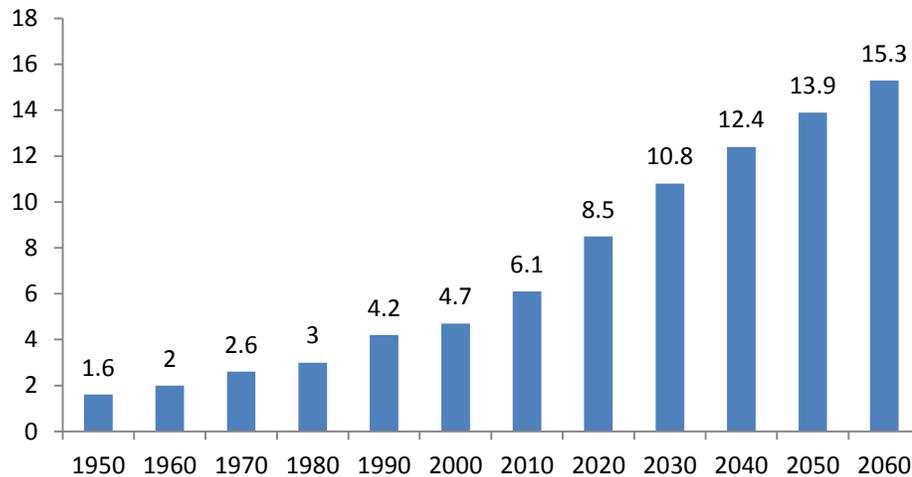


# CALIFORNIA STATE PLAN ON AGING 2013 – 2017



■ California Population Age 60 and Older in Millions



**Edmund G. Brown Jr. Governor**  
State of California

**Diana S. Dooley, Secretary**  
California Health and Human Services Agency

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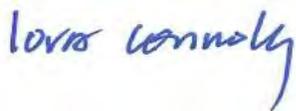
## FORWARD

As California's designated State Unit on Aging, the California Department of Aging has prepared the *California State Plan on Aging – 2013-2017* with a focus on promoting the independence and well-being of older adults, adults with disabilities, and their families throughout the State. Eligibility for many Older Americans Act services begins at age 60 and California is home to more than six million individuals in this age group. In a little over a decade, that number will increase by over 56 percent. However, most individuals accessing Older Americans Act services are in their seventies or older. By 2024, the number of Californians age 85 and over is expected to grow by over 21 percent.

In hearings conducted to receive public comments prior to submission of this State Plan, the Department heard directly from older adults, persons with disabilities, family members, advocates, and providers about the unmet need in their communities for transportation, housing, nutrition, health care, social and mental health services.

While the number of Californians who could benefit from Older Americans Act, senior employment, and health insurance counseling programs continues to grow, the Department, Area Agencies on Aging, and the local aging provider networks are losing over \$10 million in federal funding to provide these services as a result of the federal Sequestration. Ongoing reductions of this magnitude will require dialogue at all levels to realistically examine the resources and infrastructure capacity needed to carry out the requirements and services authorized under these federal programs.

Passage of the Affordable Care Act has created a historic opportunity for states to partner with the Centers for Medicare & Medicaid Services to develop new care delivery and financing models. These models focus on providing more coordinated, person-centered health, behavioral health and long-term services and supports that promote independence and community living. California is pursuing these goals through its Coordinated Care Initiative. This initiative includes implementing managed long-term services and supports and a Medicare-Medicaid demonstration program, known as Cal MediConnect, in eight participating counties. Several objectives in this State Plan address the Department's continued engagement in critical activities to promote the Coordinated Care Initiative's successful implementation and the Aging Network's active participation in this important endeavor.



Lora Connolly  
Director

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## EXECUTIVE SUMMARY

Federal law requires each State Unit on Aging to submit a State Plan to the federal Administration on Aging (AoA) at least every four years. When approved, the State of California receives federal funds to administer the State Plan. These federal funds are matched with State and local funds.

Beyond the minimum required information, the *California State Plan on Aging – 2013-2017* (State Plan) addresses: key socio-demographic factors that will shape funding needs; priorities, unmet needs and promising practices identified by the California Department of Aging (CDA or Department) and the Area Agencies Aging (AAA); and the Department's objectives in working with the AAAs and others to provide cost-effective, high quality services to California's older adults, adults with disabilities, and their caregivers.

Since 2000, California's population of persons 60 and older has grown rapidly. Between 1950 and 2000, the number of older adults in this State grew from 1.6 million to 4.7 million, an increase of 194 percent. This trend will continue as the number of people age 60 and over grows to 13.9 million by 2050, an increase of 128 percent from 2010. By 2050, it is estimated that over 25 percent of Californians will be 60 or older.

While approximately 607,000 Californians are 85 or older today, by 2050 an estimated 2.49 million individuals will be in this age group, a dramatic 310 percent increase. This rapid growth has many implications for individuals, families, communities, and government.

In the late 1990s, racial and ethnic minority populations became the largest segment of California's population. California's older population will also continue to grow more racially, ethnically, and culturally diverse. While 62 percent of older adults were White/Non-Hispanic in 2010, by 2050 the majority of older adults will be from a number of racial, ethnic, and cultural groups. Racial, ethnic, and cultural diversity has enriched California, fostered new innovations, and encouraged an appreciation of the State's multicultural traditions and the values and priorities we hold in common. Nonetheless, because some groups have been historically deprived of opportunities, or are now faced with the challenges of life in a new culture, diversity may translate into health and economic disparities that must be addressed.

This State Plan outlines goals, objectives, and strategies that are sensitive to this environment and articulates measurable outcomes that can be achieved within the Department's resources. The State Plan seeks to: increase consumer access to health and supportive services; assist people in making informed decisions about available programs and benefits; enable individuals to continue living in their communities in a manner consistent with their abilities and values; expand opportunities for civic engagement; integrate evidence-based practice into Older Americans Act (OAA) programs and services; protect consumer rights and prevent abuse. Throughout, it focuses on developing and maintaining the ongoing partnerships necessary to support

the ability of the Aging Network to address local needs. By strengthening the infrastructure for home- and community-based services, the State Plan continues to build toward a future in which every Californian has the opportunity to enjoy wellness, longevity, and quality of life in strong, healthy communities.

### **Summary of Goals and Objectives**

#### ***GOAL I: Empower older Californians, adults with disabilities, and their caregivers to easily access the information they need to make informed decisions.***

- A. Make information on health and supportive services accessible to older adults, their caregivers, and others to promote independence and wellness.
- B. Provide enhanced beneficiary outreach, counseling, and education to individuals who are dually eligible for Medi-Cal and Medicare to help them make informed decisions about their benefit options under California's Coordinated Care Initiative (CCI).
- C. Publicize information on long-term care issues and trends so that consumers and their families are empowered to make informed decisions.

#### ***GOAL II: Enable older Californians, adults with disabilities, and their caregivers to be active and supported in their homes and communities.***

- A. Support successful implementation of California's CCI.
- B. Participate in developing a universal assessment instrument (UAI) and process to support individualized care planning and facilitate care coordination for CCI participants needing long-term services and supports (LTSS).
- C. Conduct a pilot to test the merit of implementing statewide cost-sharing as allowable in OAA services.
- D. Expand opportunities for community involvement and volunteerism to increase the availability of services to older adults, persons with disabilities, and family caregivers; promote peer-to-peer support programs; and foster intergenerational service programs.
- E. Advance the availability of transportation services that are responsive to the needs of older adults, adults with disabilities, and their family caregivers.

**GOAL III: Enable older Californians, adults with disabilities, and their caregivers to be healthy.**

- A.** Promote healthier living through evidence-based chronic disease self-management education (CDSME) programs targeted to adults with various chronic conditions and family caregivers, particularly those impacted by Alzheimer’s disease or related dementia.
- B.** Support older adults in increasing their access to nutritious foods and establishing healthy eating habits.
- C.** Support efforts to make the evidence-based Savvy Caregiver Support Program and the Spanish-language adaptation of the program, *Cuidando con Respeto*, available to families impacted by Alzheimer’s disease and related dementia.

**GOAL IV: Protect the consumer rights of older Californians and adults with disabilities and assist them to obtain needed benefits.**

- A.** Evaluate coordination efforts between local Long-Term Care Ombudsman programs (LTCOP) and county Adult Protective Services (APS) agencies and local law enforcement agencies and provide technical assistance to improve coordination.
- B.** Collaborate with the University of California, Irvine (UCI) and other state and local entities to create a practical and replicable model for elder abuse prevention and risk reduction among older adults with dementia.
- C.** Improve coordination between local LTCOPs and OAA Legal Services Providers (LSP) to increase access to legal services by residents in long-term care facilities.
- D.** Participate in the state-level partnership to reduce the use of antipsychotic medications in conjunction with the Centers for Medicare & Medicaid Services’ Initiative to Improve Dementia Care in Skilled Nursing Facilities.
- E.** Establish relationships and collaborate with tribal organizations receiving Title VI funding on areas of mutual interest.

## **SECTION I – STATE PLAN PURPOSE AND VISION**

### **State Plan Purpose**

Federal law requires each State Unit on Aging to submit to the federal AoA a State Plan on Aging at least every four years. At a minimum, this State Plan must specify:

- The State’s goals and objectives for the planning period;
- Statewide program objectives to implement the requirements under Title III of the Older Americans Act (OAA) of 1965, as amended;
- A resource allocation plan indicating the proposed use and the distribution of Title III funds to each Planning and Service Area (PSA);
- The geographic boundaries of each PSA and of the designated AAA;
- The prior federal fiscal year information on low income, minority, and rural older adults; and
- Compliance with assurances currently required by the OAA of 1965, as amended, Title 45, Code of Federal Regulations (CFR) Section 1321.17(f) beginning at (f)(1).

When approved, the State of California receives federal funds to administer the State Plan. These federal funds are matched with State and local funds.

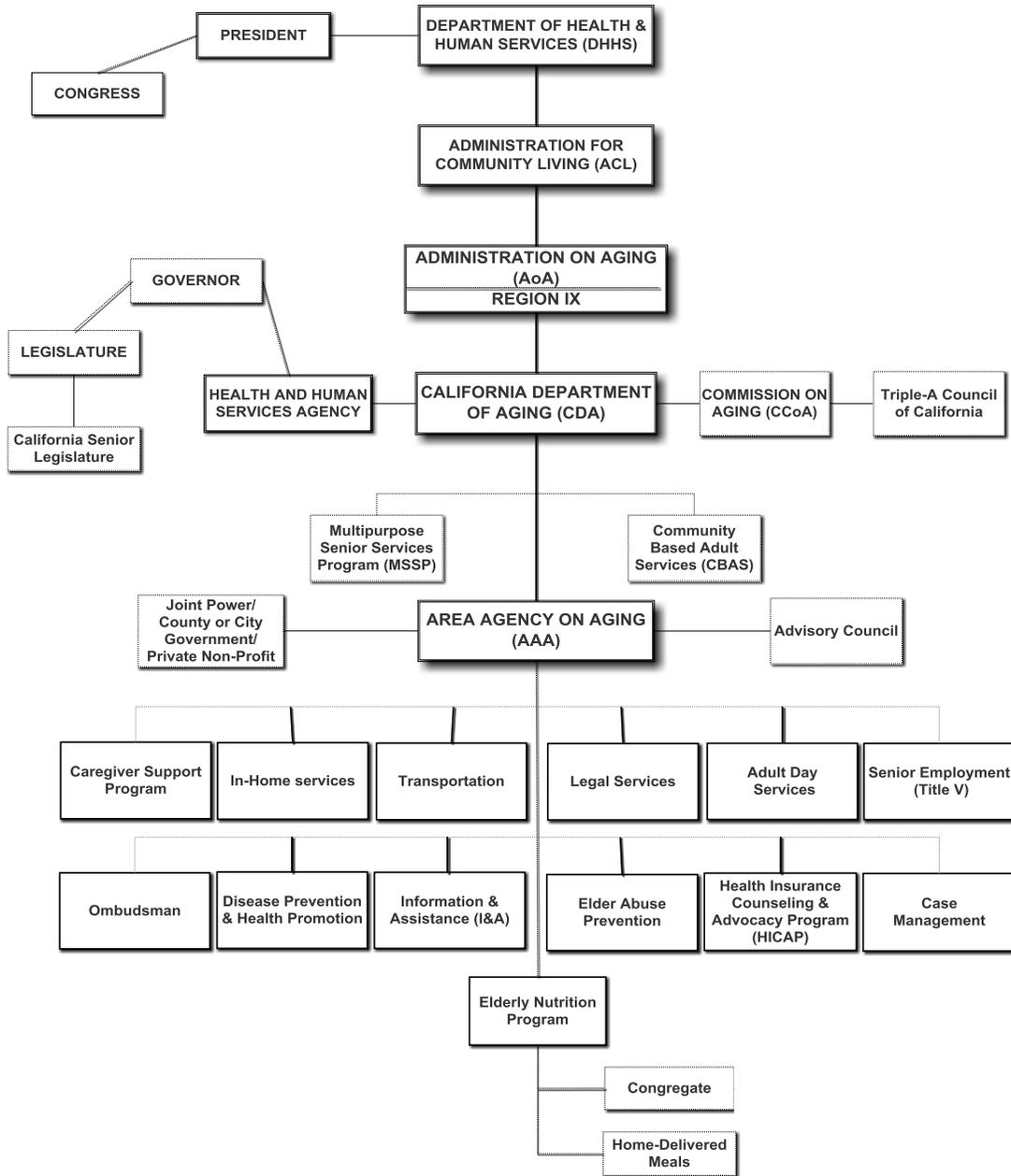
Beyond the minimum required information, California’s State Plan addresses:

- Key socio-demographic factors that will shape funding needs and priorities;
- Priorities, unmet needs, and promising practices identified by CDA and the AAAs; and
- CDA’s objectives in working with the AAAs to provide cost-effective, high quality services to older adults, adults with disabilities, and their informal caregivers.

In addition to the variety of OAA home- and community-based services authorized under the OAA, CDA and AAAs also administer the statewide Health Insurance Counseling and Advocacy Program (HICAP) to provide Medicare beneficiaries with information about their health and long-term care (LTC) insurance options. CDA also administers the Multipurpose Senior Services Program (MSSP), the Medi-Cal waiver for older adults at risk of skilled nursing placement, and certifies licensed adult day health care (ADHC) centers for Medi-Cal reimbursement as Community-Based Adult Services (CBAS) providers. CBAS providers serve adults aged 18 and older with functional impairments that place them at risk of institutionalization. Medi-Cal programs are jointly funded with federal and State dollars. Medi-Cal is California’s Medicaid program (Figure 1).

Figure 1

CALIFORNIA AGING NETWORK



Revised June 2013

## **Vision, Mission and Values**

The Department envisions every Californian having the opportunity to enjoy wellness, longevity, and quality of life in strong healthy communities.

Its Mission is to promote the independence and well-being of older adults, adults with disabilities, and families through:

- Access to information and services to improve the quality of their lives;
- Opportunities for community involvement;
- Support for family members providing care; and
- Collaboration with other state and local agencies.

The Department strives to pursue its Vision and accomplish its Mission in a manner consistent with its Values (Appendix A).

## SECTION II – CONTEXT

### Overview of the California Aging Services Network

#### **Local Level: AAAs**

The OAA and the Older Californians Act (OCA) provide the legislative context for California's 33 AAAs to fund specific services, identify unmet needs, and engage in systems development activities in their PSA (Appendix B). Systems development is a set of activities and processes used by the AAAs and other organizations to envision, plan, manage, coordinate, integrate, evaluate, refine, and improve the quality of a community's constellation of services.<sup>1</sup> Although this may be difficult when staff and funds are limited, with strong leadership, times of fiscal austerity can also create the impetus for collaboration and resource sharing.

#### **State Level: CDA**

The OAA and the OCA specify that CDA has an important role in helping AAAs and their local communities to develop systems of services. As with AAAs, CDA often does not have the administrative or budgetary authority to "require" other agencies or organizations to participate in systems development efforts. Nonetheless, its expertise on aging, disability, and caregiving issues is important to shaping programs and service systems that are sensitive and responsive to the needs of older adults, adults with disabilities, and their families.

By leveraging its resources through federal grants and collaborative partnerships, CDA continues to strengthen the infrastructure for the home- and community-based services necessary to address local needs. CDA administers a number of grants to support evidence-based health promotion and develop local service partnerships. As an active participant in California's Olmstead Advisory Committee and other policy forums, CDA joins State departments, local agencies and other stakeholders to identify strategies to prevent or delay institutionalization and improve service delivery. Section III of this Plan further describes these efforts. In addition, CDA assists AAAs and communities by:

- Working with other State departments and agencies, AAAs, and other local entities to define roles and responsibilities at both the State and local levels;
- Providing Area Plan guidance that encourages and supports systems development;
- Working to remove State-level barriers. CDA works with sister agencies to resolve implementation issues;
- Developing common program standards, including service unit definitions and reporting requirements;
- Fostering the development and implementation of common intake, screening, and assessment instruments;
- Actively supporting local efforts;
- Helping to improve access to information, resources, and services;

- Providing training and technical assistance to individuals and organizations at the local level as needed;
- Sharing promising practices; and
- Refining data collection and reporting to improve the information available to decision makers in developing policies that affect older adults.

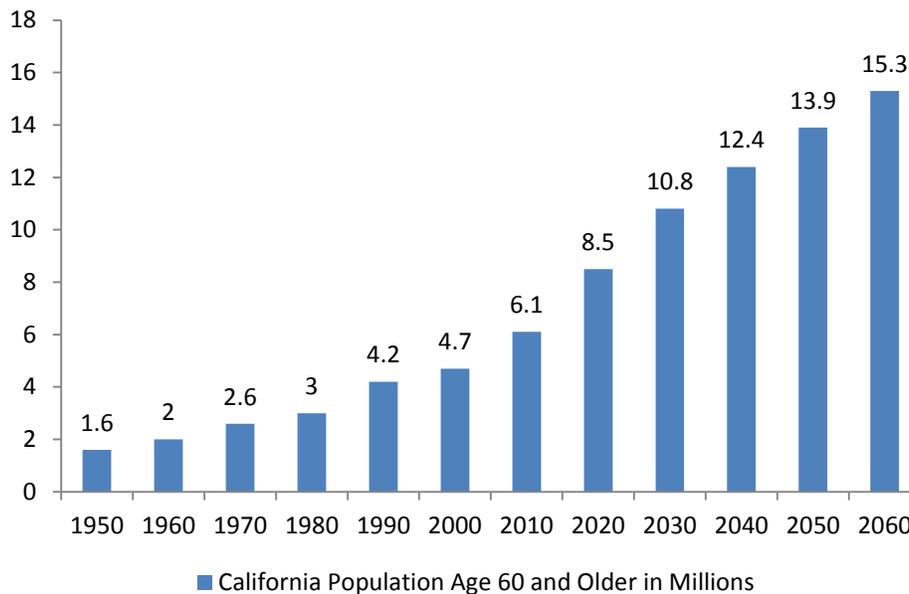
These combined efforts comprise a proactive strategy to make optimal use of limited resources during challenging times.

## **Aging in California**

### **Overview**

Since 2000, California’s population age 60 and over has grown rapidly (Figure 2). Between 1950 and 2000, the number of older adults in this State increased from 1.6 million to 4.7 million, an increase of 194 percent. This trend will continue as the cohort age 60 and over grows to 13.9 million by 2050, an increase of 179 percent from 2010.

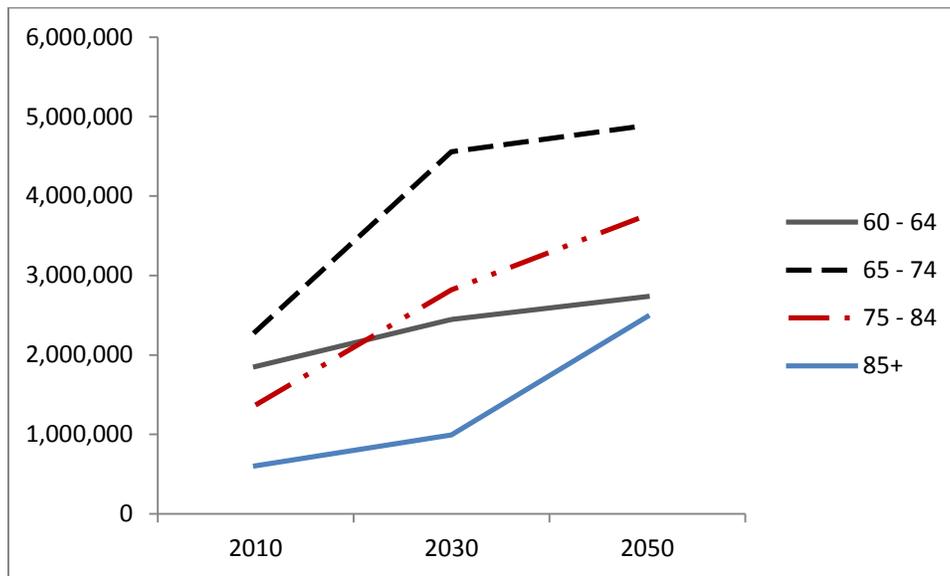
**Figure 2**  
**California Population Age 60+ Growth Trends<sup>2</sup>**  
(in millions, rounded)



While the overall population age 60 and over is growing rapidly, increases within this age group are occurring at different rates (Appendix C). The largest growth will occur during the next 30 years as the Baby Boomers, those born between 1946 and 1964, reach age 60. Between 2010 and 2024, California’s older adult population will increase by 56 percent as members of the Baby Boomer cohort turn 60. By 2050, over 25 percent of Californians will be age 60 and older.

An estimated 1.85 million Californians are currently between age 60 and 64. By 2030, this age group is projected to grow to 2.45 million, a 32 percent increase. While today over 607,000 Californians are age 85 and over today, by 2050, an estimated 2.49 million individuals will be in this age group, a dramatic 310 percent increase (Figure 3).

**Figure 3  
Age 60+ Population Growth Projections<sup>3</sup>**



The current size of the population age 85 and over, and the projected increase in this age group, is notable. Those 85 and older have a significantly higher rate of severe chronic health conditions and functional limitations that result in the need for more health and supportive services. The rapid growth of this age group has many implications for individuals, families, communities, and government.

The impact of an aging population, described by some as an “age wave” and others as an “aging tsunami,” will be felt in every aspect of society. The economic, housing, transportation, health, and social support implications of this phenomenon must also be viewed in the context of the State’s tremendous population growth, which continues to challenge the State’s overall infrastructure planning. Demographers project that California’s population, now nearly 38 million, could reach 51 million by 2050.<sup>4</sup>

While Table 1 presents an overview of older Californians today, older adults have never been a heterogeneous group in terms of educational achievement, income level, and health and disability status. In the coming decades, the gap between the “haves” and the “have-nots” among older Californians will grow even wider. Educational and employment opportunities throughout life impact access to health care, retirement savings, and pension benefits in later life. The cumulative effect of all these factors shapes older Californians’ prospects for a healthy and secure retirement. Important differences among the State’s older adults are tied to racial, ethnic, and cultural factors; gender and marital status; geographic location; and socio-economic resources.

**Table 1**  
**A Snapshot of Older Californians Age 60+**

<b>Characteristic</b>	<b>2005-2009, 2010</b>
Living in a nursing home <sup>5</sup>	1.7%
Below poverty level <sup>6</sup>	9.8%
Medi-Cal beneficiaries <sup>7</sup>	19.1%
Limited English proficiency <sup>8</sup>	20.3%
Poor or near poor (0-199% of poverty) <sup>9</sup>	28%
Living alone <sup>10</sup>	22.5%
Women age 60+ living alone <sup>11</sup>	45%
Percent with any disability <sup>12</sup>	43%
Proportion of Californians age 75 and older with a driver's license <sup>13</sup>	61%
Homeowners <sup>14</sup>	77%
With high school diploma or higher <sup>15</sup>	77%
Number of grandparents responsible for basic needs of grandchildren <sup>16</sup>	119,103

### **Geographic Location**

The Los Angeles Basin and the San Francisco Bay Area are now home to about two-thirds of the State's older population; this likely will continue over the next 40 years (Appendix D). While every region, except the most rural areas of the State, is expected to experience strong growth in its population of persons age 60 and over, the largest increases are predicted for several Central Valley and Southern California counties (Appendices E and F). By 2030, the number of older people is expected to double in Kern, Kings, Merced, San Benito, San Bernardino, and Riverside counties, and will more than double in Imperial County.<sup>17</sup>

### **Race, Ethnicity and Cultural Factors**

In the late 1990s, racial and ethnic minority populations became the largest segment of California's population. California's older adults will continue to grow more racially, ethnically, and culturally diverse. While 62 percent of older adults were White/Non-Hispanic in 2010, by 2050 the majority will be from groups formerly considered to be minorities (Appendix G).

Ethnic and cultural diversity has enriched California, fostered new innovations, and encouraged an appreciation of the State's multicultural traditions and the values and priorities we hold in common. However, because some groups have been historically deprived of opportunities, or are now faced with the challenges of life in a new culture, diversity may translate into health and economic disparities that must be addressed:

- Older adults who are not White report poor or fair health more often than Whites/Non-Hispanics. Older Hispanics and those with limited English abilities have the worst health profiles compared to statewide averages.<sup>18</sup>
- While 88 percent of U.S.-born older Californians have at least 12 years of education, only about 64 percent of older immigrants have this level of education. However, it should be noted that there has been a 10 percent increase in educational attainment for U.S.-born immigrants, while that increase is 14 percent for older immigrants.<sup>19</sup>
- Cultural customs and expectations related to a family's caregiving responsibilities can have a significant negative impact on the primary caregiver's health and future financial resources.<sup>20</sup>

Between 2005 and 2007, an estimated 38,000 residents age 60 and older migrated to California from other states and 27,000 migrated from abroad.<sup>21</sup> Approximately 1.6 million (30 percent) of California's total older adult population was foreign-born. Of these, 78 percent arrived before 1990, 15 percent in the 1990s, and 7 percent in 2000 or later. The future size and age distribution of the California population will be influenced by both international and domestic migration, each of which is difficult to predict.<sup>22</sup>

While approximately 15 percent of older Californians have limited English proficiency, in Alameda, San Francisco, San Mateo, Santa Clara, Merced, San Benito, Monterey, Tulare, Los Angeles, Orange, and Imperial counties between 12 and 21 percent of older adults have difficulty communicating in English (Appendix H).

Providing culturally appropriate outreach and assistance is essential to overcoming disparities in accessing health and social services. However, addressing these linguistic and cultural issues adds to the complexity and costs involved in serving these older adults.

