At Home

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Al Norman, Editor

State House Rally "TAKE CARE OF CAREGIVERS"

With the White House, federal and state lawmakers all focused on the minimum wage, more than 400 senior rights advocates from across the state gathered on Beacon Hill March 24th to push for a "living wage" in the state FY 15 budget for the workers who keep elders and individuals with disabilities living independently at home.

According to Mass Home Care—which represents 27 Aging Services Access Points (ASAPs),

SWMs Chairman Stephen Brewer at Elder Lobby Day

and purchases nearly $100 million in home care aide services a year--- personal care aides and home health aides top the list of projected fastest-growing occupations in the nation. As of 2012, there were roughly 20,180 personal care aides in Massachusetts .

"If we don't win this wage war," said **Christine Alessandro,** President of Mass Home Care, "we won't have a workforce to care for the half a million new elders who will swell our population by 2030, when one in five people in our state will be over the age of 60."

"Home care aides dedicate themselves to keeping elders and individuals with disabilities at home," said **Lisa Gurgone**, Executive Director of the Home Care Aide Council. "But they

earn a wage that won't allow them to support their own families and homes. It's time for the Commonwealth to take care of the caregivers with a living wage."

Nationally, demand for personal care aides and home health aides is expected to increase by 71% and 69% , respectively, according to a November, 2013 study by the Paraprofessional Health Care Institute (PHI).

In Massachusetts, the workers who manage care for elderly have been leaving the field for higher wages in related fields, like health care or other human services:

- Elder home care managers are no longer eligible for human services salary reserves.
- State care manager positions start at $13,000 higher than pay at the ASAPs
- Elder care managers are carrying client loads as high as 110 per worker.
- The turnover rate for care managers is now 25%--a total loss of workers every 4 years.
- The budget item that pays for ASAP operations and staff has been frozen for 5 years.

And the elder direct care workforce is also under financial stress:

- There are 17,000 home care aides in Massachusetts. Their average wage is $10 per hour.
- Most home care aides work 25 hours or less per week.
- A home care aide with one child working at this wage and hour level makes $13,050 per year, and lives below poverty
- 34% of home care aides today are on MassHealth, and 19% receive food stamps.

Advocates are asking for $3.3 million in added funding for the ASAP (Aging Services Access Points) that employ care managers, and a $6.1 million salary reserve for the home care aides who assist the elderly with bathing, dressing and other basic functions of living.

"It's ironic," Alessandro concluded, "that the people who take care of The Greatest Generation, get paid some of the worst wages in the nation."

Sponsors of the March 24th Elder Lobby Day include: Mass Home Care, The Caring Force Home Care Aide Council, Mass Senior Action Council, Mass Councils On Aging, Mass Human Services Provider's Council, Mass Association of Older Americans, LGBT Aging Project, Home Care Alliance, Jewish Community Relations Council of Greater Boston.

Disabled Man: "Let My Spouse Be Paid"

Front Row: (l-r)Senator James Welch, Michael Fernandes, Susumu Kishihara, Rep. Jennifer Benson.

Rear: Al Norman, Chet Jakubiak, Lisa Krinsky.

For years, **Michael Fernandes**, 69, who has a disabling condition, has been cared for at home by hired help. Under MassHealth regulations, Fernandes can hire almost anyone to be his personal care attendant---except the one person who knows him best: his spouse.

Fernandes lives in Provincetown with his spouse Susumu Kishihara. They have been married since January of 2011. Kishihara at one point was Fernandes' personal care attendant. But after they were married, Fernandes learned to his surprise that Kishihara could no longer be paid as one of his caregivers. When Fernandes heard about legislation on Beacon Hill that would add spouses to the list of approved caregivers, he launched an online petition campaign at MoveOn.org:

http://petitions.moveon.org/sign/allow-spouses-to-be-paid?mailing_id=19006&source=s.icn.em.cr&r_by=802599

Nearly 1,300 people signed Fernandes' online petition in the first two months it was posted. . H. 3716 would allow spouses to be paid caregivers—just like other family members are allowed now in 17 other states. This legislation, which was written by Mass Home Care, was reported favorably by the Children, Families, and Persons with Disabilities Committee on October

21st, and is now in the Health Care Finance Committee.

