LOS ANGELES COUNTY
COMMISSION ON HIV

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AGING TASK FORCE
Virtual Meeting

Tuesday, February 2, 2021
1:00PM-3:00PM (PST)

Agenda and meeting materials are available at
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COMMISSION ON HIV

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AGING TASK FORCE

VIRTUAL MEETING AGENDA

Tuesday, February 2, 2021 | 1:00pm-3:00pm

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1) Welcome, Introductions, December Meeting Recap 9:00am-9:10am

2) Executive Director Report 9:10am-9:30am

   - Commission Updates
   - Ending the HIV Epidemic (EHE) Updates
   - County Counsel Guidance on Subordinate Work Groups

3) 2021 Work Plan/Priorities 9:30am-9:55am

4) Discussion: 9:55am-10:30am
   - California Health & Human Services (CHHS) Master Plan for Aging
   - ATF Recommendations – Follow up

5) Determine next meeting dates and times 10:30am-10:40am

6) Next Steps/Agenda development for next meeting 10:40am-10:50am

7) Announcements 10:50am-11:00am

8) Adjournment 11:00am

LOS ANGELES COUNTY
COMMISSION ON HIV

AGING TASK FORCE

December 7, 2020 Virtual Meeting Summary

In attendance:

Al Ballesteros (Co-Chair)	Chelsea Askey	Alasdair Burton
Leopoldo Cabral	Geneviéve Clavreul	Pamela Coffey
Luckie Fuller	Joseph Green	Ronda Jacobs
Lee Kochems	Michael McFadden	Mark Mc Grath
Derrick Murray	Paul Nash	Katja Nelson
Jose Ortiz	Brian Risley	Julie Tolentino
Octavio Vallejo	Sonja Wright (COH Staff)	Dawn Mc Clendon (COH Staff)
Cheryl Barrit (COH Staff)		

1. **Welcome & Introductions**
   - Al Ballesteros, Co-Chair and Cheryl Barrit, Executive Director, welcomed attendees and led introductions.
2. **Executive Director's Report**
   - Cheryl Barrit provided updates on Commission activities as follows:
     - Last Commission meeting for 2020 will be held on December 10, 2020
     - The Commission, in partnership with DHSP, will be submitting public comment on the US Department of Health and Human Services (USDHHS) newly released the National HIV Strategic Plan to ensure alignment with local plans.
     - Planning, Priorities & Allocations (PP&A) Committee continues to work to ensure its priority setting and resource allocation (PSRA) activities are aligned with the Ending HIV Epidemic (EHE) initiatives and have also formed a Prevention Planning work group to ensure prevention is integrated into the PSRA process.
     - Public Policy Committee (PP) Committee will provide a debrief on the general elections will develop its policy priorities for 2021. Additionally, the Committee will hear from The Wall Las Memorias to learn more about their Meth & HIV mobilization efforts.
3. **Ending the HIV Epidemic (EHE) Plan**
   - Julie Tolentino, DHSP EHE Program Coordinator, provided an updated on the EHE plan and indicated the final version will be presented at the December Commission meeting and made available to the community. Ms. Tolentino indicated that the first half of 2021 will be dedicated to promoting the EHE plan followed by strategic planning in operationalizing the plan. Ms. Tolentino solicited feedback of the task force and indicated that she would like to work with the task force to ensure 50+ people living with HIV are incorporated in the EHE plan. Feedback included:

- Mark McGrath expressed concerns that the County does not provide prevention planning for those 50+ living with HIV, especially for those diagnosed at late stage. Ms. Tolentino shared that although the EHE plan doesn't identify the 50+ population by name, it is designed for all those at risk, targeting those with the highest needs.
- Al Ballesteros inquired how enhancement of services to include 50+ could be shifted to EHE funding but acknowledged that would be a difficult task given the nature of funding.
- Are there alternative prevention strategies other than bio medical interventions included in the EHE plan?
- Identify community ambassadors to spread the EHE message

4. Discussion: Draft Recommendations and Next Steps

- Ms. Barrit led the Task Force in its review of the final draft recommendations developed at the previous meeting; refer to draft recommendations. Key edits/suggestions/recommendations discussed included:
  - Address ageism
    - The task force in and of itself contributes to siloed conversations, further stigmatizing those 50+ living with HIV community. Conversations need to be integrated in the full planning conversation along w/ ongoing training on implicit biases to address ageism.
    - Basic 101 training should be provided to help educate the Commission, community and workforce on 50+.
    - Convene a panel comprised of 50+ living with HIV and utilizing Ryan White Program services for 2021 National HIV/AIDS Awareness and Aging Awareness Day (September)
    - Must address the intersectionality of ageism, racism, homophobia, hetero dominance/normativity, sexism.
  - Include an annual reporting requirement for DPH to capture updated data regarding those 50+ living with HIV and report back to Commission.
  - Add "sexual orientation" under the 4th bullet
  - Add bullet point to include a needs assessment of social injustices to include race, ethnicity, heteronormativity and other forms of social and religious injustices.
- The Task Force agreed to submit the recommendations as revised to the Commission at its next meeting. Additional revisions can be incorporated after APLA releases its white policy paper, if necessary.

5. Determine Next Meeting Dates and Times

- Due to the holidays, staff will poll the task force for its next meeting date/time for a time in February 2021, barring any urgent policy/legislative items that need to be addressed in January 2021.

6. **Next Steps/Agenda Development**
    - Staff to update recommendations as discussed and send to ATF for review and final edits
    - Include final recommendations in December Commission meeting packet for review
    - Staff to poll task force for next meeting date in February 2021.
7. **Announcements**
8. **Adjournment**

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POLICY/PROCEDURE #08.1102	Subordinate Commission Working Units	Page 1 of 12

F I N A L Revised
Approved 8/11/16

SUBJECT: **The role(s), structures and governing rules of the Commission's various types of subordinate committees and working groups.**

PURPOSE: **To describe the purpose, status, structure, rules, work and timeframes of various subordinate working groups that facilitate advancement, review and completion/fulfillment of Commission responsibilities, tasks, work and projects.**

BACKGROUND:

- Federal Ryan White legislation is the largest source of non-entitlement funding for HIV care and treatment in the country. Part A funding is directed to the most impacted urban jurisdictions across the country. The Ryan White Treatment and Modernization Act of 2009 requires all Part A jurisdictions established before 2008 to create local HIV planning councils. The Health Resources and Services Administration (HRSA) in the US Department of Health and Human Services (DHHS) administers the Ryan White Program nationally.

- The Los Angeles County Commission on HIV serves as LA County's Ryan White and Centers for Disease Control (CDC) prevention HIV planning council. The County has chartered the Commission in County Code, Ordinance 3.29. Both roles as the Ryan White HIV planning council and a County-chartered commission carry specific responsibilities and expectations. The Commission's annual work plan is driven and governed by all of these sources (Ryan White legislation, HRSA and CDC guidance, and County directive/need), yielding an annual schedule of review, discussion, decision-making and work product.

- In order to fulfill its responsibilities and accomplish the work assigned to it, the Commission adopted a strategy in 2003 that relies almost entirely on its committees to perform initial analysis of, generate recommendations to and implement actions for the full Commission. Since then, the Commission's committees have had an indispensable impact on the Commission's capacity to fulfill its varied responsibilities and advance significant initiatives benefiting people with HIV/AIDS/STDs in LA County.

- While the Commission generates, modifies and/or finalizes work and/or decisions, it rarely prepares the work directly as a full body. Rather, it relies on the standing committees and other working groups to forward recommended decisions or work for consideration by the full body. As a result, the Commission counts on the committees and related work units to complete more focused analysis. The committees, in turn, may rely on different types of working units to which they assign/delegate the work. This policy details the various working units the Commission and its committees can access to advance and expedite its decisions and work as needed.

POLICY:

1) **Policy/Procedure Description**: These policies and descriptions define and detail the organization, structure and governing rules/procedures of various working units the Los Angeles County Commission on HIV can engage to generate, develop and complete tasks and work necessary to fulfill its mission and purpose.

2) **Committee-Driven Process**: The Commission is an HIV community planning body that regularly generates planning and implementation decisions and work product consistent with federal Ryan White legislative and Los Angeles County Charter requirements and guidance. Generally, the Commission's work flow and process is "committee-driven," meaning that recommended decisions, actions and work are typically proposed by the Commission's standing committees or other working units to the full Commission for review, consideration, and final decision-making. While the Com-mission generates, modifies and/or finalizes work and/or decisions, it rarely performs the work directly as a full body.

3) **Standing Committees**: The Commission's primary working units are the five standing committees—the Executive, Public Policy (PP), Operations, Planning, Priorities and Allocations, (PP&A) and Standards and Best Practices (SBP). Each of the standing committees has specific responsibilities detailed in the Commission's By-Laws, which they, in turn, implement through ongoing analysis, study, discussion, debate, decision-making, work product, action and/or implementation.

4) **Annual Work Planning**: The Executive Director in consultation with the Co-Chairs and Committee Co-Chairs will develop an Annual Work Plan at the beginning of the program year (March – February). The annual work plan will be aligned with the Comprehensive HIV Plan's Goals and Objectives Section.

5) **Role of the Working Units**: The Commission, its Co-Chairs, the Executive Committee and the Commission's standing committees are entitled to establish caucuses, subcommittees, ad-hoc committees, task forces and various types of working groups to more thoroughly address responsibilities, decisions, work, tasks and projects in accordance with their and the Commission's work plan.

6) **Openness and Transparency Requirements**: Like the Commission, the standing committees are covered by the Ralph M. Brown Act, comply with HRSA guidance and other "sunshine" law requirements regarding meeting transparency and related agendas, notices and preparations; meeting conduct, voting procedures and decision-making; public participation; and meeting record-keeping.

7) **Caucus(es)**: The Commission establishes caucuses, as needed, to provide a forum for Commission members of designated "special populations" to discuss their Commission-related experiences and to strengthen that population's voice in Commission deliberations. Caucuses are not, by definition, Brown Act-covered bodies, and are not required to comply with open meeting, public participation and other, related "sunshine" requirements. With Commission consent, caucuses determine their membership, meeting conduct and timelines, work plans, and activities.

8) **Ad-Hoc Committee(s)**: The Commission, its Co-Chairs and/or the Executive Committee can create ad-hoc committees to address longer-term Commission special projects or initiatives that require more than one standing committee's input, involvement and/or representation. Once the project has been completed, the ad-hoc committee automatically sunsets. The Commission Co-Chairs are responsible for assigning Commission members to the ad-hoc committees, and during their tenure, ad-hoc committees maintain the same stature and reporting expectations as other standing committees. Ad-hoc committees are required to comply with all of the same Brown Act and other transparency requirements as the Commission and its standing committees.

9) **Subcommittee(s)**: Standing Committees and/or their co-chairs may establish subcommittees to address and carry out work, tasks and activities to address one of the committee's primary responsibilities. Consequently, subcommittees are not necessarily time-limited, but the committee can extend, suspend, amend and or conclude the subcommittee's work at any time. The committee may delegate certain authorities to the subcommittee, and the subcommittee's work plan is incorporated into the committee work plan. The committee's co-chairs assign committee, and possibly other Commission, members to the subcommittee. Sub-committees are required to comply with all of the same Brown Act and other transparency requirements as their respective committees.

10) **Task Forces(s)**: Task Forces can be created by the Commission, its Co-Chairs and/or the Executive Committee, and are intended to address a significant Commission priority that may entail multiple levels of work or activity and are envisioned as longer-term in nature. Task forces are similar to ad-hoc committees, except that their membership is expected to include at least as many non-Commission members as Commission members. Task force decisions, work, activities and plans must be reported to and approved by the Executive Committee. While, technically, task forces do not have to comply with Brown Act and other

transparency requirements, it is encouraged that they do so in the spirit of the law. Various community task forces are **not** formal Commission working units, unless recognized as such by the Commission; however, they are invited to report and recommend actions to the Commission.

11) **Work Group(s)**: Work groups are primarily created by the committees for work on a single, short-term project that the committee cannot as thoroughly address during its regular meetings. By definition, work groups—which can come in many different forms—are only operational for short, time-limited periods. Commission and non-Commission members may participate in a work group, but no more Commission members than the originating committee's quorum. Work groups are not covered by the Brown Act and other transparency laws, and the final decisions/recommendations/work serve as a record of the work group's deliberations and must be forwarded to the originating committee for review, consideration and modification/approval.

12) **Organizational Purpose, Structure and Responsibilities**: The following procedures comprehensively describe the various types of subordinate Commission working units; their role(s) and purpose(s); the conditions under which they can be established; and what rules, governance, processes and expectations guide their activities. Each working unit description approximates the following organization:
    - Establishing authority
    - Definition, standing and reporting responsibilities
    - Role and purpose
    - Necessary conditions/provisions
    - Legal requirements
    - Organization, membership and leadership
    - Scope of responsibility and timeframe
    - Staff support, and
    - Other distinctions.

PROCEDURE(S):

1. **Work Plan Implementation**: The Commission develops an annual work plan for the federal Ryan White program year (March – February) detailing the tasks and work projects it expects to complete in the year and that serves as the Commission's primary work outline Each of the Commission's standing committees and caucuses prepares an individual work plan, and the compilation of those work plans is modified/ approved by the Commission.
    a. Commission decisions and work products are guided by federal Ryan White legislation, Health Resources and Services Administration (HRSA), Centers for Disease Control and Prevention (CDC) and County Ordinance requirements and guidance.
    b. The work plan is a "living document" that may change as unanticipated pressing, urgent and/or time-sensitive issues need to be addressed during the course of the year.

c. Various types of subordinate working units are created at the Commission to carry out and fulfill work and decision-making responsibilities in accordance with that workplan. The organization, structures, rules, work activities and timelines for each type of working group are defined in the following procedures.

d. The group's work objectives and timeframe for completing them will dictate which type of working unit is necessary to carry out those responsibilities.

