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The Dignity Digest

Issue # 188 May 21, 2024

The Dignity Digest is information compiled by Dignity Alliance Massachusetts concerning long-term services, support, living options, and care issued each Monday.
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<tr><td></td><td>*May require registration before accessing article.</td></tr>
<tr><td>DignityMA Zoom Sessions</td><td>Dignity Alliance Massachusetts participants meet via Zoom every other Tuesday at 2:00 p.m. Sessions are open to all. To receive session notices with agenda and Zoom links, please send a request