plan called Age Forward that was approved by the board last year. And its intent is to bring the lens of aging to policy and programs across all our departments." Similarly, Santa Clara became an age-friendly community in 2018, and worked rapidly to engage cities in the initiative: "We also, in a year and a half, brought in all of 15 cities in Santa Clara County, to also be designated age-friendly with the World Health Organization. We then became the first county to have all its cities be designated age-friendly, which gives us some common vision, and goal and construct to do the work together (Santa Clara Case Study: Seniors' Agenda IV)."

CONCLUSION

As communities across California adapt to become more inclusive to people of all ages and abilities, county governments play an important role as funders, conveners, and direct providers of support. County AAS departments will continue to provide essential services to socioeconomically vulnerable older and disabled adults. However, current trends indicate that a growing number of people will rely on county programs for support as they age, and as caseloads grow, it is becoming more difficult for counties to ensure access to everyone who qualifies for services. To respond effectively to these challenges and take advantage of new policy and funding opportunities, it will be necessary to expand the capacity of Bay Area county AAS departments. This report summarizes current and emerging needs among older and disabled adults; describes key accomplishments and challenges in service provision; and outlines emerging strategies to expand and strengthen services. We hope that the report will serve to inform discussion and collaboration among county staff and officials, community organizations, and community members, in order to better support older and disabled adults in our communities.

ENDNOTES

1 Analysis of 2016 Behavioral Risk Factor Surveillance System data suggest that 26% of adults in the U.S. are affected by a functional disability. In California, this number is closer to 1 in 4 adults. Disability is particularly common in older adults aged 65+, with 2 in 5 older adults affected.

2 In 2019, 62% of older adults aged 60+ in California identified as belonging to a non-white racial or ethnic group. Additional data on race and ethnicity of the older adult population in California and the Bay Area are available in Appendix I.

3 The California Legislative Analyst's Office (2018) finds that prior to 2009, the IHSS caseload grew, on average, by 7.5% annually. However, between 2009 and 2013, the IHSS caseload remained relatively flat. In more recent years, growth in the IHSS caseload has resumed, averaging about 5% annually.

4 Santa Clara County (2021) reports that the APS caseload increased between 2016 and 2021 by 41% in the number of Abuse Reports and 20% in the number of Active Cases for investigation. Key informants verified that this trend towards growth in APS holds true across Bay Area counties.

5 Beck, L. & Johnson, H. (2015) Planning for California's Growing Senior Population. San Francisco, CA: Public Policy Institute of California.

6 Howle, E. M. (2020). (rep.). In-Home Supportive Services Program: It Is Not Providing Needed Services to All Californians Approved for the Program, Is Unprepared for Future Challenges, and Offers Low Pay to Caregivers (pp. 1–87). 621 Capitol Mall, Suite 1200, CA: California State Auditor

7 Ibid.

8 Older adults are the fastest-growing segment of California's homeless population. In an article written for CalMatters (2020) Frank J. Mecca, a member of Gov. Gavin Newsom's Regional Council of Homelessness, notes that people over 50 now account for half of unhoused adults — a four-fold increase since 1990 when 11% of homeless adults were over 50, citing research by Dr. Margot Kushel.

9 Research on substance use disorders in adults ages 65 and older is limited. However, a 2022 analysis of data from the National Survey on Drug Use and Health show that drug use among this group increased from 19.3% in 2012 to 31.2 percent in 2017. Furthermore, recent cohorts of individuals ages 65 and older show a higher prevalence of lifetime substance use than prior generations.

10 The UCLA Center for Health Policy Research (2019) reports that depression and anxiety disorders are often unrecognized and undertreated in older adults, and detection and diagnosis are complicated by medical comorbidity, cognitive decline, and changed life circumstances. Older adult substance abusers are more likely to have undiagnosed psychiatric and medical comorbidities, making treatment more complicated.

11 Research from The National Council on Aging (2021) finds that the vast majority (80%) of households with older adults—nearly 47 million—are financially struggling today or are at risk of falling into economic insecurity as they age. Additionally, the financial struggles of older adults appear to be increasing, as 90% of older households experienced decreases in income and net value of wealth between 2014 and 2016.

12 The California Master Plan on Aging (2021) reports that "one quarter of people over 65 rely almost entirely on their Social Security benefits, which average about $1,500 per month for retired workers and $1,250 per month for disabled workers. With California's fair market rent for a one-bedroom apartment at $1,522, many older renters are left with little or no money for food, healthcare, and other expenses."

13 "Property rich, cash poor" is a term many key informants used to describe people who own real property or other assets but have a fixed and/or low income, and therefore have limited or no cash to draw from to pay expenses.

14 On 7/1/22, California increased the amount of assets an individual can have and still remain eligible for Medi-Cal, and will eliminate asset limits as a factor in eligibility on 1/1/24. These changes will increase the number of Aged, Blind, and Disabled (ABD) individuals newly eligible for Medi-Cal (and, by extension, other programs such as IHSS). This will increase access among some older adults and people with disabilities who own real property or other assets but have fixed and/or low income. However, monthly income for many will leave them ineligible.

15 The Kaiser Family Foundation (2015) reports that Medicare does not cover all services that those with dementia may need (particularly long term supportive services), and that Medicaid fills some gaps in coverage. However, states can place enrollment caps on home and community-based services available to beneficiaries with dementia resulting in long waiting lists for needed services.

16 Food Research & Action Center (2021) Hunger, Poverty, and Health During COVID-19

17 State of California Health and Human Services Agency (2020) Home Safe Program Fact Sheet

18 Beck, L. & Johnson, H. (2015) Planning for California's Growing Senior Population. San Francisco, CA: Public Policy Institute of California

19 A 2017 CWDA report indicated that 71% of California counties agreed that recruitment of qualified APS social workers is a challenge. Regarding IHSS, 61% of counties report challenges in recruiting qualified workers, and 57% of counties reported non-competitive salaries as the barrier to filling vacant positions.

20 Despite the rapidly growing older adult population, very few medical providers receive specialized training to prepare them for work with older people. A 2012 report by the Institute of Medicine "The Mental Health and Substance Use Workforce for Older Adults" estimated only 1 percent of nurses, 4 percent of psychologists and 4 percent of social workers receive training in or specialize in geriatrics.

21 In the Bay Area, all county AAS departments administer APS and IHSS. Most counties (7 of 11) also administer public guardian, public conservator, or public administrator programs (2021 BASSC County Adult Workforce Survey Report) and most (8 of 11) also oversee the local Area Agency on Aging (AAA). Napa and Solano share a single AAA, which operates under a joint exercise of power agreement between the two counties.

22 Howle, E. M. (2020). (rep.). In-Home Supportive Services Program: It Is Not Providing Needed Services to All Californians Approved for the Program, Is Unprepared for Future Challenges, and Offers Low Pay to Caregivers (pp. 1–87). 621 Capitol Mall, Suite 1200, CA: California State Auditor.

23 The California Legislative Analyst's Office (2018) finds that prior to 2009, the IHSS caseload grew, on average, by 7.5% annually. However, between 2009 and 2013, the IHSS caseload remained relatively flat. In more recent years, growth in the IHSS caseload has resumed, averaging about 5% annually.

24 Howle, E. M. (2020). (rep.). In-Home Supportive Services Program: It Is Not Providing Needed Services to All Californians Approved for the Program, Is Unprepared for Future Challenges, and Offers Low Pay to Caregivers (pp. 1–87). 621 Capitol Mall, Suite 1200, CA: California State Auditor.

25 Ibid.

26 Beck, L. & Johnson, H. (2015) Planning for California's Growing Senior Population. San Francisco, CA: Public Policy Institute of California.

27 These estimates are based on the Living Wage Calculator that estimates the hourly wage required for an individual to meet minimum standards given their local cost of living. While a number of counties have living wage ordinances that exceed the State minimum wage, these ordinances do not always apply to IHSS workers and/or are lower than the living wage estimate. The average IHSS provider rate in 2022 for the Bay Area was $16.88 per hour, while the average living wage was $25.75 per hour (see Appendix I, Table 9 and Figure 14).

28 Howle, E. M. (2020). (rep.). In-Home Supportive Services Program: It Is Not Providing Needed Services to All Californians Approved for the Program, Is Unprepared for Future Challenges, and Offers Low Pay to Caregivers (pp. 1–87). 621 Capitol Mall, Suite 1200, CA: California State Auditor

29 County of Santa Clara Social Services Agency (2022) Adult Protective Services FY 2021 Annual Report

30 The legal framework for this type of public conservatorship was established in the Lanterman-Petris-Short (LPS) Act of 1967; thus, this type of public conservatorship is also known as a LPS Conservatorship.

31 In California, counties are responsible for providing Public Conservators and Public Guardians, but have discretion in how services are organized. A 2021 survey found that most county Adult & Aging Services departments administer the Public Guardian program (69%) and the Public Conservator programs (58%). In over half of these counties, the PC/PG programs are "blended" or combined. (Workforce Survey, 2021)

32 In 2022, California's Community Assistance, Recovery, and Empowerment (CARE) Act (SB-1338) established a pathway for families, healthcare providers, and various government officials to refer adults with a diagnosed schizophrenia spectrum or other psychotic disorder to a court-ordered behavioral health "CARE plan" including medication, housing, and other services provided by county behavioral health systems. The CARE Act additionally targets unhoused adults with diagnosed substance use disorder. While intended to divert from conservatorship, non-compliance with a court-ordered CARE plan can result in LPS conservatorship or incarceration.

33 Chuang E, Carnochan S, Yang E, Davis EM, & Dill J. 2021 California Adult Social Services Workforce Report. Berkeley, CA: Bay Area Social Services Consortium, the Mack Center on Public and Nonprofit Management in the Human Services, and the California Social Work Education Center, School of Social Welfare, UC Berkeley. November 2021.

34 According to a 2021 AAS workforce survey, most counties across California (71%; 37 of 52) reported using the same job classifications to perform APS and CPS investigations. One-third of counties (33%; 17 of 52) reported different pay scales for APS and CPS workers with CPS staff being paid more (e.g., 5%–15% more); and in 5 of these counties, differences in pay occurred even when the same job classifications were used. Reasons provided for pay differentials included different funding streams, different job classifications, and use of workforce retention bonuses in CPS (but not APS).

35 Data from the 2020 and 2022 State of the Nonprofit Sector Survey indicate that 60% of social service organizations experienced destabilizing conditions during the pandemic, more than half struggled with limited staff availability, and 88% changed the way they work.

36 Public sector organizations increased their use of flexible work arrangements during the pandemic (Williamson et al. 2022). With annual turnover across all industries at ~30% (Pew Research Center, 2022), many organizations have elected to sustain flexible work arrangements to improve staff retention. In 2022, a study by the Pew Research Center found that ~60% of U.S. workers whose positions can be done remotely continue to work from home all or most of the time.

37 In 2021, most (9 of 11) Bay Area counties reported consistently allowing frontline staff to telecommute at least one day per week; the other two counties allowed it sometimes but did not yet have a formal policy in place (Chuang et al. 2021).

38 In order to become a licensed clinical social worker, marriage and family therapist, or professional clinical counselor, individuals must accrue a certain number of hours of work experience under the supervision of a licensed mental health professional.

39 USAging (2022) 2022 Policy Priorities.

40 Mentis (n.d.) Healthy Minds-Healthy Aging

41 County of Santa Clara Social Services Agency (2022) Adult Protective Services FY 2021 Annual Report

42 San Mateo's Elder Dependent Abuse Protection Team was funded through a 2016 ballot measure, and is implemented as a partnership between the San Mateo County's Health System's Aging and Adult Services, District Attorney's Office, and County Counsel's Office.

43 Howle, E. M. (2020). (rep.). In-Home Supportive Services Program: It Is Not Providing Needed Services to All Californians Approved for the Program, Is Unprepared for Future Challenges, and Offers Low Pay to Caregivers (pp. 1–87). 621 Capitol Mall, Suite 1200, CA: California State Auditor.

44 California's IHSS program is based on a consumer-directed model, meaning IHSS recipients are responsible for recruiting, scheduling, training, supervising, and replacing their own providers. The consumer-directed model allows for greater client choice and autonomy, and is less costly than a home care agency model, in which agencies staffed by nurses, social workers, or paraprofessional aides are reimbursed for providing care (Benjamin, Matthias, & Franke, 2000). However, it is not effective for IHSS recipients that lack the capacity to direct their own care.

45 California is in the process of eliminating asset tests in determining eligibility for Medi-Cal for older adults and adults with disabilities. On 07/01/22, the asset limit for individuals increased from $2,000 to $13,000; effective 01/01/24 the asset limit will be eliminated altogether.

46 Older Americans Act: Overview and Funding. Congressional Research Service brief to Congress. June 23, 2022.

47 In 2022, Medi-Cal included new Enhanced Care Management and Community Supports benefits that allow eligible enrollees to receive person-centered care management and non-clinical services that address health-related social risk factors, such as medically tailored meals and housing support. In 2023, institutional long-term care services will be carved-in to Medi-Cal managed care, providing greater financial incentive for health plans to integrate care across institutional, home, and community-based settings.

48 In 2027, the proportion of race and ethnic groups other than white among adults 60+ is projected to range from 16% to 58% across the Bay Area. By 2060, the Bay Area, the proportion of non-white older adults is expected to rise to: age 65-74 - 62%; age 75-84 - 61%; age 85+ - 58%.

49 World Health Organization (2021) Ageing: Ageism Q&A

50 Ibid.

51 The Pernicious Problem of Ageism, Laura A. Robbins, Generations: Journal of the American Society on Aging, Vol. 39, No. 3, Ageism in America: Reframing the Issues and Impacts (Fall 2015), pp. 6-9 (4 pages), Published By: American Society on Aging.

52 O'Neil, M. & Haydon, A. (2015). Aging, agency and attribution of responsibility: Shifting public discourse about older adults. Washington, DC: FrameWorks Institute.

53 The WHO Global Network for Age-friendly Cities and Communities was established in 2010 "to connect cities, communities and organizations worldwide with the common vision of making their community a great place to grow old in. It focuses on action at the local level that fosters the full participation of older people in community life and promotes healthy and active aging". The AARP Network of Age-Friendly States and Communities was established in April 2012 as an independent affiliate of the World Health Organization Global Network. AARP engages with elected officials, partner organizations and local leaders to guide communities through the age-friendly network's assessment, planning, implementation and evaluation processes.

APPENDIX I: DATA

Appendix I summarizes publicly available data on changing population demographics and on Adult Protective Services (APS) and In-Home Supportive Services (IHSS) programs in California and in the Bay Area. For the purposes of this report, "Bay Area" refer to the 11 counties participating in the Bay Area Social Services Consortium: Alameda, Contra Costa, Marin, Monterey, Napa, San Francisco, San Mateo, Santa Clara, Santa Cruz, Solano, and Sonoma.

Data sources include 2020 population projections provided by the California Department of Finance Demographic Research Unit, 2021 Elder Index data developed by the Gerontology Institute at the University of Massachusetts Boston, Living Wage data developed by the Department of Urban Studies and Planning at the Massachusetts Institute of Technology, 2020 US Census and American Community Survey data, and 2019-2022 APS Monthly Statistical Reports and IHSS data provided by the California Department of Social Services.

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CHANGING POPULATION DEMOGRAPHICS

Growing older adult population

Older adults aged 60+ years are the fastest growing age group in California (Figure 1). In 2020, there were 8.7 million older adults aged 60+ years, just over a fifth (22%) of the state's population. By 2060, this number is expected to increase to 14.2 million, at which point older adults will account for close to one third of the state's population (32%).