During the past decade, the unique issues experienced by California's lesbian, gay, bisexual, and transgender (LGBT) older adults have been increasingly recognized and addressed. Older LGBT adults are as diverse as their heterosexual counterparts. Lifelong fears or experiences of discrimination have caused some of these older adults to remain invisible, preferring to go without much-needed social, health, and mental health services. It is difficult to estimate the number of LGBT older adults in the population, but studies indicate that between 5 to 10 percent of the entire U.S. population is LGBT.<sup>23</sup> Although this estimate may be low, applying this percentage to California's population of older adults suggests that there are approximately 276,000 to 552,000 older LGBT Californians. By 2030, this number is expected to nearly double.<sup>24</sup>

## **Gender and Marital Status**

On average, women live 4.8 years longer than men.<sup>25</sup> Among Californians ages 60 to 84, 55 percent are women. Beyond age 85, 66 percent are women. Owing to their longer life expectancy and their tendency to marry men who are two or three years older than they are, women have a much higher probability to be widowed and to live alone in old age. More than 40 percent of women age 65 and older in California are widowed, compared to 10 percent of men.<sup>26</sup> Women become more vulnerable as they grow older, because they are more likely than men to live alone, be (or become) poor, and have multiple chronic health conditions.

In retirement, older women are at greater economic risk than men due to income disparities. According to the 2009 California Health Interview Survey, 27 percent of men age 60 and older lived below 200 percent of the Federal Poverty Level (FPL), compared to 33 percent of older women. In 2012, for example, women age 65 and over in California had a median annual income that was 65 percent of their male peers,<sup>27</sup> while in the year prior, senior women averaged Social Security benefits of \$1015 per month, or 77 percent of those male peers' \$1,316 per month.<sup>28</sup> Not only are women's average Social Security payments less than men's, such payments are also likely to be their only source of income. Economic disparities based on gender may decrease in the future, as more women receive higher retirement income benefits from Social Security, pensions, and other retirement savings. However, the women most likely to have increased income in retirement are wealthier Baby Boomers, who are also likely to be white. Poorer women continue to tend to be of other races.

## **Income Resources**

The number of Californians aged 55 and older at both ends of the income scale is growing, creating two very different groups: persons with annual incomes over \$50,000 (45.1 percent) and persons with incomes below \$15,000 (15.7 percent), with a diverse middle class with incomes ranging from \$15,001 to \$50,000 (39.2 percent).<sup>29</sup> There are a number of factors affecting the income level of these older Californians. Older adults in higher income brackets are predominantly white, while those with incomes under \$15,000 are predominately of another race, a trend that will accelerate as Baby Boomers age. Older Californians at the middle-income level are more evenly distributed across racial and ethnic lines, although middle-income persons who are not white tend to have fewer assets and are more likely to slide into poverty than their white counterparts. Immigrant status is also a factor. Over 50 percent of older adult immigrants are under 200 percent of the FPL, compared to 22 percent of older adults born in the U.S.<sup>30</sup>

The highest proportion of older adults with income below 200 percent of the FPL is in Imperial County (61 percent), followed by several counties in Northern California and the San Joaquin Valley, where approximately 40 percent of the older population is in this income group. Eleven percent of the population age 65 and over has income below the FPL, and another 21 percent has income between 100-199 percent of the FPL.<sup>31</sup>

Persons in this latter group have incomes too high to make them eligible for many public assistance programs, yet often do not have resources sufficient to meet their most basic needs.<sup>32</sup>

In 2012, the annual income for a single individual at 100 percent of the FPL was \$11,170 and \$16,755 for a single individual at 150 percent of the FPL. In 2009, an estimated three times as many older Californians (74.3 percent) who are not White were below 100 percent of the FPL when compared to White older adults (25.7 percent). Older adults who are not White were (65.8 percent) above 200 percent of the FPL when compared to their White counterparts (65.7 percent). Among older adults of various racial groups, 13.6 percent of Hispanics, 13.4 percent of African Americans, 11.5 percent of American Indian/Alaskan Natives, 10.3 percent of Asians, and 11.1 percent of Native Hawaiian/Pacific Islanders were below the FPL (Appendix I).

Older adults in California may be adversely impacted by the costs of basic necessities (e.g., food, health care, shelter, transportation, utilities). In particular, the need for affordable and accessible housing and transportation continues to grow as California's population ages. UCLA's Center for Health Policy Research develops and updates the California Economic Security Standard Index to demonstrate the actual cost of living for older adults in each PSA (Appendix L).

For very poor older Californians, Supplemental Security Income (SSI) can be an added source of income. SSI provides a minimum guaranteed monthly income for all qualified individuals who are age 65 and over, blind, or disabled. The State of California supplements the federal benefit substantially through the State Supplementary Payment (SSP). In 2013, the combined SSI/SSP annual benefit was \$10,397 for an older individual and \$17,546 for an older couple living independently. However, SSI recipients' accumulated assets must fall below certain limits, and recipients cannot earn income that exceeds their SSI benefit without reducing their monthly payment. Many poor older adults are not eligible for SSI because their assets exceed the maximum allowed. Many others do not apply for the benefit because they do not know they are eligible or do not want to receive public assistance.

## **Health Status**

The dramatic gains in life expectancy that occurred during the twentieth century were due primarily to advances in sanitation, medical care, and the use of preventive health services. These factors also account for a major shift over the past century in the leading causes of death—from infectious diseases and acute illnesses to chronic diseases and degenerative illnesses.

In 2002, the three leading causes of death for individuals over the age of 65 were major cardiovascular diseases (32 percent), cancer (22 percent), and stroke (8 percent). These three causes accounted for 61 percent of all deaths among older adults.<sup>33</sup> Falls are the leading cause of injury death, and can have significant psychological and social consequences.<sup>34</sup>

However, many of these leading causes of death can be prevented. Although the risk of disease and disability increases with age, poor health is not an inevitable consequence of aging. Three behaviors—smoking, poor diet, and physical inactivity caused almost 35 percent of U.S. deaths in 2000.<sup>35</sup> These behaviors are often associated with the leading chronic disease killers such as heart disease, cancer, and stroke. Adopting healthier behaviors (e.g., regular physical activity, a healthy diet, a smoke free lifestyle) and getting regular health screenings such as mammograms, (e.g., colonoscopies, cholesterol checks, bone density tests, etc.) can dramatically reduce the risk for most chronic diseases.<sup>36</sup>

The World Health Organization defines health as “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.”<sup>37</sup> The Centers for Disease Control and Prevention periodically publishes *The State of Aging and Health in America* report.<sup>38</sup> This document includes a report with health, mental health, wellness, and preventive service indicators. Appendix J displays the indicators for Californians aged 65 and older between 2008 and 2009.

Overall, the majority of older Californians reported having participated in screenings and preventive care. Over ninety-three percent reported receiving a blood cholesterol test; 82.3 percent of women reported having received a mammogram in the past 2 years; 79.4 percent of men reported having a prostate specific antigen test and 66.6 percent of older adults reported receiving colorectal cancer screenings. Further, the percentage of older individuals who reported having had a pneumonia vaccine was 59.9 percent.

The 2009 California Health Interview Survey examined health and preventive service indicators considering various demographic factors. When California’s older adult percentages are analyzed by race, ethnicity and region, other trends emerge. In 2009, 35 percent of all older Californians did not get a flu shot, whereas 40 percent of older Hispanic adults and 54 percent of older African American adults reported not receiving that vaccination. While 59.9 percent of older adults reported receiving a pneumonia vaccination, older White adults had the highest pneumonia vaccination rate at 64.2 percent. Although 93.2 percent of older adults reported receiving a blood cholesterol test, that rate was only 78.5 percent among Native Hawaiian/Pacific Islander and Asian older adults.

Similarly, the smoking rate among all California’s older adults was 13.4 percent in 2009, and varied by race, ethnicity and region. For example, older African American adults had the highest smoking rate at 19 percent. California’s northeastern region had the highest older adult smoking rate at 11.5 percent, while the lowest smoking rates were in the Bay Area, at 8 percent, and Southern California, at 9 percent. Appendix K displays how older Californians in various regions reported their health status.

*The State of Aging and Health in America* report provides good indicators of where to focus additional attention to improve the health of older Californians that are reflected in the State Plan’s emphasis on health promotion activities.

## **State Plan Development**

This State Plan was developed with input from the AAAs the California Commission on Aging. These organizations reviewed and provided input to the draft Plan. The Department consulted with these organizations to identify shared priorities and opportunities for collaboration in achieving these objectives during the next four years. In partnership with these organizations, the Department conducted three public hearings on the draft State Plan in Fresno, Los Angeles, and Sacramento on May 20, 21, and 24, 2013, respectively. CDA also posted the draft State Plan on its web site. Public input was taken into consideration in the final version of the State Plan.

In addition to considering information gathered at public hearings, the Department reviewed the goals and objectives outlined in 33 local Area Plans to identify local priorities and strategies that could inform State level activities. The Department supplemented this information from targeted surveys, and consulted with AAAs and the California Commission on Aging on the development of shared priorities for inclusion in the State Plan.

## **Our Challenges and Future Priorities**

During the next four years, CDA and the State's Aging Network will face a number of challenges arising from changing demographics, severe and ongoing fiscal constraints, and shifting requirements for programs and services. While California received economic stimulus funding through the American Recovery and Reinvestment Act of 2009 for the Elderly Nutrition Program (ENP) and Title V Senior Community Service Employment (SCSEP) Programs, this ended in 2010.

This State Plan outlines goals, objectives, and strategies that are sensitive to this environment, and articulates measurable outcomes that can be achieved within the Department's existing means. CDA will leverage its resources by partnering with AAAs and other stakeholders to make progress in key areas such as transportation, volunteerism, and evidenced-based health promotion activities. Through ongoing communication and collaboration, CDA will adjust its activities to enhance local efforts.

The Department believes the State Plan sets a course which will contribute to building the infrastructure necessary to support a statewide system of home- and community-based services. The Plan includes strategies to increase the availability of consumer information, support intergenerational opportunities for volunteerism and civic engagement, promote health, protect consumer rights, prevent fraud and abuse, and assist people with obtaining needed benefits. Throughout, the Plan focuses on developing and maintaining the ongoing partnerships necessary to support the ability of the Aging Network to address local needs. By strengthening the infrastructure for home- and community-based services, the State Plan continues to build the foundation for a future in which every Californian has the opportunity to enjoy wellness, longevity, and quality of life in strong, healthy communities.

## SECTION III – GOALS AND OBJECTIVES

**GOAL I: *Empower older Californians, adults with disabilities, and their caregivers to easily access the information they need to make informed decisions.***

### **Easy Access to Information**

Information empowers people to make informed decisions about their futures and promotes self-sufficiency and independence. Area Agencies on Aging fund Information and Assistance (I&A) as a priority Access service in their Area Plans. The Department supports local I&A services by sponsoring a statewide toll-free telephone number (1-800-510-2020) to link callers directly to their local AAAs. This Senior Information Line is a component of AoA's national Elder Care Locator system.

The Department also supports the statewide toll-free Health Insurance Counseling and Advocacy Program (HICAP) Information Line (1-800-434-0222) to assist Medicare beneficiaries and others to access information about Medicare benefits and related insurance options. Further, long-term care facility residents or their family members can call the toll-free CRISISline (1-800-231-4024) 24 hours a day, 7 days a week to access information and submit complaints.

Increasingly consumers and their families are turning to the Internet for information on aging and caregiving issues. The Department is involved in efforts to increase access to this much-needed information through its support of Aging and Disability Resource Centers (ADRC) and local I&A programs, and continued efforts to make the resources available on its website both current and user-friendly.

- ***Senior Medicare Patrol***

To assist with identifying, reporting and preventing suspected Medicare fraud and abuse, the State HICAP Office and local HICAPs collaborate closely with California Health Advocates (CHA) in implementing CHA's AoA-funded Senior Medicare Patrol (SMP). CHA contracts with 23 of California's 26 local HICAPs to support registered HICAP counselors as SMP volunteers. Each SMP volunteer receives specialized training on working with Medicare beneficiaries to detect and report Medicare fraud and abuse. In addition, HICAP and CHA host joint statewide training each year for HICAP and SMP staff and volunteers on subjects such as identity theft, fraudulent billing practices, and health insurance scams. SMP volunteers serve as key resources on issues related to Medicare fraud and abuse to Medicare beneficiaries and other HICAP counselors by conducting educational presentations, providing one-on-one counseling, and delivering helpline assistance.

- ***Aging and Disability Resource Connection***

Increasingly consumers and their families turn to the Internet as their first source for information on aging, LTSS, and caregiving issues. The Department is working to

increase access to much-needed information by expanding the resources available on its website, and by supporting local I&A programs and Aging and Disability Resource Connections (ADRC). The California Health and Human Services Agency (CHHSA) currently administers California's ADRC implementation efforts with input from CDA, the Department of Health Care Services (DHCS), the Department of Rehabilitation (DoR), the State Independent Living Council, AAAs, Independent Living Centers (ILCs), and others. CDA is engaged in interdepartmental discussions to identify strategies for sustaining the State administrative infrastructure necessary to support local ADRCs. In addition, we are exploring how ADRCs could be key partners in California's managed care demonstration and expansion efforts.

### **Coordinated Care Initiative: Beneficiary Options Counseling**

In 2012, Governor Brown worked in partnership with the Legislature and stakeholders to enact the Coordinated Care Initiative (CCI) to enhance health outcomes and beneficiary satisfaction for low-income older adults and persons with disabilities who are eligible for Medi-Cal only, or for both Medicare and Medi-Cal (dual eligible).<sup>39,40</sup> California is home to approximately 1.1 million dual eligible beneficiaries.

Low-income older adults and people with disabilities are among California's highest-need populations. They tend to have many chronic conditions that require a complex range of health and supportive services from a variety of providers. Because programmatic and financial responsibilities for these services reside in multiple areas, the current service delivery system is fragmented and difficult for people to navigate. This fragmentation can contribute to beneficiary confusion and negative outcomes, inappropriate service utilization and unnecessary costs.

The CCI establishes an integrated model of coordinated, high quality care that helps people stay healthy and in their homes and communities through person-centered care. Person-centered care is sensitive to the beneficiary's functional and cognitive needs, language, and culture, and actively involves the beneficiary and caregivers in care planning and decision making. Person-centered care emphasizes providing care in the setting most appropriate to the beneficiary's needs.<sup>41</sup>

DHCS, California's single State Medicaid Agency, is partnering with CDA, the California Department of Social Services (CDSS) and the Department of Managed Health Care (DMHC) to implement the CCI. It will be implemented no earlier than April 1, 2014 in eight demonstration counties: Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.

The CCI has two major components.

- **Cal MediConnect** – a three-year demonstration project for dual eligible beneficiaries that combines the full continuum of acute, primary, institutional and home- and community-based services (HCBS) into a single benefit package, delivered through an organized service delivery system.

- **Coordinated Long-Term Services and Supports (LTSS)** – inclusion of LTSS as Medi-Cal managed care benefits for beneficiaries who are eligible for Medi-Cal only, and for those eligible for both Medicare and Medi-Cal. To receive LTSS, beneficiaries must be enrolled in Medi-Cal Managed Care.

LTSS include In-Home Supportive Services (IHSS), Community Based Adult Services (CBAS), Multipurpose Senior Services Programs (MSSP), and Nursing Facilities/Sub-Acute Care Facilities. Per interagency agreement with DHCS, CDA certifies CBAS centers for participation in the Medi-Cal program and administers California’s MSSP 1915(c) HCBS waiver.

As part of its collaboration on CCI, CDA will secure funds through the Centers for Medicare & Medicaid Services (CMS) to help dual eligible beneficiaries make informed decisions about their coverage options. CDA will work with the nine AAAs in the eight CCI demonstration counties to support local HICAPs in conducting the outreach, education, and one-on-one counseling necessary to enable dual eligible beneficiaries to understand and make decisions about how they receive their Medi-Cal and Medicare benefits.

CDA will update AAAs on developments in California’s changing managed care environment and help them to explore the potential opportunities for the Aging Network.

**Objective 1.A:** Make information on health and supportive services accessible to older adults, their caregivers, and others to promote independence and wellness.

**Strategies:**

1. Continue to support and maintain the toll-free 800 telephone numbers that connect the public to their local AAAs, HICAPs and Ombudsman programs.
2. Ensure CDA program staff and AAA I&A providers have the training necessary to support responsive and effective local I&A programs.
3. Continue to participate in the collaborative, interdepartmental effort to sustain and expand California’s ADRCs.
4. Update CDA’s website to provide Medi-Cal beneficiaries and others with current information about the CCI.

**Objective I.B:** Provide enhanced beneficiary outreach, counseling, and education to individuals who are dually eligible for Medi-Cal and Medicare to help them make informed decisions about their benefit options under California’s CCI.

**Strategies:**

1. Enhance local HICAPs’ capacity to provide impartial information to beneficiaries about their benefit options in the eight CCI demonstration counties.
2. Develop beneficiary outreach and HICAP Counselor training materials specific to the needs of beneficiaries to assist them in understanding the CCI.
3. Deliver outreach, education and counseling to dual-eligible beneficiaries in the eight CCI demonstration counties.

**Objective I.C:** Publicize information about long-term care issues and trends so that consumers and their families are empowered to make informed decisions.

**Strategies:**

1. Provide consumers with information to make informed decisions about long-term care services and supports.
2. Provide consumers with information about OSLTCO activities, including advocacy conducted on behalf of residents of long-term care facilities.
3. Provide consumers with information on how to make a complaint to and/or reach local Ombudsman programs.

**GOAL I – Performance Measures**

<b>Objective</b>	<b>Performance Measure</b>	<b>Target Date</b>
<b>I.A.1</b>	Conduct an analysis of calls to CDA’s toll-free Senior Information Line, HICAP Information Line, and Ombudsman CRISISline and develop a strategy to improve their responsiveness and efficiency.	July 2015
<b>I.A.2</b>	Ensure three CDA program staff complete Alliance of Information and Referral Systems (AIRS) certification training.	July 2015
	Work with AAAs to increase by five percent the number of AAA I&A providers who have completed Alliance of Information and Referral Systems (AIRS) certification.	July 2016
<b>I.A.3</b>	Participate in regular meetings with State and local agencies to provide technical assistance and support.	October 2013 and ongoing
<b>I.A.4</b>	Post and maintain current information about California’s CCI on CDA’s website.	October 2013 and ongoing

<b>Objective</b>	<b>Performance Measure</b>	<b>Target Date</b>
<b>I.B.1</b>	Secure CMS funding to support delivery of outreach, education, and one-on-one health benefits counseling to dual eligible beneficiaries in the eight CCI demonstration counties.	October 2013
	Execute contracts with the nine local AAAs serving the eight CCI demonstration counties to deliver options counseling to dual eligible beneficiaries through their local HICAPs.	October 2013
<b>I.B.2</b>	Convene a Steering Committee comprising the eight CCI demonstration county HICAPs, DHCS, CDSS, DMHC, the Department of Rehabilitation and other stakeholders to collaborate on materials development and training.	October 2013 and ongoing
	Develop beneficiary outreach and education materials and HICAP Counselor training materials.	October 2013 and ongoing
<b>I.B.3</b>	Train HICAP Counselors and staff in the CCI demonstration counties about dual eligible beneficiaries' options under the demonstration.	October 2013 and ongoing
	Provide community education to dual eligible beneficiaries in the eight CCI demonstration counties.	October 2013 and ongoing
	Provide group and one-on-one counseling to dual eligible beneficiaries in the eight CCI demonstration counties about their health benefit options.	October 2013 and ongoing
<b>I.C.1</b>	Compile, and post on CDA's website, information to help consumers make informed decisions about long-term care services and supports.	October 2013 and ongoing
<b>I.C.2</b>	Draft and post on CDA's website a regularly updated OSLTCO Annual Report.	April 2014 and ongoing
<b>I.C.3</b>	Post on CDA's website information on how consumers can make a complaint to and/or reach local Ombudsman programs.	January 2014 and ongoing

***GOAL II: Enable older Californians, adults with disabilities, and their caregivers to be active and supported in their homes and communities.***

**Coordinated Care Initiative Implementation**

The CCI requires demonstration managed care health plans (plans) to enter into agreements with county social service agencies and Public Authorities (for IHSS), MSSP sites, CBAS providers, and nursing facilities to deliver coordinated LTSS to their eligible enrollees. Demonstration plans must contract with MSSP organizations in their covered zip code areas to provide MSSP case management and waiver services for MSSP waiver participants. Similarly, demonstration plans must contract with all willing, licensed, and certified CBAS centers in their covered zip code areas and adjacent zip code areas to provide CBAS services.<sup>42</sup>

In addition, the CCI requires DHCS, CDSS and CDA to coordinate with stakeholders to develop and test a universal assessment process, including a universal assessment tool for IHSS, CBAS, and MSSP. The tool and process will facilitate the development of person-centered plans of care based on individual consumer needs, and may also be used to assess the need for nursing facility care and divert individuals from nursing facility care to HCBS. Once developed, plans, counties, and other LTSS providers may test the universal assessment tool and process in no more than four demonstration counties with a limited number of beneficiaries potentially eligible for HCBS.<sup>43, 44</sup>

**Cost-Sharing Policy Development**

In 2000, amendments to the Older Americans Act (OAA) allowed states to implement cost-sharing for certain OAA services. Cost-sharing provides a mechanism for states to generate revenue to expand services to a growing number of older adults. However, there has been some concern that cost-sharing could dissuade eligible individuals, particularly those with low incomes, from participating in OAA services that could benefit them.

The OAA includes a number of requirements intended to ensure that low income older individuals can obtain services in states with cost-sharing policies. States and AAAs must develop cost-sharing plans. States must ensure that AAAs and local service providers exclude individuals with incomes at or below the Federal poverty line from cost-sharing; not deny services to individuals who do not pay; and establish sliding scales for cost-sharing based on income. Both states and AAAs must develop cost-sharing plans. During this State Plan period, CDA will work with a limited number of AAAs to pilot test a cost-sharing policy and evaluate its impact before undertaking statewide implementation.<sup>45</sup>

**Volunteerism**

The Aging Network relies heavily on volunteers to provide services and leverage resources. The Department has had a long-standing objective to recruit individuals of all

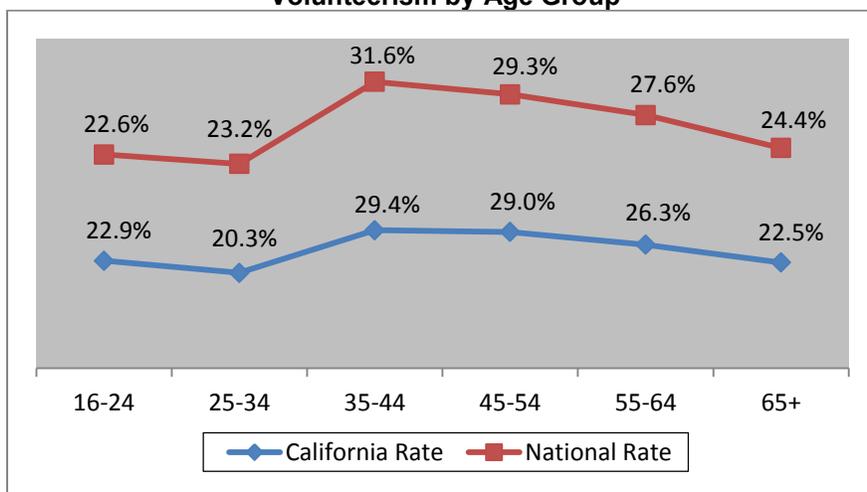
ages into community involvement and volunteerism. Among the concerns CDA has highlighted over the years are: difficulty recruiting volunteers of all ages and high volunteer turnover rates. During the next four years, CDA will focus on developing effective strategies to promote volunteerism among individuals of all ages in service to older adults, adults with disabilities, and their caregivers. The Department will also pursue strategies that encourage older adults and adults with disabilities to share their skills and talents with people of all ages in their communities.

Despite having the largest number of volunteers of any other state (7.4 million), California has one of the lowest rankings for volunteerism in the country. California ranks below 36 other states on a number of key indicators (e.g., volunteer hours, retention rates, volunteer rates among different age groups, overall civic life engagement).<sup>46</sup>

Most volunteer activity in the State is in educational/youth services (32 percent) or in faith-based services (31 percent), while volunteering in social or community services ranks third (13 percent). This is of concern since social and community services frequently serve older adults and adults with disabilities.

Consistent with the national volunteer profile, the typical volunteer in California is a woman between the ages of 35-54.<sup>47</sup> As identified in Figure 5, older and younger age groups participate less in volunteer activities.

**Figure 5  
Volunteerism by Age Group**



A number of factors are associated with higher volunteerism rates among individuals age 35 through 54, including larger social networks leading to greater community involvement, better health status, and higher socio-economic status. A number of demographic factors promote and inhibit volunteerism, requiring strategies targeted to specific age groups.

The Department previously conducted a pilot study to examine factors that impact volunteer participation in programs that serve older adults. It surveyed volunteers in various programs to identify the factors that impact individuals' continued volunteerism. This information assisted those programs to design more effective recruitment and retention strategies and understand the particular characteristics of current volunteers and their specific contributions. The Department plans to replicate this study to gain a better understanding of the programs that most interest potential volunteers, what motivates them to serve in these programs, and to project future volunteerism trends.

## **Transportation**

The absence of readily available and accessible transportation is a barrier to older adults and adults with disabilities who want to remain healthy and socially engaged in their community. In order to meet their work and other responsibilities, family caregivers need access to reliable transportation alternatives that will assist their loved ones in keeping medical appointments and participating in community life. The lack of appropriate local transportation alternatives is evident from the fact that even care coordinators who are familiar with community services routinely have difficulty finding and arranging appropriate transportation services for their clients. Local AAAs consistently identify transportation as being among the most important issues to be addressed in their communities.

The U.S. Supreme Court's 1999 decision in *Olmstead v. L.C.* requires states to provide community-based services in the most integrated setting appropriate for persons with disabilities who otherwise would receive services in an institution. CHHSA's Olmstead Advisory Committee has repeatedly noted transportation's essential role in enabling individuals to live in the most integrated community setting possible. Accordingly, the Olmstead Advisory Committee's Transportation Workgroup is identifying transportation challenges that impact community living and reviewing alternative approaches to address these challenges.

The Federal government encourages state transportation and human service departments to work together. The Federal *United We Ride* initiative supports states in developing local coordinated human service delivery systems. This initiative stems from the recognition that in the past transportation planners had no connection to those most familiar with human service needs. Consequently, the particular needs of older adults and adults with disabilities have not been fully addressed.

In 2011, CDA secured temporary funding through the California Department of Transportation (Caltrans) from the Federal *New Freedom Program*, part of the *United We Ride* effort, to provide training and technical assistance to AAAs and ILCs to support them in establishing local transportation coordination programs. As an extension of this effort, during this State Plan period CDA will coordinate with the Olmstead Advisory Committee's Transportation Workgroup, Caltrans, and others to identify and address issues that impact transportation access for older adults and adults with disabilities.

**Objective II.A:** Support successful implementation of California’s CCI.

**Strategies:**

1. Collaborate with DHCS, MSSP 1915(c) home- and community-based waiver providers, and participating managed care health plans to implement MSSP as a managed care benefit in the eight CCI demonstration counties.
2. Collaborate with DHCS, the California Department of Public Health (CDPH), and industry stakeholders to support continued implementation of the CBAS Program as a managed care health plan benefit.
3. Ensure coordinated and effective beneficiary education and outreach in CCI demonstration counties.

**Objective II.B:** Participate in developing a universal assessment instrument (UAI) and process to support individualized care planning and facilitate care coordination for CCI participants needing LTSS.

