**Planning for an Aging California Population**

# Restructuring the California Department of Aging and Long-Term Care Services in California

**Prepared by the Expert Panel to Review California Department of Aging Structure**

**September 2004**

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## Background

The Expert Panel to Review California Department of Aging Structure is the second of three committees established under the auspices of Assemblymember Patty Berg, Chair of the Assembly Committee on Aging and Long Term Care.

***The efforts of the three committees will culminate in a product that can be used to shape aging policy across California and the nation to comprehensively plan for Aging Baby Boomers.***

The first of the three committees, the *Strategic Plan Advisory Committee*, further refined the priorities in the Strategic Plan for an Aging California Population (SB 910 [Vasconcellos], Chapter 984, Statutes of 1999) to those most likely to result in fundamental systemic reform to the State's current service delivery system for older persons. The report of the S*trategic Plan Advisory Committee* served as a guide for this *Expert Panel* committee as well as the third Committee, the *Committee to Advance an Aging Agenda for the 21st Century*, in setting the guiding principles and key questions to consider as California prepares for the aging baby boomers. The *Committee to Advance an Aging Agenda for the 21st Century* will establish legislative priorities, timelines and strategic grassroots implementation steps to move an aging agenda forward in California.

As the second of the Master Plan on Aging Committees, the *Expert Panel* was charged with 1) reviewing and evaluating options for structural realignment for every state administered program serving older Californians; 2) reviewing the administration of programs for older adults in other states which have demonstrated best practices in program development and achieving consumer satisfaction; and 3) recommending an organizational structure that makes the most sense for serving California's older population in the 21st century.

The efforts of the three committees will culminate in a product that can be used to shape aging policy across California and the nation to comprehensively plan for Aging Baby Boomers. At the state level, these efforts could influence State restructuring efforts, result in a rewrite of the Older Californians Act and could also serve as a basis for California's platform for the 2005 White House Conference on Aging.

## Strategic Questions [i]:

The following twelve key questions developed by the S*trategic Plan Advisory Committee* were to be considered by the *Expert Panel* in developing an organizational structure to meet the needs of California's aging baby boomers:

1. How do we implement change and/or improvements to the system in such a geographically, ethnically and culturally diverse state as California?

***How can the arrangement of services be delivered to the consumer in a seamless, coordinated manner, regardless of program administration and jurisdiction?***

2. How can we best integrate service systems for the elderly and adults with disabilities while, at the same time, acknowledging and responding to difference between these two population groups?

3. Who are the key stakeholders whose commitment and partnership are essential?

4. How do we ensure that revenue resources are commensurate with population growth?

5. What should the criteria be for the distribution of resources?

6. How can the arrangement of services be delivered to the consumer in a seamless, coordinated manner, regardless of program administration and jurisdiction?

7. How can programs effectively eliminate individual data and eligibility silos and become consumer rather than provider-centric? In other words, how can the state move from individual eligibility and data collection to accountability in data collection, focusing more on outcomes for the consumer and cost-effectiveness of the programs and services?

8. What administrative hurdles and barriers need to be overcome at both the state and county/local level?

9. How can we ensure that adequate checks and balances are built into any service delivery system without overburdening the system with regulations, in order to achieve accountability and quality control?

***The administration of California's long-term care programs reflects a piecemeal approach in program development and funding. The complexity of the system is the greatest barrier to improved service.***

10. How do we balance the need for consumer choice and the need for local flexibility with necessary state oversight and accountability standards?

11. How do we develop service system standards that are uniform and not dependent upon income? In other words, how do we avoid having separate (and unequal) systems of care for low, moderate, and upper-income persons?

12. How do we ensure quality standards are maintained or developed across services regardless of the funding source and/or the service provider?

## Examining California's Structural Flaws

Currently, there are 3.5 million older Californians, representing 10.6 percent of the total population. California has established a number of long-term care programs that provide services that enable individuals to avoid institutionalization and live independently in their homes. However, separate funding streams, varied eligibility criteria, lack of statewide standards, inadequate data, and uncoordinated services at the state and local levels have created barriers in serving California's aging population.

The administration of California's long-term care programs reflects a piecemeal approach in program development and funding. The complexity of the system is the greatest barrier to improved service. Thirty-eight programs are housed in five different departments. Departments presently serving California's older population include the following, all of which operate under the Health and Human Services Agency (refer to the organizational chart in Appendix 1).

- **The California Department of Aging** administers programs including supportive services, congregate and home-delivered meals, the Multipurpose Senior Services Program, the National Family Caregiver Support Program, Alzheimer's Day Care Resource Centers, Linkages, respite, Adult Day Care, Adult Day Health Care, Brown Bag, Foster Grandparent, and Senior Companion.

  Most of these programs are administered at the local level by California's 33 Area Agencies on Aging (AAAs). The AAAs are responsible for planning, developing, funding, and in certain instances directly providing a range of health and supportive services to older persons living within their Planning and Service Areas (PSAs). AAAs administer funding under the Older Americans Act and the Older Californians Act and are responsible for serving as the visible focal point and advocate for issues and concerns affecting older adults. In addition, AAAs may also administer programs funded by other local, state, and federal organizations or programs.

***Separate funding streams, varied eligibility criteria, lack of statewide standards, and uncoordinated services for California's aging population have created barriers in services for this population.***

- **The California Department of Social Services** (DSS) provides aid, services and protection to vulnerable children and adults through programs including In Home Supportive Services and Adult Protective Services. DSS is also responsible for community care licensing, including the residential care facilities for the elderly (RCFE), and adult day care.

- **The California Department of Mental Health** develops, evaluates, monitors and supports an array of coordinated services that deliver care to California's adults who are severely mentally ill, and older adults and children who are seriously emotionally disturbed. Included within the Department's programs are the 11 non-profit Caregiver Resource Centers (CRCs), providing a wide range of regionally-based services to support and assist families and caregivers who care for adults with cognitive

impairments. Services are designed to deter institutionalization, and allow caregivers to maintain a normal routine and promote quality care. A separate state contract funds a Statewide Resource Consultant (SRC) to operate a statewide information clearinghouse on caregiving and brain disorders; conduct education; training and applied research; carry out program and policy development; maintain a statewide database on CRC clients served; and provide technical assistance to CRC sites.

- **The Department of Rehabilitation** grants funds to support 29 nonprofit independent living centers statewide and funds core services for information and referral, independent living skills training, housing advocacy, systems advocacy, and peer counseling. The State Independent Living Council, as well as other entities, continue to develop model assessment tools geared towards identifying and meeting consumer needs in the community.

- **The Department of Health Services** oversees the public and private providers for skilled nursing facilities, nursing facility waiver program and case management, adult day health care, Medi-Cal Managed Care, chronic disease management, Alzheimer's Disease diagnosis and treatment, the Partnership for Long-Term Care Insurance program, and innovative long-term care integration models such as the long-term care integration pilot project, the Program for All-Inclusive Care of the Elderly (PACE) and the Social HMO program, Senior Care Action Network (SCAN) health plan.

***The delivery of home and community-based services needs to be vastly improved in order to coordinate services that are appropriate to each individual' s functional needs and financial situation.***

Despite California's array of home and community-based services, multiple funding streams and varied eligibility criteria have created "silos" of services, making it difficult for consumers to move with ease from one service or program to another. The delivery of home and community-based services needs to be vastly improved in order to coordinate services that are appropriate to each individual' s functional needs and financial situation. Care services should be holistic and address the needs of the entire person, including the person's mental, physical, social, and emotional needs. A coordinated support system would better utilize state resources and provide a greater benefit to those receiving services than the current fragmented set of programs.

## The Case for Change

The Little Hoover Commission's recent report ***Real Lives: Real Reforms*** [ii] makes a compelling case for the reorganization of California's Health and Human Services Agency.

The organization of California's health and human service departments is largely the product of piecemeal evolution. As new programs have been authorized, they have been housed in various departments, often based on

***The organization of California's health and human service departments is largely the product of piecemeal evolution.***

compromises, without periodic reorganization necessary to make the multitude of programs work in concert. As a result, the missions of these departments are incongruent, some responsibilities overlap and there are unintended gaps in authority and responsibility.

