Practical Ideas for Advancing Age-Friendly Change in Alameda County – **Outputs from November 1 2019 Discussion Cafés**

ADVANCING AGE-FRIENDLY COMMUNITY IN UNINCORPORATED AREAS

- **Advance a BOS Resolution** directing all County agencies to utilize an older adults analysis in their annual budgeting, program design and implementation, and routine reporting (at least annually). The directive and results could be tied to Human Impact Budget.
    - Data to be reviewed by Age-Friendly Council on a regular basis to inform its work.
- **Create a place-based initiative in the unincorporated** areas modeled on the First Five effort. For older adults, identify one measure - eg. a survey of well-being, fall prevention, do elders feel like they have some power over things in their life? (AAA Survey.)
    - Possibilities:
        - Hayward Acres = 1 square mile, few resources
        - Sunol
        - Cherryland (>50% immigrants)
        - Ashland
    - Critera to select includes:
        - existing infrastructure of NGOs, agencies, faith orgs that maybe aren't working together yet with this population.
        - Broad political support
        - Philanthropic support available
    - Try to address as many domains as possible:
        - Existence of programs that could be built upon/expanded (e.g. a housing initiative – like tied to a specific project funded by Measure A1)
        - Senior Center without walls in Cherryland
        - Existence of an established community – goal is to strengthen and preserve social networks and supports, not create from scratch.
    - Able to generate learnings - policy or program findings that can be applied in other parts of the country
    - For example: a Senior Housing project in the unincorporated - it's the anchor to address food, security, transportation, social connections etc.
- **Partners**
    - Tiburcio Vasquez Health Center, local Meals on Wheels provider, Alameda County Community Food Bank, United Seniors, Eden Church or other faith, AC Agencies, Hayward Area Recreational District.
    - Public Works - sidewalks, lighting, benches
    - CDA – housing development, code enforcement, Healthy Homes, loan fund, 1A
    - EMS, clinics

    - Public Health Department - bring SDH place-based equity lens to this place-based initiative, take on the ageism piece.
    - Library System - another potential hub
- **Oversight**
    - Municipal Advisory Committee(s)
    - Unincorporated Services Committee of the BOS
    - Council for Age-Friendly Communities
- **Location of Planning Effort** - board office?

ADVANCING AGE-FRIENDLY HEALTH & MEDICAL SERVICES (Group 1)

- *Describe in just a few words what it is about health and medical care that sometimes conflicts with an age-friendly experience?*
    - Fragmentation of system
    - "Too many specialists"
    - Transportation!!
    - Disabilities prevent people from getting to appointments
    - Disparities between clients' access to resources
    - Doctors don't have enough time with clients. Or with helping partners
    - People are over medicated
    - Over-reliance on family and caregivers to be adjunct healthcare providers
    - Family centers not prepared for hospice discussion
    - Lack of geriatricians
        - MD ability to connect to services
        - Navigation
    - Focus on medical vs. wellness
    - Need for alternative methods
        - "Food as medicine"
        - Make this prescriptive
    - Integrated behavioral health more of an ideal vs. in practice
    - Center prioritize medical over mental health
    - Concern re: duplication and reimbursement for more than 1 service per day.
    - Integration of services with caregivers as well as the center in mind
    - Accessibility - transportation and mobility, all aspects of ability and disability
    - Cultural Sensitivity - not a "one size fits all" approach
    - Lack of geriatric training
        - MD's
        - MSWs

        - All providers
    - Low interest in serving the population
- *Imagine health care delivered in an age-friendly setting, using age-friendly practices, with results that support community living and improved health outcomes. What might that look like?*
    - Responsive
    - PACE-like programs "one stop shopping"
    - Continuous relations vs episodic
    - Less stigmatize
    - Expand eligibility
    - Need more flexibility on eligibility and choice of providers
    - Language
    - Workforce Training
    - Training for all providers eg. receptionists talking slow/enunciating
    - Follow-up providers "give up"
    - ER - training and physical environment
    - More availability of home repair/modification programs
    - Early planning for the desired "aging in place"
    - Address internalized ageism - normalize and talk about aging
- *Envision one or more practical, specific changes in policy or practice could make a difference. What would it look like? Would it address one or more of the domains of livability? Who would need to be a partner?*
    - Routine evaluation of age-friendliness of sites serving older adults
        - Intentional
        - Build into site certification progress and state of Ca
    - Workforce training expectations
        - Build into licensing process and CEUs
        - Incentives for employees who obtain certificate in geriatrics
        - Expecting competencies
    - Target adults schools to recruit
    - Helpers who look like "me" (peer navigators)
    - Flexibility re: reimbursement to providers for age-related planning
        - Write prescriptions for alt. Strategies
            - Farmer's markets
            - Music therapy
            - ipods
- *What are the next steps to make the policy/practice change(s) a reality?*

