RIDING THE WAVE:

CHARTING THE COURSE OF ADULT AND AGING SERVICES INTO THE NEXT DECADE

Developed by the

BASSC Adult and Aging Policy Workgroup

Rodger Lum, chair
Linda Kretz, Vice-Chair

Alameda County
Contra Costa County
Marin County
Monterrey County
Napa County
San Benito County
Santa Cruz County
San Francisco County
San Mateo County
Santa Clara County
Solano County
Sonoma County
University of California, Berkeley

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Executive Summary

The Context

The baby boom generation represents the largest single sustained population growth in the United States, numbering 76 million. By their size alone they have greatly impacted youth culture, family structure and roles, the economy, politics, and the very social fabric of America. The baby boom generation has reinterpreted every phase of American life and is poised to redefine the concept of aging as well. Societal behaviors, attitudes and preferences provide the context in which our communities thrive or fail. Characteristics such as the following impact the provision of services in our county Adult and Aging Agencies:

- Diverse family structures, joined with societal and economic shifts are affecting family income, retirement income, and potential for family caregiving and child rearing.
- Individuals are increasingly demanding more information, choice and control in their lives.
- Most baby boomers express a desire to remain independent and personally responsible for their retirement, health care, and long-term care requirements.
- The majority of baby boomers are not saving adequately for retirement.
- Most adults are neither knowledgeable about nor are they planning sufficiently for their long-term care needs.

Prevailing demographic trends provide a framework for predicting the future needs and preferences of the baby boomers as they age and the impact on others. The following trends indicate a high need for prevention and earlier intervention, more intense long-term care, as well as greater caregiver training and support:

- The region is growing more populous and older. The most dramatic population increase will be in age group 65 years of age and older, which will double by 2030. The dependency ratio will increase, and will be comprised of more older adults than children.
- There will be greater diversity. Minorities will grow to two-thirds of the population. By 2040, minority groups will constitute over half of the elderly and three quarters of those under the age of 65.
- Many older adults will be living alone.
- Most older adults have lived in their communities over 20 years and plan to remain there. They have high attachment to their communities, yet due

to incidents of crime, abuse, and violence, most do not feel safe within their communities.

- Most individuals express a preference for home care, yet they would rather move to a care facility than to live with or depend on their family or friends for their personal care. There is a high demand for affordable assisted living arrangements. However, due to low incomes combined with high rents and low vacancy rates, many are prematurely forced into institutions or other undesirable living arrangements.
- The size of the older population will enlarge the numbers of chronically ill and disabled older adults requiring care. There will be a great need for geriatric-specific health services as well as home and community-based care. Yet, there are shortages of caregivers as well as geriatric specialists to meet the current demand.
- There could be great personal benefits as well as tremendous cost savings if disability and disease can be delayed. Based on their proportion of the national population, older individuals in the region who lose independence each year might save roughly $686 million in medical and long-term care expenses if they had remained independent.
- New technology in health and home care may assist some in remaining independent for longer periods of time; however, it is not available, accessible, or desirable for all individuals.
- Families provide 80% of the care of disabled in at home or the community and play an important role in preventing or delaying nursing home care. Unpaid caregiving has an estimated value of $200 billion, one-fifth of the nation's total annual health care costs.

Bay Area Realities

The diversity of the Bay Area population, geography and stakeholders has a significant impact on the structure of county services. Our twelve-county Bay Area region comprises eight of the 20 most populous counties in the state. Although the population of most counties is predominantly white, the aggregate minority populations in some counties, such as San Francisco, has already reached or surpassed 50% of the total population. Older adults comprise from 9% to 15% of the total population. Seven of the twelve counties have a higher proportion of adults ages 85 and older than the state average; two, Napa (2.4%) and San Francisco (2.2%) have nearly double the state proportion (1.3%). The dispersion of the population into rural or unincorporated areas makes the provision of services difficult in many areas of the region. The development of suburban communities in outlying areas of the region, as well as the redevelopment of existing low cost housing, is pushing many low income elderly farther away from services and caregivers. Moreover, although there are major health care providers within the counties, some are inaccessible due to geographical, financial, or informational barriers.

Organizational Challenges

There are variety of county organizational structures for both adult and aging agencies and Area Agencies on Aging (AAA's). At the state level administrative authority for adult and aging services flows through five departments: the Department of Aging, the Department of Developmental Services, the Department of Health Services, the Department of Mental Health and the Department of Social Services. At the county level, administrative structures may be integrated or not. Further, some AAA's are within the county structure and some are run by nonprofits. Some services are provided through government contracts, and others through provider networks. These various fragmented administrative structures negatively impact the provision of services and cause difficulties in implementing, integrating and revising programs. The complex mix of administrative entities combined with a largely fragmented system of service providers poses administrative challenges to collaboration and coordination of services. Yet, the extensive spectrum of 63 services offers more options to our seniors than may otherwise be possible.

The BASSC Adult and Aging Policy Work Group defined two main areas as the most critical barriers to the provision of services to disabled and older adults in the region: consumer issues and administrative issues. The main consumer issues are: 1) consumer choice and access; 2) inadequate and/or affordable resources; and 3) inadequate support services. Compelling administrative issues are 1) fragmented governance, 2) fragmented and insufficient funding as well as disincentives toward institutional care; 3) service delivery gaps, service availability, and biases toward intervention; 4) inadequate data systems and common tracking elements; and 5) shortages of human resources.

Recommendations

Considering the needs and realities of the Bay Area with respect to adult and aging services, the BASSC Adult and Aging Policy Workgroup has developed the following six recommendations:

A. Adopt Policies and Values to Improve Adult and Aging Services. The group identified the following core values upon which to base policies:
   1. *Promoting collaboration and partnerships* between and among consumers, advocacy groups, relevant organizations, stakeholders and governments.
   2. *Integrating service systems* that will include uniform assessment tools and measures, integration of programs and services across age groups and systems of care, high use of technology, focus on commonalities, and local accountability and authority.
   3. *Increasing access to services* for populations with diverse characteristics.
   4. *Fostering consumer choice and independence* to maximize empowerment, self determination, interdependence, prevention, education and training, and consumer participation in the design and monitoring of services.
   5. *Promote cost benefits* within a flexible service system that supports rather than

creates dependent consumers. Higher networking between acute and long-term care service systems as well as education and training, and volunteerism will be central components.

B. Establish a Regional Policy Forum on Aging. The policy forum should be comprised of leaders from county adult and aging agencies as well as AAA's who identify regional issues, as well as commit to sharing information and data systems, connecting regional resources, promoting images of healthy aging, and increasing public awareness of aging issues. The forum will be sponsored by and report regularly to BASSC.

C. Expand Education and Public Awareness Efforts on Adult and Aging Issues. This includes training for caregivers, public awareness campaigns, increasing the number of gerontological specialists, and developing regional media campaigns.

D. Improve Access and Service Delivery. This includes identifying and eliminating barriers, cross-training personnel and increased interdisciplinary training, anticipating changes to support services, promoting caregivers as primary service recipients, exploring integrated systems, and maximizing the use of technology.

E. Expand Advocacy Efforts. This includes increased efforts for full funding of critical services and flexibility in program administration as well as the ADA, involvement of consumers in all planning processes, promotion of a consumer as well as a caregiver bill of rights, and increased access to funded services.

F. Focus on Regional Program Effectiveness. This includes assessing outcomes and evaluating programs as well as creating a shared data collection system.

The impacts of future societal characteristics and trends on our adult and aging agencies remain unknown. Yet, the current barriers to service provision require education, prevention, intervention and advocacy. Diversity of population, geography and stakeholders as well as administrative structures impact the delivery of services regionally. The BASSC Adult and Aging Policy Workgroup seeks to advance policies, values and regional integration that will respond to the current and future needs of older adults.

Introduction

In early 1998, Rodger Lum, Director of Alameda County Social Services Agency, spoke with the members of the Bay Area Social Service Consortium (BASSC) about anticipating the need for adult and aging services by the large population of Baby Boomers due to begin retiring in 2011. BASSC established the Adult and Aging Policy Workgroup in January, 1999, which met from March through September, 1999. Co-chaired by Rodger Lum and Linda Kretz of Alameda County, the 20 member group (see Appendix E) was comprised of experts in adult and aging services from many Bay Area Counties as well as gerontologists from the University of California, Berkeley. The initial charge to the group was framed around the following questions:

- How can current systems be changed to assure consumer choice?
- How can community-based interventions be designed for individuals who are hard to serve and yet be cost effective compared to institutional care?
- Why are some Area Agencies on Aging integrated into county adult and aging agencies while others are not?
- How can adult and aging services provide technical assistance and program development to build capacity in the community as well as redesign services?
- How can the Bay Area leadership influence the new Governor and legislature to seek important service waivers and seek additional funding for elderly services?

The urgency for addressing these questions can be seen in the following cases facing older and disabled adults (see Appendix C):

- Confused, disheveled woman, age 78, found living amongst decaying food and filth with undetected stomach blockage deteriorates rapidly from a healthy, active citizen to a permanent nursing home resident.
- Elderly apartment resident of six years is threatened with eviction after brief hospitalization and has no affordable housing options.
- Mentally ill woman with dementia, age 67, is bounced between board and care home and acute mental health facilities due to lack of intermediate residential resources and programming.
- Numbers of fiduciary abuse increase by 55%. Most of the alleged perpetrators are family members and caregivers.
- Reports of elder financial abuse reports in 1999 increased 60%. To meet the need, a Financial Abuse Specialist Team (FAST) Rapid Response was created; however, the ability to investigate and intervene in a timely manner is becoming more difficult as the

numbers of referrals skyrocket.

- Former leader of the community, age 83, found confused and disoriented sitting in car with motor running – neighbors call police.
- Staff and community members fear a significant loss of services when aging services are combined with adult services.
- Increases in apartment rental rates exceed SSI/SSP rates by 31%; with average rentals approaching $1,200 while SSI/SSP rates remain static at about $700 per month.

Of additional concern is the aging of the Baby Boomers who are projected to strain current resources as well as shape the services of the future. The evolving agenda of the Policy Group included the need to:

- Gain an awareness of consumer attitudes and preferences,
- Analyze the critical trends in aging,
- Map regional services available and needed, and
- Make recommendations to guide the county welfare directors in decision making and advocacy efforts on adult and aging issues.

In order to select major trends, Professor Jeanne Bader (California State University at Long Beach) provided a briefing for the Policy Group on the behaviors, attitudes and preferences of the Baby Boomers. Based on her presentation, the following trend areas were selected: 1) health and health care, 2) social issues, 3) economic issues), 4) demographics, 5) community involvement, and 6) diversity issues.

Various state and national reports were analyzed in order to identify key service issues and values. The five key service issues included promoting collaboration and partnerships, integrating service systems, increasing access to services, actively fostering consumer choice and promoting cost benefits.

This report is divided into three major sections to reflect the group's discussion and literature review:

Section I — The "Recommendations" section is based on an analysis of all the findings in order to create an action plan based on a set of core values.

Section II — "The Context"section includes two parts:

A. "Our Changing Communities," is a synthesis of the behaviors, attitudes and preferences of Baby Boomers and older adults, and

B. "Trends" highlights present and projected trends in areas relevant to adult and aging services.

Section III The "Regional Realities" section presents the current state of affairs across the counties and is divided in three parts:

A. "Regional Profiles," identifies similarities and differences across adult and aging service environments and administrative structures,

B. "Regional Service Provision" summarizes the administrative structures including the State, county and local levels, and

C. "Current Regional Issues," outlines the critical barriers to the provision of services to disabled and older adults in the Region.

Recommendations

Considering the needs and realities of the Bay Area with respect to adult and aging services, the BASSC Adult and Aging Policy Workgroup is making the following recommendations to the members of BASSC:

A. Adopt Policies and Values to Improve Adult and Aging Services

1. PROMOTING COLLABORATION AND PARTNERSHIPS between and among:
   - Consumers and advocacy groups
   - Organized labor and service providers
   - Health, mental health, and social services
   - Public-private partnerships
   - Faith-based organizations; stakeholders; influential individuals and entities in the community
   - Local, state and federal government

2. INTEGRATING SERVICE SYSTEMS including
   - Uniform assessment tools and outcomes measures
   - Intergenerational programs and services
   - Use of technology and data base systems
   - Integrated funding streams
   - Connections between levels of care such as acute care and long term care
   - Transportation within and between counties
   - Development of a range of services to maximize consumer choice
   - Focus on commonalities between systems
   - Local accountability and authority

3. INCREASING ACCESS TO SERVICES for populations with diverse characteristics
   - Age
   - Culture
   - Ethnicity
   - Gender
   - Religious affiliation
   - Sexual identity
   - Language
   - Caregivers including friends, neighbors and extended family

4. FOSTER CONSUMER CHOICE AND INDEPENDENCE to maximize
   - Empowerment
   - Self determination
   - Interdependence
   - Prevention
   - Education and training
   - Participation in design and monitoring of services for consumers, caregivers, and family members

5. PROMOTE COST BENEFITS
   - Built on the available resources of the consumer
   - Enhancing support rather than dependence
   - Including prevention
   - Focusing on community needs-based service versus medicalization
   - Networking between long-term and acute service systems
   - Focused on volunteerism, education and training
   - Built with flexibility to respond to changes such as populations and unforeseen events
   - Funding basic needs through government rather than privately to take advantage of economies of scale, minimum standards of quality ensured

B. Establish a Regional Policy Forum

Comprised of leaders from county adult and aging agencies as well as Area Agencies on Aging who will

- Develop consensus on critical regional issues and state issues
- Commit to sharing information and increasing communications among the counties within the region
- Connect various county advocacy efforts across the region
- Develop a capacity for on-going regional data collection
- Increase public awareness of aging issues and improve the image of older adults
- Create funding strategies for staffing the collaborative efforts of service evaluation and program development
- Report regularly to BASSC on issues requiring attention and action
- Follow the recommendations of this report with BASSC sponsorship

C. Expand Education and Public Awareness Efforts

1. Improving training for formal and informal caregiver services
2. Heightening public awareness of adult and aging resources through consumer education

efforts as well as promote consumer choice, direction, and advocacy
3. Developing public awareness programs to educate local, regional, and state opinion leaders on adult and aging issues
4. Increasing the number of highly qualified gerontological social workers and specialists through stipend-based internship programs, professional practice standards, and curriculum, as well as equitable salaries and benefits
5. Developing a regional media campaign to address current and future issues

D. Improve Access and Service Delivery

1. Pursuing the identification and elimination of barriers to access and delivery of services
2. Cross-training personnel and fostering interdisciplinary training
3. Anticipating the expansion and modifications of support services
4. Exploring integrated systems that ensure quality of services to older adults through a focus on consumers' needs and mixed modes of service delivery
5. Promoting a consideration of caregivers as primary service recipients
6. Maximizing utilization of technology in service delivery
7. Encouraging the development and use of technology as well as assistive living devices

E. Expand Advocacy Efforts

1. Advocating for full funding of critical services and greater flexibility in program administration to support consumer independence
2. Involving consumers in all planning processes
3. Promoting the full implementation and funding of the Americans with Disabilities Act
4. Promoting the development of a consumers' bill of rights
5. Promoting the development of a caregivers' bill of rights
6. Cultivating policies and a service continuum that advance care for persons in their own home where appropriate
7. Increasing access to funded services across the region
8. Integrating domestic violence and abuse prevention across the region for all age groups, including seniors
9. Encouraging the state to implement a statewide blueprint for continuity of care to eliminate fragmentation barriers

F. Focus on Regional Program Effectiveness

1. Assessing outcomes such as consumer satisfaction, cost benefits, and quality of life, of services provided in the continuum of care
2. Creating a shared data collection system through
   - Identifying and developing core data collection elements, common assessment tools, and outcome measures for the region,
   - Collaborating to foster shared access to information as well as development of a Regional geo-mapping system, and
   - Exploring funding support for and investigating the cost of starting new systems.

OUR CHANGING COMMUNITIES

Societal behaviors, attitudes and preferences provide the context in which our communities thrive or fail. The baby boom generation (Boomers) has reinterpreted every phase of American life and is poised to redefine the concept of aging as well. Diverse family structures are affecting family income, retirement income, and potential for family caregiving and child rearing. Moreover, individuals are increasingly demanding more information, choice and control in their lives (Institute for the Future, 1997). This section provides highlights of national and state societal characteristics that may impact the provision of services in our county Adult and Aging Agencies. A description of each of the eight topics is located in Appendix A.

1. Family Structures

- ✓ The Boomers have changed the very definition of household and family; their impact lowered the average number of persons per household to 2.7 today. It is projected to fall to 2.5 by early in the 21st century.
- ✓ Households with the most dynamic growth rates will be married couples without children, either Boomers whose kids have grown up or younger people without kids, and nonfamily households, both the very old and the very young living on their own or with friends.
- ✓ Family will play an important role in the Boomer's retirement; yet 70% said they do not want to depend on their children during retirement.

2. Retirement

- ✓ Over three-fourths of boomers expect to retire by age 65; a large percentage by age 60.
- ✓ More than 70% of Boomers believe that they, not the government, are primarily responsible for their retirement. Fewer (40%) retired older adults hold this view.
- ✓ Although only 20% of Boomers are confident that they will receive Social Security benefits, most will be dependent upon Social Security as their primary retirement income.
- ✓ Most (80%) of Boomers have begun some level of investing for retirement; about half are not saving enough and a third are not saving at all.
- ✓ Bay Area residents 55 years of age and older rate planning for retirement as their highest

concern. Most acted upon this concern by making some financial, healthcare, and housing arrangements. Yet, over a third of the employed respondents say they will have to continue to work for sufficient income after retirement.

