

# Berkeley Age-Friendly Continuum Needs Assessment

2017

**Funded by:**



# Berkeley Age-Friendly Continuum Needs Assessment

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## Executive Summary

### I. Background and Methods

Over a period of years, a group of older adults met at a kitchen table to talk because they were not happy with the options they faced as they grew older in Berkeley. This kitchen table conversation has grown to include a much broader range of individuals and has gained funding from esteemed sources in the community. The City of Berkeley has applied for and been approved as a member of the Age Friendly Cities and Communities movement, and the Continuum has hired strategic planning consultants to work with them to more sharply define a sustainable vision and start-up plan to improve the aging experience for all older adults in Berkeley.

Comprehensive needs assessment data, provided in the body of this report, is compiled primarily from existing sources. New data comes from three community forums conducted in Berkeley in September of 2016, and input from Continuum leaders and partners.

**Geographic Focus:** The leadership of the Continuum recognizes that cities do not operate in isolation, and that the broader “community” of Berkeley, Albany, Emeryville, and North Oakland, probably defines a “natural service area” with high fluidity across city lines for services, shopping, socializing, and entertainment. Because of this, the longer term vision for the Continuum is focused on this broader service area. However, the group also realizes that the pilot phase of this effort will be more manageable if it begins solely in the City of Berkeley – which has already been accepted into the World Health Organization/AARP Age Friendly Community Network, and where public-sector collaboration and financial support for this effort are already underway. For this reason, local needs data for this phase of the project focuses on Berkeley.

**Note:** The universe of needs and resources for older adults in Berkeley is vast and cannot be covered comprehensively at this stage. Once the Leadership Team establishes planning priorities, more research in any of the areas presented here (or new ones) can be conducted as appropriate.

### II. Summary and Discussion

This section summarizes key sections presented in the body of this report which address what older adults report they want, what leaders and experts think the expanding system of care for older adults needs, and environmental factors also influencing needs and the evolving system of care. A discussion of additional considerations follows.

As a point of reference, demographic projections suggest that by 2030, older adults will represent 20.05% of the population of Berkeley or more than 26,500 older adults ages 65 or older.

## **What Older Adults Want and Need**

The needs of older adults in Berkeley are fairly clear, and they are fairly representative of findings across international, national and local studies and surveys. With emphasis on local input from Berkeley older adults and Continuum leaders and partners, the top issues are summarized here.

- Enough money to live on;
- The ability to stay in Berkeley throughout the aging years;
- Housing, housing, housing. Affordable housing, housing that older adults want to live in, housing that facilitates getting needed supports as people age, housing to stay in Berkeley;
- In-Home Supports that are identifiable, affordable and trustworthy;
- Easy access to individualized information, linkages and navigational support;
- Transportation;
- Safety – Safe sidewalks, safety in their homes and in the community;
- Social Connectedness, engagement and accessible activities; and
- Access to healthy foods and prepared meals.

Looking at needs differently, older adults also express that:

- Older adults who are middle income, and those at the upper end of low-income are at high risk of falling through the cracks. They do not qualify for enough benefits to meet their needs and often cannot afford to meet those needs out-of-pocket. The extreme shortage of affordable housing in Berkeley exacerbates this. Much more focus is needed here.
- The poorest of the poor must work hard at it, but some can piece together free and low-cost services that take care of their very basic needs. However, a “little extra” communication, transportation, discounts, and human assistance would make a big difference in the quality of their lives. The critical exception to this ability to “piece it together” in Berkeley is the current norm of 6-8 year waiting lists for low income housing. This is pushing many older adults out of Berkeley.
- Even those older adults with decent retirement incomes face problems with isolation, mental health problems and memory loss, access to prepared food, finding reliable in-home supports, and managing their technology.

## **Leaders and Experts Add**

- Many of today’s older adults did not address financial planning for their aging years early enough – leading to housing instability and avoidable poverty. Today’s housing costs do not help this. Effort is needed to get rising older adults to address this earlier.
- Falling, a leading cause of hospitalization in older adults, is also not addressed early enough – with hazard evaluation, home modifications, and training needed for prevention of falls.

- Mental health issues, addiction to prescription medications, and memory care needs are growing exponentially and more people age – and the workforce as well as housing and service systems are not prepared to respond to this.
- Expanded capacity to provide in-home and residential assisted living care is critical to both offering older adults the lifestyles that they want, and reigning in the cost of care for this rapidly growing population. To do this, not only are new funding streams for in-home supports needed, but living wages and concerted recruitment and training efforts are needed to build the necessary workforce. Expanding the capacity of providers at all levels to be able to manage the growing prevalence of psychiatric and memory disorders will also be critical. Meeting workforce needs will take years.

### **Supply of Needed Resources**

Given the sheer increase in the anticipated numbers of older adults living in Berkeley, or who will be trying to stay in Berkeley by 2030 (and beyond), there are unmet needs in virtually every topic area explored in this report. To truly achieve an Age Friendly Berkeley, the bar needs to be raised across the board. If pressed to identify those areas of greatest unmet need, they include:

- Affordable, accessible housing;
- In-home supports;
- Affordable, desirable settings for out-of-home assisted living (e.g.: CCRC and alternatives);
- Expansion of eligibility criteria for subsidized services to raise access levels up to middle income;
- Innovations in both technology and care/service delivery to support community-based living (and control costs) for as long as possible;
- More “human touch” for information, referral, and system navigation; and
- More active fall prevention outreach and home modification programming.

### **Cost Containment and Social Determinants of Health**

The bottom line for medical providers is that they must control costs as the older adult population grows. Increased emphasis on prevention, use of burgeoning technology, and providing resources to address social determinants of health are key tools in this effort. Fortunately, addressing these issues on the provider side will also move older adults closer to what they want.

- More comprehensive, all-inclusive payment models that support patient centered, community-based care are needed. The PACE model is one example of this. However, currently this is limited to those lowest income individuals who are already nursing home eligible. Expansion is needed to address more adults with high needs, as well as those at a more moderate level of need.
- Avoidable hospitalizations can be reduced by a variety of different interventions, ranging from fall prevention programming, supporting adherence to medication regimens, or navigation support to be sure that people follow through on referrals. On the community-based side, support to meet every day needs can help keep people adequately housed, healthfully fed, and socially engaged – which will also contribute to reducing hospitalizations.

- Re-hospitalizations can be reduced by many of the same efforts but especially with adequate care in the home to recover properly. Re-hospitalizations are sufficiently avoidable that the Affordable Care Act has now established some payment sanctions when they do occur. Insurers and providers are more focused on this than ever.
- Long term care nursing homes will probably always be needed by a small population who have high, chronic medical care needs. But overall, nursing homes will continue to shift their focus toward shorter term, rehabilitative stays. An adequate supply of high quality nursing home beds is needed, and older adults want them to be located close to or in their home communities.
- Continuing Care Communities (CCRCs) provide a nice balance between total independence and institutional care. In fact, the availability of in-home supports (assisted living) in CCRCs is likely reducing hospitalizations and the need for short or long-term nursing home care. While the supply of CCRC beds in Berkeley will be increasing, demand certainly will outstrip supply for some time to come. Cost and alternative payment options have not yet been affectively addressed to make them adequately available to a broader portion of the older adult population.

### Technology

Not only are new technologies being used within the medical care delivery system to reduce cost and improve health outcomes, but the world of technology available in the community to support older adults to live the healthiest, fullest lives possible is also proliferating. To the extent that these technologies support individuals to take care of themselves, meet their logistical and social needs, and keep them connected, they also have great potential to reduce overall health care costs. Older adults are not the best people to stay on top of the new technologies as they emerge, and care coordinators are suggested as a bridge to their adoption and sustained use. Addressing the out-of-pocket cost of these technologies to older adults is also of concern.

### Discussion

As we look at this summary, additional issues arise that should be addressed as the Continuum plans its future. These include:

- **The Nature of Partnerships:** Referred to frequently throughout this document, partnerships between providers of clinical (medical and behavioral health) care and those who offer a range of broader supports in home and community settings are more critical than ever. Patient-centered care requires it; addressing social determinants of health requires it; and supporting older adults to age in their homes and in the community requires it. Some even speak of a “convergence” of health care and housing.

To-date, it seems that the impetus for these new partnerships is coming from the medical sector – approaching community-based providers to support them. The question of how a well-organized community sector might configure itself and provide comprehensive options to medical providers to meet mutual needs has not been explored.

- **Cross-Sector Advocacy and Leadership:** Once mission and values are defined, strategic planning is about blending responses to need, opportunities, and fit with capabilities and resources. Some of the needs outlined here could be filled by Continuum partners. Others are beyond the current

scope or scale of Continuum partners to fill (e.g. building enough market rate housing to meet the need, providing enough in-home care at an affordable rate to meet the need).

This does not, however, exclude the Continuum from taking a role in addressing these needs. While the City of Berkeley is active and proactive in this arena, more is needed. There is still a high unmet need for advocacy and leadership across sectors to develop the communication, collaboration, and multi-disciplinary resources necessary to address key areas of need to “raise the bar” overall, for an age-friendly Berkeley.

### **III. Next Steps**

As stated throughout, the universe of needs that older adults and the systems that support them face in the upcoming years is daunting. There are substantial unmet needs in almost every arena today, which will be further stretched to address the growing population.

This Needs Assessment report is designed to support the Continuum at the start as it narrows its focus and defines those areas of need that it is best suited to effectively address. This will require assessment of not just needs, but the capabilities and resources that the Continuum and its partners can bring to address these needs in Berkeley and beyond.

As this “fit” comes into focus, additional research can be conducted to collect new or refined data. Once priorities become focused, additional research may help to consolidate information on models or efforts underway elsewhere to address these same issues. This piece on “models” will be developed as an additional “chapter” for the Continuum’s final planning report.

## CONTINUUM PARTICIPANTS

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As of March, 2017

### Leadership Team

- Chair: Steve Lustig, Ashby Village Board; Associate Vice Chancellor Emeritus, UC Berkeley
- City of Berkeley: Tom Bates, Mayor (through 2016), Jesse Arreguin (current)
- Ashby Village: Andra Lichtenstein, Chair, Ashby Village Board; Principal, Capital Incubator
- Center for Technology and Aging: UC Berkeley, David Lindeman, Director
- Lifelong Medical Care: Marty Lynch, CEO
- Episcopal Senior Communities: Kevin Gerber, President and CEO
- CalQualityCare: Charlene Harrington, Professor Emeritus, UCSF School of Nursing; Principal
- Chapparral House: KJ Page Administrator
- California Advocates for Nursing Home Reform: Carla Woodworth, Co-Founder; former member Berkeley City Council

### Partners

- Ashby Village: Andy Gaines, Executive Director
- Alameda County Health Care Services Agency: Rebecca Gebhart, Acting Director
- Northern California Presbyterian Homes and Services: Janet Howley, Vice President
- Center for Independent Living, Inc. (CIL): Thomas Gregory, Deputy Director
- Center for Elders Independence (CEI): Linda Trowbridge, CEO; Lenore McDonald, Director of Development
- Episcopal Senior Communities: Tracy Powell, Vice President Community Services
- Center for the Advanced Study of Aging Services, UC Berkeley: Andrew Scharlach, Director
- J-Sei: Diane Wong, Executive Director

### Consultants

- Nancy Frank & Associates, Piedmont, CA
- Dan Geiger Consulting, San Francisco, CA (2016)

### Graduate Student Interns

- Abbey Dykhouse, Masters in Social Work Program, UC Berkeley
- Carrie Gladstone, Joint Masters in Public Health and Business Program, UC

### Funders

Kaiser Permanente Community Benefits, Alta Bates Summit Medical Center, City of Berkeley

**Berkeley Age-Friendly Continuum  
Needs Assessment**



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### I. Background and Methods

Over a period of years, a group of older adults met at a kitchen table because they were not happy with the options they faced as they grew older in Berkeley. This kitchen table conversation has grown to include a much broader range of individuals and has gained funding from esteemed sources in the community. The City of Berkeley has applied for and been approved as a member of the Age Friendly Cities and Communities movement,<sup>1</sup> and the Continuum has hired strategic planning consultants to work with them to more sharply define a sustainable vision and start-up plan to improve the aging experience for all older adults in Berkeley. A listing of The Age-Friendly Continuum's (referred to as Continuum) Leadership Team, partners, funders, and consultants as of October, 2016 is included as Attachment 1.

As it began to research the needs and wants of the community, the Continuum quickly realized that a wealth of valid needs research exists, and there is little need to duplicate it. Rather, it would focus on aggregating the existing needs data, and filling in where feasible and necessary.

With this in mind, the data reported here is largely compiled from existing sources. New data is added from three community forums conducted in Berkeley in September of 2016, and input from Continuum leaders and partners gathered through a series of interviews. Alameda County's data, collected in 2015 as part of its own planning process, included Berkeley but did not appear to be adequately representative of the range of different communities in Berkeley. The Continuum forums were held to supplement this material. Of the 57 individuals who attended the Continuum's forums, just 4 had participated in the County's input process.

**Geographic Focus:** The leadership of the Continuum recognizes that cities do not operate in isolation, and that the broader "community" of Berkeley, Albany, Emeryville, and North Oakland, probably defines a "natural service area" with high fluidity across city lines for services, shopping, socializing, and entertainment. Because of this, the longer term vision for the Continuum is focused on this broader service area. However, the group also realizes that the pilot phase of this effort will be more manageable if it begins solely in the City of Berkeley – which has already been accepted into the World Health Organization/AARP Age Friendly Community Network, and where public-sector collaboration and financial support for this effort are already underway.

For this reason, local needs data for this phase of the project focuses on Berkeley.

**Note:** Some potential areas of need have not been addressed in this report – as they have not been prominent in other efforts or our own interviews or focus groups, and therefore did not suggest immediate need. Examples include medical emergency and broader disaster response, supply of

doctors, dentists and vision specialists, elder abuse prevention and investigation, employment, and end of life care. However, within the past year, three community gatherings were held in Berkeley focused on end of life issues. Well over 400 individuals attending these gatherings – suggesting a hunger for these difficult conversations.

## II. Demographics

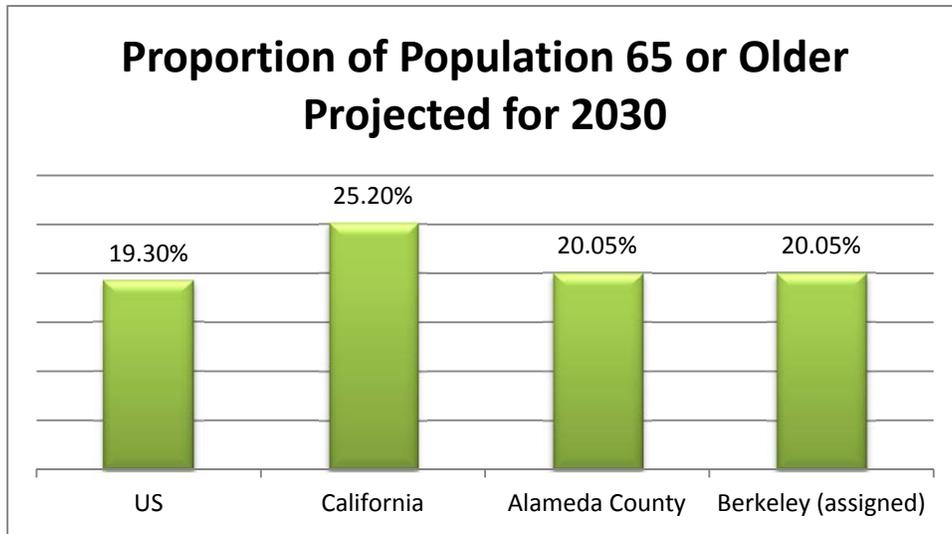
The following materials summarize basic data on the older adult population in Berkeley, as well as important information available at the county, state or national level that are useful to inform our understanding of the Berkeley older adult population. Sources of data are from the Alameda County Plan for Older Adults 2016-2017<sup>2</sup> unless otherwise cited.

### General Berkeley Data

Berkeley City-Wide Data – 2013 <sup>3</sup>				
<i>(sorted by median age)</i>				
Zip Code	Population	Median Age	Median Income	Percent Non-White
94708	11,073	52.0	\$140,611	19.50%
94707	12,324	50.4	\$138,144	21.70%
94705	12,979	44.1	\$94,750	26.30%
94702	16,324	39.6	\$57,457	51.30%
94710	6,478	35.7	\$63,125	60.20%
94703	21,281	34.9	\$55,554	47.10%
94709	12,360	29.8	\$57,433	44.10%
94704	24,906	21.7	\$31,116	55.90%
94720	<u>3,026</u> <sup>4</sup>	19.3	\$23,304	68.10%
	120,751			
Ala Cty		36.8	\$72,112	66.30%
CA State		35.4	\$61,094	60.00%

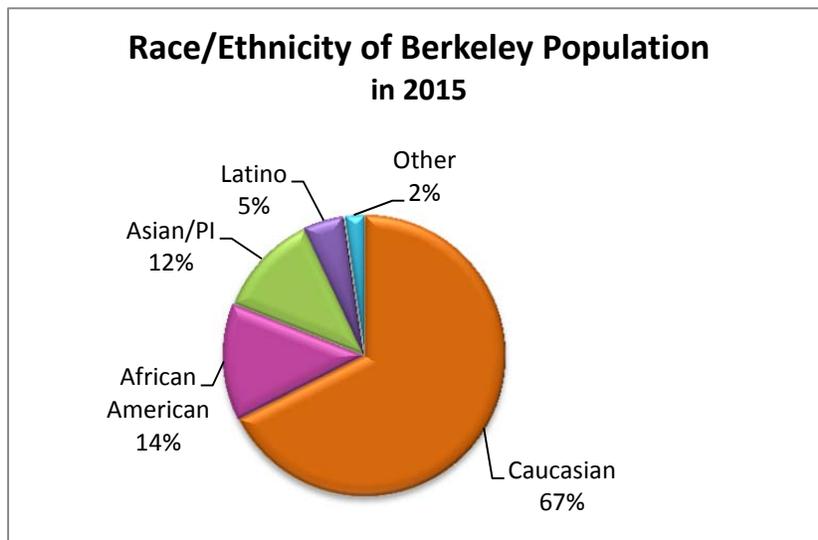
### Older Adult Population and Growth

- **Nationally:** The population of older adults in the U.S., ages 65 and older, is projected to grow from 13.1% of the total population in 2015 to 19.3% of the population in 2030. This group will account for more than half the country's total population growth during that period.<sup>5</sup>
- **Statewide:** The 65+ population in California is projected to increase proportionally from 18.9% to 25.2% in this same period with the median age rising from 36.5 to 40.3.<sup>6</sup>
- **Alameda County:** By 2030, older adults in Alameda County are projected to rise from 13.07% to 20.05% with a median age of 41.7 with almost 43,000 over the age of 85.<sup>7</sup>
- **Berkeley:** Using the Alameda County percentage of 20.05%, the 2030 population of Berkeley, ages 65 and older, would be 26,519.



**Race/Ethnicity**

We know that income drops significantly as people leave the workforce, and we know anecdotally that there is a strong out-migration from Berkeley as people age because of housing problems – whether cost or ability to meet needs of the aging. However, we don’t know the race/ethnicity of that out-migration. In 2015, the race/ethnicity of the City of Berkeley population (all ages) was:



We also know that 17.9% of residents spoke a language other than English in their home.

**Housing and Financial Status of Older Adults**

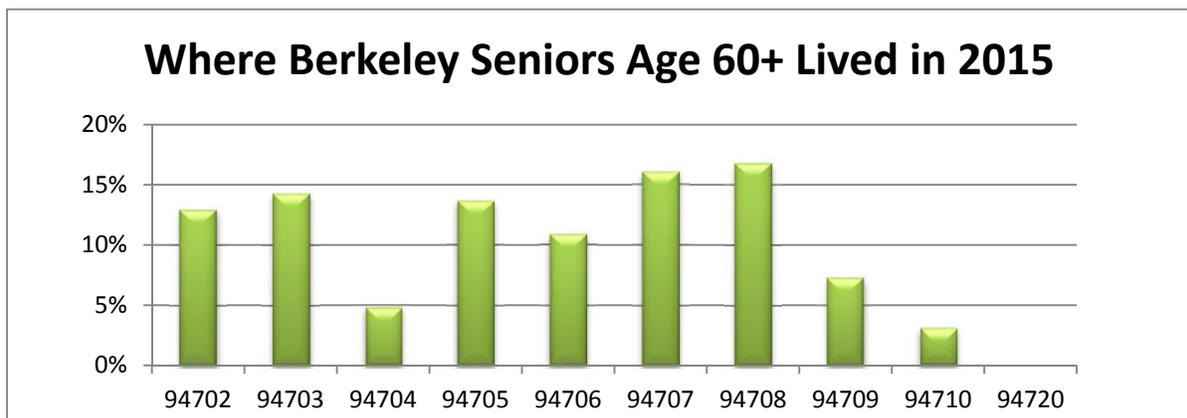
- **Economic Insecurity:** In 2015, the Federal Poverty Level (FPL) for a single person was \$11,700. This figure establishes eligibility for many federally funded programs including MediCal, CalFresh

and General Assistance. In 2015, 11% of Alameda County Older Adults were living below this FPL and 25% had incomes of less than 200% of the FPL.

However, according to the Elder Index, 49% of single older adult households (where one person age 65 or older lives alone) and 21% of adult couple households do not have enough annual income to cover basic needs without additional public assistance.

As a point of reference, the self-sufficiency level defined by the Elder Index, for an individual over age 65 living in a one-bedroom rented apartment in Alameda County in 2015, was estimated to be \$27,500.<sup>8</sup> This amount is intended to cover housing, food, medical care and transportation, with just a little left over for all other expenses. The median monthly social security payment for that renter was \$12,523. This leaves a \$15,000 gap.

- **Homeless:** One study shows that in 1990, just over 10% of the statewide homeless population was over age 50. By 2015, that number had risen to 33%.<sup>9</sup>
- **Living in Poverty:** In 2010-2014, 23% of those 60+ in Berkeley were living under 200% of the Federal Poverty Level.<sup>10</sup>
- **Household Composition:** Of households in Berkeley with an individual 60+, 48% were single person households; 69% owned their own home and 31% were renters.
  - 55% of renters were spending more than 30% of their income for housing.
  - The median sales price of a home in Berkeley in 2014 was \$813,000. More recent data from Zillow suggests that the median home price has risen to \$988,000 in 2016.
- **On Medi-Cal:** Of the 22,031 age 60+ in Berkeley in 2015, 15.7% were enrolled in MediCal (an indicator of low income).