While the *Expert Panel* focused specifically on services for California's seniors, the Committee's recommendations are compatible with the findings of the Little Hoover Commission and its recommendations for change.

The Little Hoover Commission found that the state's current organizational structure undermines quality and efficiency in three key ways:

1. **The Health and Human Services Agency cannot fulfill its intended role.** The size, complexity and political weight of individual departments undermine the efforts by the Health and Human Services Agency to streamline operations, reduce competition and promote collaboration. The Health and Human Services Agency simply cannot compete with the departments and so the value of the agency structure is not realized.

2. **Overlapping responsibilities, incongruent missions, operational silos hinder the State's capacity to ensure best use of local assistance funding.** Competition, conflict and confusion among state departments inhibit efforts to develop a unified approach to supporting local programs. And local agencies are required to work through disparate rules and regulations emanating from multiple departments. For innovative and assertive local agencies, administrative costs escalate increase as reforms are delayed. For others, improvements are thwarted by state bureaucratic barriers – or not initiated at all – because they are not required.

***Competition, conflict and confusion among state departments inhibit efforts to develop a unified approach to supporting local programs.***

3. **State departments perform duplicate functions.** Duplication results in increased costs from lost economies of scale and added complexity in working across programs. Improvements are delayed because of confusion over who is responsible for programs, outcomes and change. And opportunities are missed because departments compete rather than collaborate.

## Little Hoover Commission's Recommendations:

The Commission recommends that departmental resources dedicated to budgeting, policy-making, legal and external affairs should be shifted to the Agency. The role of the Agency would be to ensure consistency across state operations, promote collaboration among departments and track progress toward the State's goals for children, adults and families. Service Centers at the agency level would enhance state support for local services and respond to the needs of the departments. Service centers include: fiscal

***The role of the Departments would be to provide leadership, planning, research and capacity building to enhance the ability of local agencies to improve quality, service delivery, and liaison with the local level.***

operations; licensing and certification; technical assistance and training; and data collection management.

The role of the Departments would be to provide leadership, planning, research and capacity building to enhance the ability of local agencies to improve quality, service delivery, and liaison with the local level. The department directors would constitute an agency cabinet (Agency Management Council). The existing advisory and oversight boards would be replaced with an agency-wide board with the authority and resources to monitor state operations and make recommendations for reform.

In addition, the Little Hoover Commission recommends appointing an Inspector General (IG) who is empowered with the necessary authority to thoroughly investigate and monitor state and local health and human service programs. The IG would report directly to the Governor and its reports, except those involving criminal investigations, should be public.

**While the Little Hoover Commission recommendations may result in increased coordination and collaboration among programs, more is needed if true systemic change is envisioned, at least for services targeting an increasingly aged population. The one common denominator across all Health and Human Services Agency programs is the aging consumer. It is this consumer group that will, because of the aging baby boomers, dominate the political landscape in the coming years and demand that the right services are provided at the right time in the most appropriate setting. Reliance upon coordination to achieve these changes will not be sufficient. Structural change needs to occur at the state level and political change needs to occur at the legislative level.**

## California Performance Review [iii]:

On August 3, 2004, the Governor released the California Performance Review (CPR) Report, and its recommendations for the administration of aging and long-term care services. According to the report, the CPR found three core problems with the current organization of the Health and Human Services Agency:

- Responsibility for Agency functions is scattered among numerous departments;
- There is significant duplication of common administrative and leadership functions; and
- The current organizational structure does not reflect modern developments and best practices in health and human services.

The report recommends that the Health and Human Services Agency and its current departments be reorganized into one integrated Department with centers focused around core functions. The five centers would include: the Center for Public Health, the Center for Behavioral Health, the Center for Services to the Disabled, the Center for Social Services, and the Center for Finance and Supportive Services. Aging programs, currently under the California Department of Aging, would be incorporated into the Center for Social Services along with programs from the current Departments of Social Services, Community Services, and Child Support Services. According to the report, through the reorganization, the

Department should be better able to eliminate duplication and provide better service delivery in each Center (refer to the organizational chart in Appendix 2).

**Although the CPR report suggests structural changes beyond coordination of services, the recommended structure further exacerbates the administrative barriers and operational silos found in the current design. In spite of the coming age wave and subsequent increase in demand for aging and long-term care services, aging programs will be buried in an even larger administrative structure. In addition, aging and long-term care services will continue to be fragmented. While the proposed Center for Social Services will administer Older Americans Act and Older Californians Act programs, Medi-Cal and IHSS will be transferred to the Center for Health Purchasing, and health facility and community care facility licensing will be transferred to the Center for Quality Assurance.**

In contrast, the proposed Center for Services to the Disabled would be established with the goal of providing a high quality continuum of care to the developmentally and physically disabled. The report continues to state that "the Center should be the focal point for California's special needs population".

**In order for California to adequately prepare for, and serve older Californians now and in the future, aging programs need to be a priority at the state level. Any proposed structure should strive to ensure that a high quality continuum of care is provided to older Californians, and establish a focal point for California's aging population.**

## Examining Other States:

***While each state examined has been successful to some extent at integrating long-term care services in a somewhat seamless fashion, none of the models studied offer the depth, scope, and breadth necessary to deal with the impending wave of aging baby boomers.***

In an effort to examine best practices from other states, the panel reviewed three states, Oregon, Florida, and Washington, which have a reputation as leaders in long-term care service delivery and innovation. For a complete description of the models reviewed, see Appendix 5.

While each state examined has been successful to some extent at integrating long-term care services in a somewhat seamless fashion, none of the models studied offer the depth, scope, and breadth necessary to deal with the impending wave of aging baby boomers. All, for example, continue to operate under a largely traditional and linear state model of organizational boxes that report to one or more individuals within a larger organizational framework. This tends to exacerbate turf and resource issues and does nothing to break down the traditional service and data silos. Consistent from state to state, however, are the enhanced roles and responsibilities that have been delegated uniformly to the AAA network. AAAs in each of these states perform some level of case management and act as the gatekeeper for all long-term care services.

## The Five Necessary Components of a New Delivery System

After considering other states' organizational structures and options for California, the *Expert Panel* concluded that whatever California's design, the state structure should:

***The structure needs to shift the service-delivery paradigm from service-delivery based on eligibility to service delivery based on need.***

1. **Foster Gatekeeper/Care Navigator Services:** In order to minimize system fragmentation, and help consumers access the home and community based long-term care system, the structure needs to develop into its framework "care navigation" services that provide *all* consumers or caregivers with access to information and referral services, short-term assistance for the consumer or caregiver, or long-term ongoing care coordination, services coordination, or case management services. Care navigation and gatekeeping may be performed within existing programs and at multiple points of entry, with the ultimate goal being to keep an individual at home, or in the least restrictive environment.

2. **Deliver Services Based on Functional Need, not Eligibility:** The structure needs to shift the service-delivery paradigm from service-delivery based on *age* to service delivery based on *need*. In the present system, individuals receive services for which they are eligible based upon their age, or a specific program's funding stream requirements, regardless of their need for long-term care services. The structure needs to deliver services based on an individual's *functional need*, regardless of program eligibility.

***The structure needs to include options for individuals who could pay privately for services***

3. **Maximize Administrative Efficiency through Data System Collection/Tracking:** The structure needs to maximize administrative efficiency by developing data and technology systems for both consumers and providers. Various entities have developed a web-based database that specify programs available to the consumer, with information that the consumer can easily access about benefits, services, and purchase of service. In the new state structure, consumers and providers should have the capability to access a databank web site that provides specific inventory of services for each county, with eligibility, application information on line, as well as shared provider client-tracking abilities. Similar database web sites already exist, but have not yet been developed on a statewide basis. These data systems help to reduce administrative inefficiencies and duplication in services.

4. **Access Waivers:** The structure needs to maximize opportunities for receipt of federal Medicare and Medicaid waivers, with the greatest efficiency and without duplication between departments in waiver design and implementation. A statewide waiver policy is preferable to regional pilot programs.