On March 4th, Fernandes traveled to the State House to give his petition to the chairs of the Joint Health Care Financing Committee, Vice-Chairwoman **Representative Jennifer Benson** (D-Lunenburg), a lead sponsor on the bill, and Chairman **Senator James Welch** (D-W.Springfield).. Fernandes was met at the State House by his State **Representative Sarah Peake** (D-Provincetown).. The spouse as paid caregiver bill, H. 3716 has 31 legislative sponsors, and is endorsed by Mass Home Care, the Mass Association of Older Americans, and the LGBT Aging Project.

Here is the statement that Michael Fernandes and his spouse, Susumu Kishihara gave to lawmakers:

"When I was eleven years old I was (mistakenly) diagnosed with Muscular Dystrophy and was told that I would live to be about 20. My condition, called Spinal Muscular Atrophy, was unknown at that time. Next October I will be 70. I live in Provincetown, on the Outer Cape, and have been a 'Consumer' on MassHealth's Personal Care Assistant (PCA) program for more than a dozen years. I became eligible for Social Security Permanent Disability in 1980, but chose to remain working (I was a psychotherapist) for 18 more years until 1998. MassHealth and its PCA program are no less than miracles to me at this stage of a life, in which I fought to care for myself entirely until I no longer could - and to care for others as well.

But as supportive as a PCA program might be, it cannot provide 24-hours of assisted care. I was single for much of my life, but then, 5 years ago, as I came near to considering Nursing-Home care (far more expensive to the State), I met my now-spouse who was visiting from Japan and who, soon after, moved here to be with me and to help care for me.

Having someone with me, in a committed, loving relationship, has changed my waning sense of 'ability' and energized my will to keep living. While PCAs continue to offer vital help with so many of the activities of daily living, there have been impacting limits. For example: they cannot come here simply to help me put a coat and hat on, or take it off, so that I began spending many days of the year cut off from community activities. If I had a medical appointment, they could be paid by the mile, but not by the hour, making a lengthy medical visit not worth a PCA's time.

In the past, if I simply wanted to attend Church, the effort often was too involved to make it worthwhile. Now, with a spouse who would be available to absorb these and other limiting gaps in care and quality-of-life, my spouse legally must be otherwise employed.

In an expensive Nursing Care facility, at least someone would always be present to help me dress to go out or come back. Issues like these, along with living on the Outer Cape where PCAs sometimes have to drive a long distance from their homes (indeed I was left in bed on several occasions during severe weather) needlessly reduce if not remove the simple, quality benefit of remaining at home with a spouse who might earn at least enough not to have to be otherwise employed. My own devoted PCAs know that this is not a negative or ungrateful judgment on them. They too wish for a change in this law so that my spouse might be a part of the care team along with them.

I had been closely following the bill submitted several years ago by MASS HOME CARE, supporting a change to allow spouses to serve as PCAs or other types of home-care providers. Last Fall, hearing that the bill, originally H.73, now re-numbered as H.3716, "An Act Regarding Spouses As Caregivers," had progressed out of committee and gone to the Joint Committee on Health Care Financing, I created a petition on the website "moveon.org" which

has gathered nearly 1,300 signatures, along with some very poignant comments by spouses and professional care-providers. All of them, along with my spouse and I, are hoping that our effort will help to make a difference in the difficult situation we share with countless other families whose lives are made needlessly harder by this outdated regulation against spouses.

I am asking lawmakers today to strategize with me how to get this bill to the Governor's desk, where I believe it will be signed into law."

After a 50 minute meeting with Fernandes, House Vice Chairwoman Benson told the *State House News* that she planned to "take the temperature" of committee members on the bill. She said spouses as caregivers would be a good solution for some families. "It is not the right fit for everybody, but it can be the right fit for some," she said. Senator Welch said he thinks the bill has a "great deal of merit."

The Health Care Financing Committee must report this legislation out of committee by April 30, to report out bills.

One Care Reaches 10% Enrollment

The new "One Care" managed care plan in Massachusetts for people age 18 to 64 on Medicare and Medicaid (known as "dual eligibles") reported on its first 5 months of enrollment, the period October 1, 2013 through March 1st.

As of March 1st, the program has enrolled 9,766 people, or 10.3% of the total estimated eligible population of 94,705. (The program does not offer One Care plans in all counties, so the original estimate of 110,000 eligible people has been reduced.) The March 1st enrollment was only 196 new enrollees over the month before, far less than the 5,009 new enrollees that came on during a January 1st "auto enrollment" sweep, where Medicaid members are assigned a One Care Plan, and have to "opt out" if they do not want the plan.