### Health and Medical and Mental Health Care

- **Cost of Care:** While 98% of Alameda County older adults had medical insurance in 2014, over 48% reported forgoing needed medical care because of the cost.
- **Hospitalizations:** While older adults comprise 13% of the population in Alameda County, in the period 2012-2014 they accounted for 30% of all hospitalizations.<sup>11</sup>
  - The rate of **preventable hospitalizations** due to acute illnesses in those 80-84 is over 6 times higher than for 60-64 year-olds and the rate for those over 85 is 12 times higher.<sup>12</sup>

- **Falls:** California-wide, falls are the leading cause of injury-related death for older adults 65 years and older, and account for over \$2 million in medical costs per year.<sup>13</sup>
- **Behavioral Health:** In the period 2012-2014, the rate of mental health hospitalizations among 75-84 year-olds in Alameda County was 1.6 times the rate of 45-54 year olds, and rates for those over 85 were 4.3 times the rate of 45-54 year olds.<sup>14</sup>
- **Disability:** 29% of Berkeley Older Adults are living with a disability. This is one of the lower disability rates in the county (with Emeryville showing 49% with disabilities).<sup>15</sup>
  - 5.4% of older adults in Alameda received County **In-Home Supportive Services** (an indicator of being low income and frail or having a disability).

### III. Priority Needs, Wants, and Concerns

What older adults want, anticipate wanting, and/or worry about, does not vary greatly nationwide, although regional variations do occur. A quick look at just a few summaries from international, national, and statewide studies are provided here, with a more detailed look at Alameda County and Berkeley specifically.

#### A. International, National, State, and County Goals and Priorities

##### 1. International Focus

Based on its own research, the World Health Organization's (WHO) Global Network of Age-Friendly Cities and Communities has identified eight domains of livability that influence the quality of life of older adults.<sup>16</sup> The domains are also used as a framework by the U.S.-based towns, cities and counties that belong to the AARP Network of Age-Friendly Communities. The City of Berkeley has received that designation and will be expected to develop a plan that addresses issues in these domains in the next two years. The domains recognized in the WHO model are:

1. Outdoor Spaces and Buildings
2. Transportation
3. Housing
4. Social Participation
5. Respect and Social Inclusion
6. Civic Participation and Employment
7. Communication and Information
8. Community and Health Services

These are not prioritized but rather, are intended to be all-inclusive. Age-Friendly Communities are instructed to prioritize them for their locale as part of their own action planning.

##### 2. National Concerns

The National Council on Aging conducted a telephone survey in 2015 of 1,650 Americans age 60 and over and professionals who work closely with them,<sup>17</sup> to assess the priority concerns and needs of America's aging population. Top concerns of older adults in priority order included:

1. Maintaining good health
2. Staying in current home
3. Giving up driving/access to transportation
4. Financial security
5. Sudden medical bills
6. How to cut costs – especially housing
7. Social ties
8. Mental health
9. Social support/community acceptance

It is interesting to note that professionals included in this survey were more worried than older adults about:

1. The financial lives of older adults
2. Affordable housing
3. That older adults have more confidence in how prepared they are to face old age than professionals

### **3. State Priorities**

While the State of California Aging Plan for the years 2013-2017<sup>18</sup> does not specifically share the findings from its own community input process, it indicates that these wants and needs have been incorporated into the priorities of the State Plan. The network of Area Agencies On Aging (AAAs) throughout the state (including one in Alameda County) are tasked with implementing the plan. The priorities/goals of this most recent plan are to:

1. Empower older Californians, adults with disabilities, and their caregivers to easily access the information they need to make informed decisions.
2. Enable older Californians, adults with disabilities, and their caregivers to be active and supported in their homes and communities.
3. Enable older Californians, adults with disabilities, and their caregivers to be healthy.
4. Protect the consumer rights of older Californians and adults with disabilities and assist them to obtain needed benefits.

### **4. Alameda County Goals and Priorities**

While the City of Berkeley has its own Department of Health Services (DHS), other cities in Alameda County do not. The Alameda County Health Care Services Agency (ACDHCS) oversees all public health activities for the rest of the county. The County Health Department (ACDHCS) works in tandem with the Berkeley DHS to meet Berkeley's needs.

Adding another layer to this, the State of California's Department of Aging's own Aging Plan is implemented throughout the state via the State of California's Area Agencies on Aging (AAAs). While

also responsible for operationalizing the state's priorities (as listed above), the Alameda County AAA was an active partner in the development of Alameda County's Older Adult Plan. The AAA also administers considerable state and federal funding for older adult services through a network of approximately 40 providers in a broad range of service categories.

Findings from Alameda County's Older Adult Needs Assessment are shared below – as presented using countywide data and, where possible, with Berkeley data extracted and standing alone.

**Alameda County Goals:** Based on the findings of its' highly engaged stakeholder needs assessment process, Alameda County set the following goals for the period 2016-2017:

**Goal 1:** Engage older adults, community partners, and cities in planning for and developing a community framework for older adults. (This included exploring the possibility of becoming WHO-designated Age-Friendly County.)

**Goal 2:** Through Alameda County Departments, develop a coordinated approach to designing, delivering and measuring effectiveness of programs for older adults.

**Goal 3:** Working with community partners, address the growing need of services for older adults by supporting a comprehensive network of providers to provide long-term services and supports (LTSS) that engage older adults and seniors with disabilities in community settings.

**Goal 4:** Enhance the health, safety, and well-being of older adults by offering coordinated services that promote health and wellness, with an emphasis on prevention and early access to behavioral health services.

**Goals 5:** Enhance programming to create safe communities for older adults by preventing and responding to neglect and abuse of older and dependent adults.

**Goal 6:** Enhance and increase support for housing, and augment the sustainability of housing programs.

## **B. County and Local Input on Needs**

### **1. What Older Adults Say**

The remainder of this section shares specific needs data collected directly from older adults in Alameda County. Berkeley-specific data is highlighted where possible.

**a. Alameda County Survey:** Alameda County recently completed an extensive community input process as a part of developing its 2016-2017 Plan for Older Adults. Through this process, nearly 4,000 individuals participated in a survey and nearly 300 individuals participated in forums and focus groups held countywide to share their concerns and needs about aging in Alameda County. These concerns led to the establishment of priorities in Alameda County's Plan for Older Adults. Alameda County Department of Social Services (which also houses the Area Agency on Aging) has shared the survey data with Berkeley Continuum planners, and we are able to see that Berkeley's priorities are similar but not identical to countywide views.

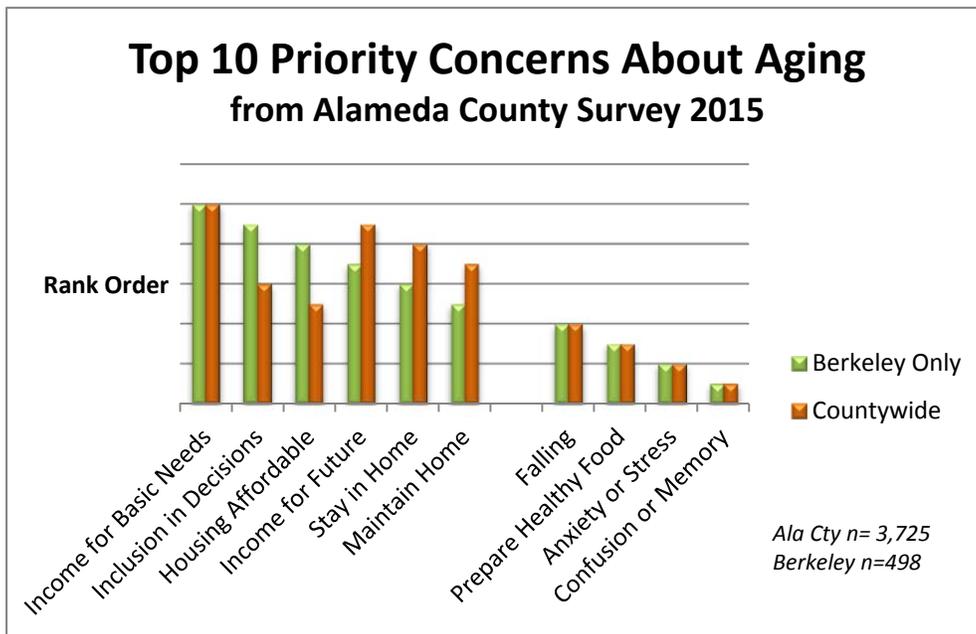
**Bias:** It is important to note that we can see from data that there is a slight bias in who participated in the survey – with lower income members of both the Berkeley community and Alameda County as

a whole somewhat over-represented. We can also probably assume that the most isolated older adults living in the community were not reached by the survey – but we don’t know for sure.

A full presentation of Berkeley-specific demographic characteristics and responses to the survey are included as Attachment 2.

**Top Findings:**

**Income and Housing:** We can see in the table below that countywide, concerns about income, housing affordability and being able to stay in and maintain one’s own home, make up the top 6 concerns identified. In Berkeley specifically, they represent 5 of the 6 top concerns. Interestingly, Berkeley residents ranked fear of not being included in their own decisions that affect their lifestyle in the top 6 as well. Concerns about falling, access to healthy food, and stress and memory problems, round out the top 10 concerns for both countywide and Berkeley residents.



We do find a few differences within Berkeley when these responses are analyzed by age, race, income and zip code – but these differences are fairly predictable. Again, it is important to remember that there is slight bias in the sample - skewed toward lower income individuals overall. A sample of significant differences (p< .05) includes:

- **Income to Meet Basic Needs:** While 57% of individuals ages 55-64 were very concerned about having enough income to meet their basic needs, this dropped to 28% among those 85+ (pr=.000). Said differently, however, more than one quarter of those 85+ were still concerned about meeting their basic needs, and this does not include those that have left Berkeley for a lower cost of living.
- **Housing:**

- **Suitable Housing:** While 86% of respondents ages 85 and older reported that they had housing that was suited to meet their needs, just 57% of those 55-64 reported that they had housing that met their needs ( $p=.000$ ). This confirms that appropriate housing is a high worry among those entering their older adult years and suggests that a shift does occur for many after age 55 to access more “suitable” housing.
- **Affordable Housing:** Fully one third (33%) of those 85+ reported that they were concerned about affordability of their housing as they age, while 58% of the 55-64 age group reported this concern ( $p=.000$ ).
- **Income and Housing:** Understandably, housing concerns are highly sensitive to income, with 56% of the lowest income bracket (\$11,770) very concerned about having affordable housing as they age, compared to just 15% of those with incomes over \$86,000 ( $p=.000$ ).

These current housing concerns do not reflect future impact of the rising demand for suitable housing as the older adult population grows in size – but we do know that already, wait lists for subsidized senior housing are 6-8 years long. This also does not reflect the unknown number of those who leave Berkeley in order to find appropriate housing (both suitable and affordable), but we hear anecdotally that these numbers are rising as well. We know from forums that the notion of “suitable” includes affordability, maintenance, access, and availability of in-home supports.

**Being Able to Prepare Healthy, Nutritious Food:** As expected, those with the lowest incomes were more likely to be very concerned about their ability to prepare healthy, nutritious food as they age (39%). However, a surprising number of the highest income individuals (20%) were also very concerned ( $p=.004$ ), affirming that this is a logistical as well as cost issue.

**Personal Safety and Protection from Abuse:** Zip code is a significant factor in feeling safe – with the fewest respondents (52%) in 94709 reporting that they feel safe and the most respondents (86%) in 94706 reporting that they feel safe ( $p=.003$ ). It is important to note, however, that the wording of this question combines such issues as elder abuse with safety while walking in public.

**b. Alameda County Forums and Focus Groups:** In addition to its survey, Alameda County conducted a series of forums and focus groups. Findings are not very different than what was learned from the survey or the Continuum’s forums with one very interesting exception that is shared below. More details on the forums and focus groups can be found in Attachment 3.

**The nearly poor need more support:** The issue of financial support and sustainability permeated the county’s forums with emphasis on “who is poor enough” to qualify for aid and assistance. The groups felt that the bar for assistance was too low, and leaves the “nearly poor” with little or no eligibility for free and subsidized services. This echoes what the Continuum heard in both its forums and through interviews (below) that middle income older adults are underserved – with too much income for public assistance, and too little to pay out of pocket.

**c. Continuum Forums :** Alameda County’s planning forums that were held in Berkeley were held exclusively in senior centers. Senior Centers seem to draw a lower income, frailer population, although people did not need to be regular users of the center to join the forums. Because of this slight “bias” in who participated, additional forums were developed to reach those who do not attend senior centers, and to hear from those with a greater spread in income. Our efforts were somewhat

more successful – with 25% of participants indicating incomes of \$35,000 or more. We did reach a population that did not participate in County forums or survey – with just 4 participants being aware of having participated in them.

While 56 of the 57 individuals who participated in the forums submitting an accompanying survey, just 49 of them answered the income question. Of these 49, we see that 77% have less than \$35,000 in annual income from all sources including savings, retirement and pensions. 57% reported income of less than \$17,500.

The zip codes of Continuum forum participants were clustered in zip codes 94703 and 94704 (71%) but in total, 7 Berkeley zip codes were represented, along with 1 North Oakland zip code and 2 individuals who reported being homeless. A summary of the demographics of the forum participants is included as Attachment 4.

A summary of forum discussion findings includes:

- **Income and Housing:** This was a hot topic. The lower the income, the more people worried about having enough income to meet all their needs in the future. This conversation quickly migrated to affordable housing in all forums. Nobody raised the issue of financial counseling to help them figure out what they can afford or where they can live.

For those who know that they cannot stay in their current home – for cost reasons or suitability for aging – the fear of having to leave Berkeley to find housing was a consistent concern. Among those who spoke up, subsidized multi-unit housing was viewed very favorably, especially if a navigator or social worker is available in the building. Participants pointed out that you can't sign up for subsidized housing until you are 62, and that wait lists are currently 6-8 years long. Home sharing was of some (not great) interest.

- **In-Home Supports:** Continuum forum participants were consistent with the Alameda County survey in terms of people wanting services and supports to come to them in their own home rather than having to go into an institution. A few reported having county-funded In Home Supportive Services (IHSS), but they consider the number of hours they receive from IHSS too limited. All were concerned about where to go to find in-home supports, how to trust the individuals coming into their homes, and how to afford them. Some want just an hour or two here and there – which is hard to find. Participants also noted that caregivers should also be trained to be more sensitive to the unique needs of older adults.

The issue of assisted living came up in this context – people want assisted living in their homes. If they can't afford that, they want something that is not a nursing home. Any facility that they would consider moving to has to be pretty and quiet. However, many folks expressed that they couldn't even imagine ever affording a Continuing Care Residential Community (CCRC) – it was largely a non-issue to the vocal members of this group. (We do think that some, with higher incomes, were less vocal in these cost discussions.)

- **Linkages and Navigation:** Most were very concerned about where to turn for help getting around the “system” – housing, health care, transportation, how to learn what you need to learn if you develop a new medical condition, what resources are available in the community – from basic to

social and entertainment. People want a “one stop shop” for help. They want to be able to call someone or see them face-to-face in addition to being able to look things up online. They want “someplace to go when you need help learning something new.” Exceptions to this were people in a subsidized housing setting that has a social worker/navigator in it part-time, and Ashby Village, where members feel their needs are mostly met.

Participants in one forum discussed the issue of receiving information electronically versus on paper – with a handful of participants acknowledging that they are a dying breed but want things a) on paper, and b) in larger than normal font. At least one person mentioned wishing that Ashby Village would distribute information periodically in a hard copy/newsletter format.

- **Transportation:** The issue of transportation was consistently raised across all forums. Points included:
  - Older adults want public transit to be more frequent and more flexible (buses not flexible enough), or something like Uber but affordable.
  - Bus drivers should get training to work with older adults – sensitivity, patience.
  - City’s taxi vouchers are too limited – just for transportation to medical care and basic needs -- and if you have three doctor’s appointment in a week, you aren’t covered. Others did not even know that vouchers were available.
  - “Good walk score” was mentioned in one forum (meaning you can walk to shopping, entertainment, etc.). This was echoed with a need for good sidewalks.

- **Safety:** This topic took two forms: Concern about crime against older adults, and concern about falling on bad sidewalks. One group mentioned safety escorts as potentially interesting.

To a lesser degree, participants confirmed that they want assurance that there will be help in the event of a fire or an earthquake. A few participants in one forum indicated that Berkeley Mental Health Services will soon have a temporary office next door to their facility – and they expressed fear for their safety if this occurs.

- **Health Care:** Participants reported that health care needs are pretty well met. A few expressed concern and even fear over losing the Alta Bates emergency department in a few years. 30% reported getting their care at Lifelong Medical Care, 25% at Kaiser, 19% from a private doctor’s office, and 9% from Center for Elders’ Independence (CEI)/PACE Program – with more than one answer allowed. A few expressed wanting holistic health care available. Mental health, memory care and cost of prescription medications were not mentioned in these groups.
- **Social Participation:** Being connected, busy, and social was addressed very differently by different sectors of the participant population. Those living in subsidized, multi-unit buildings (about half of participants) did not share feeling at all isolated, but mentioned wanting more information about things going on out in the community and how to get transportation to them. Those not in multi-unit housing were more interested in linkages to social opportunities. Ashby Village members reported satisfaction with learning about opportunities through the Village website.

In one forum, several people reported that they are active volunteers in some sort of organization, and agreed that it was key to their sense of well-being. A few use senior centers in

Berkeley, Emeryville, and Albany, and like them. A few others had visited and not liked a senior center – one reported that it seemed run down and depressing, while another reported that she had been turned away for a lunch (with others in the group quickly informing her how to book lunch in advance).

Again, it is important to remember that truly isolated older adults, living in their own homes, may well have not been reached to participate in the forums – so this voice is probably missing.

- **Technology:** Almost all participants reported having a cell phone, although very few had smart phones. When asked in one forum, none had health apps on their phones or tablets.

Most reported owning or having access to a computer and being able to access the internet – with some using it to stay in touch with their families and others using it to gain information on services or issues. Most of those who don't have their own computer reported that they can get access at the library or at a senior center. Some shared that the internet and email can be overwhelming. The sentiment was almost unanimous that having a person to turn to for computer help – for setup, training, problems, and updating was a critical unmet need. Participants from one subsidized building also noted that while their building is wired for Wifi, they have to pay for it individually, which is expensive.

While acknowledging that upcoming generations may not have the same problem, the majority of these older adults would still prefer to turn to a live person, either in person or by phone, for information and referrals. A few participants reported having buttons to push in their apartment if they need emergency help. Participants at one forum expressed being cautiously open to learning more about assistive technologies for safety, such as monitoring sensors.

**d. Berkeley Commission on Aging Forum:** In November of 2014, the Berkeley Commission on Aging held a special meeting to gain community input on older adult issues. There were 36 members of the public present at the meeting, and comments were made by approximately 22 of them. In summary, concerns were similar to those heard elsewhere and focused on: how older adults can learn about what goes on in the community (and needing on-line and in-person ways to learn that); need for affordable housing; need for sidewalk safety; need for more flexible transportation; and that senior centers should be well-supported.<sup>19</sup>

## 2. What Continuum Leaders and Partners Say

Some Continuum leaders are the older adults who started the discussion about improving life for older adults in Berkeley. Others are professionals who offer services critical to the older adult population. Most live in Berkeley. For these reasons, their opinions, as collected through individual interviews, on what older adults in Berkeley want and need are also included here. The perspectives of other researchers and professionals addressing broader older adult issues are included in Attachment 6, where areas of need are explored in more detail by topic.

**Common Views on Needs:** Wants and needs cited most commonly by leaders and partners addressed the underlying value of aging in place, and are not very different from the priorities outlined above. They include:

- **Housing:** More affordable housing in Berkeley for both low-income and middle income residents is badly needed. At least some of this should be intergenerational, and some should offer in-home assistance. Being convenient to Berkeley culture and transportation is also wanted. Along these lines, more affordable assisted living and CCRCs are needed – especially for the middle income. Alternatives such as co-housing and shared housing need to be explored. Green is desirable. For new housing that is developed, it was generally attractive to the group that this housing be located near medical care, shopping and amenities – in the form of a “walking village.”
- **In-Home Supports:** There are many problems related to the availability of in-home supportive services that need to be addressed. Workforce issues are related not just to the rapidly increasing demand, but hourly rates to pay in-home service providers have traditionally been too low to recruit and retain reliable, qualified, committed individuals. In this context, training becomes an even bigger issue, due to rapid turnover. Older adults who are prepared to pay for such services don’t know where to go to find affordable help from individuals whom they can trust. The County’s In-Home Supportive Services (IHSS) Program serves only the lowest income population and provides a small core of support hours. Middle income older adults fall through the cracks.
- **Information:** Older adults need one centralized source for information and help – which should offer both on-line access and the opportunity to connect with a person for help face-to-face or on the phone, regardless of income status.
- **Linkages and Navigation:** In addition to needing a way to learn about services and supports that currently exist, older adults need stronger support to successfully connect with those resources and to untangle confusion and problems as they arise. Leaders and partners stress that stronger cross-sector communication and collaboration is critical to narrow the gaps that older adults fall through. For some older adults, clear instructions, electronic referrals, and on-line support may be enough. For others, a relationship with a person who can provide true navigational support for both medical and everyday issues of life is needed.
- **Transportation:** Current transportation systems do not meet the needs of older adults. It would be great if everyone could afford Uber or Lyft. Older adults need to be able to be active in their community, and not just get to and from medical appointments. There was no consensus on transportation solutions.
- **Technology:** The current generation of older adults needs help with basic use of smart phones and the internet for socialization, interacting with medical and other service providers (e.g., ordering transportation), and researching topics of interest. Upcoming older adults may be more accustomed to basic electronic tasks, but the world of electronic health and safety monitoring is just one example of where support to learn about and benefit from technological innovations will likely be needed in an ongoing fashion.
- **Caregiver Support:** Family caregivers also need education and logistical and emotional support to care for their loved ones. They need somewhere to turn for information and for help when problems occur.
- **Social Connectedness:** The ability to socialize is viewed as critical for both health and happiness. Those who are able to, should be able to afford (through discounts) and access (via transportation) the vast cultural resources in Berkeley. Those with greater limitations should have

social opportunities where they live. Intergenerational activities are viewed as important, as is volunteering. The use of technology to increase connectedness also holds great promise.