5. **Enhance Private Pay Options:** The structure needs to include options for individuals who could pay privately for services and may not meet

eligibility criteria for state-run programs. These individuals are often forgotten or ignored by the system, and have difficulty accessing necessary home and community based programs.

## Rethinking California's Long-Term Care Administration:

Traditional governmental structures are a major impediment to the implementation of all of the components identified above. A new approach, blending sound business practices with broad governmental oversight is needed. The *Expert Panel* considered two models; the first model would function as a corporation under state control, but managed in a traditional business format. This format is sometimes referred to as "quasi-governmental", or "quasi-public". The model would include the following elements:

***A new approach, blending sound business practices with broad governmental oversight is needed.***

*Board of Directors*

The Board of Directors would be appointed by the Governor and the Legislature to provide overall governance. The Board of Directors would hire the Executive Director of the organization.

The advantage of this model is that the Executive Director would be politically exempt and the Board would be tasked with hiring a qualified manager for the position. The Board would be charged with evaluating the performance of the Executive Director and the agency based on performance measures set in advance. As a public corporation, this entity would be independent from the Administration, but its budget would be approved by the Legislature, and the Governor as part of the annual budget process. The entity would have the authority to procure services at the local level and would set performance standards for local entities.

*Advisory Body*

In order to ensure citizen input and oversight into California's programs and services for older adults, an advisory body would be needed. The California Commission on Aging currently serves as the statutory advocate in the state on behalf of older individuals, and as such it serves as an advisory body to the Governor, State Legislature, and State, Federal and local departments and agencies on issues affecting older individuals in order to ensure a quality of life for older Californians. With the new organizational framework, its role would be maintained and its representation expanded to include disabled adults. The Advisory Body would also need to include representatives from other departments, such as Transportation or Housing and Community Development, to ensure that all services and programs affecting older and disabled Californians are accountable to their needs.

The second model would replicate positive elements within the current state government structure and consolidate relevant aging and long-term care services into one department under the Health and Human Services Agency following the traditional departmental structure. Under this structure, the new department would have the overall strategic coordination function for all current programs as well as responsibility for policy

development, development of best practices models for service delivery, technical assistance, legal, budget development, resource allocation, and quality improvement.

*Entity Tasks / Functions*

Regardless of the structural model selected, the new state-level entity should be created to serve both older adults and younger disabled persons in order to achieve the following:

1. Create a system that is more responsive to the holistic needs of the consumer;
2. Ensure that providers have a single authority that sets standards that are consistent from program to program; and,
3. Allows policymakers to better review program costs and operations.

The new state-level entity would have the following responsibilities:

1. Procurement of services at the local level;
2. Adoption of a common (uniform) assessment process;
3. Implementation of a scoring system that results in delivery of a specified level of services at specified rates;
4. Accountability/performance review;
5. Certification standards for case managers;
6. Dissemination and adoption of best practices;
7. Providing technical assistance to local providers;
8. Strategic planning and program development;
9. Marketing of services to consumers; and,
10. Fulfill the Older Americans Act State Unit on Aging fiscal responsibilities, including auditing.

*The New Organizational Structure*

The new entity would incorporate into its structure the following programs and services (refer to organizational charts in Appendix 3 and 4):

From the Department of Aging:

- All Older Americans Act programs (with the exception of the Ombudsman program that should be relocated to another department to avoid a conflict of interest with licensing);
- All Older Californians Act programs;
- MSSP and Linkages; and,
- Adult Day Health Care (currently administered with DHS through an interagency agreement).

From the Department of Health Services:

- Nursing home care – including subacute, skilled and intermediate care licensure and inspection;
- Nursing facility waiver case management;
- PACE, SCAN and new Integrated Managed Care programs;
- Chronic disease management;
- Partnership for Long-term Care Insurance; and,
- Alzheimer's Diagnosis and Treatment.

From the Department of Social Services:

- In Home Supportive Services (IHSS) – both the Personal Care Services Program and the Residual Program (newly named IHSS Plus);
- Adult Protective Services;
- Community Care Licensing of Residential Care Facilities for the Elderly;
- Residential Care Facilities;
- Administration of SSI/SSP; and,
- Adult Day Care.

From the Department of Rehabilitation:

- Independent Living Centers; and,
- State Independent Living Council.

From the Department of Mental Health:

- Caregiver Resource Centers; and,
- Traumatic Brain Injury Project.

Similar options for the reorganization of services have been considered in the recent past. In 1997, under the Wilson Administration, the Health and Human Services Agency prepared a report on long-term care services in California, pursuant to AB 1215 (Chapter 322 Statutes of 1997) [iv]. The report included an inventory of all long-term care services to older Californians, options for how the administration of long-term care services at the state level could be better organized, and how licensing and certification programs could be effectively combined. While the report included a number of options, each with its own potential strengths and limitations, the report was introduced at the beginning of the Davis administration, and the options were not further explored.

The report recommended three options for reorganization: partial consolidation of long-term care services, comprehensive consolidation of long-term care services, or the development of a center for long-term care systems development. The comprehensive consolidation of state long-term care programs represents the broadest restructuring considered. The programs considered for consolidation included all of the programs listed above under the *New Organizational Structure*, with the exception of the Office of Deaf Access, and the Office of Services to the Blind.

Similar to the findings of the *Expert Panel*, the report noted that an organizational structure that includes not only the long-term care programs but income support and other related programs would potentially encounter fewer barriers to integrating or coordinating services, and resolving inconsistent program policies, since all of the major programs would be within that single department. In addition, restructuring the state administration of long-term care services would not in itself achieve the key policy objectives of a more seamless service system from the consumer's perspective, improved program outcomes, and increased administrative efficiencies. All of the agencies involved must truly share a common vision and adhere to these objectives for progress in creating an effective long-term care system.

## Structural Changes at the Legislative Level

***Long-term care policy direction would not be dependent upon the vagaries of term limits but would outlive them and provide a flexible framework under which coherent and consistent policies could move forward.***

Concurrent with the program changes outlined above, the Assembly Committee on Aging should become the primary committee that hears all proposed legislation relating to aging and persons with disabilities in the Assembly. In addition, the Senate Subcommittee on Aging should be elevated to a standing Senate committee with a similar mandate. Strengthening these committees would lead to greater coordination within the legislature on aging and disability issues and would foster a more coherent and interlocking set of services and service priorities from which all other related legislation could be evaluated. Providing these committees with this authority and responsibility would memorialize the functions and counter some of the negative impacts of legislative term limits. For example, long-term care policy direction once established would not be dependent upon the vagaries of term limits but would outlive them and provide a flexible framework under which coherent and consistent policies could move forward.

## Putting the Pieces Together

The new state-level entity would procure services at the local level (AAAs, Independent Living Centers, Counties, Cities, or any combination thereof) that put the client at the center and deliver services in a more integrated fashion. The local entity would be given the first right of refusal to create integrated programs, and if the entity did not want to provide the services, any other entity, non-profit or for profit, could contract to provide the services. Ideally, the local entity under the new system would have the primary role of serving as the single point of entry into a seamless, integrated community care system, and would at minimum be responsible for providing pre-admission screening, comprehensive case management, and information and assistance. In addition, a core function would be advocacy on behalf of individual consumers as well as on behalf of systemic changes that would improve the service delivery system. The local entity would be charged with the independent responsibility of assuring quality of service regardless of the provider and would be given authority to levy sanctions and monetary fines for noncompliance with established service standards.

Contracts with the local level agencies would be based on the ability of the local entity to do the following:

1. Authorize admission into a skilled nursing facility through a pre-admission screening tool (note: a fine would be levied against any facility that admits a resident without prior authorization.);
2. Provide a nexus between home and community based services and the medical system.
3. Assess the client's need for service;
4. Determine the level of service needed and the setting in which the service is to be provided;

5. Provide care navigation services through a case management system, adjusted to the level of assistance required by each individual;
6. Adhere to standards adopted for accountability;
7. Adhere to certification standards for case managers or care coordinators;
8. Demonstrate accounting and financial services competency; and,
9. Have a data system of client-based tracking (with protections for privacy) capable of sharing information across programs.

