At Home
With Mass Home Care

December, 2016
Vol 29 #12

Al Norman, Editor

Trump's Double Whammy on Health Care

In October of 2016, before the election of **Donald Trump** as President, *The Atlantic* magazine published an article called "Trump's Graying Army."

"Senior citizens are his strongest demographic," *The Atlantic* said. "In polls, voters over 65 tend to be the only age group he wins: In surveys conducted for *The Atlantic* by the Public Religion Research Institute, for example, Hillary Clinton led Trump in every age group under 65, but he beat her by a slight margin with those 65 or older. In the primaries, too, Trump supporters were older, on average, than those of other Republican candidates. Despite the stereotype of the Trump supporter as a prime-aged working man, Trump's campaign has actually been fueled primarily by support from the elderly."

According to figures taken from exit polls and from Census date, older voters have been trending Republican in recent elections, *The Atlantic* says. In 2012, **Mitt Romney** won the over-65 vote by 12 percentage points, his largest margin among any age group. In 2008, **John McCain** won them by 8 points, the only age group he won.

Old people are also much more likely to vote than younger voters: In 2012, they were 13% of the population but 16% of voters. In the **Hillary Clinton**/ Donald Trump matchup on November 8, 2016, exit polls suggest that 53% of voters age 65+ voted for Trump, 8 percentage points higher than the 45% who said they voted for Clinton. The numbers were basically the same

for voters between the ages of 45 and 64, with 53% voting for Trump

Candidate Donald Trump made a number of statements about elderly issues that ranged from comforting, on occasion, to apocalyptic on the other hand. "We're not going to hurt the people who have been paying into Social Security their whole life and then all of a sudden they're supposed to get less," Trump said at a Republican debate last February. At a rally in Florida, he told the crowd that a vote for him was a "vote to put America first and protect Medicare and Social Security!" But Trump's chief policy advisor told the *Wall Street Journal* that once Trump becomes President, he will "start taking a hard look" at Social Security and Medicare.

Trump has said he opposes "Obamacare," yet says "I like the [individual] mandate….I don't want people dying in the streets." He said he wants to allow Medicare to negotiate drug costs, and favors the importation of drugs from Canada. Trump called Alzheimer's "a total top priority for me. That's something we should be working on." But he also wants to convert Medicaid, the largest health plan for low-income people of all ages, from an individual entitlement into a capped block grant, which could significantly reduce health care benefits for the elderly poor.

In a document called "Donald Trump's Contract with the American Voter, Trump said "I will work with Congress to introduce the following broader legislative measures and fight for their passage within the first 100 days of my Administration:

• Repeal and replace Obamacare Act: fully repeal Obamacare and replace it with Health Savings Accounts, the ability to purchase health insurance across state lines, and let states manage Medicaid funds.

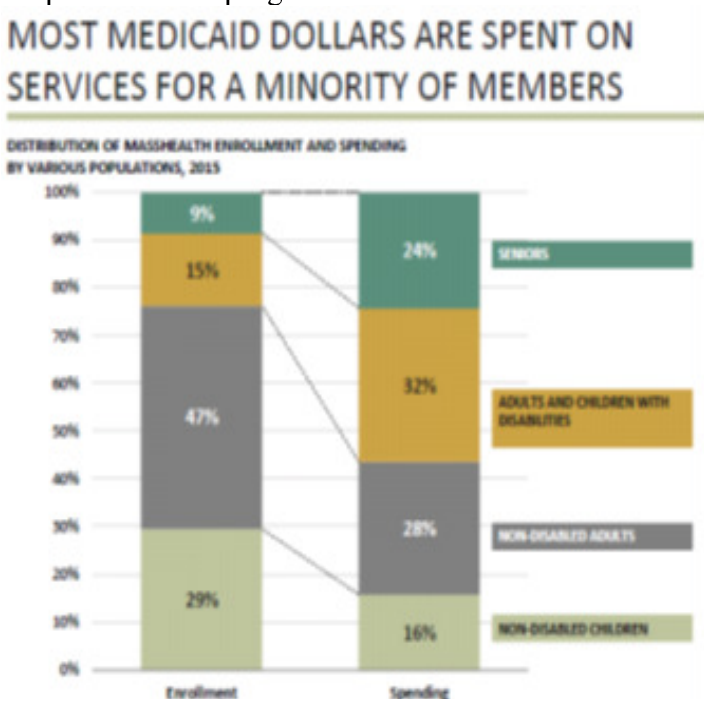
• Affordable Children and ElderCare Act: Allow American to deduct child care and elder care from their taxes, incentivize employers to provide onsite childcare services and create tax free Dependent Care Savings Accounts for both young and elderly dependents, with matching contributions for low-income families.