**Varied Other Opinions:** A wide range of views on what older adults need were offered in leader and partner interviews – depending on what “part of the elephant” individuals were looking at. A summary of those more wide-ranging concerns is included in Attachment 5.

### 3. Environmental Context

At the same time that older adults in Berkeley are becoming more vocal about wanting to stay healthy and active longer, wanting to age in their own homes, and needing financial support to do this, numerous other conditions or changes in the landscape are at play. Key issues include (but are certainly not limited to):

**Economics:** People are living longer, which their retirement nest eggs (if they have them) were not built for. In 2013, the median working-age couple was estimated to have saved only \$5,000 for their retirement.<sup>20</sup> Some are calling this low savings an anomaly of the Baby Boomer Generation, which was too busy saving the world to plan for retirement. Others point out that this is happening at the same time that pension systems in the United States, which used to cover the vast majority of workers through their employers, have been on a steady decline. We do not yet know how the coming generations will compensate for this.

These factors are occurring in tandem with the sea change in the U.S. economy that happened in 2008, as well as the longer term shift in the United States that has reduced the size of the middle class, pushing more individuals and families down into lower income levels.

Additionally, a population boom in the East Bay has been accompanied by skyrocketing housing costs (both for purchase and for rent). This boom has been fueled by the rising availability of high-paying high-tech jobs in the area and an increased housing demand related to the University.

**Health and Physical and Mental Health Care:** Several trends are causing the health care delivery system to increase its focus on prevention and community support to decrease utilization and improve population health.

- Increased access to health care services as a result of the Affordable Care Act has caused a surge in demand fueled by greater impact from adverse social determinants of health, as well as a fair amount of “deferred care” among the formerly uninsured. In Alameda County, community-based clinics are absorbing a large share of this population. This formerly uninsured group is very diverse and has also challenged health care delivery systems to expand their cultural capacity to appropriately serve broader economic and racial/ethnic groups, as well as individuals with different experiences with, and understanding of, health and health care.
- As a part of the Affordable Care Act (ACA), government fee-for-service reimbursement systems are shifting toward penalizing providers for “overutilization” of costly services. A prime example of this is a financial penalty if patients with certain conditions are re-admitted within 30 days after discharge from a hospital. Along with adjustments to the system of reimbursement, research and incentives to prevent illness are rising in prevalence.

Again, there is increasing recognition that “social determinants” such as healthy housing, food, education, reduction in racial disparities, and community supports are significant contributors to health. This challenges health care providers to partner in meaningful ways with others in the communities where their patients live to address these social factors and reduce costs.

- A shift toward consolidation of health care providers (including doctors, hospitals, nursing homes) into fewer, larger groups to reduce administrative costs and increase continuity of networks, has caused concern among some older adults about choice and geographic access to care. One key example of this is the impending closure of inpatient and emergency department services at Alta Bates/Summit Hospital with proposed consolidation in Oakland.
- While there are efforts to control the cost of prescription drugs, skyrocketing costs hit older adults especially hard. Added to the costs of housing and other supports, this contributes to their financial pressures and poor health outcomes.

**Technology:** There has been and will continue to be a strong surge in the technology available within medical care and in the community to assist older adults to live happier, healthier lives. These innovations will be rapidly transitioning from costly development stages to affordable tools for years to come. The current generation of seniors, by self-report, is more technology averse than upcoming generations when it comes to use of smart phones and computers to conduct everyday business. However, upcoming generations and their caregivers will also need to be supported to transition into more sophisticated technologic options in their homes, in communications, and in their medical care.

#### **IV. Local Resources and Gap Analysis by Topic (Summary)**

A detailed presentation of literature and data about aging supports and services, as well as an inventory of existing local resources by topic (e.g., housing, transportation) is included in this report as Attachment 6. A summary of gaps, by topic, is included here.

##### **A. Housing for Independent Community Living**

The data clearly support what older adults have told us – that there is a serious shortage of affordable, accessible, independent housing for older adults throughout Alameda County, with 30% of older adult owners and 62% of renters identified as “cost burdened,” meaning that they are paying over 30% of their income for housing.

The Berkeley Housing Element identifies a housing shortage for all populations in Berkeley – calculating that nearly 3,000 new housing units are needed in Berkeley by 2022. Given the rapidly increasing influx of new residents to the county, this number has likely risen since the data were developed. We know that there are currently 738 dedicated, affordable senior housing units in Berkeley, and that this does not begin to touch demand – with wait lists 6-8 years long. Recently, nearly 3,000 applications were received for 50 new senior housing units.

The Housing Element catalogs and maps available locations for housing and mixed use development, and notes that Berkeley’s main corridors have been, and continue to be, ripe for mixed use development.

The City of Berkeley's commitment to developing new housing appears strong. It creates multiple policies in the Housing Element that commit it to the development of new and affordable housing by 2022, including special mention of housing for seniors and the disabled. The City achieved development of over 82% of the units it committed to in its previous Element.

However, in addition to the "gap" in affordable housing for seniors in Berkeley, an additional gap may exist in the leadership to develop that housing in any planned or coordinated manner. While the city is active in this role, and there are numerous consistent housing developers working in Berkeley, additional leadership from outside of the government sector may be needed to facilitate the communication, collaboration and commitment to action needed among the multiple private and non-profit senior housing partners.

## **B. In-Home Supports**

In-home supports are a key factor in reducing medical care costs by avoiding hospitalizations, shortening hospital and rehabilitative nursing home stays, and for preventing long-term institutionalization. The needs of frail older adults can quickly out-run the capacity of family to provide – in those cases where family is available. There are some very serious and growing needs in the area of in-home care. These include:

- **Cost to Consumers:** We know that the very poor have some access to government-funded in-home supportive services – although not at the level that they feel they need. We know that Medicare, medical insurers, and veterans care providers pay for limited-term, episodic care to address primarily skilled-care needs. We know that middle income and lower income individuals (those above MediCal eligibility), cannot afford to pay for these services for any length of time. Lower costs and new funding streams are needed to provide service to a broader population.
- **Information and Referral:** Seniors report that they don't know how to find quality, trained in-home caregivers who can be trusted (when not provided by their health care provider). They want vetted referrals from a trusted source. This request comes from those of all incomes.
- **Supply and Quality:** We know anecdotally that those in upper income brackets routinely pay for care out of pocket and that finding quality care from reliable providers is a continuing problem. With a large portion of the in-home care providers not affiliated with licensed home care agencies, training may be haphazard. The traditionally low pay that in-home care providers have received has added to high turnover and inconsistent quality in the industry. As this begins to change, the cost to consumers also rises.

As many more Berkeley residents enter their senior years, the demand/need for this care – along the full continuum from light assistance to highly skilled – will continue to grow. With this growing demand, a focused effort to recruit, train, and retain a quality workforce of home care workers is badly needed.

- **Behavioral Health Needs:** The number of older adults with severe mental health and substance use disorders, as well as memory disorders, will rise exponentially both with the growth of the population and their longevity. This points to the need for increased training of in-home care providers.

### **C. Information and Referrals/Navigation Support**

Seniors report that they want help finding services and activities that they need in the community. They want a “one stop shop” for help navigating complex medical, public benefit and housing systems. We know that today’s older adults are not all comfortable learning what they need to know or navigating systems on-line and want human support to do so. We anticipate that future generations will be more comfortable looking information up on-line but the need for personal contact will not be eliminated.

Leaders and experts refer to the virtues of technology, but recognize that assistance with medical referrals and referrals for related supports for daily living are more likely to be successfully follow-through on if older adults are personally assisted; which ultimately improves health outcomes and reduces cost of care.

Older adults and their loved ones want and need “low tech,” affordable navigators (as opposed to comprehensive care managers) to help them address basic system navigation needs. Much of this assistance is needed just sporadically for such things as learning about new medical conditions, planning transportation for an outing, applying for public benefits, or getting on waiting lists for subsidized housing. This type of navigation support is readily available at senior centers, in subsidized housing complexes that have navigators or social workers stationed there, and for Ashby Village members. This needs to be expanded to serve more older adults and their caregivers.

Experts also suggest that individuals providing periodic navigation support should be prevention-focused, prompting older adults to consider taking steps to preserve their well-being before a need or crisis arises. This includes attending to financial planning, getting on waiting lists for housing, and reducing falling hazards in the home.

The topic of comprehensive care management – addressing both medical care and community support needs - is broad and rapidly changing, and it has not been addressed in depth in this Needs Assessment. More research on comprehensive care management resources available to Berkeley residents may be useful.

### **D. Transportation**

Many older adults stop driving for a variety of reasons including cost and safety. Many assume that public transportation will be adequate for them -- but find that it is not. Even the public paratransit program, developed to meet the requirements of the Americans with Disabilities Act, is limited in its scope. Evidence shows that being able to go out for not just medical appointments and grocery shopping, but for social reasons and community activities is critical to both the health and mental health of older adults.

The City of Berkeley recognizes this need and supplements public and private transportation options with a limited number of subsidies and scrip for free travel on the paratransit system and in taxis. These programs target those eligible for paratransit because of disabilities, low and middle income (up to 50% of the Median Area Income). However, again, the amount of available subsidies and scrip is limited. The City is also in early planning stages for a senior shuttle, funded with County Measure BB funds, that will address some of the identified concerns.

There are also multiple programs serving sub-populations or related populations that provide transportation for their clients or members. This includes (but is not limited to) Center for Independent Living, PACE/Center for Elders' Independence.

Walking brings sidewalk and other safety hazards. While there are programs in place to improve this, older adults in Berkeley are still very concerned.

A summary of types of needs that are still to be met includes:

**Flexibility:** While public transit and paratransit are available, the schedules and fixed routes do not meet the needs of older adults in Berkeley. Public buses can be difficult to get on and off, and seniors report that bus drivers need training to be more patient with them as they get on and off and ask for help in identifying their stops.

Taxis and ride hailing services (e.g., Lyft or Uber) do meet flexibility options, but use of the technology to hail them is confusing for some older adults. There is at least one company that, for a fee, will book ride-hailing services for older adults. Some older adults report that drivers are impatient with them. As of yet, there are no known ride hailing services with wheelchair vans.

**Cost:** More flexible options such as taxis, ride hailing services (e.g., Lyft or Uber) do meet flexibility requirements but are beyond the budgets of many seniors for regular use. The City of Berkeley helps with this with a limited number of subsidies and free vouchers. But cost remains a significant issue.

**Safety:** Older adults do not feel safe using public transit – especially at night. Sidewalks are hazardous for falls, and pedestrians over age 65 have a high incidence of being involved in automobile and bicycle accidents when they walk. More is needed here.

## **E. Nutrition and Meals**

The impact of food insecurity on health, mental health, and quality of life is clear. We know that lower income older adults are faced with making choices between paying for such critical items as prescription medications and food. CalFresh, the Food Bank, City of Berkeley, AAA and their many contracted agencies, as well as others, offer a very robust set of food resources, but we know that they are still unable to meet all of the need and are therefore, targeting the lowest income and the frailest. Key findings include:

- Middle income and the upper end of low income older adult individuals and households do not qualify for CalFresh and may not get as many food supports as lower income individuals, despite their need. There is also a traditional stigma to receiving government support and CalFresh and others are actively trying to address this.
- There is a gap in food resources for those who do not qualify for home-delivered meals because they are not medically frail enough to meet requirements, but are reluctant to access congregate meals at senior centers and other locations. This gap may be further widened by those with middle/lower incomes who are above food bank income requirements.
- Not all seniors have the ability to cook where they live. CalFresh is building a program to provide cooked meals through restaurants as an alternative to its grocery program. While there are some

home-delivered meal services and congregate meals in such locations as senior centers, the middle income are, again, probably underserved. Traditionally, there has also been stigma to accepting this type of assistance.

- While there are an increasing number of businesses on the open market that deliver restaurant meals to homes on demand, these are costly.
- Seniors in Continuum forums expressed a desire for more senior discounts in restaurants around Berkeley.
- It just makes sense that linking social opportunities with healthy meals promotes stronger physical and mental health. This should be kept in mind when planning both food and social programming.

### **F. Injury and Fall Prevention**

Injuries and particularly falls are well recognized as preventable, and programs do exist to educate emergency responders and older adults about the risks for falling. However, more direct interventions to inspect homes, talk with people about risks, and conduct home modifications are limited. We know that Berkeley emergency response personnel (e.g., fire department emergency response teams) may identify an at-risk person as a result of an intervention – and will report them to the Aging Services Department for intensive follow-up that includes a home safety inspection. For those who join Ashby Village, a home inspection is offered for free at enrollment. Some modifications are also done for free by them and a referral list for member-recommended contractors is also available. City older adult service outlets routinely refer people to Center for Independent Living and the Community Energy Services Corporation who have funds from other sources for free or low cost home modifications. More direct efforts to initiate home inspections may be needed.

### **G. Social Engagement**

Isolation is a serious problem for older adults as they quit working, lose spouses and friends, face declining health and mobility, and for many, find themselves without funds for recreation and travel. And yet, we increasingly understand how important social connectedness is for health, mental health, sense of well-being, and longevity.

Older adults report that they want help knowing what is going on in the community, help affording to participate, and help getting to activities. We can see from the Alameda County Survey as well as our own forums that many older adults recognize the importance of volunteering and enjoy it.

The City of Berkeley acknowledges that it needs to update the format of its senior centers to break old image of “who goes to senior centers” and broaden their appeal for the baby boomers and future generations. Options are wide, but more of a café environment and expanded options for physical activity may be needed.

Those who live in senior housing communities or belong to Ashby Village report feeling more connected with their communities than others. A navigator or social worker in senior housing also improves this greatly as today’s older adults prefer a “person” they can turn to for assistance. While making the resources of Ashby Village available to a much broader share of Berkeley older adults

could be desirable, it is cost-prohibitive for many, and large growth of a single village may not be the best approach to accommodate more people. Rather, in some parts of the country, several smaller villages addressing specific neighborhoods or racial/ethnic groups have been quite successful.

While more opportunities to socialize and engage in the community will always be good for older adults, a balance between age-specific and intergenerational or naturally occurring activities and volunteer opportunities in the community is also important. Perhaps the overriding needs in this area are for:

- Consistency among those who serve older adults to screen for isolation and to education about/emphasize the need for connectedness for both health and mental health with the older adult population;
- Transportation and financial incentives to access activities in the community;
- Safety to move around in the community; and
- Use of technology to reach out and offer socially engaged activities for those who are less mobile.

#### **H. Health and Medical and Mental Health Care**

As the health care delivery system continues to expand, becoming more culturally appropriate in its care of diverse populations, and shifting its focus to chronic care management and quality of life, all of the other “ancillary” aging issues addressed elsewhere in this report come into play. These ancillary services are the cost effective “wrap around” supports that address the social determinants of health, augment health and healing, improve quality of life, and reduce the stress on the medical care system itself. (See Attachment 6, Section J. for a discussion on the convergence of health care and housing.)

However, these ancillary supports have traditionally been siloed off away from the medical care delivery system. The need to “geriatricize” the health care system is another way to think about building age-friendly communities. It means that these silos need to be broken down, funding streams need to be diversified, and partnerships need to be built. As one leader interviewed for this report stated: “Traditional funding streams need to be torpedoed, and the money needs to follow the individual.”

The “gap” then becomes that of identified leadership, partnerships, and structures to make this change happen. Is it entirely up to health care providers to forge partnerships with formerly foreign community-based providers? Or is it up to communities – in both government and community sectors – to establish the leadership and advocacy needed to change public policy, change funding streams, and present themselves to health care providers as their allies?

#### **I. Technology**

The cost of medical care must come down and innovations of all types are needed to help older adults age in their homes and in their communities. Multiple technologies to address these issues are rapidly evolving – touching on the domains of body, home environment, community, and caregiving.

This boom in technologies comes with challenges. The current generation of older adults, while nearly saturated with cell phones, still has great reluctance to use smart phones and computers to access the internet – much less more sophisticated technologies.

While upcoming generations will have less resistance to this, the marketplace will continue to be confusing – to understand what is available, and how to choose between competing products. Once purchased, older adults will need help installing their products, learning to use them, updating and troubleshooting them. These products will be best accepted if they can accommodate vision and hearing challenges. One set of experts propose that the solution to this set of barriers is that care managers take the lead in understanding, recommending and supporting older adults to use these technologies.

The cost issue has not been adequately addressed. While it is likely that medical insurers will pay for those clinical technologies that can reduce cost while improving health outcomes, the question of who will pay for technologies that enhance life, support caregivers, and support community living for older adults, is not yet well addressed.

The Center for Technology and Aging (CTA), is a part of the Center for Information Technology Research in the Interest of Society (CITRIS), which itself is a research center in the University of California system. It is designed specifically to encourage and enhance the development of new technologies in aging. And that Center is located right in Berkeley. The opportunity for close communication, collaboration and potential for the City of Berkeley to serve as an incubator for new technologies must not be overlooked.

## **J. The Housing/Care Continuum Beyond Independent Living**

As the older adult population swells, and individuals live much longer, demand for a range of supports from assistance for independent living through skilled nursing facilities will continue to grow.

- **Demand:** Despite growing numbers of older adults, the demand for and length of stay at skilled nursing facilities is actually declining, with traditionally longer-term needs being met at lower levels of care. Demand at those lower levels is rising accordingly, and supply has not begun to catch up to this. This shift is driven not just by cost concerns, but by what older adults want.
- **Cost:** There are service options at all levels of the spectrum considered here. Cost of the entire assisted spectrum, from in-home supports through SNFs, however, is beyond the ability of many individuals to meet. Health insurers will pay for some, long term care insurance will pay for some, and Medicare and MediCal will pay for some. However, the lion's share of unmet need in this housing/care category is the ability of individuals to meet out-of-pocket costs – especially for the middle income and those at the upper end of low income.
- **Distribution of Existing Resources:** Older adults report that if they must leave their homes because of their health care status they want to at least stay in Berkeley – near loved ones, and in the social/political community they have been engaged in for (some) very long periods of time.

Resources to remain living in Berkeley are currently not strong. Beyond independent housing and in-home supports, there are no CCRCs in Berkeley. One CCRC with over 200 beds is currently

being built in Berkeley, but will not be affordable to many; another is in the planning stages. There are 5 SNFs – just one of which is nonprofit. There are no assisted living facilities or board and care facilities listed on the internet for Berkeley, but the State Department of Health Care Licensing suggests that there are 3 licensed board and care facilities in Berkeley.

- **Innovations:** With strong recognition that there are a multiple of social determinants of health and the need to quickly bring down the cost of care to older adults, pilots, waivers, research, and creativity abound in this area – but little has come to play yet in a way that can be taken to scale. Technology is also driving innovation. PACE programs are proven but currently have limited capacity and are open only to those who are lowest income and nursing home eligible; less expensive models of CCRCs are emerging, CCRCs without walls are promising (but not allowed in California), CCRC-type services in the community are promising, and keeping people healthy longer is promising as well.

One particularly interesting emerging concept is that of medical care providers and housing providers partnering to bring health care closer to where people live – through home-based services or sharing on the same campus. Once again, one must consider: Is it up to the health care system to seek out those partnerships? Or is it up to the community to offer options to health care providers?

## **K. Other**

This Needs Assessment was developed to support early decision making about priorities for development of a Berkeley Age Friendly Continuum. The topic areas that can be researched are almost limitless and there are a number of topics that could have been presented in more depth here, or in stand-alone chapters, rather than being embedded into other topic areas. These include (but are not limited to): disability services, faith communities, ethnic-specific communities, built environment, end of life planning and care, caregiver supports, lifelong learning, employment, and upcoming generations.

## **V. Summary and Discussion**

This Summary and Discussion consolidates the previous sections of this report. Additional considerations that are raised by these findings are also presented.

### **What Older Adults Want and Need**

The needs of older adults in Berkeley are fairly clear, and they are fairly representative of findings across international, national and local studies and surveys. With emphasis on local input from Berkeley older adults and Continuum leaders and partners, the top issues are summarized here.

- Enough money to live on;
- The ability to stay in Berkeley throughout the aging years;
- Housing, housing, housing. Affordable housing, housing that older adults want to live in, housing that facilitates getting needed supports as people age, housing to stay in Berkeley;

- In-Home Supports that are identifiable, affordable and trustworthy;
- Easy access to individualized information, linkages and navigational support;
- Transportation;
- Safety – Safe sidewalks, safety in their homes and in the community;
- Social Connectedness, engagement and accessible activities; and
- Access to healthy foods and prepared meals;

Looking at needs differently, older adults also express that:

- Older adults who are middle income, and those at the upper end of low-income are at high risk of falling through the cracks. They do not qualify for enough benefits to meet their needs and often cannot afford to meet those needs out-of-pocket. The extreme shortage of affordable housing in Berkeley exacerbates this. Much more focus is needed here.
- The poorest of the poor must work hard at it, and some can piece together free and low-cost services that take care of their most basic needs, but a “little extra” communication, transportation, discounts, and human assistance would make a big difference in the quality of their lives. The critical exception to this ability to “piece it together” in Berkeley is the current norm of 6-8 year waiting lists for low income housing. This is pushing many older adults out of Berkeley.
- Even those older adults with decent retirement incomes face problems with isolation, mental health problems and memory loss, access to prepared food, finding reliable in-home supports, and managing their technology.

### **Leaders and Experts Add**

- Many of today’s older adults did not address financial planning for their aging years early enough – leading to housing instability and avoidable poverty. Today’s housing costs do not help this. Effort is needed to get rising older adults to address this earlier.
- Falling, a leading cause of hospitalization in older adults, is also not addressed early enough – with hazard evaluation and home modifications needed for prevention of falls.
- Mental health, addiction to prescription medications, and memory care needs are growing exponentially – and the workforce as well as housing and service systems are not there to respond to this.
- Expanded capacity to provide in-home and residential assisted living care is critical to both offering older adults the lifestyles that they want, and reigning in the cost of care for this rapidly growing population. To do this, not only are new funding streams for in-home supports needed, but living wages and concerted recruitment and training efforts are needed to build the necessary workforce. Expanding the capacity of providers at all levels to be able to manage the growing psychiatric and memory disorders will also be critical. Meeting workforce needs will take years.