- ✓ Almost three-fourths of Boomers in a national survey said that the lack of money was the biggest obstacle in adequately planning for retirement

3. Diversity within the Boomers

- ✓ Older Boomers are more likely to be homeowners and have better pension programs and higher income from investments.
- ✓ Younger and minority Boomers experience high unemployment rates and more limited employment prospects and are more likely to be at risk during their retirement years.
- ✓ Senior Boomers are becoming more thrifty a they approach retirement compared to younger Boomers who have accumulated large credit card debts.
- ✓ Boomers are, on average, more educated than and have at least similar incomes to their predecessors; however, there has been a greater trend toward inequality of income distribution.

4. Independent Living

- ✓ The proportion of elderly living alone increased by two-thirds from 1960 to 1990; while the share of those living with adult children declined by two-thirds over the same period.
- ✓ Most (69%) seniors would rather move to a care facility than live with family or friends.
- ✓ Assisted living facilities are the fastest growing housing segment for seniors.
- ✓ Middle market affordability is the biggest challenge of senior housing.
- ✓ Few Boomers (3.4%) say they would move to age-restricted communities after retirement; more than half said they prefer a community open to all ages.

5. Technology

- ✓ More than half of U.S. consumers have access to a computer at home or at work.
- ✓ California has begun to develop its first "cybercommunities." One state project is finding ways to link geographically dispersed social service program-dependent populations (the elderly, the physically handicapped, etc.) with their key provider agencies. Telemedicine projects in counties throughout the state are making high-quality medical care available to Californians regardless of where they live.
- ✓ Health care consumers are using the Internet to make decisions about the health care they

receive, as well as to purchase prescriptions. However, Internet health information may be misleading or erroneous and medications taken without a physician's advice may be lethal.

- ✓ New technology in telecommunications, home modifications and assistive devices will assist many disabled and older adults to remain independently in their homes for longer periods of time as well as saving money. Home care savings may be quadrupled with home modifications and assistive devices; yet, access may be difficult for most recipients of home health care programs, including older adults.
- ✓ Advances in medicine will allow earlier detection, prevention, and amelioration of disease.
- ✓ Lack of access for certain groups and the absence of a sense of community may hinder the development of global communities.

6. Health Care Attitudes and Preferences

- ✓ Californians believe that good health is important; about half believe that too little is spent to improve community health.
- ✓ Almost half of Californians believe the balance between spending for sick and injured care versus spending for illness prevention and promoting good health is not right.
- ✓ Over a third support spending for illness prevention and health promotion
- ✓ Californians support expansion for tax credits for contributions to charities; and some targeted state and local tax increase proposals, including taxes on tobacco and alcohol products; and are willing to pay more for preventative services through their health insurance premiums.
- ✓ More than four-fifths of Californians expressed support for continuing to provide community heath services to legal immigrants; slightly over half expressed that they should not be provided to illegal or undocumented immigrants.
- ✓ The Boomers decreasingly indicate that government should be responsible for health care whereas the WWII generation continues to hold the government responsible.
- ✓ Only 39% of Boomers feel that Medicare will be available to them during retirement.

7. Plans for Long-Term Care

- ✓ Over the past three years, Americans have not increased their knowledge about long-term care nor are they planning for it.
- ✓ There are many misconceptions about long-term care; 35% believe Medicare is the primary source for long-term care and that it pays for nursing home expenses of Alzheimer's patients.
- ✓ Americans say they need help to prepare for long-term care and favor help from

government and employers.

- ✓ A majority say they would pay higher taxes to expand Medicare to cover long-term care. Most (92%) approve of making long-term care fully tax deductible; 82% support granting tax deductions to children for purchasing long-term care insurance for a parent or grandparent.
- ✓ Two-thirds would welcome a group policy through their employers and three-fourths said they would purchase a group policy this way.
- ✓ Most (82%) say it is irresponsible of them not to plan for their own long-term care needs.
- ✓ Older Boomers feel the most threatened by the cost of long-term care.

8. Care Preferences

- ✓ Parents (77%) are not likely to ask their children if they can move in with them or to get help with everyday needs such as dressing and bathing (66%). Yet most (79%) are willing to ask their children if they would assist with routine chores once or twice weekly, and to move near them, but not in the same house (62%).
- ✓ Home-based care is preferred by most (87%) care recipients.
- ✓ Care recipients prefer consumer-directed care over agency-directed care.
- ✓ Caregivers prefer direct pay respite over agency-based respite care; direct pay caregivers were mostly caring for relatives who had suffered from a stroke (32.8%), whereas agency-based users were mostly caring for a relative with Alzheimer's disease (33.3%).
- ✓ Choice is a significant factor is satisfaction with services

TRENDS

The baby boom generation (Boomers) represents the largest single sustained population growth in the United States, numbering 76 million (U.S. Census Bureau, September 1975). By their size alone they have greatly impacted youth culture, family structure and roles, the economy, politics, and the very social fabric of America. The Boomer generation provides the context in which the adult and aging population in Bay Area is evolving. The prevailing trends provide a context for predicting the future needs and preferences of the Boomers as they age and the impact on others. This section provides highlights in twelve relevant areas of the region, state or nation. A more complete description can be found in Appendix B.

1. Demographics

- ✓ The Bay Area region is becoming more populous, older, and diverse.
- ✓ The most dramatic demographic change will be in the age group of adults 65 years of age and older. Between 2000 and 2030, it is anticipated that older adults will nearly double.
- ✓ Life expectancy in the Bay Area is six months longer than that of the State and two years longer than that of the nation.
- ✓ By 2030, it is anticipated that over 67% of the people in the region will be people of color. By 2040, older minorities are anticipated to reach over 51% of the State's total elderly population, and over 77% of individuals under the age of 65.
- ✓ The dependancy ratio (children under 20 and adults 65 years of age and older) of the region is higher than the national average and less than that of the state. When combined with the proportion of adults 65 years of age and older, it is anticipated that the region will have an 89% dependency ratio by 2030.
- ✓ In 1990, nearly two out of five of the state's elderly lived alone.
- ✓ Statewide, almost one-fifth of households are headed by older adults. Nationally, grandparents increasingly are heads of households. In 1990, 5.4% of California's children lived in their grandparent's household.

2. The Economy

- ✓ The Bay Area recorded the third fastest annual rate of total job growth among the major regions of the state over the past five years.
- ✓ The Bay Area region consistently records the lowest unemployment rate among the state's major regions.
- ✓ High housing costs have limited labor force growth throughout the San Francisco Area and, consequently, have made hiring of all types of workers difficult.
- ✓ As the Boomers retire and California experiences major shifts in its population, the

state's current tax structure, which generates more revenues from the personal income tax than any other source, may not provide the necessary balance in the future. Over the next few years the best educated, highest income group in history will pass through its peak earning and taxpaying years. As significant numbers of Boomers begin to retire, California's revenue growth from personal income taxes will begin to sag.

3. Housing

- ✓ The region's housing costs are expected to remain among the highest in the nation.
- ✓ Average vacancy rates across the 12 Bay Area Counties is 6.4%. Of the 12 Counties, San Mateo and Santa Clara had the lowest average vacancy rates (3.9%) in 1998. Moreover, with the high cost of living in the Bay Area, vacant housing is beyond the reach of many individuals.
- ✓ About two-thirds of low-income California renters pay more than 30% of their incomes for housing. About one-third pays more than half. Average rent for a person with disabilities would exceed half of their income in 1999.
- ✓ About half of the state's low-income homeowners are paying more than 30%, and about one-quarter pays more than half of their income for housing.
- ✓ National research shows that 30% of all elderly households pay more than they can afford for housing.
- ✓ Many older individuals live in housing that needs repair and/or rehabilitation. Six percent of seniors across the nation live in housing that needs repair and/or rehabilitation. One in five seniors with physical limitations report unmet needs for home modifications. One in eight householders 85 years of age or older needs functional modifications to their home.

4. Urban Sprawl and Transportation

- ✓ At the same time that many Californians face serious housing availability and affordability challenges, much of the state's housing construction is occurring increasingly far from jobs.
- ✓ The design of the Bay Area's communities, particularly the modern subdivisions, has forced residents into their cars. It is not economical to provide mass transit to low-density neighborhoods with few houses per acre. This poses significant problems for the more than two million Bay Areas residents who can't drive, many of whom are seniors, or disabled. A National survey reports that older non-drivers take two or fewer trips away from home per week.
- ✓ Reasons older adults across the Nation give for not using public transportation include lack of availability, inconvenience, and individual physical problems. Moreover, many older adults avoid public transportation because they do not feel safe.
- ✓ Over one-tenth of Bay Area older adults reported they experienced difficulty going outside their home and were dependent on others for assistance. Only one in ten used

public transit or paratransit. One in eight said they did not have sufficient social contact.

5. Labor Force Participation

- ✓ The persistently high cost of housing will cause high levels of labor force participation, particularly people in older age groups. It is anticipated that by 2020, more than one-fourth of the Bay Area older adults will be working.
- ✓ Jobs such as information technology and service jobs, that place less emphasis on physical labor and more on accumulated knowledge as well present opportunities for telecommuting, will increase employment prospects for the 65+ age group.

6. Income

- ✓ It is increasingly difficult for a household to exist in the Bay Area on one income.
- ✓ Compared to the rest of the nation, California had a greater decline at the bottom and middle of the wage distribution and greater growth at the top. The leading causes of the widening wage gap were education, work experience, and immigration.
- ✓ Poverty thresholds are lower for the elderly than for adults below the age of 65. In 1992, the threshold amount for a single older individual was $6,729; for adults under 65 it was $7,299.
- ✓ Over one-half of the older adults surveyed in the region's are classified as low income; almost a third have incomes under $25,000 per year.

7. Community Participation

- ✓ Bay Area residents remain socially involved and attached to their communities; the majority give donations regularly to churches or charities.
- ✓ Measured in terms of voting, volunteering and joining associations, current levels of civic participation are lowest in California's history. State voter participation has declined. Participation rates vary highly among groups, leading to a widening gap between the diverse demography of the State as a whole and voting Californians who command the attention of elected officials.
- ✓ Over 70% of older adults surveyed in the Bay Area lived in their community more than twenty years; almost half lived in their community thirty or more years – 85% said they planned to remain in the same community.
- ✓ Most of the region's older residents reported feeling very safe in their homes; yet, almost all do not feel safe within their communities. Nearly a fifth reported being impacted by a crime and/or other form of violence; however, 8.2% had experienced some form of abuse, exploitation or neglect. In 1997, the region comprised 20% of the state's confirmed reports of elder abuse and 12% of the dependent adult abuse.

8. Retirement

- ✓ Social Security is the main source of income for older adults. In 1992, 93% of the elderly received Social Security Benefits. The Social Security program provided 90% to 100% of total income for 40% of elderly beneficiaries. Although over two-fifths were under age 65, almost three-fifths (57%) of Bay Area survey respondents received Social Security as a source of income.
- ✓ Retirement savings increase with income. Only 6% of households with incomes below $10,000 report retirement savings and fewer than half of households with incomes under $30,000 had begun to save for retirement; whereas 85% of those with incomes of $100,000 or more reported retirement savings.
- ✓ The groups most vulnerable to inadequate retirement savings are those with low incomes, single parents, non-homeowners, formerly married persons, and households with whose head has less than a high school diploma.

9. Health & Health Care

- ✓ Sixty-two percent of California's deaths are from heart disease, stroke, or cancer.
- ✓ Despite the region's high life expectancy and trends toward improved health and declining incidence of disease, the proportion of older adults is growing. Their need for medical and long-term care is substantial and will continue to grow. Yet, there are inadequate numbers of geriatric physicians, gerontological social workers and other specialists to meet the demand. Demand for home health care workers is estimate to increase 80% between 1990 and 2005.
- ✓ Chronic conditions are the leading cause of illness, disability and death in the nation. More than a fifth of the population will suffer from arthritis over the next 20 years; hearing and eyesight problems affect 29% of individuals 65 years of age and older; one-tenth of individuals over 65 and nearly half of those over 85 have Alzheimer's disease.
- ✓ Prevention or postponement of disability in older people would have a substantial impact on the quality of their lives as well as the costs of medical and long-term care. Ten billion could be saved in national health costs if the onset of osteoarthritis could be delayed just five years. National costs for individuals with mild to severe Alzheimer's disease totaled $51.3 billion in 1996; the estimated average lifetime cost per person with Alzheimer's disease $174,000. Older Americans who lose independence each year incur an additional $26 billion in medical and long-term care expenses than if they had maintained their level of independence over that year. Based on its proportion of the National population, a rough translation of this amount regionally might be $686 million.

10. Health Insurance

- ✓ Nearly all persons 65 years of age or older are eligible for Medicare; most also have additional health care coverage. Older persons in the region who were enrolled in Medicare Hospital Insurance and/or Supplemental Medical Insurance in 1998 comprised 10% of the region's population, 23% of the state's Medicare population, and 2.3% of California's total population.
- ✓ California's Medicaid population 65 years of age and older in 1998 was about 12% of the total recipients and 1.8% of the state's total population. Individuals aged 85 and older on Medicaid represent almost one-fifth (18%) of the older Medicaid population.
- ✓ Medicare beneficiaries across the nation live on relatively low incomes. In 1997, half said they spent all or most of their monthly income on basic living necessities.
- ✓ The high cost of prescription drugs is an added financial burden. Prescription drug coverage is regarded the number one reason why older persons choose HMOs, and was cited as a major reason why insurance companies are dropping Medicare plans.
- ✓ As of October, 1997, 40% of Medicare beneficiaries in California were enrolled in managed care plans. In July, 1997 36.3% of Medicaid enrollees were in managed care plans.
- ✓ As of 1995, private long-term care insurance covered less than 1% of the total long-term care expenditures; however, there has been substantial growth in the sales of policies. California is attempting to reduce expenditures on long-term care by increasing private contributions through a public-private partnership.

11. Disability & Long-Term Care

- ✓ With increased life expectancy comes the greater likelihood that persons will live to ages where more long-term chronic illnesses and health conditions occur. The major causes of death often include an extended period of disability and need for care before death. This trend would lead us to project an increased need for earlier intervention and more intense long-term care.
- ✓ Almost one in five of California adults who reside in the community are disabled; nearly 11% are severely disabled. Almost two-fifths of California's disabled are individuals 65 years of age and older. Nationally, nearly a third of the disabled individuals 65 through 79 years of age and over half of the 80+ age group report their disability as severe.
- ✓ One in six (12.5%) older Bay Area survey respondents who had limitations reported they had no one to provide assistance with personal needs.
- ✓ Public demand for nursing homes is lower in California than across the nation. In 1996, California had two-thirds the nation's proportion of Medicare skilled nursing facility admissions; and less than half the national proportion Medicaid nursing facility recipients. Only 3% of older adults age 65 years and older resided in a nursing home in 1996 compared to 5.6% nationally.
- ✓ California has responded to public demand by decreasing its supply of nursing home

beds and increasing its supply of licensed residential care facilities. Although consumer demand is driving the industry's development, like other housing in California, many of these facilities are priced too high for individuals with low incomes. Supplemental Security Income may pay for the least expensive facilities in the region; however, many of the low cost facilities are in undesirable or unsafe locations, and they may have lengthy waiting lists.

- ✓ State Medicaid expenditures for long term care in 1996 was $3.7 billion. Nursing home expenditures comprised $2.1 billion (57%) ; home and community-based expenditures comprised $1.0 billion (12%) of the total amount.
- ✓ The high cost for nursing home care and residential care facilities combined with the strong desire of consumers to receive care in their homes has underlined the need for alternative, less expensive ways to deliver care to individuals who do not require continual care. California has high support for the development of viable home and community-based systems of care and has developed adult day care programs and home health care to fill the need for lower cost, lower levels of care. Nationally, approximately 13.8% of the elderly population received home health care, substantially more than any other age group.

12. Informal Caregiving

- ✓ For individuals with illness or disability, the foundation to health care is provided by family members, friends, and neighbors. It is estimated that 80% of disabled people are cared for at home or in the community by family members.
- ✓ Informal caregivers play an important role in preventing or delaying nursing home care. Less than a fourth of the nation's elderly with function disabilities live in nursing homes.
- ✓ One-quarter of the California households may be involved with caregiving for older adults; many may also be caring for dependent children.
- ✓ Caregivers are most likely to be female (73.8%) and married (88.4%). Spouses are the largest kin group of caregivers (47%); 40% are adult children. The mean age of caregivers in California is 60 years.
- ✓ Caregiver self-rated poor or fair health grew to 50% statewide.
- ✓ Because of the quantity and value of informal care, experts promote more effective means of assisting caregivers and warn against cutting back the support provided through home health care. The value of unpaid caregiving is estimated to be $200 billion, one-fifth of the nation's total annual health care costs. In comparison, spending for home health care is estimated at $32 billion; and nursing home care $83 billion.

Regional Profile

This section summarizes the diversity of the counties' population, geography and stakeholders as well as their administrative structures; and how these factors impact the delivery of services within the counties and regionally. Appendix C includes more details about each county.

Demographics

Our twelve-county region comprises eight of the 20 most populous counties in the state. Four of these counties are among the top ten: Santa Clara ranks fourth, Alameda is seventh, Contra Costa and San Francisco are ranked ninth and tenth, respectively [California Department of Finance, 1999 #64]. Although the population of most counties is predominantly white, the aggregate minority populations in some counties, such as San Francisco, has already reached or surpassed 50% of the total population [State of California, December 1998 #6]. Older adults (65 years of age and older) comprise from 9% to 15% of the total population.

- Napa (15%) and San Francisco (15%) have the largest proportion of this population
- Marin (14%)
- San Mateo (13%) and Sonoma (13%)

Seven of the twelve counties have a higher proportion of adults ages 85 and older than the state average; two, Napa (2.4%) and San Francisco (2.2%) have nearly double the State proportion (1.3%). The state's most rapidly expanding county is San Benito, and Brentwood, located in Contra Costa, is the state's number one boomtown.

Geography / Stakeholders

The dispersion of the population into rural or unincorporated areas makes the provision of services difficult in many areas of the region. The development of suburban communities in outlying areas of the region, as well as the redevelopment of existing low cost housing, is pushing many low income elderly farther away from services and caregivers. Moreover, although there are major health care providers within the counties, some are inaccessible due to geographical, financial, or informational barriers.