Trump's proposal to create Health Savings Accounts, and to cap Medicaid funds to the states, are the most controversial elements of his health care agenda. A health savings account (HSA) is a tax-advantaged medical savings account available to taxpayers in the United States who are enrolled in a high-deductible health plan (HDHP). The funds contributed to an account are not subject to federal income tax at the time of deposit. HSAs are not of much use to low-income working families, because they don't have the disposable income to invest in a health savings vehicle. A tax credit would be of more use to low income households, who have limited tax liability, than a tax deduction,

As for capping Medicaid funds, this would have a deep financial impact on Massachusetts seniors. MassHealth represents nearly 40% of the state's budget ($13.7 billion in 2015), and brings in more than 90% of the federal funds received by the state ($9.79 billion). MassHealth is the essential health safety net for nearly 1.9 million state residents. It provides coverage to more than one in four Massachusetts residents. Half of the population with disabilities, 40% of all children, 66% of people in low-income families, and more than 60% of residents in nursing homes, rely on MassHealth. Elders are 9% of MassHealth enrollment, but account for 24% of MassHealth spending. Disabled adults and children make up 15% of the enrollees, and 32% of spending.

There were roughly 141,520 seniors on MassHealth as of January, 2016, and 22,822 seniors in nursing facilities. Six out of ten nursing facility residents are on MassHealth. Between June of 2013 and January of 2016, the total number of elders on

MassHealth grew by 12%, even though the number of seniors in nursing facilities fell by 7%. Less than 2% of MassHealth members live in nursing facilities. There were 256,659 adults with disabilities, around 14% of the total Medicaid population. The eligibility level for seniors age 65 and older is 100% of the federal poverty level, and assets up to $2,000 for an individual, or $3,000 for a couple. More generous eligibility rules apply for seniors living in nursing facilities or enrolled in special waiver programs.



Seniors are 9% of enrollees, 24% of spending. Mass. Medicaid Policy Institute.

The MassHealth benefit plan covers services that commercial insurance does not cover, plus added benefits such as long term services and supports and some behavioral health services. Seniors over the age of 65 make up 9% of MassHealth members, but according to the Massachusetts Medicaid Policy Institute, about 66 cents of every MassHealth dollar is spent for the care of seniors of members with disabilities.

Repealing the Affordable Care Act and capping Medicaid funds from the Federal government could lead to a major shortfall in health care dollars targeted to poor people. Massachusetts is one of the states that exercised its option under the Affordable Care Act (ACA) to cover most residents with incomes up to 138% of the federal poverty level. Implementation of the ACA is the reasons MassHealth enrollment has grown, shifting the distribution of members toward non-disabled, non-elderly adults.

The Commonwealth recently received approval from the Obama Administration to implement a massive 5 years managed care plan known as Accountable Care Organizations (*see next article)*. It is not clear what impact repealing the ACA and block-granting Medicaid will have on this $52 billion program. Today, nearly 70% of MassHealth members are enrolled in some kind of managed care plan. Around 569,590 MassHealth members are not in managed care, and 1,288,839 members are in managed care.

Many people with disabilities are eligible for MassHealth's CommonHealth program, which provides benefits to the disabled that are not available through Medicare or employers, such as the Personal Care Assistance (PCA) program. For more than 20% of its members, MassHealth coverage is secondary to other insurance, such as Medicare or employer-provided insurance. MassHealth benefits make it possible for many people with disabilities to work.