**Strategies:**

1. Participate with CDSS and DHCS in a state-level UAI Advisory Committee to determine the UAI development and implementation planning process.
2. Co-convene with CDSS and DHCS a stakeholder workgroup to gather input necessary to shape the UAI and process.
3. Pilot test the UAI and process in no more than four CCI demonstration counties to determine their efficacy in addressing the needs of beneficiaries, managed care health plans, and providers.

**Objective II.C:** Conduct a pilot to test the merit of implementing statewide cost-sharing as allowable in OAA services.

**Strategies:**

1. Disseminate a draft cost-sharing policy for use by participating AAAs in implementing cost-sharing in select OAA services.
2. Monitor and analyze the costs and benefits of cost-sharing to AAAs and service recipients in the pilot PSAs.
3. Issue a cost-sharing pilot evaluation and recommendations.

**Objective II.D:** Expand opportunities for community involvement and volunteerism to increase the availability of services to older adults, persons with disabilities, and family caregivers; promote peer-to-peer support programs; and foster intergenerational service programs.

**Strategies:**

1. Showcase local program volunteers in CDA-administered programs on the Department’s website to recognize the personal rewards and community benefit from volunteerism.
2. Solicit resources to conduct an analysis of volunteerism rates in key OAA programs throughout California; identify emerging issues; and formulate promising practices to increase recruitment and retention in these programs.
3. Develop and implement a realistic action plan to test and evaluate the effectiveness of recommended promising practices. Share results through presentations and webinars with local agencies and service providers.

**Objective II.E:** Advance the availability of transportation services responsive to the needs of older adults, adults with disabilities, and their family caregivers.

**Strategies:**

1. As a member of Caltrans’ Policy Advisory Committee, participate in developing *California Transportation Plan 2040* goals, policies, and strategies that address the transportation needs of older adults, adults with disabilities and their family caregivers.
2. Provide specialized training to AAAs and ILCs about transportation coordination and the unique transportation service needs of older adults and adults with disabilities.
3. Collaborate with the Olmstead Advisory Committee’s Transportation Workgroup to identify and address policy issues that impact the availability of transportation services that are responsive to the needs of older adults, adults with disabilities and their family caregivers.

**GOAL II – Performance Measures**

Objective	Performance Measure	Target Date
II.A.1	Work with DHCS, MSSP providers and managed care health plans to execute 15 contracts for MSSP waiver services between CCI demonstration plans and local MSSP providers.	October 2013
	Coordinate with DHCS, MSSP providers, and managed care health plans to deliver cross-training on MSSP waiver and health plan requirements and operations.	October 2013 and ongoing

<b>Objective</b>	<b>Performance Measure</b>	<b>Target Date</b>
	Provide focused oversight of waiver and program objectives and care coordination activities between MSSP providers and managed care plans.	October 2013 and ongoing
<b>II.A.2</b>	Train managed care health plans and providers impacted by the rural expansion of managed care on CBAS program and eligibility determination requirements.	October 2013 and ongoing
	Develop data sharing processes with managed care health plans to improve state monitoring and oversight mechanisms and assist plans in meeting quality assurance/quality improvement requirements under their contracts with DHCS.	October 2013
	Collaborate with DHCS on the renewal of its Section 1115 Bridge to Reform waiver.	January 2014
	Disseminate information to CBAS providers regarding the CCI and related requirements.	Ongoing
<b>II.A.3</b>	Convene a cross-departmental workgroup comprising CDA, DHCS, the Department of Managed Health Care (DMHC) and the Office of the Patient Advocate (OPA) to support beneficiary outreach and education about the CCI.	October 2013 and ongoing
<b>II.B.1</b>	Participate with DHCS and CDSS in meetings of the state-level Universal Assessment Advisory Committee.	October 2013 and ongoing
<b>II.B.2</b>	Collaborate with DHCS and CDSS on convening meetings of the Universal Assessment Stakeholder Workgroup.	October 2013 and ongoing
	Co-author with DHCS and CDSS and submit a report to the Legislature describing the Stakeholder Workgroup process.	March 2014
<b>II.B.3</b>	Pilot test the UAI and process in two to four Cal MediConnect demonstration counties.	January 2015 through August 2015
	Co-author with DHCS and CDSS and submit a report to the Legislature about the Universal Assessment pilot.	September 2015
<b>II.C.1</b>	Issue draft cost-sharing guidelines for pilot testing.	October 2013
	Select and train AAAs to participate in the cost-sharing pilot.	October 2013
<b>II.C.2</b>	Conduct a quarterly analysis of program income generated through cost sharing in comparison to other sources.	Quarterly through September 2014
	Host quarterly information-sharing sessions with participating AAAs to identify operational concerns and perceived cost-sharing benefits and costs.	Quarterly through September 2014
<b>II.C.3</b>	Complete an analysis of the cost-sharing pilot and issue recommendations.	October 2014
<b>II.D.1</b>	Define and implement a process to solicit information from AAAs and highlight the impact local volunteers are making in CDA-	September 2014

<b>Objective</b>	<b>Performance Measure</b>	<b>Target Date</b>
	administered programs on a quarterly basis.	
<b>II.D.2</b>	Secure resources to conduct an analysis of volunteerism in OAA programs.	December 2014
	Complete the analysis of volunteerism in OAA programs.	May 2014
<b>II.D.3</b>	Test practices for recruiting and retaining volunteers in OAA programs and evaluate their effectiveness.	September 2015
	Share lessons learned about volunteer recruitment and retention via at least three webinars/conferences.	January 2016
<b>II.E.1</b>	Contribute at least one strategy to the <i>California Transportation Plan 2040</i> to improve transportation access for older adults and adults with disabilities.	January 2016
<b>II.E.2</b>	Host a training conference for AAAs, selected ILCs, and other stakeholders focusing on strategies to improve transportation access for older adults and adults with disabilities.	November 2013
<b>II.E.3</b>	Coordinate with the Olmstead Advisory Committee's Transportation Workgroup to disseminate at least two issue papers about barriers to providing transportation alternatives responsive to the needs of older adults and adults with disabilities	November 2013
	Coordinate with the Olmstead Advisory Committee's Transportation Workgroup and key stakeholder departments to develop and implement a strategy to address at least two of the policy issues identified.	January 2014 through September 2017

**GOAL III: Enable older Californians, adults with disabilities, and their caregivers to be healthy.**

**Evidence-Based Interventions**

According to the Centers for Disease Control (CDC), chronic diseases disproportionately affect older adults and are associated with increased disability, diminished quality of life, and increased costs for health care and long-term care. Approximately 80 percent of older adults have at least one chronic condition and 50 percent have at least two. However, research over the past decade has led to evidence-based health promotion and disease prevention education (CDSME) programs that empower older adults to avoid chronic physical and mental health conditions and/or better manage them to prevent further disability.

Health trends among older Californians over the past four years reveal some good news in terms of increased use of several preventive health screening services. These services can lead to earlier diagnosis and treatment of several types of life-threatening diseases. However, California's large and diverse population continues to grow older and significant racial and health disparities persist in the rate and treatment of chronic health conditions.

- ***Chronic Disease Self-Management***

Since 2006, the Department has secured foundation grants and over \$1.7 million in federal funding to support statewide implementation of evidence-based health promotion interventions. Consequently, an expanding network of AAAs, aging network service providers, hospitals and health systems, and older adult community education programs are involved in implementing the *Chronic Disease Self-Management Program* (CDSMP also known as *Healthier Living*) and *A Matter of Balance*, a fall prevention program. CDSMP provides education and tools to older adults and adults with disabilities to help them manage chronic diseases such as diabetes, heart disease, lung disease and arthritis.

The Department continues to support CDSMP implementation through its annual OAA Title III D Disease Prevention and Health Promotion allocation and special federal grants. In 2012, Congressional appropriations language introduced the requirement that all Title III D funds be used only for effective, evidence-based activities. Accordingly, the Department provided AAAs with technical assistance and resources to assist them in using Title III D funds to deliver evidence-based interventions through their local provider networks. In addition, working in partnership with CDPH, the Department has secured additional Federal funding to expand availability of CDSMP workshops in ten counties that are home to over 48 percent of California's older and adults with disabilities. Both these efforts target for enrollment those who are low income or culturally and ethnically diverse.

- **Caregiver Support**

Alzheimer's disease and other forms of dementia are debilitating conditions that not only impact the lives of individuals who have the disease but also the family members caring for them. By 2015, approximately 678,000 older Californians will have Alzheimer's disease and be cared for by over 1.1 million Californians. California caregivers provide over 952 million hours of unpaid care per year, with an approximate value of more than \$10 billion.<sup>48</sup> Numerous studies have demonstrated the significant negative physical and emotional impact involved in caring for a person with mental illness or dementia. Access to Alzheimer's caregiver services has been very limited or non-existent in many ethnic communities throughout the State.

Over the past 15 years, California has pioneered efforts to increase and provide culturally competent services for individuals and families dealing with Alzheimer's disease. In 2007 and 2008, the Department was awarded two AoA Alzheimer's Disease evidence-based grants to support implementation of the *Savvy Caregiver*, an evidence-based program for individuals caring for people with Alzheimer's disease and its Spanish language adaptation, *Cuidando con Respeto*. The Department will continue to support these programs by encouraging AAAs to use Title III E Family Caregiver Support Program funds to implement them locally.

## **Nutrition Support**

Nearly one in 10 Californians over age 60 now lives in poverty. One in 20 has poor diet quality due, in part, to limited funds to buy food. In 2009, more than one in five low-income Californians over the age of 65 could not afford to put food on the table or had to forego other basic necessities in order to eat. For older adults, there is a significant relationship between food insecurity and poor health.<sup>49</sup> Given these facts, the importance of nutritional safety nets like the OAA Title IIIC ENP and the Supplemental Nutrition Assistance Program (SNAP) to older adults' health and well-being cannot be overestimated.

- **CalFresh**

The Supplemental Nutrition Assistance Program (SNAP or CalFresh in California) – formerly known as the federal Food Stamp Program – provides monthly assistance to purchase food for human consumption or seeds and plants to grow food for household use. When compared to other age groups, older Californians have a very low CalFresh participation rate. Misinformation, burdensome regulatory requirements, and the stigma associated with applying for public benefits are among the barriers to older adults' participation in CalFresh. To be eligible for CalFresh, adults age 60 and older must have a net income at or below 100 percent of the Federal Poverty Guidelines. Individuals receiving Supplemental Security Income (SSI)/State Supplementary Payment (SSP) are ineligible to receive CalFresh benefits because they receive an additional \$10 in lieu of CalFresh as part of their SSI/SSP payment. This policy is known as "cash out."

Nationally, approximately 34 percent of eligible older adults participate in SNAP. By comparison, only 10 percent of eligible older Californians participate in CalFresh. To address this disparity, the Department, CDPH–Network for a Healthy California (the Network) and CDSS are collaborating to implement a variety of CalFresh outreach and SNAP education (SNAP-Ed) strategies to encourage eligible individuals to apply for CalFresh benefits and make other healthy food and lifestyle choices.

The Department is collaborating with the Network, CDSS and numerous community-based organizations to develop materials to increase older adult participation in CalFresh. The forthcoming section on outreach to older adults in the *CalFresh Outreach Basics Handbook* provides outreach workers with a toolkit of materials to assist them in understanding older adults' needs and enrolling them in CalFresh. The Golden Advantage Nutrition Program (GANP) pilot will enable older adults who are enrolled in CalFresh to use their CalFresh electronic benefit card both to purchase food and make voluntary donations toward their ENP meals. As part of this effort, CalFresh older adult outreach experts will provide CalFresh application assistance to ENP participants. To date, seven counties have agreed to participate in this pilot (Lake, Riverside, Los Angeles, San Francisco, Fresno, Sonoma, and San Diego), with additional counties expressing interest.

- **SNAP-Ed**

The Healthy, Hunger-Free Kids Act of 2010 restructured the evidence-based SNAP-Ed Program to expand nutrition education and obesity prevention programs to eligible low-income individuals.<sup>50</sup> With the encouragement of United States Department of Agriculture (USDA) the Department will secure funds through CDSS to provide targeted SNAP-Ed nutrition education and obesity prevention programs to low-income older adults. CDA will contract with its statewide network of 33 AAAs to provide services to eligible ENP participants.

**Objective III.A:** Promote healthier living through evidence-based CDSME programs targeted to adults with various chronic conditions and family caregivers, particularly those impacted by Alzheimer's disease or related dementia.

**Strategies:**

1. Expand access to and sustain availability of CDSMP workshops through the use of Title IIID funds, other funding sources, and in collaboration with public health departments, healthcare entities and other partnering organizations.
2. Target CDSMP outreach to adults with chronic conditions who are low income, dually eligible for Medicare and Medi-Cal, have limited English proficiency, are veterans, or from ethnically diverse and traditionally underserved communities.

3. Provide outreach to the Medi-Cal managed care health plans participating in the CCI to make them aware of the value and impact the CDSMP can have in empowering individuals to more effectively manage their chronic health conditions; improve quality of life; and improve their interactions with their health care provider(s).
4. Conduct outreach to federally recognized tribes and tribal organizations to encourage participation in the CDSMP.

**Objective III.B:** Support older adults in increasing their access to nutritious foods and establishing healthy eating habits.

**Strategies:**

1. Collaborate with CDPH and the California Department of Social Services (CDSS) to increase the effectiveness of CalFresh outreach to eligible low-income older adults.
2. Implement a statewide Supplemental Nutrition Assistance Program Education (SNAP-Ed) project to promote healthy food and lifestyle choices among low-income older adults.

**Objective III.C:** Support efforts to make the evidence-based Savvy Caregiver Support Program and the Spanish-language adaptation of the program, *Cuidando con Respeto*, available to families impacted by Alzheimer’s disease and related dementia.

**Strategies:**

1. Encourage the use of OAA Family Caregiver Support Program funding to support the availability of these evidence-based caregiver support programs.
2. Collaborate with the Alzheimer’s Association Chapters throughout California in seeking other funding sources to support these programs, particularly targeting them to underserved and ethnically diverse communities.
3. Raise awareness of the Medi-Cal managed care health plans participating in the CCI of the value of evidence-based caregiver support programs, particularly for families impacted by Alzheimer’s disease and related dementia.

**GOAL III – Performance Measures**

Objective	Performance Measure	Target Date
III.A.1	Survey 33 AAAs annually to determine the number of AAA-supported CDSMPs and program participants.	July 2014 and Annually Thereafter

<b>Objective</b>	<b>Performance Measure</b>	<b>Target Date</b>
<b>III.A.1</b>	Increase the number of Californians completing the Healthier Living or Diabetes Self-Management Program by 9,000.	September 2015
	Increase the numbers of counties in which CDSMPs are available by five percent.	September 2015
<b>III.A.2</b>	Increase the number of CDSMP workshop leaders by five percent	September 2015
	Increase the percentage of overall CDSMP workshop completers by 10 percent.	September 2015
<b>III.A.3</b>	Participate in Medi-Cal managed care plan events to create awareness of CDSMPs and the value and opportunity for their provider network to make referrals to/conduct these programs to improve patient health outcomes and meet certain Medicare Advantage performance measures.	March 2014 and Annually Thereafter
<b>III.A.4</b>	Collaborate with three or more AAAs that have established relationships with tribal organizations and tribes to provide information about the CDSMP to tribal leaders and encourage participation.	October 2014 and Ongoing
<b>III.B.1</b>	Conduct a webinar for AAAs on the content and use of the older adults section of the <i>CalFresh Outreach Basics Handbook</i> .	October 2013
	Distribute CalFresh older adult outreach materials to California's 33 AAAs.	July 2013 through June 2017
	Increase older Californians' participation in CalFresh by five percent.	June 2017
	Pilot older adults' use of GANP electronic benefit cards to make donations toward their ENP meals in seven counties.	October 2013 through December 2014
	Collaborate with CDSS to evaluate the impact of the GANP pilot on participant and ENP outcomes.	December 2014
<b>III.B.2</b>	Secure federal SNAP-Ed funding to provide evidence-based nutrition education and obesity prevention programs to eligible low-income ENP participants.	October 2013
	Provide SNAP-Ed to 70,000 unduplicated older adult participants.	September 2015
<b>III.C.1</b>	Provide annual training and technical assistance to support 33 AAAs in implementing evidence-based caregiver support programs.	October 2013 and Annually Thereafter
<b>III.C.1</b>	Identify opportunities for California's Alzheimer's Association Chapters to collaborate with their local AAAs to implement the Savvy Caregiver and <i>Cuidando con Respeto</i> programs using Title IIIIE funds.	January 2014 and Annually Thereafter

Objective	Performance Measure	Target Date
III.C.2	Identify opportunities for California's Alzheimer's Association Chapters to secure funding to implement the Savvy Caregiver and <i>Cuidando con Respeto</i> programs in targeted communities.	Ongoing
III.C.3	Participate in Medi-Cal managed care plan meetings and events to increase awareness of the Savvy Caregiver and <i>Cuidando con Respeto</i> programs and encourage plans to collaborate with, and provide support to, the Alzheimer's Association in providing provider training, technical assistance, and Savvy Caregiver and <i>Cuidando con Respeto</i> workshops to plan members.	January 2014 and Annually Thereafter

***GOAL IV: Protect the consumer rights of older Californians and adults with disabilities and assist them to obtain needed benefits.***

As California's population ages, increasing numbers of older people are at risk of abuse, neglect and exploitation. The Department recognizes the need for strong advocacy to protect the basic rights and benefits of older adults. The Department supports a coordinated system that ensures that relevant programs work together to protect elder rights, particularly for those who are socially and economically vulnerable.

**Abuse and Neglect in Long-Term Care Facilities**

Older Americans Act Title VII authorizes vulnerable elder rights protection activities. Through its designated local programs, the Office of the State Long-Term Care Ombudsman (OSLTCO) works to improve the quality of life of residents in skilled nursing facilities and residential care facilities for the elderly by acting as their independent advocate. Local Ombudsman staff and volunteers visit long-term care (LTC) residents, monitor conditions, investigate and resolve resident complaints, advocate for needed change and provide education on LTC issues.

The National Ombudsman Reporting System indicates that in Fiscal Year 2010-11, suspected abuse, neglect, and exploitation reports comprised approximately 15 percent of all complaints investigated by California's LTC Ombudsman Program (LTCOP). These reports comprised approximately seven percent of all complaints investigated nationally.<sup>51</sup>

**Better Coordinated Reporting and Investigation**

In California, local law enforcement, local Ombudsman programs and county Adult Protective Services (APS) agencies all have jurisdiction to investigate elder and dependent adult abuse. In addition, the State facility licensing agencies – the California Department of Public Health (CDPH) and CDSS – respectively investigate alleged abuse complaints in skilled nursing facilities and residential care facilities for the elderly. The Department of Justice's Bureau of Medi-Cal Fraud and Elder Abuse (BMFEA) also conducts investigations of abuse in LTC facilities. Strict OAA confidentiality provisions prohibit the LTCOP from disclosing LTC facility residents' identity without the consent of the resident or their legal representative. This can contribute to frustration on the part of the investigating agencies.

Until 2013, mandated reporters had the option of reporting abuse and neglect in LTC facilities either to local law enforcement or the local Long-Term Care Ombudsman Program (LTCOP). The resulting multiple investigations often were not coordinated. To address these issues, Assembly Bill (AB) 40, further delineated mandated reporters' responsibilities in reporting physical abuse of LTC facility residents. It also directed local law enforcement to coordinate efforts with the local LTCOP to provide the most immediate and appropriate response to investigate the mandated report. These provisions became effective January 1, 2013.<sup>52</sup>

## **Reducing the Risk of Abuse for Persons with Dementia**

The University of California, Irvine (UCI) is partnering with the Department, CDSS, the Legal Aid Society of Orange County, and the Orange County Elder Abuse Forensic Center on a research project to develop and implement a tool for generating an elder abuse risk profile for older adults with dementia. Researchers will develop a toolkit of existing intervention methods that specifically address identified risk factors. Participating agencies will test the intervention toolkit to determine its effectiveness in reducing the risk of abuse. The goal is to create an elder abuse prevention and risk reduction model that is practical, reproducible, and will make a meaningful difference in the lives of older adults with dementia and their families.

## **Providing Legal Services to Residents of Long-Term Care Facilities**

California's 37 Title III legal services providers (LSP) advocate for and represent older clients in civil cases, particularly those involving elder abuse and neglect, financial exploitation, consumer fraud, landlord-tenant relationships, nursing home residents' rights, and conflicts over benefit programs such as Medicare, Medicaid, Social Security and pensions. In California, all local LSPs must have an MOU with their local LTCOP for providing legal consultation and services to residents of LTC facilities. Resources for legal services may, in some parts of the State, limit the availability of legal services for residents of long-term care facilities.

## **Improving Dementia Care in Long-Term Care Facilities**

Every day, approximately one in five California LTC facility residents receives antipsychotic medication to chemically alter behavior. Aside from the potential for serious side effects, studies indicate that antipsychotic medications may cause premature death in older adults with dementia. Even so, the use of antipsychotic drugs to manage behavior in residents with dementia persists, often in lieu of more appropriate behavioral interventions.

The Centers for Medicare & Medicaid Services has convened stakeholders to work together to improve dementia care and reduce the inappropriate use of antipsychotic medications. This "Partnership to Improve Dementia Care" includes approaches to raise public awareness, strengthen regulatory oversight, and ensure education and technical assistance are easily accessible to both consumers and providers.

## **Title VI Long-Term Care Ombudsman Services**

Older Americans Act Title VI provides funding for services to American Indians, Alaskan Natives, and Native Hawaiians that are comparable to those provided under Title III. These services include Ombudsman services for Native Americans who are residents of long-term care facilities. Eligible tribal organizations must ensure that their Title VI legal and Ombudsman services are in substantial compliance with the Title III requirements for those services.<sup>53</sup>

**Objective IV.A:** Evaluate coordination efforts between local LTCOPs and county APS agencies and local law enforcement agencies and provide technical assistance to improve coordination.

**Strategies:**

1. Identify which local Ombudsman programs have memoranda of understanding (MOU) in place with APS and local law enforcement agencies within their PSA.
2. Provide technical assistance to local LTCOPs that do not have MOUs in place in order to establish them.
3. Analyze the effectiveness of these MOUs in supporting coordination between local LTCOPs, county APS agencies, and local law enforcement.

**Objective IV.B:** Collaborate with UCI and other state and local entities to create a practical and replicable model for elder abuse prevention and risk reduction among older adults with dementia.

**Strategies:**

1. Participate in a workgroup of state and local entities to provide technical assistance and guidance on the grant project.
2. Provide technical assistance to UCI in the development and implementation of a risk assessment tool.
3. Assist in disseminating the model to stakeholders and others.

**Objective IV.C:** Improve coordination between local LTCOPs and OAA LSPs to increase access to legal services by residents in long-term care facilities.

**Strategies:**

1. Analyze the effectiveness of MOUs between local LTCOPs and local LSPs in supporting the delivery of these services to residents in long-term care facilities.
2. Collaborate with the State Legal Services Developer to identify gaps and barriers.
3. Provide technical assistance to local LTCOPs and LSPs so that MOUs are effective in improving access to legal services.

**Objective IV.D:** Participate in the state-level partnership to reduce the use of antipsychotic medications in conjunction with the Centers for Medicare & Medicaid Services' Initiative to Improve Dementia Care in Skilled Nursing Facilities.

**Strategies:**

1. Compile and post on CDA's website information on promising practices and behavioral strategies for reducing the use of antipsychotic medications.
2. Collaborate with CDPH, local Ombudsman programs and industry representatives to identify strategies to increase awareness and education among long-term care facility staff on alternatives to the use of antipsychotic medications.
3. Train local Ombudsman staff and volunteers on how to recognize the potential inappropriate use of antipsychotic medications and provide them with strategies for resolution.

**Objective IV.E:** Establish relationships and collaborate with tribal organizations receiving Title VI funding on areas of mutual interest.

**Strategies:**

1. The OSLTCO will work with AoA's Director of Long-Term Care Ombudsman Programs to provide training and technical assistance to the Office on strategies and techniques for local Ombudsman Programs.
2. Identify and reach out to the tribal organizations in California that are providing Ombudsman services.
3. Coordinate with the identified tribal organizations on opportunities for collaboration, including joint training.

**GOAL IV – Performance Measures**

<b>Objective</b>	<b>Performance Measure</b>	<b>Target Date</b>
<b>IV.A.1</b>	Identify existing MOUs with APS and local law enforcement.	February 2014
<b>IV.A.2</b>	Meet with local LTCOPs to discuss obstacles and action steps necessary to develop MOUs.	April 2014
<b>IV.A.3</b>	Identify any new MOUs between LTCOPs and APS and local law enforcement. Analyze the effectiveness of MOUs in improving coordination through anecdotal and PSA specific interactions.	February 2015
<b>IV.B.1</b>	Identify the number of workgroup meetings attended.	October 2013 and ongoing

<b>Objective</b>	<b>Performance Measure</b>	<b>Target Date</b>
<b>IV.B.2</b>	Identify the number of opportunities for technical assistance.	October 2013 and ongoing
<b>IV.B.3</b>	Identify the number of entities reached through dissemination efforts.	December 2014
<b>IV.C.1</b>	Identify the number of MOUs in place.	January 2015
<b>IV.C.2</b>	Identify gaps and barriers in providing services.	June 2015
<b>IV.C.3</b>	Provide training to LTCOPs and LSPs on establishing MOUs and the provision of services to residents.	October 2015
<b>IV.D.1</b>	Post regularly updated information on CDA's website.	October 2013 and ongoing
<b>IV.D.2</b>	Provide training for LTC providers and surveyors.	March 2014 and ongoing.
<b>IV.D.3</b>	Provide training to LTC Ombudsman representatives.	October 2014 and ongoing
<b>IV.E.1</b>	Secure training from AoA.	October 2014
<b>IV.E.2</b>	Identify tribal organizations providing Ombudsman services.	November 2014
<b>IV.E.3</b>	Meet with tribal organizations to discuss opportunities for collaboration.	January 2015 and ongoing

## **SECTION IV – QUALITY MANAGEMENT**

CDA manages the quality of service programs through on-site monitoring reviews and desk reviews, performance data validation, policy guidance, technical assistance and training. CDA conducts periodic on-site monitoring reviews of each of California's 33 AAAs. The purpose of this onsite monitoring is to determine each AAA's compliance with all pertinent federal and State requirements related to the administrative, program, fiscal, data collection and reporting components of their direct and contracted HICAPs and OAA programs.

On-site monitoring reviews focus on the AAA's program compliance, procurement, internal controls and fiscal processes, and other AAA administrative functions. Following the on-site review, CDA provides the AAA with a report detailing any monitoring findings. When there are findings, the AAA then submits a corrective action plan to CDA documenting how the findings have been addressed. CDA continues to work with the AAA to ensure all findings are resolved.

