

CALIFORNIA STATE RETIREES

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Testimony of California State Retirees
Executive Vice President Fritz Walgenbach
to the Joint Senate and Assembly
Committees on Aging and Long-term Care

Aug. 12, 2013

Good afternoon Senator Liu, Assemblymember Yamada and committee members.

I am Fritz Walgenbach, executive vice president of California State Retirees, which is the largest and most experienced state retiree organization.

I was gratified to learn of your hearing today on "Moving California Toward an Ideal Long-term Care System." A good percentage of the 33,000 state retirees we represent will need long-term care at some point in their lives. I, myself, have had personal experience with a family member needing long-term care.

When people need long-term care, they should be able to turn to a single entity or a collaborative network of medical providers, social services and community resources.

It is not always immediately obvious where people should turn when they or their loved ones need long-term care. For those without insurance for long-term care, the situation becomes even more complicated and frightening.

If a single entity existed for information and resources and a statewide campaign helped spread the word, people would not have to spend precious time hunting for the answers when they can least afford to do so. Ultimately, knowing the right place to start such a search would become common knowledge in our society. Referrals could be given by a neighbor or a doctor or a senior center or even an organization like ours -- California State Retirees. We represent our members before the California Public Employees' Retirement System and the state Legislature, but we are also deeply

Comment to the Joint Committee Hearing
Senate Select Committee on Aging and Long-Term Care and Assembly Committee on
Aging and Long-Term Care

Tuesday, August 12, 2014: 2:00 PM – 4:00 PM. State Capitol, Room 113

Implementing an Ideal Aging and Long-Term Care System in California

I'm Lisa Nerenberg, I chair the California Elder Justice Coalition.

I want to thank you, Senator Liu and Committee members for initiating this process, and making elder justice a priority.

We've worked closely with Assemblymember Yamada and her Committee to elevate the issue.

I'd like to take a minute to define elder justice. Our network includes the many agencies that investigate and respond to elder abuse. *and suggest how it fits in the system discussed to*
APS, Omb, PG, Elder Ct,

These agencies are stretched thin these days as we confront an epidemic of very complex cases, including the abuse of POAs, predatory lending; mass marketing scams, and abuse in long term care facilities

Need to shore up our protective services and focus on prevention.

But EJ goes beyond abuse.

- Its access to services to reduce isolation and dependency
- Access to courts for those with disabilities and who can't afford lawyers
- It's parity so that older crime victims have the same rights as others.

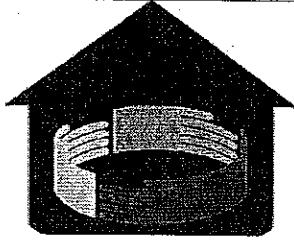
A major challenge is ensuring justice for the cognitively impaired.

- Recognizing subtle impairments that raise risk.
- Supporting decision making
- Making sure we have "safe" advance directives and trustworthy surrogates.

Elder justice isn't a system apart, it's a lens for viewing all our policies and services. It needs to be *built into* the LTSS system.

We look forward to working with you.

AUG 12 2014



YOLO COUNTY
In-Home Supportive Services
Advisory Committee

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August 8, 2014

To: Senator Carol Liu, Chair
Senate Select Committee on Aging and Long Term Care
Assemblywoman Mariko Yamada, Chair
Assembly Committee on Aging and Long Term Care

Fr: Frances Gracechild, Chair
Yolo County IHSS Advisory Committee

Cc: Patty Berg, Consultant
Robert McLaughlin, Consultant

The Yolo County IHSS Advisory Committee members respectfully request that you consider our responses to the questions posed to other organizations that are part of the IHSS program in California. We are aware that the deadline for comment has past, but after the very drastic threats and eventual changes to the IHSS program in recent months we feel our opinions should be heard by someone who is striving to create a better, more solid future for us and those who will need IHSS services in the future.

1. Establish a New Cultural Vision for Aging
 - Society should think of aging as not the end of life, but, rather a new start to a new part of life.
 - Appropriate language interpretations should be available for all documents to anyone with an "APP" on their cell phone. No more waiting for some agency to interpret what we need to know in our native language. We could point our phone and get what we need. Let technology solve it.
 - Times have changed....and aging has changed.
 - We want our independence.
 - We don't want to let go of ourselves.
 - There are many jobs that we can do using our life experiences and wisdom gained.

2. Establish a New Structural Vision

- Pharmacists should know how to accommodate to our needs. We don't want to always be correcting somebody else's errors.
- There should be universal access/design in all medical offices.
- Paratransit should be provided without borders.
- There are now cars that can drive themselves. In our best world vision we want individual transportation pods that we can program to get us to our destination.

3. Effective and Effective Partnerships

- There will be more advocates to help us with problems.
- Service clubs: Rotary, Kiwanis, Soroptomists, etc. will choose to work with the elderly in our communities.

4. Establish a Funding Mechanism that Supports Community-Based Living

- Create one pot of money for services for the elderly, those with physical disabilities and those with developmental services.
- Long Term Care Services (Assisted Living, Board and Care, etc) should be available for all instead of making people spend down all their savings before they get services.

Thank you for adding our ideas to what you have heard from others. Our ideas come out of the lives we are living now and the fights we must make just to survive.

Advisory Committee Members who contributed to these statements.

Frances Gracechild	Advocate for People with Disabilities
Marcelo (Nunie) Matta	IHSS Consumer - Woodland
Winifred deAnda	IHSS Consumer – Davis
Brad Toy	IHSS Consumer – West Sacramento
Ellen Berman	Advocate for People who are Elderly
Johanne Lewis	Former IHSS Provider - West Sacramento
Mary Helen Uribe	Former IHSS Provider - West Sacramento

TO SENATE SELECT COMMITTEE ON AGING AND LONG TERM CARE

Recommendations from San Francisco Village related to short and long term programmatic, administrative, and legislative solutions to better serve older adults in California

~ Provided in advance of the public hearing set for August 12, 2014 ~

This statement responds to the key policy focus areas including wellness and mental health, transportation and mobility, caregiving, transitional care, and long term services and supports.

There is a movement across the country – called the **Village Movement** – that is sustaining middle income older adults as they age, enabling them to remain living at home and in the community. New members join a strengthened alliance of older adults, where they get the resources and support they need to continue to live vital, active, and connected lives.

Villages are membership-driven, grass-roots organizations run by volunteers and paid staff. They coordinate access to free and affordable services including transportation, health and wellness programs, and home repair, as well as social, recreational, exercise, and educational activities. They also offer pre-screened, discounted service providers and often have a range of additional support services delivered by trained volunteers. The Village model complements other community-based approaches to aging.

Villages are being developed in large metropolitan areas, rural towns, and suburban settings. There are 125 villages in operation nationally, with 100 more in development. California has the most of any state with 26 villages in operation, and with 12 more in development.

San Francisco Village is an example of a mature village. Currently it has over 300 members and 2.5 FTE staff, with an annual budget of \$420,000. Approximately two thirds of the members are women and one third are men. About 10% of the members are LGBT. There is a board of directors that guides the management of the organization. There are over 80 trained volunteers and a volunteer ambassadors program. There is a well-organized marketing and outreach effort. Increased activities are being undertaken to reach San Francisco's Latino, African American, and Asian communities, and the LGBT community. In addition, neighborhood circles are being developed across the city to provide members with a more intimate, neighborly experience. To support this effort, a neighborhood circles leadership program has recently been created.

