At Home

October, 2014

With Mass Home Care

Vol 27 #10

Al Norman, Editor

Mass Home Care photo

Home Care Aides: "Fight For 15"

Thousands of home care workers who provide daily care to the elderly and disabled in Massachusetts have joined fast food workers in demanding higher pay. On September 4th, Personal Care Attendants and home care aides rallied in front of the State House to raise awareness about the importance of homecare work and the need to raise the wages of all homecare workers. The rally was sponsored by the Service Employees International Union 1199, which represents roughly 20,000 PCA workers in Massachusetts as their collective bargaining union.

The workers gathered as part of the larger "Fight for 15" campaign, with the goal of raising the floor for all low wage workers. Home care agency workers as well as PCAs spoke about the need to raise all home care workers out of poverty. The SEIU said it hopes to build on the great work Mass Home Care and the Homecare Aide Council did in the FY 15 budget on Beacon Hill, in which home care aides won a $6.1 million wage add-on. SEIU will push to secure more funding for agency workers, as well as the longtime work of the independent living centers to raise wages for PCAs. "This action is part of a series of actions to highlight the work of all low wage workers in Massachusetts," the SEIU said.

Mass Home Care endorsed the State House rally, and spoke in favor of the Fight for 15 campaign.

Here is the text of the speech that Mass Home Care Executive Director **Al Norman** presented at the rally:

"Last January, the Home Care Aide Council and Mass Home Care began a joint lobbying effort to get a $6.1 million wage increase for the 17,000 home care aides serving the elderly. We were successful---but we were not done!

The home care program today in Massachusetts is a circle of poverty. Low income younger women, taking care of low income older women. The caregivers today, become the clients tomorrow. And the circle is unbroken.

A recent study by the U.Mass Gerontology Institute and the Mass Association of Older Americans concluded that a single elderly person renting a one bedroom apartment in Suffolk County needs to have $30,624 a year to pay for her basic needs without going into debt, and without going onto public assistance. Of all the elders who need help with home care in this state, 74% of them live below the elder economic security level.

Mass Home Care photo

But what about their workers? An older home care aide living alone, making $11 an hour today for a 35 hour workweek, will make $20,100 a year---and be living 35% below the economic security level. That same worker earning $15 an hour, will still be living 11% below the economic security level. So Mass Home Care supports the "Fight for $15" campaign, because its time to end economic insecurity for home care workers.

As President Obama has said, "No one working full time should have to raise their children in poverty."

DPH Caught Between A Rock And A Rest Home

One of the most neglected corners of human services in Massachusetts is the residential care facility program, otherwise known to the public as "rest homes." Not a nursing home, and not assisted living, the rest home industry has dealt for more than a decade with lack of attention, and lack of sufficient reimbursement. The fragile status of rest homes in Massachusetts has reached a "crisis," according to a new state report. but potential solutions leave DPH between a rock and a rest home.

On September 8th, the state Department of Public Health convened a group of around 20 providers at its Boston headquarters to review a draft report by a workgroup of state officials including the Department of Mental Health, MassHealth, DPH, and the Executive Office of Elder Affairs, who have been studying the rest home role in the long term care sector. The workgroup was convened by DPH Commissioner **Cheryl Bartlett**, and Associate Commissioner, **Madeleine Biondolillo,** M.D. The workgroup met during late 2013 and early 2014.

Rest Homes (RHs) are licensed by DPH as Level IV Long Term Care Facilities. These facilities provide 24-hour supervision and supportive services for individuals who cannot live independently, but who do not need skilled nursing or medical care.

RHs are mandated to provide housing, meals, social/recreational activities, supervision and administration of medications for individuals who need a supportive living arrangement. The population served by the RH industry range from elderly persons who cannot live at home yet require minimal supervision and care compared with nursing home-eligible residents, to those with considerable mental health and substance abuse issues, as well as the formerly homeless. In some instances residents in RH have criminal backgrounds and therefore are not eligible to be placed in public housing, despite having few care needs. Many RH residents are choosing to age in place and hence their needs for services become more involved over time.

Here are excerpts from the DPH rest home report: "Rest Homes comprise a fragile segment of the health

care industry in Massachusetts; yet currently provide housing/healthcare to almost 3,000 highly vulnerable people. For many of these residents, Rest Homes provide a service of last resort which prevents them from becoming homeless. Currently, voluntary closures of Rest Homes due to inadequate funding as well as anticipated forced closures due to unsafe care, exacerbated by a lack of alternative resources for residents, are creating a crisis in this industry. The Commissioner of the Department of Public Health (DPH) has determined that there is an urgent need to address the sustainability of the state's Rest Homes and identify whether alternate living and care options may exist or can be identified for this frail population.