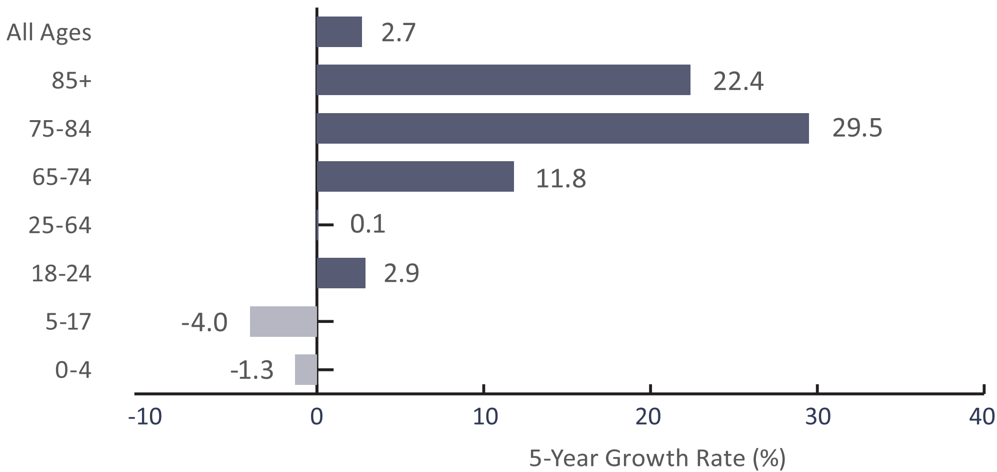

Figure 1 | California 2022-2027 population growth rate by age group

This trend is mirrored in the Bay Area (Figure 2), where the two fastest growing population groups are those aged 75-84 and 85+ years.

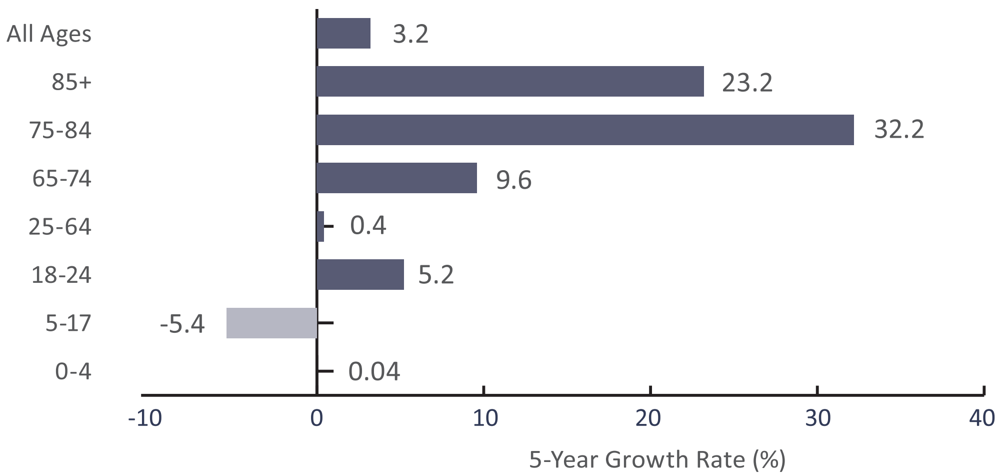

Figure 2 | Bay Area 2022-2027 population growth rate by age group

In all Bay Area counties except Monterey, older adults already outnumber children aged 0-17 years (Figure 3); Monterey's shift is projected to occur between 2028-2029.

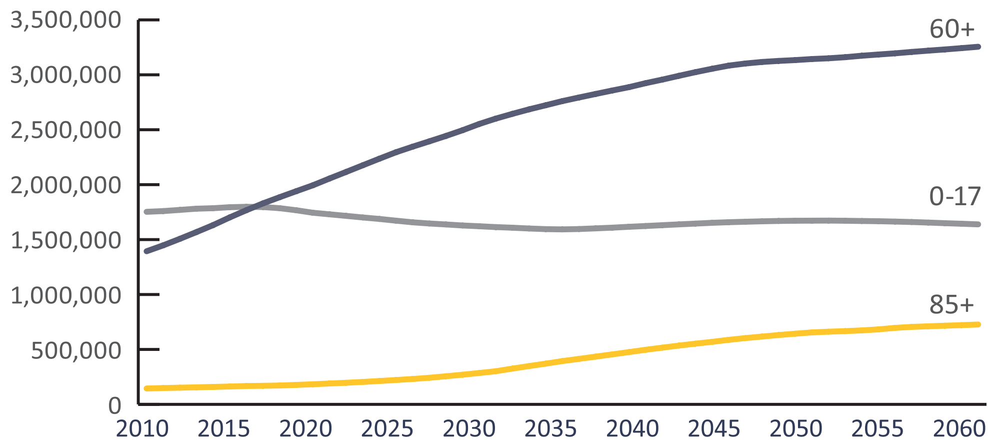

Figure 3 | Bay Area, Total population by age group, 2010-2060

Source: California Department of Finance. Demographic Research Unit. Report P-3: Population Projections, California, 2010-2060 (Baseline 2019 Population Projections; Vintage 2020 Release). Sacramento: California. July 2021. https://dof.ca.gov/Forecasting/Demographics/Projections/

Diverse older adult population

California is a diverse state. According to 2020 Census data, no single race or ethnic group constitutes a majority of the state's population. Latinos are the state's single largest race or ethnic group (39.4%), followed by Non-Hispanic Whites (34.7%).

Several Bay Area counties are among the most diverse in the state. In 2019, 62% of older adults aged 60+ years in California were of racial and ethnic groups other than white (Table 2 and 3). Population projections provided by the California Department of Finance's Demographic Research Unit suggest that the older adult population will only become more diverse over time (Figure 4, Table 1 and 2).

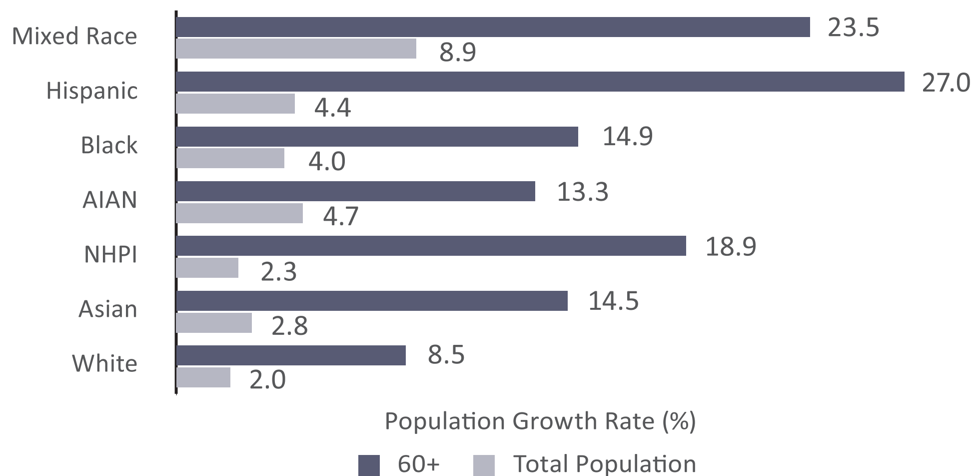

Figure 4 | Bay Area 2022-2027 population growth by race and ethnicity

Table 1 | Race and ethnicity by age group, 2022-2027 trends for California and Bay Area

	AIAN NH	Asian NH	Black NH	Hispanic	MR NH	NHPI NH	White NH
California	4%	2%	4%	4%	8%	2%	1%
0-4	4%	-11%	2%	1%	1%	-2%	-2%
5-17	5%	-2%	-1%	-9%	-1%	-6%	2%
18-24	0%	2%	0%	3%	7%	0%	3%
25-64	-3%	-2%	0%	5%	13%	-1%	-6%
65-74	12%	9%	19%	28%	24%	23%	4%
75-84	36%	31%	33%	37%	39%	37%	26%
85+	35%	22%	33%	26%	33%	33%	20%
Bay Area	5%	3%	4%	4%	9%	2%	2%
0-4	7%	-7%	5%	1%	3%	-3%	1%
5-17	8%	-6%	-1%	-11%	-4%	-8%	0%
18-24	10%	4%	-1%	6%	8%	0%	6%
25-64	-5%	1%	0%	5%	15%	-1%	-4%
65-74	13%	9%	15%	30%	25%	24%	4%
75-84	39%	33%	37%	38%	47%	39%	30%
85+	59%	19%	32%	25%	32%	28%	24%

Source: California Department of Finance. Demographic Research Unit. Report P-3: Population Projections, California, 2010-2060 (Baseline 2019 Population Projections; Vintage 2020 Release). Sacramento: California. July 2021. https://dof.ca.gov/Forecasting/Demographics/Projections/

Notes: 5-Year growth calculation = (2027 total - 2022 total) / 2022 total.

Table 2 | Minority race and ethnicity by age group as a proportion of the total California and Bay Area population, 2019 and 2060

	2019	2060
California	62%	66%
0-4	68%	56%
5-17	72%	66%
18-24	70%	67%
25-64	62%	67%
65-74	44%	65%
75-84	41%	63%
85+	39%	60%
Bay Area	59%	62%
0-4	66%	61%
5-17	69%	63%
18-24	68%	64%
25-64	59%	63%
65-74	43%	62%
75-84	42%	61%
85+	42%	58%

Source: California Department of Finance. Demographic Research Unit. Report P-3: Population Projections, California, 2010-2060 (Baseline 2019 Population Projections; Vintage 2020 Release). Sacramento: California. July 2021. https://dof.ca.gov/Forecasting/Demographics/Projections/

Notes: Minority race and ethnicity includes American Indian and Alaska Native, Asian, Black, Hispanic, Mixed Race, and Native Hawaiian and Pacific Islander.

Table 3 | Minority race and ethnicity as a proportion of the total California and Bay Area population, 2019, 2022, and 2027

	Actual		Projected			
	2019		2022		2027	
	All Ages	60+	All Ages	60+	All Ages	60+
California	62%	44%	62%	46%	63%	49%
Bay Area	59%	44%	59%	45%	60%	47%
Alameda	66%	54%	67%	55%	67%	57%
Contra Costa	54%	38%	55%	39%	56%	42%
Marin	29%	13%	29%	15%	30%	16%
Monterey	70%	44%	70%	46%	71%	51%
Napa	47%	24%	48%	26%	49%	30%
San Francisco	56%	59%	56%	59%	55%	58%
San Mateo	59%	45%	60%	46%	60%	48%
Santa Clara	66%	50%	67%	51%	67%	54%
Santa Cruz	43%	22%	44%	24%	45%	26%
Solano	61%	47%	61%	48%	62%	50%
Sonoma	36%	17%	36%	18%	37%	20%

Source: California Department of Finance. Demographic Research Unit. Report P-3: Population Projections, California, 2010-2060 (Baseline 2019 Population Projections; Vintage 2020 Release). Sacramento: California. July 2021. https://dof.ca.gov/Forecasting/Demographics/Projections/

Notes: Minority race and ethnicity includes all reported categories other than "white", American Indian and Alaska Native, Asian, Black, Hispanic, Mixed Race, and Native Hawaiian and Pacific Islander.

Heterogeneity in cost of Living: The Elder Index

The Elder Economic Security Standard Index (Elder Index) was developed by the Gerontology Institute at the University of Massachusetts Boston to measure the income older adults need to meet their basic needs and age in place with dignity. The Elder Index includes estimated costs of housing, health care, transportation, food and miscellaneous essentials, and estimates are adjusted based on household size, location, housing tenure, and health status.

Figure 5 summarizes estimated annual cost of living for older adults who are single, renters, and in poor health in California. On average, cost of living for older adults is much higher in the Bay Area than in California as a whole: $41,275/year or $3,440/month in Bay Area compared to $34,008/year or $2,834/month in California. Annual income eligibility limit for Medi-Cal is $18,755 for a single adult, or 138% of the federal poverty level.[1]

1 Department of Health Care Services. (2022, February 28). Do you qualify for Medi-Cal Benefits? Do You Qualify? | Medi-Cal Eligibility. Retrieved October 12, 2022, from https://www.dhcs.ca.gov/services/medi-cal/Pages/DoYouQualifyForMedi-Cal.aspx

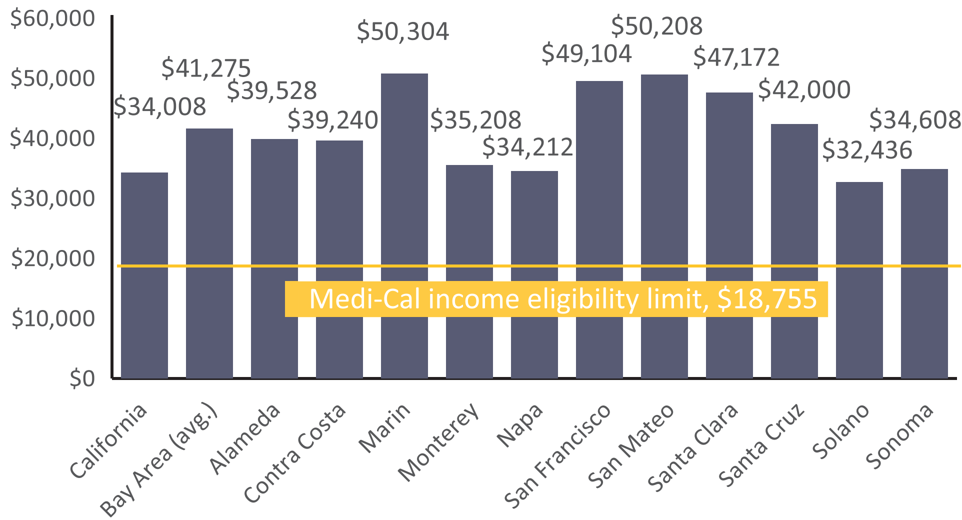

Figure 5 | Annual cost of living for older adults (single, renters) in poor health, 2022

Table 4 provides a more detailed breakdown of estimated monthly expenses for an older adult who is single, renting, and in poor health in the Bay Area. These data suggest that higher cost of living in Marin, San Francisco, and San Mateo can be explained primarily by differences in housing costs (average $2,695/month in these counties compared to $1,953 in the Bay Area as a whole and $1,470 statewide).

In July 2022, the asset limit that determines eligibility for Medi-Cal greatly increased from $2,000 per person and $3,000 for two people to $130,000 for an individual and $65,000 for each additional person.[2] Additionally in May 2022, all financially eligible individuals aged 50 and older, regardless of immigration status, became eligible for full-scope Medi-Cal benefits. These modifications to Medi-Cal eligibility largely increased the number of those eligible for Medi-Cal and enabled beneficiaries to retain more assets. The median household income for those 65 years and older is much lower than the overall California median income ($57,034 compared to $78,672 in 2020).[3]

Furthermore, the average living wage for single adult with no children living in the Bay Area is $25.75/hour, compared to the California average of $21.82/hour.[4] Both these wages are above the California minimum wage of $15.00/hour.

2 Department of Health Care Services. (2022, October 10). Asset Limit Changes for Non-MAGI Medi-Cal. Retrieved October 12, 2022 from https://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/Asset-Limit-Changes-for-Non-MAGI-Medi-Cal.aspx

3 U.S. Census Bureau. (2020). 2020 American Community Survey 5-Year Estimates Detailed Tables [Excel data file]. Retrieved from https://data.census.gov/cedsci/table?D=ACS%205-Year%20Estimates%20Detailed%20Tables

4 Glasmeier, Amy K. Living Wage Calculator. 2020. Massachusetts Institute of Technology. Livingwage.mit.edu.

Table 4 | Estimated monthly expenses for an older adult aged 65+ years who is single, renting a 1-BR apartment, and in poor health

	Monthly Total	Housing[1]	Food	Health[2]	Transportation	Misc.[3]
California	$2,834	$1,470	$275	$536	$255	$298
Bay Area	$3,440	$1,953	$275	$626	$259	$326
Alameda	$3,294	$1,795	$275	$651	$250	$323
Contra Costa	$3,270	$1,795	$275	$623	$250	$327
Marin	$4,192	$2,695	$275	$607	$250	$365
Monterey	$2,934	$1,305	$275	$712	$321	$321
Napa	$2,851	$1,356	$275	$569	$319	$332
San Francisco	$4,092	$2,695	$275	$568	$250	$304
San Mateo	$4,184	$2,695	$275	$630	$250	$334
Santa Clara	$3,931	$2,437	$275	$632	$255	$332
Santa Cruz	$3,500	$1,940	$275	$712	$236	$337
Solano	$2,703	$1,246	$275	$642	$236	$304
Sonoma	$2,884	$1,522	$275	$539	$236	$312

Source: Elder Index.

