

# Draft California Master Plan for Aging: Goal 2: Livable Communities & Purpose

We will live in and be engaged in communities that are age-friendly, dementia-friendly, disability-friendly, and equitable for all.

## **GOAL 2: LIVABLE COMMUNITIES RECOMMENDATIONS**

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# Table of Contents

<b>Executive Summary</b> .....	<b>3</b>
<b>Housing</b> .....	<b>5</b>
Executive Summary.....	5
Recommendations: Immediate and Short-Term Action (0-3 years) .....	9
Recommendations: Mid-term Action (3-5 years) .....	16
Recommendations: Long-term Action (5-10 years).....	21
<b>Accessible Transportation</b> .....	<b>24</b>
Executive Summary.....	24
Recommendations: Expand and Improve Accessible Coordinated for Transportation .....	26
Recommendations: Implement Sound Planning and Policy Agenda.....	28
Recommendations: Enhance Rural Services and Volunteer Programs .....	29
Summary .....	30
Transportation Appendices .....	31
<b>Parks and Public Spaces [to be delivered 9/15/2020]</b> .....	
xxx.....	
xxx.....	
xxx.....	
<b>Social Inclusion &amp; Engagement, Civic Participation, and Communication [to be delivered 9/15/2020]</b> ..	
xxx.....	
xxx.....	
xxx.....	
<b>Leadership [to be delivered 9/15/2020]</b> .....	
xxx.....	
xxx.....	
xxx.....	

## EXECUTIVE SUMMARY

### **MPA Goal 2: Livable Communities and Purpose – Housing & Transportation**

Every Californian should live in and be engaged in communities that are age-friendly, dementia-friendly, disability-friendly, and equitable for all. As a vital first step, all Californians should have access to housing they can afford. Housing is not only a human right, but a foundational component of our long-term care system for older adults and people with disabilities. Paired with affordable housing, accessible and affordable transportation gives individuals choice in where they live and how they access their communities. Additionally, civic engagement, health care, parks, and outdoor spaces demonstrate the best outcomes and greatest benefit to livable communities when housing and transportation exists at all stages of life.

To have truly livable communities, California must address the systemic disparities inherent in our built environment by intentionally advancing solutions that build toward equity. These disparities are the product of racially explicit government policies and a legacy of structural racism – from housing policies such as redlining to “urban renewal” and highway construction displacing Black, Latino, and low-income immigrant communities. The same laws and policy that segregates Black Americans and disenfranchises them from access to opportunity and intergenerational wealth-building through home ownership also marginalizes Hispanic, Native Peoples, and certain Asian American and Pacific Islander groups. Intentional action is required to advance livable communities that are truly for all.

#### **The MPA Goal 2 Housing and Transportation Recommendations are designed around the following principles:**

- Everyone should have access to quality housing that is affordable and accessible to them.
- Housing is a foundational component of our continuum of care for older adults and people with disabilities.
- Transportation should be accessible, safe, affordable, and address specialized transportation needs of older adults and people with disabilities.
- To have truly livable communities, California must address the historic and systemic disparities inherent in our built environment by intentionally advancing solutions that build toward equity.
- Each domain of livability is interdependent.

### **MPA Goal 2: Housing Recommendations**

#### **A phased approach is offered to achieving the following goals:**

1. Measure and assess the problem with reliable data;
2. Increase the supply of affordable housing;
3. End homelessness;
4. Create and expand innovative solutions to housing older adults, such as shared housing programs and intergenerational housing models;
5. Develop policy solutions to help redress racially explicit housing policies and their resulting discriminatory systems, and ensure equitable access to housing; and
6. Create and expand programs that help older adults stay permanently housed and allow them to age in place.

## **Immediate and Short-Term Housing Recommendations (0-3 years)**

- Measure and assess the need for affordable and accessible older adult housing.
- Build more affordable senior housing:
  - Examine existing affordable housing programs and adjust regulations to ensure that senior housing projects are funded proportionately and fairly.
  - Create a dedicated source of funding to house older adults, people with disabilities and their caregivers. This must include accessible affordable housing, caregiver housing, home modification and redesign, assistive technology and intergenerational housing and programming.
  - Reduce barriers to development.
- Create a State Flexible Housing Subsidy Pool to end homelessness.
- Support and expand Shared Housing Programs.

## **Mid-Term Housing Recommendations (3-5 years)**

- Expand funding for Permanent Supportive Housing Programs.
- Examine and improve existing Medi-Cal Waiver Programs that allow low-income older adults to receive in-home care and community-based care.
- Create an Integrated Care at Home Demonstration with CMMI grant funding to help older adults and people with disabilities who live in or near affordable housing communities age in place.

## **Long-Term Recommendations (5-10 years)**

- Evaluate progress made to date.
- Make housing a primary component of any statewide long-term care benefit that seeks to treat people at home.
- Adopt a permanent and statewide Integrated Care at Home Program to help older adults and people with disabilities who live in or near affordable housing communities age in place.

## **MPA Goal 2: Transportation Recommendations**

Transportation is the vital link that connects older adults and people with disabilities to social activity, economic opportunity, and community services, hence supporting their independence. Without transportation, people are less able to remain in their homes and communities as they age. Many older adults need specialized transportation services such as door-to-door paratransit and escorts to physician's offices. Historic discrimination and the intersection of disability and discrimination must be part of the calculus in developing a rider centric system. Safe, affordable, accessible, dependable, and user-friendly options are needed to overcome the physical limitations associated with aging and living with one or more disabilities and also being Black, Latino, Asian American and Pacific Islander, or a member of other marginalized populations, such as LGBTQ.

## **Accessible transportation recommendations fall into the following key areas:**

1. Accessible coordinated transportation and mobility spanning the entire age/ability spectrum (local)
  - a. Promote driver safety programs; expand the availability of accessible transit; increase community walkability; and improve accessibility to fixed route services, local/regional passenger rail, and other mass transit
2. Policy and Planning Imperatives (statewide)
  - a. Ensure transportation system reflects the needs of older adults; create a CA coordinated transportation commission; measure impact and outcomes, etc.
3. Rural Investments
  - a. Expand volunteer driver programs; expand RTAP; provide microtransit and flexible fixed route services

## **Adoption of these recommendations will:**

- Transform and create a transportation system that is accessible and designed around the rider, is person-centered and not system or funder-centered.
- Mitigate decades of underinvestment and unfulfilled policies in transportation/services for the population of older persons and those with disabilities, particularly minority populations
- Increase safety and support health
- Address identified needs statewide
- Bring an end to accessible transportation issues being regarded separately and unequally relative to every other mode of transportation
- Increase cost effectiveness and other systemic improvements

## **Conclusion**

Housing that is affordable and accessible transportation are core to the success of livable communities. Housing is foundational component of our long-term care system for older adults and people with disabilities and transportation allows individuals to access health care, engage in community activities, access parks and outdoor spaces, and promote a sense of purpose. Housing and transportation that is equitable, age-friendly, dementia-friendly, and disability friendly binds a community together.

## MPA GOAL 2: LIVABLE COMMUNITIES – HOUSING

### Goal 2. Livable Communities and Purpose – We will live in and be engaged in communities that are age-friendly, dementia-friendly, and disability-friendly.

#### Executive Summary

Every Californian should have access to housing they can afford. Housing is not only a human right, but a foundational component of our long-term care system for older adults and people with disabilities. Housing is healthcare, and a major social determinant of health. Without housing, individuals have diminished access to preventative health care, appropriate medication and rehabilitation, resulting in increased use of hospital and emergency department care.

Access to affordable housing in California is next to impossible for many older adults. Nearly two-thirds who qualify for affordable housing do not receive it. Access to affordable housing is even harder for California’s African American and Hispanic households, who continue to endure the negative impacts of discriminatory private and public housing policies.

California must create housing options suitable for all people, regardless of age, race, gender identity, sexual orientation, income, ability, and life stage.

The following recommendations are designed around the following principles:

- Everyone should have access to quality housing that is affordable and accessible to them;
- Housing is a foundational component of our continuum of care for older adults and people with disabilities;
- To have truly livable communities, California must address the historic and systemic disparities inherent in our built environment by intentionally advancing solutions that build toward equity; and,
- Each domain of livability is interdependent.

The recommendations offer a phased approach to achieving the following goals:

1. Measure and assess the need for housing with reliable data;
2. Increase the supply of affordable housing;
3. End homelessness;
4. Create and expand innovative solutions to housing older adults, such as shared housing programs and intergenerational housing models;
5. Develop policy solutions to help redress racially explicit housing policies and their resulting discriminatory systems, and ensure equitable access to housing; and,
6. Create and expand programs that help older adults stay permanently housed and allow them age in place.

#### 1. Overview

##### 1.1. Housing affordability is declining.

California’s increasing housing costs have particularly affected older adults and people with disabilities who are living on fixed incomes. As housing costs have risen, retirement and disability incomes, such as Social Security and Supplemental Security Income (SSI), have remained stagnant and many low-income individuals are finding it impossible to afford market-rate housing.<sup>1</sup> One in four people over 65 rely almost entirely on their social security benefit<sup>2</sup>, which averages about \$1,503 per month for retired workers and \$1,258 for

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<sup>1</sup> “SSI/SSP Grants Are No Match for California’s Housing Costs,” Scott Graves, January 2020. California Budget and Policy Center. <https://calbudgetcenter.org/resources/ssi-ssp-grants-are-no-match-for-californias-housing-costs/>.

<sup>2</sup> “Housing America’s Older Adults 2019,” Joint Center for Housing Studies of Harvard University. 2019. [https://www.jchs.harvard.edu/sites/default/files/Harvard\\_JCHS\\_Housing\\_Americas\\_Older\\_Adults\\_2019.pdf](https://www.jchs.harvard.edu/sites/default/files/Harvard_JCHS_Housing_Americas_Older_Adults_2019.pdf).

disabled workers.<sup>3</sup> The fair market rent for a one-bedroom apartment in California is \$1,522<sup>4</sup>, leaving the average elder renter with little or no money left over for food and healthcare costs.<sup>5</sup>

In California, over 1,280,000 households age 65 and over are housing cost burdened.<sup>6</sup> Of those households, over 700,000 pay more than half of their income toward housing costs.<sup>7</sup>

Older adults with housing cost burdens are more likely to cut back on food and healthcare expenses. Nationally, severely burdened low-income households age 65 and over spent only \$195 per month on food in 2018, while those without burdens spent an average of \$368.<sup>8</sup> Spending on healthcare expenses is even more unequal, with severely cost burdened households spending 50% less on average (\$174 vs. \$344 per month) than those living in housing they can afford.<sup>9</sup>

As demand increases, access to affordable housing continues to decrease. Only one-third of people who qualify for rental assistance actually receive it.<sup>10</sup> At this rate, rental assistance will become harder to come by as the U.S. population of low-income older adult households increases from 5.3 million to an expected 7.9 million by 2038.<sup>11</sup>

## **1.2. A legacy of racial discrimination and segregation has created lasting barriers to housing.**

For many Americans, a home is the most valuable thing they will ever own. Owning a home is viewed to be one of the most attainable ways to build wealth, but in reality, home ownership has not been available to everyone, especially African Americans.

The United States, at every level of government, has a long history of racially explicit housing policies that have defined where African Americans should live. Historian Richard Rothstein notes, “The stereotypes and attitudes that support racial discrimination have their roots in the system of slavery upon which the nation was founded.”<sup>12</sup>

Racially explicit government housing policies have created a legacy of structural racism in our housing markets. Even after the passage of the 1968 Fair Housing Act (Act), which terminated the discriminatory practice of redlining, government reluctance to enforce provisions of the Act effectively preserved practices and patterns of discrimination already entrenched in the private housing markets.<sup>13</sup>

Today, three out of four neighborhoods “redlined” on government maps in the 1930s continue to struggle economically.<sup>14</sup> Additional enduring negative impacts of discriminatory housing policies include residential patterns, and household accumulation of wealth.<sup>15</sup> As of 2016, the net-worth of a typical white family is

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<sup>3</sup> “Social Security Fact Sheet,” U.S. Social Security Administration, 2019. <https://www.ssa.gov/news/press/factsheets/basicfact-alt.pdf>.

<sup>4</sup> “Out of Reach 2020: California,” National Low Income Housing Coalition. <https://reports.nlihc.org/oor/california>.

<sup>5</sup> “Housing America’s Older Adults 2019,” Joint Center for Housing Studies of Harvard University. 2019. [https://www.jchs.harvard.edu/sites/default/files/Harvard\\_JCHS\\_Housing\\_Americas\\_Older\\_Adults\\_2019.pdf](https://www.jchs.harvard.edu/sites/default/files/Harvard_JCHS_Housing_Americas_Older_Adults_2019.pdf).

<sup>6</sup> “Housing America’s Older Adults 2019: Data,” Joint Center for Housing Studies of Harvard University. 2019. <https://www.jchs.harvard.edu/housing-americas-older-adults-2019>.

<sup>7</sup> Ibid.

