At Home

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With Mass Home Care

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Al Norman, Editor

photo: Candy Kuebel

Elders Tell MBTA: “No More Shut-Ins”

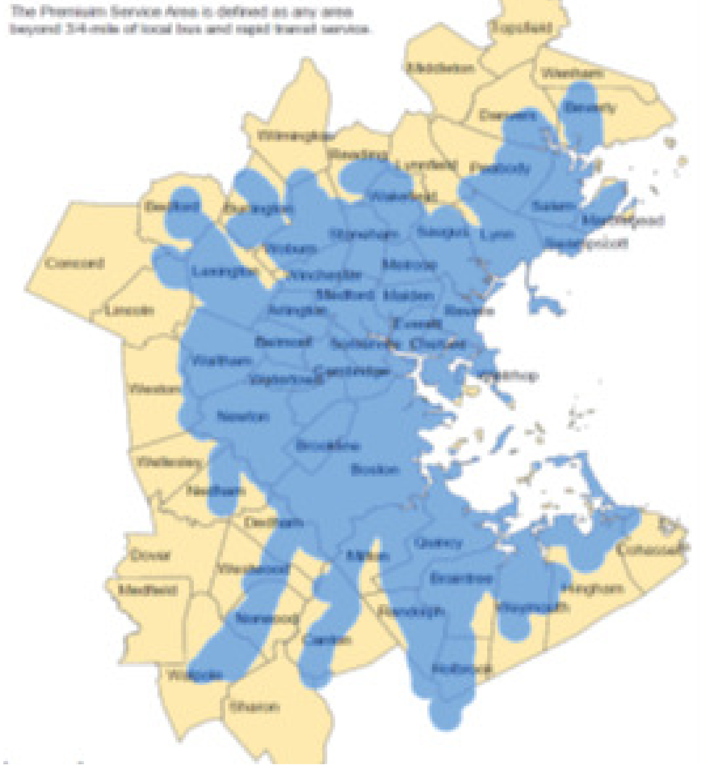
On December 14th, Mass Home Care testified at an MBTA hearing in Boston against a plan to cut RIDE services for the elderly and disabled. Here is the testimony presented by the Associaton’s Director of Member Services, **Candy Kuebel**:

“For these elderly and disabled riders, transportation is the key service that connects them to all the other services in the community: doctor’s offices, clinics, professional services, lawyers, grocery stores, basic shopping, etc. Transportation is the lifeline service in the community.

The MBTA Fiscal Management Control Board is deciding today whether or not to eliminate service for The RIDE for any so-called “premium” trips—those more than 3/4 mile from a bus or train line. The word “premium” makes it sound like these are non-essential trips, or some kind of luxury service. Nothing could be further from the truth. For those elders and disabled people who happen to live outside the ¾ mile limit—The Ride is a necessary essential mode of transport. We bring hundreds of thousands of meals into people’s homes—but we cannot bring doctors and other professionals into the homes of the elderly.

In parts of the state outside of the MBTA service area, our seniors rely on local or regional ‘demand-response’ transportation that picks them up at their door, and returns them again after their office visit or grocery shopping. If the MBTA takes The Ride off the road, we will lose more than 210,000 trips that not only link elders to needed services---but reduces their isolation in their homes for those who no longer can drive on their own. These elders may have given up their cars---but they should not be sentenced to imprisonment in their homes simply due to frailty. Residents in parts of at least 35 communities will fall into the 'No RIDE Zone.'

It was painful enough for seniors to cope with the doubling of The RIDE fares in 2012---from $2 to $4 and $5. A one way trip went from $2 to $4, and a new $5 fare for 'premium' trips and late-scheduled trips was introduced. The demand-response riders were burdened with a higher % rate hike than the fixed routes. This coming year these seniors will be living on the same Social Security check they got last year. They received no COLA—and now they may lose their community ride program! You have heard the term "shut-ins." Well, no senior wants to be called a "shut-in," but that's exactly what the MBTA will be creating if you put the brakes on "premium rides."