According to state statistics, a total of 17,701 people who received enrollment materials chose not to join the plan. This means that of the 27,423 people who were auto enrolled or voluntarily joined, nearly two-thirds (64.5%) have chosen not to enroll. Projecting this rejection rate out to the entire population of eligible people, the One Care plan would enroll roughly 33,620 at full enrollment, with 61,084 people turning down the plan.

In March, Mass Home Care continued to dialogue with state officials in the Executive Office of Health and Human Services about concerns over the lack of long term services integration in the One Care design. In a memo about One Care, Mass Home Care wrote:

"One Care plans are not operating as fully integrated plans, and medical supports have a much higher priority in the plan. The plan design is one of illness intervention, rather than healthy living and prevention. We believe the LTSC role adds value to the plan, and should be a specific marketing point to consumers. Only certain disabled members get an LTSC assessment (75% of current enrollees are considered not in need of a LTSC assessment.) Yet medical personnel are mandatory. The insistence that LTSCs are only a discretionary part of the team indicates that the medical is more important in the plan than the functional. There is no advantage to the member or the plan to create this arbitrary distinction. The LTSC role is defined more as a specialty add-on, than an integrated support to the member. This impairs the selling of the plan, and creates a medical-centric view of the patient. We also believe that EOHHS is not in compliance with state law on the role of the LTSC in "initial and ongoing assessments" of all enrollees. We heard the Independent Living Centers and the Aging

Services Access Points saying the same thing: we do not see integrated care being practiced, and if we are to help members deal with what we call "the ambush of social circumstances," that we are denying members a 360 degree view of their aspirations for well-being."

One doctor has described "the ambush of social circumstances" that can affect a person's health. Often it is non-medical events that affect health outcomes. The federal project Healthy People 2020 defines the range of impacts on health this way:

"The range of personal, social, economic, and environmental factors that influence health status are known as determinants of health. In addition to such factors as access to health services, biological or hereditary history, and public policy decisions, there are also social and individual behavior determinants that affect health outcomes: **Social Factors:** Social determinants of health reflect social factors and the physical conditions in the environment in which people are born, live, learn, play, work and age. Examples of social determinants include: availability of resources to meet daily needs, such as educational and job opportunities, living wages, or healthful foods; social norms and attitudes, such as discrimination, exposure to crime, violence, and social disorder, such as the presence of trash, social support and social interactions; exposure to mass media and emerging technologies, such as the Internet or cell phones; socioeconomic conditions, such as concentrated poverty, quality schools, transportation options, public safety, residential segregation **Individual Behaviors:** Individual behavior also plays a role in health outcomes. For example, if an individual quits smoking, his or her risk of developing heart disease is greatly reduced. Many public health and health care interventions focus on changing individual behaviors such as substance abuse, diet, and physical activity. Positive changes in individual behavior can reduce the rates of chronic disease in this country. Examples of individual behavior determinants of health include: diet, physical activity, alcohol, cigarette, and other drug use, hand washing.

According to Healthy People 2020, "It is the interrelationships among these factors that determine individual and population health. Because of this, interventions that target multiple determinants of health are most likely to be effective. Determinants of health reach beyond the boundaries of traditional health care and public health sectors; sectors such as education, housing, transportation, agriculture, and environment can be important allies in improving population health."

According to Mass Home Care, the vast majority of enrollees in the One Care program thus far do not have Long Term Support Coordinators on there care team. "We see the role of the LTSC in dealing with these social determinants of health as being a significant added value to this plan," explained Mass Home Care President **Christine Alessandro**. "It will make the plan more attractive to members,and boost enrollment, if this role is more visible and integrated."

Adult Foster Care Program Asks For $6 M Rate Hike

The Massachusetts Council of Adult Foster Care gave testimony in the State House on March 7th to the Joint Committee on Ways and Means regarding the FY2015 Budget for MassHealth. The AFC program provides a home and a 24/7 caregiver to elders and adults with disabilities. The client generally moves into the home of their caregiver.