San Francisco Village is dedicated to supporting active aging for city residents over 60, helping them remain independent in their own homes and neighborhoods. The vision is to enrich the experience of aging in San Francisco with a membership that reflects the diversity of the city. A network of service providers and volunteers can help with everything from transportation to meal prep to computer assistance. Members form a vibrant community and participate in classes, outings, and social events. San Francisco Village offers:

- Volunteer Support When You Most Need It
- Expert Guidance and Advice on Aging
- Social Activities and Neighborhood Circles
- Prescreened Service Referrals
- Support After an Illness or Hospitalization
- Opportunities to Meet People and Build Community
- An Alternative to Traditional Aging

Unlike some for-profit organizations now coming into the field of long term services and supports to respond to what they perceive as “the problem of aging”, the Village Movement considers older adults as a vital resource. Village members are organized and supported so that they can maintain one and other as they age. Every member has a set of skills and abilities they may want to share. The concept of “teaching and learning” is part of the village philosophy and members help each other in small and large ways. The types of programs and services provided are based in large part on the imagination and creativity of the members themselves. This model represents a shift in the perception and experience of aging – from a negative stereotype to a positive prototype – so that aging and elders are more highly valued by society.

As you know, California’s Coordinated Care Initiative (CCI) is now being implemented in selected counties across the state. The CCI is designed to address the needs of older adults who are eligible for both Medicare and Medi-Cal. It is intended to integrate Medicare and Medi-Cal benefits for qualifying seniors and certain people with disabilities (SPDs) over 65. These SPDs are known as the dual eligibles. The CCI is designed to improve coordination of care delivery, health outcomes, and patient satisfaction.

However, the CCI is not addressing the growing needs of the Medicare-only, middle income population, which is an even larger demographic group than the dual eligibles. San Francisco is a good example: The over 60 population will soon represent 20% of the city’s total population. Given that the total population is now 800,000, this means that 160,000 people will be over the age of 60. The *Long Term Care Integration Strategic Plan for San Francisco*, dated October 2013, estimates that the city’s dual eligibles amount to about 45,000 people. Accordingly, the remainder, or approximately 115,000 people, are above Medi-Cal eligibility and will only be eligible for Medicare.

The Village Movement is an innovative model that addresses the needs of the Medicare-only population for support, social activities, expert guidance and advice, and a strong experience of community – so older adults who become members can remain vital and independent, lead more connected lives, and avoid social isolation. In this model, older adults are an integral part of the solution, and not a problem to be addressed.

In a 2011 survey of 1,000 primary care physicians conducted by the Robert Wood Johnson Foundation:

- 85% said that social needs directly contribute to poor health.
- 4 out of 5 were not confident they could address these social needs, hurting their ability to provide quality care.
- 1 in 7 prescriptions would be to address social needs.

It is crucial that the Village Movement, which provides strong social support for middle income older adults, be included in California’s New Cultural Vision of what it means to get older. Also, the Village Movement must be included in California’s New Structural Vision, which will guide the creation of a brighter future for older adults – because this model ensures increased access to needed resources, supports maximum independence, and provides the many important benefits of remaining an integral part of the community.

Bill Haskell
Board of Directors
San Francisco Village



CONGRESS OF CALIFORNIA SENIORS

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August 12, 2014

Honorable Senator Carol Liu

Honorable Assembly Member Mariko Yamada

Senate Select Committee and Assembly Committee on Aging and Long Term Care:

Thank you for the opportunity to provide public comment at this informational hearing. And thank you Senator Liu and former Assembly Member Berg for undertaking the effort to re-think the challenges of providing essential services and supports to California's aging population.

I am here today on behalf of the members of the Congress of California Seniors, but also hoping to speak for nearly 5 million older Californians and the many providers who struggle to serve them.

You have been true champions for seniors, and let me begin by saying there are far too few of you in the California Legislature. These are issues that I think about and work on every day and you know I could talk for hours, but I will try to focus my remarks for the few minutes available.

We have just been through a budget process that perfectly frames the challenges we face. After years of freezes, cuts, and program eliminations the 2014-15 budget presented an opportunity for California government to reinvest in the crucial services our seniors need. As you know, we had record increases in revenues that allowed significant new spending for most public activities. We even had funds to pay back past borrowing and provide pay raises for state employees. We restored funding for virtually every area of government... education, the courts, financial assistance for poor families. And we were able to allocate funds for new projects like high speed rail and set aside fund for a future rainy day. But there were virtually no new revenues invested in programs and services for the elderly. The full restoration of aging programs would have cost \$25 million out of a \$12.5 billion year-over-year increase... about two-tenths of one percent but there was nothing approved.

Anyone who thinks that it was because there wasn't enough money isn't paying attention... one provision in the new budget says that, if revenues come in higher than projected, it will go to education.

We have to look at the facts as they are:

- Our advocacy is inadequate
- Our messaging is failing
- Our constituents' needs rank low on the list of public priorities

Imagine what the legislative debate would have been this year if we knew for certain that the number of school age children in California would double in the next few decades. Well, the percentage of school age children will actually DECLINE in the next few decades. It is the number of seniors, especially older seniors, that will double...but they were not even worth .2% of the new funds we allocated.

We know the fastest growing part of the population are people over 85 with multiple chronic illnesses and a high (50%) likelihood of having dementia. Many older people become as dependent and vulnerable as young children – that's the cycle of life. And we have failed to show that investments in the old and the young are of equal value.

We have lots of challenges. Let me name a few.

- Our consumers and caregivers are mostly women, but we haven't reached out to the women's caucus in the Legislature...which you're all familiar with.
- Most senior programs assist the poor who are people of color but we've made no connection with the Black caucus, the Latino caucus or the API caucus.
- We have few partnerships with the LGBT caucus even though HIV/AIDS is now a chronic disease of old age.
- We have the oldest Governor in our history who says in his budget presentation that seniors in California have it much better than elsewhere...even though California has the second highest rate of poor seniors of any state...not numbers but the rate living in poverty
- We fight with caregiver unions and health care plans, even though they alone have the resources to engage politically on behalf of our constituency.
- We have virtually no connection to the corporate community which has, for years, heavily engaged in public issues like education and infrastructure.

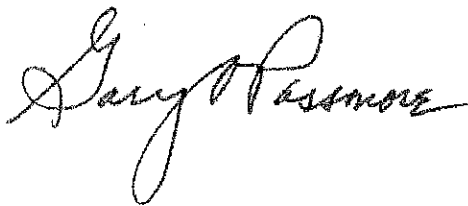
Here are some suggestions that I would offer.

- We need to be strategic. We must recognize that this administration has started down the path of organizing LTSS with primary, acute, and behavioral health services in managed care organizations. Unless there is a new administration in January, we need to get in front of that effort and make it work for seniors...not propose new models that will be ignored. Several other states have adopted this model with varying degrees of success and we should learn from them.
- We need to engage in the process to renew the 1115 Medi-Cal waiver and the proposed review of the 1915 waivers to make them work for our constituents...they could bring hundreds of millions of dollars to bear to advance more effective ways to serve the elderly that are cost neutral. Other states have used these waivers to redesign their systems of long term care.
- We need to develop new arguments for spending on the old...not just continue saying that "x" service will save on the cost of nursing homes. We have to show that nutrition IS part of health care, that companionship prevents abuse and helps people live better, that well-trained and compensated caregivers can avoid costly emergency rooms and institutionalization, that patient assessment and good discharge planning avoid re-institutionalization and service in inappropriate settings.