<sup>8</sup> “Housing America’s Older Adults 2019,” Joint Center for Housing Studies of Harvard University. 2019. [https://www.jchs.harvard.edu/sites/default/files/Harvard\\_JCHS\\_Housing\\_Americas\\_Older\\_Adults\\_2019.pdf](https://www.jchs.harvard.edu/sites/default/files/Harvard_JCHS_Housing_Americas_Older_Adults_2019.pdf).

<sup>9</sup> Ibid.

<sup>10</sup> Ibid.

<sup>11</sup> Ibid.

<sup>12</sup> Rothstein, Richard. *The Color of Law: A Forgotten History of How Our Government Segregated America*

<sup>13</sup> Taylor, Keeanga-Yamahtta. *Race for Profit (Justice, Power, and Politics)* The University of North Carolina Press.

<sup>14</sup> HOLC “Redlining” Maps: The Persistent Structure of Segregation and Economic Inequality  
By Bruce Mitchell PhD., Senior Research Analyst and Juan Franco, Senior GIS Specialist, NCRC / March 20, 2018 / Research. <https://ncrc.org/holc/>.

<sup>15</sup> Ibid.

nearly ten times greater than that of a Black family.<sup>16</sup> It is important to note that wealth in Hispanic and certain Asian American and Pacific Islander families falls far below their white counterparts' wealth as well.<sup>17</sup>

Families who cannot build and inherit wealth are more likely to need affordable, subsidized housing. In the U.S., Black, Native American and Hispanic households are more likely than white households to live in low-income housing communities.<sup>18</sup> Between 1991 and 2013, the percentage of renter households paying 30 percent or more of their income toward housing costs declined from 54 to 43 percent. However, the percentage of renter households that pay 50 percent or more of their income toward housing costs, rose from 21 percent to 30 percent. Black and Hispanic households, a majority of whom live in rental housing, are disproportionately affected by this trend. Nearly a quarter of Black and Hispanic households spent more than half of their income on housing costs in 2013.<sup>19</sup>

While the systemic racism prevalent in our housing systems is a direct result of discrimination against African Americans, research shows that other racial and ethnic groups, particularly Hispanic households, have similar experiences to African Americans in many housing markets.

### **1.3. Homelessness Among Older Adults and People with Disabilities is Rising**

Lack of access to affordable housing is causing homelessness among older adults and persons with disabilities to increase at an alarming rate. The Los Angeles Homeless Services Authority (LAHSA) reports that according to the 2019 Greater Los Angeles Homeless Count there are 13,606 adults age 55 and older experiencing homelessness in the Los Angeles Continuum of Care.<sup>20</sup> This older age group makes up 23% of the homeless population in Los Angeles County and is expected to grow rapidly over the next decade.<sup>21</sup> Older adult homelessness in Los Angeles reflects a problem facing California as a whole, nearly half of single adults experiencing homelessness are age 50 and older.<sup>22</sup>

Older adults experiencing chronic homelessness have health conditions and functional status similar to, or worse, than, adults in the general community.<sup>23</sup> Homelessness also reduces life expectancy and increases mental health and substance abuse challenges.<sup>24</sup> Moreover, as individuals experiencing homelessness age, they are likely to incur increasingly greater health care costs from hospitalization and nursing home placements.<sup>25</sup>

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<sup>16</sup> "Examining the Black-white wealth gap." Kriston McIntosh, Emily Moss, Ryan Nunn, and Jay Shambaugh, February 27, 2020. <https://www.brookings.edu/blog/up-front/2020/02/27/examining-the-black-white-wealth-gap/>.

<sup>17</sup> Systematic Inequality: How America's Structural Racism Helped Create the Black-White Wealth Gap" By Angela Hanks, Danyelle Solomon, and Christian E. Weller February 21, 2018.

<https://www.americanprogress.org/issues/race/reports/2018/02/21/447051/systematic-inequality/>

<sup>18</sup> "Racial Disparities Among Extremely Low-Income Renters," National Low-Income Housing Coalition, Apr 15, 2019.

<https://nlihc.org/resource/racial-disparities-among-extremely-low-income-renters>

<sup>19</sup> Matthew Desmond, "Unaffordable America: Poverty, housing, and eviction" (Madison, WI: Institute for Research on Poverty, 2015), <http://www.irp.wisc.edu/publications/fastfocus/pdfs/FF22-2015.pdf>.

<sup>20</sup> "2019 Greater Los Angeles Homeless Count Results," Los Angeles Homeless Services Authority, 2019.

<https://www.lahsa.org/news?article=557-2019-greater-los-angeles-homeless-count-results>.

<sup>21</sup> Ibid.

<sup>22</sup> "Brief Report: the aging of the homeless population: fourteen-year trends in San Francisco," Hahn JA, Kushel MB, Bangsberg DR, Riley E, Moss AR. *J Gen Intern Med.* 2006;21(7):775-778. doi:10.1111/j.1525-1497.2006.00493.

<https://pubmed.ncbi.nlm.nih.gov/16808781/>.

<sup>23</sup> "Homelessness in Older Adults: Causes and Solutions," Margot Kushel, MD. *LeadingAge California Engage Magazine*, Fall 2016.

<https://clid.bz/bookdata/oSTzAT/basic-html/page-12.html#>.

<sup>24</sup> "Homelessness Among Elderly Persons," National Coalition for the Homeless, September 2009.

<https://www.nationalhomeless.org/factsheets/Elderly.pdf>.

<sup>25</sup> "A Research Note: Long-Term Cost Effectiveness of Placing Homeless Seniors in Permanent Supportive Housing," Joshua D. Bamberger and Sarah K. Dobbins. *Cityscape: Journal of Policy Development and Research*, Volume 17, Number 2, 2015. U.S.

Among the nation’s racial and ethnic groups, Black Americans have the highest rate of homelessness. California has the highest Black homeless rates in the country.<sup>26</sup> In San Francisco, for every 10,000 people, there are 591 Black individuals experiencing homelessness.<sup>27</sup> In Los Angeles City and County, for every 10,000 people, there are 284 Black individuals experiencing homelessness.<sup>28</sup>

#### 1.4. Housing is a Foundational Component of California’s Continuum of Care

Housing is a foundational component of our Long-Term Care system for older adults and people with disabilities, as well as a social determinant of health. The prevalence of chronic conditions and frailty increases with age.<sup>29</sup> In many cases, deteriorating physical and cognitive functioning impede the ability of these individuals to live independently in the community.<sup>30</sup> Without a safe, stable place to live, it is difficult for older adults and people with disabilities to receive proper and effective preventative care and treatment for chronic conditions.

Data from the California Department of Aging estimates that 44.5 percent of California’s over 60 population identify as Non-White.<sup>31</sup> This number is projected to increase more than 20 percent by 2050.<sup>32</sup> In California, individuals identifying as Black and Hispanic are more than twice as likely as white counterparts to live below 100 percent of the Federal Poverty Line (FPL).<sup>33</sup> This income gap has resulted in health disparities in minority populations, including a higher prevalence of disability.<sup>34</sup>

Affordable housing properties linked with health and supportive services have proven to help significantly in meeting the varied needs of lower-income seniors and people with disabilities while also helping address multiple public policy priorities.<sup>35</sup> Senior housing communities provide unique opportunities for health care providers and community-based service organizations. Namely, these communities provide economies of scale, allowing providers to deliver on-site health care services to a large group of people.<sup>36</sup> These

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Department of Housing and Urban Development, Office of Policy Development and Research.

<https://www.huduser.gov/portal/periodicals/cityscape/vol17num2/ch11.pdf>.

<sup>26</sup> “Demographic Data Project: Race, Ethnicity, and Homelessness,” Joy Moses. 2018. Homelessness Research Institute, National Alliance to End Homelessness.

<sup>27</sup> Ibid.

<sup>28</sup> Ibid.

<sup>29</sup> “Frailty and Chronic Diseases in Older Adults,” Carlos O. Weiss, MD, MHS. Clin Geriatr Med 27 (2011) 39–52. Division of Geriatric Medicine and Gerontology, Johns Hopkins School of Medicine. [https://www.geriatric.theclinics.com/article/S0749-0690\(10\)00077-7/pdf](https://www.geriatric.theclinics.com/article/S0749-0690(10)00077-7/pdf).

<sup>30</sup> “Exploring Financing Options for Services in Affordable Senior Housing Communities,” Alisha Sanders, Robyn Stone, Marc Cohen, LeadingAge LTSS Center @UMass Boston, Nancy Eldridge, National Well Home Network, David Grabowski, Harvard Medical School Department of Health Care Policy. April 2019. LeadingAge LTSS Center @UMass Boston. [www.ltsscenter.org/reports/Financing\\_Services\\_in\\_Affordable\\_Senior\\_Housing\\_FULL\\_REPORT.pdf](http://www.ltsscenter.org/reports/Financing_Services_in_Affordable_Senior_Housing_FULL_REPORT.pdf).

<sup>31</sup> “2019 California Department of Aging (CDA) Population Demographic Projections by County and PSA for Intrastate Funding Formula,” March 15, 2019. <https://www.aging.ca.gov/download.ashx?IE0rcNUV0za6g%2fiYXuBV%2bA%3d%3d>.

<sup>32</sup> “California State Plan on Aging, 2017-2021, Appendix G,” <https://www.aging.ca.gov/download.ashx?IE0rcNUV0zbUy1iwYmWKnG%3d%3d#page=91>.

<sup>33</sup> “California State Plan on Aging, 2017-2021, Appendix I,” <https://www.aging.ca.gov/download.ashx?IE0rcNUV0zbUy1iwYmWKnG%3d%3d#page=93>.

<sup>34</sup> “Racial/Ethnic Differences in the Development of Disability Among Older Adults” American Journal of Public Health. Dorothy D. Dunlop PhD, Jing Song MS, Larry M. Manheim PhD, Martha L. Daviglius MD, PhD, and Rowland W. Chang MD, MPH. December 2007. [https://ajph.aphapublications.org/doi/full/10.2105/AJPH.2006.106047?url\\_ver=Z39.88-2003&rfr\\_id=ori%3Arid%3Acrossref.org&rfr\\_dat=cr\\_pub++0pubmed&](https://ajph.aphapublications.org/doi/full/10.2105/AJPH.2006.106047?url_ver=Z39.88-2003&rfr_id=ori%3Arid%3Acrossref.org&rfr_dat=cr_pub++0pubmed&).

<sup>35</sup> “Exploring Financing Options for Services in Affordable Senior Housing Communities,” Alisha Sanders, Robyn Stone, Marc Cohen, LeadingAge LTSS Center @UMass Boston, Nancy Eldridge, National Well Home Network, David Grabowski, Harvard Medical School Department of Health Care Policy. April 2019. LeadingAge LTSS Center @UMass Boston. [www.ltsscenter.org/reports/Financing\\_Services\\_in\\_Affordable\\_Senior\\_Housing\\_FULL\\_REPORT.pdf](http://www.ltsscenter.org/reports/Financing_Services_in_Affordable_Senior_Housing_FULL_REPORT.pdf).

<sup>36</sup> Ibid.

partnerships save providers, Medi-Cal and Medicare money while allowing individuals to age-in-place with better health outcomes.<sup>37</sup>

Long-term care is a matter of particular concern for the state because it constitutes nearly one-third of all Medicaid spending.<sup>38</sup> Although it constitutes a decreasing share of total expenditures, institutional care continues to account for more than half of Medicaid expenditures for long-term care services.<sup>39</sup> In California, the cost of keeping an older adult independent in their own home averages 64% less than nursing home care.

None of this is possible, however, without housing. California must prioritize the creation of affordable housing for older adults and people with disabilities and then create and expand programs to help them age in place.

## 2. Recommendations for Immediate and Short-Term Action (0-3 years)

- 2.1. Measure and assess the need for affordable and accessible housing among California's older adult population.** There is a lack of state-level data pertaining to the housing needs of older adults and people with disabilities. There is a particular need for data to assess rates of housing insecurity, homelessness, and the overall need for affordable housing and access to affordable housing. All metrics should require analysis of the data by the equity dimensions of race/ethnicity, income, age and ability to prevent disparities in access to housing.
- 2.2. Adopt a Right to Housing Policy for all.** The State of California should adopt a Right to Housing Policy for all people, including older adults and people with disabilities. The policy should state that all Californians have the right to safe, decent, accessible and affordable housing and would serve to guide state legislative and administrative action and increase cross-sector collaboration among state agencies.
- 2.3. Build more affordable housing for older adults and people with disabilities.** The single most important step to helping older adults and people with disabilities delay or avoid institutionalization is to facilitate aging-in-place. To do this, every older adult and person with a disability must have access to safe, quality housing that is affordable and accessible to them. It is very difficult to build affordable senior housing in California for a number of reasons, including: lack of state funding, high-development costs, and inadequate federal subsidies.

While seniors can live in non-age-restricted affordable housing, affordable senior housing plays an important role in California's continuum of care. Affordable senior housing is typically defined as affordable housing that is restricted to tenancy by individuals 55 and over or 62 and over, as well as individuals 18 and over with a disability.