Here are excerpts from the statement presented by **Lisa Prince**, President of the Council, who works at Tri-Valley, Inc, a Mass Home Care member agency:

"The Massachusetts Council for Adult Fos-

ter Care represents a diverse membership of more than 70 provider organizations that are responsible for ensuring the delivery of quality, community-based services to MassHealth members across the State. Providers oversee the administration of Adult Foster Care services delivered at home to more than 8,000 consumers of all ages who have a broad range of personal care needs, disabilities, and complex medical and behavioral health conditions.

In FY2013, total spending on the MassHealth Adult Foster Care program was approximately $160M. Services are funded through MassHealth line-items 4000-0300, 4000-0500, and 4000-0600. At a time of great change in the health care landscape in Massachusetts and across the country, Adult Foster Care remains good public policy and a great bargain for the state. By combining a qualified, full-time caregiver with the support of professional care managers and nurses, the program enables Consumers with very complex needs to be served in the community.

Adult Foster Care providers are able to demonstrate important health care and quality of life outcomes for consumers, as well as substantial savings to the Commonwealth resulting from diversions from higher cost, long-term care settings. The availability of Adult Foster Care enables consumers to make cost-effective choices. Consumers are able to live at home with caregivers who receive modest daily stipends and who are responsible for meeting the consumers' personal care needs.

For the daily stipends, caregivers help consumers to walk, dress, bathe, and go to the bathroom. Caregivers get up in the middle of the night, ensure that consumers get to necessary medical and specialist appointments, take medications as prescribed, make sure hospital discharge instructions and therapy regimens are followed, and more. They do most of those same things seven days a week and, 50 weeks or more of the year.

MCAFC appreciates the Legislature's intervention during the SFY2014 Budget process, directing EOHHS to conduct a rate review of MassHealth AFC rates which had been frozen for more than five years. In December 2013, MassHealth implemented modest increases in AFC rates which providers have used to provide slight increases in Caregiver stipends and manage increased costs associated with the administration of the program. Caregivers are, on average, now receiving between $25 and $50 per day for the care they are providing.

MCAFC does not believe that these stipends are sufficient to ensure appropriate payment for the level of supports that Caregivers provide, or to ensure the continued growth of this effective and efficient model of community care. I have included an excerpt from the Commonwealth's Community First Plan below to remind us all that Adult Foster Care was recognized in that Plan as a means by which the Commonwealth would meet its goals for increasing home and community based care. A modest increase in the current investment is needed to ensure the Commonwealth can meet this goal.

As Massachusetts continues the development and implementation of its major health policy and cost containment initiatives, we know that the Commonwealth can ill afford unnecessary increases in other sectors of the health care system. Caregivers will continue to find it increasingly difficult to continue in the Adult Foster Care program with limited stipends that do not allow them to adequately support themselves or the consumer for whom they are responsible. The alternative for a growing number of AFC participants is institutional care.

In January, I had the opportunity to provide testimony at the MassHealth rate hearing. That testimony respectfully requested that the MassHealth rates be amended to include $6 million (annualized) to support consumers in the AFC program in FY2015. We urge this Committee's consideration of that same modest request. We appreciate the Legislature's past support for Adult Foster Care and ask for your continued support. We ask that you direct MassHealth to include an additional

$6M in the rates for Adult Foster Care in FY2015 in order to continue the growth of this vital community option. The power and value of Adult Foster Care is clear. As you establish spending priorities for next fiscal year, please remember that we can do better for elders and individuals with disabilities and for their Caregivers who make significant sacrifices daily to support their loved ones and non-relatives at home."

Obama Drops Chained CPI Plan

President **Barack Obama's** FY15 budget proposal, released March 4th, includes a variety of program cuts plus investments intended to promote opportunity and growth. Perhaps most important to some elder advocates was what the President's budget did not include.

The President's request rejects earlier proposals to limit Social Security cost-of-living adjustments (COLAs). Seniors across the nation had objected to the President's proposal to create a "chained CPI,"which would have cut the annual cost of living adjustment that Social Security beneficiary's rely on to keep pace with inflation.

Yet, the Administration continues to call for shifting costs onto Medicare beneficiaries, as well as cuts rejected by Congress in job training, energy assistance, community service, and other social services for disadvantaged seniors.