Operational principles:

1) Clients would include **all** older adults and persons with disabilities regardless of health status and program eligibility.
2) Accountability for outcomes would be emphasized rather than compliance with regulations.
3) The contracting entity would achieve savings by reinvesting in the service delivery system.

## Realities: Nine Key Issues that must be addressed in any successful reorganization effort

Any reorganization effort will require the endorsement of politically active groups throughout the state and at the Capitol. Recognition of the realities and attention to the particular interests of various stakeholders and policymakers will be the key to successful restructuring. The following eight key "realities" were identified by the Expert Panel.

***Any reorganization effort will require the endorsement of politically active groups throughout the state and at the Capitol.***

1) In-Home Supportive Services (IHSS) is the home and community-based program that has the most "juice" in terms of an advocacy presence with the legislature and Administration. Advocates that support IHSS, including the unions, counties and public authorities are an important voice – perhaps the most important voice – in any restructuring conversation.

2) The voice of aging and disability groups will be stronger if advocating together for common issues. Currently, while the groups sometimes advocate together, the disabilities advocates have the ability to prevail over advocates for aging programs.

3) The administration proposes a redesign of the Medi-Cal program and it is likely that the administration's plan for an 1115 waiver will include a proposal to include the aged, blind and disabled in Medi-Cal managed care. It is not known if an integrated service delivery system (which includes the provision of home and community based services) will be a requirement for provider participation. The Medi-Cal redesign has been delayed until January 2005.

4) The Area Agencies on Aging are not responsible for either gatekeeping to, or the administration of, Medicaid long-term care programs for the aging population (with the exception of the Multi-Purpose Senior Services Program - MSSP).

5) Several systems currently serve older adults, including the 58 counties, the 33 AAAs, the 21 Regional Centers, the 11 Caregiver Resource Centers and the 29 Independent Living Centers. Of all of the "systems", the counties have the most leverage in terms of advocacy; however their capacity for planning - focused on serving older adults - has never been tested. Arguably, counties may be well suited for performing a number of direct consumer related services but cannot and should not be accountable only to themselves.

***Qualified and well-trained manpower is a challenge across the state – especially in rural areas. For any reorganization model to be successful, ensuring qualified staff must be addressed.***

6) Several counties have proposed the development of integrated systems of care that include both medical care and home and community-based supportive services. In those instances, a health plan will be the lead agency and provide services through contracts with community-based provider organizations. For Medi-Cal recipients, the Medi-Cal managed care plan in that county (for example the County Organized Health System or the Local Initiative) would have overall responsibility for the delivery of a comprehensive set of services appropriate for the individual. For private pay individuals, the health plan would be a Medicare Advantage Plan that has contracts with community-based provider organizations.

7) The Medicare Modernization Act includes new provisions for Medicare Specialty Plans. The recently released regulations allow plans to create managed care products that integrate funding and delivery of services for dually eligible individuals.

8) Qualified and well-trained manpower is a challenge across the state – especially in rural areas. For any reorganization model to be successful, ensuring qualified staff must be addressed.

9) The Little Hoover Commission has proposed that many of the functions currently performed by the departments should be relocated to the Health and Human Services Agency and that California should transition to a strong county-based system of care for providing health and human services.

## Conclusion

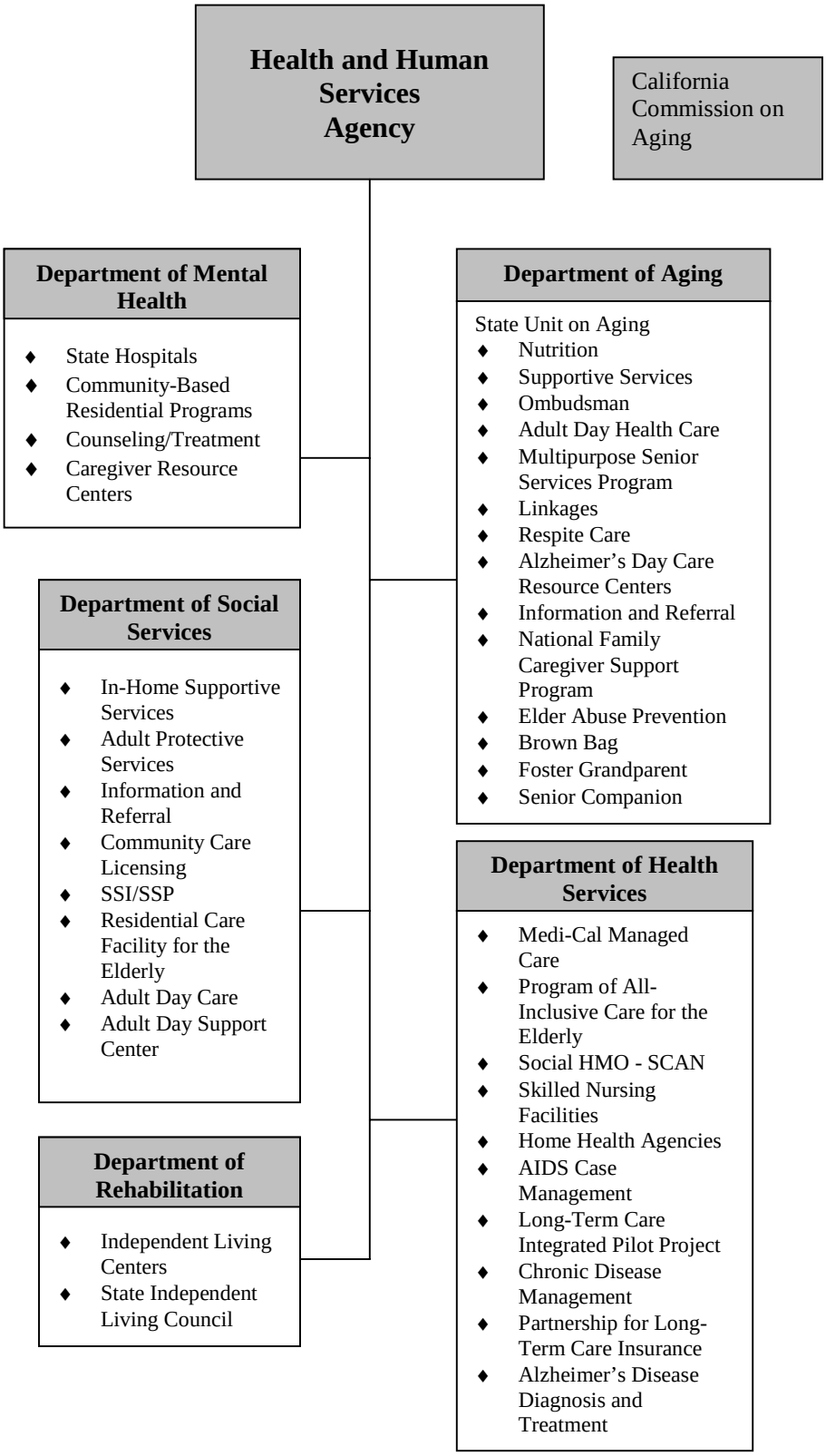
***The costs of administration of long-term care programs will soar unless policymakers can eliminate the current duplicative silos that increase administrative costs and decrease consumer and provider dissatisfaction with the bureaucracy***.

Numerous reports have noted California's fragmented service delivery system and called for major reform. With the explosive growth of the boomer population, the costs for the administration of long-term care programs will soar unless policymakers can eliminate the current duplicative silos that increase administrative costs and decrease consumer and provider dissatisfaction with the bureaucracy that exists presently.

