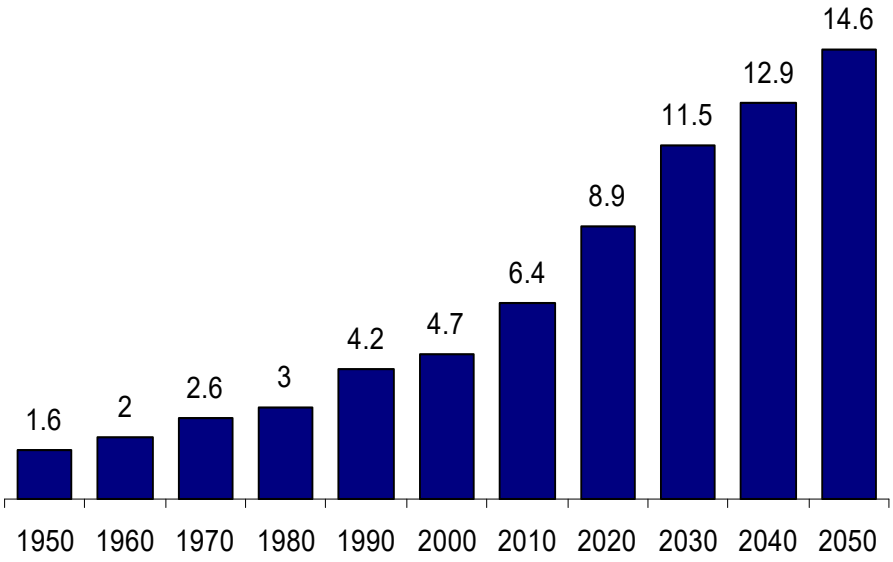
CALIFORNIA STATE PLAN ON AGING
2009 - 2013



[California Population Age 60 and Older in Millions]

Arnold Schwarzenegger, Governor
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FORWARD

The California Department of Aging has prepared the *California State Plan on Aging – 2009-2013* to promote the independence and well-being of older adults, adults with disabilities, and their families. These individuals may have a variety of needs related to their physical, mental and emotional well-being. At the same time, these individuals are resilient and have much to contribute to their communities.

By 2020, persons age 60 and older will comprise nearly 20 percent of California's total population. Increasingly diverse groups of older adults and adults with disabilities – adults who are determined to age in place and fiercely guard their independence – will require us to examine how we deliver services.

The need to provide transportation for those who are unable to drive, find caregivers to help in the home, and secure funding for services will challenge our communities. The Department and California's Area Agencies on Aging will continue to focus on developing partnerships to promote health and wellness and protect consumer rights. Empowering Californians with knowledge about available home- and community- based services remains the foundation for making informed decisions about their futures.

The Department and Area Agencies on Aging collaboratively identified key areas for accomplishment under this State Plan. These include: accessible transportation; volunteerism and community involvement; and health and wellness programs. Accordingly, the Department has developed objectives, strategies and performance measures to promote coordinated transportation systems, encourage increased volunteerism and community involvement, and advance health promotion and wellness. By closely aligning State activities to local priorities, the State Plan will maximize efforts at both levels to achieve results. The Department and Area Agencies on Aging will meet periodically during the next several years to assess progress, refine objectives, and adjust strategies.

The State Plan reflects our deep desire to make a difference in the lives of current and future generations of older adults, adults with disabilities, and their families. It will guide us as we strive to ensure that every Californian has the opportunity to enjoy wellness, longevity, and quality of life in strong, healthy communities.

Lynn Daucher
Director

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EXECUTIVE SUMMARY

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

Beyond the minimum required information, the *California State Plan on Aging-2009-2013* (State Plan) addresses: key socio-demographic factors that will shape funding needs; priorities, unmet needs and promising practices identified by the California Department of Aging (the Department or CDA) and the Area Agencies on Aging (AAA); and the Department's objectives in working with the AAAs and others to provide cost-effective, high quality services to California's older adults, adults with disabilities, and their caregivers.

California's population of persons 60 and older has grown rapidly throughout this century. Between 1950 and 2000, the number of older adults in this State grew from 1.6 million to 4.7 million, an increase of 194 percent. This trend will continue as the number of people age 60 and over grows to 14.6 million by 2050, an increase of 128 percent from 2010. By 2050, it is estimated that nearly 25 percent of Californians will be 60 or older.

While approximately 628,000 Californians are 85 or older today, by 2050 an estimated 2.9 million individuals will be in this age group, a dramatic 364 percent increase. This rapid growth has many implications for individuals, families, communities, and government.

In the late 1990s, California's White/Non-Hispanic population became a minority group for the first time since the 1849 Gold Rush. California's older population will continue to grow more racially, ethnically, and culturally diverse. While 61 percent of older adults will be White/Non-Hispanic in 2010, by 2050 the majority of older adults will comprise a variety of racial, ethnic, and cultural groups. Racial, ethnic, and cultural diversity has enriched California, fostered new innovations, and encouraged an appreciation of the State's multicultural traditions and the values and priorities we hold in common. Nonetheless, because some groups have been historically deprived of opportunities, or are now faced with the challenges of life in a new culture, diversity may translate into health and economic disparities that must be addressed.

This State Plan outlines goals, objectives and strategies that are sensitive to this environment and articulates measurable outcomes that can be achieved within the Department's existing resources. The State Plan outlines goals and strategies to increase the availability of consumer information, support intergenerational opportunities for volunteerism and civic engagement, promote health, protect consumer rights, prevent fraud and abuse, and assist

people with obtaining needed benefits. Throughout, it focuses on developing and maintaining the ongoing partnerships necessary to support the ability of the Aging Network to address local needs. By strengthening the infrastructure for home- and community-based services, the State Plan continues to build the foundation for a future in which every Californian has the opportunity to enjoy wellness, longevity, and quality of life in strong, healthy communities.

Summary of Goals and Objectives

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

A. Provide information on health and supportive services to promote independence and wellness.

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

A. Engage individuals of all ages in service to each other through intergenerational opportunities for community involvement and volunteerism.

B. Advocate for transportation systems specific to the needs of older adults, adults with disabilities, and their caregivers.

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

A. Promote wellness through public outreach and evidence-based programs.

B. Promote prevention, early intervention, and treatment of mental health and substance abuse issues.

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

A. Promote multi-disciplinary approaches to prevent, identify, and resolve abuse, neglect, and exploitation.

B. Increase consumer knowledge of Medicare plans and services through targeted community outreach, presentations, and counseling.

C. Improve the quality and quantity of legal services provided to California's older adults.

SECTION I – STATE PLAN PURPOSE AND VISION

State Plan Purpose

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

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

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

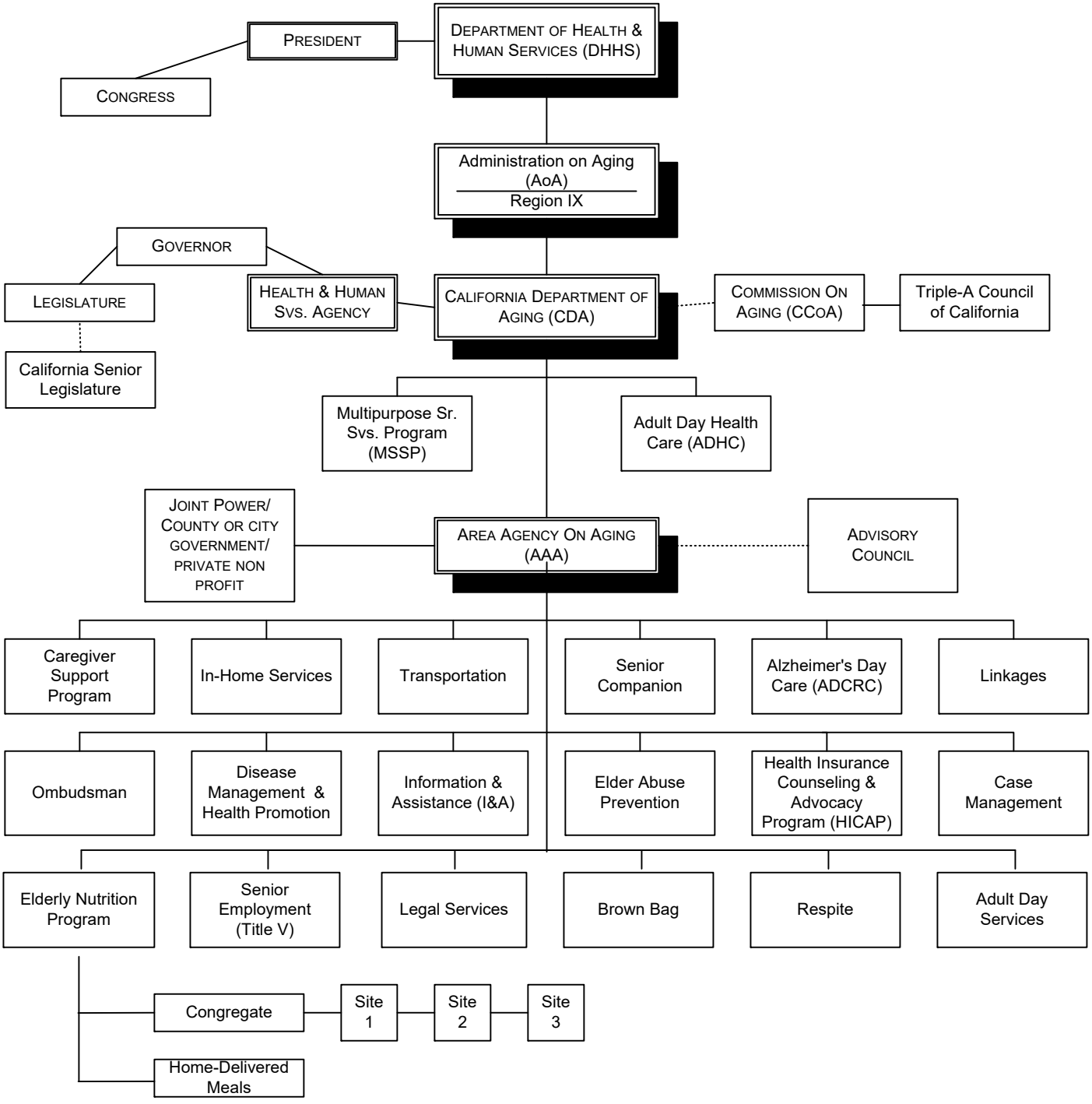
Beyond the minimum required information, California's State Plan addresses:

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

In addition to OAA programs, CDA and AAAs administer a variety of home- and community-based services authorized in the Older Californians Act (OCA), which serve older adults and one program that serves adults of all ages with disabilities (i.e. Linkages) (Figure 1). CDA also administers the Multipurpose Senior Services Program (MSSP), the Medi-Cal waiver for older adults at risk of skilled nursing placement, and certifies Adult Day Health Care (ADHC) centers for Medi-Cal reimbursement. Adult Day Health Care centers serve adults aged 18 and older with functional impairments that place them at risk of institutionalization. Medi-Cal programs are jointly funded with federal and state dollars. Medi-Cal is California's Medicaid program.

Figure 1

CALIFORNIA AGING SERVICES NETWORK



Vision, Mission and Values

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

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

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

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

SECTION II – CONTEXT

Overview of the California Aging Services Network

Local Level: AAAs

At the federal level, the OAA provides the legislative context for AAAs to carry out their systems development role. The Department contracts with 33 AAAs that are responsible for identifying unmet needs in 33 PSAs across the State, and planning, coordinating and advocating for programs and services to address them (Appendix B). Systems development is a set of activities and processes used by the AAAs and other organizations to envision, plan, manage, coordinate, integrate, evaluate, refine, and improve the quality of a community's constellation of services.

Challenges in systems development are numerous. Programs are often categorical in terms of their financing, eligibility criteria, and administrative requirements, making coordination quite challenging. Basic differences in operations and philosophy may make organizations feel threatened or challenged by collaborative efforts, and may make it difficult to create a shared "vision" of what a system of services should accomplish.

"...*without a vision or clear sense of direction, organizations are often unable to assess the impact of their efforts and some become frustrated when systems development appears to be synonymous with means, such as development of an assessment tool, rather than an ends, such as improving opportunities for frail elders to remain in the community.*"[1]

Even when local agencies conceptually have a shared vision, systems development requires a commitment of time and resources from all parties involved. Although this may be difficult when staff and funds are limited, with strong leadership times of fiscal austerity can also create the impetus for collaboration and resource sharing.

State Level: CDA

The California Legislature has explicitly charged CDA with the responsibility to develop the system of services and sanctioned interagency task forces, committees, and similar structures as vehicles for coordinating the efforts of State-level departments that serve older persons. The existence of these structures, and the expectations they create, help facilitate systems development efforts at the local level.

The OAA and the OCA make it clear that CDA is expected to play an important role in helping AAAs and their local communities to develop systems of services. As with AAAs, CDA often does not have the

administrative or budgetary authority to “require” other agencies or organizations to participate in systems development efforts. Still, by leveraging its resources through federal grants and collaborative partnerships the Department continues to strengthen the infrastructure for the home- and community-based services necessary to address local needs.

The Department administers a number of grants to support evidence-based health promotion and develop local service partnerships. As an active participant in California’s Olmstead Advisory Committee and other policy forums, CDA joins State departments, local agencies and other stakeholders to identify strategies to prevent or delay institutionalization and improve service delivery. Sections III and IV of this Plan further describe these efforts. In addition, the Department assists AAAs and communities by:

1. Working with other State departments and agencies, AAAs, and other local entities to define roles and responsibilities at both the State and local levels;
2. Providing Area Plan guidance that encourages and supports systems development;
3. Working to remove State-level barriers. CDA works with sister agencies to resolve implementation issues;
4. Developing common program standards including service unit definitions and reporting requirements;
5. Fostering the development and implementation of common intake, screening and assessment instruments;
6. Actively supporting local efforts;
7. Helping to improve access to information, resources, and services;
8. Providing training and technical assistance to individuals and organizations at the local level as needed;
9. Sharing promising practices; and
10. Refining data collection and reporting to improve the information available to decision makers in developing policies that affect older adults.

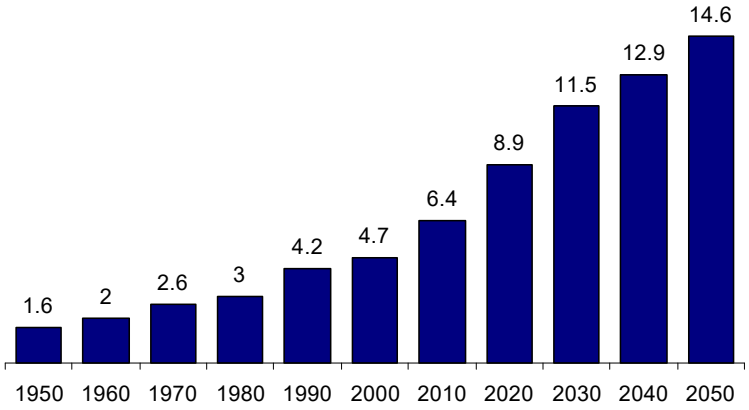
These combined efforts comprise a proactive strategy to make optimal use of limited resources during challenging times.

Aging in California

Overview

California's population age 60 and over has grown rapidly throughout this century (Figure 2). Between 1950 and 2000, the number of older adults in this State increased from 1.6 million to 4.7 million, an increase of 194 percent. This trend will continue as the cohort age 60 and over grows to 14.6 million by 2050, an increase of 130 percent from 2010.

Figure 2
California Population Age 60+ Growth Trends[2]
(in millions, rounded)

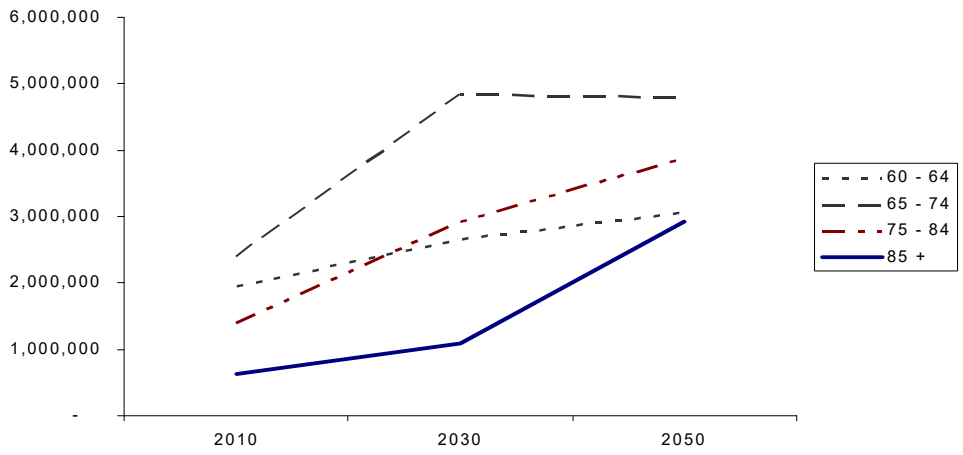


While the overall population age 60 and over is growing rapidly, increases within this age group are occurring at different rates (Appendix C). The largest growth will occur during the next 30 years as the Baby Boomers, those born between 1946 and 1964, reach age 60. Between 2006 and 2024, California's older adult population will increase by 85 percent as members of the Baby Boomer cohort reach 60. By 2050, nearly 25 percent of Californians will be age 60 and older.

An estimated 1.9 million Californians are age 60 through 64. By 2030, this age group is projected to grow to 2.6 million, a 36 percent increase.

While approximately 628,000 Californians are age 85 and over today, by 2050 an estimated 2.9 million individuals will be in this age group, a dramatic 364 percent increase (Figure 3).