Here is an analysis prepared by the National Council on Aging of the President's budget:

Health & Human Services

• Older Americans Act: Most OAA programs would be level-funded, with a few notable exceptions. The request once again proposes to move the Senior Community Service Employment Program (SCSEP) from the U.S. Department of Labor to HHS and reduce funding to $380 million—a $54 million cut from the current appropriation. The U.S. Administration for Community Living (ACL) requested $8 million for Chronic Disease Self-Management Education, $5 million for elder falls prevention, and $3 million for a White House Conference on Aging.

• Elder Justice: The Administration is seeking $25 million in new funding for elder justice. In response to work by the Elder Justice Coordinating Council, the resources would be used for very specific investments in the national Adult Protective Services network to develop a coordinated data system, support research, and strengthen programs.

• Low-Income Home Energy Assistance Program: Strong bipartisan Congressional support for LIHEAP resulted in a $168.5 million increase for energy assistance this year. However, the President's budget request calls for $2.8 billion in FY15—a $625 million cut.

• Aging and Disability Resource Centers: The budget requests $20 million each year for the next 5 years in new mandatory funding for ADRCs.

• Community Services Block Grant: The budget proposes a $234 million cut in CSBG, which supports local economic security strategies and services, despite the nearly $40 million increase Congress recently provided.

Medicare

The President's FY15 budget includes $407 billion in Medicare cuts over 10 years. Most of the savings would come from:

• Aligning Medicare prescription drug payments with Medicaid policies through additional rebates for low-income beneficiaries (saving $117 billion)

• Adjusting payment updates for certain post-acute care providers (saving $98 billion)

• Reducing Medicare coverage of bad debts (saving $31 billion)

• Increasing the Medicare Advantage coding intensity adjustment (saving $31 billion)

However, advocates are concerned about proposals that would shift about $68 billion in additional costs onto beneficiaries over 10 years by:
• Further increasing income-related Part B and D premiums, eventually affecting beneficiaries with incomes above about $50,000 (saving $53 billion)
• Increasing brand name prescription drug copayments for Part D Low-Income Subsidy enrollees, which will increase generic drug use (saving $8.5 billion)
• Requiring new enrollees to pay higher Part B deductibles (saving $3.4 billion)
• Increasing Part B premiums for beneficiaries who buy more generous Medigap policies (saving $2.7 billion)
• Requiring new enrollees to pay home health copayments (saving $820 million)

Housing & Urban Development

The President's budget calls for $440 million for Section 202 Housing for the Elderly (a $56.5 million increase) and $60 million for Housing Counseling (a $15 million increase), which includes resources for Home Equity Conversion Mortgage (HECM) counseling on reverse mortgages.

Corporation for National Service

The President's budget outlines a significant reorganization of Senior Corps. The Foster Grandparent Program and Senior Companion Program would be incorporated into the larger AmeriCorps. Retired and Senior Volunteer Program (RSVP) grants would be made under the Volunteer Generation Fund, but with two-thirds less funding. It appears that overall funding for Senior Corps programs would be cut by at least $56 million.

Social Security

As noted, the FY15 budget request drops the proposal to subject annual Social Security COLAs to the so-called "chained CPI." The President stated that this change would only be considered in the context of a "grand bargain" on deficit reduction and, given the significant budget savings achieved in recent years plus the remote likelihood of a sweeping agreement, the Administration is no longer pursing this reduction in benefits. In addition, the FY15 budget calls for a $100 million investment to modernize Social Security Administration operations and improve services, a reversal of budget cuts that have meant increased wait times and local office closures.

Money Follows the Person Demonstration

Senior groups were pleased that the Administration is proposing to extend and improve the Money Follows the Person (MFP) Demonstration, which helps those in need of long-term care transition from an institutional to home or community-based setting. The program would be extended to 2020, and funds could be used to prevent individuals from entering an institution in the first place.

Senator Warren Files Bill To Raise SSI Asset Limit

According to a group called Disability Scoop, a new bill proposed in the U.S. Senate, will raise, for the first time in more than 20 years, the amount of money that Supplemental Security Income (SSI) recipients could save without losing access to their benefits.

Currently, individuals who receive SSI can have no more than $2,000 in cash or liquid assets at any given time without forfeiting their eligibility for benefits. But the legislation, introduced in mid March, calls for that asset limit to increase to $10,000. The bill would also eliminate restrictions that currently disallow friends and family from providing financial, food and housing support to those receiving SSI and the measure would boost the amount of income beneficiaries could earn without losing out on benefits.