Affordable senior housing is often a preferred option for older renters for a variety of reasons including onsite service coordination, age-appropriate social, health and wellness programming and linkages to community services including health care, transportation, and food. These services help older adults age safely in place and prevent social isolation. This is particularly important for older adults suffering from chronic illness, physical disability and cognitive impairment.

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<sup>37</sup> Ibid.

<sup>38</sup> "Medicaid Today; Preparing for Tomorrow: A Look at State Medicaid Program Spending, Enrollment and Policy Trends. Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2012 and 2013," Vernon K. Smith, Ph.D., Kathleen Gifford and Eileen Ellis, Health Management Associates. Robin Rudowitz and Laura Snyder, Kaiser Commission on Medicaid and the Uninsured Kaiser Family Foundation. October 2012. <https://www.kff.org/wp-content/uploads/2013/01/8380.pdf>.

<sup>39</sup> "A Short Look at Long-term Care for Seniors," Kaiser Family Foundation. JAMA. 2013. <https://jamanetwork.com/journals/jama/fullarticle/1733726>.

This recommendation has been prioritized because of the time it takes to put new housing developments in the pipeline. The state must act quickly to create and rehabilitate housing that will be ready for occupancy in the next 3-5 years and beyond.

**2.3.1. Examine existing affordable housing programs and adjust regulations to ensure that senior housing projects are funded proportionately and fairly.**

**2.3.1.1. State housing programs should fund senior housing at a rate proportionate to size of the need.** The need for senior housing can be roughly estimated by the size of California’s older adult population, which is growing quickly. By 2030, California’s over-60 population will account for over 25 percent of the State’s total population.<sup>40</sup> California’s funding allocations for affordable housing should reflect the projected size of the older adult population. For example, the State’s Qualified Allocation Plan for the Low-Income Housing Tax Credit Program calls for a maximum 15 percent of funding to be allocated for senior housing. Other programs, like the Affordable Housing and Sustainable Communities program, do not set any goals for funding senior housing.

**2.3.1.2. Recognize the linkages between housing and transportation and update program objectives and scoring criteria to ensure the needs of older adults and people with disabilities are met.** Transportation is the vital link that connects older adults and people with disabilities to social activity, economic opportunity, necessities, and community services; hence supporting their independence. Despite the importance of accessible, affordable, and available transportation options for older adults and people with disabilities, state programs that seek to fund affordable housing and infrastructure projects near mass transit sites, like the Affordable Housing and Sustainable Communities (AHSC) Program and the Transit-Oriented Housing Development Program (TOD Housing Program), have consistently overlooked these needs. Each housing funding program has regulations that define the objectives of the program and detail which projects should receive priority for funding. Regulations for the AHSC and TOD Housing Program should be updated to reflect the housing and transportation needs of older adults and people with disabilities. For instance, the Transit-Oriented Housing Development Program (TOD Housing Program) guidelines state that the primary objectives of the program are to, “increase the overall supply of housing, increase the supply of affordable housing, increase public transit ridership, and minimize automobile trips.”<sup>41</sup> The objectives of the TOD Housing Program should be updated to include “connect older adults and people with disabilities to essential services.”

**2.3.1.3. Update scoring criteria for housing funding by acknowledging that older adults have special needs.** Another way to help increase funding for affordable senior housing is to acknowledge that older adults are a special needs population. Some of California’s housing programs have scoring criteria which award additional points to developers to build housing for special needs populations. While the definition of special needs populations varies from one program to another, one thing is consistent – older adults are not considered to have special needs in California’s housing programs, and are therefore not given preference for housing development funding. There is ample evidence to support a categorization of low-income older adults as a special needs population, as the

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<sup>40</sup> California Department of Finance Demographic Projections: Total Population by Age Baseline 2019.

<http://www.dof.ca.gov/Forecasting/Demographics/Projections/>.

<sup>41</sup> “Transit-Oriented Housing Development Program Round 4 Guidelines, April 30, 2020,” California Department of Housing and Community Development. <https://www.hcd.ca.gov/grants-funding/active-funding/docs/TOD-Guidelines-4-30-2020.pdf>.

term relates to housing programs. In the U.S., 85 percent of older adults have at least one chronic condition and 56 percent have at least two chronic conditions.<sup>42</sup> Additionally, rates of mobility limitations<sup>43</sup> and cognitive decline increase<sup>44</sup> with age.

Updating scoring criteria to acknowledge that older adults have special needs will help create more housing opportunities for African American and Hispanic older adults and people with disabilities who are more likely than their white peers to live in affordable housing<sup>45</sup>, and are more likely to suffer from one or more chronic health conditions.<sup>46</sup>

California's Multi-Family Housing Program awards points for projects that serve "frail elderly."<sup>47</sup> However, frail elderly is defined in a way that would limit occupancy to high-acuity individuals, who likely are not able to live independently without supportive services, which are not funded.

**2.3.2. Create a dedicated source of funding to build, rehabilitate, preserve and adapt accessible and affordable housing for older adults and people with disabilities.** Creating housing for older adults and people with disabilities should be a state priority. With recent declines in available caregivers, increased costs for long-term care and a reduction of available skilled nursing beds, California's long-term care system is not equipped to handle the imminent growth of our frail elderly population. Ensuring that our older adults have safe, stable housing and the services they need to age-in place will help keep our long-term care system, and Medi-Cal from being overwhelmed.

Older adults and people with disabilities have special housing needs that are largely not met by existing housing programs. Creating a separate source of funding will help to increase the supply of housing for older adults and people with disabilities who have varied health needs. The fund could finance the following types of projects:

**2.3.2.1. Affordable senior housing and caregiver housing:** As stated above, affordable senior housing is often a preferred option for older renters for a variety of reasons including onsite service coordination, age-appropriate social, health and wellness programming and linkages to community services including health care, transportation, and food. These services help older adults age safely in place and prevent social isolation. This is particularly important for older adults suffering from chronic illness, physical disability and cognitive impairment.

Most affordable housing designs do not include space for live-in caregivers. With the high costs of housing in California, caregivers often cannot afford to live near their patients. Caregivers end up sleeping on the couch in their patients' homes. A dedicated source of

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<sup>42</sup> "Percent of U.S. Adults 55 and Over with Chronic Conditions," U.S. Centers for Disease Control and Prevention, National Center for Health Statistics. 2009. [https://www.cdc.gov/nchs/health\\_policy/adult\\_chronic\\_conditions.htm](https://www.cdc.gov/nchs/health_policy/adult_chronic_conditions.htm).

<sup>43</sup> When Walking Fails: Mobility Problems of Adults with Chronic Conditions. Lisa Lezzoni. University of California Press. 2003.

<sup>44</sup> "Subjective Cognitive Decline — A Public Health Issue," U.S. Centers for Disease Control and Prevention, Alzheimer's Disease and Healthy Aging. 2019. <https://www.cdc.gov/aging/data/subjective-cognitive-decline-brief.html>.

<sup>45</sup> "Racial Disparities Among Extremely Low-Income Renters," National Low-Income Housing Coalition, Apr 15, 2019. <https://nlihc.org/resource/racial-disparities-among-extremely-low-income-renters>.

<sup>46</sup> "Health Disparities by Race and Ethnicity," By Sofia Carratala and Connor Maxwell, May 7, 2020. Center for American Progress. <https://www.americanprogress.org/issues/race/reports/2020/05/07/484742/health-disparities-race-ethnicity/#:~:text=regardless%20of%20race.%E2%80%9D-,Health%20coverage,health%20insurance%20coverage%20in%202017.>

<sup>47</sup> "Multifamily Housing Program Guidelines, Effective June 19, 2019," California Department of Housing and Community Development. <https://www.hcd.ca.gov/grants-funding/active-funding/mhp/docs/Round-1-MHP-Final-Guidelines.pdf>.

funding for senior housing can explore new architectural design to allow for caregivers to have their own housing in and near where their patients live.

**2.3.2.2. Intergenerational housing and programming models:** Intergenerational living is an innovative concept that seeks to blend individuals of various ages, often within the same family, to build stronger communities, enhance our understanding of one another and reduce ageism. For older adults, intergenerational housing and programming can help reduce isolation and loneliness.

Many existing intergenerational housing models in the U.S. serve higher-income individuals in life-plan communities where there is funding and staff to help create and operate multigenerational programming. There are also developers creating multigenerational living spaces in single-family homes.

A dedicated source of funding for senior housing can help to fund multigenerational housing models for people of all-incomes, and particularly low-income individuals. Funding can also help to bring multigenerational programming to existing housing communities.

**2.3.2.3. Accessibility, home repair, modification, and redesign:** California requires that all housing units be adaptable or accessible. With public funding, a development must include five to ten percent of units that are accessible and the rest only adaptable. Funding under this program should require a higher percentage of units to be accessible.

Home repair, modification and redesign programs are underfunded and fragmented. This fund should help supplant federal funding for home repair, modification and redesign that flows through the Area Agencies on Aging. Sometimes, just a simple fix, such as replacing doorknobs with pull handles can help an older adults maintain their independence and prevent accidents.

Changes can improve the accessibility, adaptability, and design of a home. Low-income older adults and people with disabilities should have access to funding to help improving accessibility in their own homes, so they can remain housed independently in a safe manner.

**2.3.2.4. Innovation, including assistive technology.** Combined with coordinated health and social service programs, technology can play a critical role for helping people with physical, cognitive and developmental limitations live safely at home independently, preventing unnecessary and unwanted institutionalization.

**2.3.3. Reduce barriers to development in California.** California’s Roadmap HOME 2030 is a coordinated, statewide initiative to develop and implement a comprehensive plan to advance actionable solutions to increase the state’s housing supply and end homelessness.<sup>48</sup>

While the Roadmap HOME 2030 is not specific to housing older adults and people with disabilities, it offers detailed, innovative approaches to reducing barriers to developing all types of affordable housing. The solutions outlined in Roadmap HOME 2030 partner well with the recommendations

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<sup>48</sup> California Roadmap HOME 2030. <https://roadmaphomeca.org/>.

made here and if implemented concurrently would help to increase the supply of affordable senior housing and end homelessness for older adults and people with disabilities.

[LINK TO BE INSERTED IN SEPTEMBER FINAL GOAL 2 REPORT]

**2.3.4. The Governor and Legislature must advocate for more federal funding.** Federal funding is responsible for the development and operation of much of the existing affordable housing for older adults and people with disabilities in California. In the absence of a statewide rental assistance program, California relies on federal rental assistance to keep rents affordable to extremely low-income (30 percent of Area Median Income) and very low-income (50 percent of Area Median Income) individuals. The Governor and Legislature should work with California’s Congressional Delegation to secure funding for the following:

**2.3.4.1. Greater investment the Section 8 Project-based Rental Assistance Program, the Section 202 Supportive Housing for the Elderly Program, and the Section 811 Supportive Housing for Persons with Disabilities Program.** Rental assistance payments from HUD programs, like Sections 8, Section 202, and Section 811, keep rents affordable for low-income individuals. Federal rental assistance ensures that a person with qualifying income pays no more than 30 percent of their income toward housing costs.

In California alone, 248,400 older adults and 281,300 people with disabilities receive federal rental assistance, however, that is estimated to be only a third of those who actually need it.<sup>49</sup> Without rental assistance, many of these households would be at risk of eviction and becoming homeless. However, as housing costs have increased, rental assistance has been harder to come by.

In addition to full funding for the renewal of existing Section 202, Section 811 and Section 8 Project-Based Rental Assistance rental assistance contracts, Congress should invest \$1 billion a year for the development of new Section 202 homes. A \$1 billion investment could produce more than 12,000 homes a year.

**2.3.4.2. Greater investment in Service Coordinator Grants.** Congress should invest \$100 million a year for new Service Coordinator Grants to ensure that every federally subsidized housing community serving older adults has a Service Coordinator. Service coordinators, often trained in social work, assist elderly and/or disabled residents by identifying, locating, and acquiring the services necessary for them to age in place and live independently in their own homes.<sup>50</sup> Currently, about 40 percent of subsidized senior housing properties have on-site service coordinators. The availability of an on-site service coordinator at federally subsidized senior housing reduced hospital admissions among residents by 18 percent.<sup>51</sup>

**2.3.4.3. Expand and strengthen the Low-Income Housing Tax Credit Program and create a credit to pay for supportive services.** The Low-income Housing Tax Credit (LIHTC) is an essential tool for creating new housing and preserving existing housing. The program should be strengthened and expanded to build more housing, provide deeper affordability, and fund supportive services which are not funded in the current model.

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<sup>49</sup> Federal Rental Assistance Fact Sheets. Center on Budget and Policy Priorities. December 2019.

<https://www.cbpp.org/research/housing/federal-rental-assistance-fact-sheets#CA>.

<sup>50</sup> Service Coordination Fact Sheet.” American Association of Service Coordinators.

[https://cdn.ymaws.com/www.servicecoordinator.org/resource/resmgr/files/Public\\_Policy/AASC\\_service\\_coordinator.pdf](https://cdn.ymaws.com/www.servicecoordinator.org/resource/resmgr/files/Public_Policy/AASC_service_coordinator.pdf).