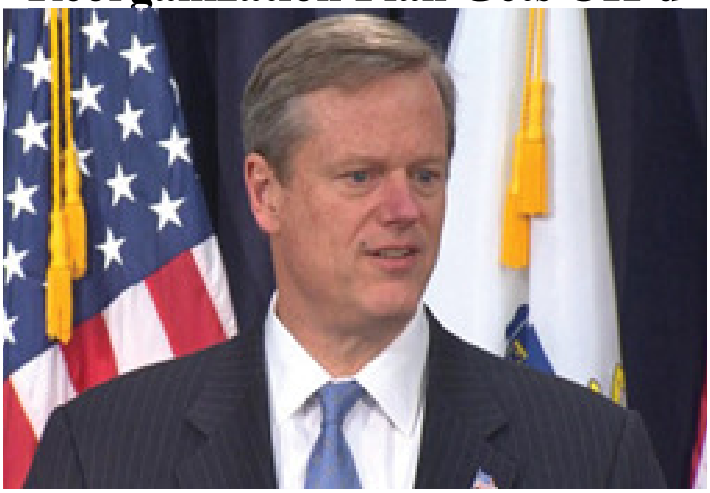
In addition, more than 50,000 people on Medicare and Medicaid are enrolled in managed care plans, like the Senior Care Options (SCO) program, and One Care for adults age 21 to 64. "These federal funds help stretch dollars the state spends for health care and long term care for populations with a high level of needs," explains the Medicaid Public Policy Institute in a report from last June. Medicaid also shares the cost of home and community based services waivers that provide long term services and supports. The Commonwealth has 10 such waivers, which are an important component of the state's "Community First" policy.

But the main driver of increased MassHealth spending over the last several years has been the increasing number of MassHealth members---not the amount spent per member. In fact, per member spending has fallen 3% from 2014 to 2015, and is now at the same level it was at in 2009. MassHealth paid nursing facility days fell -37% between 2000 and 2016. "Efforts to shift long term care from facilities to community-based services have resulted in a growth in spending on community based long term services and

supports, while spending on nursing facility care has fallen slightly.

Trump's double whammy of repealing the ACA coupled with a Medicaid block grant could result in tens of thousands of Massachusetts residents losing their health insurance entirely, and a loss of millions of dollars in federal revenue to the state.

MassHealth Accountable Care Reorganization Plan Gets OK'd



On November 4, 2016, Governor **Charlie Baker's** office issued a press release announcing that the state had received federal approval for a five-year Medicaid (MassHealth) 1115 waiver. The Centers for Medicare and Medicaid Services (CMS) approved waiver supports the restructuring of the MassHealth program to provide integrated, outcomes-based care to 1.9 million Massachusetts residents. Federal approval was a relief to state officials, who wanted to get the plan finalized before the White House changed hands.

"Our administration is pleased to announce this innovative waiver as a major step toward creating a sustainable MassHealth system for the people of the Commonwealth," said Governor Baker. "This waiver is the first major overhaul of the MassHealth program in 20 years and includes critical reforms to promote coordinated care, hold providers accountable and offer expanded access for substance abuse disorder services driven by the opioid crisis. I appreciate CMS's collaboration and the hard work of Secretary **Marylou Sudders** and Assistant Secretary **Dan Tsai** to deliver a waiver to support the people of Massachusetts."

"We're excited to approve this innovative Medicaid waiver, which is another step forward in the American health care system's shift toward value. This waiver will allow MassHealth to partner with provider-led care delivery organizations to deliver quality, patient-centered care to Medicaid beneficiaries," said U.S. Department of Health and Human Services Secretary **Sylvia M. Burwell**.

The waiver provides the opportunity for Massachusetts to move from its current fee-based model to a system of Accountable Care Organization models (ACO) who work in close partnership with community-based organizations to better integrate care for behavioral health, long-term services and supports and health-related social needs.

"Our restructuring will improve health care for 1.9 million MassHealth members and ensure a strong health care program now and in the future," said Marylou Sudders, Secretary of Health and Human Services. "The waiver authorizes more than $52.4 billion to the MassHealth program over the next five years, expands substance use benefits to address the opioid epidemic, and secures important investments for strengthening the community-based health care system for behavioral health services and long term supports."

Without the waiver, Massachusetts would have lost $1 billion a year in federal funds starting July 1, 2017. The new waiver, which is effective July 2017, authorizes $1.8 billion over five years of new Delivery System Reform Incentive Program (DSRIP) funding to support the move to ACOs, invests in Community Partners for behavioral health and long term services and supports, and allows for innovative ways of addressing the social determinants of health. It also authorizes and sustains nearly $6 billion of additional safety net care payments over five years to hospitals and the health safety net for the uninsured and underinsured, and for subsidies to assist consumers in obtaining coverage on the Massachusetts Health Connector.