"SSI is a critical program that helps mil-

lions of our poorest and most vulnerable citizens keep their heads above water," said U.S. Sen. **Elizabeth Warren**, D-Mass., who proposed the bill along with Sen. **Sherrod Brown**, D-Ohio.

Warren said the legislation would "help strengthen SSI for families who rely on these essential benefits." More than 8 million Americans — including many with disabilities — draw on SSI. Currently, the maximum federal benefit for an individual receiving SSI is $721 per month, though many states tack on additional funding for their residents meaning that actual payments can be somewhat higher.

The last time the asset cap for SSI recipients was increased was in 1989, the senators said. A similar measure was introduced in the U.S. House of Representatives last year by U.S. Rep. **Raul Grijalva**, D-Ariz.

Berkshire Medical Center Reduces Readmissions

*The following article by **John LoDico** is reprinted from the Massachusetts Hospital Association's* Monday Report *newsletter. For other hospital efforts to reduce readmissions and fight infections, visit PatientCareLink."*

Across the state hospitals are uniting with community-based organizations to form tight, integrated clusters of care with the goal of reducing hospital readmissions. Focusing on high-risk Medicare patients recently discharged from hospitals, and funded through Section 3026 of the Affordable Care Act, these Community-based Care Transition Programs (CCTPs) are successfully cutting avoidable readmissions.

There are 102 CCTPs funded nationwide and four in Massachusetts, funded by the Centers for Medicare and Medicaid Services (CMS).

While the Massachusetts programs - in Berkshire County, Merrimack Valley, the Worcester/Framingham area, and Mystic Valley Basin - are free to construct their own care transition program, they all share some core elements: a partnership between Aging Service Access Points (ASAPs) and local hospitals, the formation of caregiving teams involving Nurse Practitioners and other "care transition coordinators" or "coaches" working within the hospital and patients' homes, and close tracking of results to report back to CMS. (The Massachusetts ASAPs are a network of 27 non-profit agencies, operating in defined geographic areas, with authority from the Massachusetts Executive Office of Elder Affairs to provide a broad array of services to help consumers remain successfully in their homes. They offer information and referrals for senior services, including home care services and housing options. Many ASAPs have expanded their service offering to also include care transition services.)

The coordinated care between hospital-based case managers, home care-transition specialists, post-acute providers, the patient's primary care physician and, in many cases, the patient's family, among others, ensures that appointments are kept, medicines are ordered and taken, and the pitfalls that result in readmissions are avoided.

"It's a very collaborative process," says **Patricia Eddy,** R.N., director of Clinical Services at Elder Services of Berkshire County, one of the 27 Massachusetts ASAPs. "We have a very close relationship with Berkshire Health Systems, so we have non-medical people working with medical personnel, all united to benefit patients."

The Berkshire model was created in December 2012 and first focused on patients discharged from Berkshire Medical Center's (BMC) Heart Failure Clinic. But the Berkshire CCTP program eventually branched out to include any Medicare patient being discharged from BMC, who is at risk of being readmitted.

Karen Benzie, R.N., BMC's V.P. of

Integrated Care and Home Health, says an R.N. within the hospital receives daily reports on all Medicare patients being discharged and then "risk stratifies" them to identify those most likely to be readmitted. The R.N., often accompanied by coaches from Elder Services of Berkshire County, then interviews the patient in the hospital, assessing how much follow up care is needed and the patient's existing support structure.

Once a patient is identified as being able to benefit from the CCTP program, Elder Services' Pat Eddy says, "We follow them home to bridge the gap between hospital and home. We try to get in the home with them within the first two days."

CMS pays a per-patient amount that funds the CCPT's care team. If avoidable readmissions are reduced, Medicare saves money and hospitals' CMS penalties for readmissions will decrease. Nationwide, CMS is evaluating the progress of CCTPs to consider the sustainability of care transition programs that effectively integrate hospitals with community-based organizations such as ASAPs.

Elder Services and BMC use a combination of the two best-known care transition programs - the Coleman Care Transitions Intervention and the Naylor Transitional Care Model. The Coleman model consists of one hospital visit and one home visit, with follow-up telephone calls by a coach (either a nurse, social worker, or other caregiver), all focusing on care fundamentals such as: going through the patient's medications and helping them manage their use; ensuring that an appointment with the patient's primary care doctor is scheduled within seven days; and ensuring the patient has means to get to that appointment.