## **Supply of Needed Resources**

Given the sheer increase in the anticipated numbers of older adults living in Berkeley, or who will be trying to stay in Berkeley by 2030 (and beyond), there are unmet needs in virtually every topic area explored in this report. To truly achieve an Age Friendly Berkeley, the bar needs to be raised across the board. If pressed to identify those areas of greatest unmet need, they include:

- Affordable, accessible housing;
- In-home supports;
- Affordable, desirable settings for out-of-home assisted living (e.g.: CCRC and alternatives);
- Expansion of eligibility criteria for subsidized services to raise access levels up to middle income;
- Innovations in both technology and care/service delivery to support community-based living (and control costs) for as long as possible;
- More “human touch” for information, referral, and system navigation; and
- More active fall prevention outreach and home modification programming.

## **Cost Containment and Social Determinants of Health**

The bottom line for medical providers is that they must control cost as the older adult population grows. Increased emphasis on prevention, use of burgeoning technology, and providing resources to address social determinants of health are key tools in this. Fortunately, addressing these issues will also move older adults closer to what they want.

- More comprehensive, all-inclusive payment models that support patient centered, community-based care are needed. The PACE model is one example of this. However, currently this is limited to those lowest income individuals who are already nursing home eligible. More is needed to address more adults with high needs, as well as those at a more moderate level of need.
- Avoidable hospitalizations can be reduced by a variety of different interventions, ranging from fall prevention programming, supporting adherence to medication regimens, or navigation support to be sure that people follow through on referrals. On the community-based side, support to meet every day needs can help keep people adequately housed, healthfully fed, and socially engaged – which will also contribute to reduced hospitalizations.
- Re-hospitalizations can be reduced by many of the same efforts but especially with adequate care in the home to recover properly. Re-hospitalizations are sufficiently avoidable that the Affordable Care Act has now established some payment sanctions when they do occur. Insurers and providers are more focused on this than ever.
- Long term care nursing homes will probably always be needed by a small population who have high, chronic medical care needs. But overall, nursing homes will continue to shift their focus toward shorter term, rehabilitative stays. An adequate supply of high quality nursing home beds is needed, and older adults want them to be located close to or in their home communities.

- Continuing Care Communities (CCRCs) provide a nice balance between total independence and institutional care. In fact, the availability of in-home supports (assisted living) in CCRCs is likely reducing hospitalizations and the need for short or long-term nursing home care. While the supply of CCRC beds in Berkeley will be increasing, demand certainly will outstrip supply for some time to come. Cost and alternative payment options have not yet been affectively addressed to make them adequately available to a broader portion of the older adult population.

## Technology

Not only are new technologies being used within the medical care delivery system to reduce cost and improve health outcomes, but the world of technology available in the community to support older adults to live the healthiest, fullest lives possible are also proliferating. To the extent that these technologies support individuals to take care of themselves, meet their logistical and social needs, and keep them connected, they also have great potential to reduce overall health care costs. Older adults are not the best people to stay on top of the new technologies as they emerge, and care coordinators are suggested as a bridge to their adoption and sustained use. Addressing the out-of-pocket cost of these technologies to older adults is also of concern.

## Discussion

As we look at this summary, additional issues arise that should be addressed as the Continuum plans its future. These include:

- **The Nature of Partnerships:** Referred to frequently throughout this document, partnerships between providers of clinical (medical and behavioral health) care and those who offer a range of broader supports in home and community settings is more critical than ever. Patient-centered care requires it; addressing social determinants of health requires it; supporting older adults to age in their homes and in the community requires it. Some even speak of a “convergence” of health care and housing.

To-date, it seems that the impetus for these new partnerships is coming from the medical sector – approaching community-based providers to support them. The question of how a well-organized community sector might configure itself and provide comprehensive options to medical providers to meet mutual needs has not been explored.

- **Cross-Sector Advocacy and Leadership:** Once mission and values are defined, strategic planning is about blending responses to need, opportunities, and fit with capabilities and resources. Some of the needs outlined here could be filled by Continuum partners. Others are beyond the current scope or scale of Continuum partners to fill (e.g. building enough market rate housing to meet the need, providing enough in-home care at an affordable rate to meet the need).

This does not, however, exclude the Continuum from taking a role in addressing these needs. While the City of Berkeley is active and proactive in this arena, more is needed. There is still a high unmet need for advocacy and leadership across sectors to develop the communication, collaboration, and multi-disciplinary resources necessary to address key areas of need to “raise the bar” overall, for an age-friendly Berkeley.

## **Attachments**

- A1. Continuum Leaders, Partners, Funders and Consultants
- A2: Berkeley Responses to Alameda County Older Adult Survey (Detail)
- A3. Findings from Alameda County Forums
- A4. Summary of Continuum Forum Participant Demographics
- A5. Varied Comments from Leaders and Partners
- A6. Background and Local Resources (Detail by Topic)

**CONTINUUM PARTICIPANTS**

As of March, 2017

**Leadership Team**

- Chair: Steve Lustig, Ashby Village Board; Associate Vice Chancellor Emeritus, UC Berkeley
- City of Berkeley: Tom Bates, Mayor (through 2016), Jesse Arreguin (current)
- Ashby Village: Andra Lichtenstein, Chair, Ashby Village Board; Principal, Capital Incubator
- Center for Technology and Aging: UC Berkeley, David Lindeman, Director
- Lifelong Medical Care: Marty Lynch, CEO
- Episcopal Senior Communities: Kevin Gerber, President and CEO
- CalQualityCare: Charlene Harrington, Professor Emeritus, UCSF School of Nursing; Principal
- Chapparral House: KJ Page Administrator
- California Advocates for Nursing Home Reform: Carla Woodworth, Co-Founder; former member Berkeley City Council

**Partners**

- Ashby Village: Andy Gaines, Executive Director
- Alameda County Health Care Services Agency: Rebecca Gebhart, Acting Director
- Northern California Presbyterian Homes and Services: Janet Howley, Vice President
- Center for Independent Living, Inc. (CIL): Thomas Gregory, Deputy Director
- Center for Elders Independence (CEI): Linda Trowbridge, CEO; Lenore McDonald, Director of Development
- Episcopal Senior Communities: Tracy Powell, Vice President Community Services
- Center for the Advanced Study of Aging Services, UC Berkeley: Andrew Scharlach, Director
- J-Sei: Diane Wong, Executive Director

**Consultants**

- Nancy Frank & Associates, Piedmont, CA
- Dan Geiger Consulting, San Francisco, CA (2016)

**Graduate Student Interns**

- Abbey Dykhouse, Masters in Social Work Program, UC Berkeley
- Carrie Gladstone, Joint Masters in Public Health and Business Program, UC

**Funders:** Kaiser Permanente Community Benefits, Alta Bates Summit Medical Center, City of Berkeley

**Berkeley Responses to Alameda County Older Adult Survey (Detail)**

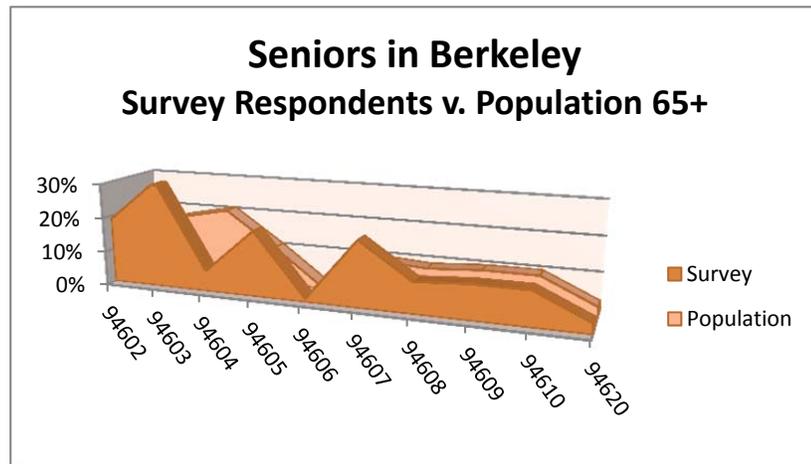
**Respondents with Berkeley or Berkeley/Shared with Other Zip Codes: 490**

**Ages:**

55-64 years	25% (42% of these were under age 60)
65-74	36%
75-84	27%
85+	12% (48% of these were 90 or older)

**Zip Code:**

94702	19%
94703	31%
94704	6%
94705	19%
94706	1%
94707	7%
94708	6%
94709	7%
94710	5%
94720	0%



**Race/Ethnicity: (n=399)**

	Survey	Census
Caucasian	61%	68%
African American	19%	14%
Latino	6%	5%
Asian/Pacific Islander	13%	12%
Native Am	2%	LT1%

**Primary Language:** English – 96%, Chinese – 2%

**Sex:** Female – 68%, Male – 32%, Transgender/Other – LT 1%

**Sexual Orientation: (n= 312 or just 64% of respondents)**

Heterosexual	81%
Bisexual	7%
LGBTQ/Other	12%

**Income:** (n= 409 or 83% of respondents)

Less than \$11,770	32%
\$11,770 to \$17,500	19%
\$17,500 to \$26,000	9%
\$26,000 to \$35,000	8%
\$35,000 to \$45,000	7%
\$45,000 to \$60,000	7%
\$60,000 to \$85,000	8%
\$85,000 or more	10%

**Living Status:**

Live alone	59%
With spouse or significant other	24%
With children/grandchildren or extended family	13%
With parents	LT1%
With friend/roommate/renter(s)	6%
In co-housing	LT1%
Homeless or in shelter	1%
Have live-in caregiver	1%

**Domicile:** (n=427)

House (ownership not specified)	42%
Apartment	38%
Indep. Retirement Community	10%
No Residence	4%
Condo/Townhouse	2%
Mobile Home/Trailer	1%
B&C/Assisted Living	LT1%
Hotel/Boarding House	LT1%
Skilled Nursing Facility	LT1%

**Have a Caregiver:** (n=415, more than one answer allowed)

No	74%
Yes	26%
In-Home Suppt. Services	48%
Family or Acquaintance	46%
Paid Caregiver	10%

**Resources:**

<b>Resources for Older Adults in Berkeley</b>	<b>Available</b>	<b>Not Available</b>	<b>Don't Know</b>
Job opties for people your age	20%	36%	44%
Clean/maintain sidewalks	71%	24%	4%
Affordable housing	67%	22%	11%
Safe/lit streets and intersections	75%	20%	6%
Housing suited to my needs	73%	18%	9%
A computer I'm comfortable using	71%	18%	11%
Resources that help me feel safe in community	69%	17%	14%
Transportation that is easy to use	79%	15%	6%
Fresh produce can afford	80%	14%	6%
Cult/language appropriate emotional health services	67%	13%	20%
A trusted source when I have a need	76%	13%	11%
A trusted source when I don't understand something	68%	12%	20%
Oppties to participate in local/community decisions	68%	12%	19%
Fitness and exercise activities appropriate	72%	12%	15%
Free/affordable opties to learn	72%	12%	16%
Volunteer opties in community	75%	10%	15%
Transportation that is affordable	85%	11%	5%
Affordable places to socialize	80%	8%	12%
Culturally/language appropriate health services	82%	8%	10%
Welcoming places to socialize	86%	5%	9%
Info about news/events in language I understand	90%	5%	5%

**Concerns (Concerned or Very Concerned - 4 or 5 on a 5 point scale):**

	<b>Concerned or Very Concerned</b>
<b>Berkeley Older Adult Concerns:</b>	
Enough income to meet basic needs	51%
Able to afford housing as age	49%
Able to stay in current home as age	49%
Enough income to save and plan for future	48%
Ability to maintain home	47%
Including in decisions affecting lifestyle	46%
Falling/risk	38%
Able to prepare healthy, nutritious food	35%
Finding health care provider	30%
Feeling anxious or stressed	28%
Personal safety/protection from abuse	26%
Ability to financially support dependents	25%
Confusion/memory loss more/worse	25%
Valued by community	24%
Ability to be caregiver for another	22%
Being isolated	22%

**Actively volunteering in community:** 52%

**Of 112 not volunteering, interested?** 62%

## Methodology and Findings from Alameda County Forums and Focus Groups from Alameda County Plan for Older Adults 2016-2017

**Alameda County Public Forum Methodology:** 22 public forums were held at a variety of sites, including senior centers, low-income housing sites, and a long-term care facility. Forums were held in each of the County's 4 geographic service areas and Board of Supervisor's districts. A total of 266 people participated, with attendance ranging from 2 to 39 people per site.

### Public Forum Findings:

- When asked to participate in visioning and values dialogue, participants consistently identified the concepts of appreciation and respect, social inclusion and participation, civic participation, and community diversity, understanding, and support as core values for the vision of an ideal age-friendly community.
- Safety emerged as an issue, with comments about public safety, level sidewalks, public rest areas, rest rooms, and walkable neighborhoods.
- Financial support and sustainability permeated throughout each individual public forum as a critical service in need of expansion.
- There was engaged discussion over the debate surrounding who is poor enough for aid and assistance and how this continues to leave economically challenged older adults fighting and struggling to “barely keep a roof over their heads,” often at the expense of food or medication. These “nearly poor” older adults face income restrictions for no or low cost services, disposable income to pay for supportive services and living expenses, personal and home security and safety, employment, and isolation.
- Suggestions included the provision of emergency cash assistance/vouchers, implementation of senior-friendly retail prices, free or affordable medic alert services, and increased free food distribution days and locations. Participants also suggested increased Visiting, Adult Day Care, In-Home Healthcare, Fraud and Safety Awareness, Senior Center Activity, Transportation, Nutrition, Housing, and Homeless Program services.
- Participants were asked to identify their 3 most important service priorities for supporting older adults living independently in the community:
  - Housing (43%)
  - Health and Safety (38%)
  - Senior Centers (35%)
  - Transportation (34%), Information (25%)
  - Financial Assistance (23%)
  - Nutrition (19%)
  - Visiting (11%)
  - Employment (4%)
  - Case Management (2%)
  - Adult Day Care (2%)
  - Elder Abuse Prevention (1%).

**Alameda County Focus Group Methodology:** 6 focus groups lasting from 45 minutes to two hours were conducted with residents of long-term facilities, participants in mental health programs, formerly homeless seniors, lesbian/gay/bisexual/transgender (LGBT) seniors, family caregivers, and senior men. The sessions were professionally facilitated, recorded and transcribed.

**Focus Group Findings:**

- Every group raised the concern of transportation. While many mentioned paratransit as a valuable service, they noted it must be reserved a week in advance and often involves long rides, with multiple pickups and drop offs, which caused some to avoid using it.
- Another prominent concern was affordable housing. Most groups expressed a desire for housing that integrated age groups, with some Section 8 units reserved for older adults.
- Some older adults in low income areas were concerned with safety almost to the exclusion of anything else and wanted housing in dedicated senior housing developments, where they believed they would be safer. Safety was a general theme especially among those who did not drive and used foot or public transit.
- Family caregivers identified a need for reasonably priced respite care, such as adult day care, once or twice a week; mobility and home health equipment; and classes on caring for older adults, especially those with a physical, mental, or cognitive disability.
- Some identified isolation as a problem, especially the LGBT group participants, who lived in a suburban community and found it hard to make connections with peers. Participants most often mentioned senior centers, churches, and local governmental agencies as community strengths.
- One prominent issue raised in nearly every group was the need for a central source of information on available services. While a senior information and assistance line exists, no one except some of the mental health providers was aware of it. Senior centers were most often mentioned as a resource for information, although some found them of limited use due to staffing by volunteers, not all of whom were well informed. Many group members expressed a desire for a social worker, service coordinator, or navigator to connect them with needed services with a warm hand-off rather than just being given the name of an agency.
- Most focus group participants were not comfortable computer users and would prefer to get informational in print, such as by flyers, pamphlets, brochures, advertisements on buses and BART, and posters at grocery stores and malls.

**Continuum Forums held in October, 2016**  
**Details**

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**Three Forums were held:**

1. **At the Ed Roberts Campus** – 17 participants recruited mostly through CIL and Lifelong, with one person from CEI/PACE. A large cluster of participants live in the Harriet Tubman subsidized housing – they found flyers in the lobby of their building.
2. **At the Townhouse Senior Condominiums** – 14 participants were Townhouse condo owners or renters and Village members (almost 50/50). Efforts to also recruit from JCC senior program were not successful. The objective of this group was to reach middle income individuals or higher.
3. **At SAHA subsidized housing on University** – 26 participants, with all but one participant living in the building. The remaining participant was a Village member. Efforts had been made to recruit from another SAHA building but were not successful. Approximately 8 participants were Mandarin-speaking, and a translator was provided.

- 57 participants
- 56 background surveys returned
- Demographics of full group:
  - ✓ **Race/Ethnicity** (est. n=57)
    - 23% African American
    - 47% Caucasian
    - 32% Asian/PI
    - Latinos were not evident in the groups
    - 23% of participants reported speaking another language before they learned English (or still speak another language). Mandarin translation was provided in the forum for about 10 monolingual individuals.
  - ✓ **Age** (n=40) – range: 48-93
    - 7% Under 60
    - 45% 60 to 75
    - 48% 75 or older
  - ✓ **Gender** (n=57)
    - 75% female, 25% male
  - ✓ **Zip Code** (n=53)
    - 5% 94702
    - 55% 94703
    - 16% 94704

- 2% 94705
- 2% 94706
- 7% 94708
- 5% 94709
- 4% 94618
- 4% Homeless
  
- ✓ **Length of Time in Berkeley** (n=45)
  - 13% Less than 5 years
  - 33% 5 to 10 years
  - 24% 10 to 20 years
  - 29% 20 or more years
  
- ✓ **Income** (n=49)
  - 57% Less than \$17,500
  - 20% \$17,500 to \$35,000
  - 10% \$35,000 to \$60,000
  - 2% \$60,000 to \$85,000 (one person)
  - 10% \$85,000+ (3 persons – 2 were a couple and share the income)
  
- ✓ **Type of Medical Coverage** (n=51)
  - 57% Medicare and Medical (Medi/Medi)
  - 35% Medicare
  - 8% MediCal
  
- ✓ **Where Go for Medical Care** (n=53 – more than one answer allowed)
  - 30% Lifelong/Over 60
  - 25% Kaiser
  - 19% Private Doctor
  - 9% CEI/PACE
  - 23% Other (e.g.: Stanford, UCSF, Berkeley City Clinic, multiple)

## Varied Comments from Continuum Leaders and Partners

A summary of common themes across those Continuum leaders and partners interviewed as a part of the needs assessment process is included in the body of this report. The list provided here provides a sample of the variety of other input from those interviewed, which varies depending on “what part of the elephant” they tend to look at. It is not possible to represent every comment made. This list is provided for informational purposes only.

### Big Picture or Approach:

- Key elements need to be focused on keeping people in their home and independent for as long as possible.
- Support staying at home, at least staying in Berkeley
- Consumer driven and independence driven
- We need a progressive, geriatric approach with interdependency recognized.

### Who to Serve:

- Must touch all economic levels
- Need to address the needs of middle income
- Expand services for middle class – lots not getting out, end up in ER, need ongoing support
- Focus on middle to low income
- Provide supports for those least able to afford
- Real concern about 85+ - a growing group
- First home visit? Sure, at 70
- Health care spectrum limited for middle income
- Needs are regional
- Build for the full continuum of income, but anchor it at the lower end

### General Brainstorm:

- Need advocacy for systems change
- Need to build in a “social care” concept
- Local tax for senior services?
- Need employer engagement and corporate support
- Looking for return on investment, tangible outcomes
- Blow up the funding and silos. The money should follow the person – like a regional center
- We need something that everyone knows about. You can go there, or call there, or go to the internet site and connect to all the component parts from Village to hospice and everything in between.
- At least some intergenerational opportunities! (many said this)
- How do we partner for a decent long term care insurance program?
- How do we scale up to handle the volume?
- Looking for partners to address social determinants of health

- Need to re-order assets to fit future model of medical care – which is community-based
- Incremental approach is good
- Deal with fragmentation

**Tech:**

- Technology needs to become seamless, ubiquitous and evolving to support simple, end-user learning and social connectedness to telemedicine, machine learning, predictive analytics and oversight for safety.
- Simple computer training for frail elderly – to communicate, read about things
- Tech is good, but will always need direct touch too. Seriously.
- Technology: Children of seniors like gadgets. Seniors don't
- Tie into virtual community

**Community Living:**

- Need a coordinated, centralized contact point.
- To stay at home, people need an “office” they can call for information, tip sheets, etc.
- Need a place where supportive services can sit.
- Need ONE place to call
- Need linkages
- Be a clearinghouse
- Keep people out of hospital: somewhere to call, better home care, navigator, case management
- Linkages are the key. The parts need to talk to each other. Warm transitions
- Seniors want economic services and community connection
- Need aggressive fall prevention efforts
- Need caregiver training – for both navigation and basic medical review
- Someone to go to the doctor with you?
- Respite if caring for spouse?
- CCRCs without walls could offer: wellness advice, engagement, purpose, basic I & R.
- Need some delivered meals tailored to specialized diets and health needs
- Food is key: Meals on wheels – 52k meals per year, 45k in senior center
- Work on neighborhood and technology (increase livability)
- Network with doctor's offices
- Visit at 70 – yes (Gateway)
- Gateway program? Depends on trust.
- Intergenerational
- Time Banking
- Take existing things and make them user friendly
  
- Need to keep people active
- Reinvent the senior center to something people want
- Need to offer home assessment and modification
- Need to plan to serve those with mental health disabilities
- Pick up on early signs of dementia, caregiver education on dementia

- Peer counseling
- Family caregiver support
- What could UC students offer?
- Need good legal and financial advice
- Need art, culture, a place to meet where people can stay engaged – that doesn't exclude those who cannot pay
- Health risk assessment tools
  
- Housing: Need to help people find the right housing.
- Housing: Need ready access to affordable housing
- Housing: Need a scattered site housing approach
- Housing: Don't forget assisted living in addition to independent
- Housing: Need more in-law units
- Housing: Need to look more into co-housing, sharing
- Housing: Tiny homes
- Housing: Catch people before they are homeless. Berkeley has case management team – includes for precariously housed. Can't keep up with need.
- Housing: Home share – match renters with owners
- Figure out how to make affordable housing advantageous for private sector
  
- Transportation: A huge issue – with Village volunteers, requires 3 days' notice, paratransit, problematic.
- Transportation: Need Uber and Lyft for power chair users
- Transportation: Need a paratransit shuttle
- Taxi script program could be larger
  
- Volunteers: Volunteers can do: transportation, home repair, gardening, dog walking, social visits. Can be trained for MedPal – support at medical visits. Giving and receiving is transformational.
- Need Volunteers
  
- Need to reinvent adult day health care
- Think about making existing things in the community more age friendly
- People don't plan. They get poor. They need MediCal. They need a place to live. They need to plan earlier.
- Need to rebrand, remarket senior centers. Speakers, teaching, volunteer opportunities, free Wi-Fi,
- Support family caregivers
- Family members need support
  
- When patients get discharged from hospital, need a *stable* set of partners and network of resources that will allow patient to re-enter community at a different level of functionality.
- Prevention critical
- Coordination needed
- Need Advanced Illness Management (AIM)
- Would like a single database on clients – one source of truth – like a health information exchange
- Need to avoid rehospitalizations

- Asset planning
- Intergenerational community center

**Institutional Continuum**

- Need for nursing home care – short or long term – isn't going to go away but emphasis will shift toward short-term rehab and memory care. Needs to be human scale, resident centered, integrated with the community, non-profit best.
- CCRC's – bricks and mortar – more are needed. Traditionally, CCRC's are quite expensive and there is a growing voice advocating for new models and funding sources that could support CCRCs for middle and lower income individuals. Public/private partnerships?
- Need assisted or CCRC with a month-month option
- Need an anchor CCRC
- CCRCs: How to have a presence outside of bricks and mortar
- Adult day care an answer, but underfunded, underutilized

## Background and Local Data and Resources – Detail by Topic

### A. Independent, Community-Based Housing

#### i. Background and Data

*Note:* This section addresses independent, community-based housing. This housing may be owned or rented. Rented housing may be subsidized or market rate. It may attract all populations, be senior-focused, or low-income focused. While technically, one may receive assistance to live independently (assisted living), this topic is addressed elsewhere (Sections on In-Home Supports and The Housing/Care Continuum above Independent Living.)