[1] Rent expenses based on US Department of Housing and Urban Development Fair Market Rents, which typically reflect the 40th percentile of rent costs in an area for a one-bedroom apartment.

[2] Health care costs drawn from the Centers for Medicare and Medicaid Services, and include average Medicare Part B health insurance premiums and out-of-pocket costs, assuming Medicare Advantage with either prescription coverage or separate Medigap Supplement and Medicare Part D coverage.

[3] Miscellaneous expenses include all other essentials, such as clothing, household items, personal hygiene items, and telephone. These expenses are estimated at 20% of all other costs, and do not allow for recreation, entertainment, gifts, or savings.

ADULT PROTECTIVE SERVICES PROGRAM DATA

In California, Adult Protective Services (APS) support older adults 60+ years old and adults affected by disabilities who are victims of abuse, neglect, or exploitation or who are unable to meet their own needs. APS staff investigate reports of alleged abuse or neglect and provide clients with assistance needed to ensure their safety and well-being. Depending on client need, services provided could include advocacy, counseling, emergency shelter, food, referral to medical or behavioral health services, assistance with money management, or conservatorship. Table 5 displays the total number of average new APS cases open and unduplicated reports of alleged abuse per month per county for California, the Bay Area, and each of the Bay Area counties in the first six months of 2022.

Table 5 | Average total APS cases open and unduplicated APS reports of alleged abuse per month per county in California and Bay Area, 2022

	New Cases Open	Reports Alleged Abuse
California	287	362
Bay Area	252	341
Alameda	401	527
Contra Costa	281	478
Marin	93	126
Monterey	152	204
Napa	62	86
San Francisco	604	760
San Mateo	168	197
Santa Clara	441	625
Santa Cruz	138	182
Solano	140	160
Sonoma	296	411

Source: Adult Protective Services (APS) Monthly Statistical Report (SOC 242) FY 2021-22, https://www.cdss.ca.gov/inforesources/research-and-data/disability-adult-programs-data-tables/soc-242

Note: Data includes all counties' reports from January, February, March 2022. BASSC counties include Alameda, Contra Costa, Marin, Monterey, Napa, San Francisco, San Mateo, Santa Clara, Santa Cruz, Solano, Sonoma. Total cases include elder and dependent adult cases.

As shown in Figure 6, in 2020 counties received an average of 330 unduplicated reports of alleged abuse. Number of unduplicated reports did not differ significantly between California and the Bay Area, or between 2020 and 2022.

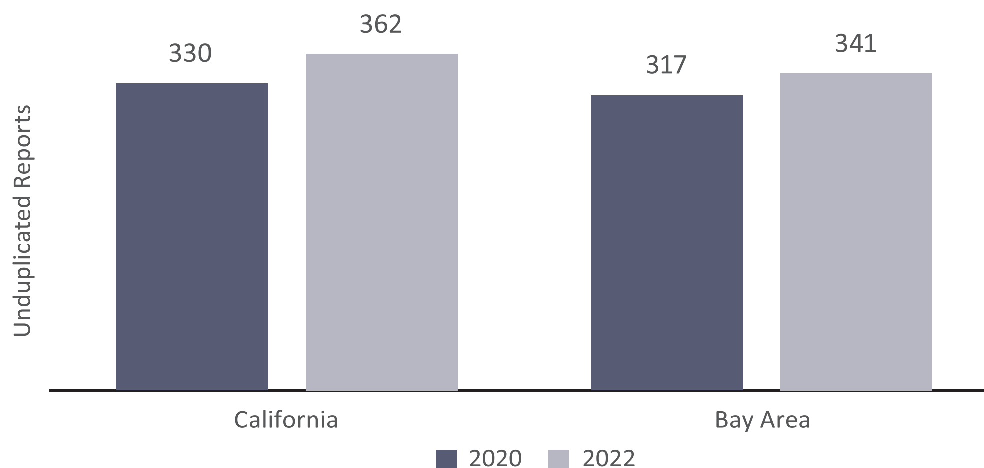

Figure 6 | Average unduplicated APS reports of alleged abuse per month per county

Source: Adult Protective Services (APS) Monthly Statistical Report (SOC 242) FY 2019-2020, 2020-21, 2021-22, https://www.cdss.ca.gov/inforesources/research-and-data/disability-adult-programs-data-tables/soc-242.

Note: Data includes all counties' reports from January, February, and March from 2020 and 2022. BASSC counties include Alameda, Contra Costa, Marin, Monterey, Napa, San Francisco, San Mateo, Santa Clara, Santa Cruz, Solano, Sonoma. Data missing for Alameda (May 2022), Napa (April and May 2022), and Marin (June 2022). Total cases include elder and dependent adult cases.

Average new APS cases open and total APS cases open per month were lower in the Bay Area than in California, and varied across Bay Area counties (Figures 7-9). Differences between California and the Bay Area in new APS cases and total cases open could likely be attributed to differences in county population (Figure 8) and APS system capacity.

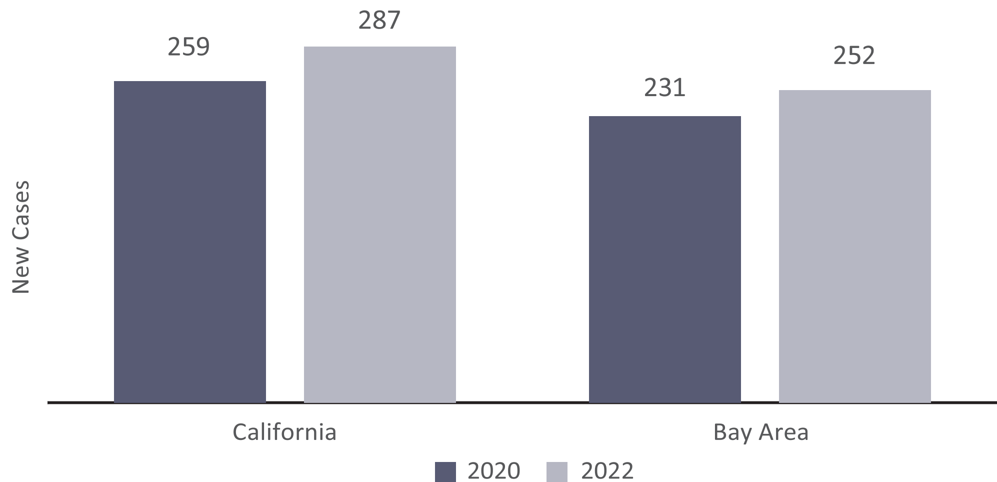

Figure 7 | Average total new APS cases open per month per county

Source: Adult Protective Services (APS) Monthly Statistical Report (SOC 242) FY 2019-2020, 2020-21, 2021-22, https://www.cdss.ca.gov/inforesources/research-and-data/disability-adult-programs-data-tables/soc-242.

Note: Data includes all counties' reports from January, February, and March from 2020 and 2022. BASSC counties include Alameda, Contra Costa, Marin, Monterey, Napa, San Francisco, San Mateo, Santa Clara, Santa Cruz, Solano, Sonoma. Data missing for Alameda (May 2022), Napa (April and May 2022), and Marin (June 2022). Total cases include elder and dependent adult cases.

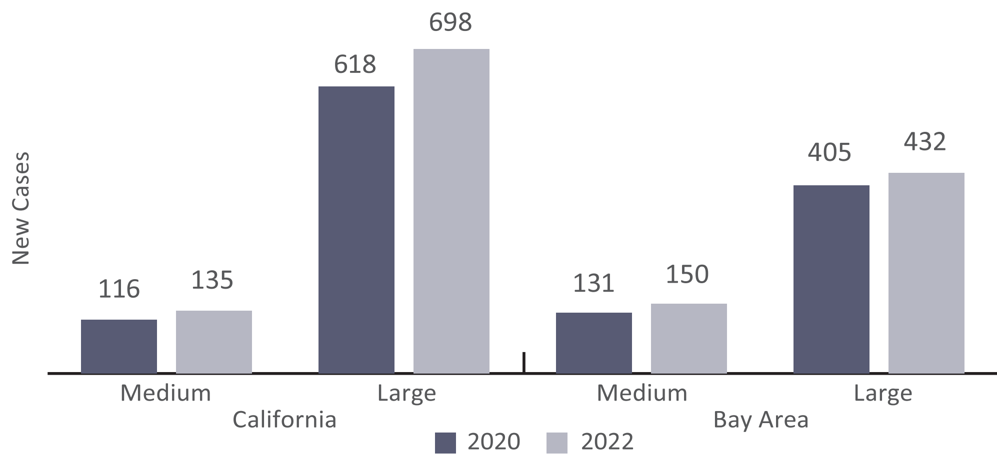

Figure 8 | Average total new APS cases open per month by county size

Source: Adult Protective Services (APS) Monthly Statistical Report (SOC 242) FY 2019-2020, 2020-21, 2021-22, https://www.cdss.ca.gov/inforesources/research-and-data/disability-adult-programs-data-tables/soc-242.

Note: Data includes all counties' reports from January, February, and March from 2020 and 2022. BASSC counties include Alameda, Contra Costa, Marin, Monterey, Napa, San Francisco, San Mateo, Santa Clara, Santa Cruz, Solano, Sonoma. Data missing for Alameda (May 2022), Napa (April and May 2022), and Marin (June 2022). Total cases include elder and dependent adult cases.

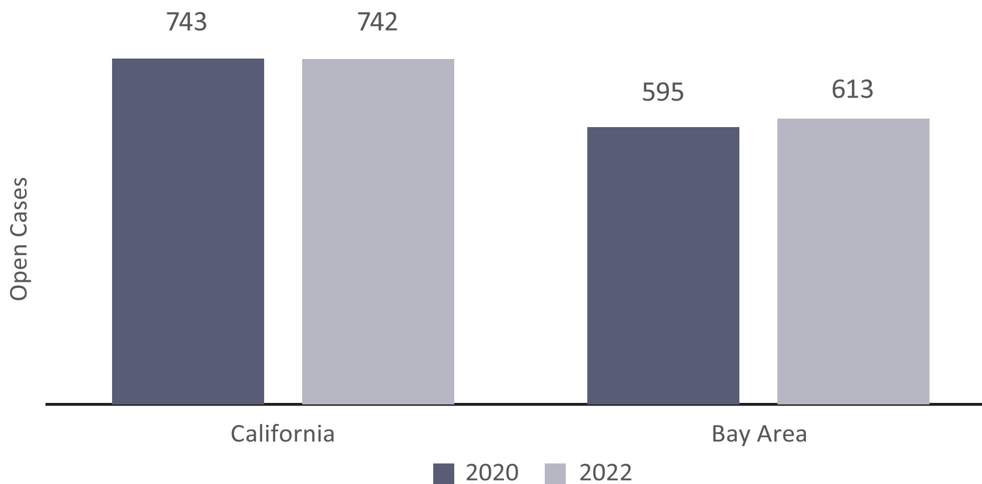

Figure 9 | Average total APS cases open per month per county, 2020 and 2022

Source: Adult Protective Services (APS) Monthly Statistical Report (SOC 242) FY 2019-2020, 2020-21, 2021-22, https://www.cdss.ca.gov/inforesources/research-and-data/disability-adult-programs-data-tables/soc-242.

Note: Data includes all counties' reports from January, February, and March from 2020 and 2022. BASSC counties include Alameda, Contra Costa, Marin, Monterey, Napa, San Francisco, San Mateo, Santa Clara, Santa Cruz, Solano, Sonoma. Data missing for Alameda (May 2022), Napa (April and May 2022), and Marin (June 2022). Total cases include elder and dependent adult cases.

Financial abuse

Financial abuse, i.e., the illegal or improper use of an individual's funds or property for another person's profit or advantage, is among the fastest-growing forms of elder abuse and can have significant consequences for victims (Weissberger et al 2021). As shown in Table 6, in 2020, **financial abuse accounted for 39% of abuse allegations in California and 37% of allegations in the Bay Area**. The proportion of financial abuse allegations increased slightly from 2020 to 2022, but these differences were not significant.

Table 6 | Proportion of allegations involving financial abuse: California, BASSC region, and by county, 2020 and 2022

	Proportion of Financial Abuse Allegations	
	2020	**2022**
California	39%	41%
Bay Area	37%	38%
Alameda	37%	37%
Contra Costa	42%	39%
Marin	48%	49%
Monterey	37%	33%
Napa	39%	33%
San Francisco	32%	33%
San Mateo	37%	45%
Santa Clara	40%	41%
Santa Cruz	37%	34%
Solano	35%	31%
Sonoma	35%	39%

Source: Adult Protective Services (APS) Monthly Statistical Report (SOC 242) FY 2019-2020, 2020-21, 2021-22

Note: Data includes all counties' reports from January, February, March of 2020 and 2022. BASSC counties include Alameda, Contra Costa, Marin, Monterey, Napa, San Francisco, San Mateo, Santa Clara, Santa Cruz, Solano, Sonoma.

IN-HOME SUPPORTIVE SERVICES PROGRAM DATA

In California, the In-Home Supportive Services (IHSS) program provides in-home assistance to eligible aged, blind, or disabled individuals to help them remain safely in their homes. There are four different IHSS programs, each with varying eligibility requirements, funding mechanisms, and rules governing spousal caregiving. Under IHSS, recipients receive care from a provider of their choice. California does permit family members to serve as IHSS providers, and in fact the majority of IHSS providers are related to recipients. Counties are responsible for administering these IHSS programs, conducting orientation and background checks of selected providers, assessing recipient eligibility and authorizing service hours, negotiating and setting hourly provider wages, and overseeing quality assurance, among other duties. In San Francisco, IHSS "contract mode" is available to support IHSS recipients without capacity to hire and manage their own IHSS providers.

Increased demand for IHSS

The growing population of older adults in California, coupled with recent Medi-Cal expansions, have resulted in increasing numbers of individuals eligible for IHSS. From January through June 2019 to 2022, the per-county average number of recipients entering IHSS as "aged" or "disabled" significantly increased in California and in the Bay Area (Figure 10). In the Bay Area, the percentage of "aged" IHSS recipients was significantly higher than in California as a whole (Table 7).

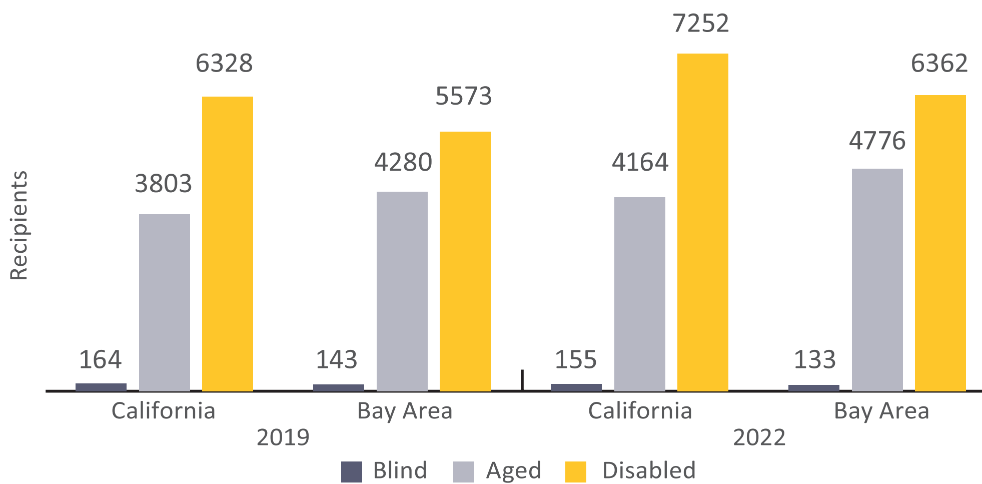

Figure 10 | Average number of aged, blind, or disabled IHSS recipients per month per county, Jan-June 2019 and 2022

Source: Department of Social Services, In Home Supportive Services Data, 2022, https://www.cdss.ca.gov/inforesources/ihss/program-data.