Madeleine Biondolillo, DPH (center)

In January 2008, there were 125 Level IV Long Term Care Facilities licensed by the DPH, representing 3,923 beds. Currently (May 2014), there are in the Commonwealth 83 RHs supporting 2,823 beds. (Note: three RHs have recently submitted closure plans with an anticipated further loss of 86 beds.) During the past three years, community advocates (including disability advocates, municipal governments and the media) have raised concerns relative to the viability of RHs.

DPH has done a limited evaluation of RHs to determine their perceived quality including evaluation for deficiency history, compliance history, need for significant infrastructure improvement, and evidence of reasonable management capacity. For this evaluation, RHs were categorized as either very good, good, or needs help. The Department identified 14 RHs that are rated as poor performers, but are located in close proximity to a RH rated as "good." These facilities are in need of both financial resources and management support in order to more optimally perform.

Quality and Safety records of the RHs were cross-walked with rates for each facility. This review demonstrated a "Tipping Point" of approximately $90/day as the rate at which facilities seem more able to maintain a very good or good status in the DPH classification system. This is a rate significantly higher than the average $50/day rate payment, yet significantly lower than the rate for a Level II SNF.

During annual licensure surveys, the nature of deficiencies routinely documented by the Bureau of Health Care Safety and Quality (BHCSQ) at DPH in RHs have included severe safety, operational and health quality issues, including:

- Physical plants in desperate need of repair: leaking roofs, lack of heat and cooling systems, inadequate septic systems, lack of handicapped accessibility;
- Failure to check Nurse Aide Registry for criminal records prior to hiring staff;
- Failure to perform fire drills; failure to enforce no smoking rules;
- Failure to keep medications including Controlled Substances in a locked cabinet; and,
- Repeatedly unresolved infestation with bedbugs, lice and scabies.

Many facilities have been inspected numerous times with multiple deficiency statements issued. Follow-up inspections and re-inspections have been conducted to verify implementation of plans of correction. Often, upon re-inspection, the documented plans of correction have not been implemented as agreed to by the facilities, and RH residents are found to be at continued risk based on the health quality and safety deficiencies cited.

It is difficult to ascertain the costs that would need to be incurred by RHs in order to ensure adequate physical plant requirements. However, one poorly rated RH reported roof repair costs of approximately $45,000. Another such home reported

a heating system replacement cost estimate at about $35,000. In a third case, a 50-bed facility is in need of a new septic system estimated to cost approximately $400,000. (This last amount may represent too great an expense per capita to be a viable solution.)

Despite the circumstances of finding severe quality and safety deficiencies, DPH has few options. If DPH acts on a Rest Home license due to such ongoing, uncorrected safety and quality violations and individual residents are not willing to accept – or are not eligible for--accommodation elsewhere, homelessness rates may increase. In addition, as releasing a resident to homelessness is not an acceptable option, yet frequently due to residents' circumstances no other option exists, DPH is literally unable to revoke the license and close the RH. This leaves both the residents and the Department in an untenable situation.

Despite the increasing need for community housing, available options for the fragile populations that RHs serve are extremely limited. Yet, RHs play a vital role in responding to the need for community housing. In 2007-2008, a task force was convened to review the implementation of a proposed Public Health regulation that was designed to move the industry to an even more involved medical model, in part to encourage provision of funding to address safety issues. The proposed regulations were not implemented due to a lack of funding. The Inter-agency work group considered a community housing approach rather than the current medical model (licensing under LTCF regulation).

The Inter-Agency work group recognized two urgent priorities: The worst-performing Rest Homes must either be closed, or resources (financial and logistical) must be deployed in order to bring them into compliance with regulation. As described above, facility closure is fraught with problems. Therefore, for the worst performers, the following strategies are suggested.

• Critical safety infrastructure support: One strategy is to create (through an urgent supplemental budget request) a mini-stabilization fund for the RHs that have critical and insurmountable infrastructure needs. For example, $10M could be held in a DPH-managed fund that facilities could apply to in order to remediate their infrastructure problems. Criteria would be established by DPH with regard to awarding funds. These could include: the need for services in a given geography (Long Term Care Health Resource Planning would benefit this process greatly); the threat of homelessness for the resident population (versus the possibility of Agency case management identifying other potential sources of housing); and, whether the funding of infrastructure improvements in a given RH would yield sufficient resident capacity to justify the expense.