<sup>51</sup> “Senior Housing Coordinators Help Reduce Hospital Admissions” MacArthur Foundation. November 2015.

<https://www.macfound.org/press/publications/senior-housing-coordinators-help-reduce-hospital-admissions/>.

- 2.3.4.4. Secure federal funding from the Centers for Medicare and Medicaid Services for an Integrated Care at Home Demonstration.** The Center for Medicare and Medicaid Innovation (CMMI) is funded to support the development and testing of innovative health care payment and service delivery systems including Integrated Care at Home Demonstrations.
- 2.3.4.5. Create a Housing Assistance Entitlement.** Congress should provide an entitlement to housing assistance for all households age 62 and over with incomes below 50% of area median income. Such housing assistance could be used toward rents, mortgages and taxes.
- 2.3.4.6. Create a unified National Home Modification Program.** Currently, the United States has a patchwork of home modification programs. Congress should create an integrated national home modification program to ensure accessibility homes, both owned and rented, for older adults.
- 2.3.4.7. Bridge the digital divide in senior housing.** Congress should invest \$800 million to install and pay service fees for wireless internet services in individual apartments of federally-assisted affordable senior housing communities, the vast majority of which lack such service. Without wireless internet, federal-assisted seniors cannot take advantage of telehealth and are shut out of tools and programming to combat social isolation.
- 2.3.4.8. Increase funding through the Older Americans Act to enable Area Agencies on Aging and Aging (AAAs) Independent Living Centers (ILCs) to expand and create Adult and Disability Resource Connections (ADRCs) to better coordinate access to affordable housing.** The AAAs and ILCs need more funding to expand and create ADRCs, which play a vital role in helping people locate and apply for affordable housing through relationships with local continuums of care, including local housing authorities, housing finance agencies and affordable housing providers. With the right support, ADRCs can help older adults and people with disabilities navigate through California’s complex housing systems. Beyond housing, they can also help identify resources to help individuals become or remain stability housed and access other needed supports while they are on housing waitlists.

**2.4. Create a State Flexible Housing Subsidy Pool to end and prevent homelessness.** California should create a Flexible Housing Subsidy Pool (FHSP) that leverages public and private funding to end and prevent homelessness. The FHSP should have a special focus on assisting special needs individuals, including older adults and people with disabilities. Special needs individuals experiencing homelessness are often among the highest utilizers of expensive health care services.<sup>52</sup>

Modeled after Los Angeles County’s FHSP, a state program could fund a variety of services including:

- Interim interventions and housing placement services;
- Intensive Case Management and Supportive Services;
- Operating subsidies; and,
- Move-in assistance, rental assistance and eviction prevention services.

A Flexible Housing Subsidy Pool would give California the ability to offer comprehensive solutions to ending and preventing homelessness.

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<sup>52</sup>“Flexible Housing Subsidy Pool Brief Evaluation of the Conrad H. Hilton Foundation Chronic Homelessness Initiative,” Conrad H. Hilton Foundation and Abt Associates. March 2017. [https://www.hiltonfoundation.org/wp-content/uploads/2019/10/Flexible\\_Housing\\_Subsidy\\_Pool\\_Brief\\_Final.3.31.17-3.pdf](https://www.hiltonfoundation.org/wp-content/uploads/2019/10/Flexible_Housing_Subsidy_Pool_Brief_Final.3.31.17-3.pdf).

**2.5. Support and expand Shared Housing Programs.** While building affordable housing for older adults and people with disabilities should remain a priority for California, the demand for affordable housing is so great, and the actual supply so low, that even with unlimited funding, it would take years to build enough housing stock to meet demand. One solution to this is shared housing. Shared housing allows individuals in homes with empty rooms or in-law quarters, to rent those spaces to older adults and people with disabilities who are in need of housing.

**2.5.1. Incentivize local governments to invest in Shared Housing Programs.** Most Shared Housing Programs are operated by nonprofits, who help connect homeowners with potential tenants. They provide matching, background checks, mediation and more at no cost. The programs typically operate with limited resources and are financed through a patchwork of funding sources including self-funding, municipal funding and support from other nonprofits and foundations. In light of the increased demand for affordable housing options, shared housing programs need additional funding and resources to scale-up their reach and community impact.

Shared Housing Programs need more investment from the localities they operate within. One controversial idea is to allow local governments to include affordable shared housing in their RHNA allocations. This would incentivize more municipal investment in shared housing programs. For this to work, there would have to be a cap on the number of shared housing rooms allowed in the allocation, as well as a way to ensure that the addition of shared housing does not offset local responsibility for creating affordable multifamily housing.

**2.5.2. Allow localities more flexibility to incentivize homeowners to build Accessory Dwelling Units (ADUs) and Junior Accessory Dwelling Units (JADUs) in exchange for affordability restrictions on units.** Allow localities to offer financial (e.g. forgivable loans) and other incentives (e.g. extra floor area or reduced parking requirements) to encourage homeowners to build ADUs and JADUs in exchange for an affordability deed restriction on the unit. This will help to increase the supply of affordable ADUs and JADUs that homeowners could place into shared housing programs.

**2.5.3. Request housing authorities create a shared housing voucher program.** California's Housing Authorities control millions of dollars of federal rental assistance funding through the Section 8 Housing Choice Voucher Program. Housing Authorities have the ability to allow vouchers to be used in a shared housing setting, thereby expanding affordable housing options for low-income individuals, but this is not offered by all housing authorities.

**2.6. Support local efforts to fight homelessness among older adults by assisting local governments in providing vital services to older adults.** Financing for homelessness services is fragmented and not equally available to cover all services. Three services are critical to help older adults at risk of, or experiencing homelessness, to access permanent housing with services: 1) Housing navigation to meet people on the streets, form trusting relationships, engage them in participating in services, connect them with local homeless systems, and assist in completing paperwork; 2) Tenancy transition services to help people move into and stabilize in housing; and, 3) Tenancy sustaining services, intensive case management promoting housing and health stability.

The Whole Person Care Program and the In Lieu of Services benefits within the California Advancing and Innovating Medi-Cal (CalAIM) proposal, are potential programmatic vehicles for these services.

### 3. Recommendations for Mid-term Action (3-5 years)

- 3.1. Bolster Area Agency on Aging (AAA) and Independent Living Center (ILC) efforts to establish Aging and Disability Resource Connections (ADRCs) as a “No Wrong Door” entry point for Californians to find and apply for affordable housing.** Like navigating health care systems and long-term care options, navigating housing systems to find affordable housing and apply for waitlists is extremely complex and difficult. There is no single place to find information about affordable housing locations, income requirements and open waitlists.

Ideally, California would have an integrated application system for affordable housing where an older adult would go to one place to identify housing communities in their desired location, determine their income eligibility, apply to be put on open waitlists and apply for temporary housing and/or rental assistance to help them become and/or remain housed until affordable housing becomes available. Unfortunately, there are many barriers to creating an integrated system like this, including funding, varying rules and regulations on each housing community, different types of applications, creating buy-in from housing providers, and managing waitlists and waitlist preferences.

With or without an integrated application system for affordable housing, California should bolster the role ADRCs play and include them in providing assistance to help fill this gap in access to affordable housing. Aging and Disability Resource Connections work to inform older adults and people with disabilities about and connect them to vital community-based resources, including housing, and are an important part of the No Wrong Door system model. More funding is needed to establish ADRCs throughout the state and to formalize relationships with local continuums of care, including local housing authorities, housing finance agencies and affordable housing providers. With the right support, ADRCs can help older adults and people with disabilities navigate through California’s complex housing systems. Beyond housing, they can also help identify resources to help individuals become or remain stability housed and access other needed supports while they are on housing waitlists.

- 3.2. Offer a tax-credit incentive for homeowners to put rooms into shared housing programs at an affordable rate.** By offering tax credits in an amount equaling the difference between the affordable rent collected and the fair market rent, California can incentivize homeowners to put rooms into shared housing programs at a rate affordable to Extremely Low-Income (30% of Area Median Income) and Very Low-Income (50% of Area Median Income) renters.
- 3.3. Expand funding for Permanent Supportive Housing Programs.** In California, there are thousands of older adults and people with disabilities experiencing homelessness or in temporary housing situations, and housed without the supportive services they need to successfully transition into permanent housing. Permanent Supportive Housing is an important tool in California’s housing toolkit; however, it is severely underfunded. PSH is essential for ensuring housing success and positive health outcomes for persons exiting homelessness and/or those experiencing serious and long-term disabilities - such as mental illnesses, developmental disabilities, physical disabilities and substance use disorders.
- 3.4. Examine and improve existing Medi-Cal Waiver Programs that allow low-income older adults to receive in-home care and community-based care.** California’s Medicaid 1915(c) Home- and Community-Based Services Waivers, including the Assisted Living Waiver, the Home- and Community-Based Alternatives Waiver, and the Multipurpose Senior Services Waiver should be renewed, improved and expanded to serve more Californians. These waiver program promote: 1) aging in place, 2) improved health outcomes, 3) well-being, and 4) a reduction in unnecessary or avoidable healthcare utilization such as emergency department visits and hospitalizations.

**3.5. Create an Integrated Care at Home Demonstration to help older adults and people with disabilities who live in or near affordable housing communities age in place.** California should utilize lessons-learned from other states to create a demonstration to coordinate the resources of community health, social services and housing organizations to support older adults and people with disabilities who choose to live independently at home.

The Demonstration would serve those within the LTC at Home, or like, Benefit, but more importantly, would provide services and supports to those who do not qualify for LTC at Home. As drafted, the LTC at Home Benefit is limited to higher-acuity individuals who have care needs that make them eligible for institutionalization in a Skilled Nursing Facility (SNF). If a person does not meet the eligibility criteria for LTC at Home, they have very few options for affordable supports and services to help them remain independent in their own home. Having to choose between paying for medications or paying rent can lead to homelessness. An Integrated Care at Home Demonstration would seek to fill this gap in California's continuum of care for low- and middle-income older adults and people with disabilities.

An Integrated Care at Home Demonstration would require California to reform its thinking about how care and services are provided to older adults. Integrated Care at Home would provide an avenue for California to meet the long-term care needs of low- and middle-income, while bridging the gap in health care access to minority populations and immigrant households where language barriers increase health inequities. This can be done without dismantling any of California's existing healthcare and long-term care programs.

The Integrated Care at Home Demonstration should be designed using elements of Vermont's Support and Services at Home Program (SASH) and the U.S. Department of Housing and Urban Development's (HUD) Supportive Services Demonstration, also known as Integrated Wellness in Supportive Housing (IWISH).

**Vermont Support and Services at Home (SASH) Program:** The State of Vermont's Support and Services at Home Program (SASH), has been extremely successful in improving population health, reducing costs and enabling aging in place safely.<sup>53</sup> The program was created as part of a larger healthcare reform initiative that utilizes the existing network of affordable housing as extenders to primary care practices.<sup>54</sup>

The SASH program facilitates a range of support and in-home services for participants, which includes Medicare and Medicaid recipients living in congregate affordable housing and in the surrounding community.<sup>55</sup> Services and supports are coordinated by an on-site wellness team that consists of a SASH Coordinator and a Wellness Nurse.<sup>56</sup> The on-site team coordinates with a core team of providers representing including social services, home health, mental health services and Area Agencies on Aging.<sup>57</sup> The on-site team also coordinates with primary care practices, hospitals and nursing homes.<sup>58</sup> Together the on-site team and the core team create comprehensive health and wellness assessments, individualized care plans, on-site one-on-one nurse coaching, care coordination, and health and wellness group programs.<sup>59</sup> Formal community partners collaborate with the core SASH staff to coordinate care and services for participants and offer on-site health and wellness programming. Each team oversees wellness coordination for 100 participants.<sup>60</sup>

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<sup>53</sup> "SASH Vermont Overview" <https://sashvt.org/learn/>.

<sup>54</sup> "Research Summary: Support and Services at Home (SASH) Evaluation: Highlights from the First Four Years," HHS Office of the Assistant Secretary for Planning and Evaluation, Office of Disability, Aging and Long-Term Care Policy, July 2017. <https://aspe.hhs.gov/system/files/pdf/257926/SASH4hl-rs.pdf>.

<sup>55</sup> Ibid.

<sup>56</sup> Ibid.

<sup>57</sup> Ibid.

<sup>58</sup> Ibid.

<sup>59</sup> Ibid.

<sup>60</sup> Ibid.