- We need to communicate in English and stop just talking to ourselves. If I stepped outside the Capitol to the corner of L and Ninth streets and paid \$5 to every person who could tell me what MSSP stands for, I would not spend very much.
- We need to broaden the political appeal of what we do...public education affects everyone, like Social Security. At the state level, aging services are mainly for the poor. We need to expand our vision to understand that middle class families struggle to meet the needs of their elders and propose ways to help them.
- We need to think outside the small, vulnerable non-profits we organized in the 1970's and 1980's. No one goes to a corner grocery store for food; very few of us go to small boutique liberal arts colleges; no one here expects an eager young guy to wash our windows or change our oil when we buy gas at a family-owned service station. We have to change. We have to imagine bigger, inclusive institutions that provide a wide range of services...and trade small operations for more person-centered care that we can measure.
- We need to accept the fact that our current organizations and funding streams may not survive when we have 10 million seniors to serve. Many baby boomers lost jobs and benefits and liquidated their retirement savings to survive the recent recession. They will not have the resources that today's 80 year olds have and a smaller workforce with lower incomes cannot possibly finance the burden as we have in the past.

There are many things we need to do differently. I've just scratched the surface. And I'm not sure where to start, but we have to start somewhere. I learned a lesson from my years in Missouri where people used to say "Talking about it isn't doing it. Doing it is doing it."

Thanks for your time and attention.

A handwritten signature in cursive script that reads "Gary Passmore". The signature is written in dark ink and is positioned above the typed name and title.

Gary Passmore
Vice President and Legislative Advocate

CALIFORNIA

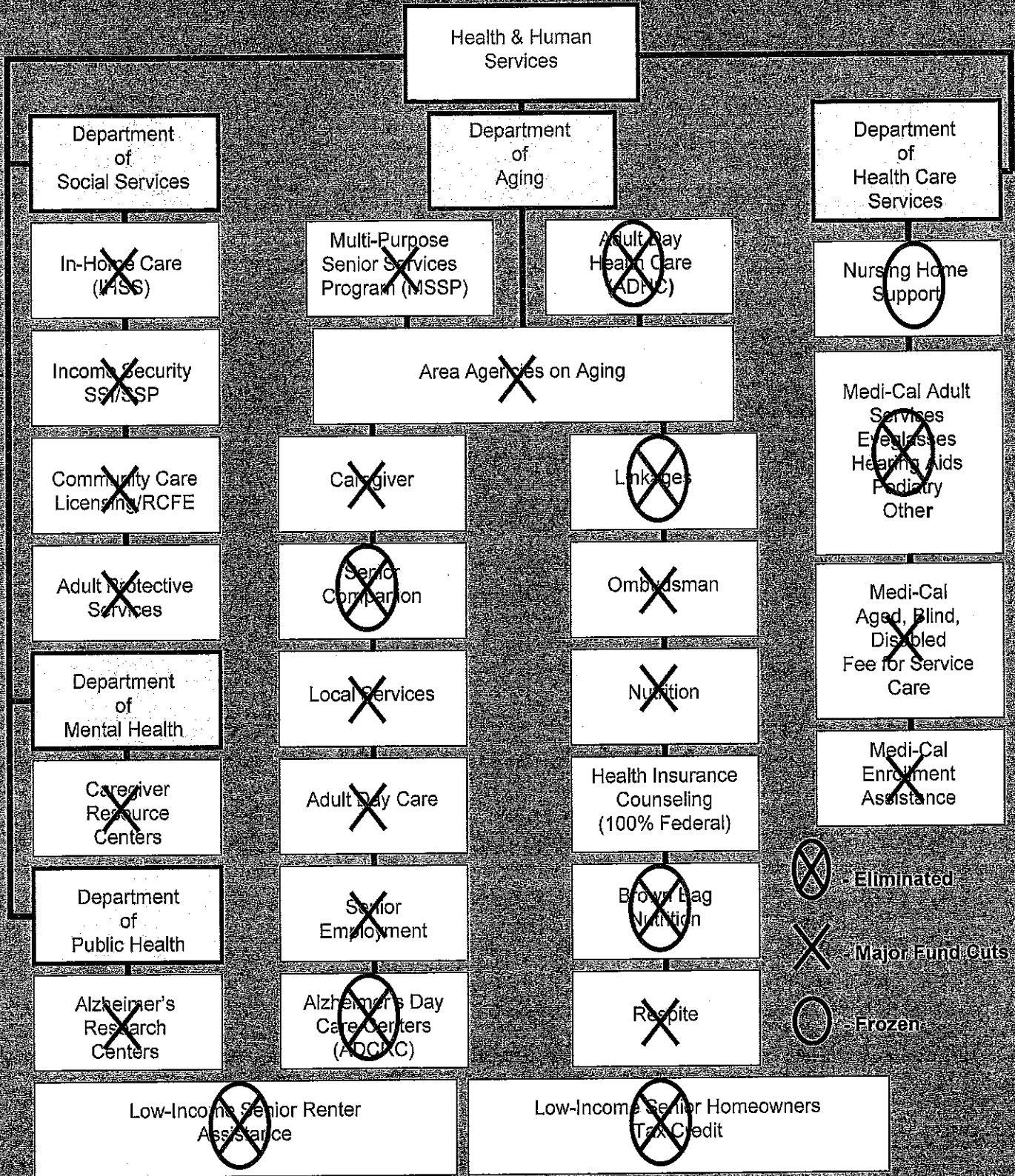
THE STATE OF AGEISM




THE NEW 2014-2015 STATE BUDGET DEMONSTRATES OUR STATE'S PRIORITIES AND OUR VALUES

The budget adds a 5% rate increase in Calworks grants for low-income children	A \$4 monthly COLA (less than 1.5%) for seniors and disabled people on SSI was thrown out
A rate increase for child care was granted	Restoration of a 7% rate cut for IHSS senior/disabled home care was rejected
The budget continues to fund vision, audiology and full dental services for children in Medi-Cal	A proposal to restore these services for older adults (cut out several years ago) was rejected
The new budget adds millions of new adults with Medi-Cal cards who may not be able to find a doctor	California continues to rank at the bottom among states in the rates it pays health providers in Medi-Cal
The Governor and Legislature agreed to a \$5.6 billion increase in education funding this year and an additional \$2.6 billion next year	The Budget conference committee cut out a \$5.1 million restoration of key aging programs, citing lack of funds
If revenues continue to grow in the coming year the budget authorizes \$2 billion more for higher education, K-12, and local governments	In order to return IHSS hours of care to authorized 2010 levels, there must be a new tax levied on caregivers
The budget includes \$2.5 million to upgrade the wiring and renovate the kitchen in the Governor's Mansion which has been unoccupied for 45 years	A proposal to restore \$2.9 million in assistance for family caregivers was deleted for lack of money
University tuitions were frozen and Cal Grants for college students were increased by 12%	None of the community-based service cuts from recent years were restored
\$10 billion in debt repayment and a \$2 billion future Rainy Day reserve were accomplished	A proposal for \$1.2 million for training in elder abuse prevention was eliminated
The Legislature authorized 43,000 slots for pre-school education	Care coordination services and community-based nursing (serving the fastest growing part of California's population) were held at their lowest funding in nearly a decade

Congress of California Seniors

The new State Budget added \$12.5 billion in spending over last year. How many essential senior services (below) had their funds restored with this record increase?