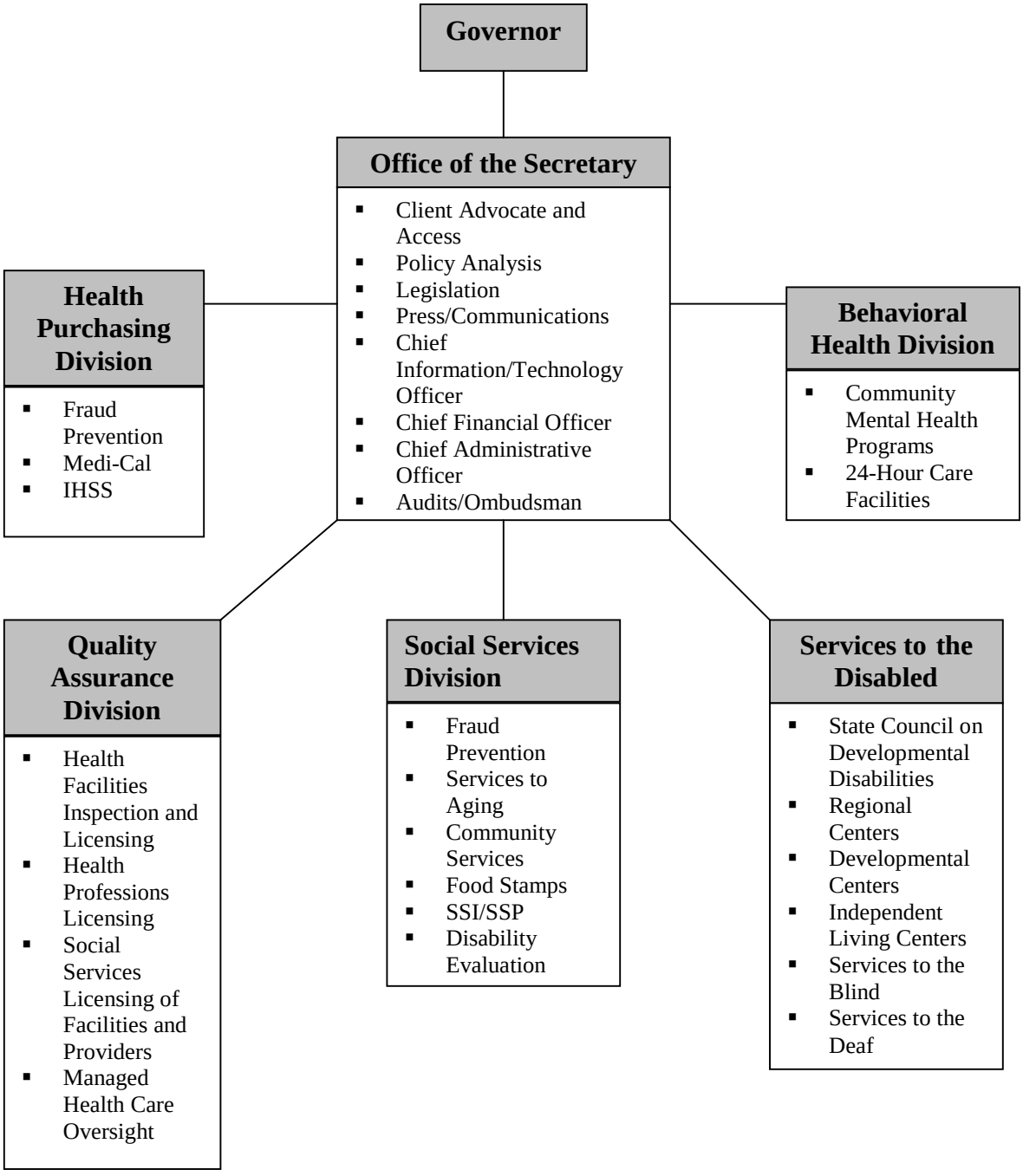
Some local entities and service providers, such as On Lok in San Francisco, have attempted to create more streamlined systems that offer long-term care integration and "one stop shopping." They argue that their efforts are impeded by the numerous departments and authorities that must be dealt with at the state level. In order to empower integrated service delivery models at the local level; the panel was in agreement that the administration at the state level must undergo radical transformation.

The *Expert Panel* concluded that the key to successful restructuring was enabling the pre-authorization for skilled nursing services at the local level with an emphasis on keeping people out of the nursing home and connecting them with the appropriate home and community-based services located within their community. While skilled nursing services and facilities are an appropriate and necessary setting for some individuals based upon their functional needs, the goal of any successful long-term care system is to avoid unnecessary placement in skilled nursing facilities. With a single administrative entity at the state level, the integration of services at the local level would be vastly enhanced. The main function of the state administration would thus become procurement of integrated service delivery systems at the local level. This can be accomplished by providing the appropriate financial incentives and disincentives for entry into skilled nursing care. The goal at the local level becomes ensuring that the consumer has the maximum amount of choice in services and remains as independent as possible.

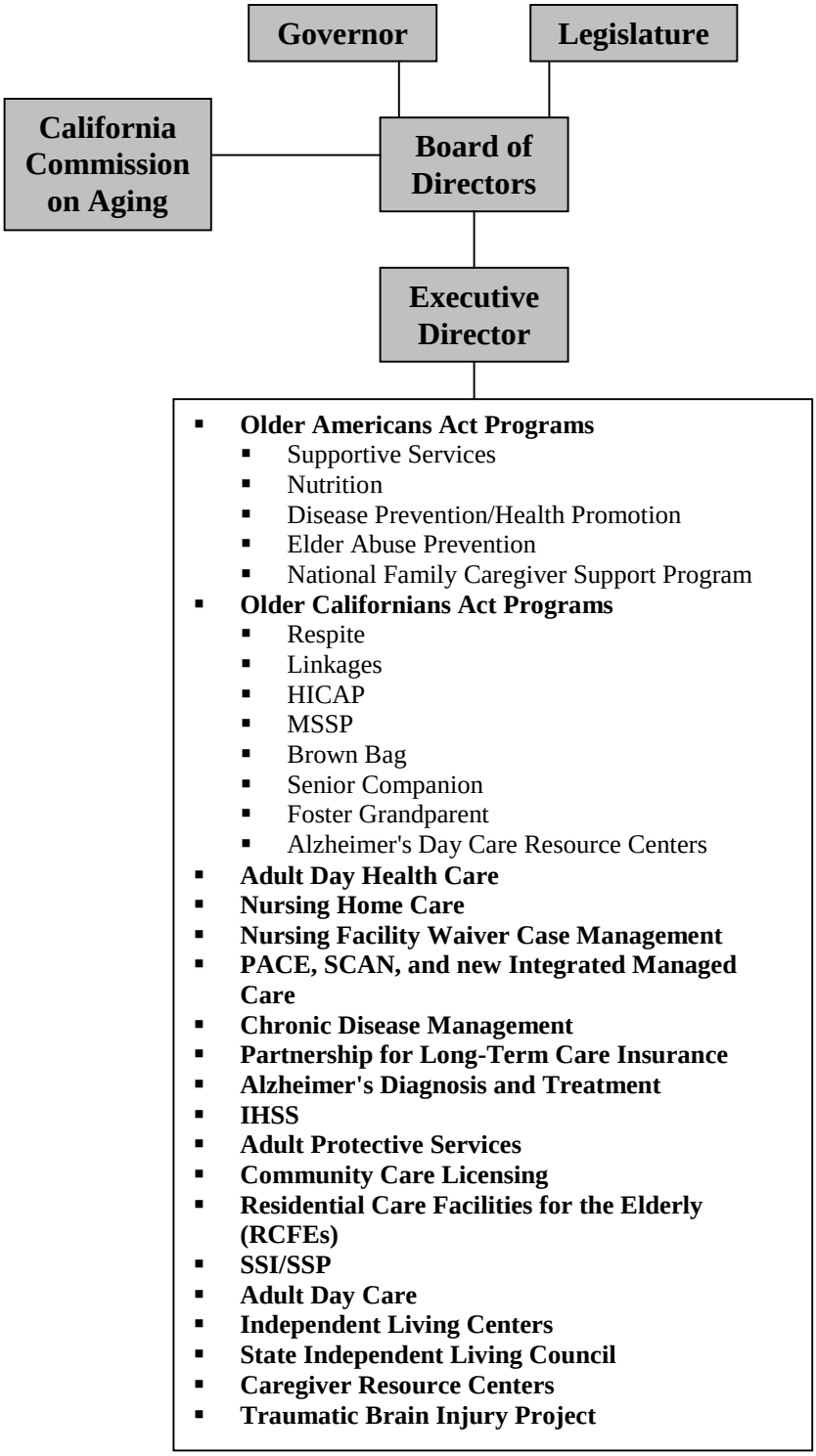
# Appendix 1:
# THE CURRENT ADMINISTRATION OF LONG-TERM CARE PROGRAMS