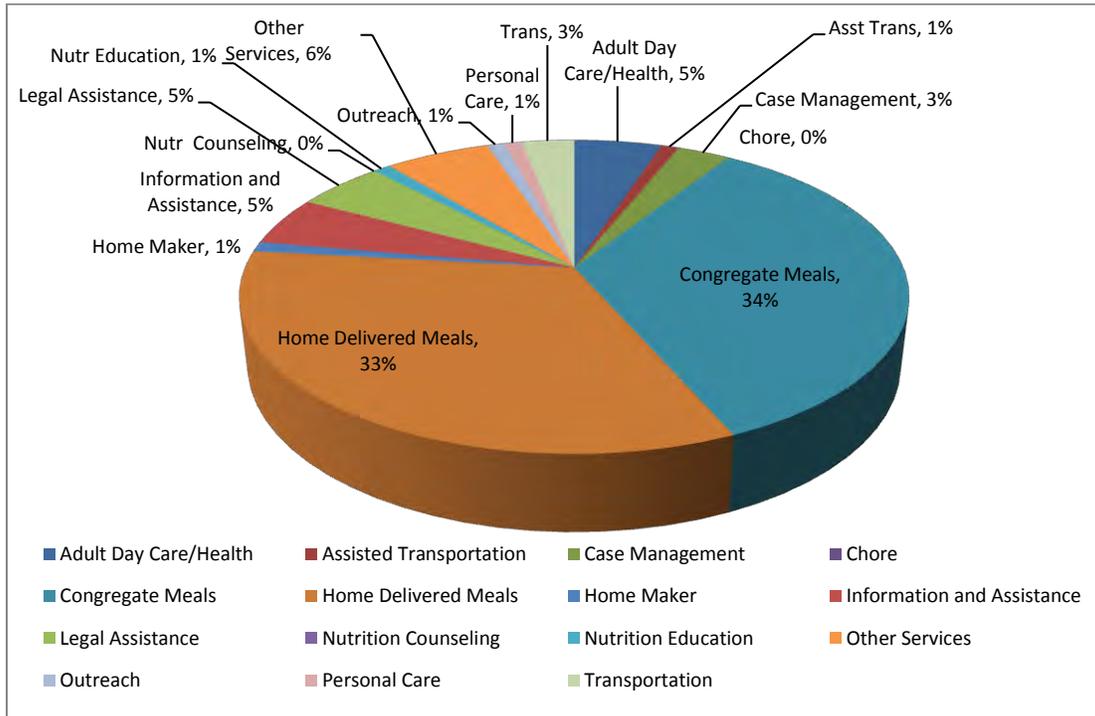
In addition to monitoring program compliance and performance, CDA conducts retrospective audits of AAAs to determine the accuracy of financial closeout reports, adequacy of internal accounting and administrative controls, and compliance with applicable laws, regulations, and contract requirements.

CDA also conducts ongoing desk monitoring of AAA budgets, expenditures, and performance data. CDA reviews AAA performance data quarterly and at year-end, providing each AAA with reports detailing all questionable and missing performance data. These reports assist AAAs to resolve or explain discrepancies in their data submissions. CDA provides AAAs with ongoing technical assistance to ensure complete and accurate data are entered into California's National Aging Program Information Systems (NAPIS) State Program Report (SPR). CDA analyzes both fiscal and performance data to identify patterns that may indicate the need for further attention.

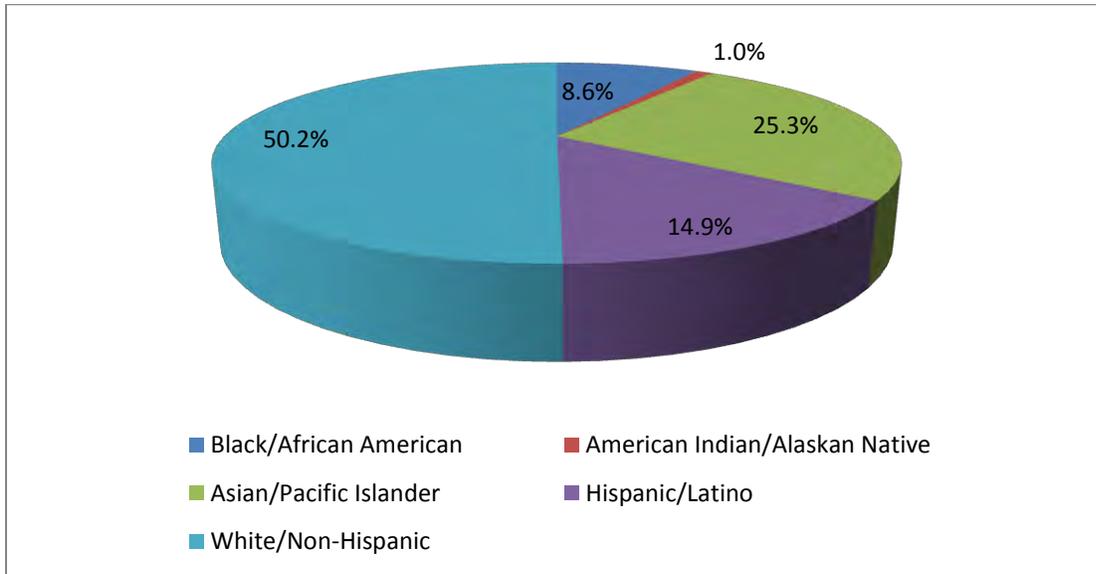
To support improved program compliance and performance, CDA provides AAAs with written guidance, and ongoing technical assistance and training via webinars, conference calls, and on-site visits. CDA targets these efforts as necessary to address emerging issues.

## RESOURCE ALLOCATIONS AND FEDERAL ASSURANCES

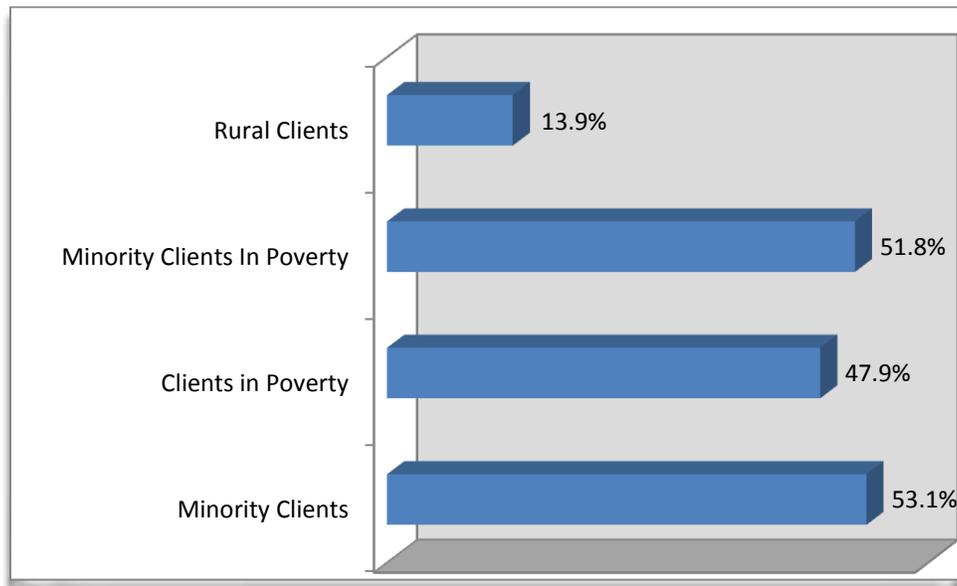
### 2011-2012 Older Americans Act Title III Services by Total Expenditures<sup>54</sup>



**2012 State Program Report  
Registered Clients by Minority Status<sup>55</sup>**



**2012 State Program Report  
Registered Clients by Targeting Status<sup>56</sup>**



**Approved Minimum Title IIIB Expenditures For Priority Services:  
Access, In-Home Services, and Legal Services<sup>57</sup>  
FY 2011/12**

<b>PSA #</b>	<b>Access</b>	<b>In-Home</b>	<b>Legal</b>
1	20.0%	3.0%	10.0%
2	30.0%	1.0%	10.0%
3	20.0%	10.0%	10.0%
4	25.0%	20.0%	8.0%
5	20.0%	5.0%	5.0%
6	45.0%	5.0%	45.0%
7	20.0%	8.0%	11.0%
8	20.0%	25.0%	5.0%
9	27.0%	19.0%	10.0%
10	60.0%	5.0%	10.0%
11	35.0%	35.0%	8.0%
12	65.0%	10.0%	2.0%
13	27.5%	1.0%	15.0%
14	40.0%	8.0%	2.0%
15	35.0 %	2.0%	15.0 %
16	50.0%	5.0%	10.0%
17	7.0%	20.0%	5.0%
18	5.0%	5.0%	5.0%
19	30.0%	20.0%	5.0%
20	40.0%	1.0%	10.0%
21	25.9%	6.0%	3.5%
22	42.0%	11.0%	10.0%
23	52.0%	22.0%	6.0%
24	30.0%	5.0%	15.0%
25	58.5%	15.5%	5.5%
26	45.0%	10.0%	20.0%
27	20.0%	10.0%	8.0%
28	31.8%	10.5%	10.5%
29	18.0%	1.3%	30.0%
30	33.04%	20.47%	22.02%
31	40.0%	1.0%	20.0%
32	30.0%	5.0%	25.0%
33	32.0%	26.0%	22.0%

# **CALIFORNIA DEPARTMENT OF AGING INTRASTATE FUNDING FORMULA (IFF)**

## **DESCRIPTIVE STATEMENT OF FORMULA**

The California Department of Aging is required under Title III of the federal Older Americans Act (OAA) to develop a formula for the distribution of funds within the State under this title. This formula is to take into account, to the maximum extent feasible, the best available statistics on the geographical distribution of individuals aged 60 and older in the State and publish such formula for review and comment. The IFF allocates funds to planning and service areas (PSAs) to serve persons aged 60 and older (60+).

While the OAA is concerned with the provision of services to all older persons, it requires assurance that preference is given to older individuals with greatest economic or social needs, with particular attention to low-income minority individuals. Under the OAA, the term “greatest economic need” means the need resulting from an income level at or below the poverty level established by the Office of Management and Budget. The term “greatest social need” means the need caused by non-economic factors that include physical and mental disabilities, language barriers, and cultural, social, or geographical isolation including that caused by racial or ethnic status which restricts an individual’s ability to perform normal daily tasks or which threatens such individuals’ capacity to live independently.

The CDA’s IFF was developed: to support the provision of needed services to older persons; to reflect the relative emphasis required by the OAA; to provide consistent emphasis to individuals with certain characteristics, regardless of their area of residence; and to be responsive to California’s diversity.

The requirement to give “preference” and “particular attention” to older individuals with certain characteristics recognizes that other older individuals with needs also are served under the OAA. The CDA takes this into account by assigning a weight of one (1.0), the least weight, to the population factor of 60+ Non-Minority, identified here as “other individuals.”

The CDA then applied the definitions of greatest economic need and greatest social need in selecting the three remaining factors listed below, and assigned weights to develop a weighted population and to achieve the relative emphasis required by the OAA.

<u>INDIVIDUALS</u>	<u>FACTORS</u>	<u>WEIGHTS</u>
Greatest Economic Need:	60+ Low Income	2.0
Greatest Social Need:	60+ Minority	2.0
	60+ Geographical Isolation (Rural)	1.5
Other Individuals	60+ Non Minority	1.0
Medical underserved (IID only)	60+ Medi-Cal Eligibles	1.0

When combined, these population factors and weights result in an allocation of Title III funds which is consistent with the OAA and which is based on the relative degree of emphasis (from 5.5 to 1.0) for the individuals noted below.

	<u>RELATIVE EMPHASIS</u>	
	<u>RURAL AREAS</u>	<u>OTHER AREAS</u>
Low Income Minority Individuals	5.5	4.0
Low Income Individuals (not Minority)	4.5	3.0
Minority Individuals (not Low Income)	3.5	2.0
Other Individuals	2.5	1.0

The CDA assumes that the IFF must: be equitable for all PSAs, and reflect consistent application among PSAs of greatest economic or social need, with particular attention to low-income minority individuals; include factors which are mutually exclusive whenever possible; utilize data that are available, dependable, and comparable statewide, and that are updated periodically to reflect current status; reflect changes in population characteristics among PSAs; and be as easy as possible to understand.

## **NUMERICAL STATEMENT OF THE FORMULA**

The following is a description of the Intrastate Funding Formula (IFF used for allocating OAA Title III and VII funds in accordance with Section 45 CFR 1321.37

1. The process begins by identifying:
  - a. Total Federal and State matching funds available for allocation to Planning and Service Areas (PSAs) for each Title III and VII program. (Total in Demonstration Column O)
  - b. Population data, updated no more than annually as information is available, by county and arraying these data by PSA. (Population Data Columns A-F on Demonstration)
2. The Statewide total amount for the administration allocation is calculated by taking ten percent (10%) of the Federal funds. (The Total in Demonstration Total Column G)
3. The Statewide total amount for the program allocation is calculated by subtracting the administration allocation from the total for State and federal funds. (The Total in Demonstration Column M and N)
4. Administrative funds are allocated as follows:
  - a. Each PSA receives a fifty thousand dollar (\$50,000) base.

- b. The balance of total administrative funds identified in 2. above is allocated to PSAs based on each PSA's proportion of California's total persons aged 60 and older.
  - c. Each PSA's total administration allocation is distributed among its qualifying Title III programs based on total qualifying administrative funds available.
- 5. Program funds are allocated based on weighted population figures. Weighted population totals are determined for each PSA by combining the following factors:
  - a. The number of non-minority persons aged 60 and older in each PSA is multiplied by a weight of 1.0 (Demonstration Column H).
  - b. The number of minority persons aged 60 and older in each PSA is multiplied by a weight of 2.0 (Demonstration Column I).
  - c. The number of low-income persons aged 60 and older in each PSA is multiplied by a weight of 2.0 (Demonstration Column J).
  - d. The number of geographically isolated persons aged 60 and older in each PSA is multiplied by a weight of 1.5 (Demonstration Column K).
  - e. The number of Medi-Cal eligible persons aged 60 and older in each PSA is multiplied by a weight of 1.0 (Demonstration Column L) for Title IIID only).
- 6. The total weighted population for each PSA is converted into a proportion of the total weighted population for all PSAs.
- 7. Each PSA's program allotments are determined in the following manner:
  - a. For Title IIIB, C-1, and C-2 programs,
    - i. Total State and federal program funds available are distributed to each PSA by multiplying each PSA's proportion or total weighted population by total statewide program allocation for Title III B, C and E.
    - ii. Each PSA's program allotment is compared to its 1979 allotment level. If a PSA is under its 1979 level, it receives an allotment equal to its 1979 level in lieu of the computed allotment in 7.a.1.
    - iii. The statewide program allocation is reduced by the total amount allocated to those PSAs receiving allotments equal to their 1979 level. The remaining statewide program allocation is then distributed to the remaining PSAs according to the formula to determine their adjusted total Title III B, C-1 and C-2 program allotments.
    - iv. Total program funds for each PSA are then distributed to each Title III program as follows:
      - 1. Federal funds are distributed based on the proportion of funds received by the Department of the latest Notice of Grant Award from the Federal Government.
      - 2. State funds are distributed based upon the statewide totals included in the most recent Budget Act, or Budget bill if allocations impact the next budget year, or other relevant legislation.

- b. For Title III E and VII program funds are allocated by multiplying each PSA's proportion of the total weighted population by the total statewide program allocation for each program, then distributing to fund sources as in 7.A.4.
- c. For Title III D program funds are allocated by multiplying each PSA's proportion of the total weighted population, including Medi-Cal eligible, by the total statewide program allocation for each program, then distributing to fund sources as in 7.A.4.

# CALIFORNIA DEPARTMENT OF AGING

## 2013 POPULATION DATA AND DEMONSTRATION OF AN ALLOCATION

Population Data (Number of Persons)								Demonstration of IFF Allocation									
a/ PSA Col>	60+ Non-Min.	c/ 60+ Minority	d/ 60+ Low Income	e/ 60+ Geo. Isolation	f/ 60+ Medi-Cal Eligibles	g/ PSA	a/ PSA	Area Admin Allocation	Weighted Population = Weight x Number of Persons							Total Federal Allocation	a/ PSA
									1.0 Non-Min	2.0 Minority	2.0 Low Income	1.5 Geo Isolation	1.0 Med-Cal Eligibles	Title IIB, C, E Weighted Total	Title IID Weighted Total		
	A	B	C	D	E	F		G	H	I	J	K	L	M	N	O	
1	36,281	32,336	3,945	4,055	11,725	4,519	1	\$96,505	32,336	7,890	8,110	17,588	4,519	65,924	70,443	\$515,715	1
2	72,720	65,373	7,347	8,780	33,482	8,927	2	143,214	65,373	14,694	17,560	50,223	8,927	147,850	156,777	1,156,436	2
3	82,338	71,623	10,715	9,040	27,986	11,557	3	155,542	71,623	21,430	18,080	41,979	11,557	153,112	164,669	1,197,944	3
4	429,995	309,932	120,063	41,050	41,636	59,069	4	601,174	309,932	240,126	82,100	62,454	59,069	694,612	753,681	5,435,629	4
5	66,670	58,656	8,014	4,470	5,180	3,902	5	135,459	58,656	16,028	8,940	7,770	3,902	91,394	95,296	714,611	5
6	165,828	66,596	99,232	28,165	0	46,458	6	262,561	66,596	198,464	56,330	0	46,458	321,390	367,848	2,517,903	6
7	212,812	140,405	72,407	15,235	1,769	22,942	7	322,785	140,405	144,814	30,470	2,654	22,942	318,343	341,285	2,490,539	7
8	150,219	85,641	64,578	11,925	3,580	17,435	8	242,553	85,641	129,156	23,850	5,370	17,435	244,017	261,452	1,909,033	8
9	275,650	131,699	143,951	27,335	1,320	51,576	9	403,332	131,699	287,902	54,670	1,980	51,576	476,251	527,827	3,728,538	9
10	312,056	162,577	149,479	26,675	4,347	57,449	10	449,998	162,577	298,958	53,350	6,521	57,449	521,406	578,855	4,082,197	10
11	114,186	64,682	49,504	14,230	11,455	20,680	11	196,365	64,682	99,008	28,460	17,183	20,680	209,333	230,013	1,638,549	11
12	49,951	45,236	4,715	3,684	31,924	3,399	12	114,028	45,236	9,430	7,368	47,886	3,399	109,920	113,319	859,271	12
13	61,302	46,701	14,601	5,285	9,588	6,851	13	128,578	46,701	29,202	10,570	14,382	6,851	100,855	107,706	788,971	13
14	174,209	100,193	74,016	23,665	30,224	36,170	14	273,304	100,193	148,032	47,330	45,336	36,170	340,891	377,061	2,668,700	14
15	86,187	50,483	35,704	12,410	14,653	18,776	15	160,476	50,483	71,408	24,820	21,980	18,776	168,691	187,467	1,320,744	15
16	7,745	6,709	1,036	500	3,869	631	16	59,928	6,709	2,072	1,000	5,804	631	15,585	16,216	335,884	16
17	143,846	113,638	30,208	12,685	16,116	13,349	17	234,384	113,638	60,416	25,370	24,174	13,349	223,598	236,947	1,748,891	17
18	154,069	106,523	47,546	13,100	5,252	17,376	18	247,488	106,523	95,092	26,200	7,878	17,376	235,693	253,069	1,843,993	18
19	1,049,603	434,056	616,252	131,495	10,719	261,479	19	1,395,396	434,056	1,232,504	262,990	16,079	261,479	1,945,629	2,137,476	15,239,874	19
20	306,955	165,462	141,493	37,440	21,182	52,050	20	443,459	165,462	282,986	74,880	31,773	52,050	555,101	607,151	4,344,630	20
21	389,414	255,061	134,353	41,090	21,442	49,126	21	549,156	255,061	268,706	82,180	32,163	49,126	638,110	687,236	4,992,701	21
22	550,389	348,152	202,237	46,830	827	79,170	22	755,496	348,152	404,474	93,660	1,241	79,170	847,527	926,697	6,633,324	22
23	550,197	364,467	185,730	56,175	22,757	73,534	23	755,250	364,467	371,460	112,350	34,136	73,534	882,413	955,947	6,905,019	23
24	28,625	7,472	21,153	5,700	4,789	11,419	24	86,692	7,472	42,306	11,400	7,184	11,419	68,362	79,781	535,805	24
25	620,326	266,054	353,567	106,460	723	154,536	25	845,142	266,054	707,134	212,920	1,085	154,536	1,187,193	1,411,360	9,298,377	25
26	40,842	35,570	5,272	5,190	17,199	6,149	26	102,352	35,570	10,544	10,380	25,799	6,149	82,293	88,442	645,816	26
27	110,978	95,361	15,617	9,435	17,953	9,521	27	192,253	95,361	31,234	18,870	26,930	9,521	172,395	181,916	1,348,282	27
28	111,293	69,755	41,538	9,890	8,942	12,171	28	192,657	69,755	83,076	19,780	13,413	12,171	186,024	198,195	1,455,163	28
29	44,439	39,779	4,660	2,240	16,600	2,671	29	106,963	39,779	9,320	4,480	24,900	2,671	78,479	81,150	613,527	29
30	87,241	60,762	26,479	10,600	8,100	16,923	30	161,827	60,762	52,958	21,200	12,150	16,923	147,070	163,993	1,151,552	30
31	38,030	21,471	16,559	5,445	5,905	8,401	31	98,747	21,471	33,118	10,890	8,858	8,401	74,337	82,738	582,029	31
32	70,217	42,459	27,758	6,775	10,445	9,548	32	140,005	42,459	55,516	13,550	15,668	9,548	127,193	136,741	995,143	32
33	124,768	79,599	45,169	17,145	17,295	21,705	33	209,929	79,599	90,338	34,290	25,943	21,705	230,170	251,875	1,801,493	33
	6,719,381	3,944,483	2,774,898	754,199	438,984	1,169,469		\$10,262,998	3,944,483	5,549,796	1,508,398	658,476	1,169,469	11,661,153	12,830,622	\$91,496,283	

## Notes for Population Data and Demonstration of Allocation:

- a. PSA: Planning and Service Area (PSA) means a geographical area, the boundaries of which are determined CDA pursuant to federal law and regulation. CDA allocates funds to an AAA to provide services to older individuals residing within a specific PSA (Appendix B).
- b. 60+ Pop.<sup>58</sup>: The number of individuals 60 years of age and older residing within the PSA.
- c. 60+ Non-Min.<sup>59</sup>: The number of individuals age 60 years and older residing within the PSA that self-identify as White (alone).
- d. 60+ Minority<sup>60</sup>: The number of individuals age 60 years and older residing within the PSA that self-identify as American Indian/Alaska Native, Asian, Black/African American, Native Hawaiian/Other Pacific Islander, or Two or More Races.
- e. 60+ Low Income<sup>61</sup>: The number of individuals age 60 years and older residing within the PSA with annual income below 125 percent of the federal poverty level.
- f. 60+ Geo. Isolation<sup>62</sup>: The number of individuals age 60 years and older throughout the PSA residing in a rural area. According to the 2010 census, a rural area encompasses all population, housing, and territory not included in an urban area. (An urban area is comprised of a densely settled core of census tracts and/or census blocks that meet minimum population requirements, along with adjacent territory containing non-residential urban land uses as well as territory with low population density included to link outlying densely settled territory with the densely settled core. To qualify as an urban area, the territory must encompass at least 2,500 people, at least 1,500 of which reside outside institutional group quarters.)
- g. 60+ Medi-Cal Eligibles<sup>63</sup>: The number of Medi-Cal-eligible individuals, age 60 years and above, residing within the PSA. Alpine County (PSA 12), Mono County (PSA 16) and Sierra County (PSA 4) are not included in the population counts. The Medi-Cal population in these counties was excluded to avoid identification of particular individuals.

## ATTACHMENT A

### STATE PLAN ASSURANCES AND REQUIRED ACTIVITIES Older Americans Act, As Amended in 2006

*By signing this document, the authorized official commits the State Agency on Aging to performing all listed assurances and activities as stipulated in the Older Americans Act, as amended in 2006.*

#### ASSURANCES

##### Sec. 305(a) - (c), ORGANIZATION

(a)(2)(A) The State agency shall, except as provided in subsection (b)(5), designate for each such area (planning and service area) after consideration of the views offered by the unit or units of general purpose local government in such area, a public or private nonprofit agency or organization as the area agency on aging for such area.

(a)(2)(B) The State agency shall provide assurances, satisfactory to the Assistant Secretary, that the State agency will take into account, in connection with matters of general policy arising in the development and administration of the State plan for any fiscal year, the views of recipients of supportive services or nutrition services, or individuals using multipurpose senior centers provided under such plan.

(a)(2)(E) The State agency shall provide assurance that preference will be given to providing services to older individuals with greatest economic need and older individuals with greatest social need, (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas) and include proposed methods of carrying out the preference in the State plan;

(a)(2)(F) The State agency shall provide assurances that the State agency will require use of outreach efforts described in section 307(a)(16).

(a)(2)(G)(ii) The State agency shall provide an assurance that the State agency will undertake specific program development, advocacy, and outreach efforts focused on the needs of low-income minority older individuals and older individuals residing in rural areas.

(c)(5) In the case of a State specified in subsection (b)(5), the State agency and area agencies shall provide assurance, determined adequate by the State agency, that the area agency on aging will have the ability to develop an area plan and to carry out, directly or through contractual or other arrangements, a program in accordance with the plan within the planning and service area.

States must assure that the following assurances (Section 306) will be met by its designated area agencies on aging, or by the State in the case of single planning and service area states.

**Sec. 306 (a), AREA PLANS**

(2) Each area agency on aging shall provide assurances that an adequate proportion, as required under section 307(a)(2), of the amount allotted for part B to the planning and service area will be expended for the delivery of each of the following categories of services-

(A) services associated with access to services (transportation, health services (including mental health services), outreach, information and assistance (which may include information and assistance to consumers on availability of services under part B and how to receive benefits under and participate in publicly supported programs for which the consumer may be eligible), and case management services);

(B) in-home services, including supportive services for families of older individuals who are victims of Alzheimer's disease and related disorders with neurological and organic brain dysfunction; and

(C) legal assistance;

and assurances that the area agency on aging will report annually to the State agency in detail the amount of funds expended for each such category during the fiscal year most recently concluded.

(4)(A)(i)(I) provide assurances that the area agency on aging will—

(aa) set specific objectives, consistent with State policy, for providing services to older individuals with greatest economic need, older individuals with greatest social need, and older individuals at risk for institutional placement;

(bb) include specific objectives for providing services to low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas; and

(II) include proposed methods to achieve the objectives described in items (aa) and (bb) of subclause (I);

(ii) provide assurances that the area agency on aging will include in each agreement made with a provider of any service under this title, a requirement that such provider will—

(I) specify how the provider intends to satisfy the service needs of low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in the area served by the provider;

(II) to the maximum extent feasible, provide services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in accordance with their need for such services; and

(III) meet specific objectives established by the area agency on aging, for providing services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas within the planning and service area; and

(4)(A)(iii) With respect to the fiscal year preceding the fiscal year for which such plan is prepared, each area agency on aging shall--

- (I) identify the number of low-income minority older individuals and older individuals residing in rural areas in the planning and service area;
- (II) describe the methods used to satisfy the service needs of such minority older individuals; and
- (III) provide information on the extent to which the area agency on aging met the objectives described in clause (a)(4)(A)(i).