-  Eliminated
-  Major Fund Cuts
-  Frozen



National
Multiple Sclerosis
Society

Case Statement for Long Term Care for people with Multiple Sclerosis

Background

Approximately 400,000 Americans, including 44,000 Californians, have multiple sclerosis. Some demographic information about these Americans with MS is known and other data must be estimated:

- The direct and indirect costs of MS in the United States total approximately \$20 billion annually
- Direct and indirect costs to the individual with MS average between \$60,000 - \$70,000 per year
- More than two-thirds of those with MS are women
- MS is more common in northern climates, among those of Northern European ancestry.
- Diagnosis of MS is usually between the ages of twenty and fifty.
- The majority of those initially diagnosed with MS exhibit relapsing/remitting multiple sclerosis in which their attacks are followed by periods of complete or partial remission.
- Approximately 30% of people are living with a progressive type of MS
 - 15% of people with MS are initially diagnosed with progressive multiple sclerosis
 - Many of those whose disease is initially characterized as relapsing/remitting undergo a passage to secondary progressive multiple sclerosis after a period of years.

Need for Long Term Care

Many of those with progressive multiple sclerosis need substantial assistance in the activities of daily living well before age sixty-five. People with MS are perhaps the largest single "disease group" needing long-term care before age sixty-five. While exact data is unavailable, best estimates by the National Multiple Sclerosis Society are that between 75,000-100,000 Americans with multiple sclerosis need some form of long-term care. It is known that approximately 14,000 people with multiple sclerosis in the United States reside in skilled nursing facilities and that more than half of these are younger than 65, with a substantial cohort in their thirties and forties. Only about 25% of people with multiple sclerosis retain employment as the disease progresses; many are low-income individuals—nearly 25% lives near poverty level. The course of MS varies greatly, but a person who has been diagnosed with MS for 25 years is likely to need some assistance with walking, dressing, bathing and personal care, and in many cases may require complete assistance with transportation, shopping, and household chores.

Impact on the Family

The impact of MS can be wide and deep, affecting spousal relationships and children living at home. The primary responsibility for shouldering the cost and care of long-term care services for people with MS usually falls to the family. Family members provide most of the assistance with activities of daily living for their loved ones. Often children act as caregivers for an adult in the home. Without appropriate respite and support, families are at serious risk of becoming stressed beyond their emotional, physical, and financial capacities. In addition, the financial burden for the long-term care falls primarily on family members since third party payers and community social service agencies do not usually provide or finance the support required by the MS population.

The Challenges of Providing Long Term Care Services to People with MS

One of the significant challenges in providing long term care services is the chronic and progressing nature of the disease across a person's lifetime. The course of the disease presents constantly changing needs. Individuals and families are faced with trying to understand and navigate a very fragmented system of care, a system with significant elements of care missing or inadequate.

For those with progressive MS, independence is often compromised placing a greater reliance on others for assistance or support. Findings from the 2009 California Statewide MS Community Survey reported that 85.8% of this population needed some assistance over the past year. There are significant differences in the reliance on others for assistance when compared to those with relapsing-remitting MS. Those with a more progressive MS pattern **need the help of others** to a greater extent with 67.8% needing assistance in 3 or more areas of care/support (compared to 47.1% of those with relapsing remitting MS.)

While many are receiving some level of support from a spouse/partner, child, parents and/or paid staff, **nearly half** (46.4%) of these respondents **expressed an unmet need** for help in one or more of the following areas:

- obtaining adaptive equipment and/or home modification
- training and relief for their family caregiver
- getting the emotional support they need
- help managing their medical care & finances
- advice on eligibility for programs like SSI, SSDI
- accessibility into the community and transportation assistance.

Additionally, **nearly 50%** felt like they could benefit from someone helping to find and coordinate care, benefits or services. The complexity of these needs may, in fact, impact around **6,650 individuals living with progressive MS statewide** at one point of time during their life with MS.

Across the continuum of long term care services people with MS are faced with issues of access and appropriateness of care.

In-Home Care

Issues related to maintaining independence and self-efficacy are of primary concern for over half of the survey respondents and may significantly impact over 11,000 individuals statewide. More than 70% of the progressive MS population cites some concern about being able to live independently in their home and remain in their current living situation. There is an extensive need for in-home care and this population could benefit from practical nursing care as well as chore service and other home and community services. Access to federally subsidized in-home care programs helps few but not the vast majority of the MS population.

Assisted Living

Chapters of the National Multiple Sclerosis Society across the United States report thousands of requests for group homes/assisted living. Cost is a significant factor that precludes people with MS from accessing this level of care. Typically people with MS who request this long-term care option are picturing facilities like those available for the elderly which offer private living accommodations with an attendant on call to help with personal care and mobility as needed on an on-call basis. Many assisted living facilities for the elderly also offer communal dining once a day or more frequently. Only a few such facilities are available for individuals under age sixty-five with progressive multiple sclerosis.

Adult Day Care/Adult Day Health Care

Many people with multiple sclerosis could benefit from adult daycare. Demand for these services far exceeds supply, and transportation and financing are always major issues. The existing adult day center model is keenly focused on the needs of older adults or adults with chronic and significant mental health issues. Programming needs to be tailored to a younger, cognitively intact and more psychiatrically stable population.

Nursing Home Care

As noted above, approximately 14,000 of people with MS reside in nursing homes, a placement that is often premature and inappropriate. Some experts believe that thousands of these residents would not need a skilled nursing facility if assisted living/adult day care were available to them in their community. Recent studies have indicated that, on average, nursing home residents with MS have less cognitive dysfunction than other residents and are therefore potentially more capable of assisted community living.¹ In addition to symptomatic differences there is a great variance in terms of age and length of stay between people with MS and the traditional nursing home population. A National MS Society publication from 2003 "Nursing Home Care of Individuals with MS: Guidelines and Recommendation for Quality Care" revealed that the median age for people with MS is 58 while the average age for elderly was 84 years and that the length of stay for MS was 7.2 years compared to 2.8 for elderly.

In the field, MS Society staff have faced significant challenges in helping families find appropriate long-term care placements when they can no longer safely or financially care for them in the home. In particular, they have had difficulty finding facilities that

- Know how to care for an MS patient and want to do so
- Will accept Medi-Cal or Medi-Cal/Medicare. There have been instances in which families try to private pay for a couple of months and then switch to Medi-Cal in order to get someone in the door.
- Want to start MS specific programs, because the general disability community sees this as "Warehousing."
- Will take more than one or two people with MS because these individuals require a higher level of care which is expensive. However, people with MS tend to want to be with others in like situations.
- Want to work with the MS Society. Facility personnel generally do not want MS Society staff involved and many have exhibited a general apathy to people affected by MS.
- Are in their communities. People living in long term care facilities want to reside locally and near their families. Unfortunately, there is not a large enough demand for facilities that accommodate the younger disabled in every city.