Note: Data represents average of all reports from January to June 2019 and 2022. BASSC counties include Alameda, Contra Costa, Marin, Monterey, Napa, San Francisco, San Mateo, Santa Clara, Santa Cruz, Solano, Sonoma. All results significant ($p < 0.0001$).

Table 7 | Average number aged, blind, disabled IHSS recipients per month per county, Jan-June 2019 and 2020

	Aged		Blind		Disabled	
	2019	2022	2019	2022	2019	2022
California*	3,803	4,164	164	155	6,328	7,252
Bay Area*	4,280	4,776	143	133	5,573	6,362
Alameda	9,423	10,362	321	306	14,800	15,730
Contra Costa	3,275	3,751	166	170	7,072	9,347
Marin	606	672	23	22	1,307	1,399
Monterey	1,683	1,719	79	71	3,271	3,777
Napa	393	451	17	16	793	877
San Francisco	12,930	14,492	316	280	9,364	10,327
San Mateo	2,640	3,132	77	69	2,611	3,099
Santa Clara	12,206	13,835	371	342	12,336	14,766
Santa Cruz	797	894	53	47	1,911	2,015
Solano	1,592	1,672	90	76	3,314	3,559
Sonoma	1,532	1,554	67	64	4,525	5,084

Source: Department of Social Services, In Home Supportive Services Data, 2022, https://www.cdss.ca.gov/inforesources/ihss/program-data

* Data represents average of all counties' monthly reports from January to June of 2019 and 2022.

Between 2019 and 2022, average new IHSS applications and application denials per month increased in the Bay Area (Figure 11). However, in 2022 there were more new applications and application denials in California than the Bay Area on average, and large counties in California had significantly more applications and denials on average than counties of a similar size in the Bay Area (Table 8). This difference is due to large counties outside of the Bay Area (e.g., Riverside, San Bernardino, San Diego) reporting nearly three times the average new applications per month than Bay Area counties of a similar size (e.g., Alameda, San Francisco, Santa Clara).

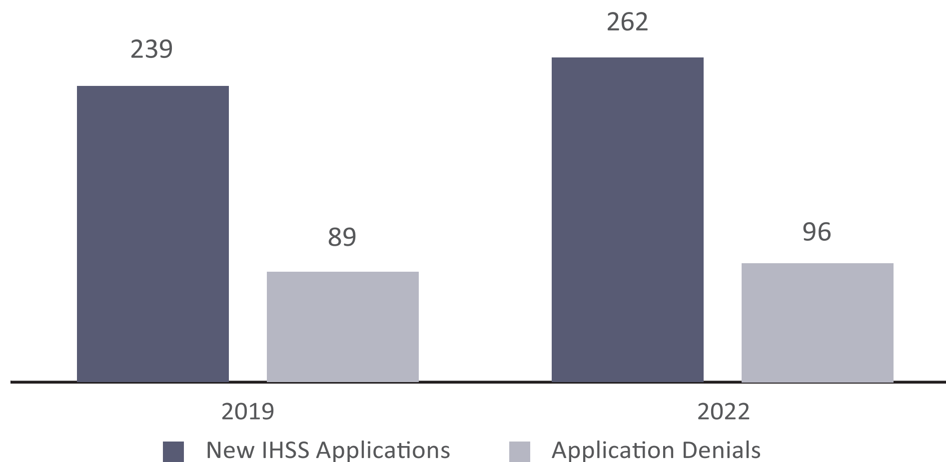

Figure 11 | Average new IHSS applications and application denials per month per county, Jan-June 2019 and 2022

Source: Department of Social Services, In Home Supportive Services Data, 2022, https://www.cdss.ca.gov/inforesources/ihss/program-data

Note: Data represents average of all counties' monthly reports from January to June of 2022.

Table 8 | IHSS Demand – Average IHSS applications and denials per month, Jan-June 2022

	Applications	
	New	**Denials**
California	**314**	**136**
Large County	**841**	**337**
Medium County	**146**	**61**
Bay Area	**262**	**96**
Large County	**497**	**174**
Alameda	642	228
Contra Costa	370	152
San Francisco	485	133
Santa Clara	490	182
Medium County	**128**	**52**
Marin	43	7
Monterey	164	60
Napa	33	8
San Mateo	198	91
Santa Cruz	65	20
Solano	192	85
Sonoma	204	91

Source: Department of Social Services, In Home Supportive Services Data, 2022, https://www.cdss.ca.gov/inforesources/ihss/program-data

Note: Data represents average of all counties' monthly reports from January to June of 2022.

In addition, from January through June 2019 to 2022, the average authorized hours increased in all age groups in California and in the Bay Area (Figure 12). In 2022, Bay Area counties authorized significantly more hours per recipient than California as a whole; this trend was significant across all age groups.

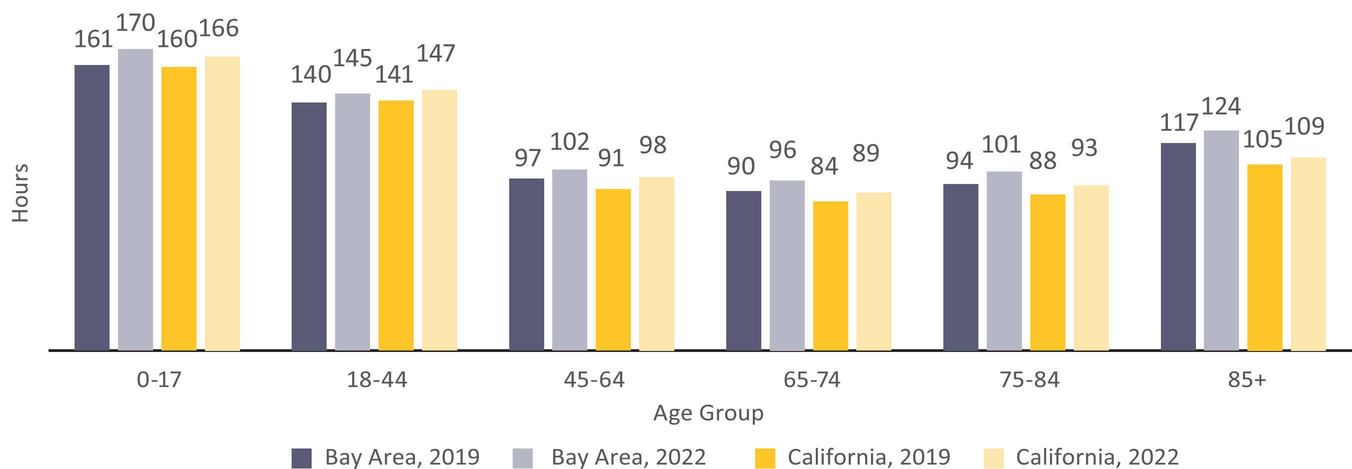

Figure 12 | Average authorized hours per IHSS recipient per month, Jan-June 2019 and 2022

Source: Source: Department of Social Services, In Home Supportive Services Data, 2022, https://www.cdss.ca.gov/inforesources/ihss/program-data.

Note: Data represents average of all counties' monthly reports from January to June of 2019 and 2022. BASSC counties include Alameda, Contra Costa, Marin, Monterey, Napa, San Francisco, San Mateo, Santa Clara, Santa Cruz, Solano, Sonoma. All results significant ($p < 0.0001$).

IHSS provider wages

Many IHSS recipients do not receive services for which they qualify, in part due to difficulty with recruitment and retention of qualified IHSS providers.[5] In 2022, the majority (71%) of IHSS providers were relatives or spouses of IHSS recipients and over half (55.3%) were live-in providers. As the number of older adults grows, IHSS recipients unable to rely on relatives or spouses for support may experience even more difficulty recruiting and retaining IHSS providers.

Low wages for IHSS providers contribute to recruitment and retention challenges. In California, the average IHSS provider wage is typically not much more than minimum wage.[6] For example, in 2019, the average IHSS provider wage in California was $12.36/hour, slightly above the minimum wage of $12/hour for employers with 26+ employees.

On average, Bay Area counties have higher IHSS provider wages than other counties in California (Table 9). These differences persist even after adjusting for differences in county size (Figure 13). For example, in 2022, average IHSS provider wages were $16.97/hour in large Bay Area counties (e.g., Alameda, San Mateo) compared to $16.15/hour in other large California counties (e.g., San Diego, Sacramento).

Table 9 | Average IHSS Provider Wage Rate by Bay Area County, 2019 and 2022

	Wage Rate	
	2020	**2022**
California	$12.36	$15.81
Bay Area	$13.31	$16.88
Alameda	$13.40	$16.75
Contra Costa	$12.25	$16.00
Marin	$14.60	$16.85
Monterey	$13.00	$16.49
Napa	$12.10	$16.45
San Francisco	$15.67	$18.00
San Mateo	$13.90	$17.70
Santa Clara	$13.50	$17.12
Santa Cruz	$12.46	$17.75
Solano	$12.50	$16.20
Sonoma	$13.00	$16.35

Source: Department of Social Services, In Home Supportive Services Data, 2022, https://www.cdss.ca.gov/inforesources/ihss/program-data

Note: Data represents average of all counties' monthly reports from January to June of 2019 and 2022.

5 California State Auditor Report 2020-109. In-Home Supportive Services Program. February 2021. https://www.auditor.ca.gov/pdfs/reports/2020-109.pdf

6 Minimum wage data drawn from the California Department of Industrial Relations. IHSS provider wage rate drawn from the California Department of Social Services In-Home Supportive Services data.

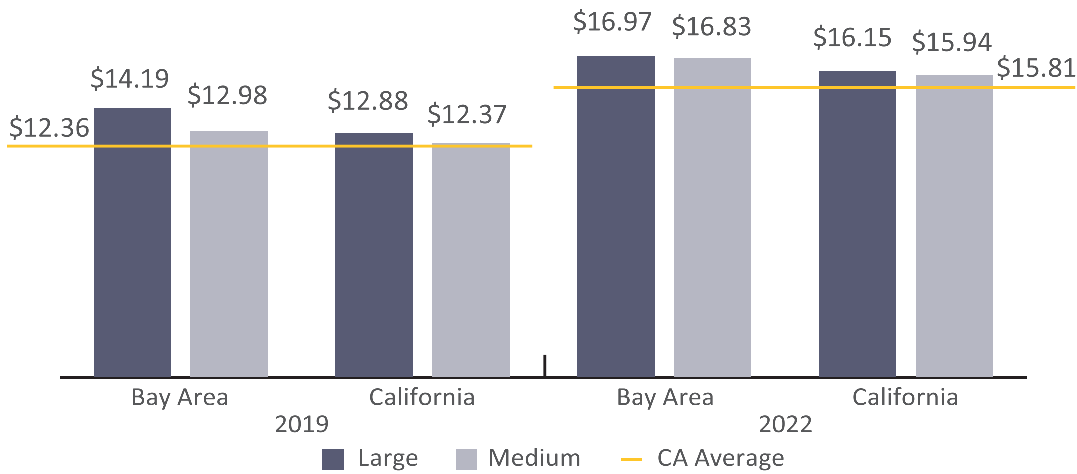

Figure 13 | Average IHSS Provider Wage Rate by County Size, 2019 and 2022

Source: Department of Social Services, In Home Supportive Services Data, 2022, https://www.cdss.ca.gov/inforesources/ihss/program-data

Note: Data shows average wage rates for medium and large counties from January to June in 2019 and 2022. BASSC counties include Alameda, Contra Costa, Marin, Monterey, Napa, San Francisco, San Mateo, Santa Clara, Santa Cruz, Solano, Sonoma.

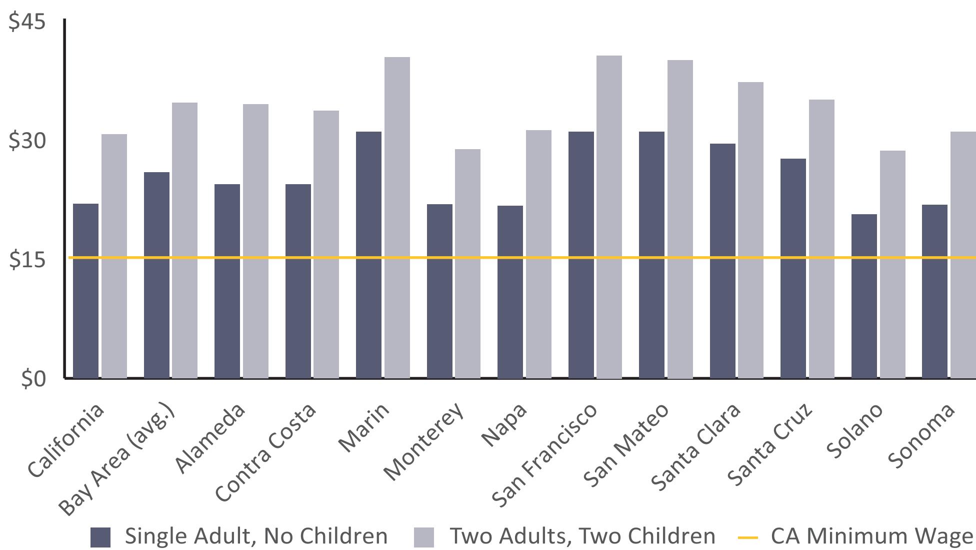

Figure 14 | Living Wage for Adults in California and Bay Area, 2022

Source: Glasmeier, Amy K. Living Wage Calculator. 2020. Massachusetts Institute of Technology. livingwage.mit.edu

Note: California minimum wage is $15.00/hour for employers with 26 or more employees, and $14.00/hour for employers with 25 or less employees (Department of Industrial Relations).

APPENDIX II: CASE STUDIES

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A. Alameda: Council for Age-Friendly Communities

OVERVIEW

Alameda County's Council for Age-Friendly Communities (Council) is a collaborative, cross-sector group focused on improving coordination of health and human services and programs for older adults as well as policy and system change efforts, using a framework of healthy aging, aging in place, and aging with dignity. The multidisciplinary group brings together county departments, cities, community-based organizations, consumers, and other stakeholders. The Council does not engage directly in service delivery; rather, its members examine how policies and programs are implemented to identify gaps, reimagine systems, advocate and achieve buy-in.

The Council was established in 2017 per a directive of Alameda's board of supervisors (BOS) to address growing concerns surrounding misconceptions about the needs of older adults and the capacity of the county's continuum of care to meet the diverse needs of the growing population of older adults. As part of its efforts to develop innovative, equitable service strategies for aging in place with dignity, the Council has considered the county's highly diverse population of older adults; examined historical inequities and equity biases prevalent in established programs; and used a healthcare lens in examining gaps and connecting people with county resources and services. The Council works to elevate policy matters and share resources and innovations implemented throughout the county.

HOW THE COUNCIL WORKS

The Council is co-chaired by the director of the Alameda County Public Health Department and the Assistant Agency Director for the Department of Adult and Aging Services (AAS), with the AAS Assistant Agency Director acting as facilitator for the monthly meetings. Council membership is based on member recommendations. Members are typically executive directors or individuals identified by executive directors to represent community-based and county agencies (e.g., PACE, day centers, senior housing, community development, emergency services, district attorney's office). Community-based member organizations play a vital role as subject matter experts. Additionally, each county district has a representative that sits on the council. For a current list of members, visit https://agefriendly.acgov.org/af-efforts/af-council.

Workgroups and subcommittees, whose membership may be distinct from the larger council, act "as more of the boots on the ground in the actual day-to-day work," reporting on their activities to the Council:

- **Age-Friendly Communities Committee:** Responsible for drafting the county's Age-Friendly Workplan to be implemented over the next two to three years, with a focus on health and wellness, outdoor spaces and buildings, transportation, social participation and inclusion, volunteering, civic engagement, community information, employment and learning opportunities, and housing.
- **Digital inclusion and telehealth work group:** Conducted a needs assessment of digital divide issues among seniors that identified gaps related to broadband access, training and devices, generating recommendations to provide broadband at low/no cost, and digital navigators to assist with device use and digital safety and security (https://agefriendly.acgov.org/af-efforts/internet-survey).
- **Embracing Aging training committee:** Develops and offers trainings including: a geriatric workforce enhancement training program in partnership with UCSF; a training series with IHSS Public Authority Department for professional caregivers; and a Social Worker Training Program focused on supporting older adults who are caring for grandchildren or navigating the foster care system. See https://agefriendly.acgov.org/af-efforts/embracing-aging-training.