Figure 3
Age 60+ Population Growth Projections[2]



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

The impact of an aging population, described by some as an "age wave" and others as an "aging tsunami," will be felt in every aspect of society. The economic, housing, transportation, health, and social support implications of this phenomenon must also be viewed in the context of the State's tremendous population growth, which continues to challenge the State's overall infrastructure planning. Demographers project that California's population, now nearly 39 million, could reach 59.5 million by 2050, given trends in birth, death, and migration rates.[2]

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

Table 1
A Snapshot of Older Californians Age 60+ (2005-2007)

Living in a nursing home [3]	3.2%
Below poverty level [4]	10.4%
Medi-Cal beneficiaries [5]	15%
Limited English proficiency [6]	21.2%
Poor or near poor (0-199% of poverty)[6]	29.5%
Living alone [4]	31.2%
Women age 60+ living alone [4]	39.1%
Percent with any disability [4]	49.7%
Proportion of Californians age 75 and older with a driver's license [7]	57%
Homeowners [6]	74.4%
With high school diploma or higher [4]	87.9%
Number of grandparents responsible for basic needs of grandchildren [6]	97,121

Geographic Location

The Los Angeles Basin and the San Francisco Bay Area are now home to about two-thirds of the State's older population; this likely will continue over the next 40 years (Appendix D). While every region, except the most rural areas of the State, is expected to experience strong growth in its population of persons age 60 and over, the largest increases are predicted for several Central Valley and Southern California counties (Appendices E and F). By 2030, the number of older people is expected to double in Kern, Kings, Merced, San Benito, San Bernardino, and Riverside counties, and will more than double in Imperial County.[2]

Race, Ethnicity and Cultural Factors

In the late 1990s, California's White/Non-Hispanic population became a minority group for the first time since the 1849 Gold Rush. California's older adults will continue to grow more racially, ethnically, and culturally diverse. While 61 percent of older adults will be White/Non-Hispanic in 2010, by 2050 the majority will be from groups formerly considered to be minorities (Appendix G).

Ethnic and cultural diversity has enriched California, fostered new innovations, and encouraged an appreciation of the State's multicultural traditions and the values and priorities we hold in common. However, because some groups have been historically deprived of opportunities, or are

now faced with the challenges of life in a new culture, diversity may translate into health and economic disparities that must be addressed.

- Older adults who are not White report poor or fair health more often than Whites/Non-Hispanics. Older Hispanics and those with limited English abilities have the worst health profiles compared to statewide averages.[8]

- While 88 percent of U.S.-born older Californians have at least 12 years of education, only about 64 percent of older immigrants have this level of education. However, it should be noted that there has been a 10 percent increase in educational attainment for U.S.-born immigrants, while that increase is 14 percent for older immigrants.[4]

- Cultural customs and expectations related to a family's care giving responsibilities can have a significant negative impact on the primary caregiver's health and future financial resources.[9]

Between 2005 and 2007, an estimated 38,000 residents age 60 and older migrated to California from other states and 27,000 migrated from abroad.[6] Approximately 1.6 million (30 percent) of California's total older adult population was foreign born. Of these, 78 percent arrived before 1990, 15 percent arrived in the 1990s, and 7 percent arrived in 2000 or later. The future size and age distribution of the California population will be influenced by both international and domestic migration, each of which is difficult to predict.[10]

While approximately 21 percent of older Californians have limited English proficiency, in Alameda, San Francisco, San Mateo, Santa Clara, Merced, San Benito, Monterey, Tulare, Los Angeles, Orange, and Imperial counties between 16 and 41 percent of older adults have difficulty communicating in English (Appendix H).

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

During the past decade, the unique issues experienced by California's lesbian, gay, bisexual, and transgender (LGBT) older adults have been increasingly recognized and addressed. Older LGBT adults are as diverse as their heterosexual counterparts. Lifelong fears or experiences of discrimination have caused some of these older adults to remain invisible, preferring to go without much-needed social, health, and mental health services. It is difficult to estimate the number of LGBT older adults in the population, but studies indicate that between 3 to 8 percent of the entire U.S.

population is LGBT.[11] Although this estimate may be low, applying this percentage to California's population of older adults suggests that there are approximately 177,000 to 473,000 older LGBT Californians. By 2030, this number is expected to nearly double.[12]

Gender and Marital Status

On average, women live 5.3 years longer than men.[13] Among Californians ages 60 to 84, 54 percent will be women. Beyond age 85, 65 percent will be women. Owing to their longer life expectancy and their tendency to marry men who are two or three years older than they are, women have a much higher probability to be widowed and to live alone in old age. Almost 57 percent of women in California are widowed, compared to 20 percent of men.[14] Women become more vulnerable as they grow older, because they are more likely than men to live alone, be (or become) poor, and have multiple chronic health conditions.

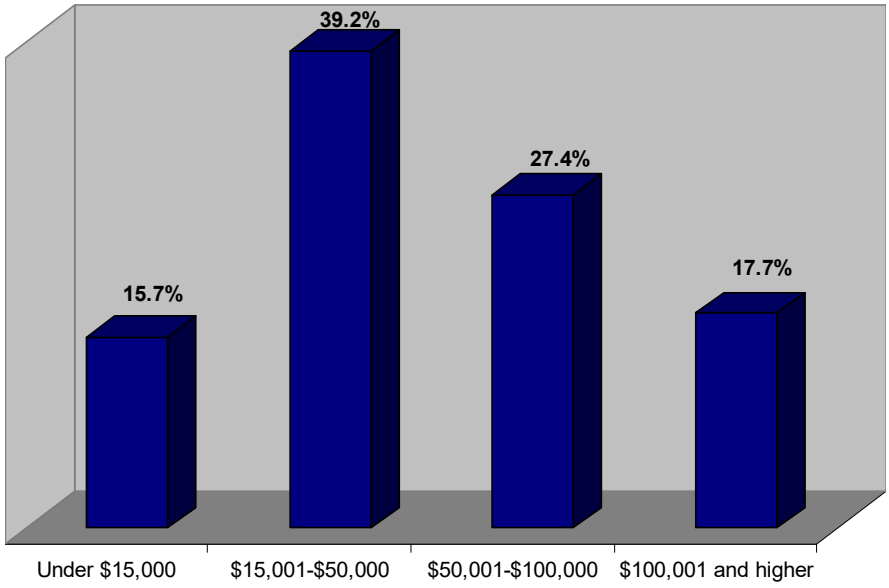
In retirement, older women are at greater economic risk than men due to income disparities. According to the 2007 California Health Interview Survey, 26 percent of men age 60 and older lived below 200 percent of the Federal Poverty Level (FPL), compared to 32 percent of older women. In 2004, for example, women age 65 and over in California had a median annual income that was 56 percent of their male peers.[14] In 2007, the average Social Security benefit for women was $896 per month compared to $1,184 per month for men.[15] Not only are women's Social Security payments less than men's, such payments are likely to be their only source of income. Economic disparities based on gender may decrease in the future as more women receive higher retirement income benefits from Social Security, pensions, and other retirement savings. However, the women most likely to have increased income in retirement will be wealthier Baby Boomers, who are likely to be white. Poorer women will likely continue to be of other races.

Income Resources

The number of older Californians at both ends of the income scale is growing, creating two very different groups: persons with annual incomes over $50,000 (45 percent) and persons with incomes below $15,000 (16 percent), with a diverse middle class in between (Figure 4). There are a number of factors affecting the income level of older Californians. Older adults in higher income brackets are predominantly white, while those with incomes under $15,000 are predominately of another race, a trend that will accelerate as Baby Boomers age. Older Californians at the middle-income level are more evenly distributed across racial and ethnic lines, although middle-income persons who are not white tend to have fewer assets and are more likely to slide into poverty than their white counterparts.

Immigrant status is also a factor. Over 50 percent of older adult immigrants are under 200 percent of the FPL, compared to 22 percent of older adults born in the U.S.[4]

Figure 4
Annual Income of Californians Age 55+ [4]



The highest proportion of older adults with income below 200 percent of the FPL is in Imperial County (61 percent), followed by several counties in Northern California and the San Joaquin Valley, where approximately 40 percent of the older population is in this income group. Eleven percent of the population age 65 and over has income below the FPL, and another 21 percent has income between 100-199 percent of the FPL.[4] Persons in this latter group have income too high to make them eligible for many public assistance programs, yet often do not have resources sufficient to meet their most basic needs.[8]

In 2009, the annual income for a single individual at 100 percent of the FPL is $10,830 and $16,245 for a single individual at 150 percent of the FPL.
In 2007, an estimated three times as many older Californians (74.8 percent) who are not White were below 100 percent of the FPL when compared to White older adults (25.2 percent). Half as many older adults who are not White (34.3 percent) were between 200-299 percent of the FPL when compared to their White counterparts (65.7 percent). Among older adults of various racial groups, 25.2 percent of Hispanics, 14.5 percent of African Americans, 14.3 percent of American Indian/Alaskan Natives, 19.4 percent of Asians, and 41.7 percent of Native Hawaiian/Pacific Islanders were below the FPL (Appendix I).

For very poor older Californians, Supplemental Security Income (SSI) can be an added source of income. SSI provides a minimum guaranteed monthly income for all qualified individuals who are age 65 and over, blind, or disabled. The State of California supplements the federal benefit substantially through the State Supplementary Payment (SSP). In 2009, the combined SSI/SSP annual benefit is $10,884 for an older individual and $18,948 for an older couple living independently. However, SSI recipients' accumulated assets must fall below certain limits, and recipients cannot earn income that exceeds their SSI benefit without reducing their monthly payment. Many poor older adults are not eligible for SSI because their assets exceed the maximum allowed. Many others do not apply for the benefit because they do not know they are eligible or do not want to receive public assistance.

Health Status

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

Between 2000 and 2005, the three leading causes of death for individuals over the age 65 were major cardiovascular diseases (40 percent of all deaths), cancer (22 percent), and stroke (7 percent). These three causes of death account for 69 percent of all deaths among older adults.[16] Falls are the leading cause of injury death, and can have significant psychological and social consequences.[16]

However, many of these leading causes of death can be prevented. Although the risk of disease and disability increases with age, poor health is not an inevitable consequence of aging. Three behaviors—smoking, poor diet, and physical inactivity—were the actual causes of almost 35 percent of U.S. deaths in 2000.[17] These behaviors are often associated with the leading chronic disease killers such as heart disease, cancer, and stroke. Adopting healthier behaviors (e.g., regular physical activity, a healthy diet, a smoke free lifestyle) and getting regular health screenings such as mammograms, (e.g., colonoscopies, cholesterol checks, bone density tests, etc.) can dramatically reduce the risk for most chronic diseases.[17]

The World Health Organization defines health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity."[18] The Centers for Disease Control and Prevention periodically publishes *The State of Aging and Health* report. This document includes a report card comparing the states on 15 key health, mental health, wellness,

and preventive service indicators. Appendix J displays the indicators and California's rank between 2004 and 2007.

Overall, California compares favorably to other states on measures related to preventive care and screenings. California ranked second in the number of older adults who had cholesterol screenings; fifth in women receiving mammograms; and thirteenth in colorectal cancer screenings. Between 2001 and 2003, California also significantly improved its ranking in cholesterol checks, moving from thirty-eighth in 2001 to second in 2003.

However, during the same period, California's performance declined in several key areas. The State's rank in the number of individuals who have had a pneumonia vaccine dropped from tenth to thirty-fifth. The State's rank for the number of older adults who experience frequent mental distress dropped from seventeenth to forty-eighth. This indicates that, when compared to other states, California has a relatively high number of older adults who have problems with stress, depression, and emotions.

The 2007 *California Health Interview Survey* examines these indicators considering various demographic factors. If California's older adult score card were analyzed by race, ethnicity and region, other trends would emerge. While 29 percent of all older Californians did not get a flu shot in the last year, 36 percent of Hispanic and 44 percent of African American elders did not receive that vaccination. While 63 percent of older adults received a pneumonia vaccination in the last five years, this represents a 5 percent decline in the vaccination rate between 2002 and 2004. Racial and ethnic disparities persist, with older White adults having the highest pneumonia vaccination rate at 68 percent. While California ranked 13th in colon cancer screenings, with approximately 68 percent of older adults being screened, that rate is significantly lower for Native Hawaiian/Pacific Islander and Asian older adults.[4]

Even though California scored just above Utah in having the lowest smoking rate among its older adults (6.3 percent), there are still variances in rates of smoking by race, ethnicity and region, with African American older adults having the highest smoking rate (9.7 percent). The Northeastern region of the State had the highest smoking rate (11 percent), while the lowest smoking rates were in the Bay Area and Southern California (6 percent). Appendix K displays how Californians from various regions reported their health status.

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

State Plan Development

This State Plan was developed with input from the AAAs and the California Commission on Aging. These organizations reviewed and provided input to the draft Plan. The Department consulted with these organizations to identify shared priorities and opportunities for collaboration in achieving these objectives during the next four years. The Department, in partnership with these organizations, conducted three public hearings on the draft State Plan. The first public hearing was conducted on May 18, 2009, in Los Angeles. The second public hearing was held on May 19, 2009, in Bakersfield. The third public hearing was held on May 22, 2009, in Sacramento. The draft plan was also posted on CDA's web site. Public input was taken into consideration in the final version of the State Plan.

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

Our Challenges and Future Priorities

During the next four years, CDA and the State's Aging Network will face a number of challenges arising from changing demographics, severe and ongoing fiscal constraints, and shifting requirements for programs and services. While California will receive economic stimulus funding through the American Recovery and Reinvestment Act of 2009 for the Elderly Nutrition Program and Title V Senior Community Service Employment Program (SCSEP), this funding is temporary and will end in 2010. The Department considers increases in State funding unlikely even though the population of older adults and adults with disabilities will continue to increase.

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

The Department believes that the State Plan sets a course which will contribute to building the infrastructure necessary to support a statewide system of home- and community-based services. The Plan includes strategies to increase the availability of consumer information, support

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

SECTION III - GOALS, OBJECTIVES, STRATEGIES, OUTCOMES, AND PERFORMANCE MEASURES

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

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

Increasingly consumers and their families are turning to the Internet for information on aging and caregiving issues. The Department is involved in two efforts to increase access to this much-needed information through its active participation on the State's California Care (CalCare) Network Advisory Group, and through its support of Aging and Disability Resource Centers (ADRC). The CalCare Network web portal is an Internet application that will enable Californians to visit a single searchable web site to find information about the full range of long-term supports available throughout the State.

In 2004, CDA received initial funding from AoA and the Centers for Medicare and Medicaid Services (CMS) to develop "one stop" community resource centers – ADRCs – in two counties to assist older adults, adults with disabilities, and family caregivers in accessing the full range of support services. In 2007, CDA received an additional one-year grant to develop two additional ADRCs. Based on lessons learned during the original three-year grant, CDA refined its model for the two new ADRCs to involve a formal regional partnership between the AAA and the Independent Living Center (ILC). The goal of these ADRCs is to become a visible, trusted source of public information and assistance in applying for needed aging and long-term supportive services. The two new ADRCs are specifically focused on assisting nursing home residents to transition into community living. Two additional ADRCs (referred to as CalADRCs) were funded through a 2006 CMS *Real Choice Systems Change* grant administered by the California Health and Human Services Agency (CHHSA). California's six ADRCs share the same core goals and objectives. However, the two CalADRCs focus specifically on helping hospital patients to successfully transition back home.

Objective I.A: Provide information on health and supportive services to promote independence and wellness.

Strategies:

1. Continue to serve on the CHHSA Olmstead Advisory Committee and pursue activities that enable individuals to stay in or return to the most integrated community setting possible.

2. Participate in the CHHSA CalCare Net web site development and expansion to enable individuals to plan for their long-term care needs and more easily access local services.

3. Maximize the capacity of CDA's web site (http://www.aging.ca.gov) to provide consumers and contractors with useful information and guidance.

GOAL I – Performance Measures

Objective	Performance Measure	Target Date
I.A.1.	Expand the four existing ADRCs into two additional PSAs.	September 2013
	Work with AAAs to increase the number of AAA I&A providers who have Alliance of Information and Referral Systems (AIRS) certification.	Ongoing
I.A.2.	Provide regular CalCare Net content updates to assist consumers in accessing needed services.	Ongoing
	Implement public outreach to increase the number of Californians who access CalCare Net by 5 percent.	Annually
I.A.3.	Redesign CDA's web site to be user-friendly with a broad array of key consumer and provider resources.	September 2011
	Achieve a 20 percent increase in the number of CDA web site visitors.	September 2013
	Increase downloads of *Taking Care of Tomorrow – A Consumer's Guide to Long-Term Care* from the CDA web site by 5 percent.	Annually

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

The Department's focus on activities to advance the development of transportation systems and opportunities for community involvement will promote the realization of strong, healthy – *livable* – communities.

"A livable community is one that has…supportive community features and services, and adequate mobility options, which together facilitate personal independence and the engagement of residents in civic and social life."[19]

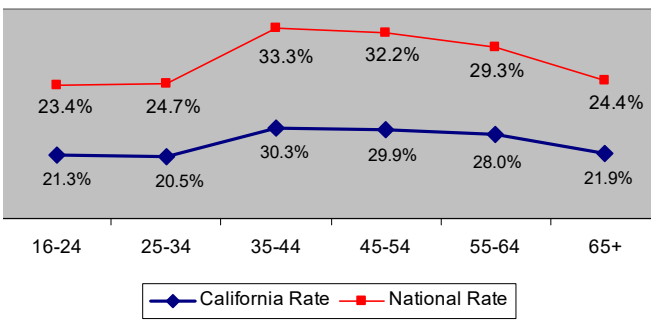
Volunteerism

The Aging Network relies heavily on volunteers to provide services and leverage resources. The Department has had a long-standing objective to recruit individuals of all ages into community involvement and volunteerism. Among the concerns CDA has highlighted over the years are: difficulty recruiting volunteers of all ages and high volunteer turnover rates. During the next four years, CDA will focus on developing effective strategies to promote volunteerism among individuals of all ages in service to older adults, adults with disabilities, and their caregivers. The Department will also pursue strategies that encourage older adults and adults with disabilities to share their skills and talents with people of all ages in their communities.