Yellow areas outside 3/4 mile will lose RIDE services

Demand-response rides are an Americans with Disabilities Act requirement for those riders within the ¾ mile limit of fixed routes, whose disability or health condition limits them from using fixed route services. Only people who are certified by the Transportation Authority (MBTA or RTA) are eligible to ride ADA Paratransit. Since October of 2012, eligibility for RIDE customers has required an in-person MBTA assessment . So elders don't get this service unless they need it.

Last November, the MBTA Fiscal Management Control Board began reviewing options to cut the RIDE budget. On the list of cutbacks was a proposal to eliminate "premium" rides. Any service not required by the ADA was vulnerable. People within ¾ of a mile of a bus or train route would not be affected—only those people further out—the ones most at risk of being stranded in their apartments. Most of these people are poor, many on Masshealth. They have no alternative transit service. They can't afford cabs, or wheelchair vans. They do not have family or friends to drive them. If they lose The Ride, they may skip a doctor's visit, and end up being driven to the ER in an ambulance instead---just what health care reformers and taxpayer's of this state are trying to discourage.

In a perfect world, everyone might be able to use the fixed route system. But this Board understands that the very people who need the MBTA the most---the disabled and the elderly---are the biggest losers if you slash The Ride. You might as well lock seniors in their homes if you enact this plan. You are creating a neighborhood of shut-ins for those who happen to live outside the invisible line. Use of the RIDE has plummeted by roughly 20% since fares were hiked in 2012.

The MBTA agreed to mitigate the RIDE fare increases, and developed a means-tested fare pilot program for the RIDE, which began six months ago. Mass Home Care urges this Board to continue to seek solutions that keep elders and disabled people on the busses—and not to kick them to the curb.

We have enough shut-ins in Massachusetts. We don't need to create more."

PCA Workers Get Overtime & Travel Time Pay

January, 2016 will make the job of a Personal

Care Attendant (PCA) a little more rewarding, as new federal labor standards go into effect.

The U.S. Department of Labor (DOL) has issued a Final Rule revising federal regulations that implement the FLSA. The result of this new rule is that PCAs may receive overtime pay for hours worked in excess of 40 hours per week for one or more consumers cumulatively and pay for intra-day travel time when traveling between one consumer employer's home and another consumer employer's home on the same day to provide PCA services.

Beginning on January 1, 2016, roughly 30,000 PCAs will automatically receive overtime pay for hours worked in excess of 40 hours per week for one--or more--consumers combined, as well as pay for intra-day travel time in which a PCA travels between one consumer employer's home and another consumer employer's home on the same day to provide PCA services. To facilitate this, MassHealth's contracted fiscal intermediaries will track the cumulative hours worked by PCAs each week, even if they work for more than one consumer, and will automatically calculate any intra-day travel time.

Prior to January 1, 2016, if a consumer needed to schedule a PCA to work more than 40 hours per week, the consumer had to contact his/her designated personal care management agency to make a request for prior authorization for premium pay for overtime. Now the process will be automatic.

The Massachusetts Executive Office of Health and Human Services (EOHHS) is holding three public statewide listening sessions on these changes implementing the Fair Labor Standards Act (FLSA) and the MassHealth PCA Program's implementation of these requirements. The purpose of these listening sessions is to “gather information from PCA consumers, PCAs, interested stakeholders and the general public on how to improve the PCA program in a way that ensures consumers receive all of their authorized PCA services while minimizing the need for PCAs to work overtime.” EOHHS said these listening sessions are an opportunity for MassHealth to “obtain input on ways to enhance the health care experience of PCA consumers and to gather ideas on how to make the MassHealth PCA program more sustainable.” The word “sustainable” means “more affordable” to the state, since the cost of these new work rules could add a significant expense to the program, which costs several hundred million dollars before the new rules go into effect.