- **Housing Workgroup:** Focuses on the needs of unhoused older adults, including supporting shelters, monitoring rent moratoriums, and collaborating with the Alameda Wellness Center to develop a wraparound service campus to house unhoused adults and operate as a one-stop shop for IHSS, medical services, and case management.
- **Legislation and Advocacy Committee:** Chaired by the Senior Services Coalition executive director, a network of community-based providers in Alameda County, the Committee writes issue briefs and focuses on state legislative and budget initiatives (e.g., CalAIM, Aging & Disability Resource Connection design).

FUNDING

The Council does not have a dedicated operating budget. Rather, the healthcare services and the social services agencies oftentimes "will pull together and help support some of the initiatives." For example, a Social Security Administration training coordinator supports the Embracing Aging Training Committee and its workforce development initiatives.

IMPACT AND KEY TAKEAWAYS

Evaluations of the Council's Embracing Aging workforce development initiative demonstrate success at increasing staff knowledge about aging. Policy advocacy by the Council and its workgroups/committees was also described as contributing to recent changes to the Medi-Cal asset limit and to IHSS. Key contributing factors to the success of the Council include the involvement and input of the county's BOS, the BOS's decision to focus on linking healthcare and social services, and the robust participation of community-based organizations. Inclusion of multiple public and private partners from different sectors at the table was perceived as critical for allowing Council members to engage in meaningful discussion of systematic and social inequities present within the community, and how to begin breaking down service access barriers for vulnerable county residents.

ILLUSTRATIVE QUOTES

"Social services and healthcare services paired together is a strong partnership… Those services should be paired together and partnered to better provide better quality care for the Alameda County residents… It's super important that our board chose healthcare and social services to join together, and then the Council took it and added in that community-based organization structure."

"We have to come together… To really address those needs of older adults…you have to have all those partners at the table … to talk about what the barriers are and why those services are not in some of our most vulnerable communities and address the inequities and social inequities, systemic inequities… to be really real around how we can address those social gaps for the older adult population..."

B. Contra Costa: Transforming In-Home Supportive Services (IHSS)

OVERVIEW

In California, the state evaluates county-administered In-Home Supportive Services (IHSS) programs to ensure that required intake assessments and annual re-assessments of IHSS cases are being carried out in a timely manner, to ensure that aged and disabled clients are receiving necessary services. In fiscal year 2020/2021, Contra Costa's intake assessment performance was determined to be among the worst in the state. In fiscal year 2021/2022, the new director of Adult and Aging Services (AAS) and new manager of the IHSS program made changes to how the program was administered, including reforms related to staffing and workflow, and were able to increase compliance while improving social worker morale.

WHAT IS IHSS?

In-Home Supportive Services (IHSS) is a publicly funded home care program that pays for services to eligible aged, blind and disabled individuals who are unable to remain safely in their own homes without assistance. Recipients must have a Medi-Cal eligibility determination and live in their own home. IHSS provides an alternative to out-of-home care (e.g., skilled nursing facilities, assisted living or board and care facilities) by assisting with the most common activities of daily living according to the needs of the individual. This assistance may include help with housekeeping, grocery shopping, meals, and transportation, as well as more complex needs such as spoon feeding, breathing equipment, toileting or incontinence-related needs, and medication management.

County IHSS social workers carry out in-home assessments to determine eligibility, including the types and hours of assistance needed to prevent institutionalization. Counties are required to re-assess each case annually, reviewing whether changes to services are needed, or a referral to Adult Protective Services is warranted in cases where abuse or neglect are occurring.

CONTEXT FOR CHANGE

The state evaluates counties on both IHSS intake and reassessment compliance. In fiscal year 2020/2021, the evaluation found that Contra Costa's performance was among the worst in the state. Contra Costa was substantially out of compliance with intake and reassessment, with only a little over 40% of applications assessed on time.

In addition to a high staff vacancy rate, the incoming AAS director and IHSS manager identified the following issues as slowing assessment and reassessment of cases:

- Social workers were holding initial IHSS applications while waiting for applicants to submit the medical form required to qualify clients for services.
- Social workers might receive a new case months into the 90-day processing period, making it very difficult to complete the application in a timely manner.
- One team of 14 social workers was assigned to manage intake assessments, while another team handled re-assessment of active cases. However, slow processing of intake resulted in active case social workers being asked to take on intake assessments in addition to their typical workload, contributing to resentment and low morale.

TRANSFORMING CONTRA COSTA'S IHSS PROGRAM

To address these issues, the program manager developed a proposal to reform the intake and reassessment process, and shared it with key stakeholders, including Medi-Cal partners, the Public Authority and the county call center, to ensure these entities would not be affected negatively. In October 2021, a number of changes were implemented, including revisions to the timing of case assignments and responsibility for intake assessments:

- Intake cases are distributed weekly, as soon as they come in, before the required medical form is submitted. When a social worker receives a case, they are expected to conduct the intake interview with the client right away, enabling them to advocate for the client and assist them to complete the required paperwork.
- The distinction between intake social workers and reassessment social workers was dismantled; all social workers now manage a mix of intake and ongoing cases.
- The program manager worked with clerical staff to ensure that they were trained in how to input data correctly to ensure that program statistics are more reliable. This enables the program manager to accurately assess case status and communicate priority cases to staff.
- Commute times are taken into consideration when assigning intake cases.

IMPACT

Contra Costa increased their compliance for IHSS intake and reassessment. Timely assessments increased from 22.78% in July 2021 to over 94% in October 2021, and remained over 90% throughout the remainder of the fiscal year. Social workers appreciate the reforms because they can start advocating for their clients earlier, and are less impacted by staff vacancies since they are cross trained in both intake and reassessment. Clients also benefit because the wait time for services has been reduced dramatically, they receive support filling out the form that qualifies them for services, and are more likely to work with a single social worker.

ILLUSTRATIVE QUOTES

"When the opportunity came up for In-Home Supportive Services, I knew that our department was struggling and I really wanted to be a part because I know that individual players and I know that individually, we have really strong and hardworking staff so that there was a break in some process flow and I really thought that I could contribute to the improvements for Contra Costa County so that it more reflects the strength of the individuals doing the work."

"Changing our process flow is we now assign the applications out once a week, they're assigned to a worker. And the expectation is that they're going out to visit a client prior to that form coming out, because then they can see the need and they can really put that social work and that advocacy in there. If that paperwork doesn't come back, they can really help facilitate and help that client on why it's important, but that we're still meeting that requirement."

C. Community-Based Organization: Meals on Wheels San Francisco System Redesign

WHAT IS MEALS ON WHEELS?

Meals on Wheels San Francisco (MOWSF) is a home-delivered meal assistance program that reaches nearly 4,000 people in their homes daily to deliver food, monitor client condition (e.g., safety checks), and reduce isolation. Many MOWSF clients are homebound and/or live alone and the meals delivered are a regular source of both food and human interaction.

Five years ago, MOWSF moved from a paper-based client tracking system to a Salesforce-based customer relationship management (CRM) platform and staff-facing mobile application. This enabled the program to have more control over its data systems, respond to live client/program data, and better understand the needs of its clients.

BACKGROUND

Over the past 15 years, MOWSF has tripled in the number of clients served, providing over two million meals per year. As the program grew so did the age range and case complexity of the clients served. In order to be more responsive in providing meals and monitoring the condition of clients, MOWSF determined that it needed to change the way data was collected, maintained, and utilized.

MOWSF initially used a paper system and an “off-the-rack”/proprietary/non-adaptable database (Microsoft Enterprise) before building their own software platform using SalesForce with the support of a consulting firm. Today, the program has a platform that enables it to operate nimbly in a variety of settings; however, it took longer than expected and required years of fundraising, roadmapping, and planning. Overall, the development and implementation of the software platform took roughly four years and $500,000.

In addition to using the SalesForce database to track active clients, MOWSF also uses the data to drive logistics like routing and mapping, real-time reporting on delivery, client condition monitoring and visit follow-up. The internal app enables field/delivery staff to report on the condition of their clients with whom they have direct engagement (e.g., reporting sad, neutral, or happy faces directly via the app). Reporting a negative condition triggers an immediate follow-up response from a dedicated staff member who calls the client, and involves a care-taker/family member or emergency services, as necessary.

IMPACT

MOWSF’s data system has enabled them to respond to changing environments, adapt and expand their programming, and achieve positive outcomes for their clients.

The software platform and app were in place before the COVID-19 pandemic began which facilitated the pandemic response of both MOWSF and the City. The familiarity with- and adaptability of- their system enabled MOWSF to quickly develop no-touch delivery and restructure delivery frequency to support staff-to-staff and staff-to-client physical distancing. When the City of San Francisco transitioned city workers away from managing their isolation and quarantine food program, MOWSF stepped in to manage the program, operating all day every day (24/7/365) to deliver food to those in isolation and track their isolation status. Additionally, MOWSF leveraged the data system to provide meals to seniors once the FEMA Great Plates program ended, onboarding 600 clients in 30 days, in addition to regular programming.

Systematic collection of data enables MOWSF to practice client condition monitoring as an official component of programming, alongside meal delivery. The ability to report on condition monitoring has established that this model of street- and neighborhood-level engagement is more impactful for clients than simple drop-off delivery. It has supported the program's preparedness to contract as a future CalAIM Community Supports provider, or other potential avenues of healthcare integration.

The platform enables efficient and high quality internal impact evaluation. The process of generating reports on client status by category now takes a matter of minutes, whereas formerly it required a half day. This functionality supports management decision-making and quality improvement efforts.

KEY ACCOMPLISHMENTS

- Improved client conditions through tracking non-medical indicators (e.g., client appearance, demeanor, etc.) and responding in real-time to clients who need additional support
- Increasing the number and diversity of clients served while responding to variation among clients with respect to technological access, literacy, and preferences
- Assumed management of SF City COVID-19 quarantine food program operating 24/7; developed a participant call response and isolation status tracking system within days
- Upon end of FEMA Great Plates program, filled gap to serve meals to 600 home-bound seniors in SF and San Mateo counties
- Annual client satisfaction survey and internal evaluation run through SalesForce, rather than paper and spreadsheet
- Two full-time staff dedicated to maintaining the platforms which now include their volunteer management, integrated fundraising and financial software systems, with plans to eventually fully integrate all program data

ILLUSTRATIVE QUOTES

"…So, [having quick access to robust client data] I think from a management point of view is almost immeasurably important when you're trying to make investments and make not just quantity decisions, but quality decisions. Nonprofits tend to count numbers and not quantify or qualify things as often as we should…And so, for me, I really want to know in the client satisfaction data, where are we doing well and where are we failing? And can we even see who we're failing?"

"[At the start of the COVID-19 pandemic] think back, people were just totally separated and most people were locked in their homes for the first six months. So, we were able to, within a period of days to totally redesign our delivery structure to be a one-person delivery system and to be able to reduce as much as possible the number of times we would have to touch every client each week, because some people were being seen every day, Monday through Friday with weekend meals. And we moved as many people as possible to twice a week. And we did that in 10 days. If we didn't have this app or we had to call up a vendor to say, Hey, we need to rechange this entire structure. We have never been able to do that."

D. Marin: "One Door"

WHAT IS "ONE DOOR"?

Marin's One Door initiative aims to provide a "one stop shop" to help clients navigate the array of services and supports available to older adults, adults with disabilities and family caregivers within the county.

BACKGROUND

Marin's Aging & Disability Resource Connection (ADRC) is a joint effort between county Adult & Aging Services (AAS) and the Marin Center for Independent Living (CIL) to provide four types of services to the community:

1. Enhanced information and assistance - going beyond sharing contacts and following up to make sure clients are able to connect to services
2. Options planning - providing resources and advising on available options based on client needs and priorities
3. Short term service coordination - 90-day short-term service coordination to help clients experiencing complex challenges address these needs
4. Community transitions - to help clients living in residential care facilities such as skilled nursing return to their own homes/spaces

To fulfill the ADRC's role as an "entry point for pretty much all aging and disability services," AAS and CIL worked together to create "One Door Marin." One Door is a free service that assists clients in locating and connecting with resources, such as housing navigation, food assistance, transportation, financial assistance, benefits assistance, and in-home caregiving, among others. Through the One Door dedicated telephone line and website, the ADRC aims to provide older adults, adults with disabilities, and family caregivers a single access point to various services available within the county.

KEY ACCOMPLISHMENTS AND TAKEAWAYS

People seeking information and resources for older adults, persons with disabilities, or family caregivers can access One Door by calling a local information number (415.473.INFO) to speak with a person, or digitally by filling out a form online whereby a team member will follow up with clients via email. Information and Assistance (I&A) social workers assist callers with clarifying needs and respond to inquiries about the range of services and related resources available. I&A social workers are available to respond to inquiries Monday through Friday from 8:30 a.m. – 4:30 p.m. Spanish translation is available during business hours, and translation services for multiple other languages are available for scheduling. Designing the ADRC to serve as the entry point for services, via phone, website or physical location, enables consumers to access intake or referral for multiple related services during a single encounter (e.g., Adult Protective Services, In-Home Supportive Services, Meals on Wheels, referral to the Long-Term Care Ombudsman's office, etc.)

In recent months, One Door was introduced to the Marin community through an extensive public marketing campaign. One Door promotional and branding materials were also presented at the statewide ADRC committee in March 2022. In branding and marketing One Door, the ARDC partners elected to replace the original, double negative "No Wrong Door," terminology with the more positively oriented "One Door" approach. The marketing campaign includes commercials (print and online) and social media strategies to inform people how to access their services. Consumer-friendly illustrations and simple information for calling in or completing an online form to receive email follow-up from program staff are provided in English and Spanish. A case vignette illustrating positive impact of One Door on a client is available in Appendix III.

ILLUSTRATIVE QUOTES

"Do you ever wish there was a one stop place to help you navigate the bewildering maze of Marin County support programs? Well, now there is. It's One Door. At One Door, a real person assists you in locating services for older adults, people with disabilities and family caregivers. And there's no charge for One Door. At One Door, we connect you to the appropriate resource, regardless of your preferred language or residency status. So when you need assistance, access the right door, One Door."

"[Integration] can be a little bit challenging because [we are] definitely two programs, [and so] sometimes it's not the most efficient for staff. But on the other hand it makes the collaboration a lot easier. We don't have to worry about information sharing. All of our staff have both systems and oftentimes one case that comes in through our APS line, we can actually kick it over to IHSS if it has to do with caregiving and things like that. So it's a nice setup."

E. Monterey: Integrated Service Model

OVERVIEW

The Aging and Adult Services Branch (AAS) of the Monterey County Department of Social Services (Department) is taking a holistic and multi-generation service delivery approach to support clients and their families. Key components of the approach include service coordination, cross-training for program staff, and the physical design of the facilities where AAS is co-located with CalWORKS Employment Services (CWES) and the Monterey County Veteran Services Office (the “La Guardia location”).

BACKGROUND

Monterey County’s AAS Branch includes the IHSS program, Adult Protective Services, SSI advocacy program, the Public Authority, and the Monterey County Area Agency on Aging (AAA). The AAS director also serves as the deputy director of the CWES Branch, where she oversaw a tremendously successful campaign that applied a holistic and whole family approach to employment and self-sufficiency services. Upon entering the adult and aging services arena, the AAS director drew on her previous experience with CWES to address the silos she observed within and among the AAS programs, and across the Department of Social Services.

KEY ACCOMPLISHMENTS AND TAKEAWAYS

Under the current director’s leadership, the AAS is developing a more holistic approach to meet the needs of clients and their families by creating “a multi-generation service delivery model.” The La Guardia location where AAS is co-located with CWES and more recently Veteran Services, is a key component of this coordinated service model, bringing together AAS programs with programs serving other client populations. In addition, most of the AAS staff have been consolidated to operate out of this location, with the exception of a group of social workers in South County.