The SASH Program is currently funded through an All-Payer Accountable Care Organization Model, with funding from Medicare, Medicaid and private insurers.<sup>61</sup>

In urban areas, SASH participants saw slower growth in Medicare expenditures of over \$1,450 per beneficiary per year.<sup>62</sup> SASH participants also had slower rates of growth for hospital, emergency department, and specialty physician costs, as well as lower rates of all-cause hospital admissions compared to non-participants.<sup>63</sup> Among dually-eligible SASH participants, growth in Medicaid expenditures for institutional long-term care was significantly slower.<sup>64</sup> The average impact was \$400 per participant per year.<sup>65</sup> Slower growth in expenditures has been sustained since the first evaluation in 2012. The SASH Program has also reported significant improvements among individuals with common chronic conditions such as high blood pressure leading to hypertension<sup>66</sup> and diabetes<sup>67</sup>. SASH has also shown to reduce social isolation and loneliness.<sup>68</sup>

The SASH Program has been successfully replicated in other states and more states are working on developing replicate programs.<sup>69</sup>

**HUD Integrated Wellness in Supportive Housing (IWISH) Demonstration:** The IWISH Demonstration leverages HUD's affordable senior housing properties as a platform for the coordination and delivery of services to better address the interdependent health and supportive service needs of older residents.<sup>70</sup> The demonstration is testing a model of housing and supportive services with the potential to delay or avoid nursing home care for low-income elderly residents in HUD-assisted housing.<sup>71</sup>

The IWISH model funds a Resident Wellness Director (RWD) and Wellness Nurse (WN) to work in HUD-assisted housing developments that either predominantly or exclusively serve households headed by people aged 62 or over.<sup>72</sup> The RWD and WN work together to create and implement a formal strategy for coordinating services to help meet residents' needs.<sup>73</sup> Some of the services include: developing Individual Healthy Aging Plans (IHAP), assisting residents with implementing these plans and accessing needed services and resources, motivating and encouraging residents to adopt beneficial behavior changes and follow-through with appointments and other activities, developing property-level programming based on identified resident needs and interests, engaging with community partners, formally and informally, to assist individuals and bring services and resources to the property, and more.<sup>74</sup>

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<sup>61</sup> "Vermont All-Payer ACO Model," Centers for Medicare and Medicaid Services. <https://innovation.cms.gov/innovation-models/vermont-all-payer-aco-model>.

<sup>62</sup> Support and Services at Home (SASH) Evaluation: Highlights from the Evaluation of Program Outcomes from 2010 to 2016," HHS Office of the Assistant Secretary for Planning and Evaluation, Office of Disability, Aging and Long-Term Care Policy, July 2019. <https://aspe.hhs.gov/system/files/pdf/262061/SASH5hl-rs.pdf>.

<sup>63</sup> Ibid.

<sup>64</sup> Ibid.

<sup>65</sup> Ibid.

<sup>66</sup> "Outcomes of the SASH Hypertension Management Program" <https://sashvt.org/wp-content/uploads/2018/11/2018-HTN-Management-Program.pdf>.

<sup>67</sup> "SASH Impact November 2018: Tackling Diabetes on Many Fronts," <http://www.resource.sashvt.org/sash/2018%20Nov%20SASH%20Impact.pdf>.

<sup>68</sup> "SASH Combatting Loneliness and Social Isolation" <https://sashvt.org/wp-content/uploads/2018/11/2018-Social-Isolation.pdf>.

<sup>69</sup> "Healthy Aging in Affordable Housing: Baltimore Fact Sheet," Enterprise Community Partners.

<sup>70</sup> "Fiscal Year (FY) 2015 Supportive Services Demonstration for Elderly Households in HUD-Assisted Multifamily Housing Program NOFA," U.S. Department of Housing and Community Development. [https://www.hud.gov/program\\_offices/administration/grants/fundsavail/nofa2015/ssdemo](https://www.hud.gov/program_offices/administration/grants/fundsavail/nofa2015/ssdemo).

<sup>71</sup> Ibid.

<sup>72</sup> Ibid.

<sup>73</sup> Ibid.

<sup>74</sup> Ibid.

HUD is implementing the 3-year demonstration in 40 affordable senior housing communities in California, Illinois, Maryland, Massachusetts, Michigan, New Jersey, and South Carolina. There are 15 IWISH Demonstration Sites in California, including nine in Southern California and six in Northern California.<sup>75</sup>

- 3.5.1. Funding an Integrated Care at Home Demonstration:** Existing Integrated Care at Home models are predominantly federally funded. Vermont and other SASH models in Rhode Island and Minnesota seek to collaborate with future Integrated Care at Home models in Maryland and potentially California to seek an Integrated Care at Home Innovation grant from CMMI. This fits well with CMMI’s purpose of supporting the development and testing of innovative health care payment and service delivery systems. CMMI was established as part of the Affordable Care Act in 2011 and receives \$10B each decade to fund innovation demonstrations.
- 3.5.2. California Integrated Care at Home Demonstration Framework:** California should develop an Integrated Care at Home Demonstration that builds upon the successes and lessons-learned from SASH and IWISH:
- 3.5.2.1. Provides comprehensive care management and coordination at home.** An Integrated Care at Home Demonstration should create a population health system where a team of providers supports a large number of participants in a flexible and cost-efficient manner, instead of a team of providers supporting one resident. A population health system can take advantage of the efficiencies provided by congregate housing communities like affordable senior housing buildings, where many participants are located in one place. This model creates a system of partnerships and communication networks that collectively support thousands of elderly as opposed to creating a separate partnership for each beneficiary.
  - 3.5.2.2. Located in an urban area with a high concentration of affordable senior housing communities:** To create efficiencies and realize the greatest cost savings, the demonstration should be located in an urban area with a high concentration of affordable senior housing communities.
  - 3.5.2.3. Target population:** Medicare and dually eligible recipients living in congregate affordable housing and in the surrounding community. By targeting Medicare recipients instead of Medi-Cal only recipients, California can provide much needed care coordination to those individuals in the “forgotten middle” – those who do not qualify for Medi-Cal, but cannot afford to pay out-of-pocket for long-term care.<sup>76</sup> Additionally, an Integrated Care at Home Demonstration would use housing as a platform for addressing health inequities in disadvantaged communities including low-income individuals, minorities and immigrants.
  - 3.5.2.4. Size of demonstration would depend on funding:** Each on-site care team would oversee a participant pool of 100 individuals. In the SASH Program, at least one-third of participants do not live in the housing community, but in the surrounding neighborhood.
  - 3.5.2.5. Services provided by on-site care teams.** Care teams would be placed on-site at affordable senior housing communities. Each onsite care team would consist of a full-time Community Health Worker and a half-time Wellness Nurse. The Community Health Worker helps participants identify their goals and connects them with health care and preventative

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<sup>75</sup> “Supportive Services for Elderly in HUD Assisted Housing,” World Health Organization.

<https://extranet.who.int/agefriendlyworld/afp/supportive-services-elderly-hud-assisted-housing/>.

<sup>76</sup> “NIC Middle Market Seniors Housing Study,” Beth Burnham Mace, Nic, Caroline F. Pearson, NORC at the University of Chicago, Robert G. Kramer, NIC, Chuck Harry, NIC, Lana Peck, NIC, Charlene C. Quinn, University of Maryland School of Medicine, A. Rupa Datta, NORC at the University of Chicago, David C. Grabowski, Harvard Medical School, and Sai Loganathan, NORC at the University of Chicago. 2019. <https://www.nic.org/middlemarket>.

programs and activities to help meet their needs. The Wellness Nurse checks-in regularly and provides health coaching, particularly for chronic conditions such as diabetes, hypertension, arthritis and behavioral health challenges including suicide. The nurse also helps participants make successful transitions following in-patient treatment at a hospital or rehab facility.

- 3.5.2.6. Care and services are coordinated through the Core Wellness Team.** The Core Team would meet once a month to coordinate care. The Core Team is comprised of community health, social services and mental health providers including the onsite team, AAA providers, ADRCs, County Mental Health and home health agencies. Coordination between the onsite team, the core team, and the community partners is essential to ensuring comprehensive care for each participant. Coordination ensures communication among providers and reduces inefficiencies by eliminating duplication of efforts. The provider networks are created through a series of Memorandums of Understanding and overseen by a program administrator.

**Program would focus on three components of care management with the goals of improving population health, reducing costs and enabling aging in place safely.** The three components of care management would include care transitions (i.e. helping individuals transition from institutional care back to a community-based care setting), self-management of chronic conditions and care coordination.

### **3.5.3. Benefits of an Integrated Care at Home Demonstration:**

- 3.5.3.1. Improved health outcomes.** Participants in the SASH and IWISH (IWISH data has not yet been evaluated) programs are reporting improvement in and better management of chronic conditions, healthier lifestyles, and fewer hospitalizations.<sup>77</sup>
- 3.5.3.2. Costs savings to Medi-Cal and Medicare.** The SASH Program evaluation reports Medicare savings of up to \$1,450 per beneficiary per year and Medicaid savings of up to \$400 per beneficiary per year.<sup>78</sup>
- 3.5.3.3. Increased access to health care for minority populations especially African American and Hispanic individuals susceptible to COVID-19.** African American and Hispanic individuals are disproportionately represented in affordable housing.<sup>79</sup> Integrated Care at Home provides an opportunity for African American and Hispanic individuals living in and near affordable senior housing communities to receive quality care and services at home. African American and Hispanic individuals are less likely than white peers to have health care coverage and more likely to report their health as fair or poor.<sup>80</sup> They are also more likely than their white peers to suffer from chronic conditions like asthma, hypertension and diabetes.<sup>81</sup> The Integrated Care at Home model would provide participants with increased access to primary and

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<sup>77</sup> Support and Services at Home (SASH) Evaluation: Highlights from the Evaluation of Program Outcomes from 2010 to 2016," HHS Office of the Assistant Secretary for Planning and Evaluation, Office of Disability, Aging and Long-Term Care Policy, July 2019. <https://aspe.hhs.gov/system/files/pdf/262061/SASH5hl-rs.pdf>.

<sup>78</sup> Support and Services at Home (SASH) Evaluation: Highlights from the Evaluation of Program Outcomes from 2010 to 2016," HHS Office of the Assistant Secretary for Planning and Evaluation, Office of Disability, Aging and Long-Term Care Policy, July 2019. <https://aspe.hhs.gov/system/files/pdf/262061/SASH5hl-rs.pdf>.

<sup>79</sup> "Racial Disparities Among Extremely Low-Income Renters," National Low-Income Housing Coalition, Apr 15, 2019. <https://nlihc.org/resource/racial-disparities-among-extremely-low-income-renters>

<sup>80</sup> "Health Disparities by Race and Ethnicity," Sofia Carratala and Connor Maxwell, May 7, 2020. American Center for Progress. <https://www.americanprogress.org/issues/race/reports/2020/05/07/484742/health-disparities-race-ethnicity/#:~:text=regardless%20of%20race.%E2%80%9D-,Health%20coverage,health%20insurance%20coverage%20in%202017.>

<sup>81</sup> Ibid.

preventative healthcare and mental healthcare, management of chronic conditions and health education.

- 3.5.3.4. Increased access to long-term services and supports for the “forgotten middle.”** There are many Californians who do not meet the income qualifications for Medi-Cal, but do not have the personal wealth to pay out-of-pocket for long-term care. These individuals are often forced to spend-down their resources on long-term care until they eventually qualify for Medi-Cal, and/or are prematurely admitted to skilled nursing. Many older adults who qualify for and live in affordable senior housing communities do not qualify for Medi-Cal. Creating a demonstration using Medicare eligibility instead of Medi-Cal eligibility as criteria for admissibility would allow these individuals to receive long-term supports and services that they would otherwise not be able to afford.
- 3.5.3.5. Reduces social isolation and loneliness.** Having an onsite care team means that each participant will have regular face-to-face contact with the Community Health Worker or the Wellness Nurse. The onsite care team members would form personal connections with the participants, making it easier to recognize when someone needs more engagement. The care team would also facilitate group wellness events and educational classes to engage participants. Vermont SASH participants report improvements in social isolation and loneliness.<sup>82</sup>
- 3.5.3.6. Increases individual participation in their own health care and likelihood of receiving preventative care.** Regular check-ins with the on-site care team build trust and connections. Having a relationship with the on-site care teams helps empower people to become more involved in their own care. It also increases the likelihood that a person will receive preventative healthcare and mental healthcare.<sup>83</sup>
- 3.5.3.7. Easily Adaptable to telemedicine.** The Integrated Care at Home Program would, by nature, be easily adaptable to telemedicine. The on-site Wellness Nurse can assist with and participate in calls between a participant and their primary care and specialty health providers.

#### 4. Recommendations for Long-term Action (5-10 years)

- 4.1. Evaluate progress made to date.** In five years, that state should evaluate the progress it has made under these recommendations by examining trends in data. All metrics should require analysis of the data by the equity dimensions of race/ethnicity, income, age and ability to prevent disparities in access to housing.
  - 4.1.1.** Rate of housing cost burden among older adults and people with disabilities.
  - 4.1.2.** Rate of homelessness among older adults and people with disabilities.
  - 4.1.3.** Number of new and rehabilitated affordable age-restricted housing units created.
  - 4.1.4.** Number of new and rehabilitated affordable housing units created.
  - 4.1.5.** Total number of shared housing units.
  - 4.1.6.** Rate of Skilled Nursing Facility Admissions from community-based settings.

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<sup>82</sup> “SASH Combatting Loneliness and Social Isolation” <https://sashvt.org/wp-content/uploads/2018/11/2018-Social-Isolation.pdf>.