Organization/Administration

There are variety of county organizational structures for both adult and aging agencies and Area Agencies on Aging (see Figure 1). They have the following characteristics:

- A third of the counties's adult and aging services agency as well as the Area Agency on Aging operate under the authority of a county social or human service agency.
- One county has a their adult and aging services under the purview of the county social services agency and a separate Area Agency on Aging.
- Two of the counties administer both the adult and aging services agency and the Area Agency on Aging through a health or health and human service agency.
- Two Area Agencies on Aging serve to two counties each, which have separate oversight for their adult and aging services.

Implications

The demographics, geography, industry and organizational structures have multiple impacts on the service delivery system.

Barriers to Service Provision:

- Population shifts into surrounding areas creating new demand in low service areas.
- Dispersal of most needy population over a wide geographical area making it difficult to target programs.
- Lack of adequate transportation increases isolation of vulnerable elders and limits their access to available community-based services.
- Access to services is limited by medical providers as well as consumers lack of knowledge about resources.
- Managed care environment with its confusing choices complicates decision making for seniors as well as making it difficult to ensure the availability of quality health care.

Inadequate Funding:

- Static federal funding coupled with expanding target population limits capacity to expand services or develop new programs to meet increasingly diverse needs.
- Difficulty in receiving funding for Area Agencies on Aging which are operating as separate entities from adult and aging service agencies.

Inadequate Resources

- Lack of affordable and/or appropriate housing poses serious challenge to maintaining consumers in a home or community-based environment.
- Lack of Medi-Cal providers for skilled nursing and out-of-home care services, as well as the trend toward deinstitutionalization is causing increased demand for IHSS/MSSP type services.

Organizational Structures of
Adult and Aging Services and Area Agencies on Aging (AAAs)

Figure 1

<table>
<tr>
<td><u>Alameda</u>
County Social Service Agency
|
Adult & Aging Services
AAA</td>
<td><u>Contra Costa</u>
County Employment and Human Services Department
|
Aging & Adult Services
AAA</td>
</tr>
<tr>
<td><u>Marin</u>
County Health & Human Services
| |
Social Services AAA</td>
<td><u>Monterey</u>
County Department of Social Services
| |
Adult Services AAA</td>
</tr>
<tr>
<td><u>Napa / Solano</u>
AAA
| |
Napa Solano
Comprehensive Services for Older Adults</td>
<td>City & County of San Francisco
| |
Commission on the Aging/AAA Human Services</td>
</tr>
<tr>
<td>San Benito / Santa Cruz
Santa Cruz AAA
Human Resource Agency Santa Cruz San Benito
Adult, Family, Children Div.</td>
<td><u>Sonoma</u>
Human Service Department
|
Adult and Aging Division
AAA</td>
</tr>
<tr>
<td>Santa Clara
| |
County Social Services Agency AAA
Department of Aging and Adult Services</td>
<td><u>San Mateo</u>
Health Services Agency
|
Aging and Adult Services
AAA</td>
</tr>
</table>

Regional Service Provision

This section summarizes the administration and provision of services by county. The complex mix of administrative entities combined with a largely fragmented system of service providers poses administrative challenges to collaboration and coordination of services. Yet, the extensive spectrum of 63 services offers more options to our seniors than may otherwise be possible. The following five state departments administer and/or provide funding for 58 of the 63 services listed in Figure 2: Aging (26); Developmental Services (2); Health Services (13); Mental Health (7); and Social Services (10).

Services are provided throughout the region under the auspices of three main county departments or local entities as follows:

- Health
- Mental Health
- Social Services
- City government
- Community-based non-profit and for-profit organizations.

Over a third (5) of the county Area Agencies on Aging are administered by a non-profit entity. A third (4) are situated within a county social service agency. The three remaining Area Agencies on Aging are under the purview of a health and human service department, a health services agency, and a city government, respectively. The North Bay (Napa and Solano) and South Bay (Santa Cruz and San Benito) Area Agencies on Aging serve two counties.

An extensive array of services is delivered through non-profits. Area Agencies on Aging contract with non-profits for a majority of the Community-Based Services Program (CBSP) and Older Americans' Act (OAA) services such as the Brown Bag Program, HICAP, Friendly Visitor, and Home-delivered meals. Moreover, adult day health care and independent living services are entirely provided through non-profits.

Social service agencies are the main providers programs such as In-Home Supportive Services, Adult Protective Services, Financial Assistance, and Special Circumstances. Cities are largely responsible for senior centers. A combination of health, mental health and for-profit entities are involved in the provision of most medical and behavioral health programs and services. For-profits are the main providers of residential care facilities.

BASSC Adult and Aging Policy Work Group
Service System

County**

LOCATION OF AAA		Ala	CC	Mar	Mon	Nap	SF	SM	SCl	SCr	Sol	Son
S = Social Services **H = Health** **HHS = Health & Human Services** **NP = Non Profit**		S	S	HHS	S	NP	City	H	NP	NP	NP	S
Services Provided through State, County or Local Entity*		***State Department:** **DA = Dept of Aging** **DD = Dept of Dev'l Services** **HS = Dept of Health Services** **DM = Dept of Mental Health** **DS = Dept of Social Services**			***County:** **H = Health** **M = Mental Health** **S = Social Services** **O = Other County Department**				***Local** **City- Service provided through city** **Non-Govt - Service is contracted to entity outside the government:** **NP = Non-Profit** **FP = For Profit**			
PROGRAM-SERVICES	**State(1)**	**Ala**	**CC**	**Mar**	**Mon**	**Nap**	**SF**	**SM**	**SCl**	**SCr**	**Sol**	**Son**
Adult Protective Services (APS)	DS	S	S	S	S	H-S-M	S	H	S	S(b)	S(a)	S
Adult Day Health Care (ADHC)	DA	NP	NP	AAA-NP	S-NP	NP	NP	NP	S-NP	NP		NP
Adult Day Care / Respite Care	DA	NP	NP	AAA-NP	S	NP	NP	NP	S-NP			S
AIDS Medi-Cal Waiver	HS	H	H		S	NP	H-NP	H	NP		S-H(a)	H
AIDS Care Management	HS	H-NP	H	H-NP	S	NP	H-NP	H	NP		S-H(a)	H-NP
Alcohol and Drug Abuse Services	DM	H-NP	HS-DM-NP	H-NP	M	H-S-M-NP-FP	H-NP	S	H		S-H	H
Caregiver Resource Center (CRC)	DM	NP	NP		NP	NP	NP	NP	NP	NP	NP	NP
CBSP/ Alzheimer's Day Care Res. Center	DA	NP	NP	AAA-NP		NP	H-AAA-NP	NP	S-NP			S-NP
CBSP/ Brown Bag Program	DA	NP	S-AAA-NP	AAA-NP	S-AAA-NP	AAA-NP	AAA-NP	NP	AAA-NP		NP	S-NP

PROGRAM-SERVICES (cont.)	State(1)	Ala	CC	Mar	Mon	Nap	SF	SM	SCl	SCr	Sol	Son
CBSP/ Foster Grandparent Program	DA	City		AAA-NP	S-AAA-NP	AAA-NP	AAA-NP	NP	AAA-NP	AAA	NP	S-NP
CBSP/ Health Ins. Counsel (HICAP)	DA	NP	S-AAA	AAA-NP	S-AAA-NP	AAA-NP	AAA-NP	NP	AAA-NP	NP	AAA	S-NP
CBSP/ Linkages & Respite Purchase of Service	DA	City	S-AAA	AAA-NP	S-AAA-NP	AAA-NP	AAA-NP	H	AAA-NP	NP	AAA	S
CBSP/ Respite Registry	DA	NP	S-AAA-NP	AAA-NP	S	AAA-NP	AAA-NP	PubHlth	AAA-NP	NP	AAA-S	
CBSP/ Senior Companion	DA	City	S-AAA-NP	AAA-NP	S-AAA-NP	AAA-NP	AAA-NP	NP	City	AAA	AAA	
Conservatorship services	DS	S	S-H	NP	H-M	0(e)	0	H	S	S(b)	O	H
County Organized Health Systems Federal Medicaid Waiver	HS	H			S		H	NP	H		H	H-S
Dept. of Developmental Services HCBS Waiver (2)	DD	Reg.Ctr				NP-FP		H	NP			NP
Ethnic Senior Programs	DS	NP-City	NP	AAA-NP			NP	NP	S-NP		AAA	NP
Emergency Housing			NP	O-NP		H-S-M-NP	NP	H-S-NP	NP			H-M
Emergency Preparedness		S	H-S-NP	O	DS-DA-S-NP-O	H-S-M-O	H-O	H	S		O	S
Financial Assistance	DS	S	S	S	S	H-S-M	NP-O	S	S		S	NP
Geropsychiatric Services	DM	H	H-NP-FP	M	H-M	H-S-M	H-NP-FP	H-M	M		M	H-M
Health Promotion	HS	NP-H	S-AAA	H-AAA-NP	H	H-S-M-NP	H-NP	H-NP	H		H	H-S
Home Improvement		City	City	FP	DS-S-City	NP	NP	S-NP	NP		AAA	NP

PROGRAM-SERVICES (cont.)	State(1)	Ala	CC	Mar	Mon	Nap	SF	SM	SCl	SCr	Sol	Son
Hospices	HS	FP	NP	NP	DA-NP	NP	NP	NP	NP		NP	NP
Housing Assistance		City	NP	O-NP	NP	NP-H-S-M-City	H-NP-O	H-S-NP	NP(c)		NP	NP
In-Home Supportive Services and Personal Care Services Program (IHSS) & (PCSP)	DS	S	S	S	S	H-S-M	S-NP	H	S-AAA-NP	S(b)	S(a)	S
Independent Living Services	DD	NP	NP	NP	NP	NP	NP	NP	NP		NP	NP
Long-term Care Integration Pilots	HS	S	S-H	HHS-AAA			H-O	H	S-H-AAA-NP			H
Long-term Care Sub-Acute Services	HS	H	H-NP-FP	H-NP-FP	DH	H-S-M-NP	H-NP-FP	H-NP-FP	H			FP
Medical and Dental Care	HS	H-FP	H-FP-NP		H-FP	H-S-M-NP-FP	H-S-NP-FP	H-NP-FP	H-City(d)		S	H-FP-NP
Medi-Cal Nursing Facility HCBS Waivers (3)	HS	FP						H	H			
Medi-Cal In-Home Medical Care (IHMC) Federal Waiver (4)	HS	H				NP-FP	H-NP-FP	H	H		H	
Mental Health / Counseling	DM	H	M-NP-FP	M-NP-FP	DA-M	HSM-NP	H-NP	M-NP	M	H	M	H-M-NP
MSSP	HS	City	S	NP	S	AAA-NP	AAA-NP	H	AAA-NP	S(b)	AAA	S
OAA/ Transportation	DA	NP	S-AAA-H	AAA-NP	O	AAA-NP	AAA-NP	City-NP	NP	NP	AAA	NP-City
OAA/ Case Management	DA	NP-City		AAA-NP	S	AAA-NP	AAA-NP	City-NP	NP	NP	AAA	S-NP
OAA/ Chore Provider	DA	City	S-AAA-NP		S-AAA-NP	AAA-NP	AAA-NP-FP	PubHlth			AAA	S-NP
OAA/ Congregate Meals	DA	NP	S-AAA-H-NP-City	AAA-NP	S-AAA-NP	AAA-NP	AAA-NP	City-NP	S-NP	NP	AAA	S-NP

PROGRAM-SERVICES (cont.)	State(1)	Ala	CC	Mar	Mon	Nap	SF	SM	SCl	SCr	Sol	Son
OAA/ Elder Abuse Prevention	DA	NP	S-AAA-NP	AAA	S	AAA-NP	AAA-S-NP	H	S-NP			S-NP
OAR/ Friendly Visiting	DA	NP	S-AAA-NP	AAA-NP	S-AAA-NP	AAA-NP	AAA-NP	NP	NP		AAA	
OAA/ Homemaker	DA	NP			S-AAA-NP	AAA-NP	AAA-NP		NP-FP			S-NP
OAA/ Home Delivered Nutrition	DA	NP	S-AAA-H-NP	AAA-NP	S-AAA-NP	AAA-NP	AAA-NP	NP	S-AAA-NP	NP	AAA	S-NP
OAA/ Multicultural I & A	DA	S-NP-City	S-AAA	AAA-NP	S	AAA-NP	AAA-NP	H-NP	AAA-NP		AAA	
OAA/ Personal Care	DA	NP	S-AAA-NP			AAA-NP	AAA-NP-FP		NP-FP			S-NP
OAA/ Health Promotion	DA	NP	S-AAA	AAA-H	AAA-H	AAA-NP	AAA-NP-FP	H-NP	AAA-NP		AAA	S-NP
OAA/ Senior I & A	DA	S	S-AAA	AAA-NP	S-AAA-NP	AAA-NP	AAA-NP	N-NP	AAA-NP	NP	AAA	S+NP
OAA/ Senior Employment	DA	NP	S-AAA	AAA-NP	S-AAA-NP	AAA-NP	AAA-NP	NP	S-NP		AAA	NP
OAA/ Senior Legal Services	DA	NP	S-AAA-NP	AAA-NP	S-AAA-NP	AAA-NP	AAA-NP	NP	NP		AAA	S-NP
Ombudsman	DA	NP	S-AAA-NP	S	S-AAA-NP	AAA-NP	AAA-NP	NP	NP	NP	AAA	S-NP
Outpatient Psychiatric Services	DM	H	H-NP-FP	M-NP	DM-HS-M		M	M-NP	M		M	H-M-NP
Program for All-Intensive Care to the Elderly (PACE)	HS	NP					NP				NP	
Public Guardian	DS	S	DM	M	DD-M	O-DA	O	H	S	S(b)	O	O

PROGRAM-SERVICES (cont.)	State(1)	Ala	CC	Mar	Mon	Nap	SF	SM	SCl	SCr	Sol	Son
Qualified Medicare Beneficiary (QMB & SLMB)	DS	S	S		S	H-S-M	S	NP	S-NP-AAA		S(a)	
Representative Payee Services	DS	NP	NP-FP	M	M-S	H-S-M-NP	NP-FP	H-M	S-NP	S(b)	O	NP-M
Residential Mental Health Services	DM	H	NP-FP	NP	M	H-S-M	H-NP-FP	NP			M	NP-M
Residential Medical Services	HS	H				NP-FP	H-NP-FP	H-NP	H		H	FP
Senior Centers	DA	NP-City	City-NP	City-NP		City	NP-O	City-NP	City		NP	S-NP
Senior Safety	DA	S		O-NP		H-S-M-NP	NP-O	H-NP			AAA	
Special Circumstances Program	DS	S	S		S	H-S-M	S	H	S	S(b)	S(a)	S
Suicide Prevention	DM	NP	NP	M	DH-M	H-S-M-NP	NP	NP	M		NP	NP
SSI/SSP--Non-Medical Out-of-Home Care (RCFE's) + Board & Cares	DS	FP	S	FP	FP	NP-FP	NP-FP	NP	NP-FP		S(a)	FP
Veterans' Services	VA	S	O	S	O	H-S-M	NP-O	H	S		O	S

a) This program is an interdisciplinary bureau for older and disabled adults.
b) Adult, Family & Children's Services Division of the County Human Resources Agency.
c) Housing authority
d) San Jose
e) Health and Human Service Agency

Legend:

**County
Ala - Alameda
CC - Contra Costa
Mar - Marin
Mon - Monterey
Nap - Napa
SB - San Benito
SF - San Francisco
SM - San Mateo
SCl - Santa Clara
SCr - Santa Cruz
Sol - Solano
Son - Sonoma

Footnotes:

1) California State Department that has administrative oversight of program
2) Home and community-based services including nursing, personal care, and other services enabling developmentally disabled beneficiaries to remain at home.
3) Nursing and other services medically necessary to maintain a person at home as an alternative to institutionalization.
4) Nursing and other Medi-Cal services provided as an alternative to acute levels of care.

Regional Issues

The BASSC Adult and Aging Policy Work Group defined the following issues as the most critical barriers to the provision of services to disabled and older adults in the region. The issues are divided into two sections: Consumer Issues and Administrative Issues.

Consumer Issues

Consumer Choice/Access:
- Lack of information about services and policies. Dissemination of information to diverse groups (multilingual)
- Access to services - single point of entry
- Consumer choice, direction and advocacy

Resources:
- Affordable Housing
- Transportation
- Affordable Home Care
- Home-delivered Meals
- High Costs of growing old (prescriptions, medical care, low income)

Support Services:
- Family caregiving
- Violence and abuse (financial, scams)
- Long-term care system

Administrative Issues

Governance:
- Fragmented governance - AAA (county or nonprofit) / government / provider networks

Funding:
- Fragmentation in funding, administrative structures, and services creates restrictions and disincentives to providing services (Medi-Cal funding for RCFEs), and disconnects between acute and long-term care.
- Funding disincentives toward high-cost services (institutions)

Service Delivery:
- Bias toward intervention instead of prevention
- Service availability is inconsistent within and across counties
- Need for continuity of care (difficult to separate health, behavioral health, social services)
- Service Gaps - continuum of care options
- Diminished capacity is not adequately addressed.