"The waiver allows us to implement a nationally-leading model of accountable, coordinated care which better serves members and recognizes the importance of integrating social services and community-based expertise into delivering health care," said **Dan Tsai**,

Assistant Secretary for Health and Human Services who leads the MassHealth program. "We appreciate the support and engagement from the Massachusetts health care community and are committed to continued stakeholder input throughout the implementation of these reforms."

The waiver also authorizes MassHealth to launch an ACO pilot program beginning December 2016. The ACO pilot program will transition MassHealth from the current fee-for-service care model towards accountable care and population-based payments with selected ACOs under an alternative payment methodology that includes shared savings and risk.

The Massachusetts waiver has several key goals:

1. **Restructures the current MassHealth delivery system** in a manner that promotes integrated, coordinated care and holds providers accountable for quality and total cost of care of its members.

1. MassHealth will **implement ACO models**, provider-led organizations that are accountable for the cost and quality of care.

2. The ACO models **reflect the range of provider capabilities** and the Massachusetts health care market; it is not a one size fits all approach.

3. **Outcome metrics** will evaluate both outcomes and delivery system change.

4. **Improves integration** among physical health, behavioral health (BH), long-term services and supports (LTSS) and health-related social services.

ACOs and community-based organizations who become BH and LTSS Community Partners will be eligible to receive $1.8 billion over five years of Delivery System Reform Incentive Program (DSRIP) funding available to improve integration of care, outcomes for members with serious mental illness and co-morbid conditions or long term services and supports.

The plan establishes DSRIP funding and expectations for ACOs and a range of community partners to address social determinants of health, including for certain approved community services, such as housing stabilization and supports and other health -related social services.

The plan aintain near-universal health care insurance coverage. Massachusetts has the highest rate of insured residents in the U.S., with an uninsured rate of fewer than three percent.

The ACO plans address the opioid addiction crisis by expanding access to a broad spectrum of recovery-focused substance use disorder services (SUD).

Under the 1115 Demonstration Waiver the MassHealth benefit will be expanded to include the full continuum of medically necessary 24-hour community-based rehabilitation services. MassHealth will use new federal funds generated under the waiver to expand the state's capacity of residential rehabilitation service programs and fund care coordination and recovery services to Members with significant SUD.

MassHealth and the Department of Public Health will adopt a standardized American Society of Addiction Medicine (ASAM) assessment across all SUD providers.

The new plan will sustainably support safety net providers to ensure continued access to care for Medicaid and low-income uninsured individuals. and xpands the number of safety net hospitals eligible for reimbursement for uncompensated care from seven to fifteen.

Elder advocates have raised concerns over the cost and medicalization of long term supports under this provider-led plan. MassHealth and Medicare are allowing providers to control the funding for care, raising concerns over conflicts interest, and fears that care plans will mirror provider needs, not patient-centered needs. Supporters of the plan say the state

will create incentives for value not volume of care, but in the field of long term supports, there are no quality out comes yet agreed upon. The ACO plan will be responsible for long term support, but elder rights groups say the ACOs have no experience in this field, and are not ready for this responsibility. The state notes that the ACOs will not be covering LTSS until the third year of the plan or later.

The wild card in the mix is what will happen to the plan if Congress supports President Donald Trump's call to repeal the Affordable Care Act.

PropertyTax Exemptions for Seniors on the Agenda

Rep. Jay Kaufman

The issue of passing legislation that would grant all cities and towns in Massachusetts the authority to implement senior citizen tax exemptions surfaced in October on Beacon Hall.

State Representative **Jay Kaufman** (D-Lexington) , who chairs the House Revenue Committee, told the *State House News* in late October, made his comments after a hearing on H. 4703, legislation filed by House Minority Leader **Brad Jones** (R-Reading) which would create a new property tax exemption in town of Reading, for a three year period only, for a homeowner age 65 or over who has lived in the town at least 10 years. The bill would allow the Board of Selectman to set an exemption amount annually within a range of 50% to 200% of the amount of the state-funded "circuit breaker" income tax credit under section 6(k) of chapter 62 of the General Laws, for which the applicant qualified in the previous year.