<sup>83</sup> “Network Success Story: Embedding Mental Health Care in Affordable Housing Sites,” OneCare Vermont. 2019. <https://www.onecarevt.org/embedding-mental-health-care-in-affordable-housing-sites/>.

**4.2. Make housing a primary component of any statewide long-term care benefit that seeks to treat people at home.** Providing home- and community-based services to older adults and people with disabilities can help them live longer, age-in-place and avoid unnecessary or avoidable healthcare utilization such as emergency department visits, hospitalizations and skilled nursing admissions. Housing will be a primary component to any statewide benefit seeking to provide long-term services and supports (LTSS) at home.

**4.2.1. Define “home” broadly.** Any statewide long-term benefit that seeks to treat people at home must define the term “home” broadly to enable people to receive appropriate care in the setting of their choice. The term “home” can embody many types of housing models including independent living, residential care facilities and congregate care.

The State has an obligation under *Olmstead v. L.C.*<sup>84</sup> to provide services in the most integrated setting appropriate to an individual’s needs. Ensuring that individuals are able to safely receive long-term care services and supports in the “home” setting of their choice will help ensure that California is meeting the requirements of *Olmstead*.<sup>85</sup>

**4.2.2. Serve more people, remedy health inequities and realize cost efficiencies by creating partnerships to serve congregate housing sites.** Housing settings like affordable senior apartment communities and mobile home parks provide unique opportunities for a statewide long-term care benefit through economies of scale. Congregate low-income housing sites have large populations of Medi-Cal eligible older adults and people with disabilities.

Partnering with home- and community-based services organizations and housing providers to provide care to individuals at congregate housing sites will help to bring essential LTSS care to a greater number of individuals while creating cost efficiencies for the state.

Partnerships will also help to ensure access to LTSS benefits for minorities. African American and Hispanic individuals are disproportionately represented in affordable housing<sup>86</sup> and are more likely than white peers to experience inequities in access to health care and services.<sup>87</sup>

**4.2.3. Any statewide long-term care benefit that seeks to treat people at home must serve low- and middle-income individuals.** There are many Californians who do not meet the income qualifications for Medi-Cal, but do not have the personal wealth to pay out-of-pocket for long-term care. These “Forgotten Middle” individuals are often forced to spend-down their resources on long-term care until they eventually qualify for Medi-Cal, and/or are prematurely admitted to skilled nursing.<sup>88</sup>

The state should ensure that any long-term care at home benefit is accessible to middle-income older adults and people with disabilities. This can potentially be done using a sliding-scale payment model, where individuals with higher incomes would pay a higher share of cost.

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<sup>84</sup> *Olmstead v. L.C.*, 527 U.S. 581 (1999).

<sup>85</sup> *Ibid.*

<sup>86</sup> “Racial Disparities Among Extremely Low-Income Renters,” National Low-Income Housing Coalition, Apr 15, 2019.

<https://nlihc.org/resource/racial-disparities-among-extremely-low-income-renters>

<sup>87</sup> “Health Disparities by Race and Ethnicity,” Sofia Carratala and Connor Maxwell, May 7, 2020. American Center for Progress.

<https://www.americanprogress.org/issues/race/reports/2020/05/07/484742/health-disparities-race-ethnicity/#:~:text=regardless%20of%20race.%E2%80%9D-,Health%20coverage,health%20insurance%20coverage%20in%202017.>

<sup>88</sup> “NIC Middle Market Seniors Housing Study,” Beth Burnham Mace, Nic, Caroline F. Pearson, NORC at the University of Chicago, Robert G. Kramer, NIC, Chuck Harry, NIC, Lana Peck, NIC, Charlene C. Quinn, University of Maryland School of Medicine, A. Rupa Datta, NORC at the University of Chicago, David C. Grabowski, Harvard Medical School, and Sai Loganathan, NORC at the University of Chicago. 2019. <https://www.nic.org/middlemarket>.

**4.3. Adopt a permanent and statewide Integrated Care at Home Program to help older adults and people with disabilities who live in or near affordable housing communities age in place.** At the end of the Integrated Care at Home Demonstration, California should evaluate the lessons learned and create a permanent statewide program.

**4.3.1. Expand Statewide:** A permanent and statewide expansion of Integrated Care at Home should adopt the same framework and goals of the Demonstration, taking into consideration and adapting for lessons learned. Urban areas, with higher concentrations of affordable housing communities will create the most savings for Medicare and Medicaid. These savings can then be cost-shifted to underserved rural areas, who often lack access to health care and supportive services.

**4.3.2. Funding Model:** Financing an Integrated Care at Home Program in a state as large as California will require a well-coordinated statewide operating and training infrastructure to ensure volume-driven cost efficiencies. The Medicare-only or Medicaid-only approach to funding healthcare allows too many people to fall through the cracks. California already has a robust network of affordable senior housing communities, that can serve as the network in which the program will operate.

A multi-payer or all-payer model is the only solution to funding aging services on a permanent sustainable basis. In Vermont, the all-payer model includes funding from Medicare, Medicaid, and private insurance.<sup>89</sup> This ensures the focus is on improving health outcomes through comprehensive care, rather than piecing together allowable services under each payment system. The money flows through an Accountable Care Organization and the savings are used to pay for SASH. Health Homes funding through Medicaid can potentially be part of the funding equation. CMS support, coupled with California state support for a statewide Integrated Care at Home model will improve health equity and reduce costs for California's growing elderly population.

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<sup>89</sup> "Vermont All-Payer ACO Model," Centers for Medicare and Medicaid Services. <https://innovation.cms.gov/innovation-models/vermont-all-payer-aco-model>.

## MPA GOAL 2: LIVABLE COMMUNITIES – TRANSPORTATION

**Goal 2. Livable Communities and Purpose – We will live in and be engaged in communities that are age-friendly, dementia-friendly, and disability-friendly.**

### Executive Summary

#### Overview

Transportation is the vital link that connects older adults and people with disabilities to social activity, economic opportunity, necessities, and community services; hence supporting their independence. California has longstanding, systemic policy, and funding disparities relative to transportation programs for this population (see Appendix A). Because of these disparities, people are less able to remain in their homes and communities as they age, have reduced quality of life, decreased participation in the economy, and suffer worse health outcomes. Many older adults need specialized transportation services such as door-to-door paratransit and escorts to physician's offices. Safe, affordable, accessible, dependable, and user-friendly options are needed to overcome the physical limitations associated with aging and living with one or more disabilities particularly when coupled with being a person of color or a member of other marginalized populations, such as LGBTQ. These needs can be met when transportation systems are built around the needs of the rider rather than the service provider.

Accessible transportation recommendations fall into the following key areas:

1. Accessible coordinated transportation and mobility spanning the entire age/ability spectrum (local)
2. Policy and Planning Imperatives (statewide)
3. Rural Investments

Adoption of these recommendations will:

- Transform and create a transportation system that is accessible and designed around the rider, not designed for the ease of the system
- Mitigate decades of underinvestment and unfulfilled policies in transportation/services for the population of older persons and those with disabilities, particularly minority populations
- Increase safety and support health
- Address identified needs statewide
- Bring an end to accessible transportation issues being regarded separately and unequally relative to every other mode of transportation
- Increase cost effectiveness and other systemic improvements

#### Background

Programs for transporting older Californians and persons with disabilities (referred to as accessible transportation in this document) are often limited in terms of availability, accessibility and quality; disproportionately impacting marginalized communities. This longstanding problem is not unique to California. In fact, state and federal studies have documented<sup>i</sup> this issue for decades with limited progress. The Coordinated Public Transit-Human Services Transportation Plan for the San Francisco Bay Area summarizes this problem concisely as a statewide issue:

*Current senior-oriented mobility services do not have the capacity to handle the increase in people over 65 years of age...the massive growth among the aging ...points to a lack of fiscal and organizational readiness...the closure and consolidation of medical facilities while rates of diabetes and obesity are on the rise will place heavy demands on an already deficient system.*

**Magnification of the Problem with Changing Demographics:** From the University of California Institute of Transportation Studies, *“The mobility needs of an aging population is one of the most substantial challenges facing California in the coming decades. The number of residents age 65 and older is expected to double between 2012 and 2050, and the number age 85 and above is expected to increase by over 70% between 2010 and 2030. Declines in physical function related to age may reduce mobility options dramatically.”*<sup>90</sup>, Systemic racial inequities are further perpetuated as the demographics shift.

Three misconceptions about transportation services contribute to the lack of public and political support for their adoption. These include:

**Misconception #1: Public transit operators adequately fulfill accessible transit needs.** Public transit is spread too thin to adequately manage an accessible transit system for all users. Public transit is expected to help solve climate change, reduce commute congestion, provide expensive off-peak service, provide lifeline service for low-income populations, etc. The largest number of providers of accessible transit are non-profit organizations, not conventional public transit operators<sup>ii</sup>.

**Misconception #2: Non-profit agencies adequately fulfill accessible transit needs.** Historically underfunded, non-profit transportation agencies are forced to compete with public transit operators for funding; rather than cooperate and collaboration. Consequentially, systems end up in silos rather than consolidated to meet ALL needs. An analogy would be if the needs of commuters were being inadequately addressed forcing them to band together and form individual organizations to maintain and build their own roads and bridges to get to and from work and home.

**Misconception #3: Transportation requirements placed on health insurance and health care providers fill transportation gaps.** (Assembly Bill 2394, Garcia – 2015/16 NMT, Affordable Care Act, etc.) While these entities provide medically-related transportation, the approach often creates yet another silo, creates additional confusion, and worsens the already challenged accessible transit system. Such systems need to be person-centered rather than funder focused.

California’s Transportation Plan 2040<sup>91</sup> unintentionally describes how the California’s limited accessible transportation options impacts this vulnerable population, *“Limited access to quality transportation can affect health, particularly among vulnerable populations, such as the poor, the elderly, children, the disabled, and in communities of color. A safe and accessible transportation system allows members of vulnerable populations to more easily travel to supermarkets for fresher foods, to integrate daily walking as a form of exercise to meet physical activity needs, and to better access health care facilities, education, jobs, recreation and other needs”*. As a social determinant of health, transportation is highly linked to improved health and quality of life<sup>92</sup>.

To create equitable access, significant investment and policy changes are necessary. Because accessible transit has been studied extensively, the path to improvement is well established. As described below, now is an ideal time to make improvements, significant funding and leadership at all levels and will be necessary for successful implementation.

The improvements to accessible transportation policies recommended in this document will:

- Mitigate decades of underinvestment
- Increase safety (i.e., health and well-being)
- Address identified needs statewide

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<sup>90</sup> [Assessing and Addressing the Mobility Needs of an Aging Population](#), April 2019, David R. Ragland, Ph.D., M.P.H. University of California, Berkeley, Kara E. MacLeod, Dr.P.H. M.P.H., M.A., University of California Los Angeles, Tracy McMillan, Ph.D., M.P.H., University of California, Berkeley, Sarah Doggett, M.S., University of California, Berkeley, Grace Felschundneff, B.S., University of California, Berkeley

<sup>91</sup> Caltrans, 2016-California Transportation Plan 2040, <https://dot.ca.gov/programs/transportation-planning/state-planning/california-transportation-plan>

<sup>92</sup> Bay Area Regional Health Inequities Initiative, 2015- *Applying Social Determinants of Health Indicator Data for Advancing Health Equity: A Guide for Local Health Department Epidemiologists and Public Health Professionals*, <https://www.barhii.org/sdoh-indicator-guide>

- Bring an end to accessible transportation issues being regarded separately and unequally relative to every other mode of transportation
- Increase cost effectiveness and other systemic improvements implementation of increased coordination through the Consolidated Transportation Services Agencies (CTSA) model will produce<sup>93</sup>:
  1. Significant reductions in service costs
  2. Greater amount of available transportation
  3. Higher quality service by improvements in coordination and safety
  4. Access to increased funding by reducing duplication and silos
  5. Creation of a one-stop shop for finding local transportation options

**Significant research and outreach examining how to improve accessible transit has been completed, the recommendations need to be funded. Now is the time for change.**

## Recommendations

### 1. Expand and Improve Accessible Coordinated for Transportation

Current policies have Californians “ageing-out” of transportation options due to significant policy and funding disparities. Policies and funding should support accessible coordinated transportation and mobility that spans the entire spectrum of aging and ability statewide. Policies and programs should support a range of modalities (e.g., safe walking infrastructure, accessible transit, conventional transit, etc.) to meet the needs of passengers with disabilities and mobility challenges.