Data Systems:
- Inadequate data for decision making and sharing data cross-county. Lack of common data elements such as tracking diverse populations.
- Inadequate county tracking systems (geomapping for providing services to diverse populations)

Human Resources:
- Labor shortage for counties and non-profits (diversity and recruitment issues)

A. Consumer Issues

1. Consumer Choice/Access

Informed choice and access to multiple services are critical to the advancement of healthy consumers. Issues such as the availability of information in multiple languages, single points of entry, and multiple options for care need to be addressed. Community providers need to join with consumers to promote vital communities.

a. Information and Dissemination. There is a paucity of information about services and policies, as well as a great demand for information on health care issues. Moreover, development and implementation of an emergency education and preparedness system is essential. Dissemination of information to diverse groups, including multilingual information, is needed. Requests for information through senior web pages, specific sections for seniors in newspapers, and Senior Fairs provide a means for disseminating information to a variety of groups. The limited automation and data systems in adult and aging services, especially case management, makes it difficult for workers to access current information and disseminate it. Furthermore, the bilingual component of social services and county programs has been found to be inadequate.

b. Access to services. Consumers desire a single point of entry for access to all services. Centralized intake is beneficial; however, there are still gaps in services which require greater integration and collaboration. Integration and coordination between health, mental health and social services as well as acute and long-term care need to be developed to ensure access to services. Managed care systems need close monitoring to assure against premature hospital discharge and access to adequate health care. Moreover, there is a need for case management services to connect people to services and oversee that care needs are being met . Additionally, diverse populations require staff that are culturally competent and possess multi-lingual skills.

c. Consumer choice, direction and advocacy. Individuals consistently indicate that they prefer to live as independently as possible in their own homes as they age. Consumers desire a network of services and supports that give them choice among multiple options for care. In addition to the provision services, programs and supports that sustain independent living and promote full participation in the community, providers need to join consumer self help efforts. Improvements in the provision of services can be gained through monitoring by consumers, advocates and providers. Community leaders, utilizing the vast resource of seniors and the energy of disabled adults, need to seek increased resources to engender and sustain safer, more accessible and livable communities.

2) Resources

SSI benefits are too low for many to remain in their homes, much less participate in community activities. Moreover, those with low incomes who require preventative health care or medications find it difficult to maintain their health. Further, it is not an easy task for dependent adults to find affordable, quality home health aides. These factors create a great demand for affordable housing complexes that provide ascending levels of care. The inability to locate affordable housing with sufficient care services may cause premature

institutionalization. Once individuals are institutionalized, the quality of care in nursing homes becomes a concern. Issues of adequate income and health care as well as affordable and accessible housing and transportation, and affordable quality home health care need to be addressed.

a. Income, Affordable Housing, and Health Care. Low income creates barriers to adequate home environments, health care, nutrition and socialization. Although the majority of older adults own their own homes, many cannot afford to keep them in good repair. There is a need for low cost home improvement services. Further, there is a need for affordable, accessible housing for low and moderate income individuals, especially with the conversion of HUD housing to market rate. Supplemental Security Income is not meeting the high cost of rent. There is a need to advocate for increased SSI benefits; however, the rising cost of SSI is a disincentive in pursuing this effort. Evictions that occur in subsidized housing when income or benefits are increased compound this dilemma.

   Additionally, individuals with low or moderate incomes cannot afford the preventative health care or prescription medications necessary to keep them healthy. In addition, nutritional requirements are difficult to maintain on a limited budget. Moreover, many older individuals remain isolated in their homes, primarily due to the inability to afford adequate or available transportation. Further, appropriate mental health services are needed for older adults. Once their health or mental health declines to the point of requiring skilled nursing, the only option remaining for many is nursing home care. Quality of care in nursing homes is questionable due to lack of regulation and oversight. Assuring the quality of nursing home care requires strengthening of the Ombudsman Program. However, low staffing ratios, double counting of nursing hours, and the trend toward earlier hospital discharges indicates the need for greater advocacy efforts.

b. Home-delivered Meals. Home Delivered Meals provide homebound seniors nutritionally balanced hot, cold and/or frozen meals. Recipients of home delivered meals are visited by social service or health workers who provide links with other services. Many seniors require assistance with nutrition and other in-home services to help them to remain in their residence. Good nutrition leads to good health. Many seniors are unable to access home delivered meals programs due to limited funding which creates waiting lists and/or the lack of culturally or medically appropriate diets. In many instances home delivered meal services are limited to weekdays only. Unfortunately, many seniors live on fixed incomes and are forced to make hard choices about how they spend their discretionary income. After paying the living expenses of rent and utilities, purchasing food may take a back seat to having to pay for prescription drugs or other medications. Oftentimes, seniors experience "food insecurity" in deciding what to spend their limited resources on. Home delivered meals answers these needs for certain segments of the senior population.

c. Transportation. Affordable and accessible transportation is necessary to meet the needs of older and disabled adults. Many areas are not adequately served by public transportation which creates barriers to services for older and disabled adults. Expanded services are required in most areas, geographically within and across counties, as well as in increased scheduling. Moreover, services need to become more sensitive to older and disabled adults, especially those with communication difficulties. Transportation services need to be held accountable unequivocally for no shows and long periods of waiting for their

services as this can be dangerous or incapacitating for older and disabled adults.

3. **Support Services**
   a. Family caregiving. Support for informal caregivers is needed, both for family and nonkin. This includes emotional and financial support as well as all levels of respite care such as overnight and weekend care, Alzheimer's day care, and adult day care. In-home support services and financial support provided to family members fortifies informal caregiving and keeps families together.
   b. Violence and abuse. Abuse, neglect and exploitation are common among the elderly. Yet there is a shortage of qualified and affordable in-home support services. To aid in the prevention of elder abuse, public education and awareness campaigns as well as expanded IHSS availability including support for caregivers are required. In addition, improved reporting, and greater investigative and enforcement mechanisms are needed. Moreover, incidents of crime need to be reduced so that seniors may feel safe within their communities.
   c. Long-Term Care System and Affordable Home Care. There is an increasing need for affordable and quality long-term care, including institutional and home and community-based care. There is a shortage of affordable resources such as residential care facilities and in-home health care. These services need to be made affordable, especially for those with high care requirements.

B. Administrative Issues

1. **Fragmented Governance**
   a. Governance is fragmented at all levels: state, county and local. At the state level administrative authority for adult and aging services flows through five departments: the Department of Aging, the Department of Developmental Services, the Department of Health Services, the Department of Mental Health and the Department of Social Services. At the county level, administrative structures may be integrated or not. Further, some AAA's are within the county structure and some are run by nonprofits. Some services are provided through government contracts, and others through provider networks. These various fragmented administrative structures negatively impact the provision of services and cause difficulties in implementing, integrating and revising programs.

2. **Funding**
   a. Inadequate and Inflexible Funding. In addition to fragmented governance, fragmentation in funding creates restrictions and disincentives to providing the most cost effective services at the appropriate level. Further, the fragmentation and categorical nature of the funding results in a major disconnect between institutional and community based services as well as between population based services and diseased based services.
   b. Challenges associated with Programs. There are administrative and cost issues related to the expansion and integration of programs (e.g. APS with other services such as Linkages and Public Guardian). There are start-up costs and program support issues related to the

implementation programs (e.g. MSSP, Public Authority). In small counties, implementation may cause financial risk as well as diminish consumer access to services (e.g. IHSS recipients have less access to contract services versus individual care providers without increased cost to the county under Personal Care Service Providers).

c. Disincentives toward Institutional Care. In California, the medicaid plan reflects a bias towards high cost institutional care. Counties have an ever increasing share of the cost of home and community based services; whereas the medicaid program assumes full responsibility for institutional care. This funding strategy coupled with low SSI benefits and high housing costs contribute to a higher rate of premature institutionalization and increased medicaid costs.

3. Service Delivery

a. Bias toward intervention instead of prevention. The reimbursement of the entire health care system is based on a traditional medical model that reimburses high tech interventions, costly surgeries and lengthy hospital stays, rather than promoting low-tech lifestyle changes. Medicare itself covers only a limited number of preventive health screening procedures. Many chronic disease conditions are seen as the inevitable result of "normal aging," but are in fact the result of life-long behavioral health choices-- poor diet, smoking, lack of exercise. Research has shown the value of identifying people at risk and targeting aggressive prevention strategies to this segment of the older population. Moreover, physicians and discharge planners have limited knowledgeable of the availability of home and community-based services for older and disabled adults. There is a tremendous potential for all of us to live longer, *healthier* lives.

b. Access to services. The availability of services is inconsistent within and across counties. Inequitable service availability depends on point of entry. There are insufficient case management services to connect people to resources and see that care needs are met.

c. Continuity of care. People need to be viewed holistically. The need for continuity of care stems from the difficulty in separating health, behavioral health, social services. Centralized intake is beneficial; however, there are still gaps in services which require greater integration and collaboration. Moreover, while some populations are integrated within programs, others are not. The fragmented categorical funding effects service delivery in a variety of ways. First and foremost is that we are unable to provide individuals and families with what they need but we give them what we have. Continuity of care is compromised by the need to label the problem's origin as physical, behavioral or mental. The current system is ill prepared to address the needs of the older population whose needs across all three disciplines. The end result can be that one discipline accepts responsibility or bears the financial cost of addressing all three areas. This gap in the system may result in inadequate, incomplete assessments; inappropriate care plans; ineffective interventions and misuses and waste of limited resources.

d. Service Gaps. Support is high for IHSS and Medicaid funding for RCFE's. These programs have the potential to fill the great need for more options within the continuum of care. Yet, there remains a shortage of affordable residential care facilities for the elderly and for disabled adults, which provide a less costly and more home-like support system than nursing homes care. There are shortages of home care workers as well as respite registries. Increased collaboration between all entities (including health, mental health

and social services) is required in light of AB 1040, the Long-Term Care Integration Pilot Project.

e. Diminished capacity. Health and mental health policies do not address issues of diminished capacity due to physical or mental health issues. This is especially critical for adults who enter the system with an emergency situation.

4. Data Systems

a. Inadequacy. There is inadequate data for decision making and sharing information regionally. Moreover, there is deficit of automation in adult and aging services, especially in case management.

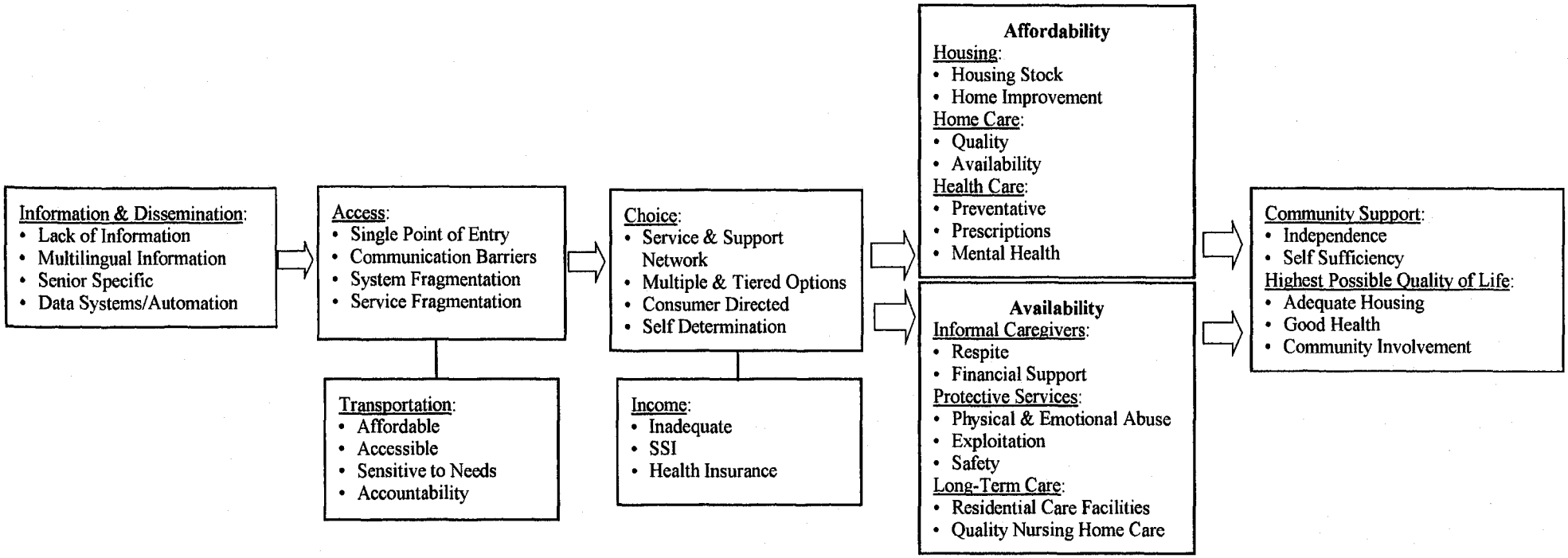
b. Inconsistency. There is a lack of common data elements to track the needs of diverse populations as well as program outcomes. On the other hand, there are time-consuming mandates for staff to gather redundant or inconsequential information during assessments.

5. Human Resources

a. Labor shortage. There is a shortage of staff within county agencies as well as non-profits. Salaries are generally low and there is competition for staff between counties and service systems. There is need for cultural competency as well as bilingual social services.

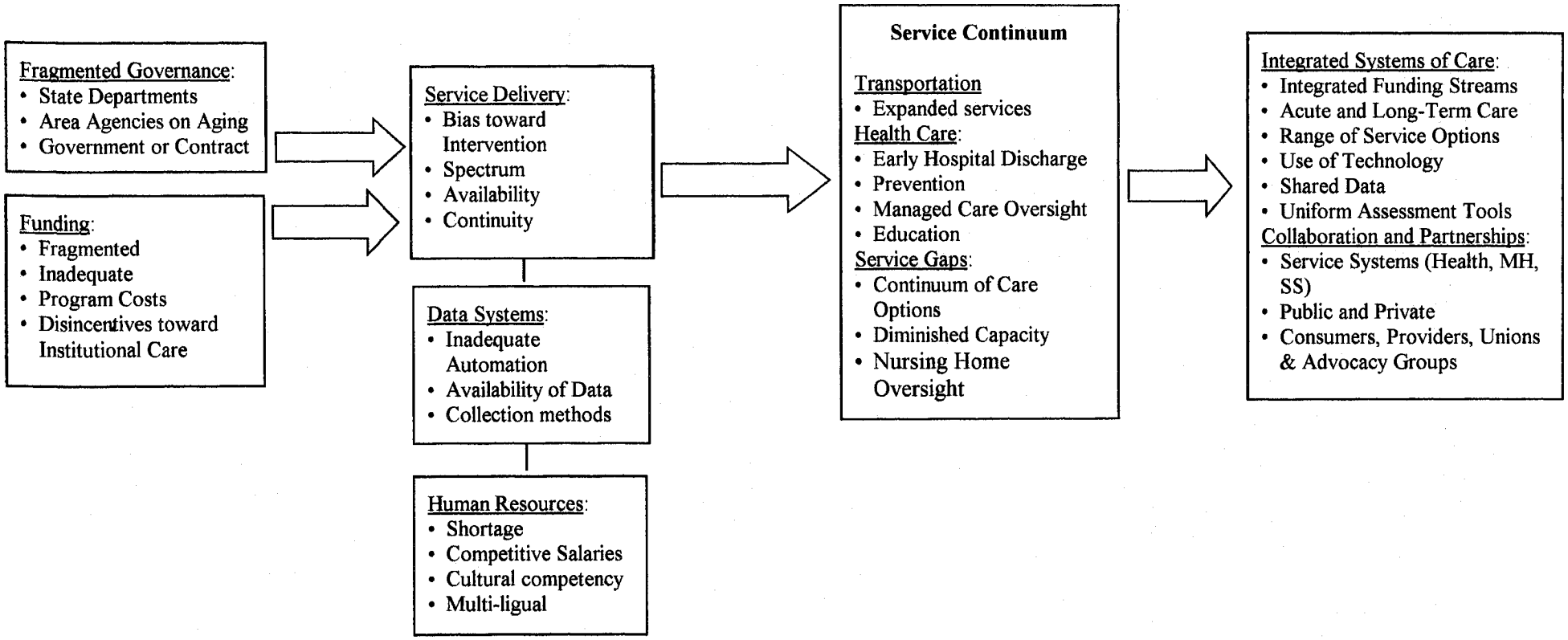
BASSC Adult and Aging Policy Work Group
Flow Chart of Consumer Issues

Figure 3



BASSC Adult and Aging Policy Work Group
Flow Chart of Administrative Issues

Figure 4



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Appendices

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Appendix A
Description of
Our Changing Communities

1. Family Structures

Boomers have typically had children later, have divorced and remarried more frequently, have raised more children as single parents, and have had smaller families, households with two working adults and a larger number of persons who have never married. These diverse family structures affect family income, retirement income, potential for family caregiving and child rearing. Moreover, the responsibility for step parents which arise in blended families will make caregiving more complex (Hagestad, 1986).

The Boomers have changed the very definition of household and family (Institute for the Future, 1998). Their impact lowered the average number of persons per household from 3.3 in 1960 to about 2.7 today. That number is projected to fall to 2.5 early in the 21st century. The composition of the house hold is changing as well. The share of households made up of married couples with children declined from 40% in 1970 to 25% in 1995, and will continue to decline. The number of households that consist of married couples with children under 18 will shrink in absolute numbers between now and 2010. Even single-parent families will grow only slightly. The households with the most dynamic growth rates will be married couples without children, either baby boomers whose kids have grown up or younger people without kids, and nonfamily households, both the very old and the very young living on their own or with friends. However, family will play an important role in the Boomers' retirement: 57% expect to live near at least one of their children; 70% say they look forward to being a grandparent (Roper Starch Worldwide Inc. and AARP, February 1999). Yet 70% said they do not want to depend on their children during retirement.

2. Retirement

Over three-fourths of boomers expect to retire by age 65, and a large percentage by age 60. Although only 20% are confident that they will receive Social Security benefits; most will be dependent upon Social Security as their primary retirement income (American Association of Retired Persons, 1998). Those with higher net worth in housing and retirement savings have lower expectations of the Social Security system (Korczyk, 1998).

Survey participants in the Bay Area 55 years of age and older express concern about planning for retirement (Pardini, 1999). Many act upon this concern by making financial (64.6%) and healthcare preparations (55.8%) as well as arrangements for housing (44.6%). However, over a third of the employed respondents say they will have to continue to work for sufficient income

after retirement. Similarly, about two-thirds of survey respondents in the annual Retirement Confidence Survey (Public Policy Institute, 1996) said they save some money for their retirement. However, about half are not saving enough and a third are not saving at all. Yet in 1997, a high percentage of boomers expressed confidence that they will have enough income in retirement to live comfortably (Public Policy Institute, 1997).