As stated earlier, growing old at home or in one's community is a priority for over 90% of older adults.<sup>21</sup> One gerontologist argues that older adults are seeking residential normalcy – or the emotional fit people have with their environment, including residential comfort and residential mastery. It encompasses feelings of pleasure, as well as feelings of competence and control.<sup>22</sup>

**Nationwide:** It is generally recognized that nationwide, the existing housing stock is unprepared to meet the escalating need for this population. Specifically:

- High housing costs force millions of low-income older adults to sacrifice spending on other necessities including food, undermining their health and well-being.
- Much of the nation's housing inventory lacks basic accessibility features, preventing older adults with disabilities from living safely and comfortably in their homes.
- Disconnects between housing programs and the health care system put many older adults with disabilities or long-term care needs at risk of premature institutionalization.<sup>23</sup>

**In Alameda County:** The Alameda County Older Adult Plan recognizes that there is a housing crisis countywide.

- The report states that the median price of a home in Alameda County, most notably Berkeley, Oakland, Dublin and Albany has increased in the 30% to 50% range.
- Vacancy rates are less than 3.5%
- 30% of older adult owners and 62% of renters are "cost burdened," meaning that they are paying over 30% of their income for housing.
- Countywide, there are fewer than 4,000 units of subsidized housing for older adults – against a population of more than 30,000 extremely low-income elderly or disabled households.<sup>24</sup>
- In a 2015 study of 350 homeless seniors in Alameda County, 43% reported that they had been housed until very recently. "Something happened to them late in life. It's never one thing. It's often complicated."<sup>25</sup>

**In Berkeley:**

- Rents in new Berkeley developments were 25%-30% higher in 2015 than 2012.<sup>26</sup>
- Length of time to gain necessary tax credits, permits, develop and open new low-income housing complexes is nearly 8 years. The process is “opportunistic and subject to financial and market forces.”<sup>27</sup> Developers note that it also requires the development of strategic partnerships.
- Subsidized senior housing in Berkeley lags the rest of Alameda County. Currently there are 9,089 affordable housing units for all populations in Alameda County, with 738 of those in Berkeley (8% of units against 8% of county population). However, across the county 3,543 vouchers for these units are reserved for the elderly, but none of these vouchers are reserved for older adults in Berkeley.<sup>28</sup>
- **Berkeley Housing Element:** The City of Berkeley Housing Element of its General Plan for the years of 2015-2023, is a 300+ page document with dense detail about the housing environment, needs, and the City’s commitments during this period. A brief look at it provides interesting information particularly relevant to this needs assessment:
  - Using a complex calculation process, the City has defined its need for additional housing (RHNA - Residential Housing Need Assessment) as 2,959 new units for all ages/populations. The RHNA is broken down by target income levels.<sup>29</sup>

| <b>Income Category</b>            | <b>Income Range</b> | <b>No. of units</b> | <b>% of Total</b> |
|-----------------------------------|---------------------|---------------------|-------------------|
| Extremely Low Income (ELI)        | Up to 30 % of AMI   | 266                 | 9%                |
| Very Low Income (VLI)             | 31% - 50% of AMI    | 266                 | 9%                |
| Low Income (LI)                   | 51% - 80% of AMI    | 442                 | 14.9%             |
| Moderate Income (MOD)             | 81% - 120% of AMI   | 584                 | 19.7%             |
| Above Moderate Income (Above MOD) | Above 120% of AMI   | 1,401               | 47.4%             |
| <b>Total</b>                      |                     | <b>2,959</b>        | <b>100%</b>       |

*Source: Association of Bay Area Governments Regional Housing Needs Allocation. AMI = Area Median Income; for a family of four in Alameda County AMI is \$92,300 (Housing and Urban Development (HUD) Department, 2011).*

*Actual income limits based on household size.*

*The City has a RHNA allocation of 532 very low income units inclusive of extremely low income units. Pursuant to CA Government Code Section 65583 (a)(1), the City must project the number of extremely low income housing units needed and may assume 50 percent of the very low income units as extremely low.*

- Berkeley has a strong rent control program that limits the increase of rents while individuals remain in their unit. However, the City also allows “vacancy decontrol” which allows owners to raise rents to market value between tenants. While the tables below are slightly outdated – especially given what we know about the East Bay’s extremely overheated housing market, we do get confirmation that rents are out of reach for many older adults. The Plan concludes that “preliminary analysis of current market rents suggests that...a single person household would need to earn \$45,564 a year, or 76% of average monthly income, to afford a studio apartment based on average market rent.”

**Table 2-23: Average Market Rents for New Multifamily Developments (2010 and 2014)**

| Number of Bedrooms | 2010 <sup>(a)</sup> | 2014 <sup>(b)</sup> |
|--------------------|---------------------|---------------------|
| Studio             | \$1,819             | \$2,239             |
| One-Bedroom        | \$1,930             | \$2,537             |
| Two-Bedroom        | \$2,508             | \$3,434             |
| Three-Bedroom      | \$3,900             | \$4,200             |

Source: Bay Area Economics, 2010 and 2014

(a) Rents reported for four new rental developments: Acton Courtyard, Library Gardens, Stadium Place, and Hillside Village.

(b) Rents reported for five new rental developments, second quarter 2014: Berkeley Central, Fourth & U, New Californian, Hillside Village, and Library Gardens.

- The Plan notes the high rate of mixed-use residential development in past years on underutilized sites along the City’s commercial corridors and identifies this practice as demonstrating the greatest capacity for new units in the City.
- With one of the objectives of the Housing Element being to address housing affordability, a few particularly relevant policies were established:
  - Policy H-1 – To increase the number of housing units affordable to Berkeley residents with lower income levels (including using the Housing Trust Fund to provide housing at the lowest income levels, including extremely low income households and units that are deeply affordable for people with disabilities, the homeless, the elderly, and very low-income families.)
  - Policy H-2 – To aggressively search out, advocate for, and develop additional sources of funds for permanently affordable housing, including housing for people with extremely low incomes and special needs.
  - Policy H-12 – To encourage construction of new medium and high density housing on major transit corridors and in proximity to transit stations.
  - Policy H-14 – To seek solutions to the problems of individuals and families who are homeless, with the goal of first providing them with permanently affordable housing.
  - Policy H-17 – Housing for Seniors – To support housing programs that increase the ability of senior households to remain in their homes or neighborhoods and, if necessary, to locate other suitable affordable housing to rent or purchase. This includes:
    - Continue the Senior and Disabled Home Rehabilitation Program.
    - Develop incentives for a range of senior housing types including, but not limited to second units to help seniors age in their homes, in a university accessible dwelling unit (ADU) on their property, and to expand as possible, funding for a range of senior housing and service types.
  - Policy H-18 – Housing for People with Disabilities – Encourage provision of an adequate supply of suitable housing to meet the needs of people with disabilities.....<sup>30</sup>

## ii. Known Local Resources

- SeniorHomes.com shows 30 retirement communities (independent living) in the East Bay ; Page A6-3 none in Berkeley. Some of those listed overlap with lists of assisted living suggesting they offer both levels of living.
- The Senior and Disabled Home Rehabilitation Loan program is available to Berkeley homeowners; it enables seniors and people with disabilities to stay in their homes by making repairs for health and safety as well as accessibility adaptations.<sup>31</sup>
- Ashby Village offers referrals to home inspection and repair services to its members.
- According to the Alameda County Older Adult Plan, there are 15 subsidized senior housing projects in Berkeley, with a total of 738 housing units. There are 3,543 Section 8 Housing vouchers reserved for seniors countywide<sup>32</sup> – with 674 or 19% allocated to Berkeley.
- There are multiple developers of affordable housing working in Berkeley.
- In 2013, the Area Agency on Aging reported that 10 of the (then) 11 senior housing properties in Berkeley had closed their waiting lists.<sup>33</sup> Waiting lists open every few years, and one can expect to be on the list for 6-8 years on average.
- Satellite Affordable Housing Associates (SAHA) reports that they received approximately 3,000 applications for 50 new units that recently became available.
- The Berkeley Older Adult Resource Guide includes many housing related resources. A few are:
  - Housing Advocacy: Berkeley Rent Stabilization Board, Housing and Urban Development (HUD) Compliance and Enforcement, Housing Rights, Inc., and Salvation Army.
  - Referrals for free or low-cost home repair: Center for Independent Living, Rebuilding Together, and the Berkeley-Albany Weatherization Program.
  - Numerous rental resources are provided including: the AAA Housing Guide and Residence Hotel List, The California Registry for elderly housing referral, Center for Independent Living, and well as contact information for City of Berkeley Housing Authority, Code Enforcement, and Rent Stabilization.
  - A comprehensive list of independent living complexes for seniors and/or low income, in Berkeley and the surrounding cities.

## B. Quality, Affordable In-Home Support Services

### i. Background and Data

As outlined throughout this report, older adults want to age in place, and have services and supports come to them in their homes. As this population grows, the numbers of older adults needing support in their homes is skyrocketing. Seniors themselves tell us of their struggles to find quality, trustworthy, and affordable in-home care.

While in-home care is not directly addressed by either the objectives of the California State Plan or the goals of the Alameda County Older Adult Plan, attention to these needs is implied in Alameda's Plan, Goal 3, which identifies a need to "address the growing need of services for older adults by supporting

a comprehensive network of providers to provide long-term services and supports (LTSS) in community settings.” It is unclear whether “community-based settings” include homes.

**Shortage of Caregivers:** Going back as far as 2000, there are news articles exploring the shortage of home health care workers. In one article, the author suggests “What it will take is a legislator’s mother who is not able to get home care” to improve the system.<sup>34</sup>

More recently, the New York Times reported that home health aides topped the list of occupations expected to grow between 2012 and 2022, with nursing assistants also appearing in the number 4 slot and nursing assistants in the number 6 slot. It states that more than 1.3 million new paid caregivers will be needed nationwide to meet demand over the next decade. With the low wages paid these workers, the supply may not be there.<sup>35</sup>

The article further states that the Affordable Care Act and Medicare and Medicaid are under dire financial pressure and are unlikely to increase funds for home care, and that the Affordable Care Act and the national Commission on Long-Term Care have failed to come up with a national financing program for long-term care. They conclude that little help is available to most families needing to pay caregivers.

## ii. Known Local Resources

The actual supply of in-home care providers balanced against demand in Alameda County or Berkeley is not known. Some of that supply is visible and licensed, but an unknown and significant portion is unlicensed and is accessed by word of mouth. We do know that while supply is an anticipated concern as the older adult population grows, today’s older adults themselves are much more focused on quality and cost. A brief scan of the environment and Alameda County resources shows that:

- California Department of Public Health licenses and certifies home health care agencies.
- Skilled, licensed, in-home providers may be paid for by Medicare and other insurance providers for limited periods of time (e.g., for acute situations) and may be covered under private long-term care insurance contracts. Some certified home nursing aides may be also reimbursed by these sources. Medicare does not pay for 24 hour/day care, homemaker services, or personal care.<sup>36</sup>
- Non-certified aides or home care assistants may also provide support for activities of daily living, light housecleaning, etc., but are not generally reimbursable whether they work for a certified home health agency or not.<sup>37</sup>
- Veterans may qualify for some limited benefits including short-term skilled nursing and help with activities of daily living. Services must be obtained by a provider who is contracted with the VA.<sup>38</sup>
- In-Home Supportive Services (IHSS) is a federally, state, and locally funded program managed by the Alameda County Social Services Agency. To be eligible for such services, one must be: On Medi-Cal, blind, disabled, or 65 years of age or older, AND be unable to live at home safely without help. The Alameda County Plan reports that as of December, 2015, the program had 21,244 recipients, 12,109 of whom were aged 65 and older. We do not know the number of hours or average number of hours of assistance provided.

We know anecdotally that those older adults who qualify for IHSS are grateful for the assistance and/but are quick to point out that they do not receive enough hours of service to meet their

perceived needs, and that the quality of providers can leave a lot to be desired. Because of MediCal eligibility as a threshold for qualifying for supports, there are many lower and middle income older adults who cannot qualify for assistance.

- The Berkeley On-Line Resource Guide<sup>39</sup> has referrals for attendant care, live-in help, and nurses. It includes private agencies, as well as organizations that can provide additional linkages (some vetted) including Senior Centers, Ashby Village, Bay Area Community Resources, Center for Independent Living, Easy does it, In-Home Supportive Services (county), and Family Bridges.
- A brief on-line search shows several websites that consolidate information on a number of in-home care providers in Berkeley and/or Alameda County. Care.com offers information and contact information about 17 providers, three of which are located in Berkeley. The providers offer a range of services from light housekeeping, to shopping, to in-home care, to care management. A few providers on this site provided cursory information on their rates – showing that services that start at \$20 to \$30/hour.
- Another website (caring.com) discusses ways to save money on in-home care – suggesting use of family, churches and student volunteers.

### C. Information and Referrals/Navigation Support/Care Coordination

#### i. Background and Data

**Information and Referral (I&R):** A brief internet search shows literally thousands of sites nationwide offering information and referrals for older adult services both for older adults and/or their caregivers. We are in the information age. However, we know from surveys and forums that there are so many resource lists and internet locations for just Alameda County and Berkeley that they become confusing to use. Older adults also report that some of these listings are out of date, adding more confusion. There is also unlimited information on the internet on resources for individuals of all agencies, for anything from transportation to internet support to home modifications, to entertainment or recreation.

Older adults in Berkeley clearly want one, single, up-to-date place to go for information about resources for daily living, medical resources, entertainment and activities. Some are happy to access that information on-line, others want it from a person – face-to-face or by phone.

**Navigation Support:** Some older adults and their caregivers also want help to access, understand and act on non-medical information that they receive – whether it is about planning for a type of housing they can afford, options for assisted living, how to qualify for some type of benefit, etc. A private industry of “navigators” or “care consultants” has sprung up across the country to address this – particularly focused on children of older adults who live too far away from their parents to manage their care directly. In fact, Wikipedia provides a summary of how to become a Geriatric Care Manager.<sup>40</sup>

This type of assistance is most often accessed when an older adult has a crisis - is transitioning out of the hospital, responding to a significant change in functioning, or losing their housing. It will often, but not always, be related to health issues.

Older adults in Berkeley report a desire for this type of support sporadically when they need it, but most cannot afford to pay for it. This leads to delayed access to resources that were not found or not understood until a crisis forced dealing with the issues. Stronger navigation support that is visible, available, can be driven by the client or their loved ones, and encourages advance planning in some key areas (e.g. housing affordability, fall prevention) could reduce stress, and could prevent homelessness and hospitalizations.

**Care Coordination:** With the rising cost of caring for the growing older adult populations – more than 20% of whom have multiple chronic conditions<sup>41</sup>, the issue of care management has taken on greater importance in the health care system than ever before. On a parallel track, recognition of the importance of the impact of social determinants of health, longevity, quality of life, and positive health outcomes, is leading to innovations in providing care management to older adults in a manner that acknowledges and addresses the wide array of variables that contribute to health.

The Affordable Care Act, as well as Medicare/Medicaid innovations are supporting more innovation in payment mechanisms and how services are configured and provided to produce the best possible health outcomes. And these innovations increasingly call for partnering medical care providers with community-based providers of related services and supports that are now well-recognized as supporting health – such as housing, food, safety, and social connectedness.<sup>42</sup> Community health centers also play a key role in addressing social determinants of health given that they serve at-risk and underserved communities with broad needs.<sup>43</sup>

Characteristics of effective community care teams are generally recognized to be: Multi-disciplinary; patient-centered; comprehensive; having a systems approach; and having clear objectives, communication, and measurable outcomes.<sup>44 45</sup>

## ii. Known Local Resources

### Information and Referral

- The City of Berkeley Department of Aging Service is in the process of converting its Resources Guide for Older Adults to an online resource that can be routinely updated. While some older adults will prefer to print this guide out, the on-line version will always be up-to-date. Through its senior centers, the City also provides one-on-one guidance to find information and assist with referrals. Appointments can be made with “case managers,” although the depth of assistance available from those case managers is not known. This service is available to anyone in Berkeley age 55 or older.
  - The Resource Guide includes a wide list of providers that also offer I & R, or offer more detailed information and referral on specialized topics ranging from housing to legal assistance to entitlement programs to homeless and disability services.
  - There are also many other organizations that provide I & R to varying degrees, but are not listed in the City’s Guide. The scope of that list is too substantial to provide here but includes Ashby Village, Center for Independent Living, Alameda County Social Services, and the University’s Eldercare Program for employees.

### Navigation Support

- City of Berkeley Aging Services offers comprehensive case management to address non-medical needs such as transportation, food, access to care, insurance issues, legal issues, housing, safety, caregiver supports, etc. This includes comprehensive assessment of needs.
- Lifelong Medical Care not only provides comprehensive case management services to its patients, but accepts referrals from Sutter/Alta Bates Medical Center for individuals of all ages who are discharged from the hospital with high community-based needs and lack a medical home. Lifelong assesses needs, assists with comprehensive transition issues, and offers a comprehensive medical home.
- In a section called “Help to Stay at Home,” the Berkeley Older Adult Resource Guide includes a subsection on Case Management and Assessments: This includes Alameda County Adult and Aging Services (public guardian), Area Agency on Aging, Center for Elders’ Independence, City of Berkeley Case Management (via Senior Centers), J-Sei, Jewish Family and Children Services – Center for Older Adults, Lifelong Medical Care, and St. Paul’s Episcopal Church Senior Resources.
- There are numerous care coordination companies on the internet that are available for hire to serve families with an older adult in Berkeley. Those are not reviewed or recommended here.
- There are also many community-based agencies that provide some form of navigation or case management support – whether comprehensive or not – to older adults in Berkeley and cannot be fully listed here.

### **Comprehensive Care Management**

The topic of comprehensive care management is broad and rapidly changing, and it has not been addressed in-depth in this Needs Assessment. It resides largely in the domain of medical and behavioral health care providers and is a key element in the evolution of patient-centered health care and accountable care organizations.

There is one Medicare-based PACE program in operation in Berkeley through Center for Elders’ Independence that is allowed to utilize dollars traditionally earmarked for medical care for a wide array of “upstream” needs to prevent medical costs and improve medical outcomes. While some innovative care management programs are being piloted or implemented with insurance and public funding, more research is needed to know what is available directly to Berkeley residents.

#### **D. Transportation**

##### **Background and Data**

A lot of people think that when older adults stop driving, public transportation and “special demand-responsive” transit systems such as paratransit will meet their needs, but find that they don’t. Studies confirm what older adults residents have told us: That older adults don’t like public transit, and that public transit and paratransit do not meet their needs.

This puts added pressure on families, and can lead to isolation of seniors living alone. One study suggests that not driving is a serious concern for social isolation in that, of all older non-drivers, 46% do not leave their homes on a given day, whereas only 17% of drivers stay home.<sup>46</sup> It is interesting to note, however, that this finding is slightly older (Bailey, 2004),<sup>47</sup> and includes a nationwide focus - with rural and suburban populations included.

**Public Transit:** According to Sandra Rosenbloom,<sup>48</sup> studies consistently show that older travelers have a variety of safety, personal security, flexibility, reliability, and comfort concerns about public transit, even if it is physically accessible. Moreover, they often do not find that actual routes and hours of service match their desired travel patterns. This mirrors what we heard locally.

Rosenbloom points to studies that suggest the ways that public transit would need to be improved to meet the needs of this group. The most basic needs are to:

- Increase safety and security in all parts of the system,
- Provide better information both before and during travel,
- Expand the hours of service and provide additional routes,
- Make services more reliable, and
- Enhance driver training.<sup>49</sup>

Optimal enhancements might also include:

- Offering more customized services that more directly link residential concentrations of older people to the destinations to which they want to travel, and at the hours they need to travel -- often outside the traditional peak period and sometimes at night;
- Providing those services in fully accessible and preferably smaller vehicles; and
- Providing attributes not commonly found in traditional transit services, such as a higher level of driver assistance, some route deviation, and allowing travelers to disembark anywhere along the route as opposed to only at designated stops.