Mount Pleasant Rest Home, Jamaica Plain

• Quality Improvement – Leveraging industry skills and knowledge: Another strategy is the establishment of a collaborative learning/mentoring model of best practices within the industry in order to try to improve performance in all poor-rated RHs, especially those that receive the above-mentioned funding. Participation in such a program would be an obligation of receiving that finding. The work group identified fourteen (14) RHs designated as poor performers which potentially could be partnered with nearby RHs rated as good. This would be mutually beneficial, because if those fourteen worst performing RHs were able to adopt effective practices to improve facility performance that would benefit the facility/mentors. This is because those facilities would be the most likely location for residents to seek care if a nearby facility that closed.

• Expansion of Case Management to identify appropriate settings of care and delivery of services: In addition to these strategies, at the request of DPH, MAHealth

Office of Long Term Services and Supports has offered the solution that the expansion of Case Management from the MassHealth Office of Clinical Affairs may benefit RH residents. This may result in the identification of RH residents who do not require supervision, medication administration or supportive services who might be able to move into a community setting (with, for example, periodic, as-needed Home Health services and/or mental health support services). This may also identify potential opportunities for service from other Agencies if appropriate (e.g., DMH; Elder Affairs--evaluation for eligibility in congregate housing; DDS; MRC; and MCB. Also, Veterans Affairs, which is very interested in identifying Veterans who have aged in place and may be eligible for expanded benefits; possibly Group Adult Foster Care is also a potential solution for MassHealth enrollees. This service could provide additional personal aide supports for Rest Home residents and therefore alleviate some financial stress to the RHs themselves.

The group also acknowledged the importance for skilled nursing facilities to be an integral part in providing quality care for this particular population. In addition, wraparound services can be provided to this community provided that "low threshold housing" be available/designated by DHCD.

These are relatively low-cost measures that follow evidence-based practices of quality improvement, and confer great potential - even for such extreme problems. Putting in place this combination of initiatives is likely to vastly decrease the need to consider the harsh reality of risking greater homelessness closing more of the Commonwealth's valuable resource of Rest Homes."

At the DPH meeting, Commissioner Bartlett made it clear that "a major rate change for rest homes is not likely to take place." Associate Commissioner Biondolillo said the DPH would be open to "piloting some interventions," and would work to "develop some potential strategies."

But without fundamental rate relief, its not clear how many rest homes will survive over the next five years, given their precarious finances today. Mass Home Care noted that in 2007 it had recommended to Elder Affairs that the home care regulations should be amended to allow home care dollars to "follow the person" who moved into a rest home. Currently home care funds cannot be used for a client living in a rest home. Home care funds could be used by the Aging Services Access Points (ASAPs) to supplement the personal care needs of patients that a RH might not be able to handle. No action was every taken on that suggestion made seven years ago.

Census Numbers Predict Greater Home Care Need

The U.S. Census Bureau has released a new report called *65+ in the United States: 2010.* Here are some of the key findings from this report:

• In 2010, there were 40.3 million people aged 65+ in America--12 times more than in 1900.

• The percentage of the population aged 65+ among the total population increased from 4.1% in 1900 to 13% in 2010 and is projected to reach 20.9% by 2050.

• Eleven states had more than 1 million people aged 65+ in 2010.

•Massachusetts had one of the lowest percentage increases in 65+ population in the nation between 2000 and 2010---a 4.9% increase.. But at 902,724 people over 65, Massachusetts had 44% of all the seniors in New England. A total of 146,961 people age 65+ were added to the New England population in the first decade of the 21st century.

• By 2030, when all Baby Boomers will have already

passed age 65, there will be fewer than three people of working age (20 to 64) to support every older person.
• In 2010, Alzheimer's disease was the fifth leading cause of death among the older population, up from seventh position in 2000. The death rate for Alzheimer's rose more than 50% from 1999 to 2007.
• Over 38% of those aged 65+ had one or more disabilities in 2010, with the most common difficulties being walking, climbing stairs, and doing errands alone.
• The share of the elders residing in skilled nursing facilities declined from 4.5% in 2000 to 3.1% in 2010.