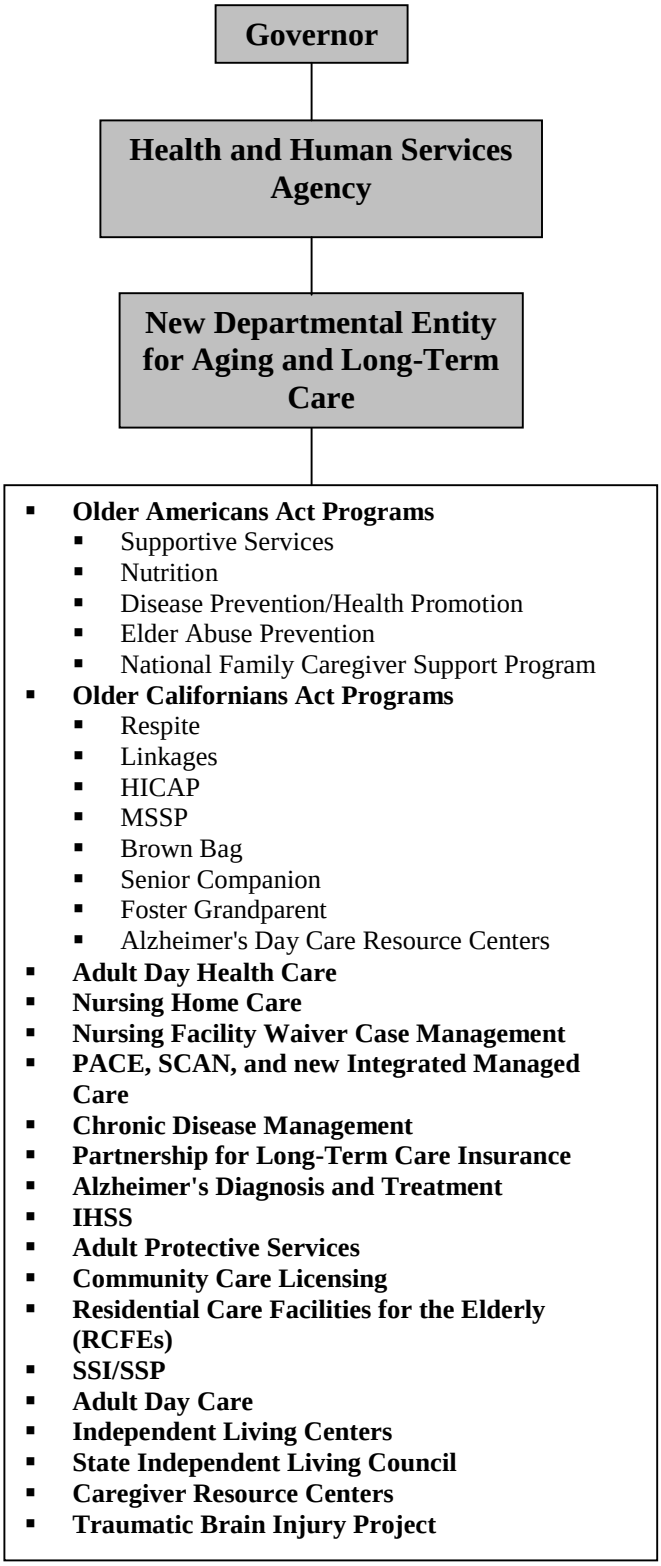
**APPENDIX 2:**
**CALIFORNIA PERFORMANCE REVIEW**
**RECOMMENDED STRUCTURE FOR AGING AND LONG-TERM CARE SERVICES**



## APPENDIX 3:
## MODEL 1 - QUASI-GOVERNMENTAL STRUCTURE FOR AGING AND LONG-TERM CARE



## APPENDIX 4:
## MODEL 2 -TRADITIONAL DEPARTMENT STRUCTURE FOR AGING AND LONG-TERM CARE



# Appendix 5 - Examining Other States:

In an effort to examine best practices from other states, the panel reviewed three states, Oregon, Florida, and Washington, which have a reputation for providing exemplary services to seniors in their state.

## Oregon

Oregon is home to 438,177 older adults, representing 12.8 percent of the state's population. The long-term care system in Oregon is based on a series of strategies that have been developed over the last 30 years. While these strategies were implemented within specific social, political, and economic realities, they may be useful as California considers reorganization of long-term care services.

Oregon has a specific state statute that creates the framework for policy and programs for older persons and those with disabilities. The law emphasizes the coordination of policy for older persons and the disabled at the state level, partnership with local government in the development and delivery of services, the prevention of inappropriate institutionalization, an investment in savings from reduced institutionalization into community-based care, and the creation of an agency to administer laws and programs for the populations served.

***The landmark legislation established broad policy direction for services to seniors with a philosophy rooted in the Older Americans Act (OAA), and stated that Oregon's seniors were entitled to health, honor, and dignity.***

**System Development Timeline**

- 1975 – created Oregon Project Independence (OPI) which is a state-funded, fee-for-service program based on an individual's ability to pay for low income seniors over the age of 60 which provides supportive in-home services, adult day care, respite, and case management.

- 1981 – the legislature passed Senate Bill 955 which established Oregon's Consumer Friendly Values. The landmark legislation established broad policy direction for services to seniors with a philosophy rooted in the Older Americans Act (OAA), and stated that Oregon's seniors were entitled to health, honor, and dignity. In addition, the legislation required support of frail older adults wanting to receive long-term care services at home – assuring a broad array of home and community based care services and supports. SB 955 also created one state division to manage Older Americans Act programs, Oregon Project Independence and Medicaid Long-Term Care programs.

  Oregon obtained a 1915 (c) waiver, the first state in the nation to obtain this waiver, to rebalance their long-term care system and limit the growth of higher cost nursing facility utilization, provide services that are desirable to consumers, and create options that serve both private-pay and Medicaid clients. As a result, nursing homes became the placement of last resort.

- 1989 – brought further consolidation of services. Oregon transferred programs for adults with disabilities to the Senior Services Division and renamed it the Senior and Disabled Services Division (SDSD).

***The single budget approach allows decisions to be made based upon the needs and preferences of individuals as they move through the system.***

**Service Delivery System Highlights**

Over half of Oregon's Medicaid long-term care expenditures for seniors and adults with disabilities are devoted to home and community-based care. The long-term care delivery system is built on a highly diverse service delivery network. The State Policy on Aging and Disability emphasized a system supporting the concept of local control. Services are coordinated by a system that is as close to the consumer as possible. In the most populated areas, the 18 Area Agencies on Aging (AAAs) administer the programs; the local SDSD offices administer the programs in the more rural parts of the state.

Single Agency/Single Budget Model

Oregon consolidates Medicaid long-term care funding for seniors and persons with physical disabilities into a single budgetary line item. The legislature projects the proportion of persons anticipated to receive supports in various settings and enacts payment rates for all types of publicly-funded supports. Once the budget is appropriated, the executive branch manages it as one allocation that can be spent at the individual level for either community-based care or for nursing home care. The single budget approach allows decisions to be made based upon the needs and preferences of individuals as they move through the system [v].

Reducing Nursing Home Utilization

Pre-Admission Screening (PAS) system

Oregon has developed a PAS system for individuals requesting or referred for nursing facility placement. Key highlights from the PAS system include:

1. Screenings for Medicaid clients are done by the local AAA or state office.
2. PAS determines if the patient is appropriate for a lesser level of community-based care is required before a patient is discharged from a hospital to a nursing home.
3. Substantial fines are imposed on nursing facilities that admit patients prior to pre-admission screening conducted by the AAA.
4. Screenings includes private pay individuals as well as Medicaid. The assessment fee is charged to the individual – approximately $200 – certified by the state.