Paratransit systems in the United States are designed to meet the requirements of the Americans with Disabilities Act (ADA) but are required only to “mirror” the existing transit system for those who meet certain disability criteria and whose disability prevents them from using the existing public system. It is a very expensive system to operate. One report shows that nationally, the average cost of providing an ADA paratransit trip in 2010 was \$29.30, an estimated three-and-a-half times more expensive than the average cost of \$8.15 to provide a fixed-route trip.<sup>50</sup>

Conversations are taking place nationwide about what it would take to improve the paratransit system with recognition of the growing aging population. One recent study lays out “how to provide quality paratransit without breaking the bank.”<sup>51</sup> Key recommendations include:

1. Partner with ride-hailing services,
2. Modernize ride reservation and fare payment systems,
3. Provide real-time information, and
4. Right-size vehicles.

**Ride Hailing Services:** While there has been much discussion and occasional news articles about ride-hailing services (e.g., Uber, Lyft) expanding to specifically serve seniors with regular and wheelchair vehicles, no concrete programs are yet in place. Seniors involved in Continuum forums pointed out that being “senior friendly” is not just about having wheelchair vans – but it involves cost, simplicity of hailing, help getting in and out of vehicles, and general understanding and patience with the older adult population.

## ii. Known Local Resources

**AC Transit and BART:** AC Transit and BART provide a robust system of buses and subway transit within Berkeley and throughout the Bay Area. Senior discounts are available and provide up to 62% off of full fares. Berkeley seniors report that they find public transit more and more difficult for them to use for numerous reasons including: feeling unsafe, difficulty getting on and off buses, waiting times for buses, limited hours and frequency of buses, and inability to get off between official stops.

**AC Paratransit:** The AC Transit Paratransit Program, while meeting federal ADA requirements, has serious drawbacks. Locally, older adults tell us that it is too limited in who can use it, too rigid in where it goes, and how far in advance it needs to be booked.

In Alameda County, the minimum fare for using paratransit is \$4.00 and as high as \$7.00 for distances up to 20 miles in the East Bay; it is \$10.00 to San Francisco and the surrounding area.<sup>52</sup> There is no mention on the local paratransit website of any discounts available, although there are general senior discounts available for both AC Transit and BART. Trips must begin and end within 3/4 of mile from a regular, fixed AC transit route or BART station, during the same hours that AC transit operates. Reservations must be made in advance.

**Berkeley's Paratransit Program:** The Berkeley Housing and Community Services Department also provides paratransit supports from their offices or through the North and South Berkeley Senior Centers. Recognizing that "the ability to perform daily activities of shopping, getting to appointments and community meetings, and seeing friends and family requires that we be able to "get around,' town."<sup>53</sup> Berkeley provides five programs:

- **Taxi Scrip Program** – Provides a limited amount of free scrip to pay for rides on conventional taxicabs, wheelchair-accessible taxicabs, vans, and other selected vehicles. Those eligible must be over age 80, or certified as disabled by East Bay Paratransit or a senior aged 70-79 whose income is not more than 50% of the Area Median Income.
- **Wheelchair Van Program** – Provides a limited amount of free scrip or vouchers for wheelchair accessible van services for rides that are beyond the scope of East Bay Paratransit. Those who are eligible must travel by wheelchair and be certified by East Bay Paratransit as requiring wheelchair service, regardless of income.
- **East Bay Paratransit Tickets** – Provides for a limited number of free East Bay Paratransit tickets to individuals certified by East Bay Paratransit.
- **Medical Return Trip Improvement Program (MrTrip)** – Provides limited subsidies for taxicab or van rides to those returning from a health-related appointment. These are offered to participants who are in the taxi scrip or wheelchair van programs.
- **High Medical Need Program** – This program assists existing Berkeley paratransit service users with transportation needs associated with frequent medical appointments by issuing extra taxi or wheelchair van scrip. (Funded by Measure BB – Alameda County transportation funds.)
- **Upcoming** – Using Alameda County Measure BB funds, the City of Berkeley is currently in the planning stages for development of an additional mini-bus/shuttle system for seniors in Berkeley. Details are not yet available. This emphasis based on its own Paratransit Needs Assessment,<sup>54</sup>

which shows that older adults use their own cash, in addition to all available subsidies and free vouchers to cover their medical and grocery shopping needs first, leaving nothing for socializing and engaging with the Berkeley Community.

- **Other Programs with Transportation** – There are also multiple programs serving sub-populations or related populations that provide transportation for their clients or members. This includes (but is not limited to) Center for Independent Living, PACE/Center for Elders' Independence.

**Volunteer Drivers:** Ashby Village (AV) has a large volunteer program (approx. 300 - half who are AV members and half who are not) and offers free transportation (and fine company) for doctor appointments, grocery shopping, AV social and cultural events, and other needs as possible. Nearly 65% of its estimated 2,400 requests for services per month are for transportation. Individuals must be AV members to receive transportation and other supports. There is a \$750 fee per year for an individual to join and \$1,200 per year for a household; some subsidies for membership are available.

**Walking:** Walking is a key form of transportation for older adults and, depending on where one lives in Berkeley, many of its assets can be reached on foot. However, there are also a significant number of neighborhoods in the hills that do not provide easy access to resources. Realtors are increasingly posting the “walk score” of properties for sale, and the website walkscore.com cites Downtown, Southside and North Berkeley as the most walkable neighborhoods in Berkeley.<sup>55</sup> It gives Berkeley an overall a walk score of 81 (out of 100).

**Sidewalks:** Both nationwide and locally, we hear loud and clear that the safety of sidewalks, and safety from crime while out walking are significant barriers that prevent older adults from walking. The poor quality of sidewalks in Berkeley is specifically highlighted in feedback. Sidewalks are a City responsibility which operates a specific “Sidewalk Program.”<sup>56</sup>

**Pedestrian and Bicycle Safety:** In late 2015, the Berkeley Transportation Commission recommended that Berkeley adopt and implement the “It’s All Up to Us” pedestrian safety campaign established by the California Department of Public Health. The Commission cited that Berkeley has one of the highest rates of bicycle and pedestrian commuting in the state, but in 2012 alone, experienced 112 pedestrian collisions resulting in an injury or fatality, with nearly one-third of these involving someone under the age of 15 or over 65.<sup>57</sup>

**On-Demand Taxis and Ride Hailing Services:** There are some taxi services in Berkeley that have wheelchair vans. A conversation with Friendly Transport showed that, for example, a trip from North Berkeley BART station to Alta Bates Hospital would cost \$12. As noted earlier, the Berkeley Paratransit Services include a limited number of free vouchers for taxi services.

An internet search for wheelchair friendly cab services was not reliable (all companies seem to be listed whether they had wheelchair vans or not), and none are listed in the Berkeley Older Adult Guide. However, Senior Centers and Berkeley Paratransit are reported to have up-to-date listings.

There is one known non-profit in Berkeley that provides assistance to the elderly and individuals with disabilities living independently – Easy Does It – a 24-hour emergency service that includes urgent errands. The charge is \$14.00 for the first hour. There is a “reduced pay” program which lowers that to \$6.50 per hour.<sup>58</sup>

Uber, Lyft and other ride-hailing companies are in operation in Berkeley. As an example, as posted on GoGoGrandparent's website, Uber fees are \$3.5 base fare + \$1.00 per mile + \$0.12 per minute (with a minimum fare of \$6.55). An additional service is available from GoGoGrandparent.com which offers a variety of "concierge" services including booking ride-hail services for you, tracking your use of them and providing family updates on your travel. There is a concierge fee of \$.19 per minute for these services plus the ride-hail company's normal fee.

## **E. Nutrition and Meals**

### **i. Background and Data**

According to the National Conference of State Legislatures, Food insecure seniors are 60% more likely to develop depression, 53 and 40% more likely to report heart attacks and congestive heart failure, respectively, and 200% more likely to develop asthma. Additionally, food insecure seniors also experience decreased resistance to infections and lengthened hospital stays, which ultimately results in higher medical costs. Almost 1/3 of food insecure Americans have a disability.

Healthcare costs directly related to hunger reach \$130.5 billion nationwide each year, of which \$16.1 billion is from hospitalizations, \$29.2 billion from depression cases, and \$19.7 billion from related suicides. Every dollar spent on feeding food insecure Americans saves approximately \$50 in Medicaid costs.<sup>59</sup>

In the U.S., over 4 million low-income adults over age 60 rely on support for purchasing groceries under SNAP – the federally funded Supplemental Nutrition Assistance Program (formerly called Food Stamps, known as CalFresh in California) to stay healthy and make ends meet. On average, they receive \$110 per month to help put food on the table.

SNAP reports that in 2013, 9.6 million older Americans faced the threat of hunger, representing 15.5% of adults aged 60+ in the U.S. African Americans and Hispanics are disproportionately at risk for hunger, with 17% of African American seniors and 18% of Hispanic seniors reported to be food insecure, compared to 7% of Caucasian seniors.

Older Americans who qualify for SNAP are significantly less likely to participate in the program than other demographic groups. In fact, 3 out of 5 seniors who qualify for SNAP do not participate. This means that 5.2 million seniors miss out on benefits. Several factors contribute to the low participation rate including mobility, technology, and stigma or a reluctance to accept government support. Because of this, SNAP has initiated the Senior SNAP Initiative to reach out and enroll more seniors in the program.<sup>60</sup>

To combat stigma (among other reasons), CalFresh has shifted to distribution of benefits via prepaid benefit/debit cards rather than their historic paper coupons. In recognition that not all people have access to cooking equipment or the ability to cook (especially with fresh foods), there is now a limited program that allows the disabled, elderly, and homeless to buy prepared meals from restaurants. In recent years, there has been a successful push to set local farmers markets up to accept CalFresh cards in order to support cost-effective, nutritious purchase of more locally grown foods.

The Alameda County Food Bank reports that it feeds over 300,000 unduplicated individuals in the county per year and compares this to 6 times more people per year than served by all 100 Starbucks in Alameda County. This equates to 1 in 5 Alameda County residents, 15.4% of whom are seniors.<sup>61</sup>

## ii. Known Local Resources

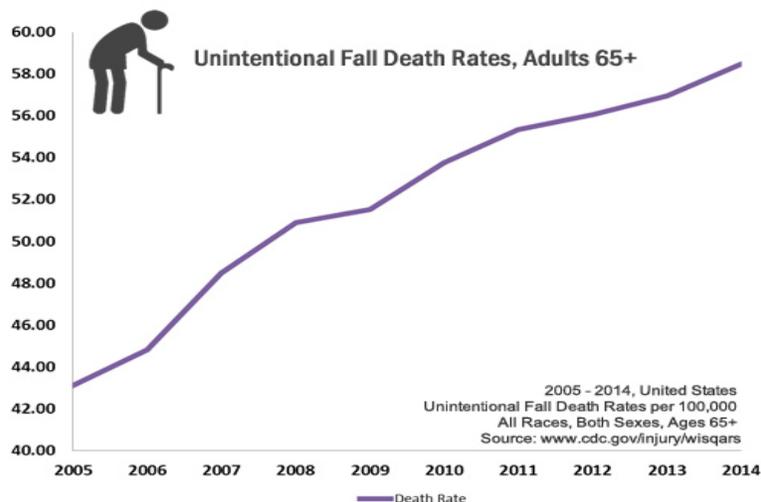
- According to the Alameda County **CalFresh** website<sup>[3]</sup>, a single person can have an annual income of up to \$23,760 to qualify for CalFresh. Note that this income is closer to the self-sufficiency level defined by the Elder Index than the poverty level. The CalFresh website indicates that, based on income, individuals may receive up to \$194 in food benefits a month, but the average amount received is \$149. In the Bay Area, this is not a lot of money for nutritious, fresh food. A two-person household can earn up to \$357 in benefits per month with an average amount of \$295 actually received. Funds can be used at certified grocery stores and farmers markets.
- **AAA and Network:** In fiscal year 2015, the local Area Agency on Aging (AAA), with state and federal funds, and working with a network of providers, provided 529,690 home-delivered meals to 3,384 older adults and 185,477 meals to 6,391 older adults at congregate meal sites (like senior centers). With current funding levels, AAA providers are able to provide meals to older adults who are prioritized based on the severity of their health conditions. Because of funding restraints, the network is not able to serve meals to everyone who requests them.<sup>[2]</sup> Home-delivered meals under this program are limited to the low-income as well, although funding guidelines are not known.
- **The Alameda County Food Bank** reports that 1 in 5 calls to their Emergency Food Line are from older adults and that it feeds 1 in 7 seniors over the age of 60 in Alameda County. It distributes bags of groceries for distribution primarily through community-based service providers, for direct support to families as well as to congregate meal sites. It also partners with CalFresh for outreach and enrollment. The Food Bank does not use the same criteria as AAA for eligibility for food and helps fill the gap left by that program.
- **Alameda Meals on Wheels** is a county-run operation that receives support from the non-profit Meals on Wheels organization. Using a volunteer delivery system, it provides a mid-day meal to over 140 Alameda County residents per day, seven days a week. Subscribers pay on a sliding fee scale, based on their ability. In tandem with this daily meal delivery, AMOW also operates a volunteer Friendly Visitor program.
- **Berkeley Mercy Brown Bag Program:** Mercy Brown Bag Program, sponsored by Mercy Retirement and Care Center, distributes a grocery bag of nutritional food to low-income seniors age 60 or older, twice a month. Income guidelines for food are about \$17,500 for one person and \$24,000 for two. Volunteers are invited to help regardless of income and usually receive a bag as well.<sup>62</sup>
- **J-SEI:** The Senior Services Program of this Japanese-focused organization includes a home-delivered meal program.
- **Tri-City Cafes:** With funding from Alameda County, offer nutritious cooked meals to older adults over age 60 and their spouse or companions. Cafes are located in the North and South Berkeley Senior Centers as well as in senior centers in Albany and Emeryville. Meals cost \$3.00 for older adults and \$5.00 for their companions.

- **Berkeley Food Pantry:** An internet search shows that the Berkeley Food Pantry serves as a distributor of USDA surplus food, receives donations of food from Berkeley stores and restaurants, and distributes food for the Alameda County Food Bank. As an emergency distributor, households can receive assistance just one time per month.<sup>63</sup> No information about income requirements or any focus on older adults is mentioned on the website.
- **Other:** A wide variety of other food providers are listed in the Berkeley Older Adult Resource Guide – divided into categories of food that is delivered, served at meal sites, or provided as bagged groceries. We don't know which of these are included in AAA network listed above or which are separate. However, the list also includes retailers such as Safeway home delivery, and ethnic-specific providers such as J-Sei (Japanese), Lifelong Medical Care, and faith-based programs.

## F. Injury/Fall Prevention

### i. Background and Data

According to the CDC, more than one out of four older people (65+) falls each year. These falls are serious, costly, can be fatal, and are on the rise as the population ages.



- Each year, 2.8 million older people are treated in emergency departments for fall injuries.
- Over 800,000 patients a year are hospitalized because of a fall injury, most often because of a head injury or hip fracture.
- Each year at least 300,000 older people are hospitalized for hip fractures.
- More than 95% of hip fractures are caused by falling,<sup>7</sup> usually by falling sideways.
- Adjusted for inflation, the direct medical costs for fall injuries are \$31 billion annually. Hospital costs account for two-thirds of the total.<sup>64</sup>

Common factors that can lead to falling include: Balance and gait, vision, medications, hazards in the environment, and chronic medical conditions. Efforts to prevent falls are necessary at the civic, home and individual level – with older adults and their caregivers needing education to understand the risks

and how to prevent falls. The National Council on Aging provides a long list of effective programs to reduce falls and recommends home-based assessments for lighting and fall hazards.<sup>65</sup>

## ii. Known Local Resources

According to its website, the **Alameda Count Senior Injury Prevention Partnership (SIPP)** is a coalition of organizations led by the Alameda County Public Health Department who are working together to reduce older adult injuries. Members include 22 organizations from public health providers, to hospitals, to senior service providers and emergency response programs. They hold fall prevention discussion groups for seniors, older driver safety discussion groups, emergency preparedness discussion groups, and bone density screenings. All services are free.<sup>66</sup>

- **The Berkeley Senior Injury Prevention Program**, run by the City of Berkeley Aging Services Division and the Fire Department, has four service areas:
  - It educates front-line fire department staff to make referrals about vulnerable older adults to the Division on Aging where they can receive follow-up assessments through staff at senior centers;
  - It distributes the Resident Emergency Information form to seniors to help them share vital information on current medical conditions in the event of an emergency medical response;
  - It provides presentations to senior groups about injury prevention and the elderly; and
  - It provides presentations about geriatric health concerns to fire department staff.
- **Ashby Village**: Provides free home inspections and minor home modifications (such as grab bar installation), as well as vetted recommendations/referrals for larger projects for its members.
- **Center for Independent Living and the Community Energy Services Corporation**: Both have funding for free or low cost home modifications. They provide this for free or at a low cost.
- **Bay Area Community Services (BACS)** is a non-profit located in Oakland that offers programming for mental health, homelessness, and aging independently. Included in its aging programming, BACS offers home modifications (such as grab bar installation) to increase home safety. Cost is unknown.

## G. Social Engagement

*“Having weak social connections is as harmful for our health as smoking 15 cigarettes a day, and is worse for our health than being obese.”<sup>67</sup>*

Healthy aging is linked to meaningful activity and a sense of belonging. The less involved someone is, the more at risk he or she is for being socially isolated or feeling disconnected from the community. Social isolation can negatively impact the quality of a person’s life. Studies have shown that older persons who have close connections and relationships not only live longer but also cope better with health conditions such as heart problems, and experience less depression and anxiety.<sup>68</sup>

With an interest in the health impact of reducing isolation, Kaiser Permanente researchers in Northern California recently demonstrated that subjects who were paired with volunteer opportunities that matched their needs and interests *“experienced significant, and sometimes profound, improvements in*

their mood, relationships, social interactions, and physical activity.”<sup>69</sup> This pilot effort lays the groundwork for a future study of health impacts.

**Risk Factors for Isolation:** As a part of its Isolation Framework, the AARP identifies primary risk factors for isolation. They are: living alone; mobility or sensory impairment; major life transitions; socioeconomic status (low income, limited resources); being a caregiver for someone with severe impairment; psychological or cognitive vulnerabilities; location: rural, unsafe, or inaccessible neighborhood/community; small social network and/or inadequate social support; language (non-English speaking); membership in a vulnerable group. Isolation also can be triggered by such major life events as a change/loss of: social network, social role, physical health, mental health, resources.<sup>70</sup>

**Connectedness and Health:** At the individual level, research has shown that higher levels of perceived social connectedness are associated with lower blood pressure rates, better immune responses, and lower levels of stress hormones, all of which contribute to the prevention of chronic disease. Social connectedness can also promote health indirectly. Bonding and bridging relationships between individuals can create healthy social norms, help people connect with local services, provide emotional support, and increase knowledge about health or “health literacy” within social networks.<sup>71</sup>

One 2012 study concludes that, among participants who were older than 60 years, loneliness was a predictor of functional decline and death.<sup>72</sup>

Suicide is a serious public health problem. In 2011, the rate of suicide among adults aged 65 years and older was 15.3 per 100,000. However, suicide is a preventable public health challenge. The CDC proposes a strategic direction focused on building and strengthening social and emotional connections as a means for suicide prevention<sup>73</sup>

**Ways to promote connectedness:** One author suggests 14 ways to help seniors avoid isolation.<sup>74</sup> They include:

1. Make transportation available
2. Promote sense of purpose
3. Encourage religious seniors to maintain attendance at their place of worship
4. Give a senior something to take care of
5. Encourage a positive body image
6. Encourage hearing and vision tests
7. Make adaptive technologies available
8. Notify neighbors
9. Encourage dining with others
10. Address incontinence issues
11. Give a hug
12. Give extra support to seniors who have recently lost a spouse
13. Identification of socially isolated seniors by public health professionals
14. Help out a caregiver in your life

**Age Friendly Communities and Social Connectedness:** Scharlach suggests that an elder-friendly community fosters both connection and contribution. An elder-friendly community will help older adults maintain social connectedness while deepening existing relationships. Such a community will recognize the social capital of these relationships, which in turn result in contribution. The concept of contribution recognizes the wisdom and experience of older citizens and sees them as more than clients but rather as active contributors to community well-being.<sup>75</sup>

**Senior Centers:** With the passage of the Older Americans Act in 1965 and the increased use of nursing homes soon after, senior centers stepped up in the 1970s and 1980s to offer an alternative to

institutional care – supporting those older adults who wanted to remain in the community. In the mid-1970s, research began to document the impact of senior centers on the health and wellbeing of participants. While there is no set model for senior centers, they serve as a “community focal point, where older adults come together for services and activities that reflect their experience and skills, respond to their diverse needs and interests, enhance their dignity, support their independence and encourage their involvement in and with the center and the community.”<sup>76</sup> Typically, they offer social, physical, and recreational activities; classes, volunteer opportunities; meals; information and referrals; and community outings.

However, times change and the programming and format of senior centers has not kept pace with the changing needs and desired of older adults. Many recognize that they need to be modernized and questions about their purpose, role, customer base, and long term financial sustainability must be addressed.

One such examination of purpose was undertaken in Louisiana, which concluded that: viable centers of the 21st century should be integrated into the heart and soul of a community. Community cannot be defined as just a group of older adults, but what people most want is to be part of a full community that includes people of all ages and abilities. Vibrant, active, and inclusive centers are, in fact, places people want to be. They are the gathering spot, the focal point and a critical element to a successful, lively and livable community that facilitates a high quality of life for residents of all ages.<sup>77</sup>

This more expansive vision of a senior center raised critical questions in Louisiana including: Should senior centers even be senior centers? Do they have to be physical centers with walls? Or can the services and programs that draw people together and offer advice and support when needed be delivered through a network or a virtual center with no walls?