• Medicaid funds for long-term care have been shifting away from nursing homes with funding for home-and community-based services increasing from 13% of total funding in 1990 to 43% in 2007.
• Labor force participation rates rose between 2000 and 2010 for both older men and older women, reaching 22.1% for older men and 13.8% for older women.
• Many older workers managed to stay employed during the recession. In fact, the population aged 65+ was the only age group not to see a decline in their employment share from 2005 to 2010. In 2010, 16.2% of the population aged 65 and over were employed, up from 14.5% in 2005.
• People age 65+ saw a rise in divorces, as well as an increase in living alone, both of which will likely alter the social support needs of aging Baby Boomers.
• The population aged 65+ was the only age group to see an increase in voter participation in the 2012 presidential election compared with the 2008 presidential election.
• In 2010, Internet usage among the older population was up 31% from a decade prior.

So there are more seniors around, they are getting more home care and less nursing home care, they are on the internet more, they are retiring less, staying in the workforce longer, and more often living alone. All of these statistics have implications for who will need care, and the growing demand for care at home. Despite these Census Bureau demographic warnings, there are concerns that the state of Massachusetts has done little planning for the growing numbers of seniors who will need help to remain living independently.

Housing : The Linchpin To Well-Being

Harvard University's Joint Center for Housing Studies has released a new report which says that housing in "the linchpin for well-being." The rising number of older people needing affordable \ housing, with supportive care, presents new challenges for the public and private sector, if we are to be able to help seniors to remain integrated in their communities.

According to the JCHS report, "affordable, accessible, and well-located housing is central to quality of life for people of all ages, but especially for older adults (defined here as 50 and over). As the single largest item in most household budgets, housing costs directly affect day-to-day financial security as well as the ability to accrue wealth to draw upon later in life."

Other findings from the Harvard report on housing need include:

"Accessibility is essential to older adults' health and safety as physical and cognitive limitations increase. Proximity of housing to stores, services, and transportation enables older adults to remain active and productive members of their communities, meet their own basic needs, and maintain social connections. And for those with chronic conditions and disabilities, the availability of housing with supports and services determines the quality and cost of long-term care—particularly the portion paid with public funds.

But the existing housing stock is unprepared to meet the escalating need for affordability,

accessibility, social connectivity, and supportive services:

•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.

•The nation's transportation and pedestrian infrastructure is generally ill-suited to those who cannot or choose not to drive, isolating older adults from friends and family.

•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. The public policy challenges are immense.

Recognizing the implications of this profound demographic shift and taking immediate steps to address the deficiencies in the housing stock, community preparedness, and the health care system are vital to our national standard of living. The private and nonprofit sectors also have critical roles to play in developing new housing and care options that support aging in the community.

The older population will also become more diverse as the wave of young immigrants that arrived in the United States in recent decades reach age 50. With this growing diversity will come significant shifts in housing demand, reflecting the different housing situations and financial circumstances of minorities.

For example, older Asians and Hispanics are more likely to live in multigenerational households than whites or blacks. Their rising numbers will therefore affect not only the demand for institutional care, but also the housing, financial, and personal situations of their family members. And as a group, minorities have lower rates of homeownership, lower median incomes, and fewer assets, all of which affect their housing options.

In addition, the numbers of older adults with physical and cognitive limitations will increase sharply over the coming decades. With age, people are increasingly likely to face disabilities that pose challenges to living independently. The US Department of Health and Human Services (HHS) estimates that nearly 70 percent of people who reach the age of 65 will ultimately need some form of long-term care. This care can be costly, adding to the pressures on financially stretched older adults.

At the same time, the numbers of low-income older adults will climb. Assuming the share remains what it is today, millions more people aged 65 and over will have low incomes in the years ahead. The incidence of housing cost burdens also rises with age as incomes fall. As it is, however, a third of households aged 50–64 already pay excessive shares of their incomes for housing. Indeed, of special concern are the younger baby boomers who are now in their 50s and less financially secure than previous generations in the aftermath of the Great Recession. With their lower incomes, wealth, and homeownership rates, members of this large age group may be unable to cover the costs of appropriate housing and/or long-term care in their retirement years. The younger baby boomers are also less likely to be parents, implying that fewer family members will be available to care for them as they age.

On top of all these challenges, aging brings greater risk of isolation. In addition to the many older adults with disabilities who have limited access to their communities, millions of older households live in outlying areas, no longer drive, and lack transportation services. Moreover, older adults—particularly women—are increasingly likely to live alone, with single-person households making up 40 percent of all households in their 70s and fully 60 percent of households in their 80s. These householders often have disabilities as well as limited financial resources.