Understanding Long Term Care as a Need for the Younger Disabled

The general public, and even social service agencies and political decision makers, often visualize the need for long-term care as an exclusively geriatric need. Certainly, it is not only people with MS who need long-term care at a younger age; so do many people with severe rheumatoid arthritis, Parkinson's disease, spinal cord injury and other chronic, long-term illnesses/injuries. Long-term care consumers' most pressing need is a reliable source of information so they may understand the choices that are available to them. In California, care and services are greatly fragmented and confusing. This ultimately results in the premature erosion of quality of life for many living with multiple sclerosis.

The National MS Society as an Eager Partner

The National Multiple Sclerosis Society offers hundreds of programs and services for people with multiple sclerosis through its network of chapters around the country, however, isolation and lack of attendant care and transportation exclude many of those most in need from participating in these programs. Several MS Society chapters and other community organizations address some in-home needs through care management services and offer some form of subsidized, time-limited, in-home support such as chore service, however, chapters know that they are only meeting a small part of the need.

In regards to options for long-term care, the Society sponsors or co-sponsors MS adult day health centers (Rochester, NY, Minneapolis, MN, and Los Angeles, CA) and extensive rehabilitation facilities (Denver, Cleveland, Baltimore, NYC and elsewhere), however, such centers and facilities can only meet a small percentage of the needs for those with progressive multiple sclerosis.

The challenge for the National Multiple Sclerosis Society and for advocates of other groups is to access long-term care programs and services similar to those currently available for the developmentally disabled (diagnosed before age twenty-one) and the elderly. In order to effectively address these challenges, the following efforts must be strongly considered:

- Fewer age restrictions on assisted living type housing so that people who don't yet have a skilled nursing need but cannot continue to live at home have greater options.
- Evaluation, assessment and a plan of what is involved in developing living communities for younger people with a chronic illness. Making these opportunities more attractive to builders and developers is key.
- A single point entry system for individuals with physical disabilities that would provide information on long-term care options and coordination of age-appropriate services.
- A partnership between organizations like the National MS Society and other like-minded chronic illness agencies to build and provide age appropriate services to individuals once they are living in a long term care setting.

Extensive services exist for developmentally disabled children and adults throughout the entire continuum of age. Substantial programs exist for those over age sixty-five. But, thousands of Americans between the ages of 21 and 65, the largest percentage of who suffer from multiple sclerosis, have substantial and urgent unmet long-term care needs. Increased advocacy efforts and strategic partnerships/collaborations are vital to developing appropriate and quality long-term care options.

¹ Buchanan RJ, Wang SJ, Juang C, Graber, D. Profiles of nursing home residents with multiple sclerosis using the minimum data set. *Multiple Sclerosis* (2001) 7: 189-20

One Family's Experience With Long-Term Care

Benefits from Germany paid for care in the U.S.:

One of my daughters spent an entire decade caring for 3 of her husband's family members. His father had a massive stroke and spent 7 years in a nursing home, his mother had dementia, and his unmarried uncle had dementia. The demands of caregiving made it impossible for my daughter to continue her work in the computer industry and she gave up her employment to meet the demands of caregiving while continuing to raise her two sons. Her mother-in-law, and later her husband's uncle were cared for at home until their condition deteriorated and nursing home care was the only alternative. Ten years later, after all of these family members had died, she was unable to return to the high paying complex technical work she had done previously. She will have less Social Security income and little if any retirement to depend on in her old age as a result. All of these relatives were private pay patients who received foreign retirement benefits as German citizens that helped pay for their nursing home care.

A long term care insurance policy paid for some care:

Another of my daughters spent 4 years caring for and supervising the care of her mother-in-law. Although care initially began at home it quickly became apparent that she would need 24 hour care. Since she had a long-term care insurance policy that only paid for nursing home care the decision was made for them. Her policy had been purchased 20 years earlier and had no inflation protection. Her share of the cost was more than a third of the nursing home charges, with the long term care policy picking up the balance after a long battle with the company to pay the required benefit.¹ The policy lasted for two years, and the remainder of her stay was paid for with funds drawn from her assets. Those assets had been intended to pay college tuition for her grandchildren.

Medicaid may pay for future care:

A son-in-law is supervising and providing some care to his mother who currently resides in a nearby assisted living facility. As her dementia worsens, and if she lives long enough, he will have to arrange for her to move into a nursing home. She has few assets and will most certainly be on Medicaid at that time.

Medicaid is paying for care:

My mother is 91 years old and living in an assisted living facility. She is on Medicaid, and has always been low income. Her only asset was her house and she negotiated a reverse mortgage on the small amount of equity she owned which quickly disappeared when she was convinced to leverage it in investments that were guaranteed to increase her income. Because she is on Medicaid I have to supervise her care from 500 miles away, including staying in touch with the facility to monitor her condition and care, and convincing her by phone to go by ambulance to the hospital following a fall, an event that is happening more and more frequently. She and our family hopes she will pass away before a nursing home becomes her only option.

Medicaid is paying for care:

My sister is disabled and on Medicaid and also lives 500 miles away. I have had to frequently intervene in her care needs. She became a dual on her 65th birthday and is eligible for benefits she sometimes gets and sometimes doesn't. Her eligibility for those benefits is frequently canceled for reason no one is able to explain and is eventually reinstated. Her income changes with some frequency based on state or federal changes to SSI or Social Security resulting in the need to pay her rent and other bills until her income is adjusted. Her health care providers frequently don't have current information about her chronic health conditions or medications resulting in medical events that occur in urgent care or the local emergency room, neither of which are in the same network and are incapable of exchanging medical records. After months of negotiation she now has a home care worker. When the home care worker doesn't show up calls have to be made to resolve the problem. When she is overcharged at the pharmacy or at the dentist that also requires personal intervention to ensure refunds are made.

¹ Claims were delayed by continual requests for information that the company insisted was insufficient or incomplete, not received, or needed to be reviewed. Eventually a personal discussion with a company executive resulted in a paid claim.



Written Testimony to the Joint Hearings of Senate and Assembly
Sub-Committee of Aging and Long Term Care

August 12, 2014

Benson Nadell
San Francisco Long Term Care Ombudsman
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Dear Senators and Assemblypersons,

My name is Benson Nadell. Besides being the Program Director of the San Francisco Long Term Care Ombudsman Program for the last 27 years I have also sat on various local stakeholder efforts to better coordinate an integrated long term care system. This work continues. I am a member of the San Francisco Long Term Care Coordinating Council. In the past, I was a member of the Expert Panel convened for Dementia Care in San Francisco. Years ago, I was also a member of the Board of Supervisors appointed Discharge Planning Task Force. In all of these local stakeholder efforts, many recommendations were generated, each with an implementation strategy for the future. Many of these recommendations are contingent on The State of California's effort and willingness to investigate a state wide approach to long term services and supports as well as licensed long term care. These comments do not address the State's quest to align its long term care plan with the recommendations from the Federal Administration for Community Living.

I wish to enter these comments into the Public Record...