Although remaining connected to family and community, there are changes in attitudes toward reliance on the government for support. A poll of 1,000 Americans (Charles D. Spencer & Associates, 1997) indicated a great difference among age groups in responsibility for retirement. More than 70% of boomers believed that they, not the government, were primarily responsible for their retirement. Fewer (40%) older adults held this view. However, most wanted to keep Social Security and were opposed to reducing benefits. A separate survey concluded that 80% of baby boomers have begun some level of investing for retirement. Eighty-eight percent said they would welcome a single investment vehicle that allocated assets among various categories of investments. Although the respondents had an average annual income of $56,000, 73% said that the lack of money was the biggest obstacle in adequately planning for retirement.

Other retirement issues of major concern reported by the Bay Area survey participants were having money for non-insured health expenses, getting long term care, and continuing to drive. Somewhat lesser concerns were remaining in one's own home, having money to meet expenses, health insurance, avoiding fraud, coping with disability or illness, preventing crime, and being physically fit.

3. Diversity within the Boomers

It has been said that the population generally referred to as the "Baby Boomers" share little as a "generation." For example, the older baby boomers will remember John Kennedy's death, will have entered a growing rather than a stagnant economy, will be more likely to be homeowners who benefitted from low housing costs and probably will have better pension programs and higher income from investments. Other the other hand, the younger baby boomers may enter their latter years served by diminished public and private pension programs, and with less wealth in terms of housing and investments. Their defining historical moment will not be Kennedy or maybe not even the civil rights movement, but perhaps Watergate and waiting in line with their parents for gas during the early 1970s. It is the younger boomers who are more likely to be at risk during their retirement years (Bouvier & Vita, 1991; Light, 1988).

Moreover, the boomers are racially and ethnically diverse. The ethnic divisions mask the important differences by income, class, education, and ethnicity (Torres-Gil, 1992). These distinct populations will have a variety of customs, family structures, and goals. Moreover, they will make up a large portion of the older population, especially those who are at risk.

Boomers are, on average, more educated than and have at least similar incomes to their predecessors (Congressional Budget Office, 1993). However, there has been a greater trend toward inequality of income distribution. The youngest baby boomers, and those who were minorities, experienced high unemployment rates and more limited employment prospects during

the mid-1980s (Jones, 1980). The "senior boomers" are becoming more thrifty as they approach retirement, compared to the younger boomers who have accumulated large credit card debts (Warner, 1996). Home ownership has declined for baby boomers compared to past cohorts – especially the younger ones (Apgar Jr., DiPasquale, McArdle, & Olson, 1990). Pensions programs are shrinking with only the higher-paid persons being able to put money away for retirement (Woods, 1989). Even in views about retirement there are differences with the Boomer group. The views relate directly with income levels. Although most feel well-prepared to enter retirement, a sizable portion do not (Roper Starch Worldwide Inc. and AARP, February 1999).

4. Independent Living

The proportion of elderly living alone increased substantially, from less than 19% in 1960 to 31% in 1990; while the share of those living with adult children declined from 59% to 20% (National Academy on an Aging Society, 1999). When they can no longer live on their own, 69% of seniors surveyed would rather move to a care facility than live with family or friends (American Association of Retired Persons, 1996). Congregate housing is chosen when there is no other alternative (Romano, 1997). Right now the fastest growing housing segment for seniors is assisted living facilities. Aging in place may occur at assisted living facilities. Some providers are forming alliances with home health care agencies and other service providers to provide additional care as needed. Assisted living residences are now replacing nursing homes as the choice for seniors with Alzheimer's and other forms of dementia. Nearly 30% of assisted living facilities have a dedicated Alzheimer's unit and this number is growing. Middle market affordability is the biggest challenge of senior housing. Eventually, it is anticipated that economies of scale will enable providers to build more efficiently and run operations leaner. Moreover, nonprofits companies may also become more of a force in the industry.

A survey of aging American baby boomers recently conducted by the "Professional Builder" suggests that master-planned communities may be a thing of the past (Koster, Prather, & Eds, 1999). Only 3.4% of respondents said they would opt to move into an age-restricted community after retirement. More than half of those queried said they would prefer a community open to all ages, and 38.1% had no preference for either one. Moreover, survey participants showed a strong preference for universal design features and upgrades. Industry trend watchers predict increased sales of luxury, maintenance free housing.

Although adult children and older parents agree about the defining independent living as the ability to take care of oneself, parents (67%) were more likely than their children (51%) to say they do not currently need help to live independently (Barnett, 1998). Moreover, parents (70%) were more likely than their children (41%) to say they do not current receive help from any source.

5. Technology

By 2005, more than half of U.S. consumers access to a computer at home or at work. Health care

consumers of the future will be more actively involved in making decisions about the health care they receive. They will expect high levels of choice, control, customer service, interaction with their health care providers, and access to information. They will use the Internet to help meet those expectations (Mittman, 1999 #198). New technology in telecommunications, home modifications and assistive devices will assist many disabled and older adults to remain independently in their homes for longer periods of time. Moreover, advances in medicine will allow earlier detection, prevention and amelioration of disease. However, lack of access and the absence of a sense of community may hinder the development of global communities.

The United Sates, and California, have begun to develop their first "cybercommunities." Large-scale public access networks for residents to access government, community, educational, and social services activities and events are being constructed. Electronic villages are being created where businesses and residents are connected to local data networks. Infrastructures are being built to allow a wide variety of local government, businesses and institutional transactions. People are accessing the internet directly from their television sets and will soon be able to make videophone calls to and from their television sets (Edgar, 1997). These communities of the future will be connected to every home, office, school, library, and health facility in the region (Eger, 1994). Standardized patient information as well as billing and insurance could link hospitals, clinics, physicians, laboratories and imaging centers resulting in increased accuracy and savings of hundreds of hours of recording labor. More than transportation, the telecommunications developments will allow for more rapid communication for businesses and social relationships.

Increasingly companies are responding to the demand for goods via the Internet. Online drugstores, such as Drugstore.com and PlanetRx.com, are competing with the local drugstores by offering better prices and more variety (Warner, 1999). An Internet grocery store allows customers to shop 24 hours a day for anything from produce and prescription drugs to alcohol, and arrange for free home delivery through 30-minute windows (Associated Press, 1999b). However, medications obtained without a valid prescription or under the advice of a physician may be lethal (Neergaard, 1999).

Not wanting to be left behind, seniors are currently cruising the Internet for Health information (National Institutes of Health, 1998). Two-thirds of seniors involved in a national survey had discussed health information they received on the Internet with their doctors. More than half reported that they were more satisfied with their treatment as a result of their search. However, Internet health information may be misleading or erroneous (Boodman, 1999).

"Smart Community" projects are being developed in California (Caves & Walshok, 1997). The Sacramento School District, the local United Way and community networks in cooperation are providing basic computer training in under-resourced populations. This project also is finding ways to link geographically dispersed social service program-dependent populations (the elderly, the physically handicapped, etc.) with their key provider agencies. The "Davis Community Network" is promoting local business on the Internet as well as using it to involve more citizens in the local government process. Santa Clara county is pursuing the use of the Internet to promote business development, employment, and educational activities in local schools. In Riverside county, government, business, and educational agencies are cooperating to link local government, business, schools and residents with the global information superhighway.

Telemedicine projects in counties throughout the state are making high-quality medical care

available to Californians regardless of where they live (Millis & Nutig, 1998). Telemedicine uses all forms of modern technology, such as telephone, fax and two-way interactive video, to allow a specialist in one location to consult with a patient in another. It gives patients who are geographically or economically isolated access to appropriate medical care. In addition to applications involving patient consultations and triage, post-operative follow-up visits can be done easily and conveniently. Moreover, continuing education courses can be arranged so that groups of physicians need not travel to a central location for a course or meeting.

Telemedicine may involve a medical specialist at one end of a communication link and a physician, nurse, caregiver or patient at the other end. A full history and physical examination can be carried out. Any "hands on" work may be easily accomplished by the caregiver or patient. Radiographs can be transmitted and annotated at the same time. This has been established by the literature which shows that this technology works well without detriment to the quality of care. There are, however, barriers such as confidentiality of patient records, informed consent, medical malpractice and the cost of telecommunications in rural areas.

The California Department of Health Services has linked with several public and private partners and is now serving 11 rural counties. The California Department of Corrections is increasing its reliance on telemedicine to provide medical specialty services to prisoners. The State of California's Office of Criminal Justice Planning funded two medical Training Center Programs to combat family violence by expanding the training they offer to rural communities.

Use of assistive devices increased more rapidly than the population (19%) (Russell, Hendershot, LeClere, Howie, & Adler, 1997). More people (7.4 million) use assistive devises to compensate for mobility impairments than any other type of impairment (i.e. canes, walkers, wheelchairs). Anatomical devices were used by 4.6 million, and hearing devices by 4.5 million. Vision devices were used by .5 million. Among persons who used any mobility device (61.5%), hearing device (68.6%), or vision device; the majority were over age 65. There is a positive correlation between the use of assistive devices and increase in age. However, for those using any anatomical device, the majority (54.6%) were 44 years or younger. Examples of innovative assistive technology ranges from a revolutionary new wheelchair, to robotic buddies. A new wheelchair being tested by the FDA is able to stand and balance like a human; it climbs stairs, rolls through sand, and raises its height to reach the top of shelves (Hockenberry, 1999). The wheelchair is narrower and more compact than the traditional wheelchair. The price is $20,000; however, it may save the expense of home modifications and home care services. Robotic buddies are being produced in Japan by Matsushita Electrical Industrial Company, Ltd (1999). These small, furry robots can show emotion, talk about the weather, and otherwise interact with their owners. It can wake them up and even save their owners' lives. Morever, a microchip inside the robot records interactions with its owner and then analyzes them. Caregivers can monitor an older person by accessing the robot's information logs via mobile phones. If the robot is programmed to do so, it can call the caregivers if there are long periods of silence.

A recent study by supported by AARP (Mann, 1999), reports that home care savings can be quadrupled with home modifications and assistive devices. The study found that the treatment group demonstrated a higher level of functional performance than the control group and that costs of health related services, particularly institutional care was significantly lower. Yet, access may be difficult for some. In their study of high-tech home health care, Kay and Davitt (Kaye &

David, 1995) found recipients of high-tech services were more likely to be younger, male, married, and living with others. Conversely, most of the recipients of home health care programs were older adults, women, people who were not married, and those living alone. Interpretation of differences in access remains open.

Access to computers is increasing, but it is disproportionate. Findings from a Commerce Department survey "Falling Through the Net" (Associated Press, 1999a) found that 55% of Asians; 47% of Whites; 26% of Hispanics and owned computers. African Americans owned computers at less than half the rate of Whites who owned them. As income increases, so does the likelihood of owning a computer; however, income did not explain all the disparities. Among families earning $15,000 to $35,000, more than 33% of whites owned computers, but only 19% of African Americans. People with a college degree were eight times as likely to own a computer and 16 times as likely to have Internet access than people with elementary school educations. Moreover, predictions for a global community seem unlikely. In a survey of social involvement, the AARP found the majority of people used their computers in the past year (American Association of Retired Persons, 1996). Many used them to communicate with others. Yet despite speculation about the developing existence of virtual communities, neither online discussion nor other types of computer groups were cited by respondents as representing a form of community for them.

6. Health Care Attitudes and Preferences

Californians believe that good health is important (Bodenhorn & Kemper, 1997). They also believe that on what health dollars are spent is critical. About half believe that too little is spent to improve community health. And the facts bear out their beliefs. Most healthcare spending funds medical treatment after an individual is already ill or injured, rather than disease prevention and health promotion services. Further, a comprehensive approach to disease prevention and health promotion is missing from national and state policy deliberations. This absence is in part a function of the separate, often categorized, funding sources for personal preventive health and community health services. For insured Californians, personal preventive health services are obtained from healthcare providers and are often employer or self-funded. Community and environmental health services are financed through local, state and federal revenue sources.

Californians have clear views about spending their tax and insurance premium dollars for programs and services to protect and improve health. They are willing to spend more on preventive services and want more for their money. Forty-nine percent of Californians believe the balance between spending for sick and injured care versus spending for illness prevention and promoting good health is not right. Over one-third support spending a greater share of healthcare dollars on disease prevention and health promotion. Underlying these beliefs are very strong assessments of both the importance and effectiveness of preventive services.

Californians believe that a variety of funding sources could generate new monies to improve preventive services. To increase funding for community and environmental health, the majority of Californians support the following: continuation of the laws that require not-for-profit hospitals and health plans to fund community benefits in return for tax-exempt status; expansion

of tax credits for contributions to charities; and, some targeted state and local tax increase proposals, including taxes on tobacco and alcohol products. In addition, a majority of insured Californians are willing to pay 5% more for their health insurance premiums to increase their plan's preventive services.

The federal welfare reform legislation enacted in 1996 had significant ramifications for community health and community healthcare services in California. The law imposed certain limitations on the provision of services to legal and illegal or undocumented immigrants and provided states with discretion to make various policy choices. Within the context of this law, more than four-fifths of Californians (81%) expressed support for continuing to provide community health services to legal immigrants. Slightly over half (53%) expressed their opinion that community health services should not be provided to illegal or undocumented immigrants.

The differences between generations in attitudes on health care are converging. The boomer generation has decreasingly indicated government should be responsible for health care (56% in 1974 compared to 49% in 1994); whereas a static 39% of the WWII generation continued to hold the government responsible at both dates (Mitchell, 1996). Yet, only 39% feel confident Medicare will be available to them during retirement (Roper Starch Worldwide Inc. and AARP, February 1999). While most boomers say they are very satisfied with various aspects of their current health plans, far fewer say they feel confident about the same aspects when it comes to their impending retirement health care coverage. Over half felt they were currently able to get the care they need (60%), visit the doctors of their own choosing (55%), and had the ability to see the specialists they felt they needed (53%); however, only 25%, 24%, and 21%, respectively, felt they could do so after retirement (Roper Starch Worldwide Inc. and AARP, February 1999).

7. Plans for Long-Term Care

Over the past three years, Americans have not increased their knowledge about long-term care nor their planning for it. Moreover, there are many misconceptions about long-term care. Sixty-six percent of respondents in a recent survey (NCOA/John Hancock, 1999) said average nursing home cost is $25,000 rather than $40,000 per year nationally. Thirty-five percent believed medicare is the primary source for long-term care and that it pays nursing home expenses of Alzheimer's patients (30%). Fifty-eight percent believe long-term care insurance is more expensive than the actual cost. Potential barriers identified were lack of intergenerational family discussion, misconceptions about long-term care and long-term care insurance, and a tendency among Americans not to make long-term care a priority in their retirement planning.

Americans say they need help in preparing for long-term care. Two-thirds agree that long-term care poses the greatest threat to their standard of living during retirement. Most (86%), continue to say that long-term care is a major problem in the nation today. Fifty-seven percent believe they have a 50% chance or greater of requiring long-term care at some point in their lives. Eight-two percent say it is irresponsible of them not to plan for their own long-term care needs. Only 23% say they can fund long-term care without insurance. Two-thirds say they would be able to afford nursing home care for 2 or less years at $40,000 annually. Only 12% have made plans, 88% do not plan to purchase a long-term care insurance policy in the next year. The majority

(80%) of those without policies want to think more about it; 77% do not want to spend the extra money now; and 77% have not given it enough consideration.

Americans favor help from government and employers (NCOA/John Hancock, 1999). Fewer than half (46%) of Americans surveyed say that Social Security will be there when they retire or that Medicaid will be available as a safety net (42%), or that Medicare will be adequate to meet their health needs (36%). A majority (61%) say they would pay higher taxes to expand Medicare to cover long-term care. Many favor tax legislation to alleviate some of the problems associated with financing long-term care. Nine out of ten (92%) approve of making long-term care fully tax deductible, 82% support granting tax deductions to children for purchasing long-term care insurance for a parent or grandparent, 80% favor using tax-free withdrawals from 401(k) plans or IRAs to pay for premiums. Two-thirds (65%) would welcome a group policy through their employers; three-fourths (76%) agree they would be likely to purchase a group policy this way.

Of all age groups in the survey, older baby boomers (ages 44 through 52) felt the most threatened by the cost of long-term care. Seventy-nine percent believed long-term care is the greatest risk to their standard of living, compared to 64% of Generation X'ers (ages 21 through 33) and 71% of respondents ages 53-64.

8. Care Preferences

In a 1997 AARP (International Communications Research, 1997; Kassner & Bectel, 1998) sponsored survey almost half (47%) of the respondents strongly disliked the option of having care provided in a nursing or other residential setting. Among the preferred options, the preference for family and friends to provide care is somewhat stronger: 48% of respondents strongly liked this option, while 38% strongly liked an agency-provided service option. When asked their first choice for receiving care, 87% stated they preferred home-based care. Of those expressing preference for home-based care, 49% said their first choice of care was family and friends; 38% agency-based care. When asked about their preference for 24-hour care for themselves or a loved one, 41% expressed their first choice for home-based agency care; 28% friends and family; and 23% nursing home or other residential care.

In the NCOA/Hancock survey (NCOA/John Hancock, 1999), 93% of parents would not want their children to spend their grandchildren's education fund, yet 50% of children said they would and 12% who were providing assistance already had. Adults were more willing to be caregivers than receive personal assistance from their children for the same needs. Nine in ten (92%) of Americans are likely to assist their parent or in-law once or twice weekly with routine chores in their homes. At least 7 in ten (77%) are willing to help with everyday personal needs, relocate their parent or in-laws nearby, but not in the same house (75%), or have them move with them (74%). Conversely, parents (77%) are not likely to ask their children if they can move in with them or to get help with everyday needs such as dressing and bathing (66%). Yet most (79%) are willing to ask their children if they would assist with routine chores once or twice weekly, and to move near them, but not in the same house (62%). Nine in ten (91%) are not willing to ask their children to sacrifice a job advancement, use money set aside for retirement

(86%), or use money set aside for immediate goals (85%).