The vast majority of the 50-and-over population currently lives independently—that is, within the community rather than in institutional care facilities. Many are still in the workforce, some embarking on

second or third careers. Younger members of this age group may be part of the so-called "sandwich generation" that juggles work, care for children, and care for parents.

But even among individuals aged 80 and over, more than three-quarters live in their own homes. Indeed, "aging in place" is the preference of most people. In its recent survey of 1,600 people aged 45 and older, AARP found that 73 percent strongly agreed that they would like to stay in their current residences as long as possible, while 67 percent strongly agreed that they would like to remain in their communities as long as possible. Still, many households opt to move in their older years. Household changes such as retirement, children moving from the home or adult children returning to it, a disability, or death of a spouse give rise to new housing needs and preferences. In particular, finding more affordable housing may become a greater concern for those living on fixed incomes. But financial constraints also prevent people from adapting to their changing circumstances. Indeed, 24 percent of survey respondents expressed a preference to stay in their homes for as long as possible because they could not afford to move. It is unclear whether the baby boomers will follow the current trend of aging in place or whether new housing options will encourage many to move from the larger homes where they raised families. But for the millions in this age group who will stay in their current homes, ensuring their ability to do so affordably, comfortably, and safely presents several challenges.

As the single largest expenditure in most household budgets, housing costs directly affect financial security. Today, a third of adults aged 50 and over—including 37 percent of those aged 80 and over—pay more than 30 percent of income for housing that may or may not fit their needs. Among those aged 65 and over, about half of all renters and owners still paying off mortgages are similarly housing cost burdened. Moreover, 30 percent of renters and 23 percent of owners with mortgages are severely burdened (paying more than 50 percent of income on housing).

Having to devote a substantial share of their incomes to housing, older cost-burdened households are forced to scrimp on other critical needs. For example, severely cost-burdened households aged 50 and over in the bottom expenditure quartile spend 43 percent less on food and 59 percent less on health care compared with otherwise similar households living in housing they can afford. Of particular note, severely cost-burdened households aged 50–64 save significantly less for retirement.

Older homeowners are in a much more advantageous position when they retire. In addition to having lower housing costs, homeowners—and even those who still carry mortgages—typically have considerably more wealth than renters in terms of both home equity and non-housing assets. Resources can support the expense of changing needs later in life, including long-term care. The typical homeowner aged 65 and over has enough wealth to cover nursing home costs for 42 months and enough non-housing wealth to last 15 months. The median older renter, in contrast, cannot afford even one month in a nursing home. Indeed, only 18 percent of renters could pay for nursing home care for more than a year.

In addition, given that households in their 50s today confront a number of financial pressures, including more mortgage and non-housing debt, cost burdens may become even more widespread over time.

Millions of older adults who develop disabilities live in homes that lack accessibility features such as a no-step entry, single-floor living, extra-wide doorways and halls, accessible electrical controls and switches, and lever-style door and faucet handles. Indeed, the 2011 American Housing Survey reports that just 1 percent of US housing units have all five of these universal design features. Roughly two in five housing units in the country have either none or only one of these features.

Publically subsidized units are more likely to have accessibility features than unassisted low-cost units. Yet rental assistance reaches only a fraction of the older low-income population—even those with disabilities. The lack of accessible, affordable housing can result in premature stays in nursing homes or the inability to return home after a hospitalization.

Additional hurdles to aging in community are insufficient supports and services and/or a lack of transit options and safe pedestrian walkways. The majority of older adults live in low-density suburban and rural areas where it is difficult to shop, access services, or visit family and friends without using a car. As a 2010 AARP report revealed, about one in five respondents aged 50 and over occasionally or regularly missed activities they would like to do because they had limited their driving or given it up entirely City dwellers have greater access to transit but are no less at risk of isolation if they are unable to leave their homes alone because they lack transportation to where they need to go, do not have friends and family nearby, or have safety concerns. While transit may be an option for some, older adults use the services less often than other age groups—suggesting that public transportation may not meet their needs for convenience, safety, affordability, and reliability.

For individuals with disabilities or chronic conditions, the ability to age in place depends on having access to long-term care in their homes or communities. While Medicaid and Medicare generally do not cover such costs, some state Medicaid Home and Community-Based Services (HCBS) waivers do. Some may even pay for the cost of home modifications to improve accessibility. But eligibility requirements for this support vary widely and need outruns availability. For those who are not Medicaid eligible or do not qualify for waivers, the costs of in-home care can be substantial.