1. An integrated policy around Aging and Long Term Care must involve a new working relationship between state agencies. The main payors of long term services and supports are the Medi-Cal Program within California Department of Health Care Services. Yet many of the components for Authorization have devolved to the County Level with the recent re-alignment of Medi-Cal into County wide Medi-Cal Managed Care. The roll out and enrollment process of Medi-Cal eligibles into these Plans has been somewhat smooth but the issue of covered services and appeal rights not so much. The consumer who is on Medi-Cal particularly the SDP persons has been some what bewildered by this process even with the ramping up of staff in the plans to assist them. The roll out of the

dual eligible plans has not been smooth and consistent. In San Francisco, which is a two plan County, many elderly and disabled, who are hospitalized, are placed out of county. The county-by – county plan model can be cumbersome for the out-migration of eligibles.

In San Francisco most of the SNF beds have converted to shorter term stay, rehabilitation, especially for those on Medicare. Though not all hospital-based, these transitions to long term care SNF take up a lot of the local Ombudsman case load. The volunteer component of the program is unable to handle the day to day required case work to advocate for an elderly or disabled person placed out of county. Staff in the Ombudsman Program struggle to answer requests for advocacy from those admitted and hurriedly discharged. Those dual eligibles coming through this rehabilitative nexus of licensed services, must dis-enroll from their plan and switch to long term Medi-cal. If they are discharged to an RCFE in an adjacent county they must enroll in that County's Medi-Cal Managed Care Plan. As confusing as this sounds in this Testimony, it is more so, for the consumer on Medi-Cal or who is a dual eligible.

2. Under the ACA, the Medicaid expansion for those newly eligible, stops at 65 with a reversion to the regular eligibility standards. For those near elderly who are discharged to home and community with IHSS and who age into 65 or older, continuing to receive IHSS with varying out, their SOC will increase. In addition they will have to dis-encumber themselves of any assets, as defined, above \$2000. Will affect any long term integration of the aging and disabled populations who would be entitled to Medi-Cal with a Share of Cost. In addition, Long term Medi-Cal includes shelter and board, but the calculation for Medi-Cal eligibility in Home and Community services – that formula, does not include any costs of housing and food. That formula is set at the Federal Level, and remains a barrier to successful community living and access to needed Medi-Cal services
3. The question of creating a long term care policy in California must address organizational and infrastructural issues. There is a need for care-coordination, communication protocols, and cooperation between state agencies. The same is true at the local County Level. At the local County Level is the lead agency the Area Agency of Aging, and would it coordinate with the Public Health and Mental Health Departments? In San Francisco the Department of Aging and Adult Services coordinates to some degree with City and County Department of Public Health. At the level of the state, who would be the lead agency? Do all the State Agencies talk effectively with each other? Case in point: CDA is involved with ADHC. But with the roll out of CBAS as the eligibility criteria determining agency California Department of Health Care Services, assumed the role of authorizing approval of the enrollment process. But again, the licensing of ACHC remains the responsibility of California Department of Health Care, Licensing and Certification. This exemplifies the need for improved communication, coordination, and cooperation.

The fact that the SF Long Term Care Ombudsman Program became involved with low income residents of RCFE who were denied CBAS coverage under the new stricter ADHC guidelines is further evidence that a person centered, due process approach becomes even murkier than before. A central command structure is needed beyond any stakeholder model. Money flows through one agency; case management is Balkanized. I agree that one size does not fit all, but a comprehensive state policy cannot remain fragmented because of local diversity of plan and approach.

4. Standards of assessment and quality of care outcomes are essential across settings. Much has been made in the Olmstead Supreme Court narrative of the mal effects of institutionalization and the valorization of community. Yet the Federal Nursing home standards predicated on the notion of positive care outcomes through the comprehensive assessment tool (:M.D.S “) allows for measuring consistency and quality outcomes. The old notion that nursing homes are medical models of care, and assisted living and community are social models of care, belies the real question of health care access. Neither RCFE nor community living LTSS have any regulatory way to gauge negative care outcomes. Hospitalizations and trips to the ER, or referrals to APS for neglect became the metrics for poor care. There is no way to measure negative decline in quality of care. If there are any measures of care quality, they reside in a particular case management system. Any state wide long term care policy must consider consistency and care coordination through unitizing the assessment language.
5. With the proliferation of the assisted living facilities in California over the last twenty years, and the negative growth of nursing homes, there has been an increased dependency on the market place to mediate access to long term residential care. Residents with Allowable health care needs are allowed to be admitted and reside in RCFE as long as they are consumer driven in terms of payment and choice(eg have the money). Community Care Licensing has no way to gauge whether these assisted living services for all incidental medical needs are effective to prevent deterioration. In fact the Assisted Living facilities are incentivized through charging more for increased care needs, without the existing RCFE Title 22 regulations addressing positive or quality of care outcomes. By extension, for community base long term services and supports will there be third party oversight as to how these providers are assessing and meeting the needs of the aging and disabled population?

6. Any state wide long term care policy must address oversight as well as consistent standards. Should new integrated LTSS systems be self regulated systems with an enhanced Quality Management function, without state involvement? Are the dollars flowing into these systems Federal and State dollars or private dollars? Medi-Cal payments were like a single payor system. With the managed care plans implemented, a risk based insurance model become more pervasive. Does that transformation of payor, mean that oversight is not important? State Oversight in terms of regulatory enforcement remains controversial on a number of fronts.

The present array of RCFE reform bills may address the need for improved CCL oversight, though most may not jump the hurdle of the Appropriations Committee votes. What is not addressed is an overhaul of Title 22 to reflect linkage of assessment appraisal to care-outcomes. The only answer maybe to embed quality or performance outcomes in the wrap-around case management systems that some of the RCFE residents may be entitled to. This would not address standards of care for those who come into assisted living through the market place. California has a fragmented Medi-Cal assisted living waiver system. It is patchwork and targets specialized populations: PACE in SF, Regional Center, HIV/AIDs, but the assistance from the Medi-Cal State Plan for any elderly and disabled to be able to live in an Affordable RCFE is lacking. And with that lack of a state wide assisted living waiver there are no generalized conditions of participation to guarantee standards of care.

7. I am an Ombudsman. The political will to develop a state wide long term care policy is embedded in the same inertia that lays behind the reluctance of California to restore state funding to the Ombudsman Program. I say this because these local programs provide the only person centered visiting focus to residents in at least the licensed sector of long term care. The common perception that all Ombudsmen are volunteers has been used as an argument to not fund the programs. In San Francisco the delivery of Ombudsman services by volunteers is curtailed by such factors as the unfunded state mandate to investigate not only elder abuse but dependent adult abuse in an expanded array of long term care facilities and that most of the SNF beds do not keep residents for any long period of time, but discharge them. A volunteer who volunteers one day a week for 5 -8 hours cannot respond to the needs for cumulative day to day case work. Also the perception of the Ombudsman Programs in some counties are not respectful because they contract with Area Agencies of Aging, some of whom have had control issues over the activities of the seemingly autonomous acting local Ombudsman Programs. (As required in the Federal Older American Act) I am an Ombudsman. These comments above come from my vantage of more then two decades. The long term care system is fragmented. Too many agencies are jockeying for money and power. There is little in the way of will to coordinate care in a meaningful and consistent way.

Here in San Francisco we all work together City and County, and Department of Aging and Adult Services. We have been working at this for over a decade. We have local leadership. We are still looking for a central command system that is consumer

centered and consumer friendly. We are looking to the State of such leadership, but a lot must be undone, and dismantled before those state agencies can work together. Data must be shared. Computer systems modernized. Assessment tools standardized.