Despite having the largest number of volunteers of any other state (6.5 million), California has one of the lowest rankings in the country. California ranks below 40 other states on a number of key indicators (e.g., volunteer hours, retention rates, volunteer rates among different age groups, overall civic life engagement).[20]

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

Figure 5
Volunteerism Rates by Age Group [20]



Consistent with the national volunteer profile, the typical volunteer in California is a woman between the ages of 35-44.[21] Figure 5 demonstrates that the age group most involved in volunteering consists of 35-64 year olds, while older and younger age groups participate less in volunteer activities.

A number of factors are associated with higher volunteerism rates among individuals age 35 through 64, including larger social networks leading to greater community involvement, better health status, and higher socio-economic status. A number of demographic factors promote and inhibit volunteerism requiring strategies targeted to age group through strategies to encourage more community involvement.

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

Transportation

The absence of readily available and accessible transportation is a barrier to older adults and adults with disabilities who want to remain healthy and socially engaged in their community. Family caregivers need reliable transportation alternatives for their loved ones in order to meet their work and other responsibilities. The lack of appropriate local transportation alternatives is evident from the fact that even care coordinators who are familiar with community services routinely have difficulty finding and arranging appropriate transportation services for their clients. Local AAAs consistently identify transportation as being among the most important issues to be addressed in their communities. California's Olmstead Advisory Committee has repeatedly noted transportation's essential role in enabling individuals to live in the most integrated community setting possible.

The Department serves on the multidisciplinary Older Californians Traffic Safety (OCTS) Task Force that recently merged with a broader and more far-reaching group to implement the California *Strategic Highway Safety Plan* (CSHSP). As part of this group, CDA continues to work collaboratively on a series of recommendations to prevent traffic accidents involving older Californians and to prepare the State for the specific transportation needs of the growing senior population. One major initiative sponsored by this group is the Department of Motor Vehicles' (DMV) Three-Tiered Driver Assessment pilot program – an integrated system for assessing driving wellness and driving fitness. In addition to ensuring a high level of traffic safety, the Three-Tiered Driver Assessment system seeks to keep people driving safely.

The federal government encourages state transportation and human service departments to work together. The federal *United We Ride* initiative supports

states in developing local coordinated human service delivery systems. This initiative stems from the recognition that in the past transportation planners had no connection to those most familiar with human service needs. Consequently, the particular needs of older adults and adults with disabilities have not been fully addressed. The *New Freedom Program*, part of the *United We Ride* effort, is intended to promote access to transportation services so that seniors and persons with disabilities can remain involved in their community.

<u>Objective II.A</u>: Engage individuals of all ages in service to each other through intergenerational opportunities for community involvement and volunteerism.

Strategies

1. Coordinate with the Governor's Office of Volunteerism and other volunteer organizations to make it easier for potential volunteers to identify and register for opportunities to serve older adults and adults with disabilities.

2. Host forums to enable AAAs and other agencies to share successful best practices, including those related to intergenerational programs.

3. Implement strategies to recruit volunteers for key programs including Legal Services, Nutrition, Ombudsman, and the Health Insurance Counseling and Advocacy Program (HICAP).

<u>Objective II.B</u>: Advocate for transportation systems specific to the needs of older adults, adults with disabilities, and their caregivers.

Strategies

1. Continue to participate in the development of the *California Transportation Plan 2035* as a member of its Policy Advisory Committee.

2. Continue to provide leadership to the Mobility Action Plan Policy Advisory Committee (MAP PAC) to advance improved coordination on transportation alternatives.

3. Advance efforts to improve traffic safety for older Californians by helping to implement the *California Strategic Highway Safety Plan.*

GOAL II – Performance Measures

Objective	Performance Measure	Target Date
II.A.1.	Provide recommendations on volunteer opportunities within organizations serving seniors for incorporation into the Governor's Office of Volunteerism web site.	September 2012
II.A.2.	Conduct an "Intergenerational Programs Roundtable" that includes AAAs, interested service agencies, and organizations such as Generations United.	Annually
II.A.3.	Recruit volunteers for key aging programs using messages on State employee and retiree payment statements.	Annually
	Distribute a model "Volunteer Recruitment Toolkit" for use by AAAs, existing providers, and other interested agencies when recruiting and retaining volunteers.	September 2012
	Collaborate with the Governor's Office on Volunteerism and other volunteer and aging organizations on a statewide effort to support volunteerism in key aging programs.	Ongoing
II.B.1.	Provide recommendations for *California Transportation Plan 2035* objectives that address the transportation needs of older adults, adults with disabilities, and their caregivers.	Ongoing through September 2010
II.B.2.	Apply for a *New Freedom Program* grant to develop a strategy with local AAAs to support mobility managers to coordinate transportation services.	September 2010
	Develop a model *New Freedom Program* grant template for AAAs to use when applying for grant funds locally.	September 2011
	Coordinate with other State departments and county and city associations to assist AAAs in advancing coordinated local transportation systems.	Ongoing
II. B.3.	Evaluate the potential impact of the DMV's Three-Tiered Driver Assessment pilot program on older adults and adults with disabilities.	June 2012
	Disseminate information on the DMV's Three-Tiered Driver Assessment program to AAAs.	September 2012.
	Disseminate a model "pedestrian audit" to AAAs to support local advocacy for walkways, streets, and intersections that are inviting, easily negotiated, and safe.	September 2010

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

Evidence-Based Health Promotion

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

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

Title IIID of the OAA provides a small amount of funding for a wide range of health promotion and disease prevention activities. In 2006, CDA sought and received a three-year AoA state grant to establish an evidence-based health promotion initiative. The California Department of Public Health (CDPH) is a key partner in this initiative. This grant also became the catalyst for developing an expanding network of AAAs, aging network service providers, hospitals and health systems, and older adult community education programs involved in implementing the *Chronic Disease Self Management Program* (also known as *Healthier Living*) and *A Matter of Balance*, a fall prevention program. Approximately 3,600 older adults will have participated in one of these two evidence-based programs before this grant ends in 2009. The Department has targeted older adults who are low income or culturally and ethnically diverse for enrollment in these programs.

In 2008, CDA was awarded a three-year competitive grant from the Atlantic Philanthropies to make *Healthier Living* more broadly available throughout the State. The network of organizations involved in the AoA grant described above will continue and expand as we seek additional partners committed to this effort in new areas of the State.

Alzheimer's disease and other forms of dementia are debilitating conditions that not only impact the lives of individuals who have the disease but also the family members caring for them. Approximately 588,208 older Californians have Alzheimer's disease and an estimated 1.1 million Californians are caring

for someone with the disease. California caregivers provide 952 hours of unpaid care per year, with an approximate value of $10 billion.[22] Numerous studies have demonstrated the significant negative physical and emotional impact involved in caring for a person with mental illness or dementia. Access to Alzheimer's caregiver services has been very limited or non-existent in many ethnic communities throughout the State.

Over the past 15 years, California has pioneered efforts to increase and provide culturally competent services for individuals and families dealing with Alzheimer's disease. Many of these efforts were funded by AoA State Alzheimer's Disease Demonstration Grants. In 2007 and 2008, the Department was awarded two AoA Alzheimer's Disease evidence-based grants to support implementation of the *Savvy Caregiver,* an evidence-based program for individuals caring for people with Alzheimer's disease. The *Savvy Caregiver* has been proven to improve caregiver skills and confidence, reduce stress, and increase access to supportive services. The 2007 grant piloted the Spanish language version of *Savvy Caregiver – Cuidando con Respeto* – in Southern California. The 2008 grant will support providing *Savvy Caregiver* to ethnically and racially diverse English-speaking caregivers throughout California.

Mental Health

Mental health is inseparable from physical health and wellness. The Surgeon General in its Mental Health Report estimated that 20 percent of people over age 55 experience mental health problems that are not a part of "normal aging." An estimated 11 percent suffer from anxiety, 6.4 percent have cognitive impairments, 4.4 percent experience depression and other mood disorders, and 0.6 percent are diagnosed with schizophrenia.[23] The AoA estimates that only half of all older adults who acknowledge mental health problems are treated.[24] This is particularly true for older adults who are racially, ethnically and culturally diverse.

Untreated mental illness in older adults can cause significant disability and increase the risk of hospitalization, institutionalization, and mortality. It also can contribute to self-neglect and abuse. Untreated depression is the strongest risk factor for suicide. Older adults age 65 and older have the highest suicide rate of all age groups. Older White men are at six times greater risk for suicide than the general population. The National Institute of Mental Health indicates that older adults who commit suicide have visited their primary care physician close to the time of the suicide: 20 percent on the same day; 40 percent within one week; and 70 percent within one month of the suicide.[25] These findings underscore the urgent need to improve the identification and treatment of depression and suicide risk among older adults. Family caregivers of persons with dementia also are at high risk for depression and its serious consequences.

In 2004, California passed Proposition 63, the Mental Health Services Act (MHSA). The MHSA established an ongoing funding source to promote mental health service development that is guided by evidence-based and promising practices. The law mandates a State and local stakeholder process through which to develop and implement MHSA policies. The Department is participating in the State-level MHSA stakeholder process and engages aging service providers to participate at the county level to promote older adult mental health service development. These activities are consistent with the 2006 Amendments to the OAA which seek to promote public awareness about mental health issues in older adults and improve diagnosis and treatment in coordination with mental health service providers.

Substance Abuse

Abuse and misuse of alcohol, prescription, and other drugs, affects an estimated 20 percent of older adults. This percentage is expected to rise as the Baby Boomers age. Physiological changes in older adults can make alcohol and medications harmful at doses lower than those used by younger people; many older adults are unaware of this fact. Older adults receive 25 to 30 percent of all prescriptions and experience more than half of all reported adverse drug reactions that lead to hospitalization.[26] Thirty percent of persons over age 65 take eight or more prescription drugs daily.[27]

Substance abuse is destructive. It can negatively impact health, mental health, family and social relationships, and quality of life. It may be difficult to identify and address due to the reluctance or lack of awareness of the older adult, the caregiver or the service provider. As with mental illness, it is important that substance abuse and misuse be identified and treated by service providers with special competencies, using an integrated approach that involves both the mental health and substance abuse treatment systems. When substance abuse co-occurs with mental disorders, it increases the risk of poor health outcomes, inpatient and outpatient service use, and suicidal thoughts and attempts.[28]

<u>Objective III.A</u>: Promote wellness through public outreach and evidence-based programs.

Strategies

1. Expand California's older adult evidence-based health promotion initiatives through the use of Title IIID funds, other grants, and coordination with the Elderly Nutrition Program.

2. Expand evidence-based health promotion programs in participating counties and introduce them into non-participating counties in collaboration with CDPH, AAAs, health systems, and adult education programs.

3. Expand availability of evidence-based programs for family caregivers of people with dementia.

Objective III.B: Promote prevention, early intervention, and treatment of mental health and substance abuse issues.

Strategies

1. Participate in State-level /MHSA stakeholder activities to ensure that MHSA funding promotes the development mental health services to benefit older adults, adults with disabilities, and their caregivers.

2. Educate aging services providers and other partners about the MHSA to engage them in the MHSA stakeholder process to advocate for the development of older adult mental health programs, including specialized workforce education and training.

3. Raise awareness about substance abuse, depression, suicide, and other mental health issues experienced by older adults, adults with disabilities, and their caregivers, including the benefits of screening.

Goal III – Performance Measures

Objective	Performance Measure	Target Date
III.A.1.	Make *Healthier Living* available to 60 percent of older Californians.	May 2011
	Increase the number of older adults completing the *Matter of Balance Program* by 5 percent.	Annually
	Develop a strategy and protocol to support appropriate referrals to evidence-based programs of persons determined to be at nutritional risk.	September 2013
III.A.2.	Establish sustainable networks in five counties that include county public health departments, a physicians group, older adult education programs and other committed partners to provide evidence-based programs.	May 2011
III.A.3.	Refer 1,200 additional families to aging programs for assistance.	March 2011
	Conduct 111 *Savvy Caregiver* workshops serving 1,000 family caregivers from diverse communities.	March 2011

Objective	Performance Measure	Target Date
III.B.1.	Participate in State-level meetings and conferences relevant to MHSA policy development and implementation convened by the California Department of Mental Health (DMH), the Mental Health Services Oversight and Accountability Commission, the California Mental Health Planning Council, and the California Mental Health Directors Association.	Ongoing
	Provide comments on MHSA policies and oversight of MHSA implementation to impact older adult mental health service development.	Ongoing
III.B.2.	Convene a meeting of aging services providers and other partners to develop an effective collaborative advocacy strategy to promote older adult mental health service development, including specialized workforce education and training.	September 2010 and annually thereafter
	Disseminate updates to aging services providers about MHSA policy and implementation activities.	Ongoing
	Encourage collaboration between mental health and aging services providers.	Ongoing
III.B.3.	Promote mental health and substance abuse workshops at the following annual conferences: California Association of Area Agencies on Aging (C4A), California Mental Health Directors (CMHDA) Older Adult System of Care; California Association of Adult Day Services (CAADS), Aging Services of California, and others.	Annually
	Collaborate with the DMH to implement suicide prevention training for aging services providers and other gatekeepers to support implementation of *The California Strategic Plan for Suicide Prevention*.	September 2011
	Collaborate with DMH to implement *The California Strategic Plan on Reducing Stigma and Discrimination* and *The California Strategic Plan to Reduce Disparities.*	Ongoing
	Collaborate with the California Department of Alcohol and Drug Programs (ADP) and its Aging Constituents Committee to promote the prevention, early intervention, and treatment of substance abuse.	Ongoing
	Disseminate the "Get Connected" Toolkit developed by the Substance Abuse Mental Health Services Administration (SAMHSA) to mental health and aging services providers to promote	September 2010

Objective	Performance Measure	Target Date
	education about alcohol and medication misuse, and mental health issues in older adults.	
	Inform aging services providers about mental health and substance abuse education/training opportunities.	Ongoing
	Explore funding opportunities to promote the education and training of aging services providers on substance abuse, depression, suicide, and other mental health issues.	Ongoing

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

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

Legal Services

California's 37 Title III legal services providers (LSP) deliver legal services to Californians 60 years of age or older. Legal services providers advocate for and represent older clients in civil cases, particularly those involving elder abuse and neglect, financial exploitation, consumer fraud, landlord-tenant relationships, nursing home residents' rights, and conflicts over benefit programs such as Medicare, Medicaid, Social Security and pensions. Legal services providers also help with simple estate planning, living wills, and powers of attorney, legal research, and education on a wide variety of legal issues. They coordinate with State-designated long-term care (LTC) ombudsmen and provide direct legal assistance and representation, both to residents of long-term care facilities, and to local LTC ombudsman programs. Legal services seek to increase the availability of low-cost legal assistance through improved coordination and planning among CDA, AAAs, LSPs – including legal hotlines – and other members of the Aging Network.

Long-Term Care Ombudsman Program

Title VII of the OAA authorizes vulnerable elder rights protection activities. The Office of the State Long-Term Care Ombudsman (OSLTCO), through its designated local programs, works to improve the quality of life of residents in skilled nursing facilities and residential care facilities for the elderly by acting as their independent advocate. Local ombudsman staff and volunteers investigate and resolve complaints on behalf of residents. They visit residents of LTC facilities, monitor conditions, identify concerns, advocate for needed change, and provide education regarding LTC issues.

Data from the National Ombudsman Reporting System indicate that in 2008 reports of suspected abuse, neglect, and exploitation comprised approximately 14 percent of all complaints investigated by the California LTC Ombudsman Program. At the national level, these reports comprised approximately 6.5 percent of all complaints.[29]

The OSLTCO is one of many California agencies that may investigate reports of abuse and neglect. Local law enforcement, local ombudsman programs

and Adult Protective Services all have jurisdiction to investigate elder and dependent adult abuse. In addition, the State licensing agencies – CDPH and the Department of Social Services (CDSS) – respectively investigate alleged abuse complaints in skilled nursing facilities and residential care facilities for the elderly. The Department of Justice's Bureau of Medi-Cal Fraud and Elder Abuse (BMFEA) also conducts investigations of abuse in LTC facilities.

The resulting multiple investigations often are not coordinated. This can contribute to frustration on the part of the investigating agencies and, more important, to the actual victims of abuse and neglect. Different agencies may interview these individuals more than once about the same complaint. Better coordination among all agencies is needed to improve the system and reduce multiple, redundant investigations.

HICAP

The State Health Insurance Assistance Program (SHIP), known as HICAP in California, serves the needs of Medicare-eligible beneficiaries through counseling, advocacy, outreach and education about the Medicare Program. In 2007, California had 4,365,487 Medicare beneficiaries, of whom 3,740,839 (86 percent) were aged and 624,621 (14 percent) were people with disabilities.[30] In California, instances of financial fraud and abuse against Medicare beneficiaries largely go unreported. National statistics indicate that financial abuse against Medicare beneficiaries is only reported 4 percent of the time.[31] To coordinate State and federal efforts at curbing fraud and abuse, the State HICAP Office oversees the training of 26 local HICAPs that report cases, provide assistance, and serve as a conduit between reporting agencies, such as the Senior Medicare Patrol (SMP), the California Department of Insurance (CDI), the CMS Medicare Prescription Drug Integrity Contractor (MEDIC), and local law enforcement.