Researchers who performed a survey in California (Benjamin et al., 1998) with Medicaid IHSS recipients reported that consumer-directed care is preferred over agency-directed care. Consumer-directed respondents reported more satisfaction with their services and freedom to select them, a stronger preference for the role of managing services, higher perceived quality of care, and higher emotional, social, an physical well-being than did agency-directed respondents. Consumer-directed respondents also reported greater satisfaction with the providers' ability to assist them in doing things inside and outside of the home than did agency-directed clients. Further, the consumer-directed respondents reported a higher sense of security, more satisfaction with services and selection, and a stronger preference for the role of managing services with family providers as compared to non-family providers.

AARP's 1997 survey (International Communications Research, 1997; Kassner & Bectel, 1998) demonstrated that respondents preferred a program that would allow them to manage their own home care services rather than receive services managed by an agency. Seventy-six percent prefer a consumer-directed home care program. Caregivers (68.5%) also prefer direct pay respite to agency-based respite care (31.5%) (Feinberg & Whitlatch, 1997). Compared to caregivers who used agency-based care, family caregivers who used direct pay were slightly younger, more highly educated, twice as likely to be employed outside the home and more than twice as likely to be of an ethnic minority group. Moreover, direct pay caregivers were mostly caring for relatives who had suffered from a stroke (32.8%) whereas agency-based users were mostly caring for a relative with Alzheimer's disease (33.3%).

An earlier study of Medicaid beneficiaries receiving home care in Maryland, Michigan, and Texas (Taylor, Leitman, & Barnett, 1991) showed that choice was a significant factor in satisfaction with services. Ninety percent of those with a great deal of choice were very satisfied with their aides compared with 60% of those with little choice. About half of those with little choice said their aides came to work as expected compared with 90% of those with a great deal of choice. Moreover, about half of those with little choice said their aides knew how to get things done very well compared with almost all of those with a great deal of choice.

Appendix B
Trend Descriptions

1. Demographics

The Bay Area Region (Region) is becoming more populous, older, and more diverse. In 1997, the Region represented 22% of the State population. By 2030 it is projected that 10 million people will inhabit the Bay Area (California Department of Finance, 1999), up from an estimated 7.7 million in 2000. Yet the region (34%) is anticipated to grow more slowly than the State of California (50%). The most significant growth will occur in the counties of Alameda, Contra Costa, Monterey, and Santa Clara. The highest proportionate growth will occur in Monterey, San Benito, Solano, and Sonoma. The most dramatic demographic change will be in the age group of adults 65 years of age and older. Between 2000 and 2030, it is anticipated that older adults will nearly double, growing from 11% to 20%. The over 85 age group will increase from 1.4% to 2.4% of the population over the same period. Across the Region the overall proportion of men is equal to the proportion of women; however, the one-to-one ratio increases with age. Within the age group 85 and older, the men to women ratio averages 55%. The Region's gender ratio of is projected to remain constant through 2030.

Life expectancy in the Bay area (81.4 in 1995) is six months longer than that of the state and two years longer than that of the nation (Association of Bay Area Governments, 1999). On average, Asians and Latinos tend to live longer than other racial groups. By 2030, over 67% of the people in the region will be people of color (California Department of Finance, 1999). Whites will fall from 53% in 2000 to 35% of the population by 2030. Hispanics will grow from 20% to 31%; Asian/Pacific Islanders from 18% to 26%, and African Americans will decline a half percent to 7.5%, and Native Americans will remain constant at about 0.5% of the region's population. By 2040, older minorities are anticipated to reach over 51% of the State's total elderly population, and over 77% of individuals under the age of 65% (State of California, December 1998).

A wide discrepancy is anticipated between the diversity of younger versus older adults, both statewide and across the region (California Department of Finance, 1999). By 2030, the difference statewide estimates project about twice as many younger adult minorities (33%) as older adults (17%). Regionally, it is projected there will be almost four times as many younger minority adults (30%) between the ages of 20 to 64 compared to adults 65 years and older (8%). In the agricultural counties of Monterey, Napa, San Benito, Santa Cruz, and Sonoma the variance is five times as many younger minority adults to older adults. Combined with limited English proficiency averaging 18% across the 12 counties and as high as 34% in San Benito (Employment Development Department, 1999a), the difference may create a divide between the two groups of adults.

The school age population will vary widely around the region. Over the next two decades, Contra Costa, Napa, Solano and Sonoma counties will experience a 25% to 35% growth in

children 17 and younger (Association of Bay Area Governments, 1999). This same population will decrease in Marin and San Francisco counties. About 12% of this population were classified as having limited English language proficiency during the 1996-1997 school year.

The dependancy ratio (children under 20 and adults 65 years of age and older) of the Region is higher than the national average and less than that of the State. California is projected to have the second largest proportion of youth in the nation. The Region has slightly less than the State's proportion of (31%) youth population, which is anticipated to decrease one percent from 2000 (28%) to 2030 (27%) (State of California, December 1998). When combined with the proportion of adults 65 years of age and older, it is anticipated that the Region will have an 89% dependency ratio by 2030, compared with a State ratio of 92%. San Francisco and Monterey are projected to have dependency ratios of 104%; reflecting an increase of 86% and 39%, respectively, between the years 2000 and 2030. State dependency rates are expected increase 32% between 2000 and 2040. From 2000 to 2040, it is anticipated that the State's individuals age 85+ will nearly quadruple, the total older adult population 65+ will triple, the number of children 19 and under will double, while adults of working age will increase by only half.

The Bay Area Region's average population per household (2.6 people per household) is slightly less than the State average (2.9) (California Department of Finance, 1999) and is consistent with National trends (2.65) (U.S. Bureau of the Census, 1998b). In 1996, California comprised 11% of the National households (California Department of Finance, 1998). The majority of older adults in the State live with family or by themselves. In 1990, 37% of the State's elderly lived alone and 60% lived with family. Statewide, 19% of households are headed by older adults (U.S. Bureau of the Census, 1998a), compared with 22% across the nation. Nationally, grandparents increasingly are heads of households. In 1997, there were 3.7 million grandparents maintaining households for their grandchildren, the majority of whom were grandmothers (Lugaila, 1998). Among all family types, grandmothers maintaining households alone are much more likely than grandparents in other family types to face economic hardship as well as to be employed. In 1990, 5.4% of California's children lived in their grandparent's household (U.S. Census Bureau, 1999). The National percent in 1997 was 5.5%. Applying this percentage to the Region, there would be roughly 116,628 children under 20 years of age living with their grandparents in the Bay Area in 2000.

2. Economy

The Bay Area (excluding Monterey and San Benito counties), recorded the third fastest annual rate of total job growth among major regions in the State over the past five years, 12.4% (Employment Development Department, 1999b). The effect of industry structure on job growth is clearly demonstrated by recent trends in this region. The Bay Area has been hit harder by the Asian financial crisis than has Southern California because of the significant international trade in electronics and electrical components. As a result, job growth in the region fell from 4.1% in 1997 to 3.1% in 1998. The slowdown is most pronounced in the San Jose area (Santa Clara County), where growth fell from 5.3% to 3.3%.

The Bay Area Region consistently records the lowest unemployment rate among the State's major regions. The average rate for the region was 3.7% in 1998. High housing costs have limited labor force growth throughout the San Francisco Area and, consequently, have made hiring of all types of workers difficult. In the Bay Area, continued strength in most of the region is being offset by sluggish growth in San Jose/Santa Clara County, a victim of weaker Asian export markets, an overheated housing market, and scarcity of office, and industrial space.

Between 1995 and 2020, the Bay Area is projected to add almost 1.4 million new jobs (Association of Bay Area Governments, 1998). The service sector will add the most jobs during the forecast period than any other sector. High technology will be an important new source of jobs during this period, and traditional sectors will continue to grow and will provide most of the future jobs.

As the Boomers retire and California experiences major shifts in its population, the state's current tax structure, which generates more revenues from the personal income tax than any other source, may not provide the necessary balance in the future. Demographic changes over the next two decades will result in a population with very different age, education, income and employment, K-12 and higher education for the age cohorts that trail the baby boomers. For the next 8 to 12 years, California will be in a Golden Age with respect to tax revenues, thanks to the baby boom generation. The first half of the baby boomers, one-third of whom are college educated, currently are in their prime earning years. Over the next few years the best educated, highest income group in history will pass through its peak earning and taxpaying years. As significant numbers of baby boomers begin to retire, California's revenue growth from personal income taxes will begin to sag. Many of the wealthiest of this group will retire early. Once retired, this age cohort will have little or no earned income. This does not mean they will be poor; rather, most of their income will come from savings and non-taxable or low-tax sources such as Social Security, pensions, and investments. Individuals in the 45 to 54 age group, the peak income years, make higher average PIT payments than any other age group. The next highest-paying group consists of those aged 35 to 44. By 2000, the entire baby boom generation will be in the two groups that pay the highest taxes. This will tend to swell tax coffers. By 2012, the peak of the baby boom will have passed through its highest earning years. Since the best educated of the baby boomers is the first half of the group, the impact of their retirement will start to be felt in about eight years (Connell, 1998).

3. Housing

Housing production will continue to lag behind demand between 1995 and 2020, despite the addition of about half a million new households (Association of Bay Area Governments, 1999). Housing production of affordable units and high housing prices remains the most serious constraints to the economic health of the region. The Bay Area's burgeoning economy has produced more jobs than housing units. Considering the amount, location and type of housing being planned, the region's housing costs are expected to remain among the highest in the nation. More than two-thirds of the housing built between 1990 and 1996 were single-family detached

units. Sixty percent of the land available for residential development between 1995 and 2020 is also earmarked for single family homes. Many of the Bay Area's households cannot afford single-family detached homes. Further, many communities in the region resist higher density housing based on real or perceived failings of older high-density projects. As a result, many developers avoid apartment and condominium developments because they are more controversial and take longer to process. According to the California Association of Realtors, in 1997 the median price of an existing Bay Area home was $292,610 compared to the statewide median price of $186,490, and nationwide median of $124,100. Rental rates were also high and anticipated to increase dramatically. Between 1995 and the third quarter of 1997, rents rose an average of 33% in San Francisco, 29.1% in Santa Clara, 24.6% in San Mateo, and 16.9% in Marin. In 1993, San Francisco and Santa Clara counties ranked among the nation's worse housing markets based on the ration of low-income renters to low-income units.

Average vacancy rates across the 12 Bay Area counties were lower (6.4%) than the average state vacancy rates (7.4%) in 1998 (California Department of Finance, 1999). While projected statewide average vacancy rates are anticipated to drop to 4.5% by the year 2010; due to growth in new home construction, the Bay Area Counties average vacancy rate is expected to remain about the same (6.5%). Of the 12 counties, San Mateo and Santa Clara had the lowest average vacancy rates (3.9%) in 1998; moreover, little growth in available housing units is projected for these two counties by 2010. San Mateo's average vacancy rate will remain at 3.9% and Santa Clara's will increase to 4.3%. Housing for the disabled is a concern in the Bay Area as well (Tootelian & Gaedeke, 1999). Across the 12 counties, the average vacancy rate for people with disabilities is 5.2%; compared to 6.1% statewide. Furthermore, available housing does not include factors such as location, amenities, and costs. With the high price of homes, rent and cost of living in the Bay Area, vacant housing may well beyond the reach of many individuals.

Based on a data from seven California metropolitan areas, it has been reported that the deficit of affordable housing units to poor renter households is increasing and is roughly double that of the nation (Housing California, 1999). There are .64 affordable housing units for each household earning between 31% and 50% of the median income, barely half the national average. Overcrowding due to unaffordability or low vacancy rates exceeded 32% in five of the seven California cities. All seven cities had higher overcrowding percentages; five of them were double the national amount. The reasons for the high percentages of unaffordability were increases in poverty and declines in federal housing assistance. There has also been a shift to development of market rate rental housing and rent increases brought on from rental operating and maintenance costs.

California's housing growth already is falling behind population growth and job creation (Krueger, 1997; Kyser, 1998; Zandi, Chen, & Basel, 1998). The shortage appears to be worst for the lower-income portion of the population, and for those in the highest-cost areas (Center for the Continuing Study of the California Economy, 1998). About two-thirds of low-income California renters pay more than 30% of their incomes for housing (California Senate Office of Research, 1999). About one-third pays more than half. About half of low-income homeowners are paying more than 30%, and about one-quarter pays more than half of their income for housing. Average rent for a person with disabilities would exceed half of their income in 1999 (Tootelian & Gaedeke, 1999). Across the Region, the HUD fair market rents per month for one-bedroom

housing ranges from $617 in the Napa/Solano area to $923 in the San Francisco, Marin and San Mateo areas (U.S. Department of Housing and Urban Development, 1999a). In 1997, the average household income in San Francisco for people living in public housing was $784 per month (San Francisco Housing Authority, 1999).

Lack of affordability also appears to lead to overcrowding. Unless there was an unexpected turn-around since the 1990 census, overcrowding is getting worse, among both homeowners and renters. The statewide percentage of renters in overcrowded households increased from 11.1% to 19.6% between 1980 and 1990, while the percentage of homeowners in overcrowded households increased from 4.5% to 6.4%. In a 1997 survey conducted for the state Department of Housing and Community Development, local government reports indicated that an estimated 1.1% of Californians, or more than 360,000 people, were homeless in 1997.

National research shows that 30% of all elderly households pay more than they can afford for housing (U.S. Department of Housing and Urban Development, 1999c). Six percent may live in housing that needs repair and/or rehabilitation. The worst housing conditions affect both homeowners and renters. More than three-quarters of severely inadequate units Nationwide are owner occupied. Fifty-five percent were renters with annual incomes of less than $10,000 and no assets. Furthermore, approximately 7% of public housing and 11% of Section 202 housing may have moderate or greater physical deficiencies. This compares positively with the market-rate rental stock in which physical problems are twice as common.

Accessibility is another issue of concern. Twenty percent of seniors with physical limitations report unmet needs for home modifications (U.S. Department of Housing and Urban Development, 1999c). The need for modifications due to the higher incidence of physical limitations increases sharply with age. The diversity of disabled and dependent adults' housing and assistance needs requires flexible settings that provide maximum independence and dignity, while safeguarding their safety and welfare. Integration of housing with the delivery of supportive services which match an individual's need has the highest potential to meet the desire to age in place.

4. Urban Sprawl and Transportation

At the same time that many Californians face serious housing availability and affordability challenges, much of the state's housing construction is occurring increasingly far from jobs. Urban sprawl has a social price. It contributes to the loss of productive farm land, inefficient energy and water use, increased air pollution, high cost to taxpayers of extending infrastructure to newly developing areas, greater freeway traffic congestion, and loss of community.

High housing costs force many people to move out of the region and commute to jobs from adjoining counties. Urban sprawl into the suburbs generates more solid waste, as well as water and air pollution than does the compact development (Association of Bay Area Governments, 1999). It also requires major infrastructure investments such as new roads and highways, water and sewer-line extensions, and reservoirs. The cost of the land development is not usually included in the development fees levied on new projects, as a result, residents of older

cities are subsidizing sprawl. Nearly 200,000 acres in the region have been set aside for residential development over the next 20 years. Much of this development is planned in areas distant from those earmarked for commercial and industrial development. The discrepancy will exacerbate the region's problems of transportation and infrastructure.

The design of the Bay Area's communities, particularly the modern subdivisions, has forced residents into their cars. It is not economical to provide mass transit to low-density neighborhoods with few houses per acre (Association of Bay Area Governments, 1999). Current trends indicate that majority of housing will be low-density, single-family developments built on the region's periphery. More than 80% will be built more than three miles away from a rail station or ferry terminal. Long distances between the home and other activities often necessitate a car. This poses significant problems for the more than two million Bay Areas residents who can't drive, many of whom are seniors or disabled.

The majority (71.8%) of individuals 55 and older who participated in a Bay Area survey drove by themselves (Pardini, 1999). However, 9% relied upon others for transportation and nearly 9% walked to their destination . Moreover, 11% of survey participants age 55 and older indicated they experienced difficulty going outside their home and were dependent on others for assistance. Only about 9% used public transit or paratransit. National research (Office of the Assistant Secretary for Transportation Policy, 1997) has found that many older adults do not use public transportation due to lack of availability, inconvenience, physical problems and safety concerns (i.e. harassment, intimidation, and criminal acts). Many depend on spouses, significant others, religious institutions or children to drive. Others reduce their activities and their expectations to fit their present circumstances. Over one in ten older adults surveyed in the Bay Area indicated that they had insufficient social contact.

5. Labor Force Participation

The persistently high cost of housing will cause high levels of labor force participation, particularly people in older age groups. By 2020, more than one-fourth of the Bay Area older adults will be working (Association of Bay Area Governments, 1999). Changes in potential retirement benefits and low rates of retirement savings by the Boomers may cause many to extend their careers. Moreover, the region's high cost of living makes it more difficult for saving and decreases the value of retirement benefits. Jobs such as information technology and service jobs, that place less emphasis on physical labor and more on accumulated knowledge as well present opportunities for telecommuting, will increase employment prospects for the 65+ age group. Furthermore, the scarcity of workers creates incentives for companies to retain and train older workers. As a way to cope with the region's high cost of living, many residents will hold more than one job.