The PCAs themselves, and their union, 1119 SEIU, have negotiated a wage agreement that calls for PCAs to earn $15 an hour by July of 2018, which would make them one of the first PCAs in the country to reach that level. Advocates for the elderly want all in-home workers, including PCAs and home care aides, to earn at least $15 an hour.

“We're pleased to see the federal government moving ahead with travel time pay and overtime pay for PCAs,” said **Dan O'Leary**, President of Mass Home Care. “If we want the elderly and individuals with disabilities to get good support from these workers, we need to show the workforce that we financially value what they do.”

The two remaining hearings on PCA wages will be held on Friday, January 22, 2016, from 1:00 - 3:00 P.M. at the Saxe Meeting Room in the Worcester Public Library, 3 Salem Square in Worcester, and on Wednesday, January 27, 2016 from 1:00 - 3:00 P.M. at the Community Room in the Mason Square Branch of the Springfield Public Library, 765 State Street in Springfield.

Hillary Clinton Proposes Tax Credit For Caregivers

According to a report in the *Los Angeles Times*, Presidential candidate **Hillary Clinton** has proposed a new federal tax break for people who care for their aging parents and grandparents.

The former Secretary of State made her proposal as part of a town-hall meeting in Mississippi in late November. Clinton said she wanted to give caregivers a tax credit to offset up to $6,000 in caregiving costs for elderly family members. The tax credit would apply to 20% of those expenses up to a maximum federal tax savings of $1,200.

"We need to recognize the value of the work that caregivers give to all of us, both those who are paid and the great number who are unpaid," Clinton told the media. Her caregiver proposal is part of a series of federal tax breaks that Clinton is targeting to the middle class. Clinton noted that the number of Americans needing long-term care will explode from 12 million people today to 27 million by 2050. Family members today often have to take time off from their job, or , use vacation time or personal time to care for their loved ones.

Photo; Odysseyonline

Clinton's campaign estimates that her tax relief could cost around $1 billion a year over the next ten years, and that she would pay for it through "other revenue" increases. "The lost wages and the work that is sometimes given up are costing families — especially women, who make up the majority of both paid and unpaid caregivers," Clinton explained.

Clinton said she also hopes to provide additional Social Security benefits to people who spend time out of the workforce—mostly women-- to care of immediate family. She wants to increase support for care workers and increase funding for a program that offers state-level grants to programs for caregivers.

During a stop in Tennessee, Clinton promoted a tax credit up to $5,000 for families and $2,500 for Americans with out-of-pocket healthcare expenses exceeding 5% of their income. Her campaign said the tax cut would be funded through tax increases on wealthy families and by "demanding" rebates from drug manufactures.

Disability Rights Group Speaks Out On Managed Care Plan

The major work product consuming the attention of MassHealth, the largest health program in Massachusetts, is the development of new managed care entities known as Accountable Care Organizations (ACOs). For the past several months, MassHealth has convened a series of 8 workgroups involving a couple of hundred stakeholders. The agenda is to create large health provider networks to manage Medicare and Medicaid funds in an integrated health plan.

Elderly and disability rights groups have approached managed care with great caution, especially when the entities in line to become ACOs are medical networks of hospitals and doctors. Advocates worry that ACOs will "medicalize" the long term services and supports (LTSS) networks, and de-emphasize the importance of functional supports, and social factors that influence health outcomes, such as income insecurity, substandard housing, poor nutrition, and inadequate transportation. Such 'social determinants' can have a major impact on health outcomes.

On December 7th, advocates for individuals with disabilities sent a letter to the EOHHS Assistant Secretary for MassHealth, **Dan Tsai**, regarding the reforms needed to make the state's proposed plan for Accountable Care Organizations (ACOs) work for the disabled. Here are excerpts from the letter from **Bill Henning** and **Dennis Heaphy**, co-chairs of the group Disability Advocates Advancing Our Healthcare

Rights:

Dear Assistant Secretary Tsai:

Disability Advocates Advancing Our Healthcare Rights (DAAHR) wishes to thank you for your commitment to building a healthcare delivery system that better meets the needs of the poorest residents of Massachusetts, including people with complex physical and behavioral health disabilities, intellectual and developmental disabilities, and a variety of other chronic health conditions. We support the state's intention to secure performance incentive payments within CMS's Delivery System Reform Incentive Payment (DSRIP) program under the broad authority of the 1115 Waiver to transform the health care delivery system.