As a result of increased training on Medicare financial fraud and abuse and more stringent reporting requirements, reported fraud and abuse cases increased 188 percent over the past year (466 cases n 2007 to 876 cases in 2008).[32] In addition to strengthening its efforts to prevent, identify, and report Medicare financial fraud and abuse, the Department is expanding its activities to encourage eligible Medicare beneficiaries to apply for Medicare Savings Plans (MSP) and the Low Income Subsidy (LIS). These programs enable low income Medicare beneficiaries to secure affordable Medicare coverage. The State HICAP will collaborate with California AAAs, local HICAPs and ADRCs to implement a statewide enrollment campaign to reach low income beneficiaries, beneficiaries from ethnically and racially diverse populations, and those living in rural areas.

Objective IV.A: Promote multi-disciplinary approaches to prevent, identify, and resolve abuse, neglect, and exploitation.

Strategies

1. Improve coordination and cross-reporting among local ombudsman programs, law enforcement, district attorneys and other entities to resolve and potentially prosecute elder and dependent adult abuse.

2. Increase reporting of financial fraud and abuse against Medicare beneficiaries through improved communication with SMP, CDI, and MEDIC and education and training of HICAP managers, staff, and volunteers.

Objective IV.B: Increase consumer knowledge of Medicare plans and services through targeted community outreach, presentations, and counseling.

Strategy

1. Strengthen outreach to Medicare beneficiaries in rural areas and those potentially eligible for LIS or MSP.

Objective IV.C: Improve the quality and quantity of legal services provided to California's older adults.

Strategies

1. Establish standards for the selection and ongoing evaluation of legal services providers.

2. Implement a strategy to recruit emeritus attorneys as volunteers for local Legal Services Programs, in coordination with the California State Bar.

3. Increase the availability of low-cost legal assistance through improved coordination and planning among CDA, AAAs, and LSPs including legal hotlines and other members of the Aging Network.

Goal IV – Performance Measures

Objective	Performance Measure	Target Date
IV.A.1.	Develop boilerplate memoranda of understanding (MOU) that local ombudsman programs can use to improve communication and coordination with local law enforcement agencies.	June 2010

Objective	Performance Measure	Target Date
	Include local ombudsman participation in the renegotiation of MOUs with the Department of Justice – Bureau of Medi-Cal Fraud and Elder Abuse, CDPH, and CDSS.	June 2011
IV. A.2.	Train HICAP managers on detecting and reporting Medicare fraud and abuse.	Annually
	Revise the *HICAP Administrative Manual* to incorporate updated reporting protocols and processes.	January 2010
IV.B.1.	Increase Medicare Part D enrollment and assistance by 20 percent.	June 2010
	Increase LIS applications by 20 percent.	June 2011
	Increase MSP enrollment by 20 percent.	June 2011
IV.C.1.	Collaborate with AAAs to develop a model Request for Proposals (RFP) that AAAs can use when procuring legal services providers.	September 2011
	Collaborate with AAAs to develop cost-effective methods to periodically monitor and evaluate legal services providers.	September 2012
IV.C.2.	Recruit legal services volunteers using messages on State employee and retiree payment statements.	Ongoing
	Distribute a model "Volunteer Recruitment Toolkit" for use by AAAs and other interested agencies when recruiting and retaining legal services volunteers.	September 2012
IV.C.3.	Partner with the Senior Legal Hotline to secure an AoA grant for a *Model Approaches to Statewide Legal Assistance Systems* project.	October 2009
	Establish an on-going advisory body to develop strategies to enhance local legal services for older adults.	October 2010
	Create an information clearinghouse for materials useful to consumers, legal services providers, and advocates that includes educational materials, legal manuals, best practice guides, and searchable resource directories.	October 2011

SECTION IV – FOCUS AREAS

Title III/VI Coordination

Local AAAs conduct a range of Nutrition Program activities focused on coordinating Title III and Title VI services. These activities include preparing, storing, and delivering meals, establishing congregate meal sites, and providing technical assistance and food safety training to Native American program staff. In addition, AAAs provide nutrition education to Native American participants. Coordination activities also include distribution of farmers market coupons to Native American elders, information and assistance outreach to tribal communities, and referrals to community–based programs, including AoA's *Matter of Balance* evidence-based program. One AAA has trained Native Americans as coaches to offer ongoing *Matter of Balance* classes at a local Native American health center.

These activities, while broad, involve a relatively small number of AAAs. Coordination is key to maximizing the resources available to serve Native American elders. During this State Plan period, CDA will work with AAAs and state tribal organizations to identify opportunities and strategies to improve coordination between Titles III and VI.

Through CDA's Medicare Improvement Participants and Providers Act (MIPPA) grant, the Statewide Steering Committee will establish new partnerships to increase the enrollment of Native American Medicare beneficiaries in Part D, LIS and MSP.

Title VII Vulnerable Elder Rights Protection Activities

Through the OSLTCO, the CDA operates a statewide program that fulfills the functions and responsibilities specified in the OAA.

The OSLTCO contracts with the AAAs for local ombudsman program services. The State Ombudsman certifies representatives of the OSLTCO. There are approximately 110 paid and 850 volunteer ombudsman representatives. The OSLTCO is working closely with CMS, CDPH, the Medicare Quality Improvement Organization, National Citizens Coalition for Nursing Home Reform, the National Consumer Voice for Quality Long-Term Care, the California HealthCare Foundation, the California Association of Health Facilities, Aging Services of California, and others to bring resident directed care to nursing homes. Through participation in the Advancing Excellence in America's Nursing Home Campaign, the OSLTCO is educating nursing home staff, residents, and families on the importance of minimizing the use of physical restraints. The Department is providing training to Title III B legal services providers and ombudsman representatives on the detection, assessment, and investigation of elder abuse.

Disaster Preparedness

State Level Coordination

The Department is actively involved in representing the needs of older adults, adults with disabilities, and family caregivers in the State's emergency planning and response efforts. The Department serves on the CHHSA Disaster Council, which involves all State health and social service departments. The Department is fully involved in the Council's two major priorities:

- Establishing guidelines for effective State interagency communications to be followed during disaster alerts and actual events, including a template for reporting status updates to CHHSA and the California Emergency Management Agency (CalEMA); and

- Recruiting and training individuals with aging and disability expertise to serve on local or state teams that would assist in addressing the needs of these groups in American Red Cross managed mass shelters.

Evidence of CalEMA's increased awareness of the unique needs of older adults and persons with disabilities has been demonstrated through the following:

- The Department has been asked to serve at the CalEMA State Operations Center during three disasters, which had never occurred before;

- CalEMA has appointed a Special Advisor to the Secretary in the Office of Access and Functional Needs specifically focused on the needs of older adults and persons with disabilities.

During the last State Plan cycle, the Department developed plans to support continued operations during times of disaster. The Department also regularly convenes an ongoing Emergency Preparedness Workgroup that includes a cross-section of CDA's program and administrative staff.

Coordination with AAAs

The Department has developed the *AAA Disaster Assistance Handbook*. The Handbook outlines regulatory requirements, and the roles CDA, AAAs, and their providers play before, during, and following disasters. It also includes a template to assist AAAs in developing a customized disaster plan, communication protocols and other resources. Both before and during disaster situations, California AAAs are required to coordinate with each county Office of Emergency Services (OES) within their PSA. CDA also

disseminates consumer information through the Aging Network to assist with personal disaster preparedness and safety.

Faith-Based Initiatives

California's evidence-based health promotion programs are currently being implemented in partnership with a number of faith-based organizations. One major partner is Catholic Healthcare West (CHW). During this State Plan cycle, CDA will continue to collaborate with CHW and its hospitals in Northern and Southern California to expand its implementation of *Healthier Living*. One CHW hospital recently funded two non-profit organizations to provide *Healthier Living* to diverse ethnic populations in San Francisco. The Department also plans to continue working with other faith-based organizations such as Jewish Family Services, which is sponsoring *Healthier Living* and *Matter of Balance* at senior housing sites, senior centers, and other locations in Southern California. In addition, *Healthier Living* and *Matter of Balance* classes are being offered by a variety of agencies at churches and similar faith-based venues in Northern and Southern California.

At the local level, AAAs coordinate with faith-based organizations to identify and recruit volunteers for a number of home- and community-based programs. In addition, AAAs coordinate with faith-based organizations to host community meetings and conduct outreach. During this State Plan cycle, CDA will continue to reach out to faith-based organizations to encourage their involvement in local volunteerism and civic engagement activities.

Health Care System Coordination

The Department works with a variety of State and local agencies to promote health care system coordination. The Department participates with other State departments, local agencies, and other stakeholders in California's Olmstead Advisory Committee to identify cost-effective strategies to prevent or delay institutionalization. As a member of DMH's Interagency Partners Meeting, CDA's MHSA-funded Geriatric Mental Health Specialist meets regularly with other State agencies that receive MHSA funding to review activities, share strategies, and identify opportunities for cross-system coordination and collaboration. The Department works in partnership with DHCS to administer the MSSP Medicaid 1915(c) home- and community-based services waiver to provide care management services to community-dwelling frail adults aged 65 and older who are at risk of skilled nursing placement. The Department meets regularly with representatives from other CHHSA departments to discuss and implement strategies for more efficient and effective coordination on Medi-Cal fraud and abuse prevention activities. In addition, during this State Plan period CDA will collaborate with California's Alzheimer's Disease and Related Disorders Advisory Committee on developing California's Alzheimer's Disease Strategic Plan.

The Department is coordinating with State departments and other stakeholders to implement ADRCs and evidence-based health promotion programs. The Department worked in close collaboration with the CHHSA, and the Department of Rehabilitation, CDPH, and DHCS to identify and select the two new ADRCs established in 2008. To inform implementation of its evidence-based health promotion activities, CDA coordinates with its statewide steering committee comprising representatives from AAAs, CDPH's injury prevention and chronic disease self-management initiatives, health care and hospital systems, health professional and consumer representatives, educators, and local non-profit organizations.

Recently enacted hospital discharge planning requirements enable more consumers to access supportive services through their local AAAs. Senate Bill 633 (Alquist, Chapter 472, Statutes of 2007), requires hospitals to provide every patient who is anticipated to be in need of LTC at the time of discharge with contact information for the local AAA, independent living center or other required information. Subsequent to this legislation being signed into law, CDA provided guidance to AAAs recommending that they include the 1-800-510-2020 Senior Information Line and the 1-800-677-1116 Elder Care Locator telephone numbers in all outreach materials provided to hospitals, patients, and caregivers. During this State Plan cycle, CDA will continue to work with AAAs and other stakeholders to support coordination between hospital discharge planning and AAA I&A.

LGBT Seniors

"*Recent studies have shown that lifelong experiences of marginalization place LGBT seniors at high risk for isolation, poverty, homelessness, and premature institutionalization. Moreover, many LGBT seniors are members of multiple underrepresented groups, and as a result, are doubly marginalized. Due to these factors, many LGBT seniors avoid accessing elder programs and services, even when their health, safety, and security depend on it.*

LGBT seniors often lack social and family support networks available to non-LGBT seniors. They may face particular health risks, as disease prevention strategies often ignore LGBT seniors..."[33]

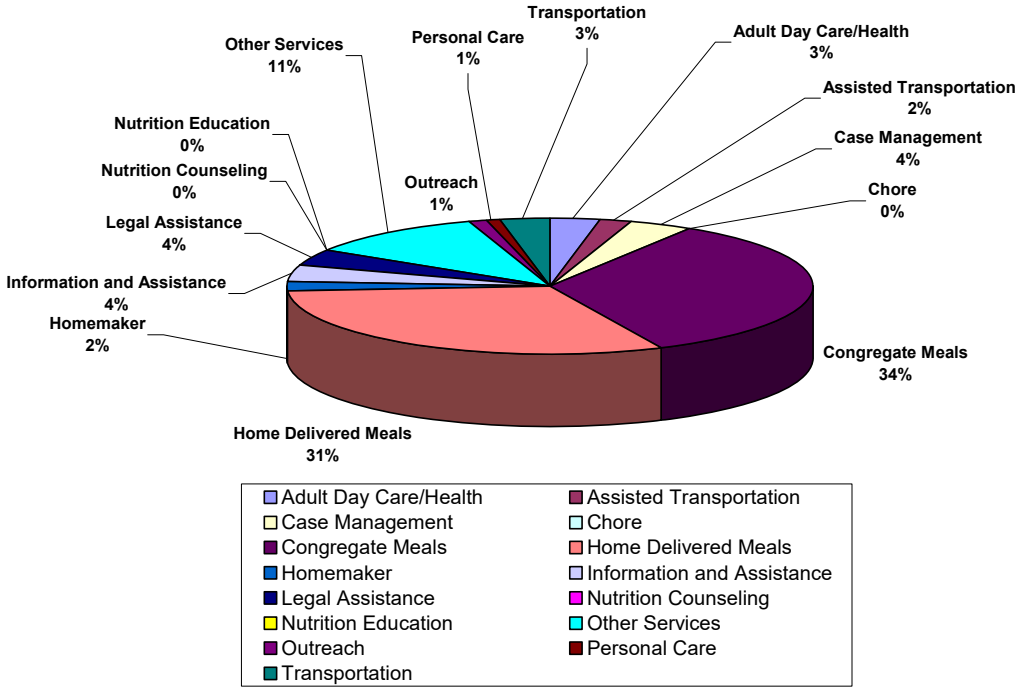
In 2007, California legislation was enacted that requires "each area agency on aging include the needs of lesbian, gay, bisexual, and transgender seniors in their needs assessment and area plans."[34] This law also requires CDA to provide technical assistance to AAAs to ensure that LGBT seniors are included in AAA needs assessment and planning processes. The Department now includes on its web site links to surveys, reports, and other LGBT resources.

In 2008 and 2009, CDA partnered with C4A to provide sessions on LGBT concerns at its annual conference. Both before and during disaster situations, California AAAs are required to coordinate with each county Office of Emergency Services (OES) within their PSA. During the next Area Plan cycle, AAAs will conduct needs assessment surveys to determine if LGBT seniors are using the resources and services provided by the AAA and identify which services are most important to LGBT seniors. The Department currently is providing input regarding the stigma and discrimination experienced by older adults – including LGBT seniors – with mental health needs in the development of *The California Strategic Plan for Stigma and Discrimination Reduction*.

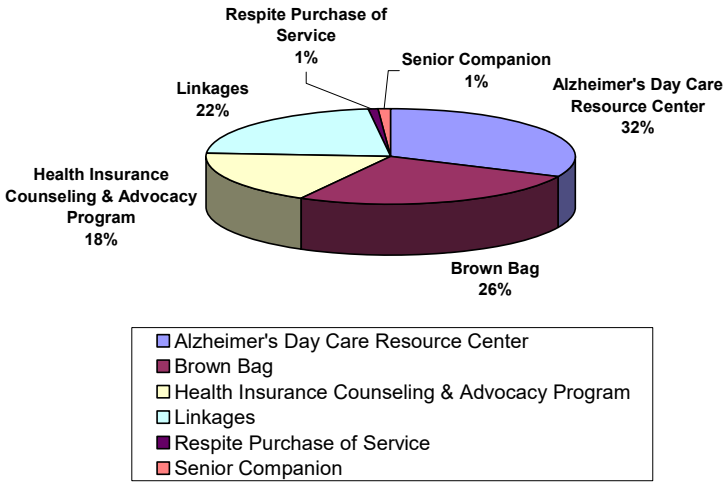
American Recovery and Reinvestment Act of 2009

On February 17, 2009, President Obama signed into law the American Recovery and Reinvestment Act of 2009 (ARRA). The ARRA is intended to preserve and create jobs, promote the nation's economic recovery, and assist those most impacted by the recession. The Department received $9,827,504 in ARRA funds for the Elderly Nutrition Program and $2,035,078 for the Title V SCSEP. The ARRA Elderly Nutrition Program funds must be completely spent by September 30, 2010, and used to provide meals and restore local nutrition services and related jobs that may have been eliminated. The ARRA SCSEP funds must be completely spent by June 30, 2010, and used to increase the number of local SCSEP participants assigned to subsidized community employment, particularly in growth industries (e.g., health care, child care, education, and "green" jobs).