(4)(B)(i) Each area agency on aging shall provide assurances that the area agency on aging will use outreach efforts that will identify individuals eligible for assistance under this Act, with special emphasis on--

- (I) older individuals residing in rural areas;
- (II) older individuals with greatest economic need (with particular attention to low-income minority individuals and older individuals residing in rural areas);
- (III) older individuals with greatest social need (with particular attention to low-income minority individuals and older individuals residing in rural areas);
- (IV) older individuals with severe disabilities;
- (V) older individuals with limited English proficiency;
- (VI) older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and
- (VII) older individuals at risk for institutional placement; and

(4)(C) Each area agency on agency shall provide assurance that the area agency on aging will ensure that each activity undertaken by the agency, including planning, advocacy, and systems development, will include a focus on the needs of low-income minority older individuals and older individuals residing in rural areas.

(5) Each area agency on aging shall provide assurances that the area agency on aging will coordinate planning, identification, assessment of needs, and provision of services for older individuals with disabilities, with particular attention to individuals with severe disabilities, and individuals at risk for institutional placement, with agencies that develop or provide services for individuals with disabilities.

(6)(F) Each area agency will:  
in coordination with the State agency and with the State agency responsible for mental health services, increase public awareness of mental health disorders, remove barriers to diagnosis and treatment, and coordinate mental health services (including mental health screenings) provided with funds expended by the area agency on aging with mental health services provided by community health centers and by other public agencies and nonprofit private organizations;

(9) Each area agency on aging shall provide assurances that the area agency on aging, in carrying out the State Long-Term Care Ombudsman program under section 307(a)(9), will expend not less than the total amount of funds appropriated under this Act and expended by the agency in fiscal year 2000 in carrying out such a program under this title.

(11) Each area agency on aging shall provide information and assurances concerning services to older individuals who are Native Americans (referred to in this paragraph as "older Native Americans"), including-

(A) information concerning whether there is a significant population of older Native Americans in the planning and service area and if so, an assurance that the area agency on aging will pursue activities, including outreach, to increase access of those older Native Americans to programs and benefits provided under this title;

(B) an assurance that the area agency on aging will, to the maximum extent practicable, coordinate the services the agency provides under this title with services provided under title VI; and

(C) an assurance that the area agency on aging will make services under the area plan available, to the same extent as such services are available to older individuals within the planning and service area, to older Native Americans.

(13)(A) Each area agency on aging shall provide assurances that the area agency on aging will maintain the integrity and public purpose of services provided, and service providers, under this title in all contractual and commercial relationships.

(13)(B) Each area agency on aging shall provide assurances that the area agency on aging will disclose to the Assistant Secretary and the State agency--

(i) the identity of each nongovernmental entity with which such agency has a contract or commercial relationship relating to providing any service to older individuals; and

(ii) the nature of such contract or such relationship.

(13)(C) Each area agency on aging shall provide assurances that the area agency will demonstrate that a loss or diminution in the quantity or quality of the services provided, or to be provided, under this title by such agency has not resulted and will not result from such non-governmental contracts or such commercial relationships.

(13)(D) Each area agency on aging shall provide assurances that the area agency will demonstrate that the quantity or quality of the services to be provided under this title by such agency will be enhanced as a result of such non-governmental contracts or commercial relationships.

(13)(E) Each area agency on aging shall provide assurances that the area agency will, on the request of the Assistant Secretary or the State, for the purpose of monitoring compliance with this Act (including conducting an audit), disclose all sources and expenditures of funds such agency receives or expends to provide services to older individuals.

(14) Each area agency on aging shall provide assurances that funds received under this title will not be used to pay any part of a cost (including an administrative cost) incurred by the area agency on aging to carry out a contract or commercial relationship that is not carried out to implement this title.

(15) provide assurances that funds received under this title will be used-

- (A) to provide benefits and services to older individuals, giving priority to older individuals identified in paragraph (4)(A)(i); and
- (B) in compliance with the assurances specified in paragraph (13) and the limitations specified in section 212;

(17) Each Area Plan will include information detailing how the Area Agency will coordinate activities and develop long-range emergency preparedness plans with local and State emergency response agencies, relief organizations, local and State governments and other institutions that have responsibility for disaster relief service delivery.

### **Sec. 307, STATE PLANS**

(7)(A) The plan shall provide satisfactory assurance that such fiscal control and fund accounting procedures will be adopted as may be necessary to assure proper disbursement of, and accounting for, Federal funds paid under this title to the State, including any such funds paid to the recipients of a grant or contract.

(7)(B) The plan shall provide assurances that--

- (i) no individual (appointed or otherwise) involved in the designation of the State agency or an area agency on aging, or in the designation of the head of any subdivision of the State agency or of an area agency on aging, is subject to a conflict of interest prohibited under this Act;
- (ii) no officer, employee, or other representative of the State agency or an area agency on aging is subject to a conflict of interest prohibited under this Act; and
- (iii) mechanisms are in place to identify and remove conflicts of interest prohibited under this Act.

(9) The plan shall provide assurances that the State agency will carry out, through the Office of the State Long-Term Care Ombudsman, a State Long-Term Care Ombudsman program in accordance with section 712 and this title, and will expend for such purpose an amount that is not less than an amount expended by the State agency with funds received under this title for fiscal year 2000, and an amount that is not less than the amount expended by the State agency with funds received under title VII for fiscal year 2000.

(10) The plan shall provide assurance that the special needs of older individuals residing in rural areas will be taken into consideration and shall describe how those needs have been met and describe how funds have been allocated to meet those needs.

(11)(A) The plan shall provide assurances that area agencies on aging will--

- (i) enter into contracts with providers of legal assistance which can demonstrate the experience or capacity to deliver legal assistance;
- (ii) include in any such contract provisions to assure that any recipient of funds under division (A) will be subject to specific restrictions and regulations promulgated under

the Legal Services Corporation Act (other than restrictions and regulations governing eligibility for legal assistance under such Act and governing membership of local governing boards) as determined appropriate by the Assistant Secretary; and (iii) attempt to involve the private bar in legal assistance activities authorized under this title, including groups within the private bar furnishing services to older individuals on a pro bono and reduced fee basis.

(11)(B) The plan contains assurances that no legal assistance will be furnished unless the grantee administers a program designed to provide legal assistance to older individuals with social or economic need and has agreed, if the grantee is not a Legal Services Corporation project grantee, to coordinate its services with existing Legal Services Corporation projects in the planning and service area in order to concentrate the use of funds provided under this title on individuals with the greatest such need; and the area agency on aging makes a finding, after assessment, pursuant to standards for service promulgated by the Assistant Secretary, that any grantee selected is the entity best able to provide the particular services.

(11)(D) The plan contains assurances, to the extent practicable, that legal assistance furnished under the plan will be in addition to any legal assistance for older individuals being furnished with funds from sources other than this Act and that reasonable efforts will be made to maintain existing levels of legal assistance for older individuals;

(11)(E) The plan contains assurances that area agencies on aging will give priority to legal assistance related to income, health care, long-term care, nutrition, housing, utilities, protective services, defense of guardianship, abuse, neglect, and age discrimination.

(12) The plan shall provide, whenever the State desires to provide for a fiscal year for services for the prevention of abuse of older individuals, the plan contains assurances that any area agency on aging carrying out such services will conduct a program consistent with relevant State law and coordinated with existing State adult protective service activities for--

- (A) public education to identify and prevent abuse of older individuals;
- (B) receipt of reports of abuse of older individuals;
- (C) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance where appropriate and consented to by the parties to be referred; and
- (D) referral of complaints to law enforcement or public protective service agencies where appropriate.

(13) The plan shall provide assurances that each State will assign personnel (one of whom shall be known as a legal assistance developer) to provide State leadership in developing legal assistance programs for older individuals throughout the State.

(15) The plan shall provide assurances that, if a substantial number of the older individuals residing in any planning and service area in the State are of limited English-speaking ability, then the State will require the area agency on aging for each such planning and service area—

(A) to utilize in the delivery of outreach services under section 306(a)(2)(A), the services of workers who are fluent in the language spoken by a predominant number of such older individuals who are of limited English-speaking ability; and

(B) to designate an individual employed by the area agency on aging, or available to such area agency on aging on a full-time basis, whose responsibilities will include--

(i) taking such action as may be appropriate to assure that counseling assistance is made available to such older individuals who are of limited English-speaking ability in order to assist such older individuals in participating in programs and receiving assistance under this Act; and

(ii) providing guidance to individuals engaged in the delivery of supportive services under the area plan involved to enable such individuals to be aware of cultural sensitivities and to take into account effectively linguistic and cultural differences.

(16) The plan shall provide assurances that the State agency will require outreach efforts that will—

(A) identify individuals eligible for assistance under this Act, with special emphasis on—

(i) older individuals residing in rural areas;

(ii) older individuals with greatest economic need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas;

(iii) older individuals with greatest social need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas;

(iv) older individuals with severe disabilities;

(v) older individuals with limited English-speaking ability; and

(vi) older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and

(B) inform the older individuals referred to in clauses (i) through (vi) of subparagraph (A), and the caretakers of such individuals, of the availability of such assistance.

(17) The plan shall provide, with respect to the needs of older individuals with severe disabilities, assurances that the State will coordinate planning, identification, assessment of needs, and service for older individuals with disabilities with particular attention to individuals with severe disabilities with the State agencies with primary responsibility for individuals with disabilities, including severe disabilities, to enhance services and develop collaborative programs, where appropriate, to meet the needs of older individuals with disabilities.

(18) The plan shall provide assurances that area agencies on aging will conduct efforts to facilitate the coordination of community-based, long-term care services, pursuant to section 306(a)(7), for older individuals who--

(A) reside at home and are at risk of institutionalization because of limitations on their ability to function independently;

(B) are patients in hospitals and are at risk of prolonged institutionalization; or

(C) are patients in long-term care facilities, but who can return to their homes if community-based services are provided to them.

(19) The plan shall include the assurances and description required by section 705(a).

(20) The plan shall provide assurances that special efforts will be made to provide technical assistance to minority providers of services.

(21) The plan shall

(A) provide an assurance that the State agency will coordinate programs under this title and programs under title VI, if applicable; and

(B) provide an assurance that the State agency will pursue activities to increase access by older individuals who are Native Americans to all aging programs and benefits provided by the agency, including programs and benefits provided under this title, if applicable, and specify the ways in which the State agency intends to implement the activities.

(22) If case management services are offered to provide access to supportive services, the plan shall provide that the State agency shall ensure compliance with the requirements specified in section 306(a)(8).

(23) The plan shall provide assurances that demonstrable efforts will be made--

(A) to coordinate services provided under this Act with other State services that benefit older individuals; and

(B) to provide multigenerational activities, such as opportunities for older individuals to serve as mentors or advisers in child care, youth day care, educational assistance, at-risk youth intervention, juvenile delinquency treatment, and family support programs.

(24) The plan shall provide assurances that the State will coordinate public services within the State to assist older individuals to obtain transportation services associated with access to services provided under this title, to services under title VI, to comprehensive counseling services, and to legal assistance.

(25) The plan shall include assurances that the State has in effect a mechanism to provide for quality in the provision of in-home services under this title.

(26) The plan shall provide assurances that funds received under this title will not be used to pay any part of a cost (including an administrative cost) incurred by the State agency or an area agency on aging to carry out a contract or commercial relationship that is not carried out to implement this title.

(27) The plan shall provide assurances that area agencies on aging will provide, to the extent feasible, for the furnishing of services under this Act, consistent with self-directed care.

### **Sec. 308, PLANNING, COORDINATION, EVALUATION, AND ADMINISTRATION OF STATE PLANS**

(b)(3)(E) No application by a State under subparagraph (b)(3)(A) shall be approved unless it contains assurances that no amounts received by the State under this paragraph will be used to hire any individual to fill a job opening created by the action of the State in laying off or terminating the employment of any regular employee not supported under this Act in anticipation of filling the vacancy so created by hiring an employee to be supported through use of amounts received under this paragraph.

### **Sec. 705, ADDITIONAL STATE PLAN REQUIREMENTS (as numbered in statute)**

(1) The State plan shall provide an assurance that the State, in carrying out any chapter of this subtitle for which the State receives funding under this subtitle, will establish programs in accordance with the requirements of the chapter and this chapter.

(2) The State plan shall provide an assurance that the State will hold public hearings, and use other means, to obtain the views of older individuals, area agencies on aging, recipients of grants under title VI, and other interested persons and entities regarding programs carried out under this subtitle.

(3) The State plan shall provide an assurance that the State, in consultation with area agencies on aging, will identify and prioritize statewide activities aimed at ensuring that older individuals have access to, and assistance in securing and maintaining, benefits and rights.

(4) The State plan shall provide an assurance that the State will use funds made available under this subtitle for a chapter in addition to, and will not supplant, any funds that are expended under any Federal or State law in existence on the day before the date of the enactment of this subtitle, to carry out each of the vulnerable elder rights protection activities described in the chapter.

(5) The State plan shall provide an assurance that the State will place no restrictions, other than the requirements referred to in clauses (i) through (iv) of section 712(a)(5)(C), on the eligibility of entities for designation as local Ombudsman entities under section 712(a)(5).

(6) The State plan shall provide an assurance that, with respect to programs for the prevention of elder abuse, neglect, and exploitation under chapter 3—

- (A) in carrying out such programs the State agency will conduct a program of services consistent with relevant State law and coordinated with existing State adult protective service activities for--
- (i) public education to identify and prevent elder abuse;
  - (ii) receipt of reports of elder abuse;
  - (iii) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance if appropriate and if the individuals to be referred consent; and
  - (iv) referral of complaints to law enforcement or public protective service agencies if appropriate;
- (B) the State will not permit involuntary or coerced participation in the program of services described in subparagraph (A) by alleged victims, abusers, or their households; and
- (C) all information gathered in the course of receiving reports and making referrals shall remain confidential except--
- (i) if all parties to such complaint consent in writing to the release of such information;
  - (ii) if the release of such information is to a law enforcement agency, public protective service agency, licensing or certification agency, ombudsman program, or protection or advocacy system; or
  - (iii) upon court order.

## ATTACHMENT A (CONTINUED)

### REQUIRED ACTIVITIES

#### Sec. 307(a) STATE PLANS

*(1)(A) The State Agency requires each area agency on aging designated under section 305(a)(2)(A) to develop and submit to the State agency for approval, in accordance with a uniform format developed by the State agency, an area plan meeting the requirements of section 306; and*

*(B) The State plan is based on such area plans.*

**NOTE: THIS SUBSECTION OF STATUTE DOES NOT REQUIRE THAT AREA PLANS BE DEVELOPED PRIOR TO STATE PLANS AND/OR THAT STATE PLANS DEVELOP AS A COMPILATION OF AREA PLANS.**

*(2) The State agency:*

*(A) evaluates, using uniform procedures described in section 202(a)(26), the need for supportive services (including legal assistance pursuant to 307(a)(11), information and assistance, and transportation services), nutrition services, and multipurpose senior centers within the State;*

*(B) has developed a standardized process to determine the extent to which public or private programs and resources (including Department of Labor Senior Community Service Employment Program participants, and programs and services of voluntary organizations) have the capacity and actually meet such need;*

*(4) The plan shall provide that the State agency will conduct periodic evaluations of, and public hearings on, activities and projects carried out in the State under this title and title VII, including evaluations of the effectiveness of services provided to individuals with greatest economic need, greatest social need, or disabilities (with particular attention to low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas). Note: "Periodic" (defined in 45CFR Part 1321.3) means, at a minimum, once each fiscal year.*

*(5) The State agency:*

*(A) affords an opportunity for a public hearing upon request, in accordance with published procedures, to any area agency on aging submitting a plan under this title, to any provider of (or applicant to provide) services;*

*(B) issues guidelines applicable to grievance procedures required by section 306(a)(10); and*

*(C) affords an opportunity for a public hearing, upon request, by an area agency on aging, by a provider of (or applicant to provide) services, or by any recipient of services under this title regarding any waiver request, including those under Section 316.*

(6) The State agency will make such reports, in such form, and containing such information, as the Assistant Secretary may require, and comply with such requirements as the Assistant Secretary may impose to insure the correctness of such reports.

*(8)(A) No supportive services, nutrition services, or in-home services are directly provided by the State agency or an area agency on aging in the State, unless, in the judgment of the State agency--*

*(i) provision of such services by the State agency or the area agency on aging is necessary to assure an adequate supply of such services;*

*(ii) such services are directly related to such State agency's or area agency on aging's administrative functions; or*

*(iii) such services can be provided more economically, and with comparable quality, by such State agency or area agency on aging.*

*Laura Connolly*

\_\_\_\_\_  
*Signature and Title of Authorized Official*

June 28, 2013

*Date*

## ATTACHMENT B

### INFORMATION REQUIREMENTS

*States must provide all applicable information following each OAA citation listed below. The completed attachment must be included with your State Plan submission.*

#### **Section 305(a)(2)(E)**

*Describe the mechanism(s) for assuring that preference will be given to providing services to older individuals with greatest economic need and older individuals with greatest social need, (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas) and include proposed methods of carrying out the preference in the State plan;*

#### **Response:**

The Department employs three primary mechanisms to assure preference is given to older individuals with greatest economic and social need; The Department uses an Intrastate Funding Formula (IFF) to distribute federal and state funds to AAAs. The IFF is based on a combination of factors, including: age, income, geographic isolation, racial or ethnic status, social isolation, and English language proficiency.

The AAA's four-year Area Plan and annual Area Plan Update must assess and describe the target population within the AAA's PSA. The AAA must also develop service goals and objectives that meet the needs of targeted populations and reduce barriers to services. CDA also assures every AAA targets high-risk populations through annual contract requirements stipulating that the AAA and its subcontractors must serve all eligible persons, especially targeted populations.

#### **Section 306(a)(17)**

*Describe the mechanism(s) for assuring that each Area Plan will include information detailing how the Area Agency will coordinate activities and develop long-range emergency preparedness plans with local and State emergency response agencies, relief organizations, local and State governments and other institutions that have responsibility for disaster relief service delivery.*

#### **Response:**

California regulations, CDA's Area Plan Guidance and CDA's Standard Agreement require AAAs to describe in their Area Plans how they identify their local Office of Emergency Services contact persons and AAA disaster response coordinator and coordinate their disaster preparedness plans. In addition, AAAs must describe how they identify vulnerable populations and plan to follow up with them in the event of a disaster.

CDA's *Disaster Assistance Handbook for Area Agencies on Aging (Disaster Assistance Handbook)* describes what AAAs are required to do before, during, and after an emergency event to address the needs of the populations they serve.

**Section 307(a)(2)**

The plan shall provide that the State agency will:

(C) *Specify a minimum proportion of the funds received by each area agency on aging in the State to carry out part B that will be expended (in the absence of a waiver under sections 306 (c) or 316) by such area agency on aging to provide each of the categories of services specified in section 306(a)(2) (Note: those categories are access, in-home, and legal assistance). Provide specific minimum proportion determined for each category of service.*

**Response:**

CDA's Area Plan Guidance requires AAAs to describe in their Area Plans how the AAA establishes priorities for the planning cycle, the factors influencing the AAA's priorities, and its plans for managing increased or decreased resources. The Area Plan must include the AAA's process for establishing an adequate proportion of funding for Title III access, in-home and legal assistance, in keeping with federal and state requirements. Changes to adequate proportion must be reflected in the Area Plan Update.

California regulations and CDA's Standard Agreement specifically require that AAAs meet the adequate proportion requirements for priority services. Please refer to page 41 for a display of approved Title IIIB minimum proportion expenditure levels for California's 33 AAAs.

**Section (307(a)(3)**

The plan shall:

...

(B) with respect to services for older individuals residing in rural areas:

(i) provide assurances the State agency will spend for each fiscal year of the plan, not less than the amount expended for such services for fiscal year 2000.

(ii) *identify, for each fiscal year to which the plan applies, the projected costs of providing such services (including the cost of providing access to such services).*

**Response:**

Thirty-one of California's 33 AAAs have some rural (geographically isolated) population. To ensure a baseline level of funding, each PSA receives annually at least as much funding in total as it received in 2000. The IFF allocates funds in part based on the number of persons aged 60 and older who are geographically isolated. Demographic data used in the formula are updated annually with the best available data. In addition,

the IFF acknowledges the cost of serving rural individuals by assigning greater weight when allocating funds to individuals who are geographically isolated.

*(iii) describe the methods used to meet the needs for such services in the fiscal year preceding the first year to which such plan applies.*

**Response:**

The Department's and AAAs' data collection and analysis assists with determining the size and location of the rural population(s) in each PSA and supports targeted outreach and service delivery. AAAs target services for older individuals residing in rural areas through their requests for proposals and contracts. AAAs monitor contractors who provide service to rural individuals to ensure they meet program and performance requirements. AAAs use nutrition sites, health fairs, and other rural venues to link older individuals to the services. AAAs collaborate with community-based organizations in rural areas to assess needs and develop responsive services and service systems. AAAs also make extensive efforts to educate elected officials, private foundations, and the general public about the needs of older individuals residing in rural areas.

**Section 307(a)(10)**

The plan shall provide assurance that the special needs of older individuals residing in rural areas are taken into consideration and shall *describe how those needs have been met and describe how funds have been allocated to meet those needs.*

**Response:**

California's IFF provides greater weight to individuals who are age 60 and older and geographically isolated (i.e., rural) than those who are not. The formula assigns a weight of 1.5 to this factor. Within rural areas, low-income minority individuals receive the highest relative emphasis. Older individuals residing in rural areas are among those individuals to whom AAAs target services through their RFP and contracting processes.

**Section 307(a)(14)**

(14) The plan shall, with respect to the fiscal year preceding the fiscal year for which such plan is prepared—

*(A) identify the number of low-income minority older individuals in the State, including the number of low income minority older individuals with limited English proficiency; and*

*(B) describe the methods used to satisfy the service needs of the low-income minority older individuals described in subparagraph (A), including the plan to meet the needs of low-income minority older individuals with limited English proficiency.*

**Response:**

The Department's and AAAs' data collection and analysis assists with determining the population and location of low-income, minority older individuals and those with limited English proficiency in each PSA and supports targeted outreach and service delivery.

The Department retrieves updated data for individuals with these and other characteristics annually from recognized sources. The Department uses the best available data to allocate funds to the AAAs, with the number of low-income minority individuals receiving the highest emphasis in the funding formula. Data on the number of low-income and minority individuals is displayed on page 46 of this State Plan. Data on the distribution of older individuals with limited English proficiency is displayed on page 89. The Department also publishes this data on its website.

AAAs conduct focus groups with multicultural older adults in their respective languages and survey service providers to identify service gaps. This helps them to target services to low-income minority older individuals with limited English proficiency through their requests for proposals and contracts. AAAs monitor contractors to ensure they meet program and performance objectives for serving targeted individuals. AAAs employ bilingual staff and culturally competent non-bilingual staff to support responsiveness to the service needs of the low-income, minority individuals with limited English proficiency. They also devote considerable effort to educating the community about the service needs of older adults, especially those for service under the OAA. AAAs use community fairs, other special events and community education publications translated into a variety of languages to reach low-income, minority individuals with limited English proficiency.

AAAs also seek to address service needs by engaging low-income minority individuals with limited English proficiency as members of their AAA Advisory Councils and other advisory committees. Doing so supports outreach, needs assessment, planning and service delivery that are sensitive and responsive to the needs of targeted individuals.

### **Section 307(a)(21)**

The plan shall:

(B) provide an assurance that the State agency will pursue activities to increase access by older individuals who are Native Americans to all aging programs and benefits provided by the agency, including programs and benefits provided under this title (*title III*), if applicable, *and specify the ways in which the State agency intends to implement the activities* .

### **Response:**

Coordination is essential to increasing access to aging programs and benefits by older individuals who are Native Americans. During this State Plan period, CDA will work with AAAs and state tribal organizations to identify opportunities and strategies to improve coordination between Titles III and VI, and involve recognized tribes in implementing evidence-based CDSME programs. CDA's Medicare Improvements for Patients and Providers Act (MIPPA) grant activities will include efforts to increase the enrollment of Native American Medicare beneficiaries in the Prescription Drug Assistance Program, Low Income Subsidy, and Medicare Savings Program.

At the local level, AAAs will continue to conduct a range of activities focused on increasing service access to older individuals who are Native Americans. These will include data collection, analysis and planning efforts to identify the particular needs of older Native Americans and target services appropriately. Title III/VI coordination activities will include establishing congregate meal sites in targeted areas, providing nutrition education and delivering meals to older individuals who are Native Americans, and providing technical assistance and food safety training to Native American program staff. Activities to increase access also will include engaging Native American individuals as AAA advisory council members, conducting outreach to tribal communities, and making referrals to community-based programs, including evidence-based CDSME programs.

**Section 307(a)(29)**

*The plan shall include information detailing how the State will coordinate activities, and develop long-range emergency preparedness plans, with area agencies on aging, local emergency response agencies, relief organizations, local governments, State agencies responsible for emergency preparedness, and any other institutions that have responsibility for disaster relief service delivery.*

**Response:**

To ensure compliance with this requirement, CDA (1) maintains a *Disaster Assistance Handbook* for AAAs; (2) provides guidance and training to the AAAs to assist them in fulfilling their contractual responsibilities in emergency/disaster preparedness, coordination, response and recovery, including a disaster preparedness webpage; (3) during on-site AAA monitoring, reviews compliance with these requirements; (4) has designated a specific lead staff disaster coordinator at CDA to provide emergency preparedness technical assistance and serve as the main contact for the AAAs and Region IX on these issues; and (5) maintains contact information for each AAA Emergency Coordinator with afterhours phone information to communicate with these organizations in an emergency situation.

The Department also maintains a Continuity of Operations and Continuity of Government Plan to ensure that critical functions and core leadership are maintained during a potential emergency that impacts its headquarters or leadership capacity.

**Section 307(a)(30)**

*The plan shall include information describing the involvement of the head of the State agency in the development, revision, and implementation of emergency preparedness plans, including the State Public Health Emergency Preparedness and Response Plan.*

**Response:**

CDA's Director serves as a member of the California Health and Human Services Agency Disaster Council. This Council, chaired by the Agency Secretary who also serves on the Governor's Cabinet, has a lead role in preparing for and responding to

emergency/disaster events. The Council serves as a forum for interdepartmental collaboration in planning, response and recovery activities, including those that involve the California Emergency Management Agency (CalEMA) and the American Red Cross.

The Director receives daily CalEMA emergency situation reports and, in the event of a major event, would receive ongoing updates and participate in daily situational conference calls/meetings. The Director is also on the California Health Alert Network to receive phone and email notification and messages from the California Department of Public Health in an emergency situation. These response systems are tested at least annually. The Director has been actively involved in the development of the California Emergency Plan, specifically in the sections addressing Emergency Function (EF) 6 – Mass Care and Shelter and EF 8 – Public Health and Medical Emergency.