Dennis Heaphy *Bill Henning*

The purpose of this letter is to ask you to consider DAAHR's recommendations for transforming the system in order to build a sustainable infrastructure, with an emphasis on quality-of-life goals, to best serve MassHealth members with disabilities. We also want to state our appreciation for the many recent steps your office has taken to support innovative healthcare, including continuation of the One Care demonstration and by delaying the inclusion of long-term services and supports (LTSS) and home and community-based services and supports (HCBS) into the ACO program currently under development.

Transformation of the service and care system for MassHealth members with disabilities requires careful design and implementation to prevent perpetuating the status quo, creating new but only marginally improved systems, or worse yet, causing harm to members. Throughout this effort, MassHealth faces a number of challenges, including ones pertaining to politics, policy priorities, and analytics. Addressing the social determinants of health by linking payments to meaningful metrics and outcomes will be essential to the reform effort. MassHealth must raise the bar for clinical care while tackling the issue of over medicalization to ensure that resources are directed to total health and wellness. Within this framework, enrollee choice will be vital.

Large systems may seek control over the flow of resources and extended control over the broader service delivery system, which can seriously dilute person-centered care and jeopardize existing community-based care and services.

Cost and value, of course, must support the vision for improved person-centered care built around total health and wellness. DAAHR asks that MassHealth use DSRIP funds to support a community-based delivery system with a strong infrastructure, investing in information technology (including provider compatibility) and workforce development, including community health workers, peer specialists and other care providers.

The administration's efforts to better compensate PCAs exhibits a commitment to community-based services and person-centered LTSS that should be replicated. CBOs must not be put in the position of balancing the books on the backs of their staff.

It is critical that this transformation effort include the points below.

DSRIP dollars should be used to support integration of service delivery systems that are central to reducing tertiary care and associated high costs. This includes ensuring that MassHealth:

1. Distribute DSRIP funds to both ACOs and community-based organizations; funds should not have to flow exclusively through ACOs.
2. Invest DSRIP funds into building provider capacity to comply with the ADA, including guaranteeing that facilities and medical equipment are accessible, with complementary policies and procedures. We can no longer embark on system transformation of healthcare for people with disabilities if the system itself is allowed to be inaccessible.
3. Invest DSRIP funds upfront into non-clinical services

"beyond the clinic walls" to reduce negative social determinants of health, food instability, homelessness, housing instability, lack of access to transportation, and underemployment.

4. Invest DSRIP funds to provide adequate compensation to CBOs, especially their staff, to ensure capacity and competency in service delivery. Value-based purchasing arrangements should reflect this commitment.

ACOs should have the flexibility and Infrastructure to support innovation while also being guided by a defined set of incentives and outcome requirements to protect MassHealth enrollees. It is requested that MassHealth:

5. Establish requirements that ACOs are led by a diversity of entities and that governance committees include consumers and community-based providers. ACO boards must be comprised of at least 50 percent non-hospital entities. The definition of "risk bearing" should be broad to allow for the most inclusive governance structures within ACOs.

6. Create a glide path to support the creation of alternatives to medically-driven ACO models; consider investing in behavioral health, disability and other community organizations that address social determinants of health, with a longer-term commitment to bring them to suitable scale and expertise.

7. Establish a risk-adjustment approach that accounts for social, cultural, and economic factors so that:

a. Resources are available to provide culturally and linguistically appropriate medical services for people who are poor, are homeless, have difficulties with English, are from ethnic and/or minority populations, and have physical, mental health, intellectual or sensory disabilities.

b. Resources are available to address social determinants of health, including need for food, fuel assistance, and housing assistance, with maximized opportunity to collaborate with community-based providers such as WIC, immigration organizations, and housing authorities to increase quality of care and support nutrition and housing security.