Coleman coaches also walk through "red flags" with patients, families and caregivers - that is, the warning signs that the patient is getting sick and susceptible to going back into the hospital. For a patient with congestive heart failure, for example, a red flag could be the sudden weight gain of two pounds or more, signaling retention of water and decreased pulmonary function. A Coleman coach from Elder Services may also be able to help a patient get other, non-medical services, such as Meals on Wheels or the transportation to and from a doctor's office that can be critical to a patient's ability to follow through with their care plan.

Berkshire Medical Center delivers the Naylor side of the care transition, which is when a Nurse Practitioner (NP) provides a more intense medical care for patients who are at high risk for post-discharge complications. "We deal with complex patients with co-morbidities and maybe even dementia," says BMC's Benzie. "Even though many of these patients have family, the spouse may have disabilities or the family may live far away. So we end up helping the family as much as the patient." She says a key role for the Nurse Practitioner is to accompany the patient to his or her primary care physician for the first follow up appointment. The NP has already reconciled all of the medications so the PCP can quickly assess the prescription list without spending too much time on that aspect of care.

Pat Tremblay, MS, R.N. administrative director of Berkshire VNA, says that when the nurse practitioner arrives at the patient home, usually within 72 hours of discharge, patients are often reluctant to receive the care they agreed to in the hospital. That is, patients will tell a hospital case manager that they're receptive to home visits, or a visit from meals on wheels, but once in the comfort of their home, patients may feel they don't really need help.

"The nurse practitioner alleviates that disconnect," Tremblay says. "The more exposure we can get with the patient the better. A lot of our nurses have very close relationships with their patients and that helps them with goal setting. So we ask, 'What do you want out of this?' For some it's getting through an upcoming holiday, or being able to keep healthy enough so they can see their grandchildren."

Tremblay says once the goal is set, the nurse can say, "Ok, this is what you have to do to get there. This is why you need to track your medications closely or weigh yourself."

But oftentimes, no matter the goal, nurses have to conduct more serious conversations - about end-of-life care. Benzie says that while "the real goal is to do whatever is necessary to meet the patient's goal, at times we have to explain if that goal is not realistic." "In a very short time frame we have very intimate conversations with the patient, their families, and their doctor," Tremblay says. "We do advance life planning in a conducive environment - the home talking to patients about MOLST forms [Medical Orders for Life-Sustaining Treatment] or end-of life care. What we're doing during these conversations in the home setting is supplementing the information patients have received from their primary care physicians; we're responding to questions that patients or their families may have. The location of these difficult conversations and the time we can devote to them is key - so that's one thing that makes this program so different."

While the four CCTP care transition teams across the state are demonstrating the efficacy of care transition interventions, including low-cost supports by ASAPs, there are many other readmission-fighting programs also occurring. Massachusetts hospitals are taking advantage of lessons learned from - among other intensive programs - the Re-Engineered Discharge (RED) Toolkit from AHRQ; the STAAR Initiative (STate Action on Avoidable Rehospitalizations); and the statewide implementation of Medical Orders for Life-Sustaining Treatment (MOLST).

Currently, the Massachusetts Hospital Association (MHA) is serving as a Hospital Engagement Network (HEN) as part of the Centers for Medicare and Medicaid Services (CMS) Partnership for Patients (PfP) Campaign. Over the past two years most Massachusetts hospitals have been enrolled in HEN and are participating in this national quality improvement initiative to reduce readmissions by 20% by implementing evidence based interventions.

"Many hospital readmissions are the result of events that occur outside of a hospital's walls," says **Pat Noga**, R.N., PhD, MHA V.P. for Clinical Affairs. "It's easy to list readmission numbers and associated costs, but it's much harder to do the hard work of educating patients and the other parts of the care continuum - in effect, changing cultures inside and outside of the hospital - to reduce readmissions and help prevent patients from returning to the hospital within 30 days. It's tough to accomplish but hospitals are committed to the challenge." http://patientcarelink.org/Success-Stories/Berkshire-MC-Reduces-Readmissions2.aspx

BayCoast Bank Donates $10,000 for Elder Money Management

BayCoast Bank recently donated $10,000 to Coastline Elderly Services, Inc. for their Money Management Program, which pairs elderly individuals with volunteers who help them manage their money, pay their bills, and avoid debt.