- **Senior Centers Without Walls (SCWW):** An example of an update to this concept is Senior Center without Walls. What started in 2004 with 2 groups and 8 older adults has grown into a program that reaches approximately 500 seniors throughout the United States. Using phones and computers, it offers opportunities to socialize, learn, engage, volunteer and find resources in the community – all without leaving home. SCWW is a non-denominational program of Episcopal Senior Communities. It is a non-profit, and the program charges no fees for the service.<sup>78</sup>
- **The Village Movement:** The principles of the Village Movement are simple: Instead of leaving their homes for senior housing or assisted living, a group of residents in a given community, typically age 50 and older, form a non-profit membership organization to provide access to services that support their goal of remaining at home as long as possible. A village can range from members in an area of a few blocks in an urban or suburban neighborhood to a rural area with a 20-mile radius. Some are population-specific – serving, as an example, Latinos or African Americans. Each is autonomous and its members determine which services it will offer. Villages address two types of supports: services and social engagement. Typical offerings shared by all members include: home-safety modifications, transportation, meal delivery, dog walking, technology training and support, health and wellness programs, social activities, and the services of visiting nurses and care managers. Most villages hire an administrator, either paid or volunteer, who can connect members with services as needed, as well as coordinate village-wide programs and activities.<sup>79</sup>

In 2016 there were known to be over 205 villages in 46 states with over 150 more in development states.<sup>80</sup> Most participate in the Village-to-Village (VTV) network, which helps them share best-practice advice for fundraising, establishing services and managing communities, as well as information about group discounts on goods and services.<sup>81</sup>

**Volunteering:** Volunteering has been shown to be very important in supporting older adults' sense of worth, social connectedness, and fulfillment. In addition to providing valuable services to individuals and communities, older volunteers are also living active lives through volunteering. A growing body of research shows an association between volunteering and mental and physical health benefits. In particular, older volunteers report lower mortality rates, lower rates of depression, fewer physical limitations, and higher levels of well-being.<sup>82</sup>

There are discreet ways to volunteer, such as doing things for other seniors through senior centers or a local Village. There are also ways to volunteer in the local community – whether ushering for arts events or working at a school or on political campaigns. And/but many seniors need help making this connection. In addition to information about volunteer opportunities that older adults gain through senior centers, villages and other places, there are numerous new programs arising to address just this. Two examples include: the online resource Retired Brains;<sup>83</sup> and the local Bay Area nonprofit Taproot Foundation.<sup>84</sup>

Among other things, the Corporation for National and Community Service recommends that as the leading edge of the Baby Boomer generation approaches retirement age, nonprofits and community organizations need to be ready to recruit and retain boomer volunteers. Adoption of key practices, such as matching volunteers with appropriate and challenging assignments, providing professional development opportunities for volunteers, and treating volunteers as valued partners, can help build organizational capacity to recruit and retain boomer volunteers.<sup>85</sup>

## ii. Known Local Resources

Berkeley's walkable community and high number of social, cultural political gatherings should provide much of what is needed to keep Berkeley's older adult population connected. However, as we have demonstrated in other sections of this report, transportation, finances, personal health status and mobility, loss and grief, as well as cultural style and personality, can also serve as barriers to connectedness. Concrete resources in the Berkeley community that help to make it easier to connect social include:

- **Senior Centers:** The City of Berkeley reports that they serve over 2,500 seniors per year in their three senior centers that offer social and recreational activities as well as a wide range of classes – some of which are also taught by seniors. There are additional ways to volunteer at or through the senior centers. Centers are wheelchair accessible, accessible by public transportation, as well as providing some free van transportation to the center and for shopping and activities out in the community. Some one-to-one information and referrals are provided on-site or by phone. The City's Department of Aging Services also provides an online Older Adult Resource Guide. There is a small fee to enroll in a senior center.
- **Ashby Village:** Volunteerism is a cornerstone of Ashby Village's philosophy.<sup>86</sup> Volunteers do not need to be members of the Ashby Village to participate. Ways to volunteer include:

- Supporting members with daily living needs such as transportation to medical appointments, helping with minor household repair, computer support, gardening, pet care and serving as a friendly visitor.
- Volunteers can also help to support the organization, helping with such things as marketing, fundraising, graphic design, managing projects, and administrative support.
- The Village also operates a Volunteer to Volunteer Program that puts groups of volunteers together for larger projects at members' homes, or assisting local nonprofits who need help with specific activities.
- A Connection Team matches specific volunteers with members who need periodic or ongoing check-in or companionship visits.
- MedPals – a program that provides retired medical professionals who help members navigate the medical system. They can also stay with a member for a short time after an outpatient surgery, provide transportation to and from medical appointment, attend those appointments with the member and take notes, help formulate questions for a provider, help fill out forms, assist with scheduling follow-up appointment.
- Volunteers don't always work – sometimes they just get together for fun.
- **Alameda County Meals on Wheels Friendly Visitor Program:** Offers weekly 1-2 hour visits to seniors or anyone who is homebound. At the heart of the service is companionship and the time spent together can vary depending on the recipient's interests and mobility. Visits are often followed up with phone check-ins.
- **Episcopal Senior Communities (ESC):** While not having an actual CCRC in Berkeley, ESC does have community social programming available in Berkeley through its national **Senior Center Without Walls**. As stated earlier, SCWW offers virtual social and learning opportunities in 25 states (including California) for people who wish or need to engage socially from their homes. The local ESC branch also contributes to farmers' markets in Berkeley that are conveniently located for seniors, and health fairs.
- **Faith Communities:** While not explored in depth in this report (yet), we know that religious communities not only provide engagement, spiritual and recreational activities, but may also assist older adults with transportation, meals, home visits, and other ways to keep in touch. We do know that Jewish Community Services of the East Bay offers fitness as well as arts and entertainment activities specifically for older adults.
- **J-SEI:** The Senior Services Program of this Japanese-focused organization offers a range of services including a senior center, transportation, home-delivered lunches, a variety of classes, and a friendly visitors and callers program.
- **AAA-funded Friendly Visitor Programs:** In addition to offering support for the Meals on Wheels Friendly Visitor Program, the Area Agency on Aging also funds five other Friendly Visitor programs in the County. Their locations are unknown.
- **Lifelong Medical Care:** While not actively operating social programming in Berkeley, Lifelong does offer veggie giveaways, walking groups, pain management classes, a music group, yoga, healthy cooking, and soon Tai Chi, well as health screenings with local AAA funding.

- **Berkeley Adult Day Health Care Center** and the **PACE Program of Center for Elders' Independence:** both offer a full set of supports for their frail elderly and disabled adults enrolled in their program – which include a strong social component.
- **Group Living Environments:** For people of all ages, multi-unit housing sometimes (depending on the mix of people in the building) offers a social environment. Some people want this and others do not. But for older adults, this offers an important opportunity to reduce isolation. Senior apartments and the Townhouse Condominiums that serves Older Adults particularly offer a sense of community that can be important to a person's sense of well-being.
- **Other:** There are too many other social opportunities available in Berkeley to provide a comprehensive list here – especially when recognizing that older adults want to socialize and participate in their communities in intergenerational groups. However, a few, known, seniors-specific opportunities have been listed above. There are additional meal programs, wellness groups, support groups, educational programs, libraries and swimming pools listed in the Berkeley Older Adult Resource Guide.

## H. Health and Physical and Mental Health Care

### i. Background and Data

Strong data on the health and medical conditions of older adults in Alameda County have been provided in an earlier section of this report. A quick summary of the national data includes that: Two-thirds of all people over age 65 experience multiple chronic conditions; and 1 in every 8 adults over age 60 has changes in thinking, including confusion and memory loss.<sup>87</sup> Treatment for this population represents 66% of the county's health care budget.<sup>88</sup>

Access to medical care in Berkeley is not the overriding problem. Local older adults reported strong access to medical care but acknowledged that getting to that care and affording their prescription medications were problems. 100% of participants in Continuum forums had Medicare, MediCal or both. 30% reported going to Lifelong Medical Care, 25% Kaiser 19% private doctors and 23% reported other or multiple sources of care.

Our focus in this section is on what is needed for the health care system to be able to care for this burgeoning population in a manner that maximizes the quality of life and treats individuals according to their needs and in the way that they want to be treated.

There is substantial national literature that analyzes the needed changes to the health care delivery system in order to reduce costs and improve health outcomes in the growing aging population. Key points include:

- Focus needs to shift from acute care to management of chronic conditions, and with that shift, an emphasis on achieving maximum quality of life for older adults and their families becomes paramount. To do this, one needs:
  - Adequate number of primary health care providers educated in geriatrics and gerontology,
  - Removing financial barriers to accessing health care and medications, and
  - Changing the cultural value system that emphasizes disease treatment over providing emotional, educational, and support resources.<sup>89</sup>

- With increased focus on prevention and management of multiple chronic conditions, a coordinated, multidisciplinary approach to care management becomes the key to maximizing health and reducing health care costs. Some call this the “geriatricizing” of health care.<sup>90</sup>
- We are all also much more keenly aware now that there are social determinants of health at play for all individuals and these become accentuated as people age. This means, that race/ethnicity, economic status, neighborhood, adequacy of housing, and access to transportation and social community, etc., all affect health and health status, and these factors must be considered and included in developing individualized care plans and supports.
- 20% of adults 55 years and older experience depression and/or anxiety disorders. According to one national expert, in 2030, about 18 million elderly persons will have one or more mental illnesses, compared to 10 million elderly persons today. Similarly, about 5.3 million elderly persons will have a substance use condition, compared with 3 million elderly persons today. For each group, the growth in prevalence of these conditions among the elderly will exceed the total number of persons being treated in the public sector for these conditions across all age groups today.<sup>91</sup>
- As people age, their unofficial caregiver networks decline. Nuclear and extended family age and may move; informal networks of friends age and become less available as well.<sup>92</sup> Those caregivers who are available to support their loved ones need substantial education, support, and occasional respite to be effective.
- End-of-life palliative care needs to be acknowledged and consistent with each individual’s needs and goals.

## ii. Known Local Resources

The Berkeley Older Adult Resource Guide lists too many sources for health care to report here.<sup>93</sup> In summary, they list Alta Bates/Summit Medical Centers, Berkeley Community Health Project, Lifelong Health Centers, Berkeley Health Center for Men and Women, Center for Elders’ Independence, Rumford Medical Center, Suitcase Clinic, and UCB Eye Center located specifically in Berkeley, with dozens more hospitals and clinics within about 10 miles. It is important to note that Kaiser Health Plan serves many Berkeley older adults but is technically located in Oakland. There are also numerous holistic and naturopathic providers in the community.

## I. Technology

### i. Background and Data

We are in an age where technology has already revolutionized our lives, and the limits to this growth are nowhere in sight. This is especially true in the area of technology in aging. It is referred to by some as “Gerontechnology,”<sup>94</sup> or “Connected Aging.”<sup>95</sup> In 2014, one researcher reported the aging technology industry was currently a \$2 billion industry, and would rise to \$30 billion by 2020.<sup>96</sup> This goes far beyond the use of cell phones and smart phones.

These emerging technologies have great potential to reduce the cost of medical care, help older adults age in place in their homes and their communities, and improve wellness and quality of life for older adults.

The Center for Technology and Aging<sup>97</sup> provides an overview of the Connected Aging landscape (beyond innovations in the medical environment) by domain:

- **Body** – Products that support monitoring and management of physiological status and mental health for maintaining wellness and managing chronic conditions. Examples range from on-line linkage of heart or glucose monitors, to activity, sleep and mood monitors, to medication reminders.
- **Home Environment** – Products that support monitoring and maintaining the functional status of older adults in home environments. Examples include: In-home well-being check-in systems, fall detectors, passive monitoring sensors, video monitoring, and notification to caregivers if normal routines are interrupted.
- **Community** – Technologies that enable older adults to stay socially connected to their families, friends, and local communities. Examples include: Basic internet and email, video conferencing for on-line support groups, social networking and classes, self-journaling sites, recreational games and games for mental stimulation, and disease-specific support lines, on-line hobby, volunteering and charity connections.
- **Caregiving** – Technologies and products that support both informal and formal caregivers in providing timely and effective care and support to older adults and persons with disabilities in their homes. Examples include formal caregiving platforms, electronic medical records, platforms that provide linkages to not medical elder care, informal caregiver supports and linkages.

Areas to watch for rapid growth (outside of the clinical setting) include: Smart medication management, wearable body sensors, remote monitoring of vital health signs; remote laboratory diagnostics, fall prevention monitors that track gait and posture, assistive technologies for hearing and vision, robots, autonomous vehicles, big data and artificial intelligence, social and health mobile apps, and networking platforms, voice activated artificial intelligence e.g.: Amazon Echo), and age-friendly transportation applications.

**Challenges:** There are challenges to the adoption of these technologies.

- **Who will convince and support older adults to use the emerging technologies?** The marketplace for these various technologies can be highly confusing and older adults and their caregivers will need help understanding the various technological solutions, how they will help address their unique needs, how to pick between competing products, how to get started, and how to troubleshoot when something goes wrong.<sup>98</sup>

Lindeman and Menack suggest that it is care managers who will need to become knowledgeable about which non-directly medical technologies are available and proposing their use to older adults; as well as training and supporting them to use them.

- **Who will pay?** The Center for Technology and Aging predicts that the costs of technology will continue to drop – but does not address who will pay for those technologies that are not

medically/clinically indicated and therefore paid for by health insurers. A brief internet search provides little insight into this issue.

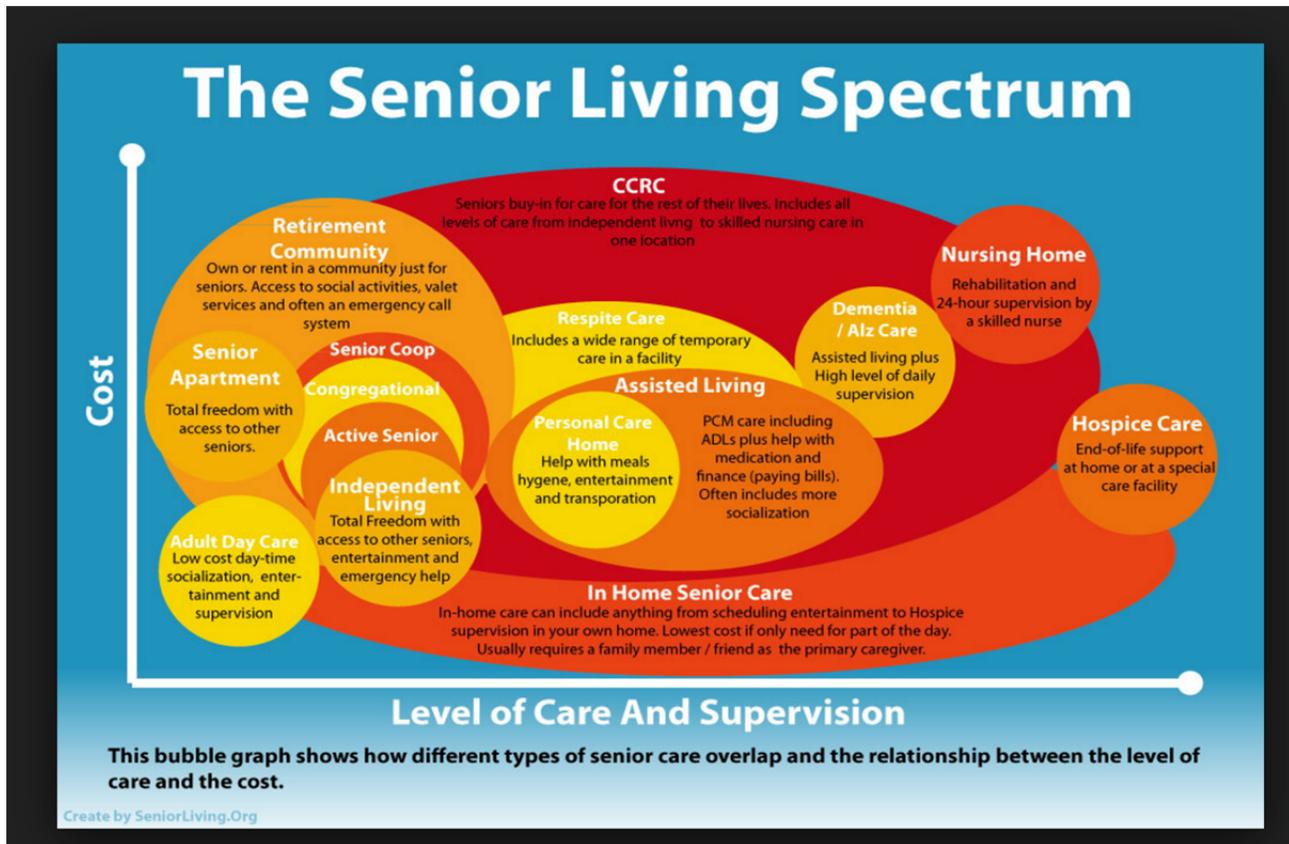
## ii. Known Local Resources

Emerging technologies don't tend to be "place-based" and therefore, inventory of resources in Berkeley is not particularly relevant here. However, it is important to note that the Center for Technology and Aging, is a part of the Center for Information Technology Research in the Interest of Society (CITRIS), which itself is a research center in the University of California system. It is designed specifically to encourage and enhance the development of new technologies in aging. And that Center is located right in Berkeley. The opportunity for close communication, collaboration and potential for The City of Berkeley to serve as an incubator for new technologies must not be overlooked.

## J. The Housing/Care Continuum Beyond Independent Living

### i. Background and Data

*Note on Organization of this Topic:* The spectrum of living options for older adults is complex and topics are overlapping. In order to write about them, we have addressed some of them separately. Purely independent living, in the community, with housing that is on the open market or subsidized, has been identified as **Independent Community Living** and is addressed earlier in this report in Section A. Independent living is also available in places where, if a person progresses to needing a higher level of support, additional supports are available in place or on-campus, possibly throughout the rest of that person's life. That sort of independent living – linked independent living – is addressed here – as part of the continuum of "senior living care."<sup>99</sup> In the same manner, we have addressed **In-Home Supports** separately above in Section B. These supports can also be provided in community-based or linked living.



As the picture above shows, there are too many types of older adult living settings to discuss each in detail. Selected elements are explored here. For most individuals, the degree of care needed and financial resources are the overriding factors that affect living choices. Choices at the lower end of the financial spectrum have typically been less desirable. Today, older adults at all levels of care and all financial status are demanding comfort, autonomy, and the opportunity to live in the least restrictive manner possible.

As a greater number of older adults need support of some kind, the cost of this assistance to the government – through Medicare and MediCal and to private insurers is skyrocketing, and there is a lot of effort being made to find more cost effective alternatives. Fortunately, many of these cost saving alternatives not only reduce institutional care and improve health, but address the wishes of older adults as well.

A key example of this cost shift is the decline of the traditional nursing home model.<sup>100</sup> In communities without multi-level CCRCs, nursing homes (also known as skilled nursing facilities) used to be almost synonymous with the concept of senior housing.<sup>101</sup> With skilled nursing care available around the clock, they are also among the most expensive options. Although stand-alone long-term skilled nursing facilities will always be needed for some people, the trend is moving rapidly toward their use for short-term rehabilitation after a hospital stay or injury, with an emphasis of returning those individuals to lower levels of care (back to home, or to an assisted setting) as soon as possible. Providers are now demonstrating that custom, intensive, in-home supports can sustain individuals in assisted settings and

in the community much longer than ever before – preventing the need for nursing home admission for many altogether. Increased technological options related to care also support this shift.

The rising need for memory care cuts across all levels of linked living for all ages – depending on the severity of need. A recent survey of senior living providers showed an explosion of new memory support programs. Almost 70% of 200 respondents to the survey reported that they are creating new assisted living programs for memory care, but almost one-quarter are addressing it continuum-wide.<sup>102</sup>

**1. Community-Based Care:** There is now accelerated movement toward providing more intensive services in the community settings that help individuals get their needs met during the day and return to their homes at night. The primary options are:

- **Senior Centers** – While not specifically offering “medical care,” senior centers do provide a range of programs and services including: meal and nutrition programs; information and assistance; health, fitness, and wellness programs; transportation services; public benefits counseling; employment assistance; volunteer and civic engagement opportunities; social and recreational activities; educational and arts programs; and intergenerational programs.

The National Council on Aging further reports that older adults who participate in senior center programs can learn to manage and delay the onset of chronic disease and experience measurable improvements in their physical, social, spiritual, emotional, mental, and economic well-being. Today’s senior centers are reinventing themselves to meet the needs and desires of the aging baby boom generation.<sup>103</sup> One innovation today is the notion of “senior centers without walls.”<sup>104</sup>

- **Senior Centers Without Walls (SSWW)** – While not actually functioning as senior centers, SSWWs are operated by a few organizations nationwide to provide some supports, by phone and by computer, to those who cannot attend senior centers.

- **Adult Day Care Centers** – Adult day care is a program that offers on-site activities that promote well-being through social and health-related services during daytime hours, in a safe, supportive, cheerful environment with nutritious meals. Their purpose is to provide older adults the opportunity get out of their houses and receive both mental and social stimulation more intensively than in senior centers. A critically important additional factor is that the regularity of hours in adult day care centers give caregivers a much needed break and assured supervision of their loved one, so that the caregiver may work, take care of family business, or get some rest. There are currently over 4,600 adult day care centers in the country, which are regulated at the state level.<sup>105</sup>

- **Adult Day Health Centers** – The activities in adult day health centers (ADHCs) provide mental, social, and physical stimulation for adults who have lost a degree of their independence because of physical or cognitive impairments or chronic health conditions. In contrast to adult day care, ADHCs serve those individuals who need skilled nursing and rehabilitative therapy services in addition to personal care services. Adult day health care services are appropriate for adults with medical or disabling conditions that require the intervention or services of a registered nurse (RN) or licensed rehabilitative therapist acting under the supervision of the client’s physician.

Because of the high degree of collaboration necessary to care for higher need older adults in the community, many ADHCs also provide caregiver supports and evening programming.<sup>106</sup>

In 2012, there were more than 3,500 adult day health centers in the U.S. serving 150,000 older adults. Nearly 78% of these centers were not-for-profit or public, and 74% were affiliated with larger organizations such as home care, skilled nursing facilities, medical clinics, medical centers, or multi-purpose senior organizations. The average age of the consumer was 72. Average cost of care per day at the time was \$56.<sup>107</sup> Adult day health centers are also licensed by each state.