### **Section 705(a)(7)**

In order to be eligible to receive an allotment under this subtitle, a State shall *include in the State plan submitted under section 307:*

*(7) a description of the manner in which the State agency will carry out this title in accordance with the assurances described in paragraphs (1) through (6).*

*(Note: Paragraphs (1) of through (6) of this section are listed below)*

*In order to be eligible to receive an allotment under this subtitle, a State shall include in the State plan submitted under section 307:*

*(1) an assurance that the State, in carrying out any chapter of this subtitle for which the State receives funding under this subtitle, will establish programs in accordance with the requirements of the chapter and this chapter;*

*(2) an assurance that the State will hold public hearings, and use other means, to obtain the views of older individuals, area agencies on aging, recipients of grants under title VI, and other interested persons and entities regarding programs carried out under this subtitle;*

*(3) an assurance that the State, in consultation with area agencies on aging, will identify and prioritize statewide activities aimed at ensuring that older individuals have access to, and assistance in securing and maintaining, benefits and rights;*

*(4) an assurance that the State will use funds made available under this subtitle for a chapter in addition to, and will not supplant, any funds that are expended under any Federal or State law in existence on the day before the date of the enactment of this subtitle, to carry out each of the vulnerable elder rights protection activities described in the chapter;*

*(5) an assurance that the State will place no restrictions, other than the requirements referred to in clauses (i) through (iv) of section 712(a)(5)(C), on the eligibility of entities for designation as local Ombudsman entities under section 712(a)(5);*

*(6) an assurance that, with respect to programs for the prevention of elder abuse, neglect, and exploitation under chapter 3--*

*(A) in carrying out such programs the State agency will conduct a program of services consistent with relevant State law and coordinated with existing State adult protective service activities for:*

- (i) public education to identify and prevent elder abuse;*
- (ii) receipt of reports of elder abuse;*
- (iii) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance if appropriate and if the individuals to be referred consent; and*
- (iv) referral of complaints to law enforcement or public protective service agencies if appropriate;*
- (B) the State will not permit involuntary or coerced participation in the program of services described in subparagraph (A) by alleged victims, abusers, or their households; and*
- (C) all information gathered in the course of receiving reports and making referrals shall remain confidential except--*
  - (i) if all parties to such complaint consent in writing to the release of such information;*
  - (ii) if the release of such information is to a law enforcement agency, public protective service agency, licensing or certification agency, ombudsman program, or protection or advocacy system; or*
  - (iii) upon court order.*

**Response:**

- 1) The Office of the State Long-Term Care Ombudsman is located within CDA and provides oversight to 35 local Long-Term Care Ombudsman Programs. AAAs provide these programs directly or by subcontract. As advocates for residents of LTC facilities, the SLTCO and the local Ombudsman representatives promote residents' rights and provide assurances to protect these rights. Statewide, approximately 1,100 state-certified Ombudsman volunteers and paid local LTCOP staff identify, investigate, and resolve complaints and concerns on behalf of approximately 296,000 residents in nearly 1,400 Skilled Nursing Facilities (SNFs), including Distinct Part SNFs and Intermediate Care Facilities, and approximately 7,500 Residential Care Facilities for the Elderly.

AAAs, directly or by subcontract, provide Programs for Prevention of Elder Abuse, Neglect and Exploitation under Title VII, Chapter 3. These services include public education sessions, distributing educational materials, training sessions for professionals and family caregivers served by Title III E and developing a coordinated system to respond to elder abuse.

- 2) The State holds public hearings to obtain stakeholder input on these programs during the State Plan review and development process.
- 3) The State reviews AAA Area Plans and Area Plan Updates to determine how Title VII funds are used to establish a coordinated system to respond to elder abuse. The State also monitors AAAs and their compliance with the provisions of Title VII, Chapter 3.

- 4) The State reviews funds expended under this Title and certifies these expenditures to AoA.
- 5) The State imposes no restrictions, other than the requirements referred to in clauses (i) through (iv) of section 712(a)(5)(C) on entities seeking designation as local Ombudsman programs.
- 6) The State, through the AAAs, coordinates services locally with funds expended under Title VII, Chapter 3, and maintains the confidentiality of any reports of abuse or neglect.

## **APPENDIX A**

### **CALIFORNIA DEPARTMENT OF AGING VALUES**

The Department strives to pursue its Vision and accomplish its Mission in a manner consistent with the Values outlined below.

Leadership: We set the direction for ensuring that strategies, systems, and methods for achieving excellence are created; and for building the knowledge and capabilities of our employees and others who work with our customers.

Diversity: We work in an inclusive environment that respects the rights of all people, their equal opportunity to succeed, and the contributions they make to accomplish our Mission.

Advocacy: We speak in support of individuals and issues that promote the overall well-being of our customers.

Accountability: We assume responsibility – individually, and in teams – for our behaviors, actions, and results and for serving our customers in the manner in which they want to be served.

Quality: Our performance demonstrates a commitment to, and recognition of, excellence, which is the balance of efficiency and effectiveness.

Innovation: We take initiative by being open and receptive to experimenting with new and creative ideas.

Collaboration: We foster partnerships and cooperation with our stakeholders, business partners, and customers in planning, delivering, and evaluating programs and services.

Integrity: We are open, honest, trustworthy, and professional in the performance of our duties and in our dealings with our customers, business partners, and stakeholders.

Empowerment: We enable individuals to make informed choices that can enrich their lives and support their ability to effectively participate in their communities.

Respect: We hold our stakeholders, business partners, and customers in the highest esteem, and show due consideration and appreciation in our interactions for their ideas, programs, and services.

## APPENDIX B CALIFORNIA PLANNING AND SERVICE AREAS AND



## CALIFORNIA AREA AGENCIES ON AGING ♦

<b>PSA 1</b>	<b>Area 1 Agency on Aging</b>	<b>Type *1</b>
County(ies) Served: Del Norte, Humboldt	434 7 <sup>th</sup> Street Eureka, California 95501 Phone: (707) 442-3763	
Maggie Kraft, Executive Director	Fax: (707) 442-3714 Home page address: <a href="http://www.a1aa.org">www.a1aa.org</a>	
<b>PSA 2</b>	<b>Planning and Service Area II Area Agency on Aging</b>	<b>Type *3</b>
County(ies) Served:  Lassen, Modoc, Shasta, Siskiyou, Trinity	208 West Center St, Yreka, California 96097 <u>Mailing Address:</u> P.O. Box 1400, Yreka, California 96097 Phone: (530) 842-1687 Fax: (530) 842-4804	
Teri Gabriel, Executive Director	Home page address: <a href="http://www.psa2.org">http://www.psa2.org</a>	
<b>PSA 3</b>	<b>PASSAGES Area 3 Agency on Aging</b>	<b>Type *2</b>
County(ies) Served:  Butte, Colusa, Glenn, Plumas, Tehama	25 Main Street, Room 202 Chico, California 95929 Phone: (530) 898-5923 Fax: (530) 898-4870	
Joe Cobery, Executive Director	Home page address: <a href="http://www.passagescenter.org">http://www.passagescenter.org</a>	

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♦ ORGANIZATIONAL TYPES:  
 \* = County AAA  
 \*1 = Private Non-Profit  
 \*2 = University Foundation  
 \*3 = Joint Powers Agreement  
 \*4 = City AAA

<b>PSA 4</b>	<b>Area 4 Agency on Aging</b>	<b>Type *3</b>
County(ies) Served: Nevada, Placer, Sacramento, Sierra, Sutter, Yolo, Yuba	2260 Park Towne Circle, Suite 100 Sacramento, California 95825 Phone: (916) 486-1876 Fax: (916) 486-9454 Home page address: <a href="http://www.a4aa.com">www.a4aa.com</a>	
Pam Miller, Executive Director		
<b>PSA 5</b>	<b>Division of Aging Marin County Department of Health and Human Services</b>	<b>Type *</b>
County(ies) Served: Marin	10 North San Pedro Road, Suite 1013 San Rafael, California 94903 Phone: (415) 499-7396 Fax: (415) 499-5055 Home Page Address: <a href="http://www.co.marin.ca.us/aging/">www.co.marin.ca.us/aging/</a>	
Larry Meredith, Director		
<b>PSA 6</b>	<b>Department of Aging and Adult Services Area Agency on Aging</b>	<b>Type *</b>
County(ies) Served: City and County of San Francisco	1650 Mission Street, 5 <sup>th</sup> Floor San Francisco, California 94103 Phone: (415) 355-3555 Fax: (415) 355-6785 Home Page Address: <a href="http://www.sfgov.org/coaging">www.sfgov.org/coaging</a>	
Anne Hinton, Executive Director		
<b>PSA 7</b>	<b>Aging and Adult Services Bureau County Employment and Human Services Department</b>	<b>Type *</b>
County(ies) Served: Contra Costa	40 Douglas Drive Martinez, California 94553 Phone: (925) 229-8434 Fax: (925) 335-8717 <a href="http://www.ca-contracostacounty.civicplus.com">www.ca-contracostacounty.civicplus.com</a>	
John Cottrell, Director		

<b>PSA 8</b>	<b>San Mateo County Area Agency on Aging</b>	<b>Type *</b>
County(ies) Served: San Mateo	225 37th Avenue San Mateo, California 94403 (650) 573-2700 Fax: (650) 573-2310	
Lisa Mancini, Director	Home page address: <a href="http://www.sanmateonetworkofcare.org">www.sanmateonetworkofcare.org</a>	
<b>PSA 9</b>	<b>Alameda County Area Agency on Aging Department of Adult and Aging Services</b>	<b>Type *</b>
County(ies) Served: Alameda	6955 Foothill Boulevard, Suite 300 Oakland, California 94605-1907 Phone: (510) 577-1900 Fax: (510) 577-1965	
Victoria Tolbert, Interim Director	Home page address: <a href="http://www.co.alamedasocialservices.org">http://www.co.alamedasocialservices.org</a>	
<b>PSA 10</b>	<b>Sourcewise Community Resource Solutions</b>	<b>Type *1</b>
County(ies) Served: Santa Clara	2115 The Alameda San Jose, California 95126-1141 Phone: (408) 296-8290 Fax: (408) 249-8918	
Stephen Schmall, Executive Director	Home page address: <a href="http://www.mysourcewise.com">www.mysourcewise.com</a>	
<b>PSA 11</b>	<b>San Joaquin County Department of Aging and Community</b>	<b>Type *</b>
County(ies) Served: San Joaquin	P.O. Box 201056 Stockton, California 95201 <u>For overnight/express mail only:</u> 102 South San Joaquin Street Stockton, California 95201 Phone: (209) 468-2202 Fax: (209) 468-2207	
Dean Fujimoto, Director	Home page address: <a href="http://www.co.san-joaquin.ca.us/hsa/aging/elderly/safer.htm">www.co.san-joaquin.ca.us/hsa/aging/elderly/safer.htm</a>	

<b>PSA 12</b>	<b>Area 12 Agency on Aging</b>	<b>Type *3</b>
County(ies) Served: Alpine, Amador,  Calaveras, Mariposa, Sonora, Tuolumne Pauline White, Executive Director	19074 Standard Road, Suite A California 95370-7542 <u>Fed Ex:</u> Standard, CA 95373 Phone: (209) 532-6272 Fax: (209) 532-6501  Home page address: <a href="http://www.area12.org">www.area12.org</a>	
<b>PSA 13</b>	<b>Seniors Council of Santa Cruz and San Benito Counties, Inc.</b>	<b>Type *1</b>
County(ies) Served: Santa Benito, San Cruz  Clay Kempf, Executive Director	234 Santa Cruz Avenue Aptos, California 95003 Phone: (831) 688-0400 ext. 15 Fax: (831) 688-1225 Home page address: <a href="http://www.seniorscouncil.org/">http://www.seniorscouncil.org/</a>	
<b>PSA 14</b>	<b>Fresno-Madera Area Agency on Aging</b>	<b>Type *3</b>
County(ies) Served: Fresno, Madera  Jean Robinson, Executive Director	3837 N. Clark Street Fresno, California 93726 Phone: (559) 600-4405 Fax: (559) 453-5111 Home page address: <a href="http://www.fmaaa.org">www.fmaaa.org</a>	
<b>PSA 15</b>	<b>Kings-Tulare Area Agency on Aging</b>	<b>Type *3</b>
County(ies) Served: Kings, Tulare  Tim Lutz, Director	5957 South Mooney Boulevard Visalia, California 93277 Phone: (559) 624-8060 Fax: (559) 737-4694 Home page address: <a href="http://www.ktaaa.org">www.ktaaa.org</a>	

<b>PSA 16</b>	<b>Eastern Sierra Area Agency on Aging</b>	<b>Type *3</b>
County(ies) Served: Inyo, Mono	163 May St. Bishop, California 93514 For overnight/express mail only: 568 West Line Street Bishop, California 93514 (760) 873-3305 (760) 873-6505	
Jean Turner, Director	Home page address: <a href="http://www.countyofinyo.org/imaaa">www.countyofinyo.org/imaaa</a>	
<b>PSA 17</b>	<b>Area Agency on Aging Central Coast Commission for Senior Citizens</b>	<b>Type *1</b>
County(ies) Served: Santa Barbara, San Luis Obispo	528 South Broadway Santa Maria, California 93454 (805) 925-9554 (805) 925-9555	
joyce ellen lippman, Executive Director	Home page address: <a href="http://www.centralcoastseniors.org/">http://www.centralcoastseniors.org/</a>	
<b>PSA 18</b>	<b>Ventura County Area Agency on Aging</b>	<b>Type *</b>
County(ies) Served: Ventura	646 County Square Drive, Suite 100  Ventura, California 93003 (805) 477-7300 (805) 477-7312	
Victoria Jump, Director	Home page address: <a href="http://aaa.countyofventura.org">http://aaa.countyofventura.org</a>	
<b>PSA 19</b>	<b>Community and Senior Services Area Agency on Aging Los Angeles County</b>	<b>Type *</b>
County(ies) Served: County of Los Angeles	3333 Wilshire Boulevard, Suite 400 Los Angeles, California 90010 Phone: (213) 738-4004 Fax: (213) 365-8649	
Cynthia Banks, Director	Home page address: <a href="http://www.dcss.co.la.ca.us/aaa/aaa.htm">www.dcss.co.la.ca.us/aaa/aaa.htm</a>	
<b>Office is closed on Fridays</b>		

**PSA 20**                      **San Bernardino County Department of Aging and Adult Services**                      **Type \***

County(ies) Served: 686 East Mill Street  
San Bernardino      San Bernardino, California 92415  
Phone: (909) 891-3900  
Fax: (909) 891-3919  
Ron Buttram,              Home page address:  
Director                      <http://hss.sbcounty.gov/daas/>

**PSA 21**                      **County of Riverside Office on Aging**                      **Type \***

County(ies) Served: 6296 Rivercrest Drive, Suite K  
Riverside                  Riverside, California 92507  
Phone: (951) 867-3800  
TDD # (951) 697-4699  
Michele Wilham,        Fax: (951) 867-3830  
Director                      Home page address: [www.rcaging.org](http://www.rcaging.org)

**PSA 22**                      **Orange County Office on Aging**                      **Type \***

County(ies) Served: 1300 South Grand Avenue, Bldg. B, 2nd Floor  
Orange                      Santa Ana, California 92705  
Phone: (714) 567-7500  
Fax: (714) 567-5021  
Karen Roper,              Home page address:  
Executive Director        [www.officeonaging.ocgov.com](http://www.officeonaging.ocgov.com)

**PSA 23**                      **County of San Diego Aging & Independence Services**                      **Type \***

County(ies) Served: 5560 Overland Ave. Suite 310  
San Diego                  San Diego, California 92123  
(858)495-5885  
Ellen Schmeding        (858) 495-5080  
Director                      Home page address: [www.sdcounty.ca.gov/ais](http://www.sdcounty.ca.gov/ais)

**PSA 24**                      **Imperial County Area Agency on Aging**                      **Type \***

County(ies) Served: 1331 South Clark Road, Building 11  
Imperial                      El Centro, California 92243  
Phone: (760) 339-6450  
Fax: (760) 339-6455  
Sherry Leon,              Home page address:  
Director                      <http://www.co.imperial.ca.us>

<b>PSA 25</b>	<b>City of Los Angeles Department of Aging</b>	<b>Type *4</b>
County(ies) Served: Los Angeles City	221 N. Figueroa St. Site 180 Los Angeles, California 90012 Phone: (213) 252-4000 Fax: (213) 252-4020 Home page address: <a href="http://aging.lacity.org/">http://aging.lacity.org/</a>	
Laura Trejo, General Manager		
<b>PSA 26</b>	<b>Area Agency on Aging Mendocino County Department of Social Services</b>	<b>Type *3</b>
County(ies) Served: Lake, Mendocino	809 South Main Street Lakeport, CA 95453 <u>Mailing Address:</u> PO Box 9000 Lower lake, CA 95457 Phone: (707) 262-4517 Fax: (707) 263-3112	
Todd Metcalf, Director		
<b>PSA 27</b>	<b>Sonoma County Area Agency on Aging</b>	<b>Type *</b>
County(ies) Served:  Sonoma	<u>Mailing Address:</u> P.O. Box 4059 Santa Rosa, California 95402 <b><u>For overnight/express mail only:</u></b> 3725 Westwind Boulevard Santa Rosa, CA 95403 Phone: (707) 565-5950 Fax: (707) 565-5957 Home page address: <a href="http://www.socoaaa.org/">http://www.socoaaa.org/</a>	
Diane Kaljian, Director		
<b>PSA 28</b>	<b>Area Agency on Aging – Serving Napa and Solano</b>	<b>Type *1</b>
County(ies) Served:  Napa, Solano	<u>Mailing Address:</u> P.O. Box 3069 Vallejo, California 94590-5990 <b><u>For overnight/express mail only:</u></b> 400 Contra Costa St. Vallejo, California 94590-5990 Phone: (707) 644-6612 Fax: (707) 644-7905 Home page address: <a href="http://www.aaans.org">www.aaans.org</a>	
Leanne Martinsen, Executive Director		

<b>PSA 29</b>	<b>El Dorado County Area Agency on Aging</b>	<b>Type *</b>
County(ies) Served: El Dorado	937 Spring Street Placerville, California 95667 Phone: (530) 621-6150 Fax: (530) 642-9233	
Janet Walker- Conroy, Director	Home page address: <a href="http://www.co.el-dorado.ca.us/humanservices/seniorservices.html">www.co.el-dorado.ca.us/humanservices/seniorservices.html</a>	
<b>PSA 30</b>	<b>Stanislaus County Department of Aging and Veterans Services</b>	<b>Type *</b>
County(ies) Served: Stanislaus	121 Downey Avenue, Suite 102 Modesto, California 95354-1201 Phone: (209) 558-7825 Fax: (209) 558-8648	
Margie Palomino, Director	Home page address: <a href="http://www.agingservices.info">www.agingservices.info</a>	
<b>PSA 31</b>	<b>Area Agency on Aging Merced County Senior Service Center</b>	<b>Type *</b>
County(ies) Served: Merced	2115 West Wardrobe Ave. Merced, California 95341-0112 Phone: (209) 385-7550 Fax: (209) 725-3836	
Janice Rector, Deputy Director	Home page address: <a href="http://www.co.merced.ca.us/index.asp?nid=451">http://www.co.merced.ca.us/index.asp?nid=451</a>	
<b>PSA 32</b>	<b>Area Agency on Aging Division Department of Social Services County of Monterey</b>	<b>Type *</b>
County(ies) Served: Monterey	1000 South Main Street, Suites 209A Salinas, California 93901 Phone: (831) 755-4400 Fax: (831) 757-9226	
Sam Trevino, Director	Home page address: <a href="http://www.co.monterey.ca.us/aaa">www.co.monterey.ca.us/aaa</a>	

**PSA 33**

**Kern County Aging & Adult Services**

**Type**  
\*

County(ies) Served:  
Kern

5357 Truxtun Avenue  
Bakersfield, California 93309  
(661) 868-1000  
(661) 868-1001

Lito Morillo,  
Interim Director

Home page address: [www.co.kern.ca.us/aas/](http://www.co.kern.ca.us/aas/)

## APPENDIX C

### Projected Population 60 + Change between 2010 and 2050 (By Age Group)<sup>64</sup>

Age Range	Actual Population 2010	Projected Population 2030	Projected Population 2050	Population Change 2010 - 2030	Percent Change	Population Change 2030 - 2050	Percent Change
60 - 64	1,854,741	2,447,481	2,733,808	592,740	32%	286,327	17%
65 - 69	1,314,480	2,374,900	2,616,307	1,059,420	81%	241,407	10%
70 - 74	997,891	2,154,378	2,274,011	1,156,487	116%	119,633	6%
75 - 79	767,530	1,661,586	2,017,022	168,465	116%	355,436	21%
80 - 84	604,308	1,156,089	1,742,031	551,781	91%	585,942	51%
85+	606,333	993,496	2,484,680	387,163	64%	1,491,124	169%
<b>Totals</b>	<b>6,126,283</b>	<b>10,787,930</b>	<b>13,867,799</b>	<b>3,916,056</b>	<b>76.1%</b>	<b>3,979,869</b>	<b>29%</b>



**APPENDIX E**  
**California Actual/Projected Population Age 60+**  
**Percentage Change between 2010 and 2030**  
**[By Planning and Service Area (PSA) and County]<sup>66</sup>**

	<b>2010 60+ TOTAL POPULATION</b>	<b>2030 60+ TOTAL POPULATION</b>	<b>DIFFERENCE</b>	<b>% CHANGE</b>
<b>CALIFORNIA</b>	<b>6,126,283</b>	<b>10,817,050</b>	<b>4,690,767</b>	<b>77%</b>
<b>PSA 01</b>				
Del Norte	5,621	9,183	3,562	63
Humboldt	26,929	41,559	14,630	54
<b>TOTAL</b>	<b>32,550</b>	<b>50,742</b>	<b>18,192</b>	<b>56</b>
<b>PSA 02</b>				
Lassen	5,403	10,243	4,840	90
Modoc	2,722	3,822	1,100	40
Shasta	42,351	72,209	29,858	71
Siskiyou	12,659	17,769	5,110	40
Trinity	4,053	5,989	1,936	48
<b>TOTAL</b>	<b>67,188</b>	<b>110,032</b>	<b>42,844</b>	<b>64</b>
<b>PSA 03</b>				
Butte	44,677	77,572	32,895	74
Colusa	3,582	6,510	2,928	82
Glenn	5,203	8,664	3,461	67
Plumas	6,075	8,425	2,350	39
Tehama	14,221	23,809	9,588	67
<b>TOTAL</b>	<b>73,758</b>	<b>124,980</b>	<b>51,222</b>	<b>69</b>
<b>PSA 04</b>				
Nevada	28,207	41,059	12,852	46
Placer	74,975	132,313	57,338	76
Sacramento	230,675	414,877	184,202	80
Sierra	1,019	1,477	458	45
Sutter	16,744	30,345	13,601	81
Yolo	29,028	56,220	27,192	94
Yuba	10,782	23,954	13,172	122
<b>TOTAL</b>	<b>391,430</b>	<b>700,245</b>	<b>308,815</b>	<b>79</b>
<b>PSA 05</b>				
Marin	61,646	84,339	22,693	37
<b>PSA 06</b>				
San Francisco	154,801	211,648	56,847	37
<b>PSA 07</b>				
Contra Costa	192,112	347,248	155,136	81

	2010 60+ TOTAL POPULATION	2030 60+ TOTAL POPULATION	DIFFERENCE	% CHANGE
<b>PSA 08</b>				
San Mateo	138,165	222,952	84,787	61%
<b>PSA 09</b>				
Alameda	248,319	427,992	179,673	72
<b>PSA 10</b>				
Santa Clara	282,414	506,562	224,148	79
<b>PSA 11</b>				
San Joaquin	103,052	206,478	103,426	100
<b>PSA 12</b>				
Alpine	273	486	213	78
Amador	11,273	17,860	6,587	58
Calaveras	13,822	20,606	6,784	49
Mariposa	4,945	9,218	4,273	86
Tuolumne	15,916	21,964	6,048	38
<b>TOTAL</b>	<b>46,229</b>	<b>70,134</b>	<b>23,905</b>	<b>52</b>
<b>PSA 13</b>				
San Benito	8,052	16,955	8,903	111
Santa Cruz	45,817	75,638	29,821	65
<b>TOTAL</b>	<b>53,869</b>	<b>92,593</b>	<b>38,724</b>	<b>72</b>
<b>PSA 14</b>				
Fresno	134,523	243,111	108,588	81
Madera	24,643	49,973	25,330	103
<b>TOTAL</b>	<b>159,166</b>	<b>293,084</b>	<b>133,918</b>	<b>84</b>
<b>PSA 15</b>				
Kings	17,702	39,989	22,287	126
Tulare	60,602	111,698	51,096	84
<b>TOTAL</b>	<b>78,304</b>	<b>151,687</b>	<b>73,383</b>	<b>94</b>
<b>PSA 16</b>				
Inyo	4,894	6,623	1,729	35
Mono	2,204	3,963	1,759	80
<b>TOTAL</b>	<b>7,098</b>	<b>10,586</b>	<b>3,488</b>	<b>49</b>
<b>PSA 17</b>				
San Luis Obispo	58,433	93,397	34,964	60
Santa Barbara	74,230	110,047	35,817	48
<b>TOTAL</b>	<b>132,663</b>	<b>203,444</b>	<b>70,781</b>	<b>53</b>
<b>PSA 18</b>				
Ventura	139,918	242,345	102,427	73
<b>PSA 19</b>				
L.A. County	934,143	1,619,921	685,778	73
<b>PSA 20</b>				
San Bernardino	270,467	586,293	315,826	117
<b>PSA 21</b>				
Riverside	359,013	687,163	328,150	91
<b>PSA 22</b>				
Orange	516,006	870,581	354,575	69

	<b>2010 60+ TOTAL POPULATION</b>	<b>2030 60+ TOTAL POPULATION</b>	<b>DIFFERENCE</b>	<b>% CHANGE</b>
<b>PSA 23</b>				
San Diego	504,520	870,067	365,547	72%
<b>PSA 24</b>				
Imperial	25,787	54,371	54,371	111
<b>PSA 25</b>				
L.A. City	597,239	1,035,688	438,449	73
<b>PSA 26</b>				
Lake	16,952	28,584	11,632	69
Mendocino	20,784	29,408	8,624	41
<b>TOTAL</b>	<b>37,736</b>	<b>57,992</b>	<b>20,256</b>	<b>54</b>
<b>PSA 27</b>				
Sonoma	100,334	156,714	56,380	56
<b>PSA 28</b>				
Napa	29,155	43,835	14,680	50
Solano	70,797	132,700	61,903	87
<b>TOTAL</b>	<b>99,952</b>	<b>176,535</b>	<b>76,583</b>	<b>77</b>
<b>PSA 29</b>				
El Dorado	39,740	72,581	32,841	83
<b>PSA 30</b>				
Stanislaus	79,066	147,371	68,305	86
<b>PSA 31</b>				
Merced	34,500	65,699	31,199	90
<b>PSA 32</b>				
Monterey	64,720	101,434	101,434	57
<b>PSA 33</b>				
Kern	110,499	257,548	147,049	133