8. I applaud the leadership of both the Assembly and Senate to investigate this issue. Aging policy and long term care policy must be looked at in the larger realm of equal access to health care and equity in terms of advocacy and protection. The voices of consumers must be heard in this process.

If the plan is designed to reduce government expenditures, and to embed long term care in county-based managed care systems, without revising the Medi-Cal State Plan to reflect state wide waivers for assisted living, and to keep the State and Government at a greater distance, then such an Aging and Long Term Care Policy will fail and drown out the very real voices of the consumer of LTSS.

To the extent that this one Ombudsman articulates the voice of the elderly and disabled caught in the nexus of this fragmented system, I want to lend my voice to this process.

Rural Health Access for Older Adults

**A summary of
findings and
recommendations
from the
California
Commission on
Aging**

Chair: James Davis

Commissioners:

Bert Bettis

Constance Chang*

Lily Lee Chen

Michael "Mike" DeNunzio

Erica Goode, MD

Karen Josephson, MD*

Henry L. "Hank" Lacayo

Richard Lundin, PhD*

Sharon Monck

Cheryl Phillips, MD

Carlos Rodriguez

Thomas "Tom" Rowe

Havard L. "Hav" Staggs

Donna Ueland

Benny Yee



May, 2009

*** Public Hearing Committee
members**

Introduction

Out of all the potential changes human beings may experience with age, increased health problems are a given. Time and hard work take their toll, and older adults experience a high degree of chronic illness, disability, and medication dependence. Despite these facts, one of the primary issues that impedes good health care for older adults in rural areas is poor access, whether from lack of transportation, the high cost of care, a lack of care management, or from the limited number of physicians caring for patients.

A variety of factors contribute to the difficulties that rural older adults can face in accessing prompt and appropriate medical care. Just getting to the doctor's office may present a significant obstacle for someone who no longer drives, has limited access to public transportation, or who lives far from the nearest provider. A shortage of support services can make it difficult for rural elders to receive the follow-up care they need in their homes. The cost of care, funding "silos" that focus on a service rather than the patient, and restrictive eligibility criteria for Medi-Cal and Medicare benefits mean that many individuals are excluded from the care they need.

These issues were among the barriers cited during three public hearings held by the California Commission on Aging in to examine older adults' ability to access health services in rural settings.

The California Commission on Aging is a citizens' advisory body created by statute to advise the Governor, State Legislature, and state departments

and agencies on programs and policies affecting older adults. As part of its 2007 strategic planning activities, the Commission identified three priority areas on which to focus its work through 2009. A series of public hearings would be held on each of the priority topics, including "Older Adult Health Access," "Aging in Place," and "Elder Abuse," from which the Commission would draw public input and develop policy recommendations.

The three public hearings on Older Adult Health Access were held in November 2006 and June and October of 2008. The hearing locations were Jackson in Amador County, Woodland in Yolo County, and Redding in Shasta County. The three locations reflect a variety of geographic settings and demographic issues affecting older adults' health. The following report summarizes the major concerns and recommendations raised in both expert testimony and in public comments at the three events.

The Issues: What prevents older adults from getting the medical care they need?

Access

In rural settings, transportation to and from medical appointments is a significant obstacle to care. Older adults no longer able to drive must find some form of transportation to the doctor, whether it be paratransit services, public transportation, a family member or friend. Paratransit and public transportation are not universally available throughout California; in many rural communities these services may be non-existent.

In many rural areas, access may be limited by a shortage of medical professionals, making lengthy travel necessary to receive even the most basic medical care. In rural communities many providers will accept few, if any, Medi-Cal patients due to low reimbursement rates and red tape associated with Medi-Cal participation. Many rural hospitals and clinics lack the most current diagnostic and treatment equipment, again requiring the elder to travel away from their home community to obtain medical care.

The number of physicians practicing in rural areas is limited by the high proportion of uninsured patients who depend upon Medi-Cal to cover the cost of their care. New medical school graduates are seldom in the position to open a practice, pay for staff and operations, and cover the costs of medical school loans and mal-practice insurance on the small salary that Medi-Cal reimbursements bring. In Amador County, the CCoA heard from a local hospital director who believes that allowing rural hospitals to directly employ physicians, as is done in

many other states, would provide support staff and shared overhead expenses to allow new physicians to set up sustainable practice in rural communities.

Many smaller communities lack sufficient long-term care services, sometimes requiring elders that need skilled nursing to be moved far from friends and family. For those rural long-term care facilities that do exist, the number of Medi-Cal beds is limited. Individuals with Medi-Cal coverage are often left out of the long-term care service loop just because of where they live. In an example offered at the Redding public hearing, a 54-bed rural long-term care facility would not make a Medi-Cal bed available to a dying patient unless fewer than 50 beds were occupied.

Support services at home

There are too few trained caregivers, home health programs and out-of-home respite options to meet current demand in either rural or urban areas. Funding for caregiver respite programs is limited, and home health visits may consist of only a few visits following hospitalization, rather than on-going care. The lack of care coordination and care management is a problem statewide, leaving family members to realize only after an elder is home from the hospital that they are unable to provide the level of care needed. Low pay for In-Home Supportive Service workers and eligibility limits for recipients make it difficult for many to secure reliable and consistent help at home.

Testimony offered during the Commission hearings outlined the difficulties that support service providers have in reaching clients in rural communities. A point raised in both the Amador and Yolo hearings was that serving clients in distant underserved communities makes services more costly to deliver. When the onus shifts to the client to get to the service provider, rather than receiving service at home, access becomes almost impossible for the chronically ill homebound elder.

In much of rural California, assisted and group living facilities are also in short supply; expansion of social institutions such as adult foster care, adult day health programs and assisted living would help to address the shortage. In Redding, the Commission heard from the medical director of a remotely-located tribal health facility, where assisted living was unavailable but desperately needed.

Funding

Limits on funding for older adult health care was discussed at every hearing, with a number of speakers noting that public funding for health services is restrictive and tied too closely to specific programs. Reimbursement for Medi-

Cal providers does not cover the cost of care, resulting in few physicians willing to take Medi-Cal patients, regardless of where they live or the location of their practice. Likewise, eligibility for Medi-Cal and other social service program support is restrictive, leaving many low-income seniors ineligible for care, yet unable to pay for it on their own.

Recommendations

The CCoA heard testimony supportive of policy recommendations in four areas.

1. Increase the number of health care providers in underserved communities

The shortage of providers can be addressed in a variety of ways. Outside of California, many states authorize Nurse Practitioners (NP) to operate as independent health care providers. The advanced training these registered nurses receive equips them to provide primary care services over a range of acute and outpatient settings. California law is inconsistent on the NP's scope of practice, allowing some to take on greater responsibilities than others. A consistent approach that grants increased responsibilities for NPs could increase primary care options in underserved areas.

An additional solution to the health workforce shortage could come from enabling former military health personnel to practice in needy communities. A recent California Health Care Foundation study of the issue found that military medical personnel often have duties that don't always fit into current civilian medical positions. By realigning qualification and licensing standards, these experienced and well-trained individuals could bolster the state's health care workforce.

Physicians in underserved areas serve a high number of uninsured patients. This factor means these physicians earn less than physicians treating fully insured patients because of California's low Medi-Cal reimbursement rates. The situation is the same for dentists in these communities, with only 40% of California dentists willing to accept Medi-Cal patients. Reimbursement rate increases that target underserved communities could encourage more providers to open their doors to Medi-Cal recipients, as would a reduced administrative burden on these providers.