The majority of the Department’s client families, particularly Latinx families, are living with multiple generations in a single household. As a result, different Branches and programs within the Department are often serving the same families. Accordingly, the AAS director implemented cross-training and coordination of AAS and CWES staff and services at the La Guardia location, aiming to provide broader and more comprehensive access for clients. For example, when a client enters the building, they are greeted at the front desk by a representative who is trained to inquire about the client’s needs and is able to direct them to the appropriate services. Internal information sharing tools and short trainings (e.g., “spotlight” trainings previously used internally for CWES) are used to cross-train and highlight a different program each month for CWES and Aging and Adult Services. This would enable clerical staff to seamlessly refer visitors to the appropriate offices and services when entering the facility. The initial trainings spotlighted various aging and adult services (e.g., IHSS, the application process, information and referral, APS, identifying main contacts, etc.). Additional trainings have educated AAS staff about CWES and the resources for clients’ family members who may need jobs or may already be taking care of their aging family members (e.g., informing them they may be eligible for compensation as caregivers, etc.)

With respect to the La Guardia location, a concerted effort was made to create an inviting, inclusive environment that made consumers feel respected and “didn’t have poverty…written all over it.” To do this, the Department completely redesigned the lobbies, included state-of-the-art television screens and furniture, added a children’s area with reading materials, and incorporated murals by local artists in the lobby design. Visitors are

greeted with three large murals as they walk in, highlighting the landscape of Monterey County and depicting a matronly figure reading to a multi-ethnic group of children.

IMPACT

The cross-training of clerical staff from both AAS and CWES resulted in greater coordination between the Branches, and clerical staff were able to connect clients to the appropriate program or service more seamlessly. To support service coordination, the cross-trained their IT and clerical staff on their separate data systems to better track the flow of clients. The spotlight cross-trainings on aging and CWES programs have also been instrumental in enabling staff to "connect [the] dots… and help the famil[ies] in a holistic way."

Visitors to their physical space seeking services are visibly comforted by the environment and made to feel "this is a good place and people make me feel welcome," versus feeling resistant, belittled or embarrassed by seeking out the services. Program staff also feel uplifted by their working environment; simply because they "work for Social Services, [it doesn't] mean the buildings … have to be the most dilapidated, old, broken down buildings that you have… [rather, it's a place] that our community … and our customers…deserve."

ILLUSTRATIVE QUOTES

"I wanted [staff] to be cross-trained because I want to say if a client comes in and they say, 'I'm interested in IHSS services,' there's not a receptionist there saying, 'Oh, I'm sorry, hold on. I just work with CWES, so let me get you an aging, clerical support person.' That doesn't work, right? It should be seamless to our families that are coming in. The main thing is like, 'Okay, what are your needs?' And then them trying to connect them with the right staff."

"…knowing the data, anyone walking in the door could be your relative, at least there's a 50% chance. So, let's treat everyone as if it is somebody you care and love … and they deserve that dignity, professional and respect."

F. Napa County: Healthy Aging Population Initiative

WHAT IS HAPI?

The Healthy Aging Population Initiative (HAPI) is a collaborative network of 25-30 public and nonprofit agencies serving older adults in Napa. HAPI's purpose is to assess and identify priorities for older adults in the community, develop and implement community-appropriate plans and programs for addressing these priorities, and advocate for more age-friendly policies and responses.

BACKGROUND

HAPI was founded in 2004 by a local mental health provider interested in better serving older adults in the community. HAPI members meet monthly, and also periodically host larger, public "summits" or conferences to support regional collaboration and learning on specific topics (e.g., addressing ageism). HAPI is facilitated by two co-Chairs; one of the co-Chairs is the Executive Director of a local nonprofit specializing in care for older adults and individuals facing transitions at the end of life, and the other is an elder law attorney and representative of the Napa County Commission on Aging. Participation in HAPI is voluntary, with no cost to member agencies. Members include a wide range of nonprofits in the community (e.g., community-based service providers, advocacy groups), as well as the Advisory Council to the local Napa/Solano Area Agency on Aging (N/S AAA).

Until 2015, HAPI's work was supported by a paid, part-time facilitator responsible for convening meetings, leading community needs assessment efforts and facilitating development of strategic action plans to guide HAPI's work. Since the facilitator's retirement in 2015, HAPI has been led by the co-Chairs; the co-Chairs are committed to HAPI but acknowledge the loss of the facilitator has negatively affected HAPI's capacity to engage in strategic planning and advocacy. The facilitator position was originally funded by a local health system's community benefit program until an institutional merger eliminated this as a viable funding source. In 2022, HAPI successfully advocated to secure funds from Napa County to support engaging a consultant to work with HAPI on an updated needs assessment, service mapping, and the development of an updated strategic plan. HAPI anticipates these activities will help the county maximize use of currently available federal funding opportunities to better meet the needs of its rapidly aging population.

IMPACT

HAPI is viewed as an important vehicle for bringing key stakeholders together to collaboratively improve care for older adults in Napa County. HAPI members have successfully collaborated to raise over $2.5 million in extramural grants to support development of new initiatives, many of which were later sustained by member organizations. HAPI has also facilitated collective advocacy within Napa County for community, institutional, and governmental responses and policies that are more age- and disability-friendly.

Key accomplishments include:

- Conducted surveys in 2005 and 2015 to identify and prioritize older adult needs in the community, each completed by more than 1,000 older adults.
- Created HAPI Rides, a volunteer-run, voucher-based transportation program for older adults who are unable to drive.
- Developed and implemented StopFalls Napa Valley, a falls prevention program that offers free home safety assessments and assistive device installations (e.g., grab bars, toilet seat risers).

- Secured MHSA funding to develop and implement Napa's Healthy Minds, Healthy Aging Program, a prevention and early intervention program for older adults aged 60+ years who show early signs of depression or cognitive decline. The program is administered as a partnership between several nonprofits and Napa County's Adult & Aging Services division.
- Partnered with N/S AAA to integrate and expand access to information and assistance for older adults in the county.

ILLUSTRATIVE QUOTES

"HAPI has been about strategic partnerships, integrated programming, and advocacy... We gathered data to identify priorities in our community… , created logic models of what we wanted our system to look like for older adults, and then evaluated what our organizations had in terms of capacity to bring these services based on this larger strategy."

"The approach we take with HAPI is that everybody's input is valuable. We make time every month for people to share things that are important within their agencies. We are an instant support network. If people are applying for money and need letters of support, not just from HAPI members but other partners, we'll do that… There's a flavor of the group that is collaborative, welcoming, warm, and I think that goes a long way."

G. San Francisco: Dignity Fund

OVERVIEW

San Francisco's Dignity Fund was established in 2016 through a voter-approved charter amendment to enhance funding for social services for older adults and adults with disabilities in the community. Funds are administered by the San Francisco Department of Disability & Aging Services (DAS) to community-based organizations (CBOs) in accordance with a rigorous community needs assessment and planning process. Funding was initially set at a baseline allocation of $38 million and increased by $6 million in FY 2017-2018. Additional $3 million increases are planned each year through FY 2026-27 except in years when the city experiences a budget deficit. The Dignity Fund's certainty of funding has significantly increased the budget for DAS, helped stabilize a robust network of CBOs in the community, and improved equity/prioritized funding for historically disadvantaged groups and underserved neighborhoods.

BACKGROUND & STAKEHOLDERS

The Dignity Fund legislation is the result of a strong tradition of community advocacy and the visibility of DAS in San Francisco; it was brought to ballot by community advocates with long-standing connections and service provision to the county's diverse communities. Advocates designed the initiative based on similar funding mechanisms available for the SF Department of Children, Youth and Their Families, in order to set aside county funding specifically for services for older adults and adults with disabilities. These funds allow for provision of services that are more robust than would be possible with only federal Older Americans Act (OAA) funding.

FUNDING & ADMINISTRATION

On a four-year cycle, DAS, which is also the Area Agency on Aging (AAA), disseminates Dignity Funds from San Francisco's General Fund to CBOs. The cycle begins with a Community Needs Assessment to identify service gaps and unmet needs (SFHSA webpage) which informs a Services and Allocation Plan that outlines the service and funding strategies to advance key priorities over the next four years. An oversight and advisory committee includes specific community members (e.g., appointments from the mayor, the Long Term Care Coordinating Council, and the AAA Advisory Council) and monitors the administration of the Fund to ensure accountability to the community (OAC Site).

Funds may be used for home and community-based care, self-advocacy and legal services, and food and nutrition programs, among other categories outlined in DAS requests for proposals (DF Coalition Site), but cannot be used to pay for medical services or to purchase property.

HOW IS THE DIGNITY FUND UNIQUE OR DIFFERENT?

Though administered by a government entity, the Dignity Fund provides the flexibility needed to meet the varying and changing needs of CBOs in San Francisco. For example, in the event there are unspent funds within a program year, the funds do not revert back to the General Fund where they may be reallocated to address other City priorities, but instead remain in the Dignity Fund. This flexibility allows DAS to work with CBOs to identify current needs and work with them to make the best use of the funds in order to meet those needs. The dependability and flexibility of funding enable DAS and CBOs to coordinate long-term strategies to meet the needs of older adults and adults with disabilities in San Francisco. For example, data from DAS are used to support CBOs in their efforts to understand funding utilization over time and identify changing population needs (e.g., changing demographics in neighborhoods may require a shift in client groups CBOs should be serving).

PERCEIVED IMPACT

San Francisco leaders describe the Dignity Fund as integral to the success of aging and disability services. The Dignity Fund has increased the stability and specialization of aging services in San Francisco, improving access among diverse communities. The growth of the Dignity Fund over time in a way that mirrors the growing size and needs of the aging population is also critical to its success. The additional funding has allowed DAS the flexibility to expand and enhance services, and provide more specialized services to meet unique needs. Further, the planning and evaluation process required of the Fund strengthens the county's AAA planning and coordination. The community advocacy integral to the establishment of the Fund continues to shape San Francisco's long-term approach to aging services.

ILLUSTRATIVE QUOTES

"We have a lot more flexibility than we've had in the past because we do have more funding. And I think we're able to be more strategic about the programs that we are funding. We think of the programs that we fund really on a continuum. And we are able to support programs for people who are thriving…"
- DAS Director

"[The Fund has enabled DAS to be] able to enhance and support some of the more bread and butter AAA programs like Home Delivered Meals, we're able to go beyond Home Delivered Meals and we're providing specific ethnic cuisines to meet specific preferences for different cultural groups. We've got a pretty robust, medically tailored meal program as well."

H. San Mateo: CalAIM Enhanced Care Management and Community Supports Provider

OVERVIEW

In 2022, San Mateo's Adult & Aging Services (AAS) successfully contracted with the county's Medicaid managed care plan as a CalAIM Enhanced Care Management (ECM) and Community Support (CS) provider of health and social services case management and other supportive services needed to help older adults and adults with disabilities live independently and safely within the community. Factors that contributed to San Mateo AAS success in contracting with a Medicaid managed care plan, as well as early lessons learned during the first six months of CalAIM implementation, relate to the presence of a local health plan, beneficiary engagement methods, and eligibility requirements.

BACKGROUND

San Mateo's Adult & Aging Services (AAS) is embedded within San Mateo County Health (County Health), and is responsible for administering a number of programs for older adults and adults with disabilities in the community. San Mateo's AAS has robust experience providing health and social services case management for older adults and individuals with disabilities via its Multipurpose Senior Services Program (MSSP), Linkages program, and Coordinated Care Initiative, and through County Health's participation in Medi-Cal Health Homes Program and Medi-Cal Whole Person Care Pilot Program. AAS has a centralized intake line that allows individuals to be referred to the most appropriate program(s) for their needs.

On January 1, 2022, California began implementing CalAIM, a multiyear initiative for transforming the state's Medi-Cal program. Two key components of CalAIM are the new Medi-Cal Enhanced Care Management (ECM) and Community Supports (CS) benefits, which allow eligible beneficiaries to receive intensive care coordination and community supports needed to address their clinical and non-clinical medical and social needs. San Mateo successfully contracted with the county's Medicaid managed care plan as an ECM provider for high-utilizers and those at-risk of institutionalization, and a CS provider of caregiver respite and personal care and homemaker services. San Mateo also successfully transitioned MSSP enrollees to the new ECM benefit. MSSP was administered by the California Department of Aging, while ECM is administered by the Medicaid managed care plan which has very different policies and requirements.

CRITICAL SUCCESS FACTORS AND LESSONS LEARNED IN THE TRANSITION TO CALAIM

- A unique feature of the San Mateo context that likely facilitated the transition to CalAIM is that the county's Medicaid managed care plan (Health Plan of San Mateo) is a local non-profit county organized health system (COHS). The presence of a local health plan allowed for co-location of the managed care plan and AAS staff, which in turn streamlined communication and strengthened collaborative ties between staff.
- Another unique feature of San Mateo is the location of AAS within County Health rather than in a separate human services agency. AAS oversees both operation of ECM and In-Home Supportive Services (IHSS). As a result, San Mateo was able to structure its ECM and IHSS programs so that social workers served both ECM and IHSS beneficiaries. This approach removed the need for coordination between ECM and IHSS social workers and reduced risk of care fragmentation and delay of services for Medi-Cal beneficiaries eligible for both ECM and IHSS. One consideration of using this approach is that social workers must be trained in both ECM and IHSS.

- One key lesson learned in implementing ECM and CS is the need for careful attention to how to successfully engage and enroll eligible beneficiaries. Early referral processes from the Health Plan of San Mateo led AAS staff to conduct numerous "cold calls," to beneficiaries, as a result of which, less than 30% of eligible beneficiaries who were referred to AAS actually enrolled in services.
- Changes in Medi-Cal eligibility requirements resulted in higher IHSS enrollment. Increased IHSS enrollment was perceived as placing further strain on a system that is already struggling with a shortage of IHSS care providers, particularly for clients with cognitive and behavioral health needs. Careful attention to the extent to which IHSS recipients are able to use authorized hours is warranted to ensure beneficiaries are receiving needed services. Attention to impact on ECM referrals will also be important.

ILLUSTRATIVE QUOTES

"Our program design means that my ECM social worker is also the IHSS social worker…this means whenever there's a client that needs increased IHSS hours or requests, the ECM provider doesn't need to contact the IHSS social worker in another county department to coordinate request for visit and reassessment… we can just adjust it right away… We don't duplicate funding. Budgetarily, we have a certain percentage of funds coming from ECM and a certain percentage from IHSS."

"Right now, working with the [Medicaid managed care plan], requires a lot of communication on how to make it better… We have regular meetings with the health plan [but]... right now a lot of things are still one way, in the sense that the referral comes from the health plan and members can't call them, they're not really doing outreach. Referrals now come from the health plan, and they use their own methodology to run them. How are they identifying them? Most likely the individuals who cost more, or are frequent fliers to the medical system. But that is not what a true Medi-Cal program is for… [so] we're still communicating with the [Medicaid managed care plan] on how to make the program work for participants."

I. Santa Clara County: Seniors' Agenda Program

OVERVIEW

Seniors' Agenda is a program within Santa Clara County's Department of Aging & Adult Services focused on helping the county become more Age-friendly. Key accomplishments of the program include helping all 15 cities in the county join the World Health Organization's Global Network of Age-friendly Cities and Communities and participating in the Dementia Friends initiative.

BACKGROUND

In 2011, the Santa Clara County Board of Supervisors commissioned an assessment and three-year strategic action plan to guide county efforts to better meet the needs of older adults in eight domains of livability. Santa Clara County subsequently used General Fund dollars to create a Seniors' Agenda program within the Department of Aging & Adult Services to help Santa Clara County become "the most Age-friendly county in the world." The Seniors' Agenda program is administered by a single, full-time manager and has an annual budget of >$30,000. The project manager is responsible for implementing the county's strategic action plan, which follows a five-year cycle and is informed by a survey assessment of opinions, needs, and challenges of older adults within Santa Clara. Strategic action plans are developed through a highly participatory process involving over 60 community stakeholders and are implemented via issue-specific workgroups (e.g., housing, transportation, food insecurity).