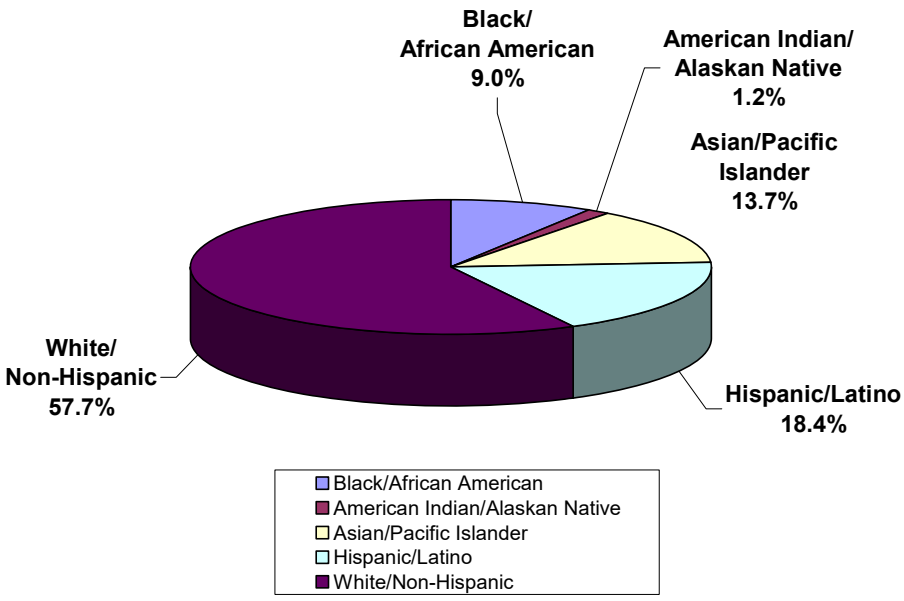
2007-2008
Older Americans Act
Title III Services by Total Expenditures [35]



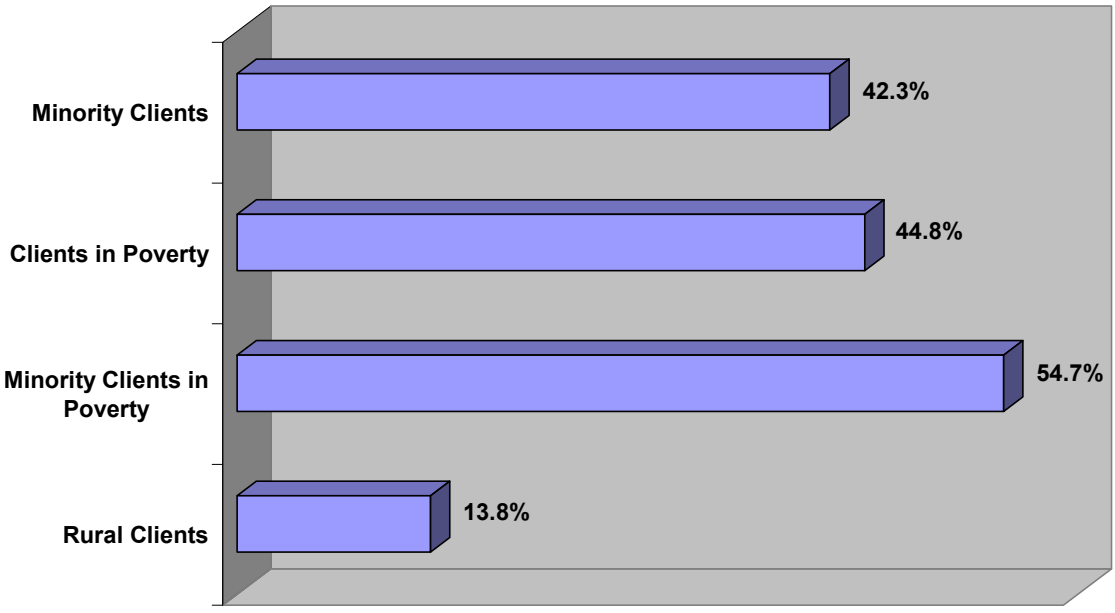
2007-2008
Older Californians Act
Community-Based Services by Total Expenditures [36]



2008 State Program Report
Registered Clients by Minority Status[35]



2008 State Program Report
Registered Clients by Targeting Status[35]



Approved Minimum Title IIIB Expenditures For Priority Services: Access, In-Home Services, and Legal Services[37] FY 2008/09

PSA #	Access	In-Home	Legal
1	25.0%	9.0%	16.0%
2	30.0%	4.0%	12.0%
3	20.0%	10.0%	10.0%
4	25.0%	20.0%	8.0%
5	20.0%	10.0%	5.0%
6	48.6%	6.6%	44.8%
7	50.0%	8.0%	11.0%
8	17.3%	54.0%	16.1%
9	27.0%	19.0%	10.0%
10	48.0%	8.0%	15.0%
11	8.4.0%	71.4%	15.4%
12	32.0%	8.0%	2.0%
13	27.5%	1.0%	15.0%
14	40.0%	8.0%	2.0%
15	40.0 %	1.0%	11.0 %
16	20.0%	22.0%	12.0%
17	7.0%	20.0%	5.0%
18	20.0%	20.2%	7.0%
19	30.0%	25.0%	5.0%
20	57.0%	10.0%	10.0%
21	25.9%	6.0%	3.5%
22	48.0%	11.0%	12.0%
23	47.1%	26.2%	7.2%
24	25.0%	10.0%	15.0%
25	60.62%	15.8%	5.2%
26	59.0%	15.0%	26.0%
27	20.0%	10.0%	12.0%
28	31.8%	10.5%	12.8%
29	18.0%	1.3%	30.0%
30	33.04%	20.4%	22.02%
31	20.0%	1.0%	40.0%
32	27.0%	3.0%	24.0%
33	34.0%	28.0%	20.0%

Revised 3/5/2009

CALIFORNIA DEPARTMENT OF AGING
INTRASTATE FUNDING FORMULA (IFF)

DESCRIPTIVE STATEMENT OF FORMULA

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

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

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

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

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

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

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

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

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

NUMERICAL STATEMENT OF THE FORMULA

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

1. The process begins by identifying:
   a. Total Federal and State matching funds available for allocation to Planning and Service Areas (PSAs) for each Title III and VII program. (Total in Demonstration Column O)
   b. Population data, updated no more than annually as information is available, by county and arraying these data by PSA. (Population Data Columns A-F on Demonstration)
2. The Statewide total amount for the administration allocation is calculated by taking ten percent (10%) of the Federal funds. (The Total in Demonstration Total Column G)

3. The Statewide total amount for the program allocation is calculated by subtracting the administration allocation from the total for State and federal funds. (The Total in Demonstration Column M and N)
4. Administrative funds are allocated as follows:
    a. Each PSA receives a fifty thousand dollar ($50,000) base.
    b. The balance of total administrative funds identified in 2. above is allocated to PSAs based on each PSA's proportion of California's total persons aged 60 and older.
    c. Each PSA's total administration allocation is distributed among its qualifying Title III programs based on total qualifying administrative funds available.
5. Program funds are allocated based on weighted population figures. Weighted population totals are determined for each PSA by combining the following factors:
    a. The number of non-minority persons aged 60 and older in each PSA is multiplied by a weight of 1.0 (Demonstration Column H).
    b. The number of minority persons aged 60 and older in each PSA is multiplied by a weight of 2.0 (Demonstration Column I).
    c. The number of low-income persons aged 60 and older in each PSA is multiplied by a weight of 2.0 (Demonstration Column J).
    d. The number of geographically isolated persons aged 60 and older in each PSA is multiplied by a weight of 1.5 (Demonstration Column K).
    e. The number of Medi-Cal eligible persons aged 60 and older in each PSA is multiplied by a weight of 1.0 (Demonstration Column L) for Title IIID only).
6. The total weighted population for each PSA is converted into a proportion of the total weighted population for all PSAs.
7. Each PSA's program allotments are determined in the following manner:
    a. For Title IIIB, C-1, and C-2 programs,
        i. Total State and federal program funds available are distributed to each PSA by multiplying each PSA's proportion or total weighted population by total statewide program allocation for Title III B, C and E.
        ii. Each PSA's program allotment is compared to its 1979 allotment level. If a PSA is under its 1979 level, it receives an allotment equal to its 1979 level in lieu of the computed allotment in 7.a.1.
        iii. The statewide program allocation is reduced by the total amount allocated to those PSAs receiving allotments equal to their 1979 level. The remaining statewide program allocation is then distributed to the remaining PSAs according to the formula to determine their adjusted total Title III B, C-1 and C-2 program allotments.

iv. Total program funds for each PSA are then distributed to each Title III program as follows:
    1. Federal funds are distributed based on the proportion of funds received by the Department of the latest Notice of Grant Award from the Federal Government.
    2. State funds are distributed based upon the statewide totals included in the most recent Budget Act, or Budget bill if allocations impact the next budget year, or other relevant legislation.

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

CALIFORNIA DEPARTMENT OF AGING
POPULATION DATA AND DEMONSTRATION OF AN ALLOCATION

	Population Data (Number of Persons) b/							Demonstration of IFF Allocation									
									Weighted Population = Weight x Number of Persons								
a/ PSA	Pop 60 +	c/ 60+ Non-Min.	d/ 60+ Minority	e/ 60+ Low Income	f/ 60+ Geo. Isolation	g/ 60+ Medi-Cal Eligibles	a/ PSA	Area Admin Allocation	1.0 Non-Min	2.0 Minority	2.0 Low Income	1.5 Geo. Isolation	1.0 Med-Cal Eligibles	Title IIIB, C, E Weighted Total	Title IIID Weighted Total	Total Federal Allocation	a/ PSA
Col>	A	B	C	D	E	F		G	H	I	J	K	L	M	N	O	
1	30,703	27,062	3,641	4,015	8,305	3,638	1	$93,995	27,062	7,282	8,030	12,458	3,638	54,832	58,470	$495,554	1
2	66,401	59,960	6,441	7,500	25,015	7,434	2	145,148	59,960	12,882	15,000	37,523	7,434	125,365	132,799	1,132,852	2
3	74,132	65,217	8,915	9,150	21,420	9,433	3	156,226	65,217	17,830	18,300	32,130	9,433	133,477	142,910	1,206,435	3
4	383,869	283,112	100,757	31,945	31,205	22,894	4	600,058	283,112	201,514	63,890	46,808	22,894	595,324	618,218	5,377,385	4
5	61,265	53,918	7,347	2,830	2,140	2,936	5	137,789	53,918	14,694	5,660	3,210	2,936	77,482	80,418	699,865	5
6	156,434	64,404	92,030	24,690	0	41,917	6	274,159	64,404	184,060	49,380	0	41,917	297,844	339,761	2,695,830	6
7	195,531	138,359	57,172	12,275	2,670	17,796	7	330,183	138,359	114,344	24,550	4,005	17,796	281,258	299,054	2,541,780	7
8	135,165	79,069	56,096	8,305	1,460	14,551	8	243,682	79,069	112,192	16,610	2,190	14,551	210,061	224,612	1,898,587	8
9	252,053	130,096	121,957	24,530	1,235	41,500	9	411,175	130,096	243,914	49,060	1,853	41,500	424,923	466,423	3,842,740	9
10	303,204	175,459	127,745	20,370	3,320	48,730	10	484,471	175,459	255,490	40,740	4,980	48,730	476,669	525,399	4,311,094	10
11	101,399	61,078	40,321	12,615	9,970	17,172	11	195,298	61,078	80,642	25,230	14,955	17,172	181,905	199,077	1,644,930	11
12	49,104	45,106	3,998	3,805	24,980	2,583	12	120,363	45,106	7,996	7,610	37,470	2,583	98,182	100,765	886,634	12
13	48,667	36,032	12,635	4,350	6,090	5,356	13	119,736	36,032	25,270	8,700	9,135	5,356	79,137	84,493	715,238	13
14	155,194	93,953	61,241	20,310	24,920	30,464	14	272,382	93,953	122,482	40,620	37,380	30,464	294,435	324,899	2,662,998	14
15	76,760	47,614	29,146	10,670	12,715	15,998	15	159,992	47,614	58,292	21,340	19,073	15,998	146,319	162,317	1,323,523	15
16	7,493	6,344	1,149	740	3,025	550	16	60,737	6,344	2,298	1,480	4,538	550	14,660	15,210	338,893	16
17	133,873	107,789	26,084	11,485	12,500	10,826	17	241,831	107,789	52,168	22,970	18,750	10,826	201,677	212,503	1,822,243	17
18	141,487	103,011	38,476	9,840	3,180	14,475	18	252,741	103,011	76,952	19,680	4,770	14,475	204,413	218,888	1,847,596	18
19	985,720	450,927	534,792	111,270	9,140	221,100	19	1,462,469	450,927	1,069,585	222,540	13,710	221,100	1,756,762	1,977,862	15,896,013	19
20	272,775	158,669	114,106	28,955	18,930	40,380	20	440,868	158,669	228,212	57,910	28,395	40,380	473,186	513,566	4,278,152	20
21	308,181	212,298	95,883	32,580	21,670	37,672	21	491,602	212,298	191,766	65,160	32,505	37,672	501,729	539,401	4,535,287	21
22	498,678	334,453	164,225	36,445	550	63,228	22	764,571	334,453	328,450	72,890	825	63,228	736,618	799,846	6,659,950	22
23	495,897	353,136	142,761	44,540	18,845	60,202	23	760,586	353,136	285,522	89,080	28,268	60,202	756,006	816,208	6,834,392	23
24	26,143	7,535	18,608	4,600	4,405	9,488	24	87,461	7,535	37,216	9,200	6,608	9,488	60,559	70,047	548,300	24
25	630,214	288,298	341,917	95,125	1,150	141,934	25	953,054	288,298	683,833	190,250	1,725	141,934	1,164,106	1,306,040	10,532,554	25
26	39,429	34,623	4,806	4,535	13,565	4,661	26	106,499	34,623	9,612	9,070	20,348	4,661	73,653	78,314	665,613	26
27	92,343	78,758	13,585	7,310	12,145	7,161	27	182,321	78,758	27,170	14,620	18,218	7,161	138,766	145,927	1,253,758	27
28	98,236	64,964	33,272	6,720	7,370	9,793	28	190,765	64,964	66,544	13,440	11,055	9,793	156,003	165,796	1,409,813	28
29	39,158	35,714	3,444	2,255	10,895	1,980	29	106,111	35,714	6,888	4,510	16,343	1,980	63,455	65,435	573,083	29
30	78,605	55,279	23,326	9,075	6,595	13,672	30	162,636	55,279	46,652	18,150	9,893	13,672	129,974	143,646	1,175,578	30
31	33,212	20,096	13,116	4,760	5,305	7,071	31	97,591	20,096	26,232	9,520	7,958	7,071	63,806	70,877	577,168	31
32	67,467	42,529	24,938	5,655	7,475	7,620	32	146,676	42,529	49,876	11,310	11,213	7,620	114,928	122,548	1,038,683	32
33	104,732	69,819	34,913	15,210	13,840	18,180	33	200,074	69,819	69,826	30,420	20,760	18,180	190,825	209,005	1,725,622	33
	6,143,524	3,784,681	2,358,843	628,460	346,030	952,395		$10,453,250	3,784,681	4,717,686	1,256,920	519,045	952,395	10,278,332	11,230,727	$93,148,143	

Notes for Population Data and Demonstration of Allocation

a. Planning and Service Areas (PSAs) by County: 1 (Del Norte, Humboldt); 2 (Lassen, Modoc, Shasta, Siskiyou, Trinity); 3 (Butte, Colusa, Glenn, Plumas, Tehama); 4 (Nevada, Placer, Sacramento, Sierra, Sutter, Yolo, Yuba); 5 (Marin); 6 (San Francisco); 7 (Contra Costa); 8 (San Mateo); 9 (Alameda); 10 (Santa Clara); 11 (San Joaquin); 12 (Alpine, Amador, Calaveras, Mariposa, Tuolumne); 13 (San Benito, Santa Cruz); 14 (Fresno, Madera); 15 (Kings, Tulare); 16 (Inyo, Mono); 17 (San Luis Obispo, Santa Barbara); 18 (Ventura); 19 (Los Angeles County minus Los Angeles City); 20 (San Bernardino); 21 (Riverside); 22 (Orange); 23 (San Diego); 24 (Imperial); 25 (Los Angeles City); 26 (Lake, Mendocino); 27 (Sonoma); 29 (El Dorado); 30 (Stanislaus); 31 (Merced); 32 (Monterey); 33 (Kern).
b. Source of data: 2000 Census updated by Department of Finance projection were available and Department of Health Services statistics for Medi-Cal eligibles.
c. Non-Minority: Persons aged 60 and older who are Caucasian not of Hispanic origin.
d. Minority: Persons aged 60 and older who are not Caucasian, or who are Caucasian of Hispanic origin.
e. Low-Income: Persons aged 60 and older at or below 125 percent of poverty.
f. Geographical Isolation (Rural): Population not classified as “urban” by the U.S. Bureau of the Census constitutes “rural” population. The U.S. Bureau of the Census defines "urban" for the 1990 census as comprising all territory, population, and housing units in urbanized areas and in places of 2,500 or more persons outside urbanized areas. More specifically, "urban" consists of territory, persons, and housing units in
    a. Places of 2,500 or more persons incorporated as cities, and towns, but excluding the rural portions of "extended cities."
    b. Census designated places of 2,500 or more persons.
    c. Other territory, incorporated or unincorporated, included in urbanized areas.
g. Medi-Cal Eligibles: Persons aged 60 and older who are Medi-Cal eligible. (DHS Medi-Cal statistics averaged for the year.)

ASSURANCES REQUIRED BY THE OLDER AMERICANS ACT

AS AMENDED IN 2006

By signing this document, the authorized official commits the California Department of Aging to performing all listed assurances and required activities.

ASSURANCES

Sec. 305(a) – (c), ORGANIZATION

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

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

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

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

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

(c)(5) In the case of a State specified in subsection (b)(5), the State agency and area agencies shall provide assurance, determined adequate by the State agency, that the area agency on aging will have the ability to develop

an area plan and to carry out, directly or through contractual or other arrangements, a program in accordance with the plan within the planning and service area.

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

Sec. 306(A), AREA PLANS

(2) Each area agency on aging shall provide assurances that an adequate proportion, as required under section 307(a)(2), of the amount allotted for part B to the planning and service area will be expended for the delivery of each of the following categories of services-
(A) services associated with access to services (transportation, health services **(**including mental health services**)**, outreach, information and assistance (which may include information and assistance to consumers on availability of services under part B and how to receive benefits under and participate in publicly supported programs for which the consumer may be eligible), and case management services);
(B) in-home services, including supportive services for families of older individuals who are victims of Alzheimer's disease and related disorders with neurological and organic brain dysfunction; and
(C) legal assistance;
and assurances that the area agency on aging will report annually to the State agency in detail the amount of funds expended for each such category during the fiscal year most recently concluded.