2. Standing Committee(s): The Commission's standing committees and their respective responsibilities are authorized by and defined in the Commission's By-Laws (*see Pol/Proc #06.1000: Commission By-Laws*). The standing committees:

- are continuing work units;
- meet monthly or more frequently;
- concurrently juggle multiple tasks and activities within their respective purviews; and
- are the Commission's primary means of discharging its duties and responsibilities.

a. All of the Commission's major function(s) and responsibilities are assigned to at least one of the standing committees. While the standing committees primarily generate recommendations and propose work products for the Commission's modification/ approval, they are authorized to make some limited final decisions—such as document revisions in the Operations and Standards and Best Practices (SBP) Committees, policy position modifications in the Public Policy (PP) Committee, and final appeals at the Planning, Priorities and Allocations (PP&A) Committee.

b. Standing committees forward reports, completed work and Committee-approved decisions/recommendations to the Executive Committee and the Commission, as appropriate, understanding agenda items at those meetings.

c. As the Commission's fundamental working units and in the spirit of transparent and open decision-making, the standing committees are subject to Ralph M. Brown Act, HRSA and other applicable sunshine law requirements .As such, the standing committees must adhere to the relevant rules governing:

- meetings open to the public;
- public participation and comment periods;
- development, notification and posting of agendas;
- quorums and voting procedures; and
- meeting record-keeping, audio-recording, and minutes.

1) The Commission's standing committees perform their work, conduct their business, and discuss and deliberate in open, public settings and meetings (except for rare closed Committee sessions that are consistent with Brown Act provisions).
2) Members of the public are encouraged to attend and participate in standing committee meetings.

3) Agendas detailing topics to be addressed are developed for all meetings, and meeting agendas are posted 72 hours in advance.
4) A quorum must be present at any meeting in which votes are taken and only Board of Supervisor (BOS)-appointed Commission members are entitled to cast votes.
5) All meetings are electronically recorded and minutes summarizing meeting discussions and actions are subsequently produced and approved.

d. Standing committee voting privileges are only conferred on Board of Supervisors (BOS)-appointed Commission members who have been assigned to the Committee by the Commission's Co-Chairs, or designated OAPP representatives consistent with the By-Laws.
   1) There is no limit to the number of Commission members who can be assigned to a standing committee.
   2) The standing committee quorum equals one member more than 50% of the assigned membership.
   3) A quorum is required before votes can be taken at a meeting. While all of the Commission's working groups aim for consensus, votes may be necessary to arrive at a decision or for record-keeping purposes.
   4) A motion is successful when more than half of the voting members at the meeting support it.

e. Standing committees elect their committee co-chairs from among their designated membership.
   1) Although a standing committee meeting can proceed without a quorum (however no voting allowed), it cannot proceed without at least one of the Committee or Commission Co-Chairs to lead the meeting.
   2) The Commission's Ordinance and By-Laws dictate that all standing committee co-chairs also serve on the Commission's Executive Committee.

f. Standing committees determine their scope of responsibilities in accordance the standing committee's charge in the Commission By-Laws. The committee outlines how it intends to fulfill those responsibilities by detailing the projecting work tasks/activities and when they will be performed in its annual work plan.
   1) Work priorities are determined by the committee and its co-chairs, shifted accordingly throughout the year due to unforeseen circumstances.
   2) The Commission, its Co-Chairs and/or Executive Committee may also shift standing committee work priorities in consideration of overall Commission priorities and/or existing resources to support the entirety and scheduling of the anticipated Commission workload.

g. The Executive Director assigns each standing committee one lead and at least one support staff person from among the Commission Office staff.

3. Caucus(es): Only the Commission is authorized to create Commission caucuses. When establishing a caucus, the Commission must balance the number of existing caucuses, their

workloads and schedules, and determine that staff resources exist to provide adequate support to the roster of caucuses and committees.

a. Only caucuses created by the Commission with BOS-appointed membership are formally recognized as formal working units of the Commission.
   1) Commission caucuses maintain the same stature as the Commission's standing committees, including monthly reporting responsibilities to the Commission.
   2) Consistent with the Commission's By-laws, caucuses do not maintain representative seats on the Executive Committee.

b. The caucus was developed as a vehicle to provide a safe and judgement-free setting where the Commission's caucus members can easily and freely discuss their reactions and experiences, share their insights, and exchange perceptions of issues addressed by the Commission among other Commission members who are more likely to share/ understand those perspectives. Second, the caucus was intended to develop a more organized voice to ensure that the caucus population's perspective is effectively heard when relevant issues are raised and discussed at the Commission. Thus, each caucus has four primary responsibilities:
   1) Facilitating a forum for a dialogue among the caucus members;
   2) Developing the caucus voice at the Commission and in the community;
   3) Providing the caucus perspective on various Commission issues; and
   4) Cultivating leadership in the caucus membership and population.

c. When forming a caucus, the Commission must adhere to the following criteria:
   1) the population proposed to be represented by the caucus must be one of the Commission's designated "special populations" ;
   2) the Commission must conclude that the population's voice can be strengthened by caucus representation; and
   3) caucus membership must include more than five Commission members and fewer members than the Commission quorum.

d. Since the caucus structurally does not comprise a quorum of the Commission or any of its standing committees, the Commission's caucuses are not governed by the Brown Act, HRSA, CDC or other rules and requirements that apply to the Commission's other committees. Consequently:
   1) the caucus is not required to adhere to quorum requirements;
   2) posted agendas are not required for the Caucuses; and
   3) caucus meetings are not open to Commission membership or the public, unless the caucus chooses to do so;
   4) caucus meetings are not audio recorded and meeting minutes are not produced, however the caucus may use meeting summaries to ensure operational efficiency.

e. Decisions about the caucus organization, structure, membership, process and schedule are left to the caucus membership:

1) all Commission members of the designated population are considered members of the established caucus, whether or not they choose to participate;
2) the caucus determines its leadership and leadership responsibilities;
3) the caucus determines how and when to involve the broader Commission and community in its meetings and activities;
4) the caucus determines its internal organization and meeting/activity schedule.

f. The caucus determines what and how many issues it will address throughout the year by establishing its own scope of responsibility and identifying the work and type of activities in which it will engage. Among the activities it may use to advance its work are education and dialogue, mobilization and advocacy, written communications, presentations, member recruitment, improved representation, events, community involvement, and other options.
   1) Like the standing committees, caucuses are expected to develop annual workplans, which, in turn, are included in the Commission's annual workplan.
   2) The Executive Committee's and Commission's modifications to caucus workplans and final approval of the annual Commission workplan constitute acceptance of the caucus' self-defined scope and timeframe of responsibility.

g. The Executive Director is responsible for determining who among the Commission staff is the most suited to provide staff support to the caucus.

4. Subcommittee(s): Standing committees create subcommittees, as needed, to carry out one or more of the standing committee's major areas of responsibility. The standing committee can "sunset" a subcommittee or continue, amend, suspend, extend and/or reclaim the work or responsibility or parts of it at will.

a. The subcommittee's work priorities are established by its respective standing committee as the standing committee deems appropriate as it endeavors to fulfill its responsibilities and determines that it does not have the time to address the topic as specifically as needed in the context of its regular meetings.

b. Subcommittees must forward their decisions, recommendations and work products to their respective standing committees for consideration, review, modification and/or approval, unless the standing committee has instructed otherwise.
   1) Subcommittee reports are regularly agendized for their respective standing committee meetings.
   2) The standing committee may delegate a portion of the committee's decision-making authority to the subcommittee or instruct the subcommittee to report its decisions/ actions directly to the full Commission.

c. During its tenure, the subcommittee is considered a formal working unit of the Commission, and, as such, must comply with the same Brown Act, HRSA and other, related legal operational rules and requirements as standing committees (*see Procedure #2.c*).

d. The standing committee co-chairs are entitled to assign members of their committee to any subcommittees the committee establishes, and to determine if they will accept other Commission members who volunteer for the designated subcommittee(s).
   1) Standing committee rules governing membership, voting privileges and meeting conduct also apply to subcommittees (*see Procedure #2.d*)
   2) Only Commission or standing committee members with voting privileges are entitled to membership on subcommittees—although the public are invited to attend and participate in subcommittee meetings.
   3) Like the standing committees, subcommittees elect their own co-chairs. At least one of the standing committee co-chairs should attend and lead the first subcommittee meeting in order for the subcommittee to choose its own leadership.

e. While the standing committee determines the subcommittee's scope and limits of responsibility, the subcommittee may elaborate on that topic, extend, revise or modify it, and design the appropriate work strategies to address it, with the standing committee's or its co-chairs' consent.
   1) The subcommittee's annual work plan is incorporated into the standing committee's annual work plan.
   2) That responsibility may be time-limited or assumed to be a long-term or permanent delegation of the standing committee's authority.

f. The respective standing committee staff support also staffs its subcommittees.
   1) With the Executive Director, the standing committee must balance the number of its subcommittees, its work-load and schedule to determine if staff resources are adequate to provide the necessary support to a subcommittee.

5. Ad-Hoc Committee(s): The Commission, its Co-Chairs or the Executive Committee are entitled to create ad-hoc committees, as needed and appropriate.

a. For the duration of an ad-hoc committee's work, the ad-hoc committee maintains the stature of Standing Committees, including regular inclusion on the agenda and reports to the Executive Committee and the Commission.
   1) Consistent with the Commission By-Laws, ad-hoc committees do not maintain representative seats on the Executive Committee.

b. Ad-hoc committees are "special project"-focused in nature, meaning they are assigned one significant project, versus limited-activity or short-term projects that can be addressed by other working units or as part of a standing committee's or subcommittee's more expansive agenda.

c. Ad-hoc committees are created for special projects that extend beyond a single standing committee's authority or purview and require membership from multiple committees.
   1) The Commission Co-Chairs determine who will serve on an ad-hoc committee by assigning members and/or accepting volunteers.

d. The ad-hoc committee determines rules, activities and schedules regarding its organization, membership and leadership.
   1) Ad-hoc committees must comply with all of the same legal requirements and guidance governing meeting preparations and their conduct as standing committees and subcommittees.

e. Given its defined purpose to address a single, significant Commission special project, an ad-hoc committee is established for a distinct time period and automatically sunsets at the conclusion or completion of the project.

f. Executive Committee staff support provides staff support to ad-hoc committees, unless the Executive Director designates other staff support.

6. Task Force(s): Task Forces can be created by the Commission, its Co-Chairs or the Executive Committee. Task forces are intended to address a topic that is broader and more expansive in nature, encompassing multiple activities and a continuing, longer-term time frame.

a. Unlike ad-hoc committees or subcommittees with similar purposes, task forces are created to include Commission members and non-Commission members alike, generally at equal proportions, or with Commission members forming a minority of the task force membership.

b. Task forces report to the Executive Committee, to which they forward their recommendations and work. Since membership is not confined to solely Commission members, any recommendation or action from a Task Force must be approved by the Executive Committee before advancing it to the full Commission.

   1) The Commission's task forces are expected to provide periodic reports to the full body.

c. Technically—only unless the Task Force membership comprises a majority of Commission members from one of its working units—it does not have to comply with public noticing and other Brown Act rules; practicality, though, suggests compliance with those rules, even if not specifically mandated.

d. The task force membership is empowered to determine its own leadership, structure, and schedule.

e. The task force assumes its scope of responsibility and develops its work plan(s) in consultation with the Executive Committee and the Executive Director.
   1) The task force work plan, scheduling and timeline is incorporated into the Executive Committee's annual work plan.

f. Executive Committee staff support provides staff support to ad-hoc committees, unless the Executive Director designates other staff support.

g. It is important to note that the HIV community has created a number of population- and service-centered task forces that are **not** Commission working units, unless formally recognized by the Commission.
   1) Community task forces are welcome, though, to report their recommendations or work to the Commission under the standing "Task Force" agenda item, as needed and appropriate.

7. Work Groups: The committees are primarily responsible for establishing work groups, the most informal of the Commission's subordinate working units. Work groups are created to complete a specific short-term, single-focused task, resulting in a final work product that concludes the work group's activities.

a. Most frequently, work groups are established to work in more specific detail on a task that the committee does not have time to address in its regular meetings, or to finish a task that requires direct involvement and input from the work group members (e.g., such as developing plans, reviewing and generating documents and/or conducting studies, among other possible activities).
   1) All work group actions must be approved by the committee of origin, as work groups are only performing work on the committee's behalf and request.

b. Due to their short-term timeframe, specific work assignment and limited membership, work groups are not governed by the Brown Act or other sunshine law requirements.

c. Work groups cannot include more members than the originating standing committee's quorum, otherwise additional meeting preparation, membership, timeline and management requirements will be invoked.
   1) Work group meetings are not intended to be open to the public, or subject to transparency and public participation requirements.
   2) Work group meetings are, instead, intended to be working meetings that produce decisions, documents and/or other products that will be presented for open, public discussion, debate and/or consideration at the originating standing or other committee.
   3) Agendas and meeting minutes are not needed for work groups. Summaries may be provided, if needed, to capture information discussed at prior meetings or to ensure continuity and progress of meeting discussions.
   4) Generally, the final documentation and/or work product from the work group serves as a record of the work group meeting proceedings.

d. Work groups can come in many forms: as a committee work group, an expert review panel, a focus group or in other formats.

e. Non-Commission members can be included in the work group with the consent of the standing committee or the Executive Director, as needed.
   1) Due to the mix of Commission and non-Commission members on work groups, votes and voting procedures are not used at work group meetings.

2) Due to its short-term nature, work groups do not require formal leadership.

f. The work group's scope of responsibility is defined by the originating committee, are short-term limited, and range from one to a dozen meetings in total.
   1) More frequently work groups meet only once or twice and finish their assigned projects within a month (for example, by the committee's next meeting).

g. Work groups are staffed by one of the committee's support staff and the work is not intended to exceed six months, at the maximum.