        - Establish
            - Competency expectations
            - Monitoring expectations
        - Highlight providers/businesses that are age-friendly
            - By standardized expectations
        - Use social media
            - Yelp
            - Age-friendliness
        - Certified Age-Friendly Providers:
            - May attract practitioners with higher commitment and competency in serving aging community
            - If providers want to get $$ they must meet competency expectations
        - Working upstream to inspire people early to serve older adult population

ADVANCING AGE-FRIENDLY HEALTH & MEDICAL SERVICES (Group 2)

- *Describe in just a few words what it is about health and medical care that sometimes conflicts with an age-friendly experience?*
    - Ageism - preconceptions about who is has value in medical care
    - Fragmented Care - Mental Health - Coordinating care
    - Dementia
        - Make it a 9th domain of the County Age-Friendly plan
        - Barrier to receiving quality of care
        - Few facilities are available to practice this care
        - Medical care and mental health care are siloed, and this is especially problematic with ageism and dementia
    - HCBS - integral to medical care in social determinants of health
    - Under and over treatment
        - People with 20+ meds
        - Some elders getting over treated
        - Some elders getting under treated
        - No communication about care between the silos
    - Need to integrate palliative care with spiritual support, psychosocial
    - Lack of research
        - What facilitates care
        - Need research that addresses diversity
    - Need to address intersection homeless and medical
    - Train doctors

- *Imagine health care delivered in an age-friendly setting, using age-friendly practices, with results that support community living and improved health outcomes. What might that look like?*
    - Geriatric ED - Dedicated to elders
    - Social ED - transferred form medical ED and to social services center
    - Community health record (pulling up in real time wherever the person enters)
    - Comprehensive medical care where people live
        - PT/OT
        - X-rays
        - Blood draws
    - Redirecting resources to more preventative services (address falls etc)
    - Health and wellness centers interpreted - adult services support
    - Multi-generational mode
- *Envision one or more practical, specific changes in policy or practice could make a difference. What would it look like? Would it address one or more of the domains of livability? Who would need to be a partner?*
    - Big focus is care coordination with advocacy
    - Schedule/fund socialization activities
    - Develop curriculum for Age-Friendly concepts for health care providers and others.
    - Promote cultural humility education/training for providers.
    - Increase/expand CalFresh eligibility also for SSI.
- *What are the next steps to make the policy/practice change(s) a reality?*
    - Form exploratory committee to identify ways to use AAA funds more strategically/efficiently in the context of environmental assessments (whole-person care) and more care coordination
    - AAA – use funds more strategically to organize care coordination, environmental access and promote socialization.
    - Have teams of especially trained providers – IHSS providers – who can be part of the care team with the physician.
    - To add to political agenda for next round of SSC: Change means testing for IHSS
    - Study Homebridge model in SF to address the IHSS needs of complex care populations. Can it be developed here?

ADVANCING AGE-FRIENDLY EMPLOYMENT & EMPLOYERS

- Research availability of Title 5 Funds - senior community service employment program for partnering and best practices
- Host hiring events with support staff available to help with online application process

- Educate employers on benefits of hiring older adults
- Partner with chamber of commerce and rotary groups to help advance age friendly change in the workplace
- Host trainings for 55+ adults that focus on resume writing, interviewing, self-worth, self-esteem, and new skills needed
- Foster age-friendly work place, include ageism in diversity and inclusion trainings, committees etc.
- Employers can market being senior-friendly work place, 55+ encourage to apply

- **ADVANCING AGE-FRIENDLY COMMUNITIES VIA SENIOR CENTERS**
- Determine what is the senior center standard and develop an initiative to scale them to this standard.
- All senior centers should have core behavior health/mental health services/programs.
- Similarly, determine funding needs to meet this core standard (of services, access and accommodation) and allocate county and state funding to ensure each center is funded at the level needed. This is an equity issue. Community members' ability to pay must be part of the formula so that poor communities have the same quality and capacity.
- Establish a universal fee for use at any senior center – in each city (but ideally in the county). Should be able to go to any center like a library, without paying a separate center fee.
- Reconcile the age requirement at senior centers to represent reality and data related to race, culture or ethnicity.
- Align Senior Center programming to meet the reality of the community: Schedule programs in evenings and weekend so that 55 or older who are working can benefit.
- Make Senior Centers the One-Stop Shop - Single door for all programs and seniors. Health leads: doctor's prescription/referral to the services provided at senior centers.
- Oakland could benefit by looking at models used in other cities in county and adjusting its programming and schedules accordingly. Make the membership worth it.
- Senior centers should have their own transportation/vehicles, not depend on paratransit. Back it free or lower for people over 62.
- Transportation to and from senior center, regional solutions for transportation.
- Pilot a program at a critically located senior center that supports older adults who are transitioning from homeless to housed.