At any given time, only about 2 percent of older adults reside in group care settings. Even so, assisted living facilities, nursing homes, and hospices provide critical support for those recovering from acute medical episodes or at the end of life. According to HHS, 37 percent of those aged 65 and over will receive care in an institutional facility at some point in their lives, with an average stay of one year.

But many people in their 50s and 60s simply lack the resources to obtain appropriate housing and services as they age. Middle-income adults may discover that long-term care insurance and senior housing communities or other suitable alternatives are too expensive. Low-income households have even more limited options for good-quality, affordable, and appropriate housing… For these reasons, it is critical that the public and private sectors take steps to ensure that housing and health care systems support appropriate and cost-effective options for low-income older adults, and that communities provide housing, transportation, and service options for their older populations regardless of income.

Various nonprofit and public initiatives are demonstrating the benefits of linking housing with long-term care. The private sector is also developing new housing options, technologies, and services in recognition of the potential market for assisting older adults with aging in the community. A number of federal efforts need to be expanded.

In particular, rental assistance makes a crucial difference in the quality of life for those who recieve it. At their current scale, however, programs reach only a fraction of older renters with low incomes and high housing costs. Additional funding for housing with supportive services is also essential, given the

limited number of new units added in recent years and the need for reinvestment in much of the housing that does exist. In addition, changes to Medicare and Medicaid would enable better coordination of affordable, accessible housing with long-term care.

For their part, state and local governments can...require that all new residential construction include certain accessibility features, and offer tax incentives and low-cost loans to help owners modify their homes to accommodate household members with disabilities. Localities can also change their zoning to support construction of accessory dwelling units and mixed use developments that add housing within walking distance of services or transit.

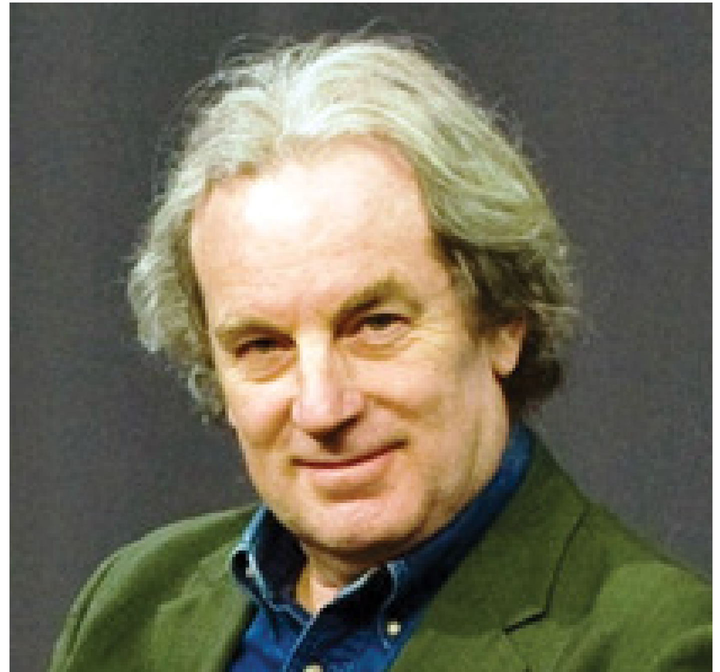
Municipalities—particularly the growing number with large 50-and-over populations—need to ensure that a range of services are available to older adults, including social and volunteer opportunities; education programs centered on health, finance, and housing maintenance; adult day care and meals programs; and health and wellness services. Meanwhile, state Medicaid programs can reorient their funding to enable low-income households to age in the community rather than in institutional facilities, as many are doing through HCBS waivers. And with better coordination, state and local government programs for older adults would not only save on costs but also provide better outcomes.

For the private sector, the growth of the older adult population provides vast opportunities to innovate in the areas of housing and supportive care. Indeed, substantial business opportunities exist in helping older adults modify their homes to suit evolving needs, delivering services at home, and developing new models of housing with services that promote independence and integrate residents with the larger community.

While there are significant challenges ahead, the potential is there for older adults to have a higher quality of life than ever before, and for communities to be increasingly livable and vibrant as a result.

But effective action will require concerted efforts at all levels of government as well as by the private and nonprofit sectors, and through the advocacy of older adults themselves.