NOTED AND APPROVED: Cheryl A Barnett

EFFECTIVE DATE: December 9, 2010; 8/11/16

Original Approval: 12/9/10 *Revision(s):7/25/16*

LOS ANGELES COUNTY COMMISSION ON HIV

LOS ANGELES COUNTY COMMISSION ON HIV 2021
AGING TASK FORCE WORKPLAN (2.2.21)

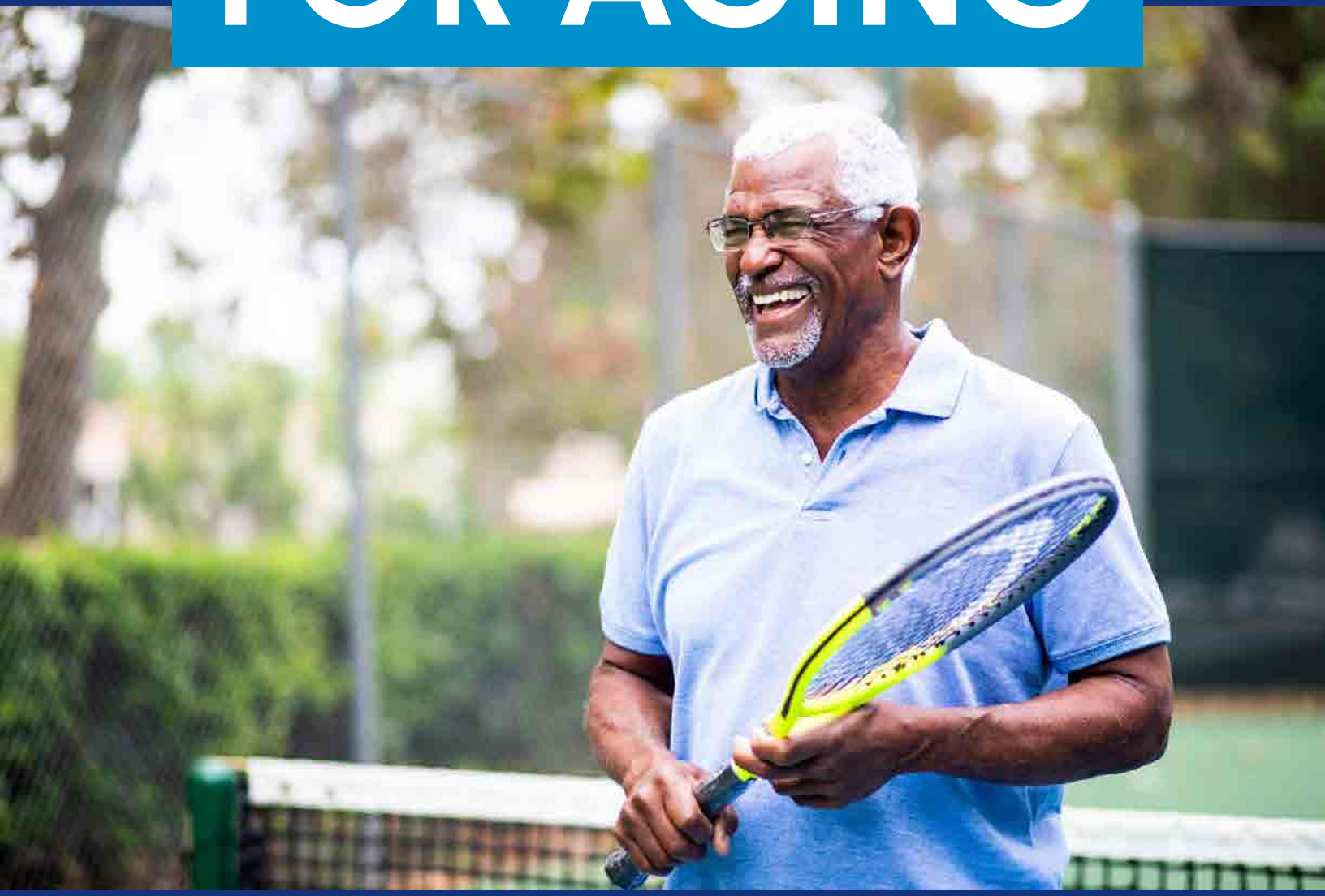
Task Force Name: Aging Task Force	**Co-Chairs: Al Ballesteros**
Task Force Approval Date:	**Date: 2.2.21**

Purpose of Work Plan: To focus and prioritize key activities for COH Committees and subgroups for 2021.
Prioritization Criteria: Select activities that 1) represent the core functions of the COH and Committee; 2) advance the goals of the Comprehensive HIV Plan and Los Angeles County HIV/AIDS Strategy; and 3) align with COH staff and member capacities and time commitment.

#	TASK/ACTIVITY	DESCRIPTION	TARGET COMPLETION DATE	STATUS/NOTES/OTHER COMMITTEES INVOLVED
1	Determine Next Steps for Recommendations	Final recommendations completed 12.20.10.	TBD	Recommendations presented at November & December 2020 Executive Committee and December 2020 & January 2021 full Commission meetings
2				

JANUARY 2021

Master Plan FOR AGING



CALIFORNIA DEPARTMENT OF AGING

CALIFORNIA ALL AGES

A Message from Governor Gavin Newsom

Ten years from now, California will be home to 10.8 million people age 60 and over—nearly twice as many as in 2010. One out of every four Californians will be older adults, a seismic demographic shift that will change every aspect of our lives, from the structures of our families and communities to the drivers of our state's economy.

The next generation of older Californians will be significantly more diverse, will live longer, and will contribute in untold new ways to making our state a more vibrant place. As our state ages, we will also share new challenges across the decades—with more people staying in the workforce, more of our neighbors living alone, and too many of us enjoying less economic security than in decades past.

Each of these trends presents their own unique opportunities—and each one requires a significant response to ensure all people in California are engaged, valued, and afforded equitable opportunities to thrive as we go through different ages and stages of life. This is the purpose of the Master Plan for Aging.

In June of 2019, I called for the development of a comprehensive new framework for supporting Californians as we age. Only a unified, coordinated effort can provide a response on the necessary scale—combining a bold vision, detailed strategies, and the partnerships necessary to promote healthy and equitable aging for all Californians. The urgency behind this initiative has been magnified by the onset of COVID-19, which has disproportionately impacted older Californians, people with disabilities, and communities of color. The pandemic has exposed persistent and systemic inequities, while also serving as a reminder of how much we can do to keep the most vulnerable among us safe and healthy.

The Master Plan incorporates the hard lessons we have learned into a 10-year strategy that will help every community to build back better—with bold goals and targeted policies that can transform the way aging is experienced in California. The proposals outlined on the pages that follow, on issues from housing to health care, have been shaped by more than a year of outreach to stakeholders and the public, as well as coordination with complementary initiatives like the Task Force on Alzheimer's Disease Prevention & Preparedness.

The final result is a call to action, with accountability. For the Master Plan to succeed, each of us—in state government, local communities, private organizations, and philanthropy—will have a role to play. Our engagement will harness our state's innovative spirit, channel resources where they are needed most, and open up new opportunities for working together to create inclusive, equitable communities for Californians of all ages.

This plan is intended to be a living document for years to come. We will measure our success against a series of key indicators, and my Administration will share an annual report with updates and improvements to the strategies the state needs to pursue. Public engagement will continue to guide us, and I encourage you to get involved through mpa.aging.ca.gov.

Together, I believe we can build the age-friendly California every one of us deserves. This new Master Plan gives us a way to get there.

Sincerely,

Gavin Newsom, Governor of California

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California for All Ages:

WHY A MASTER PLAN?

Aging is changing and it's changing California. California's over-60 population is projected to diversify and grow faster than any other age group. Increasing from 16 percent in 2010 to one quarter of the population by 2030, when there will be 10.8 million older adults in California. Recognizing this, Governor Gavin Newsom issued an executive order in June 2019 calling for the creation of a Master Plan for Aging (Master Plan) (Executive Order N-14-19). The Executive Order affirmed the priority of the health and well-being of older Californians and the need for policies that promote healthy aging. It also called for a "blueprint" for state government, local government, the private sector, and philanthropy to prepare the state for the coming demographic changes and to continue California's leadership in aging, disability, and equity.

After work began on the Master Plan, the COVID-19 pandemic reached California. The virus disproportionately harmed older and other at-risk adults, and it strained aging and disability services like never before. Older adults have experienced unprecedented death rates – particularly among Latino, Black and Asian Pacific Islander communities and those living in nursing homes. Intensified social isolation and ageism have been especially burdensome. The suffering, resilience, and leadership of older adults, people with disabilities, caregivers, service providers, and advocates during this time have made the Governor's Master Plan for Aging even more urgent.

This is not a plan simply for today's older adults. Instead, the Master Plan is a blueprint for aging across the lifespan. The Master Plan calls on all California communities to build a California for All Ages: for older Californians currently living through the many different stages of the second half of life; for younger generations who can expect to live longer lives than their elders; for communities of all ages – family, friends, neighbors, coworkers, and caregivers –surrounding older adults. As Californians, we can create communities where people of all ages and abilities are engaged, valued, and afforded equitable opportunities to thrive as we age, how and where we choose.

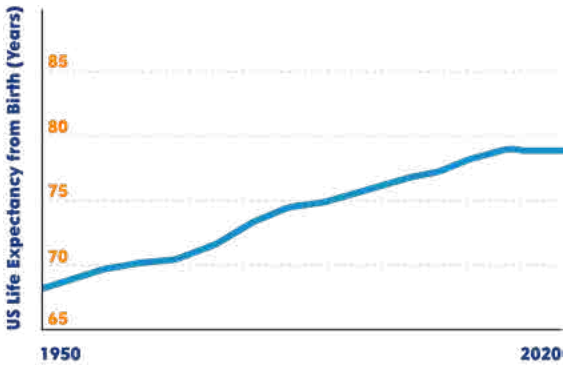
The Master Plan for Aging outlines five bold goals and twenty-three strategies to build a California for All Ages by 2030. It also includes a Data Dashboard for Aging to measure our progress and a Local Playbook to drive partnerships that help us meet these goals together.

Aging is changing and

IT'S CHANGING CALIFORNIA

California's demographics are shifting. We will be prepared to ensure that all residents have the opportunities needed to thrive as we age in the Golden State.

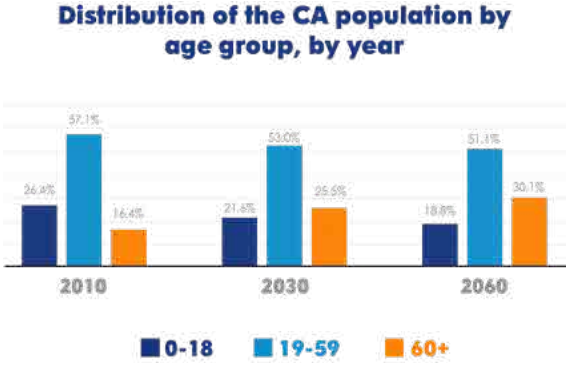
Californians are living longer than ever before

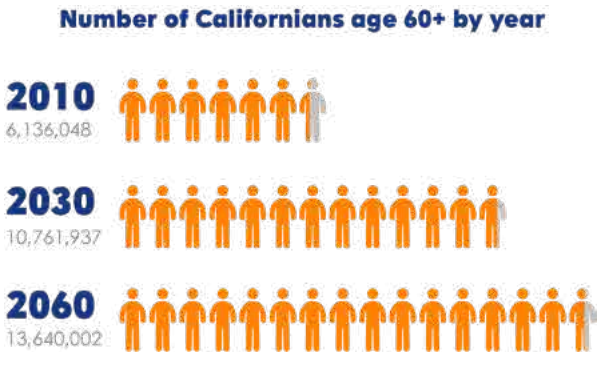


Source: www.macrotrends.net

California's overall population is rapidly becoming older

By 2030 adults 60 and over will make up 30% of California's population.



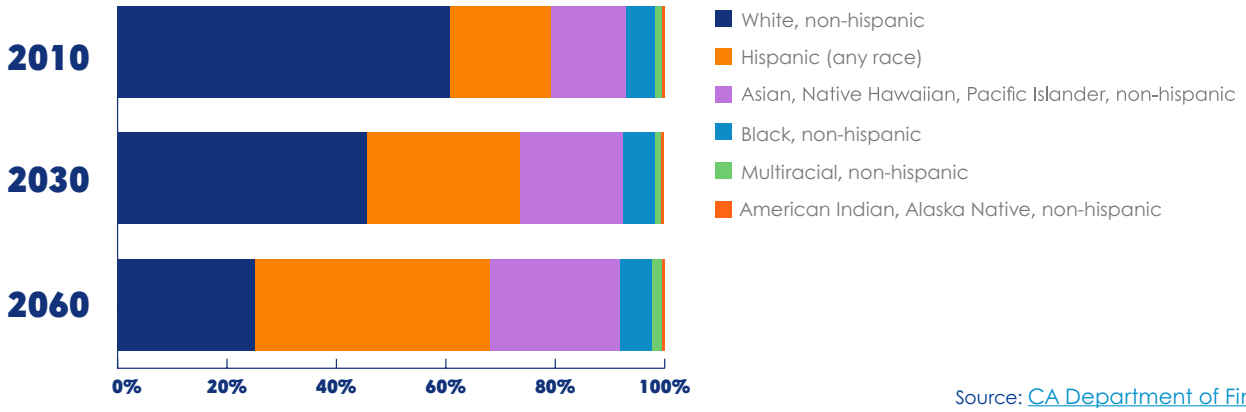


Source: CA Department of Finance

California's older population is becoming more racially and ethnically diverse

By 2030, white, non-Hispanic older adults will no longer represent the majority of older adults.

California's 60+ population by race/ethnicity, by year



Source: CA Department of Finance

California's households are changing

1.8M

Californians 60 and over live alone[1]

The number of people aging alone is increasing

746,000

California households consist of three or more generations[2]

California has more multigenerational households than any other state. Reasons why include housing costs and other financial constraints, care needs, and cultural preferences.

95,000

Californians live in nursing homes[3]

Nursing homes offer an important, and sometimes necessary, option for individuals needing LTSS.

300,000

The number of people that Long-term care and Residential Care Facilities for the Elderly are licensed to serve in California.