(4)(A)(i)(I) provide assurances that the area agency on aging will—
(aa) set specific objectives, consistent with State policy, for providing services to older individuals with greatest economic need, older individuals with greatest social need, and older individuals at risk for institutional placement;
(bb) include specific objectives for providing services to low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas; and
(II) include proposed methods to achieve the objectives described in items (aa) and (bb) of subclause (I);
(ii) provide assurances that the area agency on aging will include in each agreement made with a provider of any service under this title, a requirement that such provider will—
(I) specify how the provider intends to satisfy the service needs of low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in the area served by the provider;

(II) to the maximum extent feasible, provide services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in accordance with their need for such services; and
(III) meet specific objectives established by the area agency on aging, for providing services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas within the planning and service area; and
(4)(A)(iii) With respect to the fiscal year preceding the fiscal year for which such plan is prepared, each area agency on aging shall--
(I) identify the number of low-income minority older individuals and older individuals residing in rural areas in the planning and service area;
(II) describe the methods used to satisfy the service needs of such minority older individuals; and
(III) provide information on the extent to which the area agency on aging met the objectives described in clause (a)(4)(A)(i).

(4)(B)(i) Each area agency on aging shall provide assurances that the area agency on aging will use outreach efforts that will identify individuals eligible for assistance under this Act, with special emphasis on--
(I) older individuals residing in rural areas;
(II) older individuals with greatest economic need (with particular attention to low-income minority individuals and older individuals residing in rural areas);
(III) older individuals with greatest social need (with particular attention to low-income minority individuals and older individuals residing in rural areas);
(IV) older individuals with severe disabilities;
(V) older individuals with limited English proficiency;
(VI) older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and
(VII) older individuals at risk for institutional placement; and
(4)(C) Each area agency on agency shall provide assurance that the area agency on aging will ensure that each activity undertaken by the agency, including planning, advocacy, and systems development, will include a focus on the needs of low-income minority older individuals and older individuals residing in rural areas.

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

(6)(F) Each area agency will:

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

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

(11) Each area agency on aging shall provide information and assurances concerning services to older individuals who are Native Americans (referred to in this paragraph as "older Native Americans"), including-
(A) information concerning whether there is a significant population of older Native Americans in the planning and service area and if so, an assurance that the area agency on aging will pursue activities, including outreach, to increase access of those older Native Americans to programs and benefits provided under this title;
(B) an assurance that the area agency on aging will, to the maximum extent practicable, coordinate the services the agency provides under this title with services provided under title VI; and
(C) an assurance that the area agency on aging will make services under the area plan available, to the same extent as such services are available to older individuals within the planning and service area, to older Native Americans.

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

(13)(B) Each area agency on aging shall provide assurances that the area agency on aging will disclose to the Assistant Secretary and the State agency--
(i) the identity of each nongovernmental entity with which such agency has a contract or commercial relationship relating to providing any service to older individuals; and
(ii) the nature of such contract or such relationship.

(13)(C) Each area agency on aging shall provide assurances that the area agency will demonstrate that a loss or diminution in the quantity or quality of the services provided, or to be provided, under this title by such agency has

not resulted and will not result from such non-governmental contracts or such commercial relationships.

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

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

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

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

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

Sec. 307, STATE PLANS

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

(7)(B) The plan shall provide
assurances that--
(i) no individual (appointed or otherwise) involved in the designation of the State agency or an area agency on aging, or in the designation of the head of any subdivision of the State agency or of an area agency on aging, is subject to a conflict of interest prohibited under this Act;
(ii) no officer, employee, or other representative of the State agency or an area agency on aging is subject to a conflict of interest prohibited under this Act; and

(iii) mechanisms are in place to identify and remove conflicts of interest prohibited under this Act.

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

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

(11)(A) The plan shall provide assurances that area agencies on aging will--
(i) enter into contracts with providers of legal assistance which can demonstrate the experience or capacity to deliver legal assistance;
(ii) include in any such contract provisions to assure that any recipient of funds under division (A) will be subject to specific restrictions and regulations promulgated under the Legal Services Corporation Act (other than restrictions and regulations governing eligibility for legal assistance under such Act and governing membership of local governing boards) as determined appropriate by the Assistant Secretary; and
(iii) attempt to involve the private bar in legal assistance activities authorized under this title, including groups within the private bar furnishing services to older individuals on a pro bono and reduced fee basis.

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

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

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

(12) The plan shall provide, whenever the State desires to provide for a fiscal year for services for the prevention of abuse of older individuals, the plan contains assurances that any area agency on aging carrying out such services will conduct a program consistent with relevant State law and coordinated with existing State adult protective service activities for--
(A) public education to identify and prevent abuse of older individuals;
(B) receipt of reports of abuse of older individuals;
(C) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance where appropriate and consented to by the parties to be referred; and
(D) referral of complaints to law enforcement or public protective service agencies where appropriate.

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

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

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

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

(15) The plan shall provide assurances that, if a substantial number of the older individuals residing in any planning and service area in the State are of limited English-speaking ability, then the State will require the area agency on aging for each such planning and service area—
(A) to utilize in the delivery of outreach services under section 306(a)(2)(A), the services of workers who are fluent in the language spoken by a predominant number of such older individuals who are of limited English-speaking ability; and
(B) to designate an individual employed by the area agency on aging, or available to such area agency on aging on a full-time basis, whose responsibilities will include--

(i) taking such action as may be appropriate to assure that counseling assistance is made available to such older individuals who are of limited English-speaking ability in order to assist such older individuals in participating in programs and receiving assistance under this Act; and
(ii) providing guidance to individuals engaged in the delivery of supportive services under the area plan involved to enable such individuals to be aware of cultural sensitivities and to take into account effectively linguistic and cultural differences.

(16) The plan shall provide assurances that the State agency will require outreach efforts that will—
(A) identify individuals eligible for assistance under this Act, with special emphasis on—
(i) older individuals residing in rural areas;
(ii) older individuals with greatest economic need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas;
(iii) older individuals with greatest social need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas;
(iv) older individuals with severe disabilities;
(v) older individuals with limited English-speaking ability; and
(vi) older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and
(B) inform the older individuals referred to in clauses (i) through (vi) of subparagraph (A), and the caretakers of such individuals, of the availability of such assistance.

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

(18) The plan shall provide assurances that area agencies on aging will conduct efforts to facilitate the coordination of community-based, long-term care services, pursuant to section 306(a)(7), for older individuals who--
(A) reside at home and are at risk of institutionalization because of limitations on their ability to function independently;

(B) are patients in hospitals and are at risk of prolonged institutionalization; or
(C) are patients in long-term care facilities, but who can return to their homes if community-based services are provided to them.

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

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

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

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

(23) The plan shall provide assurances that demonstrable efforts will be made--
(A) to coordinate services provided under this Act with other State services that benefit older individuals; and
(B) to provide multigenerational activities, such as opportunities for older individuals to serve as mentors or advisers in child care, youth day care, educational assistance, at-risk youth intervention, juvenile delinquency treatment, and family support programs.

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

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

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

contract or commercial relationship that is not carried out to implement this title.

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

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

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

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

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

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

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

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

(5) The State plan shall provide an assurance that the State will place no restrictions, other than the requirements referred to in clauses (i) through

(iv) of section 712(a)(5)(C), on the eligibility of entities for designation as local Ombudsman entities under section 712(a)(5).

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

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

(i) public education to identify and prevent elder abuse;

(ii) receipt of reports of elder abuse;

(iii) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance if appropriate and if the individuals to be referred consent; and

(iv) referral of complaints to law enforcement or public protective service agencies if appropriate;

(B) the State will not permit involuntary or coerced participation in the program of services described in subparagraph (A) by alleged victims, abusers, or their households; and

(C) all information gathered in the course of receiving reports and making referrals shall remain confidential except--

(i) if all parties to such complaint consent in writing to the release of such information;

(ii) if the release of such information is to a law enforcement agency, public protective service agency, licensing or certification agency, ombudsman program, or protection or advocacy system; or

(iii) upon court order.

REQUIRED ACTIVITIES

Sec. 307(a) STATE PLANS

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

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

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

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

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

(5) The State agency:

(A) affords an opportunity for a public hearing upon request, in accordance with published procedures, to any area agency on aging submitting a plan under this title, to any provider of (or applicant to provide) services;
(B) issues guidelines applicable to grievance procedures required by section 306(a)(10); and
(C) affords an opportunity for a public hearing, upon request, by an area agency on aging, by a provider of (or applicant to provide) services, or by any recipient of services under this title regarding any waiver request, including those under Section 316.

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

(8)(A) No supportive services, nutrition services, or in-home services are directly provided by the State agency or an area agency on aging in the State, unless, in the judgment of the State agency--
(i) provision of such services by the State agency or the area agency on aging is necessary to assure an adequate supply of such services;
(ii) such services are directly related to such State agency's or area agency on aging's administrative functions; or

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

June 30, 2009

Lynn Daucher
Director

SECTION VI – APPENDICES

APPENDIX A
CALIFORNIA DEPARTMENT OF AGING VALUES

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

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

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

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

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

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

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

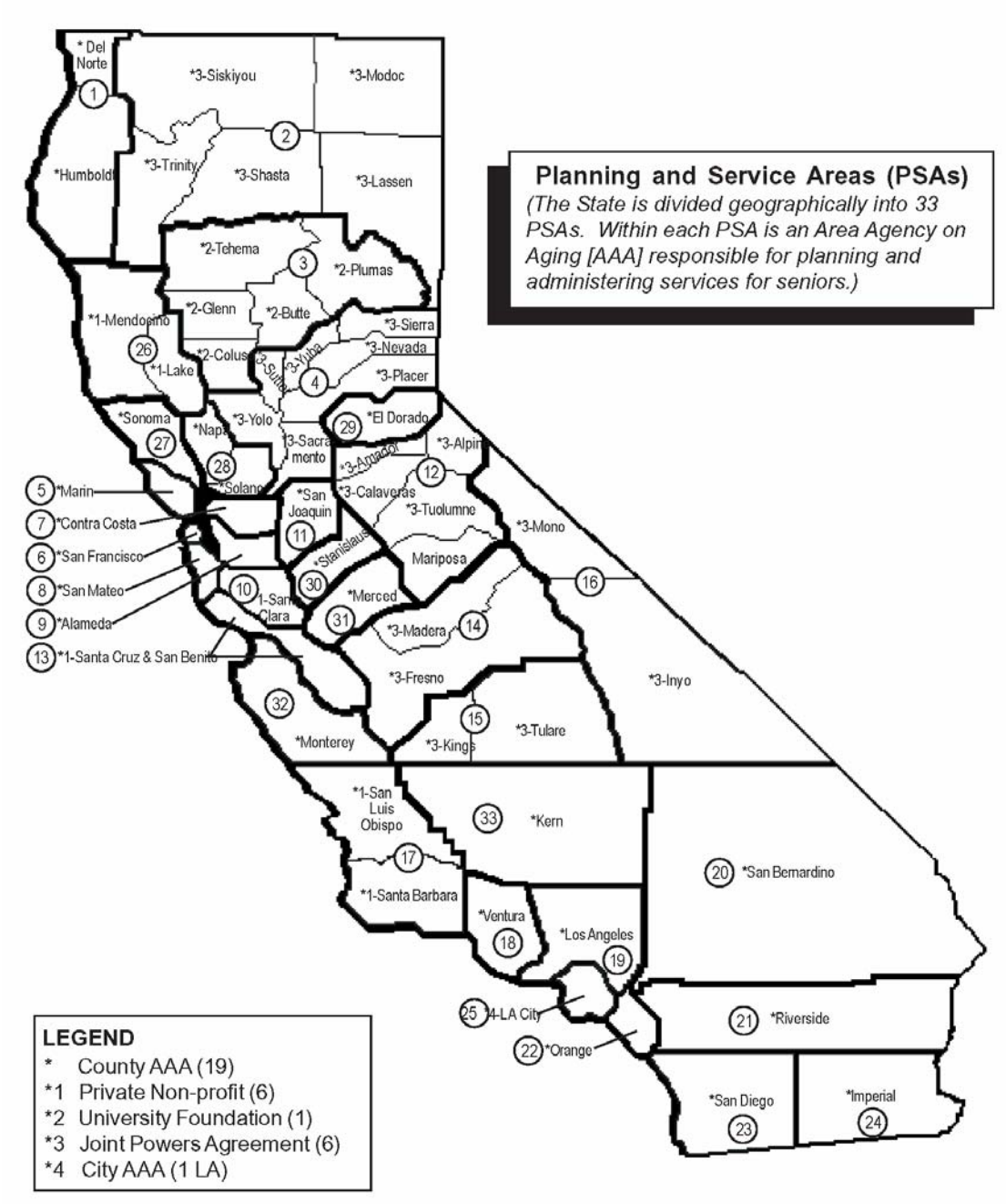
Collaboration: We foster partnerships and cooperation with our stakeholders, business partners, and customers in planning, delivering, and evaluating programs and services.

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

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

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

APPENDIX B
CALIFORNIA PLANNING AND SERVICE AREAS



Developed by the California Department of Aging (Rev 4/09)

CALIFORNIA AREA AGENCIES ON AGING

AAA STATUS LEGEND	
*	COUNTY AAA (19)
*1	PRIVATE NONPROFIT (6)
*2	UNIVERSITY FOUNDATION (1)
*3	JOINT POWERS AGREEMENT (7)
*4	CITY AAA (1 LA)

PSA 1	**Area 1 Agency on Aging**	**Status *1**
County(ies) Served: Del Norte, Humboldt Cynthia Denbo, Executive Director	434 7th Street Eureka, California 95501 Phone: (707) 442-3763 Fax: (707) 442-3714 Home page address: www.a1aa.org	

PSA 2	**Planning and Service Area II Area Agency on Aging**	**Status *3**
County(ies) Served: Lassen, Modoc, Shasta, Siskiyou, Trinity Barbara Swanson, Executive Director	Mailing Address: P.O. Box 1400, Yreka, California 96097 Street Address: 208 West Center St, Yreka, California 96097 Phone: (530) 842-1687 Fax: (530) 842-4804 Home page address: http://www.psa2.org/index.htm	

PSA 3	**PASSAGES Area 3 Agency on Aging**	**Status *2**
County(ies) Served: Butte, Colusa, Glenn, Plumas, Tehama Joe Cobery, Executive Director	2491 Carmichael Drive, Suite 400 Chico, California 95928 Phone: (530) 898-5923 Fax: (530) 898-4870 Home page address: http://www.passagescenter.org/AAOA	

PSA 4	Area 4 Agency on Aging	Status *3
County(ies) Served: Nevada, Placer, Sacramento, Sierra, Sutter, Yolo, Yuba Deanna Lea, Executive Director	2260 Park Towne Circle, Suite 100 Sacramento, California 95825 Phone: (916) 486-1876 Fax: (916) 486-9454 Home page address: www.a4aa.com	

PSA 5	Division of Aging Marin County Department of Health and Human Services	Status *
County(ies) Served: Marin Nicholas Trunzo, Director	10 North San Pedro Road, Suite 1012 San Rafael, California 94903 Phone: (415) 499-7118 Fax: (415) 499-5055 Home Page Address: www.co.marin.ca.us/aging/	

PSA 6	Department of Aging and Adult Services Area Agency on Aging	Status *
County(ies) Served: City and County of San Francisco Anne Hinton, Executive Director	1650 Mission Street, 5th Floor San Francisco, California 94103 Phone: (415) 355-3555 Fax: (415) 355-6785 Home Page Address: www.sfgov.org/coaging	

PSA 7	Aging and Adult Services Bureau County Employment and Human Services Department	Status *
County(ies) Served: Contra Costa John Cottrell, Director	40 Douglas Drive Martinez, California 94553 Phone: (925) 229-8434 Fax: (925) 335-8717	

PSA 8	San Mateo County Area Agency on Aging	Status *
County(ies) Served: San Mateo Lisa Mancini, Director	225 37th Avenue San Mateo, California 94403 (650) 573-2700 Fax: (650) 573-2310 Home page address: www.smhealth.org/aging.html	

PSA 9	Alameda County Area Agency on Aging Department of Adult and Aging Services	Status *
County(ies) Served: Alameda Victoria Tolbert, Interim Director	6955 Foothill Boulevard, Suite 300 Oakland, California 94605-1907 Phone: (510) 577-1900 Fax: (510) 577-1965 Home page address: http://www.co.alameda.ca.us/assistance/adult	

PSA 10	Council on Aging, Silicon Valley	Status *1
County(ies) Served: Santa Clara Stephen Schmoll, Executive Director	2115 The Alameda San Jose, California 95126-1141 Phone: (408) 296-8290 Fax: (408) 249-8918 Home page address: www.scccoa.org	

PSA 11	San Joaquin County Department of Aging and Community	Status *
County(ies) Served: San Joaquin Wendy Moore, Director	P.O. Box 201056 Stockton, California 95201 For overnight/express mail only: 102 South San Joaquin Street Stockton, California 95201 Phone: (209) 468-1000 Fax: (209) 468-2207 Home page address: www.co.san-joaquin.ca.us/hsa/aging/elderly/safer.htm	

PSA 12	Area 12 Agency on Aging	Status *3
County(ies) Served: Alpine, Amador, Calaveras, Mariposa, Sonora, Tuolumne Linda Zach, Executive Director	19074 Standard Road Suite A California 95370-7542 Phone: (209) 532-6272 Fax: (209) 532-6501 Home page address: www.area12.org	

PSA 13	Seniors Council of Santa Cruz and San Benito Counties, Inc.	Status *1
County(ies) Served: Santa Benito, San Cruz Clay Kempf, Executive Director	234 Santa Cruz Avenue Aptos, California 95003 Phone: (831) 688-0400 Fax: (831) 688-1225 Home page address: http://www.seniorscouncil.org/	

PSA 14	Fresno-Madera Area Agency on Aging	Status *3
County(ies) Served: Fresno, Madera Jo Johnson, Director	3845 N. Clark Street, Suite 103 Fresno, California 93726 Phone: (559) 453-4405 Fax: (559) 453-4779 Home page address: www.fmaaa.org	

PSA 15	Kings-Tulare Area Agency on Aging	Status *3
County(ies) Served: Kings, Tulare John Davis, Director	5957 South Mooney Boulevard Visalia, California 93277 Phone: (800) 321-2462 Fax: (559) 737-4694 Home page address: www.ktaaa.org	