The 1115 waiver must support person-centered care and protect MassHealth beneficiaries from harm. This can be done by ensuring that MassHealth:

8. Maintain the independence of LTSS for a minimum of the first two years of the initiative, with integration occurring only after a transparent review of the suitability of integration. All ACOs must be required to create a plan for integrating community-based LTSS into their system, with participation from LTSS providers, users of LTSS, and advocates that must be approved by vote of an implementation council established for the initiative (see below).

9. Keep auto assignments to ACOs or health homes to low numbers, and any successive assignments should be informed by performance data. The salient lesson of One Care is that initiatives for people with complex service and healthcare needs should be allowed to grow to scale, not be forced to do so. Enrollment in an ACO or health home must be intentional on the part of members.

10. Protect consumer choice by including choice of plans, services, and coordination. Consumer choice is vital. This includes but is not limited to consumer access to:

a. A delivery system that is equitable, population-based, and person-centered with services provided to consumers based on identified need, not payer.

b. An "opt out" provision for enrollees of ACOs so they can, at the end of each month, be able to join another ACO or leave the ACO system and receive services through the fee-for-service system.

c. An independent, conflict-free case manager or service coordinator for all enrollees in ACOs and health homes.

d. A care coordinator function carried out by the person of the consumer's choosing— and not necessarily a primary care doctor.

e. All providers outside the ACO network through single-case agreements to support continuity of care and access to expertise that may not exist within a network, ensuring that the complexity of a person's needs and/or lack of choice of specialists within a geographic area is not a barrier to care or service.

f. In-person comprehensive assessment of enrollee needs within 30 days of enrollment in an ACO at a place of the enrollee's choosing, with preference given to assessments being done in the enrollee's home.

g. Measurable integration of recovery principles and independent living philosophy into the development and implementation of care plans.

h. Control over medical records, including determination of who has access to a consumer's medical records and the right of the consumer to have access to her or his medical records, including medical notes.

There also must be strict monitoring and enforcement of the requirement that ACOs not discriminate against those who request to join the group.

11. Establish an implementation council or similar MassHealth consumer-majority body. Its role should include guiding the overall growth and implementation of the waiver, including the review of systemic trends in collaboration with MassHealth, CMS, the various plans and providers, and an ombudsman office. The council should have access to and control over its own budget.

12. Establish an independent ombudsman office similar to what exists for One Care to support innovation, protect members on an individual basis, and address systemic concerns as they arise. Other consumer protections, such as rights to appeal services, must be established.

13. Extend enhanced benefits available to One Care enrollees to ACO enrollees. This includes the integration of oral health through provision of full dental benefits for enrollees and zero co-pays for prescriptions and all other services.

Put in place systems that support innovation in value-based purchasing and creation of transparent quality metrics:

14. Develop outcome measures reflecting consumer values such as independence, self-direction, employment, and integration, documenting rebalancing of spending and use of a variety of LTSS by consumers. To be effective a value-based purchasing system must include incentives that may not result in direct savings but will lead to overall enrollee wellness.

15. Create a public-facing dashboard that includes population-specific metrics and a star rating system. The dashboard should include current quality metrics and metrics to be piloted over the course of the five-year waiver. Community involvement in the determination of ACO performance criteria and transparency is fundamental. The dashboard should include objective metrics that assist consumers to make an informed choice when choosing an ACO.

We thank you very much for your consideration of our concerns and the exhaustive work that you and your team have undertaken to engage the disability community in health reform."