- Acknowledge the obligation to provide equitable transportation improvements for this population. While funding and program advances for accessible transportation have stagnated, systems for every other transportation mode and user group have continually improved and expanded. Roadway improvements for automotive travel, fixed-route bus, bicycling, pedestrian, passenger rail, new-wheeled mobility options (e.g., bikeshare, electric bikes or scooters) have all advanced. **Accessible transportation has been inexplicably segregated from similar advances.** The same multimodal approach must be implemented as it pertains to the life continuum for all people of all ages and abilities. The system must expand and improve affordable mobility options beyond just paratransit, including but not limited to: door through door services; wheelchair accessible transportation network companies (TNCs) and demand response real time ride systems; volunteer driver program expansions; nonprofit service provider systems; stipends/free rides for caregivers; gas subsidies and more.
- Expand, improve, and empower CTSA. Poor accessible transit options can only be solved with systemic solutions. Improving CTSA is a systems approach and elevates the statewide ability to coordinate, collaborate and improve comprehensive accessible transportation (see Appendix C for a consolidated CTSA summary). The objectives are: a) to have pervasive, consistently administered CTSA providing accessible transit; b) to have higher quality, convenient accessible transit be the standard, rather than the rarity that it is now, and; c) coordinate the various transportation funding silos into a No Wrong Bus model that appears seamless to the rider despite a complexity of rules and funders. For decades there have been conferences, summits, reports<sup>94</sup>,

<sup>93</sup> FTA, [Accessible Transit Services For All](#), 12/14 | Transit Cooperative Research Program Rpt. 91, [Economic Benefits of Coordinating Human Service Transportation and Transit Services](#) | TCRP Report 101, [Toolkit for Community Coordinated Transportation Services](#)

<sup>94</sup> **Transportation Task Team to the California Commission on Aging**, 2005, 2007 reports. “Barriers..., Lack of: 1) state and local leadership to coordinate programs and services, 2) regulatory authority to mandate that CTSA be established and perform service coordination and improvement functions, 3) incentives to coordinate or improve services, 4) consensus by stakeholders due to programs being funded from different “silos” and subject to differing requirements, 5) resources, particularly funding and staffing, at the local and state level, Lack of local leadership to coordinate. Lack of coordination incentives. Lack of political will to make systematic changes”, and (the presence of) “Funding Silos”, and “the need for “Dollars need to follow the person (from various funders) not follow the program.” **Government Accountability Office (GAO) reports**

etc. that all point to the need for robust coordination (which is the core CTSA function) to improve accessible transit. However effective coordination is a project in and of itself and as such it requires dedicated funding, leadership, and support, “...invocation of coordination does not necessarily provide either a statement of or a solution to the problem, but it may be a way of avoiding both when an accurate prescription would be too painful.”<sup>iii</sup> This report is providing the accurate prescription, stronger policies and additional funding.

Funding sources used by CTSAs are also used by public transit agencies. This competition suppresses the growth of CTSAs. A significant allocation of funding must be sole sourced to CTSAs and not be part of fixed route operations. CTSAs can house many functions which would be dictated by the locality, funding will eventually be used for direct service contracted or organized by the CTSA, including paratransit, travel training, mobility management, TNC (Lyft/Uber) enabled transportation, volunteer driver programs, , etc. A baseline level of funding should be made available so that rural communities receive equitable allocations to support adequate program infrastructure and produce successful services.

Examples (not exhaustive) of programs that must be included in CTSA implementation are detailed below:

a. Promote Driver Safety Programs

Giving up one’s ability to drive can be a life changing and traumatic experience. Offering pathways to allow individuals to improve their ability to drive independently and be provided support in transitioning from a personal vehicle to alternative transportation options addresses both ends of the equation.

- Create a Referral Program Between DMV & California Highway Patrol & Transportation Ambassadors. Using the options counseling approach, a locally designated Transportation Ambassador can work with individuals and family members to review transportation options available in the community, and develop a training program or referral process that best fits the needs of the individual transitioning from driving their own car to accessing other options.
- Promote driver participation in safety programs like CHP “Car-Fit” and AARP Driver Safety Program, and other similar courses designed to enable older adults to retain their ability to drive safely in their own vehicles.

b. Improve Community Walkability

Walking is the oldest form of public transportation. It’s the most cost effective, the most independent, and (provided safe paths of travel can be provided), the healthiest – for both the individual, the community, and the environment.

- Install pedestrian islands at intersections.
- Remove artificial barriers between businesses, housing & services, designed to discourage easily moving from one vendor to another.
- Amend the Government Code to require local jurisdictions to 1) circulate capital improvement plans, or other lists of significant public works to the local CTSA, 2) circulate general/specific plans to the local CTSA, and 3) respond to comments from the CTSA whose goal it is to ensure that local planning infrastructure investment incorporate accessible transportation issues.

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[109878](#), [591707](#), [650079](#), [658766](#), [660247](#), [667361](#), et al: “...duplication of effort and inefficiency in providing transportation when agencies do not coordinate...”, “...state and local agencies are unaware that they are...providing transportation services identical and parallel to those of another agency”...transit agency officials that we spoke with said that they would like to implement coordination efforts, but have been unable to get various parties to come together...”, “continuing challenges such as insufficient leadership at the federal level and limited financial resources and growing unmet needs at the state and local level.”, “...state and local officials expressed concern about their ability to adequately address expected growth in elderly, disabled, low-income, and rural populations.”, “...agencies providing similar transportation services to similar client groups may lead to duplication and overlap when coordination does not occur.”

- Establish a Vulnerable Road User (VRU) Law<sup>95</sup>: VRU laws provide legal protection to older adults walking on roads and sidewalks.
- Increase funding to the California Active Transportation Program (CATP) and provide legislative direction and support to more efficiently and equitably administer the program: State agencies, such as Caltrans, are charged with fulfilling the ATP objectives of N-19-19, have concerns with adequate staffing and resources. Legislation providing additional funding and direction can assist.
- Give cities and local transportation agencies the ability to lower speed limits on roads within their jurisdiction and direct the California Department of Transportation (Caltrans) to eliminate the 85th percentile rule in speed-limit setting: The 2019 Zero Fatalities Task Force Report contains further details on these two specific proposals, including extensive research on the ineffectiveness of the 85th percentile rule.

**c. Improve Accessibility to Fixed Route Services, Local/Regional Passenger Rail, and Other Mass Transit Services**

High density transportation **benefits** communities financially, reduces air pollution, increases fuel efficiency, reduces traffic congestion, saves money, increases mobility, frees up time, and reduces traffic collisions and injuries. A few simple augmentations to existing systems will expand the availability of these services to be more easily utilized by older adults and persons with disabilities.

- Provide free rides for older adults and people with disabilities during off-peak hours.
- Provide safe and comfortable places to wait for the bus - benches, shelters to protect from rain and sun.
- Design transit stops in front of stores, rather than bordered by large parking lots. Or, as an alternative within existing malls, parking lots, etc., create driverless shuttles to take shoppers from the front door to bus stops. These systems solve the challenge of navigating a large parking lot between the store and the main roadway where buses are boarded.
- Adjust transit design to match changes in the shopping habits and evolution of shopping technologies
- Commission a California Vehicle Economy study: Conducted via a collaboration of research universities and state agencies, with the goal of providing a clearer financial assessment of the direct and indirect costs that California taxpayers pay per year to subsidize car-centric transportation infrastructure.

**2. Implement Sound Planning and Policy Agenda**

A statewide effort to expand and improve services will only succeed with the adoption and implementation of new policies, measurement tools, enhanced revenue, and comprehensive system design. These policies must address the provision of transportation services, as well as integrate & promote civic planning, public/private partnerships, and the inclusion of accessible transportation operations. Statewide efforts should build upon local coordinated public transit human services transportation plans, county unmet transit needs hearings and short-range transit plans (see Appendix B for a brief list).

- Ensure the Broader Transportation System Reflects the Needs of Older Californians (Caltrans): Transportation planning and policies made advances in the last decade including policies and increased funding related to the complete streets, active transportation, context sensitive design, vision zero and other safety programs, and intelligent transportation systems<sup>96</sup>. Caltrans should ensure that Californians, regardless of age, race, economics, or travel mode (walking, cycling, driving, etc), benefit equitably from these investments. The “equitable” standard needs to take in to account the vulnerability of the traveler and mode, as well as historic policy and expenditure inequities.

<sup>95</sup> League of American Bicyclists Model Vulnerable User Law: <https://bikeleague.org/content/model-vulnerable-road-user-law>

<sup>96</sup> Links to Caltrans Programs: [Complete Streets](#); [Active Transportation](#); [Intelligent Transportation Systems](#).

- Create a California Coordinated Transportation Commission: The Commission will be immediately charged with implementing the recommendations of this document, emphasizing the coordination of accessible services under CTSA's. The Commission's ongoing role will include developing legislative recommendations that ensure emerging transportation technologies will benefit Californians of all ages, abilities, races, and be accessible regardless of existing income or place disparities. Lastly, the Commission will ensure the state has a strategic policy approach to understanding the rapid changes in revolutionary transportation technology, from consumer data privacy to automated vehicle technology to shared mobility devices.
- Measure Meaningful Transportation Impact & Outcomes - Adopt new qualitative measurements of transportation impacts to augment or replace quantitative approaches. Rides serving challenged populations often lead to medical care revenue positive results by reducing hospitalization or other institutionalization or expensive interventions of the passenger. Unfortunately, traditional transportation measures focus on cost per trip, riders per hour, cost per mile, etc. Those measures reward systems that provide shorter trips to more mobile passengers and punish those that provide life-sustaining trips to physically challenged riders. Social service organizations are being held more responsible than ever to provide data that proves services have health benefits for those being served. It is time for public transit systems to be held to these same sorts of standards.
- Ensure no statewide budget or legislative bill related to transportation omits consideration of accessible mobility options for older adults, people with disabilities and historically marginalized communities.
- Provide financial incentives for development projects that integrate housing, grocery shopping, community services, etc. into the same development, thereby decreasing transportation demands. New building projects need to include Accessible Transportation considerations when being designed; not focusing merely on parking and fixed route
- Evaluate effectiveness and adjust:
  - CTSA statutes: Ensure the creation, effectiveness, pervasiveness, and stability of CTSA's.
  - Funding levels and policies: Funding, disbursement formulas, eligible activities, maintenance of effort, should be continually analyzed for effectiveness and to ensure service deficiencies are addressed with an unrelenting focus on issues of equity, age, race, cultural, etc.
  - Oversight structure: Internal/External meta-review of oversight effectiveness.

### 3. Enhance Rural Services and Volunteer Programs

Transportation in rural communities is challenged by a lack of infrastructure and resources to address accessible transportation needs. Tens of thousands of older adults and people with disabilities live in these rural communities, often due to urban housing shortages, requiring creative solutions for a truly age-friendly state to exist.

- Expand Volunteer Driver Programs: Volunteer driver programs can be extremely effective in meeting the needs of older adults, especially in rural areas where service needs are episodic. To meet these needs, fund the Senior Volunteer Program<sup>97</sup> described in Older Californians Act (OCA), which would also augment volunteer-based programs like Health Insurance Counseling and Advocacy Program, Ombudsman, TCE/VITA, Meals on Wheels, etc. Provide a baseline level of funding so that rural communities receive enough of an allocation to provide adequate program infrastructure and produce successful services.
- Expand the Rural Transportation Assistance Program (RTAP): Allocations would combine with OCA funding to establish or complement operating expenses for volunteer transportation programs throughout rural California. Using the RTAP resources for training, planning, and best practices will ensure the rural volunteer transportation programs are operating at the highest levels of efficiency and impact possible.

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<sup>97</sup> Welfare and Institutions Code: Div 8.5: MELLO-GRANLUND OLDER CALIFORNIANS ACT: Art. 3: Engaging Elders Through Volunteerism [\[9118 - 9118.5\]](#)

- Provide MicroTransit & Flexible Fixed Route services, which allow low population density areas to adjust transit routes “on-the-fly” to pick up riders in need of services who do not live exactly on bus route. These variable routes work well in rural areas where a small route deviation will allow the pickup of additional riders without compromising the availability of fixed route services.

## **Summary**

Transportation services must be designed for and benefit all Californians, especially people who can no longer drive, cannot afford a car, or who choose not to drive. Accessible, available, and affordable travel options enable people of all ages, abilities, and socioeconomic backgrounds to stay active and engaged in their communities. For some, regular, fixed-route public transportation services are ideal. For others, specialized transportation services are needed, such as paratransit, dial-a-ride, reduced-fare taxis, or rides in private vehicles through volunteer driver programs.

To succeed in meeting the needs of a diverse society, our success will depend on creating an equally diverse approach to transportation services. This diversity is our greatest strength as state, as a country, and as a society. It is essential that we develop an equally diverse approach to maximizing the mobility options for all; especially those targeted for service in this Master Plan for Aging.

## TRANSPORTATION APPENDICES

### Appendix A: Evolution of Accessible Transportation via the Americans with Disabilities act of 1990

The 1990 passage of the Americans with Disabilities Act was not only landmark civil rights legislation for people with disabilities, but simultaneously catapulted specialized transportation into the modern world. Service was now mandatory for locations that had fixed route transit, and trip purpose was no longer a restraint to mobility. Unprecedented growth in the industry benefited both older adults and people with disabilities. Service provision became the responsibility of public transit agencies, both large and small, rather the programs often pieced together by underfunded grassroots organization. Public for profit companies proliferated, merged, and became true experts in the field. Smaller, community-based programs with varying operating models gave way to larger, homogenized systems with more service and more consistent service standards.