1,079

Homeless adults aged 50 or over in Sacramento alone[5]

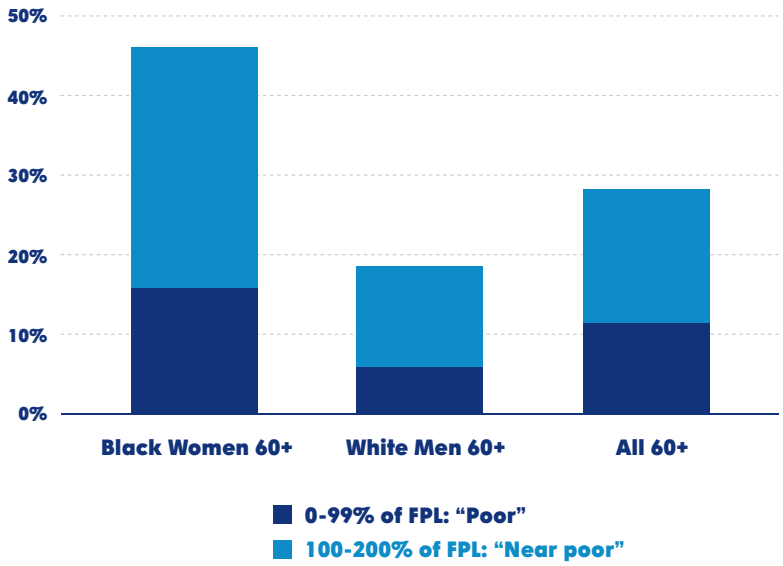
Older Californians are the fastest growing age group experiencing homelessness. Sacramento County's 2019 Point-in-Time Count identified 1,079 homeless adults aged 50 or over.

[1] U.S. Census | 2019 California Health Interview Survey [2] Pew Research [3] California Department of Social Services
[4] California Office of Statewide Health Planning and Development [5] Sacramento Steps Forward 2019 Point-In-Time Count

Affordable aging is becoming harder

Over 2 million Californians aged 60 and over are economically insecure, struggling to afford the rising costs of housing, health, and care.[1] Saving for retirement is becoming more difficult and private pensions are declining, leaving people overly reliant on Social Security benefits*. Almost 30% of older Californians are considered poor or near poor, but dramatic economic disparities exist.[2]

Percent of poor and near-poor Californians aged 60 and over



What is considered the Federal Poverty Level (FPL)? 100% of the FPL is an income of $12,760/year for a single-person household and $17,240 for a two-person household.

*Social Security benefits average $1,500/month for retired workers and $1,250/ month for disabled workers. California's fair market rent for a one-bedroom apartment is $1,522, leaving little money for health, care, food and other needs.

[1] U.S. Census
[2] 2019 California Health Interview Survey

Together we engage:

HOW WE GOT HERE

Partnerships: 2019-2020: Building a California for All Ages requires the engagement and expertise of residents from across the state, in a range of inclusive and interactive ways. The Master Plan's development reflected this same approach, including more than a year of public engagement, stakeholder outreach, community roundtables, and alignment with the Governor's Task Force on Alzheimer's Prevention, Preparedness & Path Forward.

Public Engagement

Between September 2019 and October 2020, the Department of Aging oversaw the Together We Engage Campaign, which collected input from the public, stakeholders, and partners through pledges, surveys, meetings, webinars, and community roundtables. Public opportuni-ties included the Together We Engage pledge and survey to identify Master Plan priorities (sum-mer 2019); Webinar Wednesdays to hear from experts and gather community input on specific topics (winter 2020); and an Equity in Aging Town Hall to address ageism (summer 2020).

Stakeholder Engagement

As called for in the Governor's Executive Order, a Stakeholder Advisory Committee (SAC), a Long-Term Services and Supports Subcommittee, and a Research Subcommittee were formed in August 2020 comprised of seventy-eight members from local government, healthcare providers, health plans, employers, community-based organizations, academia, researchers, and consumers.

Building the Master Plan during COVID-19

In March 2020, the first COVID-19 stay-at-home orders was issued. The pandemic highlighted the cracks and dire inequities in our systems, as well as the prevalence of ageism. Subsequently, stakeholders active in the Master Plan process pivoted to rapid response activities, including virtual and home-delivery of aging and disability services; new check-in calls, postcards, and warmlines; caregiving support; and digital divide resources. Lessons learned along the way were flagged for incorporation into the Master Plan. After the Master Plan process resumed in May 2020, a COVID-19 Impacts & Recommendations Survey was conducted in July 2020 to assess the breadth of pandemic impacts on older Californians.

Equity at the Center

Recognizing the diversity of California's population – both the strong and varied cultural traditions around aging as well as the need to address life-long disparities and inequities faced by Black, Indigenous, and People of Color (BIPOC) and Lesbian, Gay, Bisexual, Transgender, Queer (LGBTQ+), and other Californians – the SAC formed an Equity Work Group in December 2020 tasked with ensuring that equity is fully "baked in" to the Master Plan.

Stakeholder Recommendations

Throughout the stakeholder engagement process, these committees and the Administration received over 240 policy recommendation letters that were submitted by stakeholder organizations and over 1,000 public comments. This engagement process culminated in the SAC's submission of an Equity Tool and Glossary, a Long-Term Services & Supports Stakeholder Report, a Livable Community and Purpose Stakeholder Report, a Health and Well-being Stakeholder Report, and an Economic Security, Safety, and Emergency Preparedness Stakeholder Report. In all, over 800 SAC Stakeholder Advisory Committee recommendations were provided to the Administration to inform the creation of the final Master Plan for Aging. Their input is summarized in the SAC's final report, which lifts up five core priorities: Fix the Long-Term Services and Support System; Assure that California has Housing that is Affordable to All; End Poverty; Uphold the Core Value of Equity; and Strong State Leadership.

Community Roundtables with Electeds

State legislative and local elected leaders convened community roundtables with California Health and Human Services Agency Secretary Mark Ghaly, from September 2019 to September 2020. The first virtual roundtable focused on housing and health, was hosted by Assemblymember Jim Wood (D-Santa Rosa), representing Northern California coastal counties.

Task Force on Alzheimer's

In early 2020, the Governor's Task Force on Alzheimer's Prevention, Preparedness & Path Forward (Task Force on Alzheimer's) aligned its efforts with the Master Plan for Aging to build mutually beneficial plans for California, including a dementia-friendly workforce, culturally responsive diagnoses and treatments, affordable care, and targeted research. The Task Force submitted a report, Our Path Forward, with recommendations to the Governor in November 2020.

Cabinet Work Group

The Cabinet Work Group, representing all ten Cabinet departments and other Executive offices, met throughout the Master Plan process to consider public and stakeholder input and also to provide expertise and strategic direction to the Governor. The Master Plan spans multiple policy areas requiring coordination and integration across the government to improve the delivery of programs and services that are centered on the needs of older Californians.

Knowing Our History, Listening to our Elders: 1900-2020

The Master Plan for Aging would not have been devised without the preceding decades of advocacy from aging and disability leaders across California. As part of the Master Plan, a history of aging in California chronicles the development of aging and disability services, from the early 1900s to today. This document was based on interviews with retired and long-serving leaders of California's aging network, as well as data related to the history of independent living. This acvcount is available on the Master Plan webpage.

For a list of stakeholder and public engagement activities, click here.

The Master Plan for Aging:

FIVE BOLD GOALS FOR 2030

The Master Plan for Aging presents a comprehensive approach for every Californian to help build a California for All Ages by 2030. The Plan identifies five bold goals and twenty-three innovative and flexible strategies for state and local leaders in government, business, philanthropic, and community-based organizations to collaborate. Each of these goals is in alignment with Governor Gavin Newsom's California for ALL vision.

The Master Plan for Aging for 2030 is to be considered a living document for the long-term. Just as California pivoted to ensure the safety and well-being of older adults in new and different ways during COVID-19 pandemic, the Master Plan will be nimble and responsive to shifting social and economic realities.

Beginning in 2021, the five bold goals will be powered by over 100 action-ready initiatives in the short-term that have already been adopted by state agencies for implementation, in partnership with stakeholders and the Legislature. (See page 22 for a detailed list of these proposals.) These initiatives will be continually informed by the publicly accessible, user-friendly, and routinely updated Data Dashboard for Aging, which will track the Master Plan's targets over ten years. Progress, updates, and new initiatives will be addressed in an annual report produced by the Administration.

The Master Plan for Aging's Five Bold Goals for 2030

GOAL 1: Housing for All Ages and Stages

We will live where we choose as we age in communities that are age-, disability-, and dementia-friendly and climate- and disaster-ready.

TARGET: Millions of New Housing Options to Age Well

GOAL 2: Health Reimagined

We will have access to the services we need to live at home in our communities and to optimize our health and quality of life.

TARGET: Close the Equity Gap in and Increase Life Expectancy

GOAL 3: Inclusion & Equity, Not Isolation

We will have lifelong opportunities for work, volunteering, engagement, and leadership and will be protected from isolation, discrimination, abuse, neglect, and exploitation.

TARGET: Keep Increasing Life Satisfaction as We Age

GOAL 4: Caregiving That Works

We will be prepared for and supported through the rewards and challenges of caring for aging loved ones.

TARGET: One Million High-Quality Caregiving Jobs

GOAL 5: Affording Aging

We will have economic security for as long as we live.

TARGET: Close the Equity Gap in and Increase Elder Economic Sufficiency

GOAL ONE

HOUSING FOR ALL AGES & STAGES

We will live where we choose as we age, in communities that are age-, disability-, and dementia-friendly and climate- and disaster-ready.

TARGET: Millions of New Housing Options to Age Well

Older adults, like people of all ages, need housing options that meet changing needs across the decades. Housing that allows for different household sizes, with accessible transportation options, welcoming parks and public spaces, and strong climate and disaster readiness, are foundational to well-being and continued engagement in civic, economic, and social life.

A wider range of housing models are emerging for the second half of life -- such as duplexes and accessory dwelling units to support multi-generational families and caregivers, and new models of residential communities with a range of services -- and these models can be scaled. California's most well-known housing policy for older homeowners, Proposition 13, has limited property taxes to support affordability as people age; Proposition 13 may also have discouraged moving. The recently enacted Proposition 19 may encourage more older adults to consider moving into different homes and communities for the different stages of aging. While most older Californians are homeowners, older adults who rent homes are facing rising affordability challenges. Sharp gaps in home ownership rates by race and ethnicity, due to the legacy of housing discrimination, means Latino and Black elders are more likely to be renters than White older Californians. Housing policies grounded in equity – for owners and renters, for all races and all ages, for living alone and all household sizes – can begin to remedy discrimination and advance more housing options for all.

> Housing is essential to our ability to age where and how we choose with dignity. We must ensure that all Californians have access to safe and affordable housing options that meet our needs at every stage of life.
>
> – **Lourdes Castro Ramirez**
> *CA Business, Consumer Services, and Housing Agency Secretary*

Local Model:

Age Well San Diego

Transportation choices beyond cars both help slow climate change and help adults live in homes of choice, especially after experiencing a decline in the physical mobility or the ability to safely drive. The future of transportation includes more choices for people of all ages ("multi-modal"). Some older adults and people with disabilities need specialized transportation services, such as door-to-door paratransit and escorts to physician's offices. Accessible transportation networks of buses and additional options keep people of all ages and abilities connected to services, social opportunities, and community activities.

California's climate and natural landscape offer some of the country's most beautiful parks and public lands. These spaces are integral to both mental and physical health, playing a critical role in promoting

social inclusion. While adults aged 60 and over account for 20 percent of the population, older adults only represent approximately 4 percent of total park users (although, at same time, they are the majority of State Park volunteers).[1]

California's increasing wildfires and the COVID-19 pandemic have highlighted the pressing need for community design that improves our ability to remain safe during climate and human-made disasters, while also taking measures to prevent and prepare for them. While all Californians are impacted by climate change, some populations, including older adults, are more vulnerable than others to its dangers and health consequences.[2]

California will pursue Housing for All Ages and Stages through five strategies:

More Housing Options

California communities are increasingly developing more affordable housing options to meet the needs of all stages of life for all people, regardless of age, race, income, ability, or household size. The production, protection, and preservation of affordable housing, including Accessory Dwelling Units and Residential Care Facilities of all sizes, will support older adults, caregivers, and their families.

Transportation Beyond Cars

Age- and disability-friendly transportation networks can be strengthened through improved community walkability and expansion of bus and transit stops, transit rider education and subsidies, seamless paratransit across transit district lines, and driver safety education.

Outdoor & Community Spaces for All Ages

All Californians can benefit from more convenient park access within a ten-minute walk or less, co-location of parks with community centers offering programming for all ages, and incorporation of smart park technologies.

Emergency Preparedness & Response

Preparation and planning with and for older adults and people with disabilities is especially important to prioritize, given the higher risk of death or harm due to emergencies and disasters. Improving technologies and communications that address the access and functional needs of residents during disasters can also improve preparedness and response to these growing populations.

Climate-Friendly Aging

Age-friendly communities are naturally in alignment with environmentally friendly initiatives, including low-emissions transportation systems; walkable and low vehicle-miles-traveled (VMT) neighborhoods and cities; and in-home energy-saving modifications. Community planning can factor in climate impact and safety, including disaster resiliency, in new, updated, and rebuilt housing and transportation.

For a full list of each strategies' 2021-2022 Initiatives, see the next section or visit the MPA website. To find out how we are tracking our progress, visit the Data Dashboard for Aging.

GOAL TWO

HEALTH REIMAGINED

We will have access to the care and services we need to optimize our health and quality of life and to continue to live where we choose.

TARGET: Close the Equity Gap and Increase Life Expectancy

Health is a lifelong journey. To age well, from birth to 100-plus years old, all Californians need access to both health care and healthy communities across the lifespan. Tragically, the COVID-19 pandemic is laying bare the health impacts of systemic racism over a lifetime, with disproportionate deaths by Latino, Black, and Native Hawaiian and other Pacific Islander adults who are 60 and over. More than 7,700 people in these categories died of COVID-19 in 2020. Vaccine distribution centered on equity by age and by race, among other factors, is key to California's response to the pandemic.

As we age, many adults find that the need to focus on health increases. Nearly half of all Californians will acquire one or more chronic illnesses. Nearly nine in ten older adults take at least one prescription drug, with one in four finding their costs to be unaffordable, even with insurance coverage.3 Older adults are also at particular risk for mental health issues, like depression. Access to health care at all ages is the foundation for healthy living and aging, and California leads the nation in health care coverage for older adults – most recently through the expansions of Medi-Cal and Covered California, California's health insurance exchange. Those still most at risk for not having access to comprehensive health care coverage include people with lower incomes, those living in rural areas, and those without citizenship status.