IMPACT

In the U.S., local Area Agencies on Aging (AAAs) play an important role in advocating for the needs of older adults, as well as in planning, coordinating, and in some cases directly providing services in the community. In Santa Clara County, the AAA is administered by a nonprofit rather than by the county. The Seniors' Agenda program helps ensure that the county maintains a leadership role in meeting the needs of older adults within the community. Dedicated funds for a full-time project manager also allow for focused attention on building the relationships with county agencies and community-based organizations needed to enact change in the eight domains of livability (e.g., housing, transportation).

KEY ACCOMPLISHMENTS

In 2018, Santa Clara became the first county in the nation to have all of its cities designated as Age-friendly by the World Health Organization. For cities, the Age-friendly designation required completing an application and assessment and obtaining a letter of support from the Mayor. Seniors' Agenda hired a consultant group to support cities in this process and help identify champions (either on city council, city staff, or among older adults living in the community) to advocate for the actions needed to achieve the Age-friendly designation. Becoming Age-friendly is viewed as important for ensuring the needs of older adults are consistently considered and incorporated in policy and program development.

Other accomplishments of the Seniors' Agenda program include:

- Organizing bi-annual summits to raise awareness of issues facing older adults nationally and in the local community, report on progress and key accomplishments in becoming more Age-friendly, and provide networking opportunities for participants.

- As part of a broader effort to become a more dementia-friendly community, Santa Clara County joined the global Dementia Friends initiative, to help raise awareness of the nature and impacts of dementia.
- Organized a workgroup involving over 40 organizations in the community to develop a white paper on promoting digital inclusion for older adults in the county which has facilitated advocacy efforts to secure state and county funds to support digital access and training in technology use for older adults.
- Growth in volunteer driver programs for older adults (from three to seven programs across the 15 cities in the county)

ILLUSTRATIVE QUOTES

Role of Seniors' Agenda program
"We don't have an AAA within our county agency. It is a nonprofit. So… what makes the Seniors' Agenda unique is… partnerships. Before, the county was siloed – we had APS, Public Guardian, IHSS, and Senior Nutrition. The Seniors' Agenda put the county in more of a leadership position on aging and gave them more of a spotlight… [The project manager] is like a truck driver, driving from one silo to the other to build connections and coordinate with other county departments and also the nonprofits out in the community."

Critical success factors
"It is really important to have relationships. So what I invest in is meeting people one-on-one and establishing a relationship and seeing what they're interested in."

J. Santa Cruz: Design Team

OVERVIEW

The Design Team (DT) was created in 2016 to provide an opportunity for multilevel, cross-disciplinary staff engagement in development and implementation of initiatives, projects, and change management efforts within Santa Cruz County's Division of Adult and Long-Term Care (see ALTC Accelerated Strategic Planning 2017-2018.pdf). The DT is comprised of division leaders and representatives from each ALTC unit that work together to assess community and program needs and develop and implement new initiatives. The DT has enhanced engagement and development of the ALTC workforce and resulted in expansion of services within existing ALTC programs and creation of several new programs.

BACKGROUND

The DT was developed by the ALTC Services Division Director in coordination with the Human Service Department's Organizational Development manager in response to staff survey results indicating poor trust and lack of communication between management and line staff (see ALTC Survey group tool 2016.pdf). The DT sought to improve communication and staff engagement by providing a mechanism for leadership to work collaboratively with staff on ALTC needs assessment, problem-solving, program design, and implementation.

HOW THE DESIGN TEAM WORKS

The DT includes at least one representative from each unit in the ALTC. DT participation is voluntary and unit representatives are rotated every two years in order to provide everyone in the division an opportunity to work with leadership to identify ALTC needs and design and implement programs or services. All division leaders (e.g., social work supervisors, program managers, and the Division Director) attend DT meetings. The DT is responsible for working with the Division Director to develop and implement the ALTC strategic plan. Each year, the DT reviews results from an annual staff survey and helps the Division Director formulate focus group discussion questions and identify two to three priority areas of focus for the coming fiscal year. Work in each priority area is led by a subcommittee co-chaired by one division leader and one line staff member; subcommittees are responsible for working with different stakeholders to implement DT plans, and report on progress at DT meetings. Periodically, the DT also offers training for line staff members to build professional skills (e.g., meeting facilitation).

DT meetings occur monthly or bi-monthly depending on project needs and workload constraints. Meetings are co-facilitated by the Division Director and a line staff member of the DT (see ALTC Design Team Structure). The Division Director noted the importance of considering staff workload and competing projects when scheduling and adjusting DT meetings so as not to overwhelm staff.

FUNDING

DT has no dedicated funding source and staff voluntarily participate in DT in addition to their regular duties. When needed, the Division Director works with the fiscal department to identify potential funding sources for specific DT projects (e.g., grants, line item shifts, etc.).

IMPACT AND KEY TAKEAWAYS

The DT has helped empower and engage ALTC staff, increase staff trust in leadership, and improve staff professional skills. The DT has also played a central role in improving existing ALTC programs and in creating new programs to address gaps in care. Two particularly notable examples include:

- **Creation of a new Transforming Lives with Care (TLC) Unit:** In 2018, the DT created a new unit to provide case management support services for "clients with medically complex conditions and/or mental health issues that are not being treated" because staff felt they "had no place to refer them to." The TLC unit was initially staffed by two public health nurses and two mental health specialists, and now has its own representative on the DT. The TLC team is often lauded for the important support it provides clients. One particularly notable success story involves a medically complex, homeless client who three years after referral to the TLC team was in permanent housing and medically stable in remission.
- **Streamline process for enrolling IHSS caregivers:** Through DT advocacy, the division was able to become a Live Scan site, decreasing costs and streamlining the process for IHSS caregiver fingerprinting and enrollment. Inclusion of clerical staff on the DT was essential to this process; these staff advocated for the change because they could see the benefit to the community and were willing to develop skills needed to take on these new roles.

ILLUSTRATIVE QUOTES

"Design Team has been a key success and has allowed the division to thrive … it really has been something that has been an asset to the division… Since we started Design Team, staff that had been here for a while have definitely changed their perception of being part of the division. They feel like they are part of the decision-making process."

The success of the Design Team (and the ensuing programs) comes from the fact that it "involves all level of line staff and everybody has different backgrounds and experiences and ways of looking at things and so people get very creative [e.g., from the perspective of a supervisor vs. where the paperwork initially comes in]. And so given the fact that we have all those individuals at the table and being able to participate allows us to identify things that may otherwise have been missed, plus the fact that everybody feels like that they own this project. And so everybody's vested on making sure that the project works."

K. Solano: Community Advancing Race Equity (CARE) Team & Public Health Ad-Hoc Leadership Team

OVERVIEW

Solano County's Community Advancing Race Equity (CARE) team aims to create an infrastructure that institutionalizes expectations for equitable practices within the Health & Social Services (H&SS) Department by providing trainings and tools for advancing racial equity, and building teams within each of the H&SS Divisions. With the CARE team acting as the "driving force," the initial effort grew into the CARE collaborative, a much larger group whose membership includes H&SS (the largest County Department), other public agencies, and community organizations to examine and raise DEI awareness on a broad, county-wide level. Within the H&SS Public Health Division, the Public Health Leadership Ad Hoc team was subsequently established to ensure ongoing leadership engagement in promoting equity.

SOLANO COUNTY'S CARE TEAM

Solano County's CARE team began as a Public Health Division initiative in 2017. With the encouragement of the Solano County Health Officer/Public Health Deputy Director and the H&SS Department, staff from the Public Health Division participated in the 2016 Government Alliance for Race Equity (GARE) Learning Cohort. After the first cohort session, invitations were extended to staff in other Solano County Departments (e.g., Employment & Eligibility, Behavioral Health, Medical Services, Public Defender) and a local community-based organization to join the CARE team and participate in the GARE Learning Cohort.

Following their GARE experience, the Solano CARE team began hosting "Advancing Racial Equity" Trainings to normalize the conversation around the history of racial inequity, implicit & explicit bias, and individual, institutional and structural racism. These trainings were rolled out to all H&SS staff, along with follow-up training on how to use the GARE Race Equity Tool. To create an infrastructure to promote and sustain equitable practices throughout H&SS, the Solano CARE team also worked to form equity teams within each H&SS Division. Members of these teams, having participated in CARE equity trainings, worked within their divisions to spread DEI efforts and focus on division-specific issues. Finally, the CARE team also formed a number of special interest groups, including an African American/Black caucus, a Latinx caucus, and an Asian Pacific Islander caucus, to address staff and client issues relevant to its constituents. For example, the Latinx and African American/Black caucuses held COVID webinars and conferences for communities of color experiencing the greatest COVID health impacts, and most affected by the death of George Floyd and the ensuing protests for racial justice.

SOLANO COUNTY PUBLIC HEALTH LEADERSHIP AD HOC TEAM

The Public Health Leadership Ad Hoc team was subsequently developed following a town hall meeting of the African American caucus held in the wake of George Floyd's death. Data was presented on racism as a pandemic, health disparities in Solano County and nationally, and the impact of social determinants of health and COVID on health inequity. Public Health leadership learned that much of the work to alleviate these disparities was already being done by staff, and that it was important for agency leaders to partner with staff and play a more engaged role in efforts to improve equity. Subsequently, managers and leaders from all the different divisions agreed to form the Public Health Leadership Ad Hoc Team. Membership is voluntary, and has evolved over time. The current team consists of 5-6 representatives from different divisions.

Since its formation, the Public Health Leadership Ad Hoc team has worked to institute new communication tools and practices that would highlight the importance of equity within the division. For example, meeting agendas were revised so that content related to race and equity efforts was addressed at the beginning of meetings rather than at closing; the team also began implementing "icebreaker" activities that would introduce different equity principles, key terms, and their definitions. The team has also worked to create a safe space to voice and help address staff priorities. For example, when staff voiced interest in discussing changes to current hiring and promotion practices, the leadership team brainstormed ways they could "help support that change … who do we need to [get] involved … [who are] the allies and how do we get around barriers and all of that kind of stuff," even though these policies and practices were not directly under their purview. Finally, in 2022, the Public Health Ad-Hoc Leadership team created a new toolkit for all H&SS divisions to use in improving diversity, equity, and inclusion within their policies, procedures, strategies, and initiatives.

FUNDING/ADMINISTRATION

There are no dedicated funding streams or resources available for the caucuses or the Public Health Leadership Ad Hoc team. Members of these groups often also serve on the CARE team, and one concern is how to "divide out the work … [and] avoid the trap of having the same people … who are passionate [and] gravitate towards it … do the same work in different committees … so it's not the same group who's doing most of the heavy lifting because I think that's where you see a lot of burnout." Sustainability challenges associated with the lack of a dedicated funding stream or backbone staffing means the Public Health Leadership Ad Hoc team currently serves primarily in a consulting capacity, to raise awareness and help train other leaders to be able to create change within their own programs and divisions.

IMPACT AND KEY TAKEAWAYS

Evaluations of the CARE team equity trainings were overwhelmingly positive, with over 50% of participants requesting more time and more frequent opportunities to continue the conversation.
(See https://www.racialequityalliance.org/jurisdictions/solano-county-california/). Similarly, staff surveys and testimonials suggest that icebreakers and other meeting tools implemented by the Public Health Leadership team were also well received by staff.

ILLUSTRATIVE QUOTES

"[W]e've been working on … trying to figure out how to really embed equity and not just it being an additional thing that we're doing. I think that is challenging for a lot of people to switch their thinking…"

"[W]e get a lot of feedback from staff over the icebreakers and comments of either A) they saw something that they may not have thought of before in a different light or B) they felt validated of their own experiences and was happy that it was being talked about on a leadership level and that leadership was willing to donate time to that for us to speak about it. Which I think is at least a good thing when staff feel supported in that way."

L. Sonoma: Community Integrated Health Network

WHAT IS A COMMUNITY INTEGRATED HEALTH NETWORK (CIHN)?

A community integrated health network (CIHN) refers to a network of partners that work together under the direction of a central organization to deliver services that address health-related social risk factors within a specific geographic area. By creating a single entity for contracting with the health sector and adopting centralized processes for patient recruitment, referral, enrollment, marketing, quality assurance, and program evaluation, CIHNs allow smaller organizations to compete more effectively for contracts with health plans or other health care entities. Since 2021, Sonoma Adult & Aging Services (AAS) Division has worked closely with other partners in the community to assess readiness and feasibility of becoming a CIHN.

BACKGROUND

Sonoma AAS has a longstanding commitment to improving integration of medical and social services for older adults and adults with disabilities in the community. For example, since 2016, Sonoma AAS has used extramural grant funding to embed social workers in local community clinics to provide patients with depression screening and referral to social services. Over the last several years, Sonoma AAS has begun working with community partners to assess the feasibility of obtaining health plan reimbursement for these services, e.g., under the CalAIM Enhanced Care Management benefit. In particular, Sonoma AAS and its partners are interested in the feasibility of becoming a CIHN.

In 2021, Sonoma's AAS Division secured funding from the National Council on Aging Network Development Learning Collaborative to work closely with a group of community partners to collectively develop their capacity as a CIHN. Example partners include the county's Aging & Disability Resource Hub, the Council on Aging, the local health care district, several local community clinics, and legal aid providers, among others. As part of the process, Sonoma AAS and its partners participate in monthly webinars led by external faculty/consultants and also engage in facilitated dialogue with each other to learn more about their individual and collective readiness to become a CIHN. Example topics addressed include potential costs, value, and return on investment for becoming a CIHN; what type of organizational entity may be most appropriate to serve as the "lead entity" for the CIHN; and how to more successfully negotiate with and secure contracts from third-party payers.

The Sonoma County Learning Collaborative is still in progress; however, regardless of the outcome, participating in the Learning Collaborative is perceived as strengthening cross-sector collaboration within the community.

KEY LESSONS LEARNED

- Ensuring adequate time and resources for CIHN development
- Securing funding for a business development manager to serve as a neutral lead with dedicated time for planning and moving CIHN activities forward
- Need to develop or ensure appropriate business capacity and data sharing infrastructure, including associated Business Associate Agreements

ILLUSTRATIVE QUOTES

"We need someone to corral us on a consistent basis, to convene us for more thoughtful discussion and strategic planning. We have smart, willing people but we need a savvy knowledgeable business development manager, a catalyst to have more people say "They're serious" or "We are serious… about getting covered through third-party payer support."

"Third-party payers are looking for the pathway of least resistance. They want to streamline… but they don't want to pay for it. 'Why buy the cow when you can get the milk for free?' So we have to convince them… and know how to present to a third-party payer… how to structure the cost, e.g., if they may want a contract at a per member per month rate."

APPENDIX III: CLIENT CASE VIGNETTES

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A. Marin One Door

The following case vignette illustrates the instrumental role that an Aging & Disability Resource Connection initiative such as Marin's One Door can play in connecting older adults, adults with disabilities, or family caregivers to key services and resources in the community.

J, an African-American male with a disability, said that 473-INFO was his first phone call after his release from Marin County Jail on misdemeanor charges. Utilizing options counseling, a One Door I&A social worker was able to help him identify his available options and next steps. His main needs were access to transportation, public assistance benefits, housing, and medical and behavioral health care.

By the end of a two-month period of working with the One Door I&A social worker, J had access to public transit and medical transportation services, was gainfully employed, had active Medi-Cal and CalFresh benefits, had access to ongoing medical and behavioral health care, had successfully scheduled and recovered from a necessary surgery, and had secured temporary housing with a plan in place to find permanent, affordable housing.

For his transportation needs, the One Door I&A social worker assisted J with getting a Clipper Card to use for public transit and connected him to a program for transportation to medical appointments (through a Medi-Cal Partnership Health Plan). She directed him to Marin County Public Assistance, where he was able to get CalFresh and General Relief benefits. The I&A social worker provided J with their affordable housing resource list, which he used to connect with a housing case manager at St. Vincent de Paul (through Coordinated Entry/Whole Person Care) who was then able to help him find temporary housing at a motel. Soon after, J was able to secure gainful employment and work with his housing case manager to find permanent affordable housing. J was also able to get connected to medical care through Marin Community Clinics, including a long-overdue and necessary surgery. J's Marin County Probation Officer was able to assist him with paying for his temporary housing during his two-week recovery from his surgery and also helped him get connected to ongoing behavioral health care.