Caregiver Bill Advances in U.S. Senate

Sen. Susan Collins/ Huff Po photo

In early December, the Senate passed the Recognize, Assist, Include, Support, and Engage (RAISE) Family Caregivers Act (S. 1719/H.R. 3099), which would require the development of a national strategy to recognize and support family caregivers. The bipartisan measure was promoted by AARP and others and was originally introduced by Senators **Susan Collins** (R-ME) and **Tammy Baldwin** (D-WI) and Representatives **Gregg Harper** (R-MS) and **Kathy Castor** (D-FL).

According to the National Association of Area Agencies on Aging (n4a) the bill would implement the bipartisan recommendation of the federal Commission on Long-Term Care that Congress require the development of a national strategy to support family caregivers, similar in scope to the national strategy developed to address Alzheimer's disease.

The AARP said, the bill would bring together key federal agencies and others from the private and public sectors, such as family caregivers, older adults and people with disabilities, health care and LTSS providers, employers, relevant industries, state and local officials, and others on an advisory council to advise and make recommendations regarding the national strategy. The advisory council meetings would be open to the public and there would be opportunities for public input.

The strategy would identify specific actions that government, communities, providers, employers, and others can take to recognize and support family caregivers, including with respect to:

- promoting greater adoption of person-and family-centered care in all health and LTSS settings, with the person and the family caregiver (as appropriate) at the center of care teams;
- assessment and service planning (including care transitions and coordination) involving care recipients and family caregivers;
- training and other supports;
- information, education, referral, and care coordination;
- respite options;
- financial security; and
- workplace policies and supports that allow family caregivers to remain in the workforce.

There would be 18 months for the development of the initial strategy, followed by annual updates of the strategy. The bill would improve the collection and sharing of information, including related to evidence-based or promising practices and innovative models regarding family caregiving; better coordinate, maximize the effectiveness, and avoid unnecessary duplication of federal government activities to recognize and support family caregivers; assess federal programs around family caregiving; and address disparities and meet the needs of the diverse caregiving population. The strategy and work around it could help support and inform state and local efforts to support family caregivers.

Advocates now look to the House to pass the companion bill, H.R. 3099.

Improve Nutrition, Improve Health Outcome

A new study concludes that many hospital patients receive no information about nutrition benefits that could be important to their health.

The Gerontological Society of America survey found that only 6% of hospitalized elderly received information about Supplemental Nutrition Assistance Program (SNAP) benefits, the federal government's food stamp program. Only 3% of hospitalized older people received information about group meals programs such as Meal on Wheels, or congregate meal sites at senior centers. Yet the malnourished generate bills $2,000 to $10,000 higher per hospital stay than others do, according to another study in the Journal of the American Dietetic Association.

In a story produced by WBUR radio, it was noted that "between 8% and 16% (2.5 to 4.9 million) of the elder population have experienced food insecurity within a 6-month period. Federal programs to combat food insecurity reach only one-third of needy elders. While hunger and poverty are linked directly to malnutrition, the multifaceted nature of elderly malnutrition cuts across all economic, racial, and ethnic groups. Malnourished patients experience 2 to 20 times more complications, have up to 100% longer hospital stays, and compile hospital costs $2,000 to $10,000 higher per stay." Dietitians have advocated conducting routine nutrition screening in hospitals to target elders at highest risk and have lobbied for expansion of appropriate nutrition services in home, community, and institutional settings.

Another study published in the journal Clinical Nutrition found a threefold increase in medical costs among the malnourished. Hospital stays can also cause or worsen elder malnourishment: Older patients often don't eat well in the hospital, and doctors may prohibit them from eating or drinking in preparation for medical procedures. Malnutrition has been identified as affecting patient outcome. The purpose of this study was to correlate the nutritional status of hospitalized patients with their morbidity, mortality, length of hospital stay and costs. The patients were nutritionally assessed within the first 72 hours of hospital admission. The patients' charts were surveyed on the incidence of complications and mortality. Hospital costs were calculated based on economic tables used by insurance companies.