> Aging is a universal process throughout the lifespan and health shapes this experience, across physical, emotional, social, spiritual, and functional dimensions. Individuals age in the context of their multiple identities, influenced by our communities of belonging and the challenges and opportunities of our social and political world.
>
> – **Fernando Torres-Gil**
> UCLA Luskin School of Public Affairs; MPA SAC Member

Local Models:
Inland Empire Health Plan
Partners in Care Foundation

At the same time, services beyond health care are increasingly understood as essential to maintaining health and to aging well at home and in the community. For example, over half of older adults, especially women, will eventually need home care or adult day health care to assist with daily activities such as meal preparation, physical activity, and bathing. California's In-Home Supportive Services is a national leader in this model of care.

As more Californians live longer lives, more people will seek home or community care to support optimal health and to continue to live well within homes and communities of choice. Critically, these services are often unaffordable for individuals, particularly for middle income older adults covered by Medicare only, which still largely does not cover these home and community services. To provide the care needed for optimal health and choice as we age, medical services and non-medical supports

can be integrated and made accessible to people living both in home and in community. Ultimately, coordinated care between health plans and community organizations serving older adults and people with disabilities can improve lifelong health outcomes and life satisfaction.

Another byproduct of more Californians living longer is the need for more health care informed by geriatric expertise – yet only about 5 percent of providers have this training.[4] California will need a larger health care workforce that is trained in geriatrics, including Alzheimer's and all dementias, and is more representative of the diversity within California. Dementia's growing impact requires urgent focus. The Governor's Task Force on Alzheimer's Prevention, Preparedness & Path Forward, led by the state's former First Lady Maria Shriver, spotlighted the 690,000 Californians aged 65 and older living with Alzheimer's Disease, a devastating illness with physical, emotional, and financial tolls that impacts not just those individuals, but also friends, families, caregivers, communities, and health systems.

For those adults requiring full-time health care, the COVID-19 pandemic has been a stark reminder of the vulnerability of Californians living and working in skilled nursing facilities (SNFs). While only 2 percent of our state's population live in these facilities, they account for over a third of the pandemic death toll.[5] Preliminary data suggest a significant minority of long-term care residents who died of COVID-19 in 2020 had dementia. California's nursing homes can be national leaders in applying lessons learned and innovating new models of care for this most vulnerable population.

California will pursue Health Reimagined through six strategies:

Bridging Health Care with Home
Through innovative partnerships with the federal government, health plans, health systems, and community-based organizations, California can innovate and test new models of health care delivery that maximize access to services – and, as a result, avoid unnecessary institutionalization.

Health Care as We Age
California can continue to lead the nation in pursuing strategies to increase access across the spectrum of health care services, including modernizing Medicare counseling services and developing new generic drug manufacturing partnerships, to improve access and care options.

Lifelong Healthy Aging
By fostering healthy environments beginning at birth, expanding access to prevention programs, and developing culturally competent public health educational tools and services, California communities can reduce some of the greatest and most inequitable health disparities.

Geriatric Care Expansion
California is home to some of the foremost geriatric experts in the country. Expanding Geriatric Emergency Department certification and increasing geriatric training opportunities will ensure our health care system is staffed by teams including geriatricians and gerontologists, as well as nurses and social workers with geriatric training.

Dementia in Focus
California can lead the nation in both preventing cognitive impairment and improving the lives of Californians living with dementia through comprehensive and coordinated strategies on research, brain health awareness, public information portals and hotlines, standards of care for dementia, and dementia-friendly communities, among other forward-leaning recommendations from the Governor's Task Force on Alzheimer's.

Nursing Home Innovation
California can emerge from the COVID-19 pandemic with renewed commitment to innovation in quality care, including such areas as value-based payment and architectural redesign to smaller, more home-like environments.

GOAL THREE

INCLUSION & EQUITY, NOT ISOLATION

We will have lifelong opportunities for work, volunteering, community engagement, and leadership and will be protected from isolation, discrimination, abuse, neglect, and exploitation.

TARGET: Keep Increasing Life Satisfaction as We Age

Older adults have many essential roles in California's communities: workers, business owners, volunteers, community leaders, mentors, lifelong learners, neighbors, friends, family members, and more. Each of these roles can provide a vital sense of purpose at any age. A cornerstone of building a California for all ages is continuing, evolving, and creating new opportunities for meaningful engagement at 60, 70, 80, 90, and 100-plus years old.

Digital technologies are fostering new opportunities for connection and inclusion for work, play, community, culture, and commerce. However, over two million Californians do not have access to high-speed internet and approximately 34 percent of adults over 60 do not use the Internal at all.[6] The COVID-19 pandemic has brought these issues into greater focus and heightened the need for improved access to broadband, digital devices, and technology support for older adults.

Employment and volunteer opportunities, particularly those offering intergenerational engagement, can provide a powerful sense of purpose and connection. Over the past five years, Californians over the age of 55 accounted for 29 percent of all new employment.[7] Many older adults need or want to keep working – at least part time. However, two thirds of older adults seeking employment cite age discrimination as a challenge to finding work.

> Equity should be at the center of the Master Plan for Aging's implementation. Systemic racism, ageism, able-ism, and sexism can only by eliminated through intentional systemic solutions. It's time to transform our systems so that they may positively impact the lives of those most affected by historical and institutionalized discrimination and who, therefore, have disproportionately suffered during COVID-19.
>
> **– Kiran Savage-Sangwan, MPA**
> California Pan-Ethnic Health Network

Local Model:
Los Angeles' Purposeful Aging LA (PALA)

Older adults can also be a major source of volunteers. Many older adults, especially if paid work and caregiving responsibilities become lighter, choose to devote time and energy to their communities – for example serving at food banks, as tutors to young children, and as poll workers.

One of the greatest threats to full inclusion and equity for all ages is elder abuse, which is estimated to impact 10 percent of older adults living at home and to result in losses totaling in the billions of dollars annually. Elder abuse can take many forms, including physical, sexual, abandonment, isolation, financial, neglect, self-neglect, and mental suffering. Women are as much as 35 percent more likely than men to suffer from some form of it. Our growing aging population requires increased planning and coordination to prevent growing abuse.

To build a California for all ages, all stakeholders and partners agree: leadership is key. California has a long tradition of extraordinary aging leadership, stretching back decades. (see Listening to our Elders). The State now has a growing and diversifying community of leaders at all levels poised to build on this foundation for the future, bringing forward the best of proven practices and new innovations to meet the needs of people we serve. Throughout this network, older adults and people with disabilities are the true leaders and essential participants in all planning, policy, programs, and advocacy.

California will pursue inclusion and equity, and prevent isolation, through six strategies:

Inclusion and Equity in Aging

As the most racially, ethnically, and linguistically diverse state in the nation, California can lead in combatting ageism, ableism, racism, xenophobia, sexism, homophobia, and all prejudices and in expanding opportunities for all older adults and people with disabilities to be economically, civically, and socially engaged, without experiencing discrimination or bias. California's aging and disability leaders, providers, and partners are committed to becoming increasingly culturally responsive through strategies including trainings, data collection, public campaigns (including with partners in California's entertainment industry), and targeted equity and inclusion goals in workforce, service planning, and service delivery.

Opportunities to Work

Scaling flexible work and education models, including virtual options, and preventing age discrimination in the workplace, can increase the inclusion of older adults and people with disabilities and harness all of California's talent, professionalism, knowledge, and expertise.

Opportunities to Volunteer and Engage Across Generations

Volunteer programs for community priorities can intentionally and effectively recruit, support, and connect adults of all ages through volunteer centers, schools, community sites, libraries, and more.

Closing the Digital Divide

In August 2020, Governor Gavin Newson signed Executive Order N-73-20 to deploy affordable and reliable broadband throughout the state. Closing the digital divide by increasing access to the internet and digital devices will improve the ability of older adults and people with disabilities to connect to family and friends, health care providers, and to access additional support during the COVID-19 pandemic and beyond.

Protection from Abuse, Neglect & Exploitation

Through new statewide coordinated efforts focused on prevention and equity, California can strengthen prevention and responses to elder abuse, neglect, exploitation, and fraud with person-centered, data-driven, and culturally competent approaches.

California Leadership in Aging

Strategies to advance California's leadership include establishing public information, assistance, and resource connection portals and telephone networks that serve the entire state; facilitating a nation-leading aging research collaboration with California's leading universities; participating in AARP's Age-Friendly initiative; forging international agreements; and reviewing and strengthening state and local government leadership and partnership structures, including those related to the California Department of Aging and local Areas Agencies on Aging.

For a full list of each strategies' 2021-2022 Initiatives, see the next section or visit the MPA website. To find out how we are tracking our progress, visit the Data Dashboard for Aging.

GOAL FOUR

CAREGIVING THAT WORKS

We will be prepared for and supported through the rewards and challenges of caring for aging and disabled loved ones.

TARGET: One Million High-Quality Direct Care Jobs

At some point in our lives, most Californians will seek care from family, friends, or paid caregivers. Likewise, most Californians will also have the privilege and responsibility of caring for an older loved one. The COVID-19 pandemic has meant even more of us are in one or both of those roles, in more challenging circumstances. Supporting caregiving for adults, like caregiving for children, is essential for family life, the economy, and a California for all ages.

Across California, almost five million family caregivers help their parents, spouses, and friends who need assistance with everyday tasks to live well in their homes and communities. Of these, almost 1.7 million are caring for someone with Alzheimer's Disease or dementia, usually with little support or training. This constitutes about 4 billion hours of unpaid time, valued at $63 billion, each year. Women, particularly Black, Indigenous, Latino, and Asian-American women, are providing a disproportionately large share of this care – often while simultaneously caring for children. Households of color are more likely than white households to be multi-generational, which may indicate these families are more likely to be providing unpaid caregiving across the generations.[8] As rewarding as this work may be, the time needed to care for a loved one can result in financial hardship and a decrease in lifelong Social Security earnings, which can continue the cycle of poverty and debt for low-income households. The emotional and physical stress of caregiving can also lead to poor health outcomes for the family caregiver.

> Caregivers of family and friends too often have to choose between their own health and financial needs and caring for a loved one. Caregivers need culturally competent options that not only improve their own health and quality of life, but also those of the person for whom they are caring. Accessible and affordable long term services and supports, paid family leave, resources and training, and assistance navigating services will improve the lives of millions of caregiving families in California.
>
> – **Donna Benton**
> USC Leonard Davis School of Gerontology, MPA SAC Member

Local Model:
Healthcare Career Pathways – Ombudsman of Contra Costa, Solano, and Alameda

Paid caregiving is essential to older adults' ability to choose where to live. Caregivers provide direct care in many settings – in private homes, through community-based services like adult day centers, or in residential care homes, such as assisted living facilities or nursing homes. In the coming years, California will face a labor shortage up to 3.2 million paid direct care workers.[9] Direct care workers earn less than half of California's median annual income and one in four falls below the federal poverty line. Most caregiving jobs are held by women; many are immigrants, and they are twice as likely as other Californians to live in low-income households. Low wages, stress, and an elevated risk of job-related injury

reduce prospects for financial stability for those employed in the caregiving workforce.

As the population age, and the need for caregiving increases, virtual caregiving and telehealth will become more vital for empowering aging adults, people with disabilities, and caregivers to age well at home. However, recent research has shown that older adults with dementia, hearing loss, and impaired vision may have a hard time using digital devices and programs designed without their needs in mind.[10] The lessons from COVID-19's rapid pivot to telehealth, coupled with California's global leadership in the tech sector, have the potential to drive transformative advances in virtual care.

California will pursue Caregiving that Works through three strategies:

Family & Friends Caregiving Support

Family caregivers need supports – such as paid family leave, multilingual training resources, virtual care options, and respite – so that the role remains rewarding and caregivers can maintain health, well-being, and income while caring for a loved one. Given that lower-income women, particularly women of color, disproportionately provide family caregiving, resources and support should be tailored and prioritized accordingly.

Good Caregiving Jobs Creation

The caregiving workforce can be grown through caregiver training and professional development opportunities, along with livable wages, job placement support, and improved job quality. Higher wages will help paid caregivers work toward financial security, alleviate economic disparities, and better reflect the true value of their work.

Virtual Care Expansion

New technologies, many pioneered in California, are paving the way for innovations in personal devices, smart home and community design, telehealth and more, and have the potential to help support caregiving and aging well across the state, nation, and globe.

For a full list of each strategies' 2021-2022 Initiatives, see the next section or visit the MPA Website.
To find out how we are tracking our progress, visit the Data Dashboard for Aging.

GOAL FIVE

AFFORDING AGING

We will have economic security as long as we live.

TARGET: Close the Equity Gaps and Increase Elder Economic Security

Economic security is essential to living and aging well, but retirement income is being outpaced by the rising costs of housing, health, and care. Further, retirement income has traditionally relied on a combination of three sources for stability: individual savings, employer-paid pensions, and Social Security. However, individual retirement savings are lower than previous generations, and private pensions are declining. As a result, more older Americans and Californians are overly reliant on Social Security income alone and therefore more vulnerable to poverty. Women are particularly at risk because of work that did not count towards Social Security earnings (such as domestic work and unpaid family caregiving) and longer lifespans.