According to the *State House News*, Rep. Kaufman invited other lawmakers to work with him on a bill that would grant such permission for all 351 cities and towns. "Help me craft some legislation for next term that would spare the other 348 communities the need to go through this process," Kaufman said, excluding Wayland, Sudbury and Reading. The first two communities already have a local exemption, and Reading has asked for one. "I think by now this is a proven commodity and there is absolutely no reason why we have to sit on each one of these. We really ought to produce some generic legislation."

Kaufman said there has "been some resistance" to legislation that would grant all municipalities the authority to implement senior citizen tax exemptions, but asked that other legislators join him in pushing for it. "Hopefully we'll be able to come back next session with enough momentum from us," he said. "I would hope we would come back and discuss that next term.

Elder rights groups, like the Massachusetts Councils on Aging, would like to see the that lower the interest rate on the property tax deferral law so that more seniors could take advantage of deferred tax payments, and they want the state to do a much better job of letting seniors know about the existing "circuit breaker" tax law, which can reduce an elder's property tax bill by as much as 25% per year.

Nursing Facilities Sue Over Pre-Dispute Binding Arbitration

A group of nursing facilities, joined by the American Health Care Association (AHCA) which represents 13,000 nursing facilities, filed a lawsuit in late October to block a new federal rule that goes into effect right after Thanksgiving, that forbids nursing homes from requiring their residents to sign a binding arbitration agreement before a dispute happens.

The nursing facilities asked the U.S. District Court to invalidate the new rule, on two grounds: 1) the

new rule violates the Federal Arbitration Act (FAA), and 2) the federal Department of Health and Human Services ("HHS") lacks the statutory authority under the Medicaid and Medicare Acts to regulates alternative dispute resolution procedures such as the use of arbitration.

Medicare and Medicaid nursing facilities would no longer be permitted to require that a resident sign an arbitration agreement as a condition of admission to the nursing facility. Any arbitration agreements agreed to before November 28, 2016 would be allowed to stand. The new rule still allows arbitration agreements—but only after a dispute arises. If a dispute happens, the facility can ask the resident to enter into a binding arbitration under certain conditions, including:

• The LTC facility must explain the agreement to the resident in a clear and understandable manner and language understood by the resident.

• The resident must acknowledge her understanding of the agreement.

• The resident must enter into the agreement voluntarily.

• The facility cannot condition the resident's right to continue living at the facility upon agreement to arbitrate.

• The agreement must provide for the appointment of a neutral arbitrator agreed upon by the parties,

• The facility must not prohibit or discourage the resident from contacting federal, state, or local officials, including surveyors, state health department employees, state nursing home ombudsman, etc.

• When the facility and a resident resolve a dispute with arbitration, a copy of the signed agreement for binding arbitration and the arbitrator's final decision must be retained by the facility for 5 years and be available for inspection upon request by CMS.

According the Boston lawfirm of Donoghue, Barrett and Singal, nursing facilities should remove binding arbitration language from future admission and other residency agreements (such as a separate pre-dispute arbitration agreement) as of November 28, 2016. If a facility tries to require residents to agree to arbitration before a dispute arises, they will be in violation of the new federal rule.

But on November 11th, the nursing facilities won the first legal round. The regulation scheduled to go into effect on November 28, 2016 was blocked temporarily by the United States District Court for the Northern District of Mississippi, preventing the Centers for Medicare & Medicaid Services ("CMS") from prohibiting pre-dispute arbitration agreements for residents as a condition of their admission to nursing homes. The decision in *American Health Care Association v. Burwell* also casts serious doubts as to whether CMS has the authority to issue a regulation that is contrary to the Federal Arbitration Act

End Of Life Care: "Earlier Conversations" Needed

On November 2, 2016, the state's Health Policy Commission (HPC) released a new report call "Serious Illness and End of Life Care in Massachusetts."

According to the HPC, 25% of all Medicare spending in the U.S. occurs in the least year of life. Better aligning care with individual patient preferences will not reduce spending on all cases: failure to base care on patient preferences results in some receiving more services than they wish, while others receive less than they wish. "High quality serious illness care addresses medical and emotional needs," the HPC says, "with patients receiving care based on their individual preferences and priorities. However, numerous challenges often drive a disconnect between best practices and actual practices, with well-documented

deficiencies in quality of care." Literature suggests that increasing the quality of end of life care tends to reduce total healthcare spending overall.