The incidence of complications in the malnourished was 27%. Mortality in the malnourished patients was 12.4% vs 4.7% in the well nourished. Malnourished patients stayed in the hospital for 16.7 to 24.5 days vs 10.1 to 11.7 days in the nourished. Hospital costs in malnourished patients were increased up to 308.9%. It was concluded that malnutrition is an independent risk factor impacting on higher complications and increased mortality, length of hospital stay and costs.

Rose Ann DiMaria-Ghalili, a nurse and researcher with Drexel University's College of Nursing, says better nutrition can improve hospital outcomes and reduce hospital readmissions. "We know," she says, "that weight loss increases the risk of 30-day readmission. And that failure to thrive and weight loss are frequent reasons for readmission in surgical patients." Another researcher commented: "If you can't eat well, you're going to end up in a nursing home, or you're going to end up back in the hospital."

Given mounting evidence that better nutrition in both older patients and seniors living at home is a cost-effective way to improve health outcomes—not to mention quality of life—nutrition researchers suggest several fixes: hospitals should establish systematic screenings and intervention models for patients entering and leaving the hospital; doctors and nurses also could review patients' nutritional status as a vital sign, just as they do blood pressure or temperature.

Is This The Year Of the Caregiver?

Could 2016 be the Year of the Caregiver? Activity on Capital Hill and Beacon Hill suggests that family caregiving is moving to the center of the public policy stage. And not a moment too soon.

Caring for aging relatives might seem like a task most commonly performed by people in their 50s and 60s, but almost a quarter of the adults who take care of older peopled—along with holding down a full-time job--are people between the ages of 18 and 34, according to research published by the AARP Policy Institute and the National Alliance for Caregiving.

Kaiser Health News reports that families and communities are grappling with how best way to take care of the aging adults. Roughly 40 million Americans considered themselves caregivers in 2013, according to the AARP report. These caregivers are typically women, and their median age is 49. The work they do caring for older relatives---usually parents and grandparents--was estimated that same year to be worth about $470 billion.

This caregiving can prove exhausting to family members. The federal Administration for Community Living (ACL) says that one third of the caregivers they interviewed said they spend more than 40 hours per week caring for an older relative. More than 1 in 4 said stress was the most significant challenge they faced; 11% said financial strain was their greatest challenge, and 16% said their biggest concern was not having enough time to do everything.

Almost 90% of people who care for their older relatives perform medical tasks, like managing medications or taking care of wounds, said **Edwin Walker**, the ACL's deputy assistant secretary for aging. Often, those people don't have medical training. "A significant number are doing more than just the basic assistance with family living," Walker told *Kaiser Network News.*

The issue of caregiver needs has reached Congressional policymakers. A number of bills pending in Congress would alleviate some of the pressures on caregivers: for example, offering Social Security credits for people who have to take care of their relatives. Such credits would help people who had to drop out of the workforce to take care of a family member preserve their contribution to Social Security retirement benefits.

The Institute of Medicine is releasing a report next year on the state of family caregiving, and a number of states are processing legislation that would help hospitals better communicate with and train an older person's caregiver, especially after a hospitalization. Such legislation has been introduced on Beacon Hill by AARP Massachusetts. As noted earlier, Democratic presidential candidate **Hillary Clinton** has proposed a tax credit to help caregivers, which would pay back up to $1,200 of the money they spend. Her plan would also give Social Security credits for people who stop working because of their caregiving responsibilities.

Holiday Cheer: Mass Home Care's 'Little Necessities' Fund

With the 2015 holiday season upon us, Mass Home Care disclosed recently that it has been managing for 16 years the selection of recipients from a private trust fund that pays for "little necessities" for women over the age of 60 across Massachusetts.

Mass Home Care uses 26 local non-profit agencies to carry out the program on behalf of elderly clients who receive home care assistance to remain living independently at home. Between 2001 and 2015, the Little Necessities program has awarded $2.34 million dollars to 8,435 older women. These women are all elder home care program clients.