As a result, many middle-income Californians are experiencing downward economic mobility with age. Nearly half of all U.S. households are headed by someone aged 55 or older with no retirement savings.[11] One quarter of people over 65 rely almost entirely on their Social Security benefits, which average about $1,500 per month for retired workers and $1,250 per month for disabled workers. With California's fair market rent for a one-bedroom apartment at $1,522, many older renters are left with little or no money for food, healthcare, and other expenses. California has the second highest rate of poverty among older adults in the country, leading to high levels of hunger and increasing homelessness. Approximately 20 percent of all people 65 and over in California live in poverty; however, the portion of Black, Indigenous, and Latino older adults living in poverty is double that.[12]

> The concentration of financial assets among the wealthiest families, combined with increasing housing and health care costs, dwindling pension plans, and low savings among most households threatens the retirement security of many working Californians. CalSavers is a great start and through innovative policy options and tailored outreach, California can encourage employers and individuals to build toward a financially secure future.
>
> – **Nari Rhee, PhD**
> UC Berkeley Labor Center, MPA
> SAC Member

Local Model:

San Francisco's Project Homekey and Meals Expansion during COVID-19

A particularly alarming trend is that residents over age 50 are now the fastest growing population of homeless people in many parts of the state, with the median age of the homeless expected to rise. Black men are disproportionately represented within the population of older Californians without homes, reflecting cumulative effects of decades of inequities in housing, education, employment, and criminal justice. The harsh reality of aging without a stable home includes dire health impacts: older adults without homes experience health problems that you would typically see in people who are 20 years older , including cognitive decline and decreased mobility.[13]

California will pursue Affordable Aging through three strategies:

End Homelessness for Older Adults

California will continue to invest in innovative solutions to prevent older adult homelessness, reduce barriers to accessing housing programs and services, and promote the transition of those experiencing homelessness to affordable and accessible housing models, with supportive services.

Income Security as We Age

Challenges require multiple approaches: For income, California will pursue partnerships to assess and strengthen all three sources – individual savings, employer-based retirement, and Social Security – and to expand employment opportunities and economic security at all ages. For expenses, reducing housing and health costs (as discussed in goal one and two) will increase elder economic security.

Protection from Poverty & Hunger

The federal/State safety net for older adults and people with disabilities, Supplemental Security Income/State Supplementary Payment (SSI/SSP), has not kept up with poverty levels. A recent state budget agreement proposes to begin to address the SSP in January 2022. The hunger and nutritional needs of older Californians need greater assessment and coordination to provide affordable and culturally appropriate foods through CalFresh (SNAP), food banks, meal delivery at home, congregate meals at day centers and long-term care facilities, farmers markets, and medically tailored meals, among others.

For a full list of each strategies' 2021-2022 Initiatives, see the next section or visit the MPA website.
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IMPACT:

FROM PLANNING TO IMPLEMENTATION

California is committed to making sure this plan does not sit on a shelf, but rather is continually revisited and improved upon to drive action toward better lives for Californians of all ages over the next ten years. To do that, the State will:

Take Action: Initiatives for 2021-2022

California's Cabinet Work Group is kickstarting implementation of the Master Plan in the next two years with over 100 catalytic and pragmatic initiatives detailed in the following pages, in partnership with stakeholders and the Legislature. It will continue to meet in 2021-2022 to advise on and continually improve implementation. The Administration will issue an annual progress report, which will include recommended changes and new initiatives for future years.

Support More Local Leaders: MPA Local Playbook

California succeeds when all communities succeed. Local counties and cities are leading with plans for aging, disability, and dementia. The new MPA Local Playbook shares tools and resources from leaders everywhere to help all California communities create their own master plans for aging, disability, and dementia.

Measure Progress: Data Dashboard for Aging

California is launching a Data Dashboard for Aging to provide a transparent, comprehensive, and user-friendly information source about aging and disability trends, with a equity lens. The dashboard will also help us measure our progress as state and local communities on Master Plan goals and strategies to advance equity and well-being for all ages. This information resource will help drive decision making and be regularly updated as more data, from more sources and with more indicators, is made available.

Continue to EngAGE Public & Partners

Public opportunities for participation will continue through a range of webinars, surveys, public comment processes, and other interactive and inclusive forums:

- **Stakeholder partnerships:** A new stakeholder committee will be named in early 2021 to advise the Administration on implementation. It will be called the Implementing Master Plan for Aging in California Together (IMPACT) Committee. The IMPACT Committee will include both continuing representatives from the Master Plan Stakeholder Advisory Committee and newly engaged voices to increase the diversity of representation and to strengthen the expertise guiding the Master Plan's implementation. New advisory committees will also be created to address Long Term Services and Supports for Aging and Disability, Equity in Aging, and Elder Abuse and Justice.

- **Legislative leadership:** As a co-equal branch of government, the Legislature remains an essential leader and partner in assessing and implementing these strategies through hearings, legislation, and budget priorities, as well as continuing community roundtables.

- **Philanthropic support:** California's philanthropic leaders provided vital support for the robust planning process; potential new strategic investments for implementation are in development.

Public & Stakeholder Engagement Activities

Webinar Wednesdays*:

- Housing
- Transportation4
- Isolation & Inclusion
- Parks & Community Spaces
- Healthy Aging
- Work Opportunity
- Poverty, Hunger, Homelessness
- Emergency and Disaster Preparedness & Response
- Preventing and Responding to Abuse, Neglect, and Exploitation

*series ended early in March due to COVID-19

Virtual Town Hall: Combating Ageism & Promoting Equity in Aging

MPA Stakeholder Meetings:

- 9 Stakeholder Advisory Committee meetings
- 13 Long-Term Services & Supports Subcommittee meetings
- 6 Research Subcommittee meetings
- 4 Equity Work Group meetings

State Legislator and Local Leader Community Roundtables:

- Bakersfield
- San Diego
- Nevada County
- Mountain View
- Santa Barbara County
- Santa Clara County
- Sacramento County
- Humboldt County

MPA SAC Recommendations to the Administration:

- Executive Summary
- Full Stakeholder Report
- Long-Term Services & Supports
- Livable Communities & Purpose
- Health & Well-Being
- Economic Security, Safety, and Emergency Preparedness
- Research & Data
- Equity in Aging
- Climate Change

Governor's Task Force on Alzheimer's Prevention, Preparedness & Path Forward

- 10 Recommendations to Governor

The next step:

MPA INITIATIVES FOR 2021-2022

While the Master Plan for Aging is a ten-year Blueprint for building a California for All Ages, the ten Cabinet Agencies, in strong partnership with local leaders, the private sector, the federal government, and all stakeholders, will launch over 100 initiatives within the first two years. These initiatives will be advised by a new stakeholder group for MPA implementation. Progress will be tracked by the Data Dashboard for Aging and shared via an annual report.

GOAL ONE for 2030: Housing for All Ages and Stages

Person Centered: We will live where we choose as we age in communities that are age-, disability-, and dementia-friendly and climate- and disaster-ready.

Target: Millions of New Housing Options to Age Well

Local Model: San Diego County: Age Well San Diego

Strategy A: More Housing Options

Data Indicators: Number of subsidized housing units per 10,000 population, Number of new housing options to age well

Initiatives for 2021-2022:	Lead Agency
1. Identify ways to bolster production of more housing options to age well in all California suburban, rural, and urban communities - such as Accessory Dwelling Units that are affordable - to support aging well, caregiving, and affordable housing.	BCSHA
2. Provide tax credits and pursue other strategies to continue to prioritize the types of housing units that are not being produced by the market, especially those serving people who are Extremely Low Income (ELI), Very Low Income (VLI) and Low Income individuals (LI), and others experiencing or at risk of homelessness, including but not only older adults and people with disabilities.	BCSHA & STO
3. Further facilitate affordable housing production by using monitoring, technical assistance, and enforcement strategies of existing housing production laws.	BCSHA
4. Advance fair housing and equity by conducting outreach, education, and surveys, as well as prosecuting violations of anti-housing discrimination laws.	BCSHA

Initiatives for 2021-2022:	Lead Agency
5. Review housing planning and data indicators with Strategic Growth Council for older adult demographics and characteristics, for opportunities to update to reflect changes in aging and advance equity goals, including Statewide Housing Assessment, Regional Housing Needs Allocations and Housing Assessment, and include in Data Dashboard for Aging.	SGC & BCSHA
6. Review current housing program definitions with Strategic Growth Council for inclusion of older adults and advancement of equity, such as the Transit Oriented Housing Development Program, Multi-Family Housing Program, Accessibility and Adaptability standards, the State's Qualified Allocation Plan for Low Income Housing Tax Credit Program, and Affordable Housing and Sustainability Community Program, among others.	SGC, BCSHA & CalEPA
7. Explore increasing the Veterans Housing and Homelessness Prevention Program.	CalVet
8. Assess the feasibility of expanding the Adult Family Homes model (currently for adults with a developmental disability) to more aging adults, including with dementia.	CHHS
9. Explore opportunities to increase availability of housing options with "housing for health" strategies – for example, within the anticipated federal planning grant to develop a Medi-Cal Home and Community Based Services Roadmap, include assessments of the availability of services, providers, and residential options and within a new focus on Medicare innovation – to meet need as federally allowable funds are available.	CHHS
10. Identify innovative models and solutions to enhance technology in housing options for aging well, in alignment with State Broadband Council's new Strategy per August 2020 Exec Order, including the California Teleconnect Fund and California Advanced Services Fund, and in partnership with housing developers and UC.	GovOps, BCSHA
11. Assess need for housing modifications for aging, such as fall prevention programs, to meet growing and changing needs.	CHHS

Strategy B: Transportation Beyond Cars

Data Indicators: Percent of trips made by walking, personal vehicle, transit, and other, among older adults

Initiatives for 2021-2022:	Lead Agency
12. Promote within existing resources ways to improve community walkability for older adults and people with disabilities through the California Active Transportation Program and Complete Streets projects.	SGC, CalSTA
13. Promote within existing resources safer transportation for older adults using multiple transportation modes by implementing recommendations from the Zero Traffic Fatalities Task Force, including consideration of lower speed limits in urban, suburban, and rural areas, to meet needs as funds allow.	SGC, CalSTA

Initiatives for 2021-2022:	Lead Agency
14. Promote within existing resources free bus/transit (including using digital ID solutions to streamline access) and transit rider education, both beginning at younger ages, as well as integration of fare systems to increase access in urban, suburban and rural areas, to meet needs.	CalSTA, GovOps
15. Promote expansion of bus/transit stops that are age- and disability-friendly (e.g., locations, seating, weather) to meet needs.	CalSTA
16. Establish person-centered MOU'S between transit districts to allow paratransit to cross transit district lines to meet rider needs.	CalSTA
17. Encourage innovation in flexible transit options, for example demand response, especially but not only in rural communities.	CalSTA
18. Provide older driver safety education training, including information about transportation options other than driving, to meet needs as funds allow.	CalSTA
19. Review community walkability scores and Vehicle Miles Traveled data for opportunities to analyze with aging demographics and to include in Data Dashboard for Aging.	SGC, CalSTA

Strategy C: Outdoor & Community Spaces for All Ages

Data Indicators: Percent of adults age 60 or older who live within a half mile of a park, Percent of adults age 60 or older who live in communities with less than three acres of parks or open space per 1,000 residents

Initiatives for 2021-2022:	Lead Agency
20. Explore targeting public and private park funds to age- and disability-friendly activities for all ages, including models such as slow streets, SMART parks, parklets for emerging placemaking, and more, in all areas of state.	CNRA
21. Explore targeting new public and private park funds to communities that are more than a 10-minute walk from a park (currently 25%) so all Californians of all ages and abilities can access parks in all areas of state.	CNRA
22. Consider co-location of child care and adult care, youth centers and adult centers, and schools and adult centers, along with joint programming, such as arts.	CHHS
23. Promote Blue Zones for dementia-friendly communities, especially in cities and counties with higher proportions of racial groups with disparate rates of dementia.	CHHS

Strategy D: Emergency Preparedness

Data Indicators: Percent of adults age 60 or older who live in a hazard area

Initiatives for 2021-2022:	Lead Agency
24. Consider improvements in online emergency tools for older, disabled, and at-risk adults and caregivers, in multiple languages, to meet needs.	ODI & CHHS
25. Develop online and other tools within existing resources to coordinate mutual aid for residents by Residential Living and Nursing Home facilities during emergencies.	CHHS
26. Continue LISTOS CA "Check in" telephone calls begun during COVID-19, as well as other disaster preparedness work, with isolated and harder to reach older adults, in multiple languages, to meet needs within existing funding.	OES
27. Conduct after-action analyses of COVID-19, including the impact on older, disabled, and at-risk adults, as one way to identify strategies to prevent future pandemic, emergency, and disaster-related deaths and disparities in deaths by age, ability, income, race, language, and other equity measures.	CHHS

Strategy E: Climate Readiness

Data Indicators: Percent of all trips that are low emission trips by adults age 60 or older

Initiatives for 2021-2022:	Lead Agency
28. Gradually factor in climate impact and safety, including disaster resiliency, in new (and rebuilt) Residential Living and other age- and disability-friendly housing, by considering infill opportunities and wildland urban interface issues.	BCSHA & CDI
29. Advocate for the new federal administration to increase support for housing modifications for climate, via weatherization services reaching older adults and people with disabilities, to meet need and as funds available.	CHHS
30. Set targets and develop strategies to include older adults and people with disabilities, of all races and ethnicities, in California Climate Action Corps.	CalVols
31. Support paratransit conversion to zero emission vehicles, including new light-duty paratransit vehicles by 2035 and all other transit vehicles by 2045, within existing resources.	CalEPA & CalSTA
32. Reduce Vehicle Miles Traveled and overall climate impact by aging and disability services at state and local levels.	CHHS

GOAL TWO for 2030: Health Reimagined

Person Centered: We will have access to the care and services we need to optimize our health and quality of life and to continue to live where we choose.