B. Adult Protective Services

This case vignette from Napa County illustrates the critical role that Adult Protective Services can play in ensuring safety and well-being of older adults with complex medical, behavioral health, and social needs.

Background. The client was first brought to Adult Protective Services (APS) attention when she was found wandering late at night. It is unknown how many times she was found to be wandering prior to the initial APS report due to the small-town nature of the police department (PD) where they assist residents frequently without reporting. Client had worn, tattered clothing and was combative. When at home, she and her partner are often at odds, which neighbors call on PD for additional assistance. The apartment is unsanitary, and client is often found unclothed and dirty or with hazards in the home. There was often no food. She was found to be drying her clothing on the stove, causing a small fire in the apartment, and burnt clothing. She drank lice medication on one occasion and could not explain why. PD had reported to have removed the knobs from the stove to prevent a fire although client and partner have been seen cooking.

There were also multiple reports from law enforcement of the client wandering unclothed and attempting to flag down passing cars. The client had also previously been hospitalized several times under a 5150 and released home to her partner with same conditions.

Adult Protective Services Intervention. An APS social worker recognized the client needed care at home to assist with activities of daily living (ADLs) and instrumental activities of daily living (IADLS). The client did not have medical insurance and the APS social worker coordinated with Medi-Cal to start a Medi-Cal application, with the goal of helping the client qualify for In-Home Supportive Services (IHSS). The social worker contacted client and her partner to obtain needed information for the Medi-Cal application but met with resistance and was unable to access needed information to move the application forward.

The social worker later learned that the client drinks alcohol (beer) daily. Due to client's cognitive impairment, the social worker relied on the partner to obtain information and establish appointments for further care. Due to the partner's lack of understanding of service systems, the social worker had to assist both of them. Because client and partner were unable to establish an appointment, the social worker went to the client's doctor's office herself to schedule the appointment. Once scheduled, the social worker and an interpreter coached client and partner about the date and time of appointment; ultimately, the social worker and interpreter found they needed to go physically assist client in getting ready and provide transport to the appointment.

Eventually, a multidisciplinary team meeting (MDT) was held with multiple community partners. The MDT expected that APS should "do something"; education around the scope of APS services was provided. Following the meeting, the client was placed on a 5150 hold again due to strange behaviors, breaking windows or cleaning money then ripping it up. The social worker visited the client in the hospital and relayed information over the phone to client's partner regarding her status.

The social worker also collaborated with the local family center, who assisted with purchasing client new clothing and providing food boxes during the holidays. The client was subsequently discharged to a skilled nursing facility (SNF) but continued to exhibit concerning behaviors. The social worker requested a capacity declaration be completed by the attending physician prior to client discharge so that the social worker could assist with placing care in the home. The social worker also collaborated with county Social Services about client's needs.

Unfortunately, the capacity declaration was not completed and days after discharge client was seen wandering and flagging down cars on the local highway. She was again brought home by law enforcement to unsanitary conditions.

The social worker was contacted again, and picked up the client to take to the doctor as well as the bank to obtain statements for Medi-Cal application. Eventually, the Medi-Cal application was approved and the IHSS app expedited. APS encouraged partner to go through the process of becoming client's IHSS provider, but he refused because he didn't understand why he needed to provide his fingerprints.

In the interim, the client was placed on another hold for aggression to partner. She was subsequently discharged to a long-term care facility. Eventually, a PG conservatorship was established. The client's family was notified. Over time, the client's partner continues to call asking for client's whereabouts.

Summary of Tangible and Intangible services provided by APS to Client:

- Food
- Transport client to appointments
- Obtain information (bank statements, etc.) for the applications
- MDT with above providers and local law enforcement
- Multiple phone calls/ reports/ documentation service plans and assessments
- Interpretation services provided throughout life of the case
- Coordinate with Up valley family centers, Medi-cal, IHSS and Public Guardian programs
- Collaboration with local hospital and SNF while client was in-patient
- Client resides an hour away from APS office. Need to book a car and coordinate schedules with interpreter
- Intensive case management provided to both client and her partner
- Accountability to community partners to ensure client's safety and resolution of the protection issue.
- Care coordination amongst multiple providers

C. Lanterman, Petris, & Short (LPS) Conservatorship

In California, LPS conservatorships provide legal authority to a responsible adult to make decisions for a seriously mentally ill person who is unable to take care of him/herself. These conservatorships are only for individuals who are seriously mentally ill and unable to appropriately manage their own food/ clothing/shelter or safety. This case vignette from Santa Clara County provides an example of an LPS conservatee and the types of services provided by Public Conservators.

Mr. M had ongoing struggles with mental illness but was able to live with his father in San Jose. Their family plan was to move to the Tahoe area to be closer to the rest of their family, especially Mr. M's young daughter. Mr. M left his father's home and at the height of COVID, Mr. M was homeless and his family was unable to find him. In January 2021, Mr. M remained missing, his family had no idea as to his whereabouts. They didn't know if he remained in San Jose or was living in the woods and mountains of the Sierra. Even though Mr. M was still missing, with the families' plan to move already in motion, his father felt he had no choice but to close on the sale of the home in San Jose and move north. In desperation, his family wrote letters to anyone they could within the Santa Clara County mental health and criminal systems. The family subsequently learned that Mr. M had been arrested several times and had even placed on 5150s, but still had no idea where to find him. The family started a social media campaign to try and locate him, to no avail.

In the spring of 2021, Mr. M was located in Santa Clara County and admitted to the hospital on a 5150 hold. The hospital referred him for an LPS conservatorship and within one month, he was admitted to a long-term custodial psychiatric hospital. The following few months were difficult for Mr. M. Initially he was upset with his family and upset with the Public Conservator and wanted to go back to the streets. To add to the chaos, the hospital had several COVID outbreaks and was under general quarantine for a long time, meaning no one could leave and no one could visit either. It was understandable for Mr. M to "regress" and stop participating in groups and stop taking his medications due to the frustration of the quarantine. The quarantine began just as he started to feel "better" and make progress. He was unable to have outside pass privileges or in-person visits with his family.

Mr. M did persevere and in December 2021, he was released from the hospital and placed at a residential mental health program. He was linked with a full scope of outpatient services including a community case manager at a nonprofit mental health agency (Momentum for Mental Health) and a mental health clinic psychiatrist. The mental health agency provided services such as crisis stabilization, psychosocial assessment, case management, medication management and also serves as a link to mental health professionals and community resources.

Mr. M now lives in the community and sees his family as often as he can. Mr. M continues to have a nurse coming to him for IM meds, daily visits from case manager, housing financial assistance, assistance with transport to appointments, catered treatment plans per his needs, coordinating with outpatient psychiatrists for medication adjustments, as well as assisting and coordinating lab draws regarding psychiatric medications.

D. Joint Case Between Public Conservator, Adult Protective Services, and the Independent Living Center

This case vignette provides another example of an LPS conservatorship, as well as the type of coordination often required between different Adult & Aging Services programs in care for older adults and adults with disabilities.

During the COVID Shelter in Place, the office of the Public Conservator received a referral from Adult Protective Services regarding a young single woman, Ms. C., who was hospitalized for grave disability and self-neglect. Ms. C had been dependent on her mother for support and assistance with daily living, but her mother had passed away two years prior. When referred by Adult Protective Services, there was nothing in Ms. C's refrigerator. She was getting daily deliveries from Starbucks for both food and beverages. A temporary Lanternman, Petris, & Short (LPS) conservatorship was established. While Ms. C sought mental health treatment, the County Public Administrator/Guardian/Conservator (PAGC) contracted with a local vendor to enter her home and clean out a hoarded mess of magazines, papers, Starbucks trash, excessive number of purses, etc. While Ms. C received mental health services at a local locked facility and developed a stable medication regimen, PAGC temporarily marshalled her bank accounts and paid her outstanding bills, which were more than three months overdue and reestablish utilities, including electricity and water. Although Ms. C's temporary LPS conservatorship was eventually terminated, LPS staff continued to meet with Ms. C and connected her with the Silicon Valley Independent Living Center to assist with grocery shopping. She was also linked to outpatient mental health after care and eventually gained her independence to live safely in her own townhome.

E. San Francisco In-Home Supportive Services (IHSS) Contract Mode

In San Francisco, IHSS contract mode allows IHSS recipients who have challenges identifying, hiring, and supervising an IHSS provider (e.g., due to complicating behavioral health conditions) to voluntarily receive some or all their services through a home care agency model. In IHSS contract mode, professionally trained and supervised home care workers provide clients with case management services, with additional support provided by peer mentors and certified nursing staff. Currently, approximately 3-5% of the total IHSS qualifying population in San Francisco are referred to IHSS contract mode. The following case vignette illustrates an IHSS recipient that may benefit from IHSS contract mode, and the additional supports that IHSS contract mode can provide to help these individuals remain safely in-home.

Jerry is a 70 year single African American male who has been residing in a Shelter in Place hotel unit since August 2020. For over two decades Jerry worked construction jobs and was able to independently support himself without accessing public benefits. When he was in his 50s Jerry suffered a back injury, was unable to work and quickly depleted his savings paying monthly bills. At the age of 59 Jerry was evicted from his apartment and started living on the streets of San Francisco. In order to cope with the difficulties of living on the street, Jerry started to use heroin and quickly became addicted. Jerry was well connected to the services for people experiencing homelessness in San Francisco and was able to access occasional shelter beds and food when he needed it. However, Jerry regularly used the emergency room in order to manage medical situations that often resulted from his diabetes and hypertension.

When San Francisco opened Shelter in Place hotels during the pandemic, Jerry was able to move into a building on Market Street where he had a private room and bathroom as well as three meals a day delivered to his door. Although Jerry was pleased to have his own private space, he struggled to maintain his room clean or keep up with his hygiene and he was not taking any medications to manage his chronic conditions.

A social worker from the Department of Disability and Aging Services conducted a home visit and an assessment with him and enrolled him into the IHSS program. He was soon connected to Homebridge, San Francisco's contract mode provider for provision of his IHSS services. Homebridge had a nurse meet and assess his needs. In the hotel where Jerry resided, there were several Homebridge home care providers and a supervisor who assisted the providers from 8am – 7pm at night. Home Care Providers would come to his room several times a day to offer care, cleaning and assistance. If he wasn't ready for them to provide care, he would ask them to come back a little later.

Through the daily support that he received from Homebridge, Jerry was able to start accessing methadone and stopped using heroin. Additionally, Jerry started a regular medication routine and he was able to manage his blood pressure and diabetes on his own. After moving into the Shelter in Place hotel, Jerry never accessed a hospital emergency room for medical care. He reports that the daily support from Homebridge has helped him to feel connected.

F. San Francisco Community Living Fund

San Francisco's Community Living Fund (CLF) provides short-term financial assistance to clients transitioning to independent living from hospitals and care facilities. CLF funds may be used to purchase equipment, residence modifications, or support services. The following case vignette illustrates how CLF can help individuals who might not otherwise qualify for services transition safely from institutional settings to the community.

Anna is a 50 year Latina female who was born with cerebral palsy that impacted her ability to walk. Throughout her childhood she received excellent care from her parents who prioritized her ability to participate in school as well as extracurricular activities such as choir. Anna grew up proud and confident. After completing college, she worked as a disability advocate at a non-profit in San Francisco. She continued to reside with her parents in their rented house because they continued to offer her companionship and personal care, and the house had been sufficiently rehabilitated to support as much independence as possible.

Anna's mother passed away when Anna was 47 years old and her father passed away the following year. As a result of her grief, Anna sank into a deep depression and was no longer able to work. She used her savings and the small inheritance that she received from her parents to pay the rent, COBRA, and her caregivers. During this time, Anna's mobility declined significantly, she stayed in bed for days at a time and developed pressure ulcers on her backside. She was ultimately hospitalized secondary to the wounds and later transferred to a skilled nursing facility (SNF) for wound care.

Anna absolutely hated living at the SNF. To make matters worse, Anna's landlord evicted her while she was in the hospital and she no longer had a home to return to if she was able to discharge. The social worker at the SNF called San Francisco's Department of Disability's Information and Resources Hub to find out what services Anna could access to discharge from the SNF. A social worker at the Hub consulted with the social worker and then later called Anna directly. After talking with Anna, the Hub social worker completed a referral for Anna to receive case management through the Community Living Fund (CLF). Within 10 days, Anna received a visit from a social worker at a non-profit that operates the case management program from CLF.

The CLF social worker was able to set up a comprehensive discharge plan for Anna that included accessing an array of services such as home delivered meals that are offered by San Francisco's Area on Agency on Aging, the Office of Community Partnerships. CLF was able to access a housing unit for Anna by utilizing available purchase of service dollars to pay an on-going housing subsidy for Anna. The Department of Disability and Aging Services (DAS) connected Anna to IHSS and by accessing the Public Authority's registry, Anna was able to hire her own home care provider. When Anna first discharged to the housing unit, a DAS nurse visited with her to assess whether she had any unmet medical needs. She also had regular contact with her CLF social worker. Through the support that she received from CLF and DAS, Anna's depression subsided. She started doing volunteer work over the phone, conducting friendly visitor calls with individuals who are homebound. Anna is currently looking for employment and optimistic about the future.

G. Sonoma Linkages Program

Care management programs can help older adults and adults with disabilities remain safely in home instead of moving to a nursing home or care facility. Sonoma's Linkages program provides short-term care management for adults 60+ years who require help due to illness, injury, disability, or major life event in order to live independently. Linkages services include in-home assessment, referrals to needed programs and services, benefits advocacy, and regular contact with a social worker. The following case vignette provides an example of the positive impact that programs like Linkages can have on the lives of older adults.

Charlie, 67, is a retired private school teacher who lives alone in rural, wooded West Sonoma County. He was navigating early symptoms of Parkinson's disease until a fall in his home caused a significant change in his disability and mobility. Charlie was struggling to care for himself while living at home when he first came into contact with Adult & Aging, Adult Protective Services (APS).

The APS Social Worker and Public Health Nurse evaluated his risk and provided the support needed to address his immediate needs and referred him to the in-house Information & Assistance (I&A) program. The I&A Social Worker collaborated with the referring APS Social Worker to identify what type of support care management could offer and what unaddressed needs Charlie was motivated to address. She reported that Charlie was very receptive to resources and guidance. He needed support addressing significant home safety issues, developing a sustainable financial plan, navigating caregiver supports, and mental health services. Charlie was not eligible for Medi-Cal.

When the Linkages Social Worker met Charlie for the in-home care management assessment, it was evident that the dirt pathway and stairs leading to his home posed a risk. Each time Charlie left the home, he needed assistance from his neighbors. The social worker partnered with Charlie to complete an in-home assessment and provided suggestions to address fall risks. The primary concern was the uneven walkway, obstructed by twisted tree roots and rain-water drainage.

The Linkages Social Worker reached out to the Aging & Disability Resource Connections (ADRC) Liaison at Disability Services & Legal Center (DSLC), the Sonoma County Independent Living Center, to brainstorm resources to address his home modification needs. He initially didn't meet the low-income eligibility requirement, but from what the social worker knew about Charlie's specific circumstance and the expertise about eligibility requirements from DSLC, they jointly discovered a way to get Charlie the services he needed.

DSLC partnered with Linkages to cover the cost of the $8200 cement pathway. Linkages was able to fund half of the project through the Dignity at Home Fall Prevention Program (a program through the California Department of Aging). DSLC funded the other half through their Diversion Funding program (a grant funded program). To provide access up and down his stairs, DSLC signed Charlie up for the Home Access Modification (HAM) waitlist for an outdoor lift-chair. Given the collaboration and partnership, the Linkages program was able to assist with all of Charlie's care plan goals and Charlie now has a plan to age in place.