## APPENDIX F

### California Actual/Projected Population Age 85+ Percentage Change between 2010 and 2030 (By Planning and Service Area [PSA] and County)<sup>67</sup>

	2010 85+ TOTAL POPULATION	2030 85+ TOTAL POPULATION	DIFFERENCE	% CHANGE
<b>CALIFORNIA</b>	<b>606,333</b>	<b>993,496</b>	<b>387,163</b>	<b>64%</b>
<b>PSA 01</b>				
Del Norte	438	844	406	93
Humboldt	2,548	3,941	1,393	55
<b>TOTAL</b>	<b>2,986</b>	<b>4,785</b>	<b>1,799</b>	<b>160</b>
<b>PSA 02</b>				
Lassen	459	837	378	82
Modoc	214	386	172	80
Shasta	3,952	7,574	3,622	92
Siskiyou	1,138	1,837	699	61
Trinity	265	576	311	117
<b>TOTAL</b>	<b>6,028</b>	<b>11,210</b>	<b>5,182</b>	<b>86</b>
<b>PSA 03</b>				
Butte	5,661	7,127	1,466	26
Colusa	337	582	245	73
Glenn	509	709	200	39
Plumas	415	849	434	105
Tehama	1,175	2,148	973	83
<b>TOTAL</b>	<b>8,097</b>	<b>11,415</b>	<b>3,318</b>	<b>41</b>
<b>PSA 04</b>				
Nevada	2,780	3,936	1,156	42
Placer	7,196	14,014	6,818	95
Sacramento	23,211	36,347	13,136	57
Sierra	69	71	71	103
Sutter	1,506	1,675	1,675	111
Yolo	2,971	5,337	2,366	80
Yuba	762	1,691	929	122
<b>TOTAL</b>	<b>38,495</b>	<b>63,071</b>	<b>26,151</b>	<b>64</b>
<b>PSA 05</b>				
Marin	6,535	8,845	2,310	35
<b>PSA 06</b>				
San Francisco	17,578	21,351	3,773	21
<b>PSA 07</b>				
Contra Costa	19,456	30,771	11,315	58

	<b>2010 85+ TOTAL POPULATION</b>	<b>2030 85+ TOTAL POPULATION</b>	<b>DIFFERENCE</b>	<b>% CHANGE</b>
<b>PSA 08</b>				
San Mateo	15,380	20,638	5,258	34%
<b>PSA 09</b>				
Alameda	24,945	38,023	13,078	52
<b>PSA 10</b>				
Santa Clara	27,875	45,492	17,617	63
<b>PSA 11</b>				
San Joaquin	10,005	18,410	8,405	84
<b>PSA 12</b>				
Alpine	5	40	35	700
Amador	1,003	1,680	677	67
Calaveras	961	1,903	942	98
Mariposa	365	832	467	128
Tuolumne	1,470	2,219	749	51
<b>TOTAL</b>	<b>3,804</b>	<b>6,674</b>	<b>2,870</b>	<b>75</b>
<b>PSA 13</b>				
San Benito	741	1,344	603	81
Santa Cruz	4,646	6,349	1,703	37
<b>TOTAL</b>	<b>5,387</b>	<b>7,693</b>	<b>2,306</b>	<b>43</b>
<b>PSA 14</b>				
Fresno	13,709	22,794	9,085	66
Madera	1,925	5,045	3,120	162
<b>TOTAL</b>	<b>15,634</b>	<b>27,839</b>	<b>12,205</b>	<b>78</b>
<b>PSA 15</b>				
Kings	1,348	2,963	1,615	120
Tulare	5,379	10,268	4,889	91
<b>TOTAL</b>	<b>6,727</b>	<b>13,231</b>	<b>6,504</b>	<b>97</b>
<b>PSA 16</b>				
Inyo	520	684	164	32
Mono	79	299	220	278
<b>TOTAL</b>	<b>599</b>	<b>983</b>	<b>384</b>	<b>64</b>
<b>PSA 17</b>				
San Luis Obispo	6,306	8,585	2,279	36
Santa Barbara	9,141	10,978	1,837	20
<b>TOTAL</b>	<b>15,447</b>	<b>19,563</b>	<b>4,116</b>	<b>27</b>
<b>PSA 18</b>				
Ventura	14,138	23,168	9,030	64
<b>PSA 19</b>				
L.A. County	93,956	150,248	56,292	60
<b>PSA 20</b>				
San Bernardino	21,075	48,562	27,487	130

	<b>2010 85+ TOTAL POPULATION</b>	<b>2030 85+ TOTAL POPULATION</b>	<b>DIFFERENCE</b>	<b>% CHANGE</b>
<b>PSA 21</b>				
Riverside	32,421	64,399	31,978	99%
<b>PSA 22</b>				
Orange	50,184	83,327	33,143	66
<b>PSA 23</b>				
San Diego	54,460	77,205	22,745	42
<b>PSA 24</b>				
Imperial	2,047	5,832	3,785	185
<b>PSA 25</b>				
L.A. City	60,070	96,060	35,990	60
<b>PSA 26</b>				
Lake	1,364	2,239	875	64
Mendocino	1,961	2,964	1,003	51
<b>TOTAL</b>	<b>3,325</b>	<b>5,203</b>	<b>1,878</b>	<b>56</b>
<b>PSA 27</b>				
Sonoma	11,183	15,886	4,703	42
<b>PSA 28</b>				
Napa	3,471	4,730	1,259	36
Solano	6,027	11,606	5,579	93
<b>TOTAL</b>	<b>9,498</b>	<b>16,336</b>	<b>6,838</b>	<b>72</b>
<b>PSA 29</b>				
El Dorado	3,116	6,084	2,968	95
<b>PSA 30</b>				
Stanislaus	7,460	14,054	6,594	88
<b>PSA 31</b>				
Merced	3,027	6,122	3,095	102
<b>PSA 32</b>				
Monterey	6,839	9,345	2,506	37
<b>PSA 33</b>				
Kern	8,535	20,007	11,472	134

## APPENDIX G

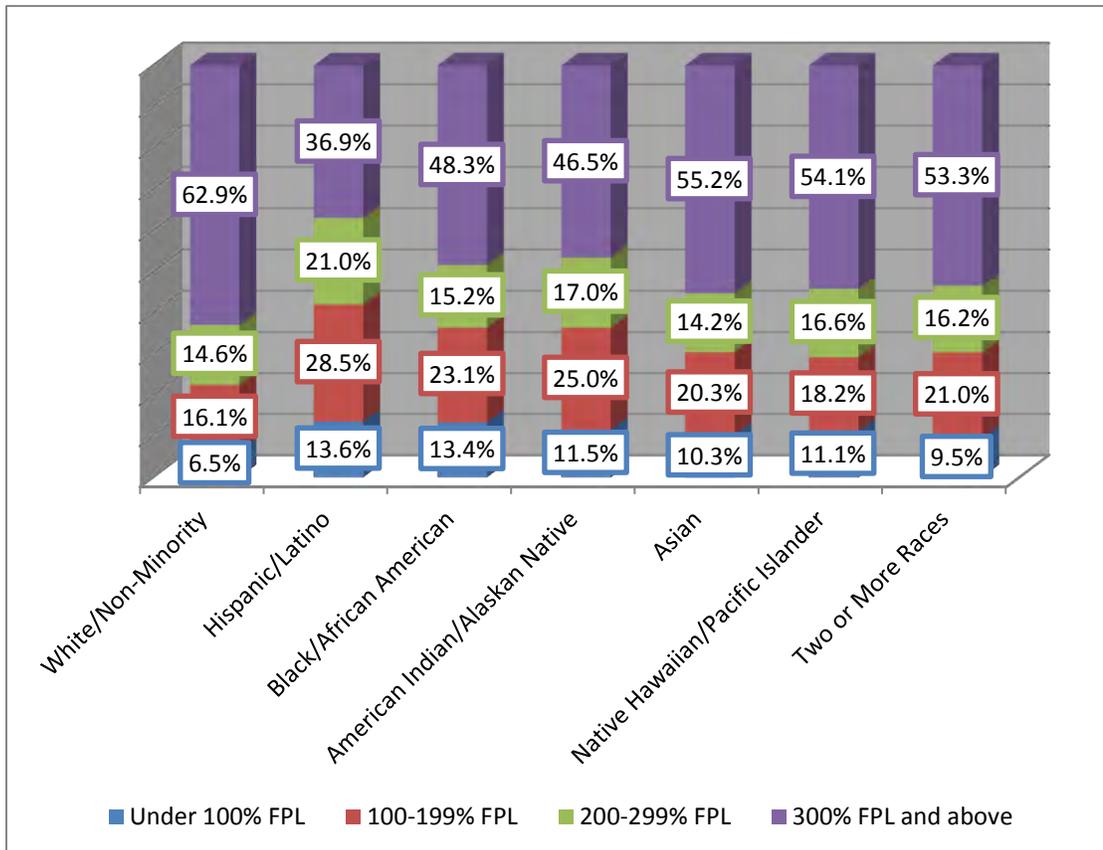
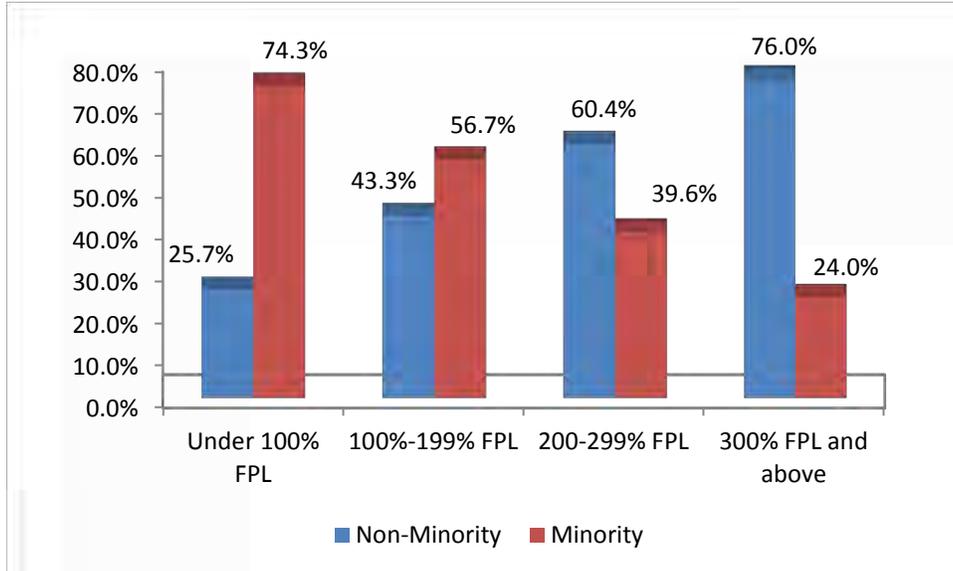
### California's Projected Population Age 60+ as a Percent of Total Population Age 60+ (by Race and Ethnicity)<sup>68</sup>

<b>Race/Ethnicity</b>	<b>2010</b>	<b>2030</b>	<b>2050</b>
White/Non-Hispanic	61.8%	46.7%	35.8%
Hispanic/Latino	18.5%	29.1%	38.8%
Asian	13.5%	16.2%	17.3%
Black/African American	5.4%	5.6%	5.5%
American Indian/Alaskan Native	0.4%	0.49%	0.4%
Native Hawaiian/Other Pacific Islander	0.20%	0.35%	0.30%
Two or More Races	1.1%	1.6%	2.2%



## APPENDIX I

### Poverty Level of Californians Age 60+ (By Minority/Non-Minority Status)<sup>70</sup>

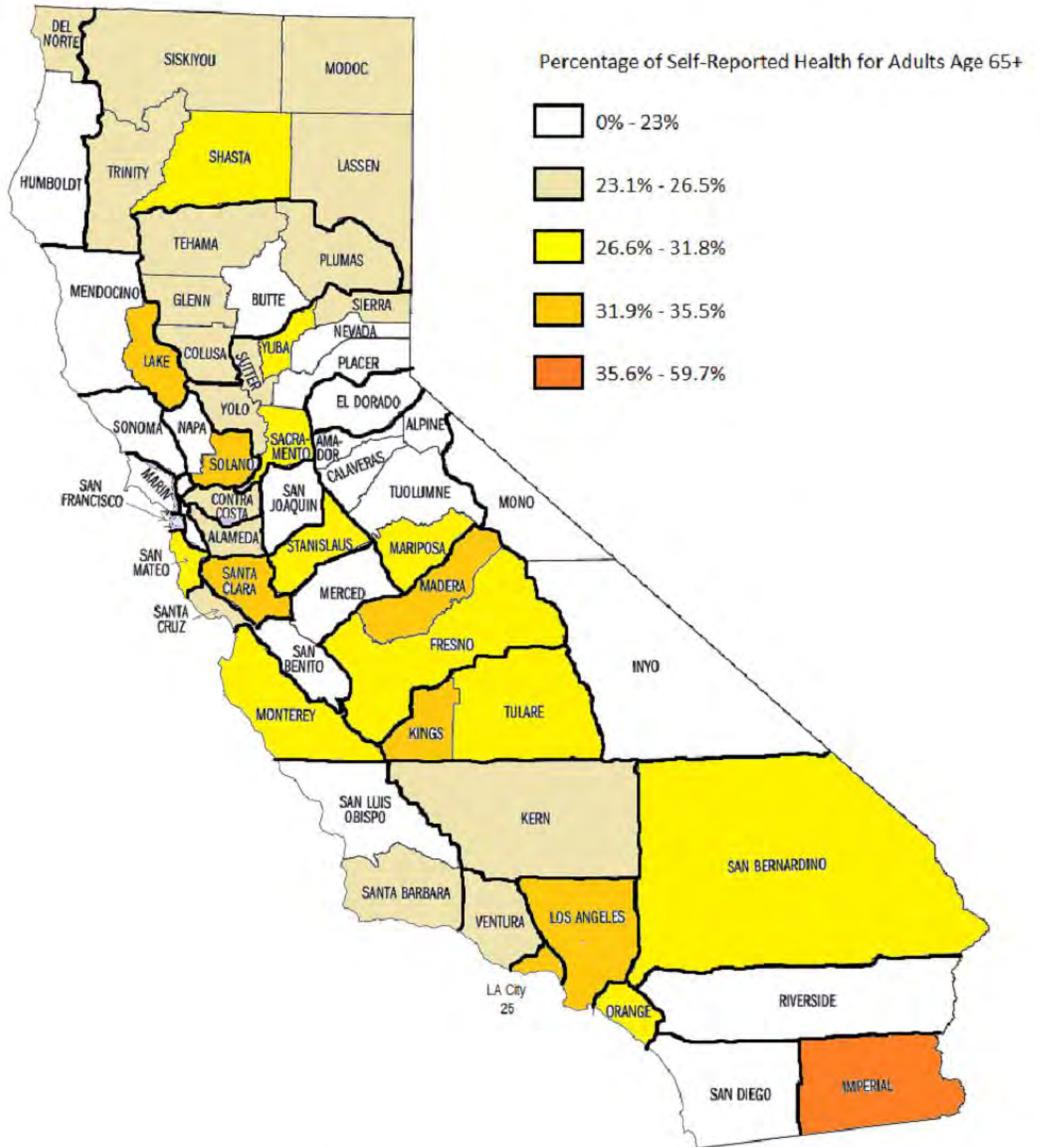


**APPENDIX J**  
**California's Health Report on Aging for Individuals 65 +<sup>71</sup>**

	<b>Health Indicator</b>	<b>Year data collected</b>	<b>% of adults 65+</b>
	<b>Health Status</b>		
1.	General health status fair to poor	2009	5.6
2.	Frequent mental distress	2009	9.2
3.	Oral health: complete tooth loss	2009	10.1
4.	Disability	2009	35.4
	<b>Health Behaviors</b>		
5.	Physical activity in past month	2009	27.2
6.	How often do you eat fruits & vegetables eaten daily	2009	3.35* *Denotes frequency not %
7.	Obesity	2009	23.9
8.	Current smoker	2009	13.4
	<b>Preventive Care &amp; Screenings</b>		
9.	Flu vaccine in past year	2009	65.1
10.	Ever had pneumonia shot	2009	59.9
11.	Mammogram in past 2 years	2008	82.3
12.	Ever had colorectal cancer screening	2008	66.6
13.	Up-to-date on select preventive services - men	2008	36.9
14.	Up-to-date on select preventive services - women	2008	38.9
15.	Ever had blood cholesterol checked	2009	93.2
16.	Ever had a prostate specific antigen test	2009	79.4

## APPENDIX K

### Percentage of Self-Reported Health for Adults Age 65+<sup>72</sup>



(Percentage of Self-Reported Health as Fair, or Poor, Age 65 or over). Counties with populations under 100,000 were grouped together into regions to produce reliable estimates.

## APPENDIX L

### 2011 California Elder Economic Security Index<sup>73</sup> Basic Living Costs for Single Older Adult, No Mortgage

PSA	County	Housing <sup>1</sup>	Food <sup>1</sup>	Health Care <sup>2</sup>	Transportation <sup>1</sup>	Misc	Monthly Total	Annual Costs
01	Del Norte	\$367	\$253	\$403	\$239	\$252	\$1,515	\$18,179
	Humboldt	\$358	\$253	\$403	\$239	\$251	\$1,504	\$18,049
02	Lassen	\$437	\$253	\$403	\$239	\$266	\$1,598	\$19,177
	Modoc	\$347	\$253	\$403	\$239	\$248	\$1,490	\$17,881
	Shasta	\$378	\$253	\$403	\$239	\$255	\$1,527	\$18,329
	Siskiyou	\$369	\$253	\$403	\$239	\$253	\$1,517	\$18,208
	Trinity	\$309	\$253	\$403	\$239	\$241	\$1,445	\$17,343
03	Butte	\$392	\$253	\$403	\$239	\$257	\$1,544	\$18,529
	Colusa	\$383	\$253	\$403	\$239	\$256	\$1,534	\$18,404
	Glenn	\$358	\$253	\$403	\$239	\$251	\$1,503	\$18,041
	Plumas	\$379	\$253	\$403	\$239	\$255	\$1,529	\$18,347
	Tehama	\$304	\$253	\$403	\$239	\$240	\$1,439	\$17,273
04	Nevada	\$540	\$253	\$403	\$239	\$287	\$1,722	\$20,662
	Placer	\$485	\$273	\$275	\$239	\$254	\$1,526	\$18,313
	Sierra	\$408	\$253	\$403	\$239	\$261	\$1,564	\$18,768
	Sacramento	\$390	\$273	\$275	\$239	\$235	\$1,412	\$16,946
	Sutter	\$355	\$253	\$403	\$239	\$250	\$1,501	\$18,007
	Yolo	\$427	\$273	\$275	\$239	\$243	\$1,456	\$17,476
	Yuba	\$307	\$253	\$403	\$239	\$240	\$1,443	\$17,314
05	Marin	\$598	\$253	\$281	\$239	\$274	\$1,646	\$19,756
06	San Francisco	\$450	\$278	\$263	\$239	\$246	\$1,476	\$17,707
07	Contra Costa	\$473	\$278	\$271	\$239	\$252	\$1,514	\$18,166
08	San Mateo	\$464	\$278	\$281	\$239	\$252	\$1,515	\$18,175
09	Alameda	\$436	\$278	\$263	\$239	\$243	\$1,459	\$17,506
10	Santa Clara	\$467	\$291	\$259	\$239	\$251	\$1,507	\$18,082
11	San Joaquin	\$391	\$253	\$257	\$239	\$228	\$1,368	\$16,417
12	Alpine	\$426	\$253	\$403	\$239	\$264	\$1,586	\$19,027
	Amador	\$424	\$253	\$275	\$239	\$238	\$1,430	\$17,163
	Calaveras	\$456	\$253	\$403	\$239	\$270	\$1,622	\$19,459
	Mariposa	\$327	\$253	\$403	\$239	\$245	\$1,467	\$17,604
	Tuolumne	\$458	\$253	\$403	\$239	\$271	\$1,624	\$19,487
	San Benito	\$476	\$253	\$403	\$239	\$274	\$1,645	\$19,744
13	Santa Cruz	\$426	\$253	\$403	\$239	\$264	\$1,585	\$19,023
	Fresno	\$384	\$275	\$263	\$239	\$232	\$1,394	\$16,729
14	Madera	\$410	\$253	\$263	\$239	\$233	\$1,399	\$16,791
	Kings	\$325	\$253	\$403	\$239	\$244	\$1,464	\$17,565
15	Tulare	\$358	\$253	\$403	\$239	\$251	\$1,503	\$18,041
	Inyo	\$402	\$253	\$403	\$239	\$259	\$1,557	\$18,678
16	Mono	\$469	\$253	\$403	\$239	\$273	\$1,637	\$19,641
	San Luis Obispo	\$442	\$253	\$422	\$239	\$271	\$1,628	\$19,530
17	Santa Barbara	\$448	\$253	\$422	\$239	\$272	\$1,635	\$19,616
	Ventura	\$432	\$253	\$182	\$239	\$221	\$1,328	\$15,937
19	Los Angeles County (excluding L.A. City)	\$393	\$258	\$182	\$239	\$214	\$1,287	\$15,438
20	San Bernardino	\$374	\$260	\$182	\$239	\$211	\$1,267	\$15,205
21	Riverside	\$440	\$260	\$182	\$239	\$224	\$1,347	\$16,161
22	Orange	\$433	\$255	\$182	\$239	\$222	\$1,331	\$15,975
23	San Diego	\$417	\$255	\$182	\$239	\$219	\$1,312	\$15,747
24	Imperial	\$371	\$253	\$439	\$239	\$261	\$1,563	\$18,761
25	City of Los Angeles	\$506	\$258	\$182	\$239	\$237	\$1,422	\$17,062
26	Lake	\$388	\$253	\$422	\$239	\$260	\$1,563	\$18,755
	Mendocino	\$411	\$253	\$403	\$239	\$261	\$1,568	\$18,810
27	Sonoma	\$449	\$253	\$275	\$239	\$243	\$1,460	\$17,515
28	Napa	\$518	\$253	\$263	\$239	\$255	\$1,529	\$18,345
	Solano	\$368	\$253	\$257	\$239	\$224	\$1,341	\$16,092
29	El Dorado	\$524	\$253	\$275	\$239	\$258	\$1,550	\$18,597
30	Stanislaus	\$383	\$253	\$245	\$239	\$224	\$1,345	\$16,140
31	Merced	\$358	\$253	\$403	\$239	\$251	\$1,503	\$18,037
32	Monterey	\$406	\$253	\$403	\$239	\$260	\$1,562	\$18,743
33	Kern	\$353	\$256	\$207	\$239	\$211	\$1,266	\$15,191
	CA Avg	\$412	\$257	\$334	\$239	\$249	\$1,491	\$17,893

<sup>1</sup> Three-year average for Housing, Food, and Transportation.

<sup>2</sup> Health Care is actual costs for someone in good health.

## 2011 California Elder Economic Security Index

### Basic Living Costs for Older Couple, Owner, No Mortgage

PSA	County	Housing <sup>1</sup>	Food <sup>1</sup>	Health Care <sup>2</sup>	Transportation <sup>1</sup>	Misc	Monthly Total	Annual Costs
01	Del Norte	\$367	\$472	\$805	\$335	\$396	\$2,375	\$28,500
	Humboldt	\$358	\$472	\$805	\$335	\$394	\$2,364	\$28,371
02	Lassen	\$437	\$472	\$805	\$335	\$410	\$2,458	\$29,498
	Modoc	\$347	\$472	\$805	\$335	\$392	\$2,350	\$28,202
	Shasta	\$378	\$472	\$805	\$335	\$398	\$2,388	\$28,651
	Siskiyou	\$369	\$472	\$805	\$335	\$396	\$2,377	\$28,530
	Trinity	\$309	\$472	\$805	\$335	\$384	\$2,305	\$27,664
03	Butte	\$392	\$472	\$805	\$335	\$401	\$2,404	\$28,851
	Colusa	\$383	\$472	\$805	\$335	\$399	\$2,394	\$28,725
	Glenn	\$358	\$472	\$805	\$335	\$394	\$2,364	\$28,362
	Plumas	\$379	\$472	\$805	\$335	\$398	\$2,389	\$28,669
	Tehama	\$304	\$472	\$805	\$335	\$383	\$2,300	\$27,594
04	Nevada	\$540	\$472	\$805	\$335	\$430	\$2,582	\$30,984
	Placer	\$485	\$508	\$550	\$335	\$376	\$2,253	\$27,039
	Sierra	\$408	\$472	\$805	\$335	\$404	\$2,424	\$29,090
	Sacramento	\$390	\$508	\$550	\$335	\$357	\$2,139	\$25,672
	Sutter	\$355	\$472	\$805	\$335	\$393	\$2,361	\$28,329
	Yolo	\$427	\$508	\$550	\$335	\$364	\$2,184	\$26,203
	Yuba	\$307	\$472	\$805	\$335	\$384	\$2,303	\$27,635
05	Marin	\$598	\$472	\$562	\$335	\$393	\$2,361	\$28,328
06	San Francisco	\$450	\$517	\$526	\$335	\$366	\$2,194	\$26,323
07	Contra Costa	\$473	\$517	\$542	\$335	\$374	\$2,242	\$26,898
08	San Mateo	\$464	\$517	\$562	\$335	\$376	\$2,254	\$27,051
09	Alameda	\$436	\$517	\$526	\$335	\$363	\$2,177	\$26,123
10	Santa Clara	\$467	\$541	\$518	\$335	\$372	\$2,234	\$26,803
11	San Joaquin	\$391	\$472	\$514	\$335	\$342	\$2,054	\$24,644
12	Alpine	\$426	\$472	\$805	\$335	\$408	\$2,446	\$29,349
	Amador	\$424	\$472	\$550	\$335	\$356	\$2,137	\$25,649
	Calaveras	\$456	\$472	\$805	\$335	\$414	\$2,482	\$29,781
	Mariposa	\$327	\$472	\$805	\$335	\$388	\$2,327	\$27,926
	Tuolumne	\$458	\$472	\$805	\$335	\$414	\$2,484	\$29,809
13	San Benito	\$476	\$472	\$805	\$335	\$418	\$2,505	\$30,066
	Santa Cruz	\$426	\$472	\$805	\$335	\$408	\$2,445	\$29,344
14	Fresno	\$384	\$513	\$526	\$335	\$352	\$2,110	\$25,317
	Madera	\$410	\$472	\$526	\$335	\$349	\$2,092	\$25,103
15	Kings	\$325	\$472	\$805	\$335	\$387	\$2,324	\$27,886
	Tulare	\$358	\$472	\$805	\$335	\$394	\$2,364	\$28,363
16	Inyo	\$402	\$472	\$805	\$335	\$403	\$2,417	\$29,000
	Mono	\$469	\$472	\$805	\$335	\$416	\$2,497	\$29,962
17	San Luis Obispo	\$442	\$472	\$844	\$335	\$419	\$2,511	\$30,133
	Santa Barbara	\$448	\$472	\$844	\$335	\$420	\$2,518	\$30,218
18	Ventura	\$432	\$472	\$364	\$335	\$321	\$1,924	\$23,084
19	Los Angeles County (excluding L.A. City)	\$393	\$480	\$364	\$335	\$314	\$1,887	\$22,638
20	San Bernardino	\$374	\$485	\$364	\$335	\$312	\$1,870	\$22,442
21	Riverside	\$440	\$485	\$364	\$335	\$325	\$1,950	\$23,397
22	Orange	\$433	\$475	\$364	\$335	\$321	\$1,929	\$23,144
23	San Diego	\$417	\$476	\$364	\$335	\$318	\$1,910	\$22,920
24	Imperial	\$371	\$472	\$879	\$335	\$411	\$2,468	\$29,613
25	City of Los Angeles	\$506	\$480	\$364	\$335	\$337	\$2,022	\$24,262
26	Lake	\$388	\$472	\$844	\$335	\$408	\$2,446	\$29,358
	Mendocino	\$411	\$472	\$805	\$335	\$405	\$2,428	\$29,132
27	Sonoma	\$449	\$472	\$550	\$335	\$361	\$2,167	\$26,001
28	Napa	\$518	\$472	\$526	\$335	\$370	\$2,221	\$26,657
	Solano	\$368	\$472	\$514	\$335	\$338	\$2,027	\$24,319
29	El Dorado	\$524	\$472	\$550	\$335	\$376	\$2,257	\$27,082
30	Stanislaus	\$383	\$472	\$490	\$335	\$336	\$2,016	\$24,194
31	Merced	\$358	\$472	\$805	\$335	\$394	\$2,363	\$28,359
32	Monterey	\$406	\$472	\$805	\$335	\$404	\$2,422	\$29,064
33	Kern	\$353	\$476	\$414	\$335	\$316	\$1,894	\$22,729
	CA Avg	\$412	\$479	\$667	\$335	\$379	\$2,273	\$27,272

<sup>1</sup> Three-year average for Housing, Food, and Transportation.