Target: Close the Equity Gap in and Increase Life Expectancy

Local Models: Inland Empire Health Plan (Health Plan); Partners in Care Foundation (CBO)

Strategy A: Bridging Health Care with Home

Data Indicators: Availability of services and supports, Enrollment in Medicare plans and programs, Difficulty with Activities of Daily Living (ADLs)

Initiatives for 2021-2022:	Lead Agency
33. Advocate with the new federal Administration to create a universal Long-Term Services and Supports benefit and assess opportunities for federal/state partnership (e.g., Milliman study, Washington State model).	CHHS
34. Plan and develop innovative models to increase access to long-term services and supports for people receiving Medicare only.	CHHS
35. Plan and develop innovative models to increase access to long-term services and supports and integrated health care for people receiving both Medicare & Medi-Cal ("duals"): by implementing statewide Managed Long-Term Services and Supports (MLTSS) and Dual Eligible Special Needs Plan (D-SNP) structure, in partnership with stakeholders.	CHHS
36. Expand access to home and community-based services for people receiving Medi-Cal: via CalAIM, by implementing "In Lieu of Services" (including: Housing Transition Navigation Services, Housing Deposits, Housing Tenancy and Sustaining Services, Short-term Post Hospitalization Housing, Recuperative Care, Respite, Day Habilitation Programs, Nursing Facility Transition/ Diversion to Assisted Living Facilities of Home, Personal Care and Homemaker Services, Home Modifications, Medically Tailored Meals, Sobering Centers, and Asthma Remediation) and "Enhanced Care Management."	CHHS
37. Consider home and community alternatives to short-term nursing home stays for participants in Medi-Cal managed care through utilization of combination of the home health benefit, in lieu of services, and proposed expanded telehealth benefit, including remote patient monitoring.	CHHS
38. Explore options within existing authority and new state plan authority for community health workers to conduct isolation checks/home visits for older and other adults, to meet need and as funds available.	CHHS

Initiatives for 2021-2022:	Lead Agency
39. Explore opportunities to increase stability for IHSS beneficiaries through back-up provider systems and registries.	CHHS
40. Apply for federal funding to assess and plan for home and community-based services in all counties, with diversity of providers, via the anticipated federal planning grant to develop a Medi-Cal Home and Community Based Services Roadmap, in partnership with Stakeholder process beginning 2020.	CHHS
41. Assess need and opportunities to expand community-based aging and disability networks' "business acumen" for health partnerships.	CHHS
42. Assess need and opportunities to modernize regulatory and licensing barriers for CBAS and MSSP.	CHHS
43. Reformulate an LTSS aging and disability stakeholder group to advise on long-term services and supports for all older adults and people with disabilities, drawing on stakeholders with experience on MPA LTSS Subcommittee and Olmstead Advisory, as well as new members, with increased diversity and continued participation by older adults, people with disabilities, and care providers.	CHHS

Strategy B: Health Care as We Age

Data Indicators: Percent of adults age 60 or older who are uninsured, Percent of adults age 60 or older who have a usual place to go to when sick or in need of health advice, Percent of civilians who live in areas with primary care shortages

Initiatives for 2021-2022:	Lead Agency
44. Modernize Medicare counseling services (HICAP) to serve more beneficiaries, continually improving cultural competency and language access, within existing resources.	CHHS
45. Assess opportunities to modernize enrollment process for Medicare Savings programs.	CHHS
46. Consistent with AB 80 (2020) when the DOF projects that the budget can accommodate the associated costs over a multiyear period, prioritize for inclusion in the budget the expansion of Medi-Cal to older adults who are undocumented.	CHHS
47. Include older adult behavioral health needs and geri-expertise in Behavioral Health Task Force planning, beginning with CDA joining the Task Force.	CHHS
48. Implement new generic prescription drug manufacturing partnerships for production or distribution, making essential medications affordable and accessible to more consumers – including older adults who are more likely to have a chronic condition requiring prescriptions and people with disabilities with co-occurring health conditions requiring prescriptions.	CHHS
49. Highlight to Medi-Cal plans and providers the value of palliative care to improve patient outcomes and support patient and family choices for care.	CHHS

Initiatives for 2021-2022:	Lead Agency
50. Identify ways to promote care wishes – such as Advanced Planning Directives and Physician Orders for Life Sustaining Treatment – for all ages.	CHHS

Strategy C: Lifelong Healthy Aging

Data Indicators: Number of hospitalizations for unintentional falls per 100,000 adults age 65 or older, Number of hospitalizations for unintentional falls per 100,000 adults age 65 or older, Percent of adults age 60 or older who experienced psychological distress in the past year, Number of adults age 60 or older who died by suicide per 100,000 people

Initiatives for 2021-2022:	Lead Agency
51. Share a series of public health/public education tools, with culturally competent and equity-targeted approaches, that promote brain health and address other healthy aging priorities (e.g., physical activity, nutrition, tobacco, oral health, mental health, substance abuse, and trauma).	CHHS
52. Continue to seek federal funding for a friendship warmline for older adults to address isolation and loneliness needs, and partner with state departments who host crisis lines and access lines.	CHHS
53. Build in older adult focus to existing Suicide Prevention Programs.	CHHS

Strategy D: Geriatrics Care Expansion

Data Indicators: Percent of emergency department visits by adults age 65 or older, Number of accredited geriatric emergency departments, Percentage of 30 day all-cause Medicare hospital readmissions

Initiatives for 2021-2022:	Lead Agency
54. Diversify and align with aging demographics the pipeline of residents in clinical geriatrics, primary care, and geriatric psychiatry, including dementia care, through career incentive strategies such as workforce shortage and loan forgiveness programs.	CHHS
55. Explore including geriatric training requirements, including dementia training, as well as racial and diversity demographics, via all state health licensing boards for new and continuing licensing.	CHHS & BCSHA
56. Include geriatric training in new community paramedic initiative.	CHHS
57. Support expansion of geriatric emergency department certifications statewide.	CHHS

Initiatives for 2021-2022:	Lead Agency
58. Assess opportunities for advance practice providers trained in geriatrics to fill gaps in geriatrics and primary care.	CHHS
59. Consider opportunities for gerontologists and geriatric social workers to participate in interdisciplinary teams.	CHHS
60. Collect data on geriatric care provision to assess strengths and gaps, with equity metrics including race and disability (for example, dementia care, oral health).	CHHS
61. Continue COVID-19 ad hoc geriatrics advisory group and broaden scope and participants in 2021 to include geriatric care expansion initiatives.	CHHS

Strategy E: Dementia in Focus

Data Indicators: Percent of adults age 65 or older who talked with a health care professional about cognitive decline or memory loss, Number of dementia-related deaths per 100,000 adults age 65 or older

Initiatives for 2021-2022:	Lead Agency
62. Continue California's leadership commitment to target clinical research into Alzheimer's on gender and racial disparities.	CHHS
63. Develop plan for an equity-focused dementia-prevention public health campaign, to meet needs as funds available.	CHHS
64. Promote screening, diagnosis, and care planning by health care providers for patients and families with Alzheimer's and related dementias, through hub and spoke training model of health care providers; direct caregiver training opportunities; and consideration of how dementia standards of care could be further incorporated in Medi-Cal and Medicare managed care.	CHHS
65. Seek stakeholder feedback on models of care coordination for IHSS participants with dementia or cognitive impairment.	CHHS
66. Assess options to increase Adult Day Services, especially for people with dementia	CHHS
67. Strategically plan and lead the growing number of California's pioneering Alzheimer's and all dementia initiatives with renewed leadership and partnership for the CHHS Alzheimer's Advisory Committee beginning 2021.	CHHS

Strategy F: Nursing Home Innovation

Data Indicators: Percent of adults age 65 or older who live in a Skilled Nursing Facility (SNF), Number of SNF licensed beds per 100,000 adults age 65 or older, Number of safety deficiencies per bed in SNF

Initiatives for 2021-2022:	Lead Agency
68. Produce "COVID 2020" report on skilled nursing facilities and COVID-19, with California lessons learned and recommendations for national (CMS) policy reform.	CHHS
69. Continue to expand transparency on state data on nursing homes, including quality, staffing, financing, both in COVID-19 and ongoing.	CHHS & LWDA
70. Reengage stakeholders to revisit pilot for "small house" nursing homes.	CHHS & LWDA
71. Explore additional value-based payment methodology changes in skilled nursing, focused on care quality, job quality, equity, and health outcomes.	CHHS
72. Begin planning for growing skilled nursing and mental health needs in veterans' homes, per the Veterans Home Master Plan of Jan 2020.	CalVet
73. Begin planning for growing skilled nursing needs in custodial settings, including State Hospitals and correctional facilities, within existing resources.	CHHS & CDCR
74. Develop approach for patient representatives for residents of skilled nursing facilities without capacity, representatives, or written care wishes.	CHHS

GOAL THREE for 2030: Inclusion & Equity, Not Isolation

Person Centered: We will have lifelong opportunities for work, volunteering, community engagement, and leadership and will be protected from isolation, discrimination, abuse, neglect, and exploitation.

Target: Keep Increasing Life Satisfaction as We Age

Local Model: Los Angeles: Purposeful Aging LA

Strategy A: Inclusion & Equity in Aging

Data Indicators: Percent of adults age 60 or older who said people in their community are willing to help each other

Initiatives for 2021-2022:	Lead Agency
75. Continue to expand culturally and linguistically competent communications to older adults, people with disabilities, and families.	CHHS & GovOps
76. Utilize private partnerships and existing funds to implement anti-ageism and equity campaign ("California for All Ages") with public, employers, and entertainment industry, including equity by age, race, ethnicity, language, citizenship status, sex, gender identity, sexual orientation, family status, disability, dementia/cognitive status, and income.	CHHS & GovOps
77. Continue new "Equity in Aging" Provider Peer-to-Peer Training for aging networks.	CHHS
78. Produce report on CARES funding to Older American Act programs on impact and equity.	CHHS
79. Set and work towards diversity, equity, and inclusion goals for representation in aging and disability departments and related State boards, such as CDA, DOR, Commission on Aging, and more.	CHHS
80. Convene a stakeholder Equity in Aging Advisory group.	CHHS

Strategy B: Closing the Digital Divide

Data Indicators: Percent of older adults with Internet access at home, Number of adults age 60 or older who participate in the California Lifeline Program

Initiatives for 2021-2022:	Lead Agency
81. Execute the State Broadband Council's new Strategic Plan, including older adults and using an equity lens, per Executive Order in August 2020, within existing resources.	GovOps & CHHS

Initiatives for 2021-2022:	Lead Agency
82. Seek private donations and use existing funds to distribute personal technology devices to OAA program participants.	GovOps & CHHS
83. Develop plan to launch digital literacy support for older adults and for providers.	GovOps & CHHS

Strategy C: Opportunities to Work

Data Indicators: Percent of adults age 60 or older who are in the civilian labor force, Number of age discrimination complaints filed with State for employment investigations

Initiatives for 2021-2022:	Lead Agency
84. Consistent with the goals of the Future of Work Commission, explore ways to promote flexible work models, especially as people age, experience disability, or after retirement.	LWDA & GovOps
85. Execute State Workforce Plan's recent inclusion of older adults and CDA's employment program/Title V with local CWDBs and begin mapping job training and apprenticeship opportunities available to older adults and people with disabilities to match available jobs, through all LWDA and CHHS channels, such as Workforce Boards, CalFresh E&T, OAA Employment, Disabled Worker.	LWDA & CHHS
86. Provide assistive technology equipment and devices available to workers with disabilities, to meet need and advance equity, within existing resources.	LWDA & CHHS
87. Provide re-entry services to older adults that increase employment and engagement and address inequity, to meet need and advance equity, within existing resources.	LWDA & CDCR

Strategy D: Opportunities to Volunteer and Engage Across Generations

Data Indicators: Percent of adults age 60 or older who reported having done volunteer work or community service in the past year that they had not been paid for

Initiatives for 2021-2022:	Lead Agency
88. Engage the diversity of Californians, including older adults and people with disabilities of all races and ethnicities, in #CaliforniansForAll, AmeriCorps, and all CalVols programs.	CalVols
89. Scope opportunity for new intergenerational volunteerism partnerships in schools, with philanthropic partners.	CHHS & CDE

Initiatives for 2021-2022:	Lead Agency
90. Promote and adapt "village models" for older adult volunteerism and services, building on the strengths of California's diverse communities.	CHHS
91. Launch an elder story project, in partnership with libraries and aging services, and engage the diversity of California elders.	CHHS & California State Library
92. Assess older adults' engagement in lifelong learning at Aging services, Adult Schools, and Community Colleges, including online, continually improving cultural competency and languages.	CHHS, CDE & Community Colleges

Strategy E: Protection from Abuse, Neglect, and Exploitation

Data Indicators: Number of confirmed allegations of abuse and of self-neglect among Adult Protective Services (APS) clients age 65 or older, Percent of APS clients age 65 or older for whom a prior report was filed within the past 12 months, Number of complaints in Residential Care Facilities for the Elderly and Skilled Nursing Facilities

Initiatives for 2021-2022:	Lead Agency
93. Create a statewide California Elder Justice Council to increase coordination and develop recommendations to prevent and address elder abuse, neglect, exploitation, and fraud, including consideration of particular COVID-19 risks and of the 28 recommendations from the Elder Justice Coalition.	CHHS, BCSHA, OAG
94. Review roles of Licensing, Long Term Care Ombudsmen, and Adult Protective Services and the experiences in other states to prevent and address abuse and neglect in long-term care facilities.	CHHS
95. Assess Adult Protective Services' capacity, age of people served, and services provided, especially for complex cases, given growing and changing needs.	CHHS
96. Assess needs and capacities of local Public Guardians, Public Conservators and Public Advocates, given growing and changing needs.	CHHS
97. Assess needs and capacities of Legal Services for Older Adults, given growing and changing needs.	CHHS

Strategy F: California Leadership in Aging

Data Indicators: Number of counties with a local plan on aging

Initiatives for 2021-2022:	Lead Agency
98. Build out No Wrong Door/"One Door" statewide for public information and assistance on aging, disability, and dementia, via upgraded web portal, statewide network of local ADRCs with shared training, tools, and technology, and continually improving cultural competency and language access.	CHHS
99. Create a Governor's Office Leadership Position on Aging, Disability, and Alzheimer's.	GO
100. Begin process for California to become an AARP-Certified Age-Friendly State within existing resources.	GO & CHHS
101. Revisit California's Area Aging on Agency local leadership structures - including local area map, funding formulas, and designations - via California's Federal Older Americans Act State Plan 2021-2024, to meet growing and changing needs and continue to advance equity.	CHHS
102. Facilitate a nation-leading research partnership on aging with California's universities.	CHHS
103. Seek opportunities to include aging in development of international partnership agreements between California and other nations engaged in planning and leading around aging.	GO
104. Launch "Implementing MPA in California Together (IMPACT)" Committee to oversee implementation 2021-2022 and produce MPA annual report, with results and recommended updates, within existing resources.	CHHS
105. Consider stakeholder recommendations and opportunities to broaden into Master Plan for Aging and Disability.	GO & CHHS
106. Continually improve Data Dashboard for Aging, to advance equity – specifically, expand data collection and quality by age, race, ethnicity, language, citizenship status, sex, gender identity, sexual orientation, family status, disability, dementia/cognitive status, income.	CHHS

GOAL FOUR for 2030: Caregiving that Works

Person Centered: We will be prepared for and supported through the rewards and challenges of caring for aging and disabled loved ones.