PSA 16	**Inyo-Mono Area Agency on Aging**	**Status *3**
County(ies) Served: Inyo, Mono Jean Dickinson, Interim Director	P.O. Box 1799 Bishop, California 93515 For overnight/express mail only: 568 West Line Street Bishop, California 93514 (760) 873-6364 (760) 873-6505 Home page address: www.countyofinyo.org/imaaa	
PSA 17	**Area Agency on Aging Central Coast Commission for Senior Citizens**	**Status *1**
County(ies) Served: Santa Barbara, San Luis Obispo joyce ellen lippman, Executive Director	528 South Broadway Santa Maria, California 93454 (805) 925-9554 (805) 925-9555 Home page address: http://www.centralcoastseniors.org/	
PSA 18	**Ventura County Area Agency on Aging**	**Status ***
Ventura Victoria Jump, Director	646 County Square Drive, Suite 100 Ventura, California 93003 (805) 477-7300 (805) 477-7312 Home page address: http://aaa.countyofventura.org	
PSA 19	**Community and Senior Services Area Agency on Aging Los Angeles County**	**Status ***
County(ies) Served: County of Los Angeles Cynthia Banks, Director	3175 West 6th Street, Room 302 Los Angeles, California 90020 Phone: (213) 738-4004 Fax: (213) 365-8649 Home page address: www.co.la.ca.us/dcss/cripts/aaa.htm	

PSA 20	San Bernardino County Department of Aging and Adult Services	Status *
County(ies) Served: San Bernardino Colleen Krygier, Director	686 East Mill Street San Bernardino, California 92415 Phone: (909) 891-3900 Fax: (909) 891-3919 Home page address: http://hss.sbcounty.gov/daas/	

PSA 21	County of Riverside Office on Aging	Status *
County(ies) Served: Riverside Edward F. Walsh, Director	6296 Rivercrest Drive, Suite K Riverside, California 92507 Phone: (951) 867-3800 TDD # (951) 697-4699 Fax: (951) 867-3830 Home page address: www.rcaging.org	

PSA 22	Orange County Office on Aging	Status *
County(ies) Served: Orange Sylvia Mann, Interim Executive Director	1300 South Grand Avenue, Bldg. B, 2nd Fl. Santa Ana, California 92705 Phone: (714) 567-7500 Fax: (714) 567-5021 Home page address: www.officeonaging.ocgov.com	

PSA 23	County of San Diego Aging & Independence Services	Status *
County(ies) Served: San Diego Pamela B. Smith, Director	9335 Hazard Way, Suite 100 San Diego, California 92123 (858)495-5885 (858) 495-5080 Home page address: www.sdcounty.ca.gov/ais	

PSA 24	Imperial County Area Agency on Aging	Status *
County(ies) Served: Imperial Rebecca Sanchez, Director	1331 South Clark Road, Building 11 El Centro, California 92243 Phone: (760) 339-6450 Fax: (760) 339-6455	

PSA 25	City of Los Angeles Department of Aging	Status *4
County(ies) Served: Los Angeles City Laura Trejo, General Manager	3580 Wilshire Boulevard, Suite 300 Los Angeles, California 90010 Phone: (213) 252-4000 Fax: (213) 252-4020 Home page address: http://aging.lacity.org/	

PSA 26	Area Agency on Aging Mendocino County Department of Social Services	Status *3
County(ies) Served: Lake, Mendocino Susan Era, Deputy Director	747 S. State Street Ukiah, California 95482 Mailing Address: P.O. Box 839 Ukiah, California 95482 Toll Free #: (800) 606-5550 (for Lake & Mendocino residents only) Phone: (707) 463-7902 Fax: (707) 463-7979	

PSA 27	Sonoma County Area Agency on Aging	Status *3
County(ies) Served: Sonoma Diane Kaljian, Director	Regular Mailing Address: P.O. Box 4059 Santa Rosa, California 95402 For overnight/express mail only: 3725 Westwind Boulevard Santa Rosa, CA 95403 Phone: (707) 565-5950 Fax: (707) 565-5957 Home page address: http://www.socoaaa.org/	

PSA 28	Area Agency on Aging – Serving Napa and Solano	Status *1
County(ies) Served: Napa, Solano Leanne Martinsen, Executive Director	Regular Mailing Address: P.O. Box 3069 P.O. Box 3069Vallejo, California 94590-5990 For overnight/express mail only: 601 Sacramento Street, Suite 1401 Vallejo, California 94590-5990 Phone: (707) 644-6612 Fax: (707) 644-7905 Home page address: www.aaans.org	

PSA 29	El Dorado County Area Agency on Aging	Status *
County(ies) Served: El Dorado Janet Walker-Conroy, Director	937 Spring Street Placerville, California 95667 Phone: (530) 621-6150 Fax: (530) 642-9233 Home page address: www.co.el-dorado.ca.us/humanservices/seniorservices.html	

PSA 30	Stanislaus County Department of Aging and Veterans Services	Status *
County(ies) Served: Stanislaus Margie Palomino, Director	121 Downey Avenue, Suite 102 Modesto, California 95354-1201 Phone: (209) 558-8698 Fax: (209) 558-8648 Home page address: www.agingservices.info	

PSA 31	Area Agency on Aging Merced County Senior Service Center	Status *
County(ies) Served: Merced Kathy Hassett, Deputy Director	851 West 23rd Street Merced, California 95340 Phone: (209) 385-7550 Fax: (209) 384-8102 Home page address: http://www.co.merced.ca.us/index.asp?nid=1475	

PSA 32	Area Agency on Aging Division Department of Social Services County of Monterey	Status *
County(ies) Served: Monterey Mary Goblirsch, Director	713 La Guardia Street, Suite A Salinas, California 93905 Director's Office: 1000 South Main Street, Suite 211A Salinas, California 93901 Phone: (831) 755-4400 Fax: (831) 757-9226 Home page address: www.co.monterey.ca.us/aaa	

PSA 33	Kern County Aging & Adult Services	Status *
County(ies) Served: Kern	5357 Truxtun Avenue Bakersfield, California 93309 (661) 868-1000 (661) 868-1001	
Kris Grasty, Director	Home page address: www.co.kern.ca.us/aas/	

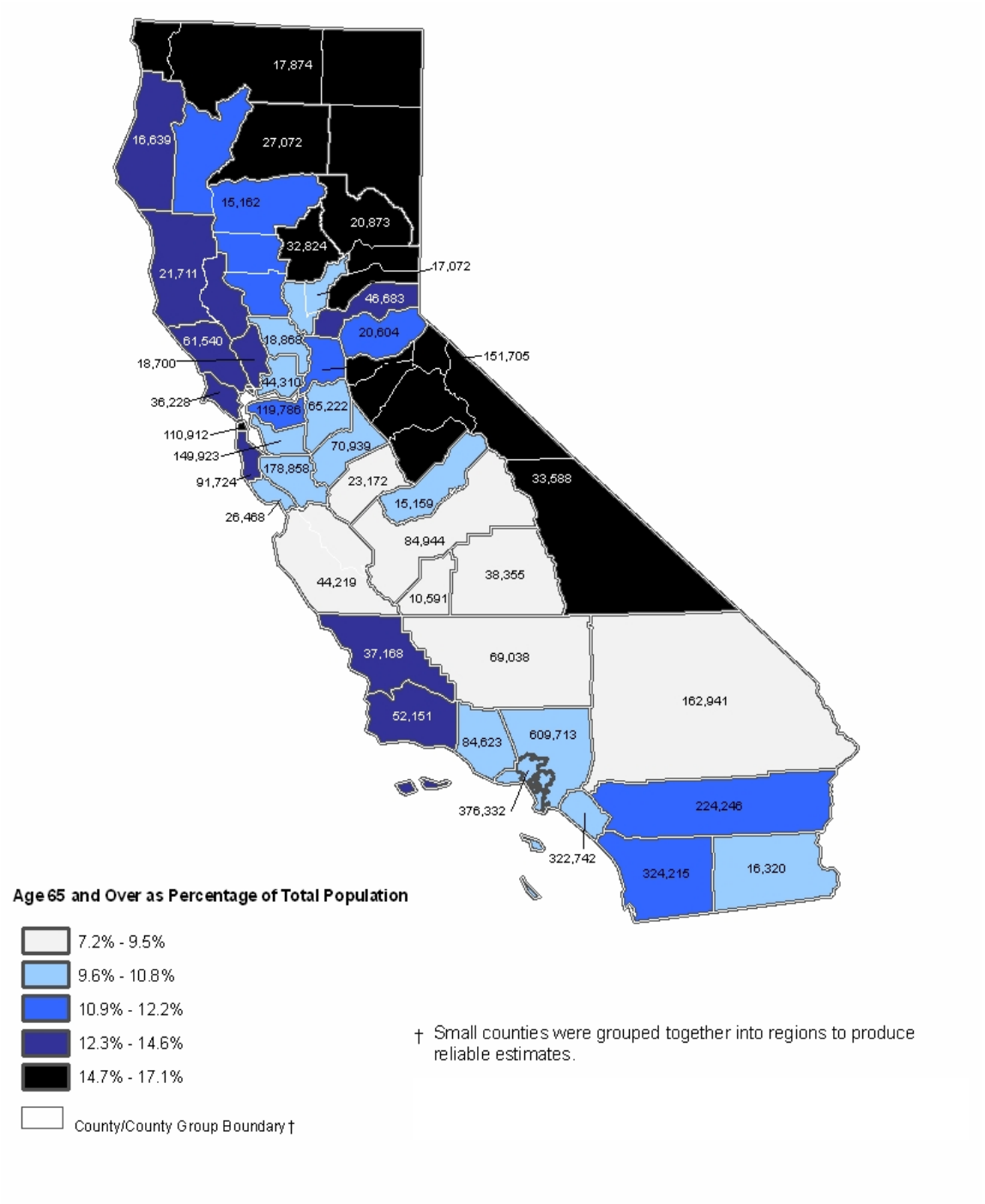
APPENDIX C

Projected Population 60 + Change Between 2010 and 2050 (By Age Group) [2]

Age Range	Projected Population 2010	Projected Population 2030	Projected Population 2050	Population Change 2010 - 2030	Percent Change	Population Change 2030 - 2050	Percent Change
60 - 64	1,949,148	2,646,732	3,058,741	697,584	36%	412,009	16%
65 - 69	1,375,998	2,581,614	2,603,594	1,205,616	88%	21,980	1%
70 - 74	1,012,136	2,248,957	2,186,015	1,236,821	122%	-62,942	-3%
75 - 79	784,021	1,720,016	2,048,562	935,995	119%	328,546	19%
80 - 84	611,699	1,201,571	1,822,037	589,872	96%	620,466	52%
85+	628,276	1,083,159	2,917,948	454,883	72%	1,834,789	169%
Totals	**6,361,278**	**11,482,049**	**14,636,897**	**5,120,771**	**80%**	**3,154,848**	**27%**

APPENDIX D

Age 65+ As Percentage of Total Population[4]



APPENDIX E

California Projected Population Age 60+
Percentage Change Between 2010 and 2030
(By Planning and Service Area [PSA] and County)[2]

	2010 60+ TOTAL POPULATION	2030 60+ TOTAL POPULATION	DIFFERENCE	% CHANGE
CALIFORNIA	**6,361,278**	**11,602,016**	**5,240,738**	**82%**
PSA 01				
Del Norte	5,776	9,559	3,783	65%
Humboldt	26,209	39,076	12,867	49%
TOTAL	**31,985**	**48,635**	**16,650**	**52%**
PSA 02				
Lassen	5,932	10,854	4,922	83%
Modoc	2,860	4,771	1,911	67%
Shasta	42,582	70,009	27,427	64%
Siskiyou	12,761	16,338	3,577	28%
Trinity	4,364	6,800	2,436	56%
TOTAL	**68,499**	**108,772**	**40,273**	**59%**
PSA 03				
Butte	46,610	80,727	34,117	73%
Colusa	3,694	6,953	3,259	88%
Glenn	5,574	9,826	4,252	76%
Plumas	6,431	7,919	1,488	23%
Tehama	13,786	21,175	7,389	54%
TOTAL	**60,396**	**101,902**	**41,506**	**69%**
PSA 04				
Nevada	28,581	47,163	18,582	65%
Placer	70,105	133,610	63,505	91%
Sacramento	240,576	442,167	201,591	84%
Sierra	1,117	1,327	210	19%
Sutter	17,507	33,646	16,139	92%
Yolo	29,194	57,533	28,339	97%
Yuba	11,354	21,815	10,461	92%
TOTAL	**39,935**	**68,978**	**29,043**	**73%**
PSA 05				
Marin	63,376	84,480	21,104	33%
PSA 06				
San Francisco	161,078	250,720	89,642	56%
PSA 07				
Contra Costa	203,146	314,588	111,442	55%

	2010 60+ TOTAL POPULATION	2030 60+ TOTAL POPULATION	DIFFERENCE	% CHANGE
PSA 08				
San Mateo	140,759	228,413	87,654	62%
PSA 09				
Alameda	261,712	474,864	213,152	81%
PSA 10				
Santa Clara	314,517	604,428	289,911	92%
PSA 11				
San Joaquin	105,394	197,612	92,218	87%
PSA 12				
Alpine	362	625	263	73%
Amador	11,715	18,993	7,278	62%
Calaveras	15,158	23,656	8,498	56%
Mariposa	5,702	9,949	4,247	74%
Tuolumne	17,688	26,197	8,509	48%
TOTAL	**18,050**	**26,822**	**8,772**	**49%**
PSA 13				
San Benito	8,606	17,812	9,206	107%
Santa Cruz	42,360	77,916	35,556	84%
TOTAL	**50,966**	**95,728**	**44,762**	**88%**
PSA 14				
Fresno	133,843	253,186	119,343	89%
Madera	27,548	69,590	42,042	153%
TOTAL	**161,391**	**322,776**	**161,385**	**100%**
PSA 15				
Kings	17,340	37,943	20,603	119%
Tulare	67,242	117,965	50,723	75%
TOTAL	**84,582**	**155,908**	**71,326**	**84%**
PSA 16				
Inyo	5,150	7,104	1,954	38%
Mono	2,609	5,039	2,430	93%
TOTAL	**7,759**	**12,143**	**4,384**	**57%**
PSA 17				
San Luis Obispo	60,281	91,707	31,426	52%
Santa Barbara	77,500	130,368	52,868	68%
TOTAL	**137,781**	**222,075**	**84,294**	**61%**
PSA 18				
Ventura	147,136	249,083	101,947	69%
PSA 19				
L.A. County [38]	1,018,082	1,767,197	749,115	74%
PSA 20				
San Bernardino	285,273	592,923	307,650	108%
PSA 21				
Riverside	317,811	648,500	330,689	104%
PSA 22				
Orange	516,006	909,029	393,023	76%

	2010 60+ TOTAL POPULATION	2030 60+ TOTAL POPULATION	DIFFERENCE	% CHANGE
PSA 23				
San Diego	512,870	1,004,055	491,185	96%
PSA 24				
Imperial	25,628	61,511	35,883	140%
PSA 25				
L.A. City [38]	650,905	1,129,848	478,943	74%
PSA 26				
Lake	19,612	31,087	11,475	59%
Mendocino	21,293	29,204	7,911	37%
TOTAL	**40,905**	**60,291**	**19,386**	**47%**
PSA 27				
Sonoma	95,867	143,363	47,496	50%
PSA 28				
Napa	29,703	44,047	14,344	48%
Solano	72,415	138,331	65,916	91%
TOTAL	**102,118**	**182,378**	**80,260**	**79%**
PSA 29				
El Dorado	41,050	78,758	37,708	92%
PSA 30				
Stanislaus	81,495	152,191	70,696	87%
PSA 31				
Merced	34,345	69,170	34,825	101%
PSA 32				
Monterey	69,850	112,768	42,918	61%
PSA 33				
Kern	108,870	225,267	116,397	107%

APPENDIX F

California Projected Population Age 85+
Percentage Change Between 2010 and 2030
(By Planning and Service Area [PSA] and County)[2]

	2010 85+ TOTAL POPULATION	2030 85+ TOTAL POPULATION	DIFFERENCE	% CHANGE
CALIFORNIA	**628,276**	**1,083,159**	**454,883**	**72%**
PSA 01				
Del Norte	561	1,159	598	107%
Humboldt	2,461	3,995	1,534	62%
TOTAL	**3,022**	**5,154**	**2,132**	**71%**
PSA 02				
Lassen	520	1,170	650	125%
Modoc	301	551	250	83%
Shasta	3,961	7,089	3,128	79%
Siskiyou	1,404	2,272	868	62%
Trinity	351	853	502	143%
TOTAL	**6,537**	**11,935**	**5,398**	**83%**
PSA 03				
Butte	5,430	7,258	1,828	34%
Colusa	399	687	288	72%
Glenn	611	1,062	451	74%
Plumas	603	1,168	565	94%
Tehama	1,445	2,412	967	67%
TOTAL	**8,488**	**12,587**	**4,099**	**48%**
PSA 04				
Nevada	2,379	4,186	1,807	76%
Placer	7,503	14,351	6,848	91%
Sacramento	23,337	40,567	17,230	74%
Sierra	102	188	86	84%
Sutter	1,563	3,801	2,238	143%
Yolo	2,727	5,171	2,444	90%
Yuba	1,034	2,211	1,177	114%
TOTAL	**38,645**	**70,475**	**31,830**	**82%**
PSA 05				
Marin	6,095	10,659	4,564	75%
PSA 06				
San Francisco	20,445	28,111	7,666	37%
PSA 07				
Contra Costa	18,522	34,382	15,860	86%