Mass Home Care Staff Receives Elder Advocacy Award



Al Norman, the Executivae Director of the Mass Home Care Association, has been fighting for elderly rights in Massachusetts for 34 years---and on September 19th, he received an award honoring the battles he's fought.

The Massachusetts Association of Older Americans (MAOA) honored Norman with the **Elsie Frank** Elder Advocacy Award this year for his work at Mass Home Care. Elsie Frank was a past president of MAOA, and mother of former U.S. Congressman **Barney Frank**.

"Each year this award is given in recognition of a person whose work is committed, consistent and dedicated, a person who works on behalf of elders to make their lives better," said **Chet Jakubiak**, executive director of the MAOA. "Al Norman has been working in this field a lot of years. He's amassed an invaluable record of successes. It was an obvious choice."

MAOA is a statewide advocacy group promoting social and economic security for elders. It was founded in 1969 by **Frank J. Manning** and a group of retired men and women to fight for elder issues. The 45th annual ceremony was held Sept. 19th at the Boston Common Hotel and Conference Center.

In 1980, Norman began working with seniors as the Executive Director of the Franklin County Home Care Corporation in Greenfield, MA. Six years later, he became the head of the statewide Mass Home Care Association, based in Bedford, MA, a network of 30 non-profit agencies whose mission it is to help elders remain living at home in the least restrictive setting possible, at their highest level of functioning possible, for as long as possible. Norman calls that goal the "Three Possibles."

In his role at Mass Home Care, Norman serves as the policy point person and lobbyist for the Association on Beacon Hill. Norman currently is heading a legislative effort to expand MassHealth programs to allow spouses to be paid caregivers. While the Senate unanimously approved the bill this year, the House did not bring it forward for a vote before the end of the session. But Norman vows this bill will become law, after 7 years of trying.

Norman is used to long battles: the legislature debated his bill to require the state to give elders care in the "least restrictive setting" for six years—before the bill was signed into law by then-Governor **Mitt Romney**.

Norman also led a campaign this year for more funding in the home care budget, which resulted in a $24 million boost for seniors living at home. He also helped home care aides win a $6.1 million wage add on in the Elder Affairs budget.

He also helped created two elder care programs that expanded home care: the Enhanced Community Options Program (ECOP), and the Community Choices program, which today are close to $200 million in funding for elders who are at imminent risk of nursing home care.

Norman helped write key sections of community care law in the Commonwealth, including Aging Services Access Points (ASAPs), and the Senior Care Options (SCO) statutes. In addition, Norman was one of the original founders of the Massachusetts Money Management Program in 1991, a partnership with the Executive Office Elder Affairs and AARP Massachusetts, the largest program of its kind in the nation.

Norman manages the Little Necessities Program, funded by a private foundation since 2001, which has disbursed nearly $2 million in direct grants to older women who need goods and services they cannot receive from government sources.

Norman has served as the editor of Mass Home Care's AT HOME newsletter---which is archived on the Mass Home Care website---since 1986, and is a regular op-ed columnist for the *50+ Senior Advocate* for two decades.

Speaking of the work of a legislative agent, Norman says, "A good advocate is sometimes happy---but never satisfied."

One Care Plan, One Birthday

One year ago October 1st. the state of Massachusetts became the first state in the nation to begin a managed care plan for people age 18 to 64 who were enrolled in both the Medicare and the MassHealth programs. These people are known as the "duals" because of their eligibilty for two federal health plans.

After more than two years of planning, the One Care plan was launched with three managed care companies: Commonwealth Care Alliance, Network Health, and Fallon total Health. The state estimated that roughly 94,000 people in Massachusetts would be eligible for the program. Despite protests from disability rights groups, MassHealth decided to "passively enroll" clients into the plan, a form of mandatory enrollment. Members can "opt out" of the plan if they notify the state. In the first 9 months of the program, more people opted out than signed up.

The state has produced very little data about the plan, other than enrollment levels by county and plan, plus member rating classifications. No revenue or expenditure data has been made public.

Every member of a One Care plan is entitled to the services of an independent Long Term Supports coordinator---but as of July, only 3,300 people had been referred to a LTS Coordinator, around 17% of enrollees. A survey of 375 members found that 45% said they were referred to a LTSC, but 53% said they did not get referred, or were not sure.

The One Care plan covers full long term care supports, so state law requires all members to have initial an initial LTSC assessments