Amending California's Corporate Practice of Medicine law could be a significant step toward ending the physician shortage in underserved communities. Currently doctors who want to practice in these areas often find the costs of setting up practice while paying off medical school loans unsustainable. Again, low Medi-Cal reimbursement rates make it nearly impossible for practitioners to pay for staff, utilities, rent, and malpractice insurance. Amending the law to permit rural hospitals to employ staff physicians would address the overhead and insurance issues, enabling rural doctors to focus on patient care.

Eliminating Medicare reimbursement disparities for rural areas could help improve physician recruitment, a solution that has been proposed to improve health care equity on a national basis as well. Another suggested approach to bring more physicians to rural areas might be the development of incentive programs beyond current student loan reimbursement programs.

2. Make health care technology more available in underserved areas

A health access concern that is unique to rural areas is the absence of specialized care. Medical specialists, such as cardiologists, osteopaths, oncologists, etc., usually practice in population centers where they can be reached by the greatest number of patients. For patients in the most remote reaches of California, traveling six or more hours to San Francisco, Los Angeles or Sacramento to see a specialist is not uncommon. Technology has the power to change outcomes for these patients by bringing specialized care into rural communities. The use of telemedicine and telepharmacy, to provide consultations with specialists, advanced diagnostic techniques and medication advice in rural clinics, could vastly improve the level of care available locally.

Older adults in rural areas can also benefit from home monitoring systems that enable medical professionals and long-distance caregivers to track an elder's vital statistics and activity levels throughout the day. Technology to assist frail older adults with difficult medication regimens should be more widely available in underserved communities. Medication dispensers that release the appropriate medication at the appropriate time, remind the elder to take the pills, and alert a contact person if the medication is not taken, could do much to help isolated elders stay well.

A common theme at the Woodland hearing was the ability of technology to bring training and educational opportunities to health care providers. Medical providers could gain access to new diagnostic and treatment techniques, such as

a congestive heart failure "tele-work" program offered by the University of California at Davis. Authorizing Medi-Cal reimbursement for telemedicine services will be important if physicians are to take advantage of the services once the technology is in place.

3. Coordination of services across agencies

Better coordination of care would improve the health of older adults throughout the state. By utilizing care managers to advise and advocate for elderly clients, patients could gain improved access to the full range of health care and social supports available in their areas. A multidisciplinary approach that combines health care and social programs, such as adult foster care and adult day health programs can also contribute to better care. Program expansion could be enhanced statewide through cost-sharing and collaborative partnering between the State and local governments, Veteran's Administration and tribal governments.

Recognizing that dementia patients can stay longer in their homes (at a lower cost than nursing home care) when caregivers have access to support services is key. The State should consider non-traditional models of care, such as a mobile day care model pioneered in Georgia, where social day care programs are delivered to rural communities for one or two days per week, providing respite, counseling, care coordination and other supports in communities without the resources to offer their own respite service.

The development of caregiver assessment tools for use by home health care, family practitioners, senior centers and other community-based care providers could help these services better assist families with the planning of care and in coping with its challenges.

Elders with disabling conditions and those without family or social supports need better representation in order to gain access to home and community-based programs. Obtaining information on the services available in a community can also be daunting. More information distribution -- through media, doctor's offices, and other public venues -- is needed in order to increase awareness of available community services.

4. Person-centered approach

Advocates for improved older adult health access endorse a person-centered approach that provides the support and care access an individual requires across the full spectrum of services. An example would be providing long-term care

services based on the levels of support the individual requires, rather than on her/his diagnosis. Health care for older adults should include expanded preventive services and health education opportunities using a culturally appropriate, holistic and multidisciplinary approach.

Conclusion

Improving rural older adults' access to health care requires a combination of creativity, flexibility, and investment in the underserved areas of our state. As California's older adult population grows, keeping this group healthy will be essential in order to avoid the enormous cost burden that would come with a sudden jump in the numbers of elders with disabilities and in need of nursing home care.

Policy makers must seriously consider the alternative approaches offered in this report. Many of these ideas are not new: increasing Medi-Cal reimbursement rates and facilitating the employment of physicians in rural communities are long-identified goals that merit a public commitment of dollars and flexibility. Telemedicine is well-established in certain regions and better-accepted for some procedures than others, but the benefits the technology makes possible cannot be ignored. Collaborations between varying levels of governments, between programs and providers will be necessary if older adults in rural communities are to receive the care they both need and deserve.

Expert Witnesses

Woodland: David Soto, MA, Senior Program Manager, Area 4 Agency on Aging; Dawn Myers Purkey, MSW, Program Manager, Yolo Adult Day Health Center; Nancy Guenther, MST, Program Manager, California Department of Public Health, Injury Control Section; Teri Boughton, MHA, California HealthCare Foundation

Redding: Steven Burns, M.D., Medical Director, Karuk Tribal Health; Lynn Dorroh, Director, Hill Country Health and Wellness Center; Mona Johnston, Mercy Hospice, Mount Shasta; Mark Montgomery, PsyD, Shasta County Mental Health and Drug Department

Jackson: Laurie Webb, R.N., P.H.N., Director, Amador Senior Center; Nancy Slenger, M.S.W., home delivered health care services; Michelle Nevins, M.B.A., Executive Director, Del Oro Caregiver Resource Center; Pauline Campbell, R.N., M.S.N., Vice President, Sonora Regional Medical Center; Andrew Scharlach, Ph.D., School of Social Welfare, UC Berkeley; Steve Fowler, Technical Program Manager, California Telemedicine and eHealth Center

Therefore, as a starting point, the current capacity of all of the following components of the health care and long-term support system must be evaluated in the 28 rural jurisdictions in order to determine whether and how a workable managed care model for rural California can be structured:

- Primary care
- Specialty care
- Inpatient hospital
- Care management (nursing and/or social work)
- Home health and ancillary
- SNF/nursing home care
- Emergency and non-emergency medical transportation
- Pharmacy
- Linkage to IHSS and other long-term supports
- Behavioral health (mental health and substance abuse services)
- Other community based supports such as:
 - Adult Day Care (social model)
 - Adult Day Health Care (medical model)
 - Adult Foster Care
 - Assistive Devices
 - Assisted Living Services
 - Attendant Care
 - Caregiver Assistance/Support
 - Case/Care Management
 - Companion Services
- Congregate Meals
- Durable Medical Equipment
- Fiscal Intermediary
- Group Home/Supportive Living Services
- Handyman Services
- Health Insurance Counseling
- Home Delivered Meals
- Homemaker Services
- Home Modification Services
- Housing Services
- Hospice Services
- Independent Living Skills Training
- Information & Referral
- Visiting Nursing Services
- Nutritional Services
- Personal Care Assistant Services
- Personal Emergency Response System
- Physical, Speech, Respiratory, or Occupational Therapy
- Recreational Services
- Respite Care
- Specialized Dementia Care
- Transition Counseling (skilled nursing to community or from service to service)

Restructuring Long-term Care In Humboldt County- Final Report

June 2012

Prepared by: Patty Berg, Consultant For the North Coast Long-Term Services and Supports Coalition

On behalf of the Area I Agency on Aging