- **Programs for All-Inclusive Care** – There have been multiple demonstrations of all-inclusive models of care that were developed to help older adults remain living in the community. Some have shown great promise, and some have graduated to ongoing funding status. Locally, PACE (Program of All-Inclusive Care for the Elderly) is an ongoing joint Medicare program and Medicaid state-funded, capitated option that supports community-based, interdisciplinary team care and services to people age 55 or older who otherwise would need a nursing home level of care. On-Lok in San Francisco was one of the original pilot sites. Viewed as a cost-saving innovation, PACE was created as a way to provide older adults, their families, and their health care providers flexibility to meet a person’s health care needs while he/she continues to live in the community. PACE programs are authorized to provide full, coordinated care from transportation, meals, and socialization, to social work care and nutritional counseling, to doctor care, prescription drugs, hospital visits, and even nursing home stays when necessary.<sup>108</sup>

This multi-disciplinary and capitated approach to addressing nursing home-level needs has freed providers up to use health care dollars “up-stream” and in more holistic and cost effective ways to maximize the health and well-being of older adults. It is also an example of breaking down traditional “silos” between care funding streams and applying them more flexibly to meet individual needs and reduce the cost of care at the same time.<sup>109</sup>

According to a very recent article in the New York Times, until recently, only nonprofits were allowed to run PACE programs – with a total of just 40,000 older adults enrolled nationwide at the end of 2015. But a year ago, the government flipped the switch, opening the program to for-profit companies as well, ending one of the last remaining holdouts to commercialism in health care. The hope is that the profit motive will expand the services faster. Hanging over all the promise, though, is the question of whether for-profit companies are well-suited to this line of work.<sup>110</sup>

**2. Assisted Living:** Residential Care Facilities for the Elderly (RCFEs) — also called “Assisted Living” (e.g., 16+ beds) or “Board and Care” (e.g., 4 to 6 beds) — are non-medical facilities that provide room, meals, housekeeping, supervision, storage and distribution of medication, and personal care assistance with basic activities like hygiene, dressing, eating, bathing, and transferring. Residential Care Facilities for the Elderly (RCFEs) serve persons 60 years of age and older. This level of care and supervision is for people who are unable to live by themselves but who do not need 24-hour nursing care. They are considered non-medical facilities and are not required to have nurses, certified nursing assistants or doctors on staff.<sup>111</sup>

Some residents in assisted living have memory disorders including Alzheimer's, or they may need help with mobility, incontinence or other challenges. In California, These facilities are licensed by the Department of Social Services (DSS) Community Care Licensing Division (CCL). According to the DSS, Department of Social Services (DSS)<sup>1</sup>, California currently has 7,545 licensed Residential Care Facilities for the Elderly (RCFEs) that can provide a home and care for more than 179,000 residents. Based on

projections by the California Department of Finance, that accounts for about one-fourth of the state's 85-plus population.<sup>112</sup> Demand is growing steadily as the population ages.<sup>1</sup>

The national median monthly rate for a one-bedroom unit in an assisted living facility was \$3,500, according to a 2014 Cost of Care Survey. The primary ways that older adults pay for assisted living are out-of-pocket (savings, retirement, reverse mortgages or after the sale of a home) or in part with long-term care insurance. That said, the typical assisted living resident has an income of about \$19,000 per year. Low-income individuals without assets (who may have spent down their assets) may qualify for some subsidy for assisted living from Medicaid (MediCal Assisted Living Waiver).<sup>113</sup>

**3. Skilled Nursing Facilities (SNFs):** Nursing homes are discussed in some detail earlier in this section. They are the most expensive level of care available, and there is great pressure to reduce their use. In fact, Medicare spent more than \$32 billion on SNFs in fiscal year 2012 alone.<sup>114</sup> The desire to reduce cost, combined with older adults' overriding preference to be anywhere but a nursing home, has led to an increased focus on acute rehabilitative visits with more rapid return to home or assisted living. There continues to be great concern about the quality of care in long-term nursing facilities with regulatory and watchdog organizations challenged to hold for-profit owners accountable for care issues and fiscal management across rapidly changing corporate entities. A preference for not-for-profit skilled nursing facilities was expressed by leaders interviewed for this needs assessment.

**4. Continuing Care Retirement Communities (CCRCs):** CCRCs, also called Life Plan Communities, include all levels of care rolled into one. To be defined as a CCRC, a community must offer independent living and assisted living on one campus, with ties to a skilled nursing facility – commonly on that same campus. Older adults move into a CCRC when they are generally healthy. Although settings vary, most have a common dining room, activity centers, gyms, outdoor recreation areas, and swimming pools. Social events happen on campus, and often there are outings to events, such as a night at the symphony.<sup>115</sup>

CCRCs are typically expensive to buy into, and low and middle income individuals historically are unable to afford this option. While plans differ, there is usually a substantial entrance fee – from as little as \$100,000 (elsewhere in the country) to nearly \$1 million in California. There are also monthly costs that may range from \$2,500 to \$7,500. While these buy-in costs normally mirror the local housing market, this doesn't buy the unit that the older adult is living in but rather, guarantees them a place to live and appropriate care for the rest of their life – including hospice care. Using an array of different formulas, CCRC contracts often allow for some refund of the buy-in payment to the individual's heirs.

CCRCs typically have a strong emphasis on health, wellness, and social activities and provide meals on-site as well as transportation to off-site shopping and recreational activities. CCRCs may be for-profit or nonprofit. While demand has risen, the higher cost continues to limit their market.

With the high cost of CCRC's out of reach for many, there is pressure for new alternatives to make CCRC-type services available and affordable to more older adults. Berkeley residents also voiced the desire for more CCRC capacity directly in Berkeley – allowing individuals to remain their families and community.

- **New models for contracts:** Based on demand, CCRCs are developing alternatives to large “buy-ins” for care. In a 2012 article from *Leading Age*, there were (at least) three prevalent models for contracts and a rental approach that attempt to address this. They include:
  - **Traditional Life Care Contract** – with a (usually) non-refundable entrance fee and a non-inflating monthly fee for life.
  - **Modified Life Care Contract** – with an entrance fee that is lower and more likely to be at least partially refundable. This includes a limited period of free or reduced cost care if a person moves to a higher level of care (e.g., 90 days in skilled nursing) but shifts to market rate charges after that initial period.
  - **Fee for Service Contract** – with a refundable entrance fee that covers a set amount of services as long as the person is in an independent living apartment, but if he/she needs more services or needs to move to a higher level of care, he/she must pay market rate.
  - **Rental** – This option has no true entrance fee. Each level of care is separate with no right to access the other levels of care on campus.<sup>116</sup>
- **CCRCs Without Walls (CCRC-WW):** “CCRCs without Walls” emerged 15-20 years ago in other parts of the country but by law, is not allowed in California. A CCRC-WW brings the concept of the life care contract and a bundle of needed services into the home. A CCRC-WW contract is all-inclusive, with a comprehensive approach to providing the health and wellness lifestyle to seniors in their homes. It is a package - not just services which can be purchased on as needed basis. A CCRC-WW is designed to attract seniors who either don’t want to move or can’t move because they don’t have the financial resources to do so. With much lower entrance fees and monthly fees, more people many can afford a CCRC-WW contract. Nationally, there is a large market for these services.<sup>117</sup> Again, however, they are not allowed in California.

It is critical to distinguish CCRC-WWs from CCRCs that provide some home and community based services in the community as part of their mission. There are a few CCRCs (such as Episcopal Senior Services) that have programs that provide a subset of services to seniors in their homes, possibly home health care, personal care, or chore services. Others provide or participate in services in the community – such as conveniently located farmers’ markets or health fairs.

**5. Convergence of Health Care and Housing:** An anticipated new trend is the “convergence” of housing and health care services. This evolves from the increasing understanding of social determinants of health, and the recognition that housing places a very large role in this. Combined with mobility and transportation challenges that older adults face, the two industries are already moving toward alliances in several places in the country. Some states are offering Medicaid waivers that allow housing supports to the low income. In a survey of 200 senior living providers and consultants in 2015, 80% reported a strong belief that reimbursement/healthcare reform would drive convergence of health care and senior living. However, while 50% thought they would be partnering in the future, just 10% had a health care partner at that time.<sup>118</sup>

From the perspective of promoting healthy aging and reducing medical care costs in the older adult population, there have been calls for demonstration projects that would allow Medicare funds to pay for congregate housing and providing medical care in that setting.<sup>119</sup> Another approach is to build

medical office buildings that are contiguous to senior housing.<sup>120</sup> Still others are promoting a return to a home visitation model for medical care.<sup>121</sup>

**6. Long-Term Care (LTC) Insurance:** While medical insurance may pay for short-term, rehabilitative supports in-home or in a SNF, for many older adults, payment for long-term in-home supports, assisted or skilled nursing facilities comes out-of-pocket. Health savings accounts and reverse mortgages can be used. This seriously limits who can afford such supports and reduces their availability for those who need them. There are two issues related to this that are worth noting:

Long-Term Care Insurance is another option for older adults who do not qualify for MediCal, but only about 8 million Americans were covered in 2014.<sup>122</sup> While policies vary, they generally cover some portion of home-based supports, assisted living facilities, memory-care special facilities, and nursing homes. This low uptake on LTC insurance is indicative of its lack of relevance to most older adults. Significant issues include:

- LTC insurance needs to be purchased when a person is healthy – people who have certain pre-existing conditions such as Alzheimer’s, strokes and cancer can be denied. Because of this, there is a need to engage older adults to consider long-term care insurance before they feel ready to think about it. And yet, the earlier it is purchased, the more years it is paid for before it is needed (if ever).
- Coverages are limited. It appears that most policies limit residential care to 90 days.
- It is expensive and, because the price of LTC insurance varies greatly by geographic region, by insurance company, and by age of applicants, it is difficult to get estimates of cost. One 2012 report estimated the median cost for a healthy 55-year old to be about \$2,000 per year for an individual and \$2,500 per year for a couple, with cost rising to \$3,400 per year for a 60-year-old.<sup>123</sup> At this price, residential care would be covered for just 90 days at \$150 per day, which is well below what most facilities cost. If this policy were held from 65 until age 80 before it was needed, an individual would already have spent \$68,000 on premiums (not counting inflation in premiums).

The California Partnership for Long Term Care is a consumer education program set up by the State of California to educate consumers and offer support to consider costs and options.<sup>124</sup> According to them, on the open market, a lifetime plan, covering up to \$200 per day for 90 days (plus other types of care as well) is estimated to cost a 65 year-old \$8,000 a year!

Even the LTC insurance industry itself acknowledges that the current structure of policies is not attractive to consumers and needs to change. In one current insurance industry paper, potential variations and innovations are analyzed. This includes putting LTC benefits into Medicare Supplement Plans or linking them to 401(k) plans. The paper also cites additional research into innovations by such interested organizations as the Scan Foundation and Leading Age. Nevertheless, no affordable approaches with meaningful coverage have been identified yet.<sup>125</sup>

## ii. Known Local Resources

The Berkeley Older Adult Resource Guide and several websites provide information on SNFs, assisted living and CCRCs in the Bay Area. Few of these resources are actually in Berkeley. Using the Berkeley Resource Guide and two on-line search sites (A Place for Mom and SeniorHomes.com), we can see:

- **Assisted Living and Memory-Care:** The Berkeley Older Adult Resource Guide reports one assisted living community in Berkeley: The Silverado (formerly The Berkshire) – with an emphasis on

memory care. An online search sites show 50 assisted living facilities within 15 miles of Oakland, with none in Berkeley. A list of memory care providers has the same number and seems nearly identical. An on-line list of 50 board and care homes in the East Bay is provided but again, there are none in Berkeley. The California Department of Health Care Licensing shows three licensed Board and Care homes in Berkeley but it is not known if they are operating.

- **CCRCs:** Caring.com shows numerous CCRCs in the greater Bay Area with 5 in Oakland and Alameda and none listed for Berkeley. We do know that there is one CCRC currently being built on University of California property on San Pablo in Berkeley, due to open in 2017.<sup>126</sup>
- **SNFs:** 50 SNFs in a 21-mile radius are shown on open internet search sites and/but we see just 3 located in Berkeley. Interestingly, a fourth SNF, the nonprofit Chaparral House, a 49-bed SNF with national recognition,<sup>127</sup> is not listed on this commercial referral site. Chaparral House is the only non-profit SNF in Berkeley. Nonprofit SNFs are often favored by consumers because of greater stability of ownership and therefore greater accountability for quality of care.

#### L. Other

This Needs Assessment was developed to support early decision-making about priorities for development of a Berkeley Age Friendly Continuum. The topic areas that can be researched are almost limitless and there are a number of topics that could have been presented in more depth here, or in stand-alone chapters rather than being embedded into other topic areas. These include (but are not limited to):

- **Disability Services** – Supports provided by Center for Independent Living for disabled older adults, as a part of their broader support to those with disabilities, are identified throughout this report. However, there has not yet been a “deep dive” into what the broader disability community, and network of funders for those with disabilities provide to the aging continuum.
- **Faith Communities** – Churches and other faith-based groups have been traditional supporters of members who are frail, sick, or need food and supports. Many churches provide robust support to their older members and this has not been reported on here. A few non-profits that are affiliated with faith communities have been mentioned.
- **Ethnic-Specific Communities and Support Systems** – As with faith communities, both social groups and organizations that serve ethnic-specific populations often provide a robust range of support to their older and disabled members who need it. This can be especially important when addressing groups of individuals who typical face more disparities in health than others. More information on local resources could be provided.
- **Built Environment** – There is much emphasis on the age friendliness of the “built environment” in the World Health/AARP Age Friendly model. While this report looks at the availability of housing and touches on the location of housing, walkability, and safety of community, more background on this topic could be provided.
- **End-of-Life Planning and Care** – Again, end-of-life planning and care is touched on in various sections of this report but is not addressed directly. Within the past year, three community

gatherings were held in Berkeley focused on end of life issues. Well over 400 individuals attended these gatherings – suggesting a hunger for these difficult conversations.

- **Caregiver Supports** – The need for caregivers – both informal and formal – will only rise. These caregivers must take care of themselves in terms of the physical and emotional demands of their role. Informal and family caregivers face additional burdens in terms of managing their own lives and running families while they care for loved ones, managing the additional emotional stress related to caring for a loved one, and navigating the necessary systems to understand and access available resources. Much more analysis of needs and resources in this area could be conducted.
- **Lifelong Learning** – We have a major university right in Berkeley as well as the Osher Lifelong Learning Institute. Along with other resources, the learning potential for older adults at all stages is vast. Combined with on-line potential – it is almost unlimited. While acknowledged in the Section on social connectedness, there may be interest in outlining the issue further.
- **Employment** – Many older adults, especially those at the younger end of the spectrum, want very badly to keep working full or part-time. However, there are many barriers to finding work at their age.
- **Upcoming Generations** – The data and analysis presented here places primary emphasis on Baby Boomers. However, Generation Xers and Millennials are not far behind. Given the length of time to develop housing and services, a strong analysis of how these upcoming generations differ from the Baby Boomers, and how their needs and wants will differ, is necessary.

## Endnotes:

- <sup>1</sup> Managed in this Country by AARP – <http://www.aarp.org/livable-communities/network-age-friendly-communities/>.
- <sup>2</sup> Alameda County Plan for Older Adults 2016-2017.  
[http://www.alamedasocialservices.org/public/services/elders\\_and\\_disabled\\_adults/docs/planning\\_committee/Alameda\\_County\\_Area\\_Plan\\_Final.pdf](http://www.alamedasocialservices.org/public/services/elders_and_disabled_adults/docs/planning_committee/Alameda_County_Area_Plan_Final.pdf)
- <sup>3</sup> Alta Bates Summit Medical Center Community Health Needs Assessment 2016. Note: zip codes approximate (p. 83).  
<http://www.altabatesummit.org/CHNA/absmc-2016-chna.pdf>
- <sup>4</sup> Note: 94720 is the zip code for UC Berkeley.
- <sup>5</sup> [http://www.behavioral.net/blogs/ron-manderscheid/policy/preparing-dramatic-growth-elderly-population#.V\\_U3Dpt5Kuc.email](http://www.behavioral.net/blogs/ron-manderscheid/policy/preparing-dramatic-growth-elderly-population#.V_U3Dpt5Kuc.email)
- <sup>6</sup> California Department of Finance. <http://www.dof.ca.gov/Forecasting/Demographics/projections/>
- <sup>7</sup> Ibid.
- <sup>8</sup> Alameda County CAPE unit with 2014 1-year Community Survey PUMS data as presented in AC Older Adult Plan, p.15.
- <sup>9</sup> Kushel, MD, Margot. “Growing Older, Getting Poor.” *New American Media*, April, 2015, as presented in Alameda County Area Plan, p. 17.
- <sup>10</sup> American Community Survey 2010-2014, US Census Bureau.
- <sup>11</sup> ASHPD Patient Discharge Data as presented in the Alameda County Plan, Appendix C-40.
- <sup>12</sup> OSHPD data 2012-2014 as shown in Alameda County Plan, appendix C-47.
- <sup>13</sup> Wallace, PhD., Steven. More than Half a Million Older Californians Fell Repeatedly in the Past Year. *UCLA Center for Health Policy Research, Health Policy Brief*. November, 2014.
- <sup>14</sup> OSHPD data 2012-2014 as shown in Alameda County Plan, Appendix C-43.
- <sup>15</sup> American Community Survey 2010-2014 as shown in Alameda County Plan appendix C-45.
- <sup>16</sup> <http://www.aarp.org/livable-communities/network-age-friendly-communities/info-2015/8-domains-of-livability-resources.html>
- <sup>17</sup> United States of Aging Survey 2015 Results. <https://www.ncoa.org/news/resources-for-reporters/usoa-survey/2015-results/>
- <sup>18</sup> [https://www.aging.ca.gov/docs/About\\_CDA/California\\_State\\_Plan.pdf](https://www.aging.ca.gov/docs/About_CDA/California_State_Plan.pdf)
- <sup>19</sup> [https://www.cityofberkeley.info/uploadedFiles/Health\\_Human\\_Services/Commissions/Commission\\_for\\_Aging/01-21-15%20-%20FullPacket\(1\).pdf](https://www.cityofberkeley.info/uploadedFiles/Health_Human_Services/Commissions/Commission_for_Aging/01-21-15%20-%20FullPacket(1).pdf)
- <sup>20</sup> 2013 Federal Reserve 2013 Survey of Consumer Finances, Monique Morrissey, Economic Policy Institute.  
<http://www.federalreserve.gov/econresdata/scf/scfindex.htm>
- <sup>21</sup> AARP quoted here: <http://reversmortgagedaily.com/2011/12/21/aarp-survey-finds-90-of-people-65-want-to-stay-in-their-homes/>
- <sup>22</sup> [gerontologist.oxfordjournals.org/content/56/3/599.extract](http://gerontologist.oxfordjournals.org/content/56/3/599.extract)
- <sup>23</sup> [http://www.jchs.harvard.edu/sites/jchs.harvard.edu/files/jchs-housing\\_americas\\_older\\_adults\\_2014.pdf](http://www.jchs.harvard.edu/sites/jchs.harvard.edu/files/jchs-housing_americas_older_adults_2014.pdf)
- <sup>24</sup> Alameda Older Adult Plan p.16.
- <sup>25</sup> Kushel, MD, Margot. “Growing Older, Getting Poor.” *New American Media*, April 2015. As presented in Alameda County Older Adult Plan, p. 17.
- <sup>26</sup> [http://www.ci.berkeley.ca.us/uploadedFiles/Planning\\_and\\_Development/Level\\_3\\_-\\_Commissions/Commission\\_for\\_Planning/2015-2023%20Berkeley%20Housing%20Element\\_FINAL.pdf](http://www.ci.berkeley.ca.us/uploadedFiles/Planning_and_Development/Level_3_-_Commissions/Commission_for_Planning/2015-2023%20Berkeley%20Housing%20Element_FINAL.pdf)
- <sup>27</sup> Comments from interview with Dan Sawislak, RCD CEO, and Steve Oliver of Oliver & Company.
- <sup>28</sup> [http://www.alamedasocialservices.org/public/services/elders\\_and\\_disabled\\_adults/docs/planning\\_committee/5.2016\\_County\\_Area\\_Plan.pdf](http://www.alamedasocialservices.org/public/services/elders_and_disabled_adults/docs/planning_committee/5.2016_County_Area_Plan.pdf)
- <sup>29</sup> [http://www.ci.berkeley.ca.us/uploadedFiles/Planning\\_and\\_Development/Level\\_3\\_-\\_Commissions/Commission\\_for\\_Planning/2015-2023%20Berkeley%20Housing%20Element\\_FINAL.pdf](http://www.ci.berkeley.ca.us/uploadedFiles/Planning_and_Development/Level_3_-_Commissions/Commission_for_Planning/2015-2023%20Berkeley%20Housing%20Element_FINAL.pdf) p.44
- <sup>30</sup> Ibid p. 80-86.
- <sup>31</sup> [http://www.ci.berkeley.ca.us/uploadedFiles/Planning\\_and\\_Development/Level\\_3\\_-\\_Commissions/Commission\\_for\\_Planning/2015-2023%20Berkeley%20Housing%20Element\\_FINAL.pdf](http://www.ci.berkeley.ca.us/uploadedFiles/Planning_and_Development/Level_3_-_Commissions/Commission_for_Planning/2015-2023%20Berkeley%20Housing%20Element_FINAL.pdf) p 121
- <sup>32</sup> Alameda County Older Adult Plan, 2016-2017, Appendix B, p. 38.
- <sup>33</sup> [https://self-sufficiency.org/wp-content/uploads/2014/12/senior\\_housing\\_guide\\_2013\\_english.pdf](https://self-sufficiency.org/wp-content/uploads/2014/12/senior_housing_guide_2013_english.pdf)
- <sup>34</sup> [http://www.nytimes.com/2000/07/16/nyregion/home-health-care-aides-are-in-demand-but-in-short-supply.html?\\_r=0](http://www.nytimes.com/2000/07/16/nyregion/home-health-care-aides-are-in-demand-but-in-short-supply.html?_r=0)
- <sup>35</sup> <http://newoldage.blogs.nytimes.com/2014/02/26/a-shortage-of-caregivers/>
- <sup>36</sup> <https://www.medicare.gov/coverage/home-health-services.html>
- <sup>37</sup> <http://www.carepathways.com/HC-types-of-caregivers.cfm>

- <sup>38</sup> [http://www.va.gov/GERIATRICS/Guide/LongTermCare/Skilled\\_Home\\_Health\\_Care.asp](http://www.va.gov/GERIATRICS/Guide/LongTermCare/Skilled_Home_Health_Care.asp)
- <sup>39</sup> <https://docs.google.com/spreadsheets/d/1G0WKKKIXFgznUcJgLS4ggMt3Ea9q55cBsYJhS1o8FmQ/edit#gid=0>
- <sup>40</sup> <http://www.wikihow.com/Become-an-Elder-Care-Consultant>
- <sup>41</sup> <http://kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/>
- <sup>42</sup> <http://kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/>
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