In a Bay Area survey (Pardini, 1999), while over half (54.4%) of the 55+ individuals reported being retired, 18.4% worked full-time and 12.8% worked part time. Many (37%) stated that they would have to work after retirement to make enough income; however, 80% reported that they would choose to work part-time after retirement. Current labor force participation in

the Nation is high, but will decline with age (Roper Starch Worldwide Inc. and AARP, February 1999). Ninety percent of the Boomer men and 75% of the women are in the work force. But if current trends continue, this will drop in their 50s. Men participating in the labor force declines rapidly between the ages of 60 (67.5%) and 70 (16.3%) (DHHS Office of Disability, Aging and Long-Term Care Policy, & National Institute on Aging, 1997). The decline in labor force participation from 1950 (72%) to 1995 (30%) has shown a reverse trend (Roper Starch Worldwide Inc. and AARP, February 1999). The sense of financial security provided by social security, early retirement packages, and necessity to leave work for health reasons have diminished. Boomers make up over one third of contingent workers with no employee or retirement benefits. Over 70% of the baby boomers say they plan to continue working at least part-time after their formal retirement. However, few anticipate their current employer would permit them to work part time even with less pay.

6. Income

It is increasingly difficult for a household to exist in the Bay Area on one income. The minimum amount of money working adults must earn to meet their family's basic needs has been defined as the "self-sufficiency standard" (Association of Bay Area Governments, 1999). In the Bay Area Region (excluding Monterey and San Benito), this ranges from $1,840 per month for a single parent with one preschool-age child living in Sonoma county; to $2,550 for the same family unit living in San Francisco county. A two wage-earner household with a preschool child would need $2,880 per month. Two adults earning $8.20 per hour could achieve this monthly income; however, the $5.75 minimum wage is the entry-level pay for occupations expected to net the most jobs over the next few years. Families who remain on welfare and other low-income working families who are unable to meet the self-sufficiency standard will create a higher cost to society. As a result, the region could experience more homelessness, higher crime rates, and greater demands on social and municipal services.

Regional data reflect state trends in income. Compared to the rest of the nation, California had a greater decline at the bottom and middle of the wage distribution and greater growth at the top (Connell, 1999). The leading causes of the widening wage gap were education, work experience, and immigration. Having a diploma and greater years of work experience contributed to higher wages and immigration to lower wages. Between 1989 and 1997, the share of immigrants in the male workforce grew from 29% to 36%. Over 40% of immigrants had less than a high school diploma compared to 7% of native born.

Poverty thresholds are lower for the elderly than for adults below the age of 65. In 1992, the threshold amount for a single older individual was $6,729; for adults under 65 it was $7,299 (U.S. Bureau of the Census, 1996a). Section 8 low income limits for the Bay Area ranges from $33,450 for two adults in Napa to $43,500 for two people in San Francisco (U.S. Department of Housing and Urban Development, 1999b). Many of the region's older adults who were surveyed are classified as low income (Pardini, 1999). Over half (51.5%) of a five-county survey had annual incomes of $40,000 or below. Almost a third (29.4%) had incomes under $25,000.

Although some were younger than the eligibility age for Social Security, the majority (57%) of these individuals received Social Security income. Thirty-nine percent received retirement income. Over one-third received income from employment and nearly a third (30%) received investment incomes. Seven percent reported SSI income.

Although they were 10 years younger than 65, the age generally considered as retirement age, survey respondents appear to be headed toward national trends in retirement income. In 1996, 92.5% of persons aged 65 and over had Social Security Income, with a median annual amount of $7,749 (Public Policy Institute, 1998b). Almost a third of those 65+ had pension income in 1995. The median annual pension income was $6,240. About 16% of older persons were working in 1995. The median earnings income was $9,000, while the mean was over twice as large ($19,612). Interest income received was by approximately two-thirds of both men and women with a median amount of $800 and $771, respectively.

Overall, retirement prospects of baby boomers are anticipated to be better than those of cohorts born 20 years earlier (Crystal & Johnson, 1998). Mean family income at midlife was higher for women born after World War II than for women born in the 1920s and 1930s, primarily because of increasing labor force participation rates of married women and declining family sizes. Yet, retirement outcomes for single men and those with limited education are unlikely to show much improvement over the outcomes experienced by their parents' generation. Moreover, the dual-earner family pattern that is increasingly typical brings additional financial and non-financial costs that offset part of the additional income. Smaller family sizes also have implications for the future availability of informal care to members of the baby boom cohorts.

7. Community Participation

Bay Area residents remain socially involved and attached to their communities. Many (39%) Bay Area community members age 55 and older report they are highly involved in their community (Pardini, 1999). The community contribution averaged over 2 hours per week per person. The three greatest reasons given for volunteering time and service were to stay healthy and active, to help others, and to use special skills. Other important reasons were to work with those who have the greatest need, to make good use of their time, and to learn new things. The majority (79%) of survey participants gave donations regularly to churches or charities.

In a survey of Boomers nationwide, close to 49% say they expect to devote more time to community services or volunteer activities during retirement (Roper Starch Worldwide Inc. and AARP, February 1999). According to a recent AARP Survey (American Association of Retired Persons, 1996) they were engaged with their communities through organizational memberships and volunteer work, and involved in politics at the local level. The average American was affiliated with 4.3 groups or about 3.3 types of organizations; 44% volunteer within organizations and 86% help another person on an individual basis.

Measured in terms of voting, volunteering and joining associations, current levels of civic participation are the lowest in history (Moloney, 1996; Putnam, 1996). Since 1964, time devoted civic involvement has declined by about half, from 54% to 35% in 1995. The Boomers and the

Generation X'ers have each been progressively less involved at each state of their lives than those who were born earlier. The most engaged group on a lifelong basis are seniors now between the ages of 65 and 70. The number of Californians eligible to vote has declined. The voter participation declined from 69% in 1960 to 47% in 1994 (Moloney, 1996; The Field Institute, 1994). The State's participation rates vary highly among groups, leading to a widening gap between the ethnic characteristics of the state as whole and those of the active, voting Californians who command the attention of elected officials. While the faster-growing non-white population now represents about half of the state's population, they represent only 19% of the electorate. While the population is becoming multi-racial, lack of participation at the polls is leaving an electorate that has an Anglo complexion and an older-aged outlook on the future (Moloney, 1996; Walters, 1997).

Community services that were utilized by more than a fifth of the seniors surveyed in the Bay Area were recreation or social (30.6%), yard or lawn care (27.6%), healthcare information (27%), housekeeping services (22.4%) home repair services (21%), educational classes (20.6%) (Pardini, 1999). Other selected services that were utilized are general information (16.8%), transportation services (15.65), home health care (7.2%), caregiver support groups (6%), personal care (5.2%), and home delivered meals (5.2%). Participants reported they learned of these services mostly through five main sources: newspapers (36.3%), family members (29.4%), television or radio (26.1%), health centers and hospitals (25.8%) and the telephone book (21.8%). Over a sixth of the older adults surveyed received information from the senior center (16.4%) and over a tenth from religious organizations (10.4%). Three-fourths were not aware of the special phone numbers that provide information to older adults in the Bay Area. Remarkably, although the Bay Area is becoming increasingly diverse, language was not perceived as a barrier to obtaining information by most survey participants (94.4%).

Survey participants were strongly connected to their communities. Over two-thirds (68.6%) lived in a single family home and just over 4% lived in senior housing. Almost half of adults 55 and older have lived in their community thirty or more years. Over 70% have lived in the community for more than 20 years. Over two-thirds (68.2%) of the participants stated they did not anticipate any change in their living situation and 85% said they planned to remain living in the same community. Nearly 10% said they would move to a non-clinical retirement or community home, and about 9% said they would move to a smaller place. Independence appeared to be an important consideration among survey respondents. Only about 5% stated they would move in with their children. At the time of the survey, close to half (48.1%) lived with their spouse and over a third lived alone (35.7%). About 11% lived with an adult child.

Most (74.2%) felt very safe within their homes, yet nearly all (97%) seniors expressed concern about their safety within the community; over 60% were very concerned (Pardini, 1999). Nearly one-fifth (19.2%) reported that a crime and/or other form of violence had an impact on them. Additionally, 8.2% had experienced some form of abuse, exploitation or neglect. In 1997, the region comprised 20% of the state's confirmed reports of elder abuse and 12% of the dependent adult abuse.

8. Retirement

Social Security has become the main income support for older adults. In 1992, 93% of the elderly received Social Security Benefits (U.S. Bureau of the Census, 1996a). The Social Security program provided 100% of total income for 14% of elderly beneficiaries; 90% or more of the total income for over a quarter (26%) of elderly beneficiaries; at least 50% of total income for almost two-thirds (63%) of elderly beneficiaries. Although over two-fifths were under age 65, almost three-fifths (57%) of Bay Area survey respondents received Social Security as a source of income (Pardini, 1999). Private pensions and retirement income are important additional sources of income for the elderly. About two-fifths of the Bay Area respondents received pension income; and close to a third received investment income. Gender and ethnicity are important factors in the receipt of pension benefits. Nationally, two-thirds of pension benefits were received by men. Moreover, 35% of the elderly who receive pensions are White; 20% are African American and 19% are Hispanic.

Across the nation, after the age of 54 the proportion of individuals who have retirement savings decreases (Korczyk, 1998). Of individuals between the ages of 45 to 54 years, over half (54%) had retirement savings; the median amount was $25,000. Under half (47%) of the 55 to 64 age group had retirement savings with a median value of $32,800; 35% of the 65 to 74 age group had retirement savings at a median value of $28,500; and only 17% of the group individuals 75 years and older had retirement savings with a median of $17,500.

Retirement savings increase with income. Across the nation, only 6% of households with incomes below $10,000 report retirement savings and fewer than half of households with incomes under $30,000 had begun to save for retirement; whereas 85% of those with incomes of $100,000 or more reported retirement savings. Although there are no absolute patterns in retirement savings, the groups most vulnerable to inadequate retirement savings are those with low incomes, single parents, non-homeowners, formerly married persons, and households with whose head has less than a high school diploma.

9. Health and Health Care

It might be expected that the region would reflect state and national trends in incidence of disease and leading causes of death. Sixty-two percent of California deaths are from heart disease, stroke, or cancer in 1996 (Department of Health Services, 1999). Almost 2% of the state's deaths are from AIDS. The region's high life expectancy may be attributed to factors related to longevity such as education. Education has been found to be inversely related to deaths due to chronic disease and communicable disease as well as to declines in smoking and alcohol consumption (California Department of Finance, 1999). In 1990, the region had a median of 14 years in school (California Department of Finance, 1999). Moreover, self-perceived health has been found to influence longevity (Rogers, 1995). In a Bay Area survey of adults age 55 and older, 71.5% of the respondents rated their health as good or excellent (Pardini, 1999). Risk factors such as being

overweight (U.S. Department of Health and Human Services, 1998) might also be lower since over 80% of the survey participants reported they walked or did aerobics regularly (Pardini, 1999). Nearly nine out of ten reported they exercised every day or a few times a week.

Despite a trend toward improved health and declining incidence of disease, older adults' needs for medical and long-term care are substantial and growing. Many of the elderly have one or more chronic conditions that require continued health care. Chronic conditions are the leading cause of illness, disability and death in the United States (The Institute for Health & Aging, August 1996). More than 20% of the population will suffer from arthritis over the next twenty years (Alliance for Aging Research, 1999). Bone impairments affect 12% of the total population (Adams & Marano, 1995). Hearing and eyesight impairments affect 29% of the 65+ age group. One-tenth of individuals over 65 and nearly half of those over 85 have Alzheimer's disease (Alzheimer's Association, 1999). National costs for individuals with mild to severe Alzheimer's disease totaled $51.3 billion in 1996 (Leon, Cheng, & Neumann, 1998). The Estimated average lifetime cost per person with Alzheimer's disease $174,000 (Alzheimer's Association, 1999).

Notwithstanding the increasing need there are inadequate numbers of geriatric physicians. National supply is not meeting the demand (California Healthline, 1999). Prescription drugs is an example of the need for geriatric training. Prescription drug misuse and abuse is prevalent among older adults because of multiple drug interactions, interaction of drugs with alcohol, and the aging body's vulnerability to the effects of drugs and alcohol (Center for Substance Abuse Treatment, 1998). Nearly half of seniors take medication not related to pain, such as medication for high blood pressure (National Council on Aging, 1997). Nearly one-fifth of individuals over the age of 60 takes medication for chronic pain; one in four suffers from side effects caused by these drugs, yet almost 40% say their doctors do not warn them about potential drug interactions. In addition to physicians, a greater number of health care and social service professionals will be required. Between 1993 to 2005 California anticipates tremendous job growth for physical therapists (71%) , occupational therapists (41%), and nurse aides (41%). Demand for home health care workers is estimate to increase 80% between 1990 and 2005 (Employment Development Department, 1995). Moreover, geriatric social workers supply only 10% of the current demand. The National Institute on Aging projects a need for 60,000 to 70,000 geriatric social workers Nationally by the year 2020 (National Institute on Aging, 1987). Yet only about 3% of MSW students select an aging concentration. Of the remaining 97% of students, only 2 percent take any course in aging while in school (Damron-Rodriguez & Lubben, 1997). Increasing state caseloads in various public programs such as Medicaid, SSI/SSP, and IHSS reflect the growing need for gerontological social workers.

Prevention or postponement of loss of independence in older people would have a very substantial impact on the quality of their lives as well as the costs of medical and long-term care. Loss of independence is most commonly attributable to disabilities that result from several specific age-related diseases and conditions such as visual impairment, dementia, mental impairment, and mobility impairment (Alliance for Aging Research, 1999). Ten billion could be saved in National health costs if the onset of osteoarthritis could be delayed just five years. Further, it has been reported that older Americans who lose independence each year incur an additional $26 billion in medical and long-term care expenses than if they had maintained their level of independence over that year. Of the $26 billion, $22 billion is for people who begin the

year independent and then lose independence, resulting in need for help with self-care at home or admission to a nursing home. An additional $4 billion is incurred for those who begin the year disabled in the community and make the transition directly to nursing home care during the year. The $26 billion estimate does not reflect the total costs of caring for disabled persons in the community or living in nursing homes, but only the increase incurred during the year when older persons actually lose their independence. Based on its proportion of the national population, a rough translation of this amount regionally might be $686 million.

10. Health Insurance

Nearly all persons 65 years of age or older in the nation are eligible for Medicare (U.S. Department of Health and Human Services, 1998). Most of the elderly also have additional health care coverage. In 1996, 72% of the elderly had private health insurance and 38% had private health insurance obtained through the workplace. In 1996, 9% of the elderly had Medicaid or other public assistance and 18% had Medicare only, with no other health plan. Older persons in the region who were enrolled in Medicare Hospital Insurance and/or Supplemental Medical Insurance in 1998 comprised 10% of the region's population, 23% of the state's Medicare population and 2.3% of California's total population.

Medicare beneficiaries are at high risk due to a combination of problematic health and low or modest incomes (Schoen, Neuman, Kitchman, Davis, & Rowland, 1998). In 1997, one-third lived on an income below 200 percent of the poverty level (about $15,000 annually for an individual) and reported health problems. Half (49%) said they spent all or most of their monthly income on basic living necessities. Additionally, the high cost of prescription drugs is an added financial burden. Over one-tenth (11%) of Medicare beneficiaries reported spending more than $100 out-of-pocket per month to pay for medications, above the amount paid for premiums (U.S. Department of Health and Human Services, 1998). Indeed, prescription drug coverage is regarded the number one reason why older persons choose HMOs, and was cited as a major reason why insurance companies are dropping Medicare plans (National Council on Aging, 1999). Beneficiaries with low incomes were more likely than those with higher incomes to have health problems. They were more likely to be in fair or poor health, have one or more ADL impairment, and experience certain health problems such as diabetes. Disabled Medicare beneficiaries under age 65 had a greater likelihood of having their health problems compounded by poverty; more than two-fifths lived below the poverty level. In 1998, there were 434,747 disabled Medicare beneficiaries in the state, 1.3% of the total population.

California's Medicaid population 65 years of age and older numbered 597,046 in 1998; about 12% of the total recipients and 1.8% of the State's total population. The number of individuals aged 85 and older on Medicaid was 109,995, representing almost one-fifth (18%) of the older Medicaid population (Health Care Financing Administration, 1999).

In 1994 government-sponsored programs such as Medicare and Medicaid accounted for about 41% of California's total health care expenditures of $105.3 billion (Managed Health Care Improvement Task Force, 1998). During this same year the total health care expenditures by

California employers were $35.3 billion, or 34% of the total. These figures include coverage for public employees, who constitute another major sector of government-sponsored health care spending. In California, an increasing portion of government health care dollars are going to managed care organizations. For example, as of October, 1997, 40% of Medicare beneficiaries in CA were enrolled in managed care plans. The Medicaid program has also exhibited a notable trend toward managed care coverage. From January, 1995 to January 1997, total Medicaid enrollment decreased from 5.46 million to 5.30 million. During the same time period, the percent of Medicaid enrollees covered by managed care plans increased from 17.1% (93 million) to 28.5% (1.51 million). This trend continued through the most recent data collection period, with 1.86 million, or 36.3% of Medicaid enrollees in managed care plans in July of 1997.

As of 1995, private long-term care insurance covered less than 1% of the total long-term care expenditures (U. S. General Accounting Office, 1998). However, there has been substantial growth in the sales of policies. In 1996, more than 600,000 policies were sold (Levit & Lazenby, 1996). Cost is a major factor that discourages or prevents many individuals from purchasing these policies. According to Colonel (1998), the average annual premium for a long-term care insurance policy ranged from $364 for a 50-year-old of a base plan to $7,440 for a 79-year-old of a policy that included a nonforfeiture benefit and lifetime 5% compounded inflation protection. People with low incomes are more likely to be eligible for Medicaid coverage of their long-term care expenses. However, because Medicaid has very restrictive asset rules, some individuals with relatively low incomes have too many assets to qualify for Medicaid. Rather than deplete their assets and turn to Medicaid, some individuals choose to purchase long-term care insurance (Kassner & Bectel, 1998). The average age at which individuals purchase long-term care insurance policies is 69. Although the cost of long-term care insurance is considerably lower when purchased at younger ages, most individuals do not begin to be concerned about their future need for long-term care until they are older.