Sandra Sevigney, Vice President & Retirement Plan Specialist at Plimoth Investment Advisors, an affiliate company of BayCoast Bank, has been an Advisory Board member for the program for several years and helped facilitate BayCoast's involvement. "Because of the essential service it provides the elderly and its focus on financial literacy, the Money Management Program seemed like a perfect fit for BayCoast. I was glad to be able to present them with the opportunity and help secure this grant for Coastline Elderly Services."

The first installment of the 2-year grant

was presented to Coastline by VP Regional Branch Manager **Paula Freitas**, who works at the Bank's Ashley Boulevard location, and Branch Manager **Monica Furtado** from the William Street office. "This is exactly the type of program our 'just right' philosophy is geared toward," said Freitas. "Monica and I are both very familiar with Coastline. It's our pleasure to present them with this grant for their Money Management Program."

Coastline's Money Management Program serves elders living in 23 towns from New Bedford to Fall River to Attleboro and towns in between. The elders are paired with volunteers who meet with them on a monthly basis to help them sort through their mail, and pay their bills. They also help protect elders from financial scams and abuse.

The BayCoast funding, awarded over two years, will help build more capacity in the program and allow volunteers to reach even more elders.

"This is such an important program," says **Paula Shiner**, Coastline's CEO, "for many older adults, this program is vital to their independence. In some instances, a volunteer helps them avoid excessive debt or eviction, allowing them to continue living in their own home, which is always Coastline's number one goal."

The Massachusetts Money Management Program was created in 1991 as a partnership between Mass Home Care, AARP Massachusetts, and the Executive Office of Elder Affairs. It is supported with state Protective Services funding, and by private donors, including BayCoast Bank.

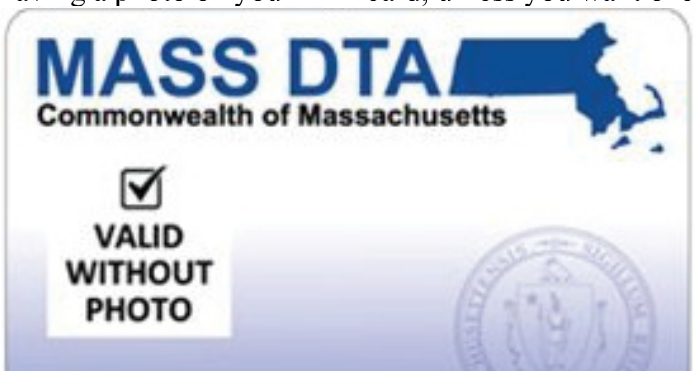
According to program founder **Al Norman** of Mass Home Care, support from BayCoast Bank will be key to the Money Management program's success. "This gives us a tremendous lift," Norman says "and shows how much BayCoast Bank is committed to its elderly customers and the Southcoast communities."

Using Photo EBT Cards

To update food stamp (SNAP) households, the Massachusetts Law Reform Institute has issued "3 Things You Need to Know About Photo EBT Cards." Massachusetts state law now requires that certain EBT card holders be issued Photo EBT Cards with their picture. If you receive SNAP or cash benefits, you may get a letter from DTA about the new photo EBT card. Here's what you should know:

1. About half of SNAP households will have a photo EBT card.

Under state law, households will get a photo-less EBT card when the head of household is: age 60 or older, disabled or blind, under age 19, a victim of domestic violence, or if you have a sincere religious objection to a photo. If you meet one of the above categories, you should be exempt from having a photo on your EBT card, unless you want one.



2. Every SNAP household member has the right to use the EBT card

Stores cannot refuse to accept the EBT card from household members, such as spouses or older children. This is true even if their name or photo is not on the card. In addition, caregivers you authorize can also use your EBT card to food shop for you. Just like a debit card, your PIN is what keeps your benefits safe and is your electronic signature. If the proper PIN is used, the shopper can use the card.

3. Stores cannot treat SNAP recipients differently from other shoppers.

A store clerk cannot ask to see your EBT photo card unless they routinely ask everyone using credit or debit cards to show a photo ID. Also, stores that accept EBT cards cannot set up "SNAP-only" checkout lines or discriminate against SNAP households. Federal rules protect the right of all authorized members to use the EBT card and to not be discriminated against. If a household member is not allowed to use the EBT card, or if you are being hassled or treated different from others shoppers, call your local Legal Services office, or 617-357-0700 x 315.