<sup>2</sup> Health Care is actual costs for someone in good health.

## 2011 California Elder Economic Security Index

### Basic Living Costs for Single, Older Adult, Owner with Mortgage

PSA	County	Housing <sup>1</sup>	Food <sup>1</sup>	Health Care <sup>2</sup>	Transportation <sup>1</sup>	Misc	Monthly Total	Annual Costs
01	Del Norte	\$1,205	\$253	\$403	\$239	\$252	\$2,353	\$28,231
	Humboldt	\$1,440	\$253	\$403	\$239	\$251	\$2,586	\$31,026
02	Lassen	\$1,252	\$253	\$403	\$239	\$266	\$2,414	\$28,965
	Modoc	\$1,011	\$253	\$403	\$239	\$248	\$2,154	\$25,851
	Shasta	\$1,270	\$253	\$403	\$239	\$255	\$2,420	\$29,039
	Siskiyou	\$1,130	\$253	\$403	\$239	\$253	\$2,278	\$27,340
	Trinity	\$1,154	\$253	\$403	\$239	\$241	\$2,290	\$27,482
03	Butte	\$1,200	\$253	\$403	\$239	\$257	\$2,353	\$28,234
	Colusa	\$1,397	\$253	\$403	\$239	\$256	\$2,548	\$30,574
	Glenn	\$1,265	\$253	\$403	\$239	\$251	\$2,410	\$28,924
	Plumas	\$1,322	\$253	\$403	\$239	\$255	\$2,472	\$29,665
	Tehama	\$1,164	\$253	\$403	\$239	\$240	\$2,299	\$27,588
04	Nevada	\$1,797	\$253	\$403	\$239	\$287	\$2,979	\$35,746
	Placer	\$1,844	\$273	\$275	\$239	\$254	\$2,885	\$34,626
	Sierra	\$1,183	\$253	\$403	\$239	\$261	\$2,339	\$28,066
	Sacramento	\$1,508	\$273	\$275	\$239	\$235	\$2,531	\$30,368
	Sutter	\$1,319	\$253	\$403	\$239	\$250	\$2,465	\$29,575
	Yolo	\$1,658	\$273	\$275	\$239	\$243	\$2,688	\$32,256
	Yuba	\$1,294	\$253	\$403	\$239	\$240	\$2,430	\$29,157
05	Marin	\$2,362	\$253	\$281	\$239	\$274	\$3,410	\$40,916
06	San Francisco	\$2,396	\$278	\$263	\$239	\$246	\$3,422	\$41,062
07	Contra Costa	\$2,118	\$278	\$271	\$239	\$252	\$3,159	\$37,903
08	San Mateo	\$2,457	\$278	\$281	\$239	\$252	\$3,508	\$42,091
09	Alameda	\$2,006	\$278	\$263	\$239	\$243	\$3,030	\$36,356
10	Santa Clara	\$2,280	\$291	\$259	\$239	\$251	\$3,321	\$39,846
11	San Joaquin	\$1,600	\$253	\$257	\$239	\$228	\$2,578	\$30,936
12	Alpine	\$1,936	\$253	\$403	\$239	\$264	\$3,096	\$37,149
	Amador	\$1,586	\$253	\$275	\$239	\$238	\$2,592	\$31,099
	Calaveras	\$1,553	\$253	\$403	\$239	\$270	\$2,718	\$32,617
	Mariposa	\$1,259	\$253	\$403	\$239	\$245	\$2,399	\$28,789
	Tuolumne	\$1,484	\$253	\$403	\$239	\$271	\$2,649	\$31,794
	San Benito	\$2,117	\$253	\$403	\$239	\$274	\$3,286	\$39,435
13	Santa Cruz	\$2,073	\$253	\$403	\$239	\$264	\$3,233	\$38,791
14	Fresno	\$1,281	\$275	\$263	\$239	\$232	\$2,291	\$27,496
	Madera	\$1,389	\$253	\$263	\$239	\$233	\$2,378	\$28,533
15	Kings	\$1,166	\$253	\$403	\$239	\$244	\$2,305	\$27,659
	Tulare	\$1,254	\$253	\$403	\$239	\$251	\$2,400	\$28,799
16	Inyo	\$1,413	\$253	\$403	\$239	\$259	\$2,568	\$30,811
	Mono	\$1,827	\$253	\$403	\$239	\$273	\$2,995	\$35,941
17	San Luis Obispo	\$1,858	\$253	\$422	\$239	\$271	\$3,044	\$36,525
	Santa Barbara	\$1,867	\$253	\$422	\$239	\$272	\$3,054	\$36,654
18	Ventura	\$1,944	\$253	\$182	\$239	\$221	\$2,840	\$34,081
	Los Angeles County (excluding L.A. City)	\$1,885	\$258	\$182	\$239	\$214	\$2,778	\$33,335
19	San Bernardino	\$1,531	\$260	\$182	\$239	\$211	\$2,424	\$29,085
21	Riverside	\$1,667	\$260	\$182	\$239	\$224	\$2,573	\$30,876
22	Orange	\$2,045	\$255	\$182	\$239	\$222	\$2,943	\$35,317
23	San Diego	\$1,951	\$255	\$182	\$239	\$219	\$2,847	\$34,161
24	Imperial	\$1,242	\$253	\$439	\$239	\$261	\$2,434	\$29,211
25	Los Angeles City	\$2,121	\$258	\$182	\$239	\$237	\$3,037	\$36,441
26	Lake	\$1,523	\$253	\$422	\$239	\$260	\$2,698	\$32,375
	Mendocino	\$1,765	\$253	\$403	\$239	\$261	\$2,922	\$35,059
27	Sonoma	\$1,916	\$253	\$275	\$239	\$243	\$2,927	\$35,125
28	Napa	\$2,218	\$253	\$263	\$239	\$255	\$3,229	\$38,744
	Solano	\$1,751	\$253	\$257	\$239	\$224	\$2,724	\$32,683
29	El Dorado	\$1,876	\$253	\$275	\$239	\$258	\$2,902	\$34,821
30	Stanislaus	\$1,460	\$253	\$245	\$239	\$224	\$2,422	\$29,061
31	Merced	\$1,296	\$253	\$403	\$239	\$251	\$2,442	\$29,304
32	Monterey	\$1,926	\$253	\$403	\$239	\$260	\$3,082	\$36,979
33	Kern	\$1,272	\$256	\$207	\$239	\$211	\$2,185	\$26,217
	CA Avg	\$1,629	\$257	\$334	\$239	\$249	\$2,707	\$32,488

<sup>1</sup> Three-year average for Housing, Food, and Transportation.

<sup>2</sup> Health Care is actual costs for someone in good health.

## 2011 California Elder Economic Security Index

### Basic Living Costs for Older Couple, Owner with a Mortgage

PSA	County	Housing <sup>1</sup>	Food <sup>1</sup>	Health Care <sup>2</sup>	Transportation <sup>1</sup>	Misc	Monthly Total	Annual Costs
01	Del Norte	\$1,205	\$472	\$805	\$335	\$396	\$3,213	\$38,552
	Humboldt	\$1,440	\$472	\$805	\$335	\$394	\$3,446	\$41,348
02	Lassen	\$1,252	\$472	\$805	\$335	\$410	\$3,274	\$39,287
	Modoc	\$1,011	\$472	\$805	\$335	\$392	\$3,014	\$36,173
	Shasta	\$1,270	\$472	\$805	\$335	\$398	\$3,280	\$39,361
	Siskiyou	\$1,130	\$472	\$805	\$335	\$396	\$3,139	\$37,662
	Trinity	\$1,154	\$472	\$805	\$335	\$384	\$3,150	\$37,804
03	Butte	\$1,200	\$472	\$805	\$335	\$401	\$3,213	\$38,556
	Colusa	\$1,397	\$472	\$805	\$335	\$399	\$3,408	\$40,896
	Glenn	\$1,265	\$472	\$805	\$335	\$394	\$3,270	\$39,245
	Plumas	\$1,322	\$472	\$805	\$335	\$398	\$3,332	\$39,987
	Tehama	\$1,164	\$472	\$805	\$335	\$383	\$3,159	\$37,910
04	Nevada	\$1,797	\$472	\$805	\$335	\$430	\$3,839	\$46,067
	Placer	\$1,844	\$508	\$550	\$335	\$376	\$3,613	\$43,352
	Sacramento	\$1,508	\$508	\$550	\$335	\$357	\$3,258	\$39,094
	Sierra	\$1,183	\$472	\$805	\$335	\$404	\$3,199	\$38,388
	Sutter	\$1,319	\$472	\$805	\$335	\$393	\$3,325	\$39,896
	Yolo	\$1,658	\$508	\$550	\$335	\$364	\$3,415	\$40,983
	Yuba	\$1,294	\$472	\$805	\$335	\$384	\$3,290	\$39,479
05	Marin	\$2,362	\$472	\$562	\$335	\$393	\$4,124	\$49,488
06	San Francisco	\$2,396	\$517	\$526	\$335	\$366	\$4,140	\$49,679
07	Contra Costa	\$2,118	\$517	\$542	\$335	\$374	\$3,886	\$46,635
08	San Mateo	\$2,457	\$517	\$562	\$335	\$376	\$4,247	\$50,967
09	Alameda	\$2,006	\$517	\$526	\$335	\$363	\$3,748	\$44,973
10	Santa Clara	\$2,280	\$541	\$518	\$335	\$372	\$4,047	\$48,567
11	San Joaquin	\$1,600	\$472	\$514	\$335	\$342	\$3,264	\$39,163
12	Alpine	\$1,936	\$472	\$805	\$335	\$408	\$3,956	\$47,471
	Amador	\$1,586	\$472	\$550	\$335	\$356	\$3,299	\$39,585
	Calaveras	\$1,553	\$472	\$805	\$335	\$414	\$3,578	\$42,939
	Mariposa	\$1,259	\$472	\$805	\$335	\$388	\$3,259	\$39,110
	Tuolumne	\$1,484	\$472	\$805	\$335	\$414	\$3,510	\$42,116
	San Benito	\$2,117	\$472	\$805	\$335	\$418	\$4,146	\$49,757
	Santa Cruz	\$2,073	\$472	\$805	\$335	\$408	\$4,093	\$49,112
14	Fresno	\$1,281	\$513	\$526	\$335	\$352	\$3,007	\$36,084
	Madera	\$1,389	\$472	\$526	\$335	\$349	\$3,070	\$36,845
15	Kings	\$1,166	\$472	\$805	\$335	\$387	\$3,165	\$37,980
	Tulare	\$1,254	\$472	\$805	\$335	\$394	\$3,260	\$39,121
16	Inyo	\$1,413	\$472	\$805	\$335	\$403	\$3,428	\$41,133
	Mono	\$1,827	\$472	\$805	\$335	\$416	\$3,855	\$46,262
17	San Luis Obispo	\$1,858	\$472	\$844	\$335	\$419	\$3,927	\$47,128
	Santa Barbara	\$1,867	\$472	\$844	\$335	\$420	\$3,938	\$47,256
18	Ventura	\$1,944	\$472	\$364	\$335	\$321	\$3,436	\$41,228
	Los Angeles County (excluding L.A. City)	\$1,885	\$480	\$364	\$335	\$314	\$3,378	\$40,535
20	San Bernardino	\$1,531	\$485	\$364	\$335	\$312	\$3,027	\$36,322
21	Riverside	\$1,667	\$485	\$364	\$335	\$325	\$3,176	\$38,112
22	Orange	\$2,045	\$475	\$364	\$335	\$321	\$3,540	\$42,486
23	San Diego	\$1,951	\$476	\$364	\$335	\$318	\$3,444	\$41,334
24	Imperial	\$1,242	\$472	\$879	\$335	\$411	\$3,339	\$40,063
25	Los Angeles City	\$2,121	\$480	\$364	\$335	\$337	\$3,637	\$43,641
26	Lake	\$1,523	\$472	\$844	\$335	\$408	\$3,581	\$42,978
	Mendocino	\$1,765	\$472	\$805	\$335	\$405	\$3,782	\$45,380
27	Sonoma	\$1,916	\$472	\$550	\$335	\$361	\$3,634	\$43,611
28	Napa	\$2,218	\$472	\$526	\$335	\$370	\$3,921	\$47,056
	Solano	\$1,751	\$472	\$514	\$335	\$338	\$3,409	\$40,910
29	El Dorado	\$1,876	\$472	\$550	\$335	\$376	\$3,609	\$43,306
30	Stanislaus	\$1,460	\$472	\$490	\$335	\$336	\$3,093	\$37,115
31	Merced	\$1,296	\$472	\$805	\$335	\$394	\$3,302	\$39,626
32	Monterey	\$1,926	\$472	\$805	\$335	\$404	\$3,942	\$47,300
33	Kern	\$1,272	\$476	\$414	\$335	\$316	\$2,813	\$33,755
	CA Avg	\$1,629	\$479	\$667	\$335	\$379	\$3,489	\$41,867

<sup>1</sup> Three-year average for Housing, Food, and Transportation.

<sup>2</sup> Health Care is actual costs for someone in good health.

## 2011 California Elder Economic Security Index Basic Living Costs for Single, Older Adult, Renter

PSA	County	Housing <sup>1</sup>	Food <sup>1</sup>	Health Care <sup>2</sup>	Transportation <sup>1</sup>	Misc	Monthly Total	Annual Costs
01	Del Norte	\$641	\$253	\$403	\$239	\$252	\$1,788	\$21,461
	Humboldt	\$688	\$253	\$403	\$239	\$251	\$1,833	\$22,001
02	Lassen	\$661	\$253	\$403	\$239	\$266	\$1,822	\$21,868
	Modoc	\$617	\$253	\$403	\$239	\$248	\$1,761	\$21,126
	Shasta	\$681	\$253	\$403	\$239	\$255	\$1,831	\$21,967
	Siskiyou	\$602	\$253	\$403	\$239	\$253	\$1,750	\$21,000
	Trinity	\$597	\$253	\$403	\$239	\$241	\$1,733	\$20,796
03	Butte	\$707	\$253	\$403	\$239	\$257	\$1,860	\$22,317
	Colusa	\$648	\$253	\$403	\$239	\$256	\$1,798	\$21,578
	Glenn	\$567	\$253	\$403	\$239	\$251	\$1,713	\$20,551
	Plumas	\$674	\$253	\$403	\$239	\$255	\$1,824	\$21,890
	Tehama	\$597	\$253	\$403	\$239	\$240	\$1,732	\$20,780
04	Nevada	\$849	\$253	\$403	\$239	\$287	\$2,031	\$24,374
	Placer	\$853	\$273	\$275	\$239	\$254	\$1,894	\$22,728
	Sacramento	\$853	\$273	\$275	\$239	\$235	\$1,875	\$22,501
	Sierra	\$793	\$253	\$403	\$239	\$261	\$1,948	\$23,380
	Sutter	\$621	\$253	\$403	\$239	\$250	\$1,766	\$21,196
	Yolo	\$867	\$273	\$275	\$239	\$243	\$1,896	\$22,757
	Yuba	\$621	\$253	\$403	\$239	\$240	\$1,757	\$21,080
05	Marin	\$1,403	\$253	\$281	\$239	\$274	\$2,451	\$29,408
06	San Francisco	\$1,403	\$278	\$263	\$239	\$246	\$2,429	\$29,144
07	Contra Costa	\$1,147	\$278	\$271	\$239	\$252	\$2,187	\$26,249
08	San Mateo	\$1,403	\$278	\$281	\$239	\$252	\$2,453	\$29,438
09	Alameda	\$1,147	\$278	\$263	\$239	\$243	\$2,170	\$26,043
10	Santa Clara	\$1,245	\$291	\$259	\$239	\$251	\$2,285	\$27,423
11	San Joaquin	\$764	\$253	\$257	\$239	\$228	\$1,742	\$20,901
12	Alpine	\$721	\$253	\$403	\$239	\$264	\$1,880	\$22,561
	Amador	\$813	\$253	\$275	\$239	\$238	\$1,819	\$21,827
	Calaveras	\$709	\$253	\$403	\$239	\$270	\$1,874	\$22,489
	Mariposa	\$721	\$253	\$403	\$239	\$245	\$1,860	\$22,324
	Tuolumne	\$743	\$253	\$403	\$239	\$271	\$1,909	\$22,906
13	San Benito	\$1,080	\$253	\$403	\$239	\$274	\$2,250	\$26,997
	Santa Cruz	\$1,276	\$253	\$403	\$239	\$264	\$2,435	\$29,223
14	Fresno	\$718	\$275	\$263	\$239	\$232	\$1,728	\$20,736
	Madera	\$675	\$253	\$263	\$239	\$233	\$1,664	\$19,965
15	Kings	\$681	\$253	\$403	\$239	\$244	\$1,820	\$21,840
	Tulare	\$589	\$253	\$403	\$239	\$251	\$1,735	\$20,820
16	Inyo	\$609	\$253	\$403	\$239	\$259	\$1,764	\$21,163
	Mono	\$912	\$253	\$403	\$239	\$273	\$2,079	\$24,954
17	San Luis Obispo	\$954	\$253	\$422	\$239	\$271	\$2,140	\$25,675
	Santa Barbara	\$1,115	\$253	\$422	\$239	\$272	\$2,303	\$27,631
18	Ventura	\$1,184	\$253	\$182	\$239	\$221	\$2,080	\$24,963
19	Los Angeles County	\$1,137	\$258	\$182	\$239	\$214	\$2,030	\$24,359
20	San Bernardino	\$957	\$260	\$182	\$239	\$211	\$1,850	\$22,204
21	Riverside	\$957	\$260	\$182	\$239	\$224	\$1,864	\$22,363
22	Orange	\$1,323	\$255	\$182	\$239	\$222	\$2,222	\$26,663
23	San Diego	\$1,136	\$255	\$182	\$239	\$219	\$2,031	\$24,377
24	Imperial	\$686	\$253	\$439	\$239	\$261	\$1,879	\$22,546
25	City of Los Angeles	\$1,137	\$258	\$182	\$239	\$237	\$2,053	\$24,640
26	Mendocino	\$799	\$253	\$403	\$239	\$261	\$1,955	\$23,459
27	Lake	\$681	\$253	\$422	\$239	\$260	\$1,856	\$22,268
	Sonoma	\$1,031	\$253	\$275	\$239	\$243	\$2,042	\$24,501
28	Napa	\$1,044	\$253	\$263	\$239	\$255	\$2,054	\$24,652
	Solano	\$1,059	\$253	\$257	\$239	\$224	\$2,032	\$24,385
29	El Dorado	\$853	\$253	\$275	\$239	\$258	\$1,879	\$22,544
30	Stanislaus	\$766	\$253	\$245	\$239	\$224	\$1,728	\$20,736
31	Merced	\$658	\$253	\$403	\$239	\$251	\$1,804	\$21,646
32	Monterey	\$972	\$253	\$403	\$239	\$260	\$2,127	\$25,530
33	Kern	\$652	\$256	\$207	\$239	\$211	\$1,565	\$18,781
	CA Avg	\$864	\$257	\$334	\$239	\$249	\$1,943	\$23,317

<sup>1</sup> Three-year average for Housing, Food, and Transportation.

<sup>2</sup> Health Care is actual costs for someone in good health.

## 2011 California Elder Economic Security Index Basic Living Costs for Older Couple, Renter

PSA	County	Housing <sup>1</sup>	Food <sup>1</sup>	Health Care <sup>2</sup>	Transportation <sup>1</sup>	Misc	Monthly Total	Annual Costs
01	Del Norte	\$641	\$472	\$805	\$335	\$396	\$2,649	\$31,782
	Humboldt	\$688	\$472	\$805	\$335	\$394	\$2,694	\$32,322
02	Lassen	\$661	\$472	\$805	\$335	\$410	\$2,682	\$32,189
	Modoc	\$617	\$472	\$805	\$335	\$392	\$2,621	\$31,448
	Shasta	\$681	\$472	\$805	\$335	\$398	\$2,691	\$32,289
	Siskiyou	\$602	\$472	\$805	\$335	\$396	\$2,610	\$31,322
	Trinity	\$597	\$472	\$805	\$335	\$384	\$2,593	\$31,118
03	Butte	\$707	\$472	\$805	\$335	\$401	\$2,720	\$32,639
	Colusa	\$648	\$472	\$805	\$335	\$399	\$2,658	\$31,900
	Glenn	\$567	\$472	\$805	\$335	\$394	\$2,573	\$30,873
	Plumas	\$674	\$472	\$805	\$335	\$398	\$2,684	\$32,212
	Tehama	\$597	\$472	\$805	\$335	\$383	\$2,592	\$31,102
04	Nevada	\$849	\$472	\$805	\$335	\$430	\$2,891	\$34,695
	Placer	\$853	\$508	\$550	\$335	\$376	\$2,621	\$31,455
	Sacramento	\$853	\$508	\$550	\$335	\$357	\$2,602	\$31,227
	Sierra	\$793	\$472	\$805	\$335	\$404	\$2,808	\$33,702
	Sutter	\$621	\$472	\$805	\$335	\$393	\$2,626	\$31,517
	Yolo	\$867	\$508	\$550	\$335	\$364	\$2,624	\$31,484
	Yuba	\$621	\$472	\$805	\$335	\$384	\$2,617	\$31,401
05	Marin	\$1,403	\$472	\$562	\$335	\$393	\$3,165	\$37,980
06	San Francisco	\$1,403	\$517	\$526	\$335	\$366	\$3,147	\$37,760
07	Contra Costa	\$1,147	\$517	\$542	\$335	\$374	\$2,915	\$34,981
08	San Mateo	\$1,403	\$517	\$562	\$335	\$376	\$3,193	\$38,313
09	Alameda	\$1,147	\$517	\$526	\$335	\$363	\$2,888	\$34,660
10	Santa Clara	\$1,245	\$541	\$518	\$335	\$372	\$3,012	\$36,145
11	San Joaquin	\$764	\$472	\$514	\$335	\$342	\$2,427	\$29,128
12	Alpine	\$721	\$472	\$805	\$335	\$408	\$2,740	\$32,882
	Amador	\$813	\$472	\$550	\$335	\$356	\$2,526	\$30,313
	Calaveras	\$709	\$472	\$805	\$335	\$414	\$2,734	\$32,810
	Mariposa	\$721	\$472	\$805	\$335	\$388	\$2,720	\$32,645
	Tuolumne	\$743	\$472	\$805	\$335	\$414	\$2,769	\$33,228
13	San Benito	\$1,080	\$472	\$805	\$335	\$418	\$3,110	\$37,319
	Santa Cruz	\$1,276	\$472	\$805	\$335	\$408	\$3,295	\$39,545
14	Fresno	\$718	\$513	\$526	\$335	\$352	\$2,444	\$29,324
	Madera	\$675	\$472	\$526	\$335	\$349	\$2,356	\$28,277
15	Kings	\$681	\$472	\$805	\$335	\$387	\$2,680	\$32,161
	Tulare	\$589	\$472	\$805	\$335	\$394	\$2,595	\$31,141
16	Inyo	\$609	\$472	\$805	\$335	\$403	\$2,624	\$31,485
	Mono	\$912	\$472	\$805	\$335	\$416	\$2,940	\$35,275
17	San Luis Obispo	\$954	\$472	\$844	\$335	\$419	\$3,023	\$36,278
	Santa Barbara	\$1,115	\$472	\$844	\$335	\$420	\$3,186	\$38,233
18	Ventura	\$1,184	\$472	\$364	\$335	\$321	\$2,676	\$32,109
19	Los Angeles County (excluding L.A. City)	\$1,137	\$480	\$364	\$335	\$314	\$2,630	\$31,559
20	San Bernardino	\$957	\$485	\$364	\$335	\$312	\$2,453	\$29,440
21	Riverside	\$957	\$485	\$364	\$335	\$325	\$2,467	\$29,600
22	Orange	\$1,323	\$475	\$364	\$335	\$321	\$2,819	\$33,832
23	San Diego	\$1,136	\$476	\$364	\$335	\$318	\$2,629	\$31,551
24	Imperial	\$686	\$472	\$879	\$335	\$411	\$2,783	\$33,398
25	City of Los Angeles	\$1,137	\$480	\$364	\$335	\$337	\$2,653	\$31,840
26	Lake	\$681	\$472	\$844	\$335	\$408	\$2,739	\$32,871
	Mendocino	\$799	\$472	\$805	\$335	\$405	\$2,815	\$33,781
27	Sonoma	\$1,031	\$472	\$550	\$335	\$361	\$2,749	\$32,987
28	Napa	\$1,044	\$472	\$526	\$335	\$370	\$2,747	\$32,965
28	Solano	\$1,059	\$472	\$514	\$335	\$338	\$2,718	\$32,612
29	El Dorado	\$853	\$472	\$550	\$335	\$376	\$2,586	\$31,029
30	Stanislaus	\$766	\$472	\$490	\$335	\$336	\$2,399	\$28,790
31	Merced	\$658	\$472	\$805	\$335	\$394	\$2,664	\$31,967
32	Monterey	\$972	\$472	\$805	\$335	\$404	\$2,988	\$35,852
33	Kern	\$652	\$476	\$414	\$335	\$316	\$2,193	\$26,319
	CA Avg	\$864	\$479	\$667	\$335	\$376	\$2,725	\$32,696

<sup>1</sup> Three-year average for Housing, Food, and Transportation.

<sup>2</sup> Health Care is actual costs for someone in good health.

## END NOTES

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