Quality of care at the end of life appears to be decreasing in the U.S. overall. In 200, 57% of family members or close friends of decedents reported excellent end of life care, but by 2011-13, that number had decreased to 47% of those surveyed. Respondents reported frequent unmet need for pain management, anxiety/sadness, and dyspnea (shortness of breath.)

Research suggests that many patients prefer less aggressive treatment at the end of life. A study of 1,146 families of decedents found strong correlations between rating "excellent" end of life care and useage of hospice less than 3 day, no intensive care unit admissions within 30 days of death, and dying outside of a hospital setting. Spending in the last six months of care for the Medicare population in Massachusetts totaled over $1 billion. Much of this spending was concentrated in hospital settings. Total use of Medicare services in the last six months of life averaged $39,194, of which 42% was hospital spending. In 2012, the spending per Medicare decedent included $18,282 for inpatient hospital care, $6,040 for nursing facility care, for a combined total of 62% of all Medicare spending. Spending per person for home health care was only $1,473, plus $4,428 for hospice, for a combined total of only 15% for community spending per decedent, showing a heavily weighted spend for institutional care opposed to care in the home setting.

Among patients on Medicare who died, those in the highest income communities had the lowest intensity of service use at the end of life. The Commonwealth had a substantially lower use of ICUs in the last six months of life than in the nation, but our rate of hospitalizations is higher, consistent with the state's higher admission rate among all Medicare beneficiaries.

The HPC found that Massachusetts, especially the eastern part of the state, ranks among the lowest for average number of days spent at home in the last six months of life among people on Medicare. "Findings of high institutionalization at the end of life in Massachusetts are consistent with practice patterns favoring institutionalization across many measures in the state, including high rates of hospital admissions and institutional post acute care," the HPC noted. One of the HPC conclusions from the report is that differences in use by population and regions suggest the need for attention to access to care, "particularly earlier conversations about preferences and shared decision making regarding options," and the need to ensure that patients with serious illness have access to palliative care services before enrolling in hospice, given the current Medicare requirement to forgo curative treatment.

The HPC report concludes that Massachusetts is in a position 'to be a leader in improving serious illness care." State law (Chapter 224) requires doctors to inform their patients with serious illness about their options. The Department of Public Health has implemented the Medicare Orders for Life Sustaining Treatment (MOLST) program for documenting advanced directives.

Mass Home Care Releases Result of Health Care Proxy Challenge

Honoring Choices photo

In April of 2016, Mass Home Care issued a challenge to its member agencies: The Aging Services Access Points (ASAPs) would attempt to get one-third of our Boards and staff to learn more about the need for a health care proxy, then proceed to name a health care agent, complete the health care proxy form, and finally submit it to their doctor, and have a conversation with a doctor.

The Challenge was conducted over the period from July until the end of October. A total of 19 Aging Service Access Point members of Mass Home Care accepted the Challenge. In April of 2016, Mass Home Care proposed a format for a Health Care Proxy Challenge to the Coalition on Serious Illness Care. As part of its challenge, Mass Home Care agreed to set a goal of getting one third (33%) of its Board of Directors, and one third of its staff to attend an online seminar on making a personal health care plan, and to carry out the rest of the challenge.

To get the Challenge launched, Mass Home Care partnered with the Executive Office of Elder Affairs (EOEA), and enlisted the support of the group Honoring Choices to produce a 30 minute online webinar that our Boards and staff could review at their convenience.

The webinar was produced at EOEA, and put online on July 14, 2016, with an introduction by Secretary of Elder Affairs **Alice Bonner**, with content and presentation by **Ellen DiPaola** of Honoring Choices. To make it accessible to all board and staff, the webinar was posted at 800ageinfo: *https://recordings.join.me/Gn0w4Jr06kaCzPffz3169g*

Mass Home Care member agencies were then encouraged to have their board and staff attend the webinar, and take follow up action to complete a proxy, name an agent, give the form to their doctor, and have a conversation about their personal health care preferences. Mass Home Care told its members that at the end of October, data would be collected in the aggregate from each agency indicating the number of board and staff members who took the Health Care Proxy challenge. On October 28, 2016 Mass Home Care collected the Health Care Proxy challenge sheets from the Aging Services Access Points that participated in the challenge.