Target: One Million High-Quality Direct Care Jobs

Local Model: Contra Costa: Healthcare Career Pathways

Strategy A: Family & Friends Caregiving Support

Data Indicators: Percent of adults who provided help in the past year to a family member or friend who has a serious or chronic illness or disability

Initiatives for 2021-2022:	Lead Agency
107. Promote current state paid family leave benefits to older Californians, people with disabilities, and family caregivers.	LWDA
108. Assess participation in state paid family leave, including recent legislation to expand equity, for equity, including LGBTQ, race, income, gender.	LWDA
109. Develop options to include family caregivers in home and community assessments.	CHHS
110. Consistent with CalAIM, expand respite care for family caregivers.	CHHS

Strategy B: Direct Care Job Creation

Data Indicators: Number of paid caregivers per 1,000 adults age 65 or older

Initiatives for 2021-2022:	Lead Agency
111. Convene a Direct Care Workforce Solutions Table to address workforce supply challenges and opportunities in skilled nursing facilities.	CHHS & LWDA
112. Consider expanding online training platforms for direct care workers – including opportunities for dementia training for IHSS family caregivers seeking a career ladder and more - to meet need as funding available.	CHHS, LWDA & Community Colleges
113. Diversify pipeline for direct care workers in home and community settings by testing and scaling emerging models (e.g., Healthcare Career Pathways; High-Road Direct Care; Universal Home Care Workers; more), to meet need as funding allows.	CHHS, LWDA, CDE & Community Colleges

Strategy C: Virtual Care Expansion

Data Indicators: Percent of Medicare primary care visits delivered via telehealth

Initiatives for 2021-2022:	Lead Agency
114. Identify innovative models and solutions to enhance telehealth access for Californians of all ages, races, and ethnicities, in alignment with State Broadband Council's new Strategy per August 2020 Exec Order, within existing resources.	CHHS & GovOps
115. Expand telehealth access to multiple Medi-Cal delivery systems, incorporating lessons from COVID-19 and including virtual communication, remote patient monitoring, provider education, beneficiary education, family caregivers, and language access considerations, within existing resources.	CHHS & GovOps
116. Consider opportunities to access personal and home technologies that promotes healthy aging, to meet need and advance health equity, as funds available.	CHHS & GovOps

GOAL FIVE for 2030: Affording Aging

Person Centered: We will have economic security as long as we live.

Target: Close the Equity Gap in and Increase Elder Economic Security

Local Model: San Francisco COVID-19 Response: Project Homekey & Meals Expansion

Strategy A: End Homelessness for Older Adults

Data Indicators: Percent of adults age 60 or older who are experiencing homelessness or at risk for homelessness

Initiatives for 2021-2022:	Lead Agency
117. Building on the success of Homekey, further develop the network of housing needed to end homelessness, prevent older and other at-risk individuals from falling into homelessness, and provide expanded supports at housing placements.	CHHS & BCSHA
118. Expand older homelessness programs, such as HomeSafe (APS) and Housing and Disability Advocacy Program (HDAP/SSI), to meet needs as funds allow.	CHHS
119. Assess IHSS plus Housing models.	CHHS

Strategy B: Income Security as We Age

Data Indicators: Percent of adults age 60 or older who have access to workplace retirement benefits

Initiatives for 2021-2022:	Lead Agency
120. In State Planning for Affordability, include aging, disabled, and caregiving populations and life course considerations.	LWDA
121. Advocate for new federal Administration to assess Social Security gaps for California's diverse workforce, including caregivers, farmworkers, and more.	LWDA
122. Assess and propose pension data indicators – such as availability and adequacy to aging and older adults – to include in Data Dashboard for Aging.	GovOps, CHHS, SCO & STO
123. Continue to promote CalSavers.	STO
124. Review CalSavers participation data for equity and consider CalSavers reforms to expand access and impact.	STO
125. Continue to promote CalABLE.	STO

Initiatives for 2021-2022:	Lead Agency
126. Review CalABLE participation data for equity and consider reforms to expand access and impact, such as expanded eligibility.	STO
127. Continue to promote the California Earned Income Tax Credit (EITC), the only EITC in nation available to people 65 and over.	CHHS
128. Review CalEITC participation data by older adults for equity and consider reforms to expand access and impact.	CHHS & FTB

Strategy C: Protection from Poverty & Hunger

Data Indicators: Percent of basic cost of living covered by SSI/SSP for older adults age 65 or older living alone or as a couple; Percent of low-income older adults age 60 or older who are food insecure and who are enrolled in CalFresh

Initiatives for 2021-2022:	Lead Agency
129. Consistent with the Budget Act of 2018, begin to bring older adult basic income (Supplemental Security Income/State Supplementary Payment and Cash Assistance Program for Immigrants) up to meet Elder Economic Index and Federal Poverty Level, to meet need as funding available.	CHHS
130. Map and identify opportunities – at federal, state, and local level - to address older Californians' needs for nutrition, with lessons learned from COVID-19 Food CBO work group, across CalFresh, Older Californians' Home and Congregate Meals, Food Banks, Senior Farmers' Market Nutrition, Adult Care Meals, Medically Tailored Meals, Residential Facility Meals, Great Plates, and more.	CHHS, CDFA, OES & CDE
131. Continue to streamline older and disabled adult enrollment, renewal, and online shopping in CalFresh, as allowable.	CHHS
132. Seek federal funds to expand the senior food box program (Commodity Supplemental Food Program) statewide.	CHHS

Lead Agency Acronyms

BCSHA	Business, Consumer Services & Housing Agency
CalEPA	CA Environmental Protection Agency
CalSTA	CA State Transportation Agency
CalVet	CA Department of Veteran Affairs
CalVols	CA Volunteers
CDCR	CA Department of Corrections & Rehabilitation
CDE	CA Department of Education
CDI	CA Department of Insurance
CDFA	CA Department of Food & Agriculture
CHHS	CA Health & Human Services Agency
CNRA	CA Natural Resources Agency
FTB	Franchise Tax Board
GO	Governor's Office
GovOps	Government Operations Agency
LWDA	Labor & Workforce Development Agency
OAG	Office of the Attorney General
ODI	Office of Digital Innovation
OES	Office of Emergency Services
SCO	State Controller's Office
SGC	Strategic Growth Council
STO	State Treasurer's Office

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LOS ANGELES COUNTY
COMMISSION ON HIV

3530 Wilshire Boulevard, Suite 1140 • Los Angeles, CA 90010 • TEL (213) 738-2816 • FAX (213) 637-4748
HIVCOMM@LACHIV.ORG • https://hiv.lacounty.gov

AGING TASK FORCE RECOMMENDATIONS
(Final 12/10/20)

Background: The Aging Task Force (ATF) was formed in February 2019 to address the broad health needs of those over 50 years living with HIV and long-term survivors. According the Health Resources and Service Administration (HRSA), the RWHAP client population is aging. Of the more than half a million clients served by RWHAP, 46.1 percent are aged 50 years and older and this continues to grow. While Ryan White clients in Los Angeles County show higher engagement and retention in care, and viral suppression rates, within the 50+ population there exists disparities by racial/ethnic, socioeconomic, geographic, and age groups stratification.

The ATF developed the following recommendations to the Commission on HIV, Division of HIV and STD Programs (DHSP) and other County and City partners to address the unique needs of this population. The term older adults refer to individuals who are age 50 and older.

**This is a living document and the recommendations will be refined as key papers such the State of California Master Plan on Aging and APLA's HIV and Aging Townhall Forums are finalized. **

Ongoing Research and Needs Assessment:

- Encourage the Division of HIV and STD Programs (DHSP) to collaborate with universities, municipalities, and other agencies that may have existing studies on PLWH over 50 to establish a better understanding of the following issues:
    - Conduct additional analysis to understand why approximately 27% of new diagnoses among persons aged 50-59 and 36% of new diagnoses among person aged 60 and older were late diagnoses (Stage 3 – AIDS) suggesting long-time infection. This may reflect a missed opportunity for earlier testing as it seems likely that persons aged 50 and older may engage in more regular health care than younger persons. (Data Source: http://www.publichealth.lacounty.gov/dhsp/Reports/HIV/2019Annual_HIV_Surveillance_Report_08202020_Final_revised_Sept2020.pdf)
    - Gather data on PLWH over 50 who are out of care or those who have dropped out of care to further understand barriers and service needs.
    - Conduct studies on the prevention and care needs of older adults.
    - Understand disparities in health outcomes within the 50+ population by key demographic data points such as race/ethnicity, gender, geographic area, sexual orientation, and socioeconomic status.

- Gather data on the impact of the aging process as PLWH over 50 reach older age brackets. Articulate distinct differences in older age groups.
- Conduct deeper analysis on mental health, depression, isolation, polypharmacy and other co-morbidities that impact the quality of life of older adults living with HIV.
- Conduct analysis of best practices on serving older adults in non-HIV settings and adapt key strategies for a comprehensive and integrated model of care the population. Examples of best practices to explore are National Association of Area Offices on Aging (https://www.n4a.org/bestpractices) and Substance Abuse and Mental Health Services Administration and Health Resources and Services Administration, Growing Older: Providing Integrated Care for an Aging Population. HHS Publication No. (SMA) 16-4982. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2016.
- Request DHSP to develop a data collection and reporting plan with a timeline on an annual report to the community.

Workforce and Community Education and Awareness:

- Educate the Commission on HIV, Department of Public Health, HIV workforce and community at large on ageism, stigma, and build a common understanding of definitions of older adults, elders, aging process and long-term survivors.
- Address ageism on the Commission on HIV and the community at large through trainings and by convening panels composed of Ryan White and prevention services clients and subject experts.
- Openly discuss and examine as part and parcel of HIV planning and implementation, the impediments to HIV prevention and care among aging populations posed by the historically embedded discrimination and bigotry institutionalized in mainstream US culture and society, as well as embedded in subcultural (ethnic, racial, social, religious, etc.) cultures and institutions that often goes unacknowledged: that is the interconnected/overlapping linkages between ageism (or what is expressed in ageism) and societal heteronormativity/homophobia (internalized and cultural), sexism, misogyny, racism, xenophobia, ableism, and all forms of discrimination and bigotry targeting "The Other."
- Educate the HIV workforce on HIV and aging, including but not limited to how to work with the non-profit sector to link seniors to health, social services, and HIV prevention and treatment services.
- Train the HIV workforce on diseases of aging, such as cardiovascular disease and osteoporosis and dementia, and equip staff with the knowledge and skills to properly assess and treat conditions that impact older adults.
- Train older adults on how to adapt to the new realities of seeking care as they progress in the age spectrum. Train the HIV workforce on how to develop and deliver classes to older adults with respect, compassion, and patience.
- Expand opportunities for employment among those over 50 who are able and willing to work.
- Provide training on the use of technology in managing and navigating their care among older adults.

- Collaborate with the AIDS Education Centers to train HIV service providers on becoming experts and specialists on caring for older adults with HIV.
- Collaborate with local resources and experts in providing implicit bias training to HIV service providers.

Expand HIV/STD Prevention and Care Services for Older Adults:

- Expand and develop service models that are tailored for the unique needs of PLWH over 50. Specifically, community members representing older adults living with HIV have identified ambulatory/outpatient medical, medical care coordination, and mental health as key services they need. Unify and coordinate care within a medical home and reduce referrals to specialty care, if appropriate.
- Integrate an annual patient medical records review by gerontologist for PLWH over 50 in the Medical Care Coordination and Ambulatory/Outpatient Medical programs. The annual medical records review should review care needs for mental health, polypharmacy, social support, mobility, and other markers of overall health and quality of life. Ensure that MCC teams monitor and assist patients affected by cognitive decline in navigating their care.
- Customize food/nutrition and physical activity and mobility services for the aging population. Remedial exercise and rehabilitation to maintain or regain muscle mass may be needed for some older adults to help them remain in care and virally suppressed.
- Enhance the payment structure for services rendered to older adults living with HIV as they may require more frequent, longer, and more intensive and individualized medical visits and routine care to maintain their overall health as they progress in the age continuum.
- Expand supportive services, such as financial assistance, as incomes become more fixed in older age. As frailty increases with age, services should be customized by specific age groups.
- Address social isolation by supporting psychosocial and peer support groups designed for older adults. Leverage the work of agencies that already provide support groups for older adults and encourage the community to join or start a support group.
- Address technological support for older adults living with HIV as medical service modalities rely more and more electronic, virtual, and telehealth formats.
- Dedicate at least 15% of prevention funds to programming specifically tailored for individuals over 50. According to the California HIV Surveillance Report, persons over 50 accounted for 15% of all new infections. A similar trend is observed for Los Angeles County with about 13-14% of new HIV diagnoses occurring among persons aged 50 and older
- Address the lack of sexual health programs and social marketing efforts geared for older adults. Social marketing and educational campaigns on PrEP and Undetectable=Untransmittable (U=U) should include messages and images with older adults.

- Integrate programming for older adults in the use of Ending the HIV Epidemic funds in Los Angeles County. Schedule annual reports from the Division of HIV and STD Programs (DHSP) on how they are addressing HIV and aging.

General Recommendations:

- Collaborate with traditional senior services or physicians, or other providers who specialize in geriatrics and leverage their skills and expertise of those outside the HIV provider world.
- Ensure access to transportation and customize transportation services to the unique needs of older adults.
- Benefits specialists should be well versed in Medicare eligibility and services to assist those individuals who are aging with HIV
- Direct DHSP to start working with agencies that serve older adults such as the Los Angeles County Workforce Development, Aging and Community Services, City of Los Angeles Department of Aging, and DPH Office of Senior Health to coordinate and leverage services.
- Ensure robust and meaningful input from older adults living with HIV in Commission deliberations on HIV, STD and other health services.