Not all problems were solved, however. The new “ADA paratransit” systems were often designed to meet ADA minimum standards rather than meet community needs. While many transit agencies exceeded those minimums, financial pressures, especially during economic downturns, often forced reduction in service areas and service models. The ADA paratransit programs were too often seen as the stepchild of traditional fixed-route transit; more costly per ride, more costly for passengers, and were “required” rather than being a primary goal of the public provider. ADA Paratransit is often limited to “where the buses go”, to various operating windows, and to those who can meet the parameters of the service model, including costs, rather than servicing everyone in need, including those who can’t afford ADA Paratransit fares.

Many ADA Paratransit services are now contracted with large for-profit providers whose focus is delivering service dedicated to meeting the requirements outlined in their contracts, rather than community need. While this focused approach to meeting the requirements of the ADA creates greater consistency of service, it shifts the service priority away from meeting the needs of the community to meeting the requirements of the local ADA plan and fixed route provider. Contracted out-of-area providers do NOT have community roots or priorities; instead, their loyalty lies with their contracting agency and corporate homes. This shift has changed the nature of system designs. In the past most specialized transportation programs were locally based and created to respond to community needs and challenges, but were woefully underfunded. Today, ADA Paratransit has replaced many of these agencies with a much better-funded model, but one that is less responsive to existing, to new and to emerging needs, including the inability to pay the required fares.

Thirty years after the passage of the ADA, it’s time to revisit the ADA Paratransit systems if our hope is to insure equitable access to transportation options for these populations. Significant investment and policy changes are necessary. Because accessible transit has been studied extensively, the path to improvement is well established. As described throughout this document, the time is now to make improvements. Leadership and funding will be necessary for implementation, and coordination between ADA Paratransit programs and local communities and community-based and community-driven specialized transportation programs needs to be at the heart of that mix.

## **Appendix B: Statewide Need: Excerpts from selected Coordinated Public Transit Human Services Transportation Plans, County Unmet Transit Needs Hearings and Short-Range Transit Plans document the need for additional funding throughout the state**

- **Butte County:** *“Top-ranked barriers to accessing needed transportation: Funding challenges for directly operating or contracting for transportation...”*
- **Fresno County:** *“Lack of Funding: Funding is insufficient to meet needs for expanding fixed-route service and equivalent paratransit...Duplication and Redundancy: Various sources of funding restrict transportation services to specific populations for specific purposes...results in service duplication and redundancy...”*
- **Inyo-Mono Counties:** *“The greatest barrier to coordination for all rural counties is lack of funding. There is simply not enough money available to meet all transportation needs for the target population... particularly in light of the dispersed communities and long travel distance...as such, the various human service agencies piece meal together trips for the most critical needs. Lack of funding/resources contributes to the limited staff time available for all agencies to pursue further coordination efforts”*
- **Kern County:** *“Priorities for the 2007 Coordinated Plan were identified as... Identify and pursue new funding sources...Barriers Identified: insufficient agency funding for Transportation...Very limited transportation funding was reported...difficulty in securing operating dollars to expand or develop new services in both rural communities and Metropolitan Bakersfield...transit systems are operating at their limits of their present funding base is among the most significant of constraints...”*
- **Kings County:** *“Increasing revenue resources: Identified as the core issue...an efficient coordination process must be established...there are many benefits to consolidating on a large scale...there has been no movement towards consolidating transportation entities...The greatest barrier to coordination is lack of funding...There is simply not enough money available to meet all transportation needs for the target population...human service agencies piece meal together trips for the most critical needs.”*
- **Lake County:** *“PRIORITY 1 – Critical: Pursue and secure funding to support, maintain, improve safety and enhance the Lake County public transportation network...” “...Continued priority must be placed on securing new funding sources...”*
- **Los Angeles County:** *“Roadblocks to further coordination. Several were identified, including the following: Funding restrictions; capacity constraints...”*
- **Madera County:** *“The greatest barrier to coordination for many smaller counties is lack of funding. There is simply not enough money available to meet all transportation needs for the target population, particularly in light of the dispersed development pattern and long travel distance in Madera County”*
- **Metropolitan Transportation Commission (San Francisco Bay Area):** *“Current senior-oriented mobility services do not have the capacity to handle the increase in people over 65 years of age...the massive growth among the aging ...points to a lack of fiscal and organizational readiness...the closure and consolidation of medical facilities while rates of diabetes and obesity are on the rise will place heavy demands on an already deficient system.”*
- **Riverside County:** *“Securing funding is critical to maintain, enhance and expand transit services...Goal 1: Strategy: Secure Funding, including discretionary sources, to maintain, enhance and expand transit and specialized transportation...The STRATEGIC ASSESSMENT proposes various strategic actions to address system-wide deficiencies...3) Increase Funding...Goal 2 – Connect and Coordinate Services Improve connectivity among public transportation services and coordination with human service transportation...”*
- **Sacramento Area Council of Governments:** *“...gaps in service remain due to geography, limitations in fixed-route/demand responsive services, program/funding constraints, eligibility limitations, knowledge, training...”*
- **San Bernardino:** *“...Coordinated Plan strategies can be supported with 5310 funds ...however, this competitive funding source is modest...” “...agencies and their transit programs need for assistance continues as they face funding*

uncertainties “, “...First Priority Strategies: Secure funding...to maintain, enhance and expand transit and specialized transportation services...”

- **San Diego:** “...gaps in service remain due to geography, limitations in transit service, funding constraints, eligibility, knowledge, and training...”
- **Shasta County:** “...limited resources in the form of staff availability, interest, leadership, service and/or capital capacity, funding, and time...”
- **Stanislaus Council of Governments:** “While public transportation services do receive Local Transportation Funds...and State Transit Assistance (STA) funds, it is generally not sufficient to address many of the service challenges, such as limited frequencies and longer service hours, which were common themes...”
- **Tulare County:** “Activities that better coordinate and consolidate transportation services and resources... Secure funding devoted to maintaining and strategically improving service levels...Secure funding and pursue low-cost, open source Find-a- Ride capabilities...”

**Ventura County:** “...limited funds suggest that it will be critically important to seek other funding sources to address many of the proposed strategies. Such additional funding sources could include but are not limited to...State cap and trade funding...”

## **Appendix C: Consolidated Transportation Services Agency (CTSA) Summary Description**

Below are excerpts from the [California Association for Coordinated Transportation’s CTSA eBook](#)<sup>98</sup>.

Consolidated Transportation Services Agencies (CTSAs) are designated by county transportation commissions (CTCs), local transportation commissions (LTCs) regional transportation planning agencies (RTPAs), or metropolitan planning agencies (MPOs) under auspices of the Social Services Transportation Improvement Act<sup>99</sup> to achieve the intended transportation coordination goals of that Act.

The Act, sometimes referred to as Assembly Bill 120 (Chapter 1120, Statutes of 1979), added Part 13 (commencing with Section 15950) to Division 3 of Title 2 of the Government Code and amended Sections 99203 and 99233.7 of, and added Section 99204.5 to the Public Utilities Code relating to transportation

**Legislative Intent:** The purpose of the Act was to improve the quality of transportation services to low mobility groups while achieving cost savings, lowered insurance premiums and more efficient use of vehicles and funding resources. The legislation took the middle course between absolutely mandating and simply facilitating the coordination of transportation services. Designation of CTSAs and implementation of other aspects of the Act were seen as a flexible mechanism to deal with the problem of inefficient and duplicative social service transportation programs that proliferated due to a dramatic increase in the number of social service programs offered by government agencies and private nonprofit organizations to meet their clients’ mobility needs.

### **Who is Eligible to be Designated a CTSA?**

Each CTSA shall be an entity other than the transportation planning agency and shall be one of the following: a) a public agency including a city, county, operator, any state department or agency, public corporation, or public district, or a joint powers entity created pursuant to Chapter 5 (commencing with Section 6500) of Division 7, Title 1 of the Government Code. b) A common carrier of persons as defined in Section 211 of the Public Utilities Code engaged in the transportation of persons as defined in Section 208. c) A private entity operating under a franchise or license. d) A

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<sup>98</sup> California Association for Coordinated Transportation: Credit for most of the text in this CTSA eBook goes directly to individuals in the Division of Mass Transportation who created the Final Report to the Legislature (July 1982) related to the Act and specifically to the Project Manager, Ms. Chris Hatfield; and to the individuals who created the follow-up report, SB 157 Action Plan (January 1987), specifically to the Project Manager, Mr. Peter Steinert

<sup>99</sup> [Gov Code: Title 2, Div. 3: Part 13: SOCIAL SERVICE TRANSPORTATION \[15950 - 15986\]](#)

nonprofit corporation organized pursuant to Division 2 (commencing with Section 9000) of Title 1 of the Corporations Code.

### **What are CTSAs Required to Do?**

Before the Social Service Transportation Improvement Act became law, California had no requirement for the coordination of social service transportation services. It was enacted to promote the consolidation of such transportation services so that the following benefits may accrue:

1. Combined purchasing of necessary equipment so that some cost savings through larger number of unit purchases can be realized.
2. Adequate training of vehicle drivers to insure the safe operation of vehicles. Proper driver training should promote lower insurance costs and encourage use of the service.
3. Centralized dispatching of vehicles so that efficient use of vehicles results.
4. Centralized maintenance of vehicles so that adequate and routine vehicle maintenance scheduling is possible.
5. Centralized administration of various social service transportation programs so that elimination of numerous duplicative and costly administrative organizations can provide more efficient and cost effective transportation services permitting social service agencies to respond to specific social needs.
6. Identification and consolidation of all existing sources of funding for social service transportation services can provide more effective and cost efficient use of scarce resource dollars. Consolidation of categorical program funds can foster eventual elimination of unnecessary and unwarranted program constraints.

The Act did not define social service agency transportation, so an advisory definition was promulgated for purposes of implementing all aspects of the Act. "Social Service agency" was defined as a public or private, nonprofit organization which provides services to any of these four target groups: elderly individuals, individuals with disabilities, youth, and individuals with low-income. The following nine functional areas were identified:

1. Services to children
2. Employment services
3. Provision of food, clothing, and housing
4. Guidance
5. Health services, both mental and physical, including services to individuals with disabilities
6. Recreation
7. Services to special groups, including non-English speaking individuals, individuals with alcoholism, et.
8. Welfare

### **CTSAs Designees Today and Yesterday**

Prior to enactment of the Social Service Transportation Improvement Act, there was no previous requirement or large-scale experience with coordination in California, and as might be expected with such an ambitious undertaking, problems surfaced during implementation and exist even today. While intent of the legislation was to allow for a maximum degree of flexibility, the end result was vagueness in terms of several critical points. The Act:

1. Assumed that some form of coordination would be found feasible in each geographic area.
2. Lacked a clear definition of social service transportation services.
3. Used the terms coordination and consolidation interchangeably.

4. Mandated the creation of CTSAs without defining their function or limitations.
5. Made TDA Article 4.5 funds available to CTSAs at the discretion of the transportation planning agencies, but did not appropriate any additional funding for the purposes of planning or implementation.
6. Did not include a provision for updating either the inventory reports or the Action Plans.
7. Did not include sanctions for noncompliance by either the transportation planning agencies or social service agencies which provided some leeway to avoid fulfilling the coordination mandate.
8. Did not address nor mandate implementation of the Action Plans.
9. Specified that the Secretary of the Business and Transportation Agency (now called Business, Transportation, and Housing Agency) comment on the adequacy of each Action Plan, but did not provide for sanctions if the Action Plans were found to be inadequate.

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<sup>i</sup>Transportation Task Team to the California Commission on Aging, 2005, 2007 reports: “Barriers..., Lack of: 1) state and local leadership to coordinate programs and services, 2) regulatory authority to mandate that CTSAs be established and perform service coordination and improvement functions, 3) incentives to coordinate or improve services, 4) consensus by stakeholders due to programs being funded from different “silos” and subject to differing requirements, 5) resources, particularly funding and staffing, at the local and state level, Lack of local leadership to coordination. Lack of coordination incentives. Lack of political will to make systematic changes”, and (the presence of) “Funding Silos”, and “the need for “Dollars need to follow the person (from various funders) not follow the program.” Government Accountability Office (GAO) reports 109878, 591707, 650079, 658766, 660247, 667361, et al: “...duplication of effort and inefficiency in providing transportation when agencies do not coordinate...”, “...state and local agencies are unaware that they are...providing transportation services identical and parallel to those of another agency“...transit agency officials that we spoke with said that they would like to implement coordination efforts, but have been unable to get various parties to come together...”, “continuing challenges such as insufficient leadership at the federal level and limited financial resources and growing unmet needs at the state and local level.”, “...state and local officials expressed concern about their ability to adequately address expected growth in elderly, disabled, low-income, and rural populations.”, “...agencies providing similar transportation services to similar client groups may lead to duplication and overlap when coordination does not occur.”

<sup>ii</sup> *American Public Association Transit Association Fact Book*, 2015

<sup>iii</sup> *Implementation: How Great Expectations in Washington Are Dashed in Oakland*, Jeffrey L. Pressman, Aaron Wildavsky, 1984