Summary of Results

• A total of 19 out of 26 ASAP agencies (73%) took part in the Health Care Proxy Challenge. Nearly 3 out of 4 of our ASAP agencies responded to this Challenge.

BOARD results:

• A total of 377 directors serve on the participating ASAP boards at the participating agencies.

• Of that total, 166 (44%) board members viewed our Health Care Proxy webinar. This exceeded our 33% goal.

• A total of 147 board members (39 %) indicated they had named a proxy agent. This exceeded our 33% goal.

• A total of 122 board members (32 %) said they have given a completed proxy to their MD.

• A total of 74 board members (20%) have discussed their proxy with their MD.

Honoring Choices online seminar

Comments

By state law, 50% of the boards of directors of ASAPs must be age 60 or over, and be from the local service area, appointed by area Councils on Aging. This is a demographic that would be expected to have a higher degree of interest in the subject of advanced health care planning. At least 4 agencies did not follow up with their board members to track if they chose an agent, submitted their proxy to their doctor, or had a conversation with their doctor. A number of agencies reported that many board members only see their doctor once or twice per year, so a conversation with their doctor about the proxy form was outside the reporting period for this Challenge. The most tracked metric was the number of board members who viewed the webinar co-produced by Mass Home Care and EOEA. On this metric, 44% response exceeds the Challenge, and if we count only those agencies which closely tracked this metric, the percentage of board members who saw the video is actually 70%.

Staff results

• A total of 2,881 staff are employed at the ASAPs who participated in this Challenge.

• Of that total, 1,140 (39.6 %) staff viewed the Proxy webinar. This exceeded our goal.

• A total of 666 staff members (23 %) indicated they had named a proxy agent

• A total of 485 staff members (17 %) said they have given a completed proxy to their MD.

• A total of 314 staff members (11 %) have discussed their proxy with their MD.

Comments

Many staff who work for ASAPs are in their 30s or 40s, and may be concerned with other life challenges.These decisions may seem very distant to many workers. Two agencies did not report staff actions beyond viewing the webinar. The most successful element of the Challenge was getting staff to view the webinar. If we eliminate the two agencies that did not report staff activity beyond the webinar, then 43% of staff viewed the webinar, 25% of staff had named an agent, 18% had given a proxy to their doctor, and 12% had discussed their proxy with their doctor.

Total Board & Staff Results

• A total of 3,258 board and staff are represented at these participating agencies.

• As a result of this challenge, 1,306 board and staff watched the Challenge training webinar.

• A total of 813 board and staff reported that they have named a proxy agent.

• A total of 607 board and staff have completed a proxy form and given it to their doctor.

• A total of 314 board and staff have had a discussion with their doctor about their proxy form.

General Discussion

For a first time effort to gain the attention of ASAP board and staff to the issue of advanced health care planning, the Health Care Proxy Challenge attracted a reasonable level of agency response (73%). A number of ASAPs indicated that some of their board and staff already had in place a Proxy. Some of these board and staff were counted in these Challenge numbers, but many were not.

The timeframe for the Challenge (the 4 month period July through October, 2016) was shorter than the timeframe for board or staff to bring their proxy form to their doctor and/or to have a conversation with that doctor, due to the fact that many people have not seen their physician during this 4 month time period.

The greatest success clearly was in educating board and staff through this Challenge about the issue of end-of-life planning. A number of our agencies have indicated that they are doing their own local activities around end-of-life care decisions, including seminars, special events, etc. That activity is not captured in this survey. The number of board and staff who have completed proxies is not fully captured by this survey, given the fact that this Challenge was measuring new activity stimulated by this project.

MASSACHUSETTS HEALTH CARE PROXY

A further limit to this Challenge was the fact that agencies had no funding to underwrite staff time to participate in the project, so it was an "extra-curriculum" activity on the part of staff at participating agencies. This Proxy Challenge was a valuable consciousness-raising exercise that will lead to other activity.

The larger question which remains is how to present this issue to the 45,000+ elderly clients in the daily home care caseload. Mass Home Care will continue to work with the Executive Office of Elder Affairs, the Serious Illness Coalition and its partners, to explore the best way to have this conversation with our elderly clients. We will also continue to encourage all of our members and affiliated agencies to have their board and staff take the Proxy challenge, and watch the Honoring Choices webinar.