A Trust for older women was created in 1912 to assist "needy and deserving gentlewomen, in reduced circumstances, that their lives may be made more comfortable." In 1999, the Trust asked Mass Home Care to manage the selection of gift recipients , and the Little Necessities Program was created. The Trust has asked to remain anonymous.

Little Necessities awards help older women maintain their independence, living comfortably and safely in their own homes. Typical grants are in the $250 range, but run as high as $900. Awards covered a broad spectrum of goods and services, including such standard items as lift chairs, mattresses and bedding, bed frames, rollators, vacuum cleaners, microwave ovens, and air conditioners, along with items like furnace repair, portable oxygen, dentures, hearing aids, and groceries—the basics of daily living. The fund has prevented evictions, replaced broken railings and steps, and helped people get to medical appointments.

A 73 year-old woman with diabetes and pulmonary disease was forced to leave her apartment when her landlord sold the building. She moved into a homeless shelter and used what little funds she had left to pay for storage for her belongings. Workers at her local Mass Home Care member agency found her a first floor apartment, and paid $500 to help the elder move and unpack into her own apartment.

"We can pay for many of the things that low-income seniors can't afford---and most grants won't cover," explained **Al Norman** of Mass Home Care, who created and oversees the program.

Mass Home Care said it is hoping this philanthropy will inspire others to offer support for low-income seniors. Any member of the public who wants to help Mass Home Care expand the Little Necessities program can contact: info@masshomecare.org.

State Adopts Public Hearings for SNF, Rest Home Closures

On December 16th, the state's Public Health Council voted to amend state regulations to require nursing facilities and rest homes to hold public hearings in the case of proposed facility closure, application for a license, or transfer of a license. During calendar year 2014, 56 nursing facilities were acquired by a new owner, 9 nursing facilities and 2 rest homes closed. Current Department of Public Health regulations do not provide for public hearings for either closures of changes of ownership—except in Southeastern Massachusetts, where 50 individuals can petition DPH for a hearing.

But in 2014 the State Legislature passed a law directing that a public hearing process be established that allows for public input on any application for a license, notice of intent to transfer ownership or notice of intent fo sell or close any skilled nursing facility, whether for profit or not for profit.

Existing state regualtions required DPH to review and monitor the adequacy of the licensee's closure plans, and to ensure the ultimate safe and orderly transfer of patients. But it has no public hearing process. A nursing home owner must submit notice to DPH of its intent to close at least 60 days in advance of the closure, and each patient needs to be notified at least 45 days before they are relocated.

The new regulations approved by the Public Health Council regarding facility closures and license transfers allows "10 adults" to request a public hearing. Family members and staff who might live out of state will be able now to petition for a hearing.

The new regulations require the owner to provide initial notice to residents, family, staff and community at least 14 days before a public hearing. The public hearing on a draft closure plan must be held at least 90 days prior to the proposed closure date, and the facility must submit a draft closure plan to DPH following such a hearing, with DPH approval or comments within 14 days after receiving the plan. The owner then has another 14 days to finalize their closure plan.

The facility must provide formal notice to the residents and to their family, and to facility staff, at least 60 days prior to closure. A facility cannot close until all residents have been relocated---which is a current requirement as well.

When a nursing home is being transferred, the new regs provide the opportunity for public input, a public hearing allowed upon petition on a statewide basis, not just in Southeastern, Mass.

In a statement to the Public Health Council, DPH said its "objective is the safe and orderly transition of residents." The new regs do not give DPH authority over the sale of real estate, or to require a LTCF to stay open after each resident has been relocated.

Paul Lanzikos, the Executive Director of North Shore Elder Services, and a former Secretary of Elder Affairs, who sits on the Public Health Council, said:"These regulatory changes are intended to enhance the ability of nursing facility residents and staff members to influence the process and timing of a proposed closure or transfer of ownership of the facility. The regulations provide for public hearings and specify minimal timelines and key milestones for the process. While they do not provide the opportunity to delay or avoid closure or transfer, they do offer an effective mechanism to create meaningful safeguards for residents' and staff members' rights and well being."