	2010 85+ TOTAL POPULATION	2030 85+ TOTAL POPULATION	DIFFERENCE	% CHANGE
PSA 08				
San Mateo	15,439	22,233	6,794	44%
PSA 09				
Alameda	26,104	43,643	17,539	67%
PSA 10				
Santa Clara	29,136	55,074	25,938	89%
PSA 11				
San Joaquin	10,384	19,892	9,508	92%
PSA 12				
Alpine	43	133	90	209%
Amador	1,038	2,198	1,160	112%
Calaveras	1,273	3,036	1,763	138%
Mariposa	462	1,128	666	144%
Tuolumne	1,734	3,342	1,608	93%
TOTAL	**4,550**	**9,837**	**5,287**	**116%**
PSA 13				
San Benito	756	1,691	935	124%
Santa Cruz	4,175	6,295	2,120	51%
TOTAL	**4,931**	**7,986**	**3,055**	**62%**
PSA 14				
Fresno	12,886	22,639	9,753	76%
Madera	2,467	5,788	3,321	135%
TOTAL	**15,353**	**28,427**	**13,074**	**85%**
PSA 15				
Kings	1,449	3,060	1,611	111%
Tulare	5,790	11,066	5,276	91%
TOTAL	**7,239**	**14,126**	**6,887**	**95%**
PSA 16				
Inyo	615	965	350	57%
Mono	149	530	381	256%
TOTAL	**764**	**1,495**	**731**	**96%**
PSA 17				
San Luis Obispo	6,520	10,504	3,984	61%
Santa Barbara	9,133	12,729	3,596	39%
TOTAL	**15,653**	**23,233**	**7,580**	**48%**
PSA 18				
Ventura	12,996	24,741	11,745	90%
PSA 19				
L.A. County [38]	101,689	167,992	66,302	65%
PSA 20				
San Bernardino	23,604	51,090	27,486	116%

	2010 85+ TOTAL POPULATION	2030 85+ TOTAL POPULATION	DIFFERENCE	% CHANGE
PSA 21				
Riverside	33,847	56,322	22,475	66%
PSA 22				
Orange	49,015	91,421	42,406	87%
PSA 23				
San Diego	54,188	80,821	26,633	49%
PSA 24				
Imperial	2,585	5,968	3,383	131%
PSA 25				
L.A. City [38]	65,015	107,404	42,390	65%
PSA 26				
Lake	1,588	3,194	1,606	101%
Mendocino	2,000	3,547	1,547	77%
TOTAL	**3,588**	**6,741**	**3,153**	**88%**
PSA 27				
Sonoma	9,808	13,664	3,856	39%
PSA 28				
Napa	3,552	5,238	1,686	47%
Solano	6,330	12,847	6,517	103%
TOTAL	**9,882**	**18,085**	**8,203**	**83%**
PSA 29				
El Dorado	3,291	7,048	3,757	114%
PSA 30				
Stanislaus	8,066	16,053	7,987	99%
PSA 31				
Merced	3,152	6,201	3,049	97%
PSA 32				
Monterey	7,259	12,179	4,920	68%
PSA 33				
Kern	8,984	18,180	9,196	102%

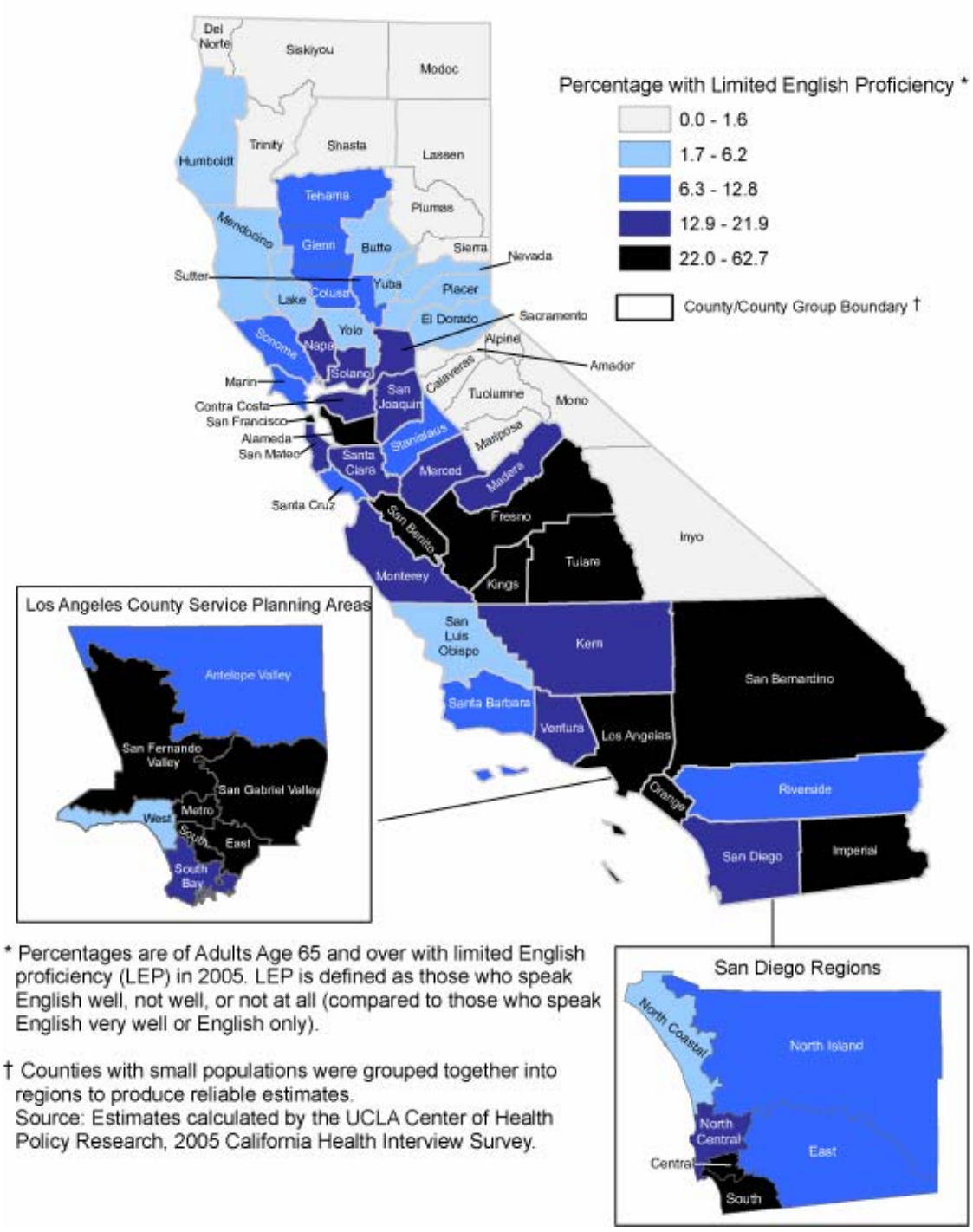
APPENDIX G

California's Projected Population Age 60+ as a Percent of Total Population Age 60+ (by Race and Ethnicity)[2]

Race/Ethnicity	2010	2030	2050
White/Non-Hispanic	60.9%	47.7%	35.7%
Hispanic/Latino	18.8%	29.2%	39.1%
Asian	13.0%	15.2%	16.9%
Black/African American	5.1%	4.9%	4.6%
Two or More Races	1.3%	1.7%	2.1%
American Indian/Alaskan Native	0.6%	0.9%	1.0%
Native Hawaiian/Other Pacific Islander	0.3%	0.4%	0.6%

APPENDIX H

Adults Age 65+ with Limited English Proficiency[4]

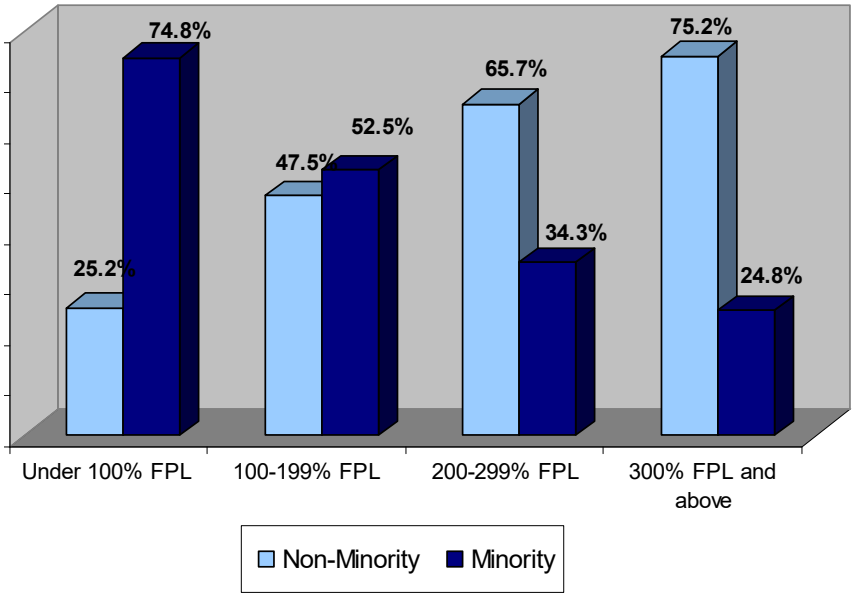


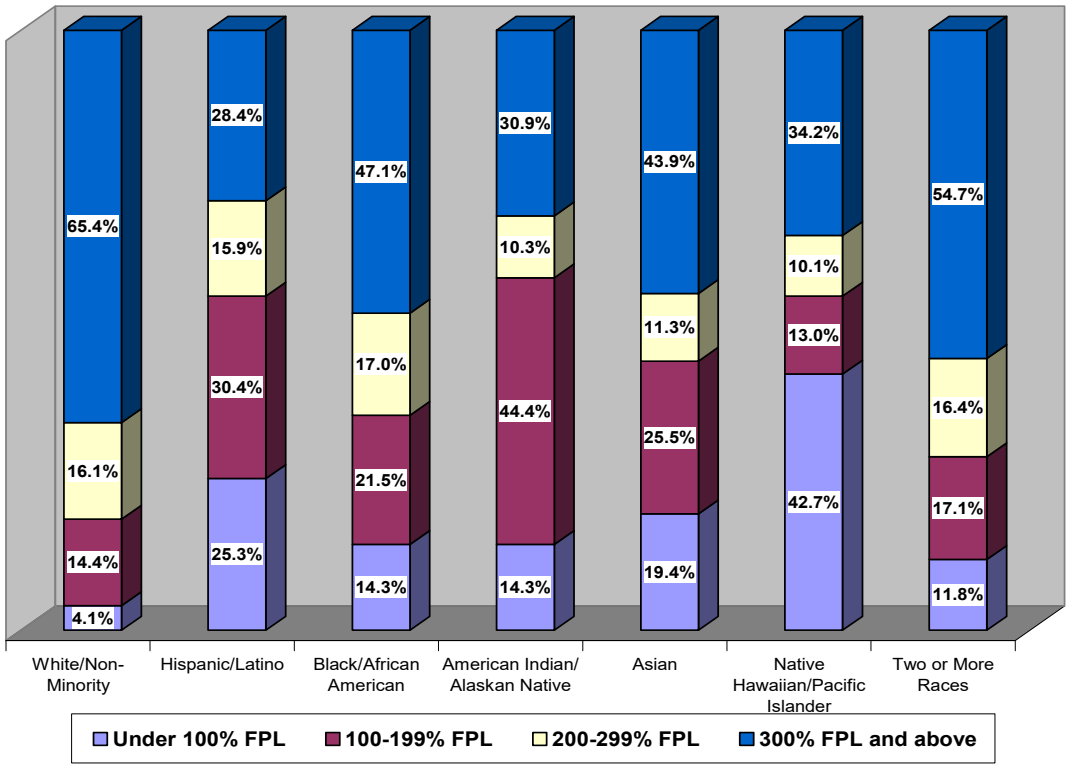
* Percentages are of Adults Age 65 and over with limited English proficiency (LEP) in 2005. LEP is defined as those who speak English well, not well, or not at all (compared to those who speak English very well or English only).

† Counties with small populations were grouped together into regions to produce reliable estimates.
Source: Estimates calculated by the UCLA Center of Health Policy Research, 2005 California Health Interview Survey.

APPENDIX I

Poverty Level of Californians Age 60+ (By Minority/Non-Minority Status)[4]





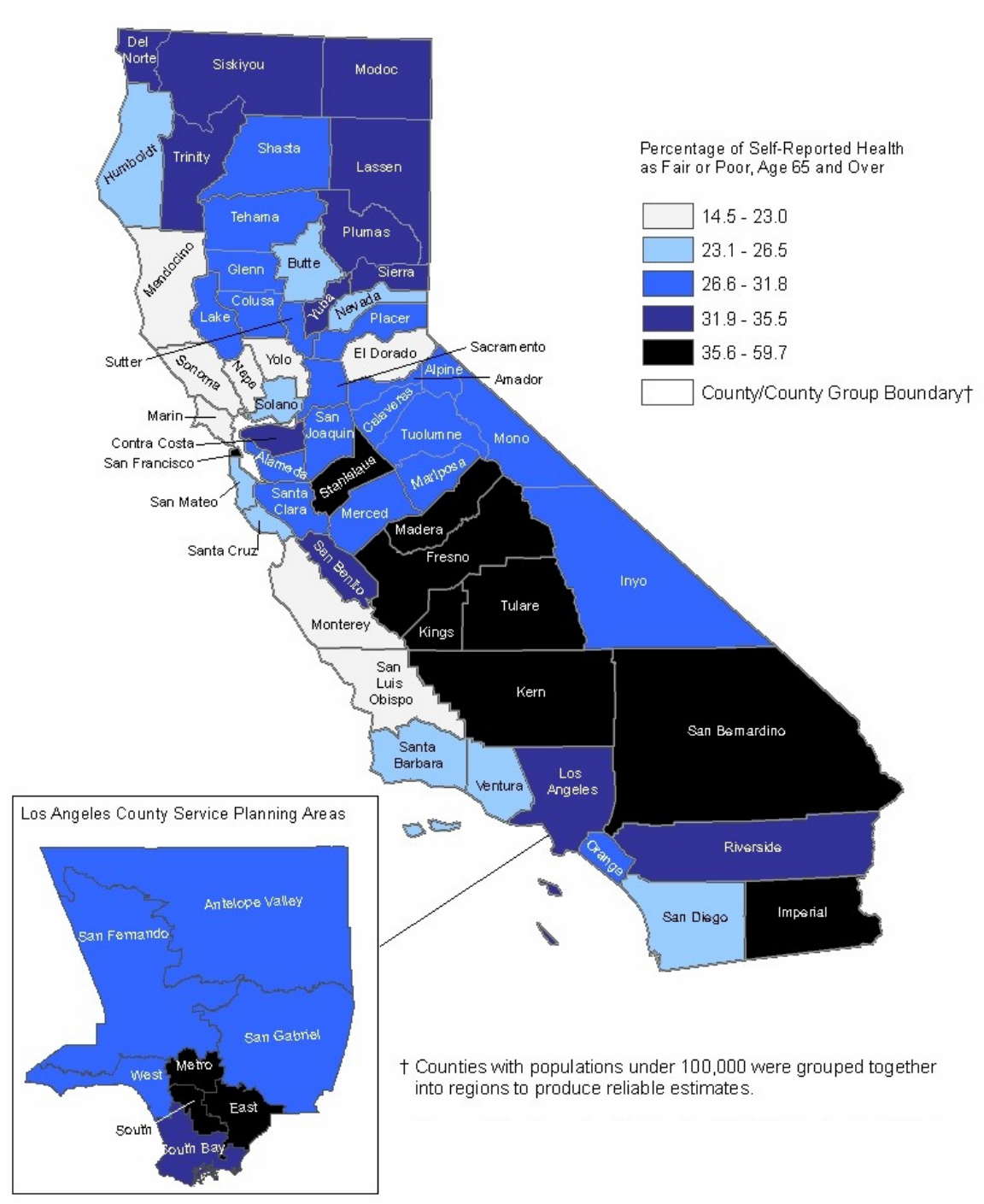
APPENDIX J

The National Report Card on Aging for Individuals 65 + (California's Rankings)[39]

Health Indicator	Year data collected	% of adults 65+	Rank Among States	Year data collected	% of adults 65+	Rank Among States
Health Status						
1. Physically unhealthy days (mean number of days in past month)	2001	5.1	12	2004	5.4	16
2. Frequent mental distress (%)	2000-01	5.9	17	2003-04	8.5	48
3. Oral health: complete tooth loss (%)	2002	13.2	1	2004	13.8	3
4. Disability (%)	2001	29.7	17	2004	32.4	21
Health Behaviors						
5. No leisure time physical activity in past month (%)	2002	25.8	6	2004	25.5	3
6. Eating 5+ fruits & vegetables daily (%)	2002	35.6	10	2003	36.2	6
7. Obesity (%)	2002	19.1	22	2004	18.6	14
8. Current Smoking (%)	2002	9.9	24	2004	6.3	2
Preventive Care & Screenings						
9. Flu vaccine in past year (%)	2002	71.5	15	2004	70.9	18
10. Ever had Pneumonia Shot (5)	2002	66.7	10	2004	63.6	35
11. Mammogram in past 2 years (%)	2002	80.7	12	2004	82.8	5
12. Ever had colorectal cancer screening (%) [40]	2002	62.2	13	2004	68.1	13
13. Up-to-date on select preventive services -men (%)	2002	43.9	8	2004	40.0	17
14. Up-to-date on select preventive services women (%)	2002	38.5	11	2004	34.8	14
15. Cholesterol checked in past 5 years (%)	2001	82.6	38	2003	94.6	2

APPENDIX K

Percentage of Self-Reported Health for Adults Age 65+[4]



END NOTES

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