California is attempting to reduce expenditures on long-term care by increasing private contributions through a public-private partnership, The California Partnership for Long-Term Care program. A grant was received from the Robert Wood Johnson Foundation to implement the program which combines long-term care insurance with Medicaid. Consumers who purchase qualified insurance policies can become eligible for Medicaid after their private insurance is exhausted, but without spending all their assets. The intent of the partnership is to increase the number of middle-income elderly who have long-term care insurance coverage and thereby keep them from impoverishment. Eight companies were participating in the program at the end of 1996, with only 4,762 policies in force.

11. Disability and Long-Term Care

With increased life expectancy has come the greater likelihood that persons will live to ages where more long-term chronic illnesses and health conditions occur. The major causes of death often include an extended period of disability and need for care before death. In spite of an overall decline in death rates, socioeconomic differences in mortality rates have actually increased

in recent decades in the U.S. (Pappas, Queen, Hadden, & Fisher, 1993), reflecting a widening gap between the richest and the poorest (Danziger & Weinberg, 1994). As a larger proportion of the population experiences relative socioeconomic disadvantage and its accompanying health disadvantage, rates of morbidity at young, middle, and older adult ages will increase. This trend would lead us to project an increased need for earlier intervention and more intense long-term care.

Estimates from the 1990 Census indicate that almost 21% of California's noninstitutionalized population 16 years of age and older (U.S. Census Bureau, 1997) and 19% of the 65+ population (U.S. Bureau of the Census, 1996b) were disabled. Nearly 11% were severely disabled (U.S. Census Bureau, 1997). It is currently estimated that over 38% of California's disabled are individuals 65 years of age or older (Tootelian & Gaedeke, 1999). The 1990 incidence and severity of disability mirrored National percentages. In 1995, the largest proportion of disabled in the nation (26.2%) were between the ages of 65 and 79 (McNeil, August 1997). Nationally, over 47% of individuals 65 through 79 years of age and 71.5% of individuals 80 years or older, had a disability. Nearly a third of the 65 through 79 age group and over half of the 80+ age group reported their disability as severe. If disability rates continue to reflect state and national trends, as well as remaining constant (Manton, Stallard, & Corder, 1997), it might be projected that there will be 782,152 disabled adults 65 years of age and older in the region in 2030. About 42,677 of the adults 65 through 79 and 279,794 of those 80 years and older would be severely disabled.

Most survey respondents of Bay Area adults 55 years of age and older (94%) said they experienced no difficulty caring for their own personal needs, such as bathing, cooking and cleaning their homes (Pardini, 1999). When asked upon whom they would rely to provide future assistance, most (35.6%) stated they would depend upon their children, or their spouse or partner (25.1%). Those with limitations relied mainly on family or partners to assist them. Most depended on their children (25%), followed by a paid worker (18.8%). About an eighth said they relied on a spouse or partner, and the same proportion relied on another relative. Of concern is approximately one-sixth (12.5%) reported they had no one to provide assistance with personal needs.

Bay Area survey results parallel those of a national survey performed in 1997 (International Communications Research, 1997). Forty-eight percent of the national respondents preferred care from family and friends and 38% desired agency-based care. When asked their first choice for receiving care, 87% stated they preferred home-based care. Almost half expressed strong dislike for the option of having care provided in a nursing or other residential setting.

Public demand for nursing homes is lower in California than across the nation. In 1996, California had two-thirds the nation's proportion of Medicare skilled nursing facility admissions; and less than half the national proportion of Medicaid nursing facility admissions (Public Policy Institute, 1998a). Only 3% of older adults age 65 years and older resided in a nursing home in 1996 compared to 5.6% nationally (Public Policy Institute, 1998a). Nursing home residents per 1,000 of the State's 65+ population was 30.6, compared to 43.7 across the nation. California has responded to public demand by decreasing its supply of nursing home beds and increasing its supply of licensed residential care facilities. The State comprised 21% of the nation's facilities in 1995 and had more than double (44) the nation's (21) residential care beds per 1,000 individuals

65 years of age or older. Moreover, California has 5,900 residential care facilities for the elderly (RCFEs) which provide varying levels of non-medical care and supervision (California Department of Social Services, 1999). Although consumer demand is driving the industry's development, like other housing in California, many of these facilities are priced too high for individuals with low incomes. The cost of RCFEs range from $700 to $4,000 per month, depending on location and care needs (California Registry, 1999). The average cost for shared accommodation, including care needs, is around $1,400 a month. Most (81%) residents pay for accommodations from their private funds, although an increasingly number long-term care insurance policies cover assisted living (American Health Care Association, 1999). Supplemental Security Income may pay for the least expensive facilities in the Region; however, many of the low cost facilities are in undesirable or unsafe locations, and they may have lengthy waiting lists. California's Little Hoover Commission has urged the State to embrace federal waivers to receive Medicaid dollars for residential care facilities (Haddock, 1999).

In addition to residential care facilities, California has developed adult day care programs and has high support for the development of viable home and community based systems of care (Administration on Aging, 1999). California is the home of the nationally recognized On Loc program in San Francisco which is being replicated at many sites around the country under the federal demonstration program known as PACE, Program for All-Inclusive Care for the Elderly.

State Medicaid expenditures for long term care in 1996 was $3.7 billion. Nursing home expenditures comprised $2.1 billion (57%) ; home and community-based expenditures comprised $1.0 billion (12%) of the total amount (Public Policy Institute, 1998a). The high cost for nursing home care and residential care facilities combined with the strong desire of consumers to receive care in their homes has underlined the need for alternative, less expensive ways to deliver care to individuals who do not require continual care. California is attempting to fill this void through home health care. In 1996, home health agencies in California provided care to 750,228 patients. Home health care patients received an average of 22 visits from providers during the course of the year (Office of Statewide Health Planning and Development (OSHPD), 1999). Between 1988 and 1996, the number of home health care patients increased more than 130% and the number of home visits increased almost 300%. Nationally, approximately 13.8% of the elderly population received home health care, substantially more than any other age group. Regionally, this would translate to about 119,952 older adults in 2000.

Most home visits are provided by home care nurses, certified nurse assistants, and home care workers. Salaries for home health workers differ from one district to another by additional education and licensing, and the amount of work or experience. Workers with no experience earned as little as $4.25 to $12.00 in 1995. Those with three years or more years of experience earned from $5.50 to $14.00 per hour. In 1996, Medicare and Medicaid paid for 85% of home health visits in California. Health maintenance organizations and preferred provider organizations accounted for another 7.7% percent of reimbursements.

California's Residual Program, funded entirely by the state, is available for people who meet all but the federal Medicaid income criteria. About 14% of beneficiaries have incomes too high for Medicaid eligibility and are served by IHSS Residual Program. California provides beneficiaries with access to consumer-directed or agency-based long-term care models (California Health and Human Services, 1999). Beneficiaries of the consumer-directed model are responsible

for recruiting, hiring, training, and supervising their workers and can hire a family member if they chose (Taylor et al., 1991). More than 40% have hired a family member. People who live alone, who are considered unable or unwilling to manage their care, and who have relatively few care needs are generally assigned to the agency-directed model. Those with heavy care needs are usually assigned to the consumer-directed care. Because the workers who work in consumer-directed care are paid only minimum wage, persons with heavy care needs are able to purchase more services than if they had to rely on agency services which cost about $14 per hour. Increases in wages and benefits due to unionization of home care workers (Tansey, 1999; Wood, 1999) may make it increasingly difficult for individuals with low and middle income individuals to obtain the care they require.

12. Informal Caregiving

Most of us think of health care as services provided by medical professionals in hospitals, doctor's offices, and nursing homes. However, for individuals with chronic illness or disability, the foundation to health care is help with daily living tasks, such as eating, bathing, and transportation to the doctor or to church. In most instances, this type of assistance is provided by family members, friends, and neighbors. It is estimated that 80% of disabled people are cared for at home or in the community by family members (U. S. General Accounting Office, 1995).

In their 1997 survey, the Family Caregiver Alliance found that one-quarter of the California's households may be involved with caregiving for a older person; many may also be caring for dependent children (Feinberg, Pilisuk, & Kelly, 1999). Researchers in a study of California caregivers utilizing in-home care reported that one-fifth were also caring for children 17 years of age or younger (Feinberg & Whitlatch, 1997). Caregivers are most likely to be female (73.8%) and married (88.4%). Although still the largest kin group, spouse caregivers fell statewide from 51% to 47% from 1992 to 1997 (Family Caregiver Alliance, 1998). The mean age of caregivers in California is 60 years. Increasingly caregivers are adult children; their proportion in the Bay Area grew from 36% in 1992 to 40% in 1997. Caregivers across the state were more likely to be employed, increasing from 45% to 53%. Those who reduced their work hours to provide care increased dramatically from 18% to 43%. Caregivers 75 years or older grew from 16% to 21%. Almost half (47%) were less likely to receive the help they needed from family or friends compared to five years ago (28%) and their risk for physical health problems increased. Self rated poor or fair health grew from 43% to 50% statewide.

Research indicates that caregivers to the elderly provide an average of 20 hours of care per week (Manton, Doty, & Elizabeth, 1994). On average, older care recipients have 1.7 caregivers and receive 29 hours of care per week. Informal caregivers play an important role in preventing or delaying nursing home care. Less than a fourth of the nation's elderly with function disabilities live in nursing homes. In fact, 1.6 million elders with severe long-term disabilities, those with three or more ADLs or severe cognitive impairment, are able to live in the community in their own or relatives' homes. Two-thirds (68%) of primary caregivers live in the same household with the disabled elders for whom they provide care. The high cost of housing might make it more

difficult for children and other caregivers in the region to live in separate housing but in the same community as their ailing elders. This could lead to overcrowding within the same household or greater distances between the caregiver and care recipient.

Because of the quantity and value of informal care, experts promote more effective means of assisting caregivers and warn against cutting back the support provided through home health care (Arno, Levine, & Memmott, 1999). The value of unpaid caregiving is estimated to be $200 billion, one-fifth of the nation's total annual health care costs. In comparison, spending for home health care is estimated at $32 billion; and nursing home care $83 billion.

Vignette 1:

MONTEREY COUNTY VIGNETTE

Ms. B., a 78 year old single woman, was reported to APS as being in severe danger by neighbors who were concerned that she was disoriented and who observed her sitting on her front porch day and night for the last few weeks. Prior to these recent events, neighbors reported that Ms. B was very active, drove her care daily to visit with friends, and appeared to be a healthy, active, senior. APS STAFF FOUND Ms. B. To be living alone in a filthy, cluttered house with rotting food throughout the house and on the front porch. Utilities had been disconnected for lack of payment. Ms. B was a retired post office worker with federal pension and lived in an upscale neighborhood for 20 years. She had no family and her only visitors were old friends from the post office. Ms. B received home-delivered meals, but appeared not to have eaten any food for a long period of time. She was extremely thin with a disheveled appearance and was confused and disoriented. Ms. B had an open infected sore on her lower leg, which made walking difficult, but she had not seen a physician in a number of years. Environmental Health and the Fire Department assisted APS in assessing conditions found at the residence. Beneath all the rotten food and containers, APS observed lovely antique furniture and memorabilia of Ms. B's travels. Ms. B was not seen to be in imminent danger, so initial contacts with her focused on further assessment and engaging Ms. B in responses to the presenting issues. She was coaxed to go with the social worker to the ER to have her leg treated by physician with the idea that the ER staff would likely see her as unable to provide for her basic needs and hospitalize her for a comprehensive assessment. However, the leg was treated and Ms. B was released to the APS social worker at 2:00 a.m. for transport home. Ms. B remained disoriented, did not eat and continued to spend most of her days on the porch. The Public Guardian is unable to provide emergency response to probate referrals, and could not assist on an immediate basis. Over the next several weeks, the APS social worker continued to work with Ms. B and ultimately arranged placement in a board and care home located close to Ms. B's old post office friends. Although Ms. B made an initial adjustment in her new residence, she continued to be extremely thin and did not eat. She could not be maintained at the board and care home and was placed in a skilled nursing facility. There it was found that she had a significant stomach blockage which made eating very painful and caused her to regurgitate her food. She remains placed in the skilled nursing facility. A comprehensive geriatric assessment, which would have addressed bio-phycho-socio spheres may have assisted the APS staff in developing a service plan that addressed Ms. B's presenting issues.

Vignette 2:

SAN FRANCISCO VIGNETTE

Seniors, who are poor, live on a fixed income, have no life savings, and cannot rely on family support, often find they are confronted with a range of housing crises. For the senior who wants to live independently, they are currently shut out of the S.F. rental market by skyrocketing rents and an extremely low vacancy rate of 1%. Our clients can not count on finding subsidized senior housing as the waiting lists range from two to ten years. Section 8 and the Voucher programs, which also enable seniors to subsidize their rent, are all in a state of flux and many landlords resist accepting tenants with Section 8 due to the increased oversight from an outside agency.

If a senior on a fixed income wants to remain in the community, but can no longer live totally independently and needs some assistance, they have very few assisted living unit options. However, a senior with greater means, now has a myriad of supportive housing option, as this area is a burgeoning industry, responding to the increased demand from our aging population. It is projected that the senior population of San Francisco will increase by 57% from 116,080 presently to 181,981 in the year 2020.

Our options for our clients are limited. Throughout the city, Board and Care beds for SSI recipients are very limited and for non-ambulatory seniors are almost nonexistent.

VIGNETTE: R.D., a client of six years, was living independently at a residence hotel. Her health was well as her mental functioning began to deteriorate. She was hospitalized and the hotel said that if the hospital discharged her to her apartment, they would begin eviction proceedings. She is fiercely independent and needs a supportive housing arrangement, yet she can not afford the options currently available. The going rate for the lower end assisted living units range from $995 to $1,500 per month, which is out of her range. She remains in limbo in the hospital because no appropriate housing can be found.

Vignette 3:

NAPA COUNTY VIGNETTE

Napa County is suffering from a serious lack of residential resources and programming for mentally ill older adults.

We are currently serving a 67 year old woman with a long history of paranoid schizophrenia and alcoholism. She has had many acute psychiatric hospitalizations and IMD placements. Besides her mental illness and alcoholism, she is now exhibiting the early stages of dementia. The dementia is exacerbating her mentally illness since she is becoming confused, anxious and is beginning to wander. She is under a Public LPS Conservatorship of Person and is currently living in an IMD. She receives SSI/SSA and her funds are being managed through our Representative Payee Program.

Historically this client's housing needs have been met primarily through the licensed board and care system. These facilities are willing to accept the SSI rate, which now is $731.00 per month. For the most part these board and care homes lack structured programming during the day -- activities are usually limited to watching TV and some occasional outings. The staff at these homes often lack the professional skills to deal with these clients. Besides the issues of mental illness, alcoholism, and dementia, many of our elderly clients have serious medical problems that most of these homes cannot adequately address.

Because of the lack of professional support, monitoring and structure in these facilities, many of our mentally ill clients decompensate and require more expensive placements at higher levels of care.

This dynamic also works in reverse. This client has been repeatedly "stepped down" to the board and care level after many months in a highly structured setting, only to be readmitted to an acute psychiatric hospital or IMD because she couldn't maintain at the lower level. There is a dearth of resources for this population between the highly structured IMD and the almost "anything goes" board and care home.

Vignette 4:

SONOMA COUNTY VIGNETTE

In the last five years (1994/1995 - 1998/1999), the number of reports of Fiduciary Abuse in Sonoma County has increased 55% (40% since last program year). The ratio of Female to Male reported victims is 2:1. Fifty-seven percent of the suspected abusers have been family members (35% have been offspring of the victim and 22% have been some other relation); another 20% of the suspected abusers have been caregivers.

Vignette 5:

MARIN COUNTY VIGNETTE

Adult Protective Services received a call from the police about an 83 year old woman who had been a leader in the community. Her neighbors had called the police because she had been sitting in her car in the driveway for two hours with the motor running. They had been unable to get her to go into the house. She told them that she had an appointment and was going to the doctor. The police were already aware of this woman because she had been calling them several times in the middle of the night, asking if they could come and cook for her. She also claimed that she had no food in the house. Family was also concerned and had in fact hired someone to help her, but she continually fired these persons. An Adult Protective Services Social Worker made a visit and engaged with her. She agreed to have a thorough medical check-up and that she would allow her family to coordinate this for her. After APS' first visit, her physical condition deteriorated rapidly. The Social Worker facilitated the communication among the client, her family and the doctors. The client subsequently accepted placement in a board and care and agreed to have financial management.

Vignette 6:

SANTA CLARA COUNTY VIGNETTE

Santa Clara County has seen a 60% increase in elder financial abuse reports in 1999. To meet the demands of this community need, a Financial Abuse Specialist Team (FAST) Rapid Response was created to expedite the investigation and prosecution of financial abuse cases and to protect elders from additional abuse. The FAST team consists of an Adult Protective Services (APS) Social Worker, Public Guardian (PG) Investigator, PG Estate Administrator (to perform legal research), District Attorney (DA) Investigator and Deputy DA (to handle criminal actions), and a Deputy County Counsel (to handle civil actions). In addition, we are in the process of establishing a FAST Consultative Team, consisting of private and public sector professionals (such as mental health counselors, medical doctors, financial planners, real estate, bankers, etc.). The FAST Consultative Team members will donate a few hours of confidential consultative services each month to assist the FAST and APS personnel in the management of these cases.

The ability to investigate and intervene in a timely manner, in situations of financial abuse, is becoming more difficult as the numbers of referrals skyrocket in Santa Clara County. It has been often said that only one in fourteen instances of abuse is reported. This leads us to believe that we can only anticipate increasing numbers of referrals and the subsequent increase in the critical need for investigation of financial abuse. Meeting this need becomes one of our top priorities in the Department of Aging and Adult Services. This department, which consists of Public Administrator/Guardian/Conservator, Adult Protective Services, Senior Nutrition, In-Home Supportive Services and Veterans Services, is dedicated to protecting and enhancing the lives of residents of our community. We anticipate the creation of numerous additional FAST teams is clearly needed in order to meet the increased demand of this service.

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