To receive Medicaid coverage of nursing home care, individuals must have functional limitations that match at least one of the following levels:

1. Dependent in mobility, eating, toileting, and cognition
2. Dependent in mobility, eating, and cognition
3. Dependent in mobility, or cognition, or eating

4. Dependent in toileting
5. Needs substantial assistance with mobility, and assistance with toileting and eating
6. Needs substantial assistance with mobility and assistance with eating
7. Needs substantial assistance with mobility and assistance with toileting
8. Needs minimal assistance with mobility, and assistance with eating and toileting
9. Needs assistance with eating and toileting
10. Needs substantial assistance with mobility
11. Needs minimal assistance with mobility and assistance with toileting
12. Needs minimal assistance with mobility and assistance with eating
13. Needs assistance with toileting
14. Needs assistance with eating
15. Needs minimal assistance with mobility
16. Dependent in bathing or dressing
17. Needs assistance in bathing or dressing

The majority (74 percent) of Medicaid clients served is within the top seven service priority levels. Services to individuals in levels 14 to 17 were eliminated in budget reductions in early 2003, and not restored. Oregon's 2003-2005 budget continues long-term care services for people in levels 1 through 11 [vi].

***In Oregon, AAAs enhance the long-term care system through local networks of community services, and operate as the single point of entry for the elderly and younger disabled needing a wide range of services***

Area Agency on Aging Service Delivery Models

In Oregon, AAAs enhance the long-term care system through local networks of community services, and operate as the single point of entry for the elderly and younger disabled needing a wide range of services including long-term care, financial assistance, food stamps, Older Americans Act programs, and Oregon Project Independence services. O.R.S. Chapter 410 allows AAAs to optionally choose to administer state social, health, and independent living services for seniors and people with disabilities. As a result, the following two options exist:

Type A

Contracts with the state to provide Oregon Project Independence and Older Americans Act programs only. This option is available to private, non-profits or to AAAs that are part of a unit of local government. This type serves only persons 60 years of age and older, and does not administer any Medicaid, Food Stamp, or Adult Protective Service Programs. In Type A areas, the state also operates local multi-service offices that administer the Medicaid, General Assistance, Food Stamps, and Adult Protective Services programs to seniors and people with disabilities.

Type B

This option is available to AAAs that are part of a unit of local government. The governmental entity can be counties, councils of government, or a consortium of counties. Over 90 percent of Oregon's long-term care caseload is administered using this model.

Type B1 - Contracts with the state to provide Medicaid, Oregon Project Independence services and Older Americans Act programs for seniors over 60, and Medicaid, Food Stamps, and Adult Protective Services programs to seniors over age 65. It does not serve people with disabilities that are under age 65. In areas operating as Type B1 agencies, the state also operates a disability service office.

Type B2 – Administers all the programs that a Type B1 agency administers, plus provides services to people with disabilities under the age of 65. In Type B2 areas, there are no state operated offices for seniors or people with disabilities.

Case Management

Oregon bases its eligibility for long-term care services on the level of care determination for each participant. Each individual receives an identical comprehensive assessment conducted by a case manager employed by the single entry point. The case managers serve as the navigators and gatekeepers for the overall long-term care system. Case management services include the initial assessment of functional abilities using a computer-based tool and the availability of social supports, the development of an individualized plan of care, and the authorization of appropriate types and amounts of services. The assessment information is entered into a database that calculates whether a person meets the state's nursing facility level of care criteria.

Adult Foster Homes

Foster care homes in Oregon have been successful in helping seniors and people with disabilities remain independent in a home-like setting. An adult foster home is a licensed home operated in a family-type setting, which provides 24-hour supervision and room and board for 1 to 5 residents. The homes are licensed and monitored by Area Agencies on Aging. Approximately 14% of Oregon's long term care Medicaid caseload receives services in Adult Foster Care homes.

Oregon also funds Relative/Limited License Adult Foster Care Homes. Relative adult foster care can be provided by any relative, other than a spouse. The system allows SDSD to reimburse an individual for providing care to his or her older or disabled relative. The limited license adult foster care option allows for care by an unrelated provider, with whom the care recipient has an established relationship [vii]. Adult foster care is not an option currently available in California.

## Florida

***Similar to other states, the principal goal of all programs operated by the Department is to help elders remain in their own homes and communities in the least restrictive and most appropriate setting, to prevent unnecessary or premature nursing home placement.***

Florida has the highest concentration of older adults among the states examined, with 2.8 million older Floridians, representing 17.6 percent of the state's population. In 1991, The Florida Department of Elder Affairs was created as a result of a 1988 constitutional amendment and its later statutory enactment in the "Department of Elderly Affairs Act. The Department began operation in 1992, charged as the primary agency for the administration of services for older individuals, and developing long-term care policy and recommendations. Similar to other states, the principal goal of all programs operated by the Department is to help elders remain in their own homes and communities in the least restrictive and most appropriate setting, to prevent unnecessary or premature nursing home placement. The Department provides the following services:

- Statewide home and community-based services
- Self-care and community volunteer initiatives
- Nursing home pre-admission screening
- Consumer advocate services
- Long-term care pilot programs
- Employment training for older workers

**Reducing Nursing Home Utilization**

To carry out its mission, the Department developed a Master Plan on Aging entitled "Communities for a Lifetime", to establish a policy framework to guide future resource allocation decisions. The report states that Florida's long-term care system is confusing to access and out of balance with consumer preference for in-home care. Long-term care expenditures are heavily weighted towards nursing home care. Reimbursement mechanisms have become a driving force in care options, making nursing homes the most accessible care options for eligible individuals. Florida's Medicaid expenditures for nursing home care exceeded $1.5 billion in 2001 [viii].

Over the last three years, Florida has made progress towards achieving balance in the long-term care system. Appropriations for Medicaid-funded long-term care services other than nursing home care has increased significantly. Assisted living care and home and community-based care have each increased by 50 percent. In 2001, the Florida Legislature established a five-year moratorium on the development of new nursing home beds and established a workgroup to develop recommendations for a certificate of need (CON) process.

The Nursing Home Pre-Admission Screening program – CARES program (Comprehensive Assessment and Review for Long-Term Care Services) was established to certify medical eligibility for Medicaid nursing home and community-based waiver services with the goal of recommending the least restrictive placement. To be eligible, individuals must meet one of the following criteria:

1. Require assistance with four or more activities of daily living (ADLs) or three ADLs plus assistance with medication administration: OR
2. Require total assistance with one or more ADLs: OR
3. Have a diagnosis of Alzheimer's Disease or another type of dementia and require assistance with two or more ADLs.

CARES will also periodically perform assessments on nursing facility residents to determine that they continue to meet the eligibility requirements, and to assess their potential for returning to the community. Private pay individuals may be assessed at their request, at no charge.

In addition, the Department has developed a targeting mechanism based upon a comprehensive assessment of the elder's care needs and their available resources to address those needs. The resources include the extent to which the individual is provided informal care, and their ability to purchase services [v].

**Area Agency on Aging Service Delivery**
The Department formally designates, funds, and monitors the Older Americans Act-mandated AAAs. The Florida Statutes (Section 430.203(9)(c)) provide that the 11 AAAs contract with "Community Care System Lead Agencies" to provide case management and other services. The Lead Agencies provide the services directly, or through sub-contracts.

## Washington State

Currently, there are 662,148 older adults in Washington, representing 11.2 percent of the population. Washington has historically been a national leader in the development of community-based services for long-term care. Over the past 25 years, Washington has taken a number of important steps aimed at improving the availability and quality of services for its older adults and individuals with disabilities. Washington was one of the first states to provide state-funded chore services to enable individuals with disabilities to remain in their own homes. Like Oregon, Washington has a single long-term care budget, and a single state operational structure for both nursing facility and home and community-based services [ix].

***Like Oregon, Washington has a single long-term care budget, and a single state operational structure for both nursing facility and home and community-based services.***

**System Development Timeline [x]**

- 1983 – Washington receives federal approval for its Community Options Program Entry System (COPES) Medicaid Waiver, thereby allowing nursing home eligible clients to be served in home and community-residential settings.
- 1984 – the Department of Social and Health Services (DSHS) adopted a formal policy limiting the growth of nursing home care and promoting the expansion of home and community-based care.
- 1986 - The Bureau of Aging and Adult Services is merged with the Bureau of Nursing Home Affairs to form the Aging and Adult Services Administration (AASA).

- 1989 – The Washington State Legislature enacts Substitute House Bill (SHB) 1968 and forms the Long-Term Care Commission, charged with studying and recommending comprehensive reforms in the state's system of services for people with chronic disabilities. The Commission issues a report documenting reform recommendations to the legislature.
- 1995 – The Washington State Legislature enacts Long-Term Care Options Program through E2SHB 1908 which enables AASA to limit unnecessary nursing home utilization in favor of home and community-based care.
- 1998 – Boarding home licensing responsibilities are transferred from the Department of Health to DSHS.
- 2003 – The Division of Developmental Disabilities is combined with AASA to form the Aging and Disabilities Services Administration.

**Service Delivery System Highlights**

The Aging and Disability Services Administration (ADSA) is part of the Department of Social and Health Services, the Washington state agency that includes all social services except veterans and prisons. Unlike many other states, ADSA brings together under one administrative organization the major long-term care programs – Home-Based Care, Community-Residential Care, and Nursing Facilities designed for adults with chronic illness, cognitive impairment, and functional disability. In brief, ADSA is responsible for the Older Americans Act, nursing facilities, adult family homes, boarding homes – including assisted living, Medicaid as it pertains to long-term care for seniors and adults without mental illness, and state financed home and community-based long-term care programs [xi].

The ADSA organization includes:

Statewide Network of Home & Community Services Offices

- Financial eligibility for state/federal long-term care benefits
- Functional needs assessment for adults with disabilities
- Case management for adults in residential care settings
- Quality Assurance for client eligibility, care planning/case management
- Adult protective services investigation and response

Statewide Residential Care Quality Assurance

- Nursing facilities
- Boarding homes/assisted living facilities
- Adult family homes
- Intermediate care facilities/mental retardation

Statewide Network of Contracted Area Agencies on Aging

- Specialized senior information and assistance program
- Local contracting and quality assurance for home care
- Case management for adults receiving care in their homes
- Nursing services for adults in home/community care

- Other specialized home and community-based care programs

Aging and Long-Term Care Payment Administration
- Home care and other community-based aging programs
- Community-residential care and nursing facilities

**Single Agency/Single Budget Model**
Washington consolidated its administration of all long-term care for older people and people with physical disabilities in 1986, creating a single agency. The agency has a single budget line item for both community and institutional long-term care [vi].

**Reducing Nursing Home Utilization**
More than half as many Washington Medicaid beneficiaries receive care in adult family homes and in group homes or assisted living facilities as in nursing homes. Home and community-based care services provided to individuals with physical assistance needs average approximately $12,000 per year per client, or about 40 percent of nursing home costs. As a result of explicitly diverting resources from nursing homes into the home and community-based system, it has reduced institutionalization among both the non-elderly with disabilities, and the elderly.

Washington diverts avoidable nursing home admission and limits nursing home utilization in three key ways:
- Options are provided to nursing home clients on the front end through an eligibility screening and care planning process. Screenings for all long-term care services are managed by local and regional offices throughout the state.
- State caseworkers are explicitly directed to relocate significant numbers of current nursing home residents to the community on an annual basis. Nursing home relocation is an important mechanism for financing home and community-based care expansion.
- The Certificate of Need (CON) program and incentives for nursing homes to close unused beds, or convert to assisted living structures are used as direct inducements to reduce nursing home censuses.

***Washington also has developed a rigorous response system designed to ensure that individuals at high risk of institutionalization receive information about their long-term care options quickly.***

Case Management
ADSA district offices determine Medicaid eligibility for all institutional and community-based long-term care programs. These offices provide case management for individuals in institutional or residential care settings. The 13 AAAs provide case management for individuals receiving Medicaid-financed in-home services.

Case managers located in nursing facilities must contact residents within seven days of their admission, conduct a functional assessment, and discuss the potential for transitioning to home and community-based care with the resident. Washington offers a variety of funding sources to support Medicaid residents with transition expenses.

Washington also has developed a rigorous response system designed to ensure that individuals at high risk of institutionalization receive information about their long-term care options

quickly. If individuals are being discharged from a hospital or rehabilitation center, or if an applicant is in the community and is considered an immediate risk for admission into a nursing facility, local staff must perform a face to face interview within one working day of the referral.

COPES

In Washington, both home care and residential alternatives to nursing homes are part of a larger Home and Community-Based Services (HCBS) Waiver called the Community Options Entry System (COPES). Washington also has a smaller state plan personal care benefit with more intensive services, more restrictive income eligibility, and a less restrictive functional eligibility standard than COPES or nursing facility requirements. Washington's home care system is mostly consumer –directed, with case management provided by AAAs. Service limits in COPES are 112 hours per month for the more expensive providers, and 184 hours for independent providers. The personal care benefit has significantly higher service caps.

Skilled home nursing services are integrated into the COPES home care benefit. Home care aides are allowed to perform medical services, such as delivering medications, inserting catheters, and similar services. ADSA is seeking to expand medicalized in-home services further by proposing to allow in-home nurse delegation at the extensive level permitted in group homes and in assisted living facilities.

**Key Factors in Washington's Organizational Restructuring**

In 1991, the Long-Term Care Commission issued its report and recommendations to the legislature [xii]. The report included three options for reorganizing long-term care services administration at the state level. These options included:

- An **Incremental Change** model which would leave most existing state and local administrative arrangements intact, but make a number of changes intended to reduce fragmentation and duplication in service access, eligibility determination, and case management systems. The model also included a "State Centralization" and a "Regional Systems" variation.
- A **State/Regional Commission** model which would consolidate the various age and disability-related services into a single long-term care program, and assign substantial responsibility and flexibility in management of this program to newly-established state and regional commissions.
- A **Local Area Management Organization** model which would consolidate and regionalize service administration as with the Commission model, but make state and regional-level system management the responsibility of existing units of government, rather than citizens' commissions.

## Endnotes

[i] California Strategic Plan on Aging Advisory Committee (2004). *Planning for an aging California population, preparing for the "Aging Baby Boomers".*

[ii] Little Hoover Commission (2004). *Real lives, real reforms: improving health and human services.*

[iii] California Performance Review (2004). *Government for the people for a change*. Volumes II and III.

[iv] California Health and Human Services Agency (1998). *Report:* l*ong term care services in California, response to AB 1215 (Chapter 322 Statutes of 1997).*

[v] U.S. Department of Health and Human Services Assistant Secretary for Planning and Evaluation Office of Disability, Aging and Long-Term Care Policy (2003). *Using Medicaid to cover services for elderly persons in residential care settings: state policy maker and stakeholder views in six states.*

[vi] U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services Disabled and Elderly Health Programs Division (2003). *Money follows the person and balancing long-term care systems: state examples.*

[vii] Governor's Task Force on the Future of Services to Seniors and People with Disabilities, Oregon Department of Human Services Seniors and People with Disabilities (2002). *Initial report, September 2002.*

[viii] Department of Elder Affairs, State of Florida (2002). *Communities for a lifetime, master plan on aging 2002-2004.*

[ix] Haugen J.C.; Purcell, N.; Quaal, M.; and Zajchowski, N. (2001) *Maintaining long-term care: Washington demographic and economic trends threaten access and quality.* Evans School of Public Affairs, University of Washington.

[x] Aging and Adult Services Administration, Department o Social and Health Services (2002). *State plan on aging under the Older Americans Act for Washington state 2002-2006.*

[xi] Washington State Department of Social and Health Services (2003). *Report to the Legislature: the impact of the creation of the Aging and Disability Services Administration. First follow-up report.*

[xii] Washington State Long-Term Care Commission (1991). *Report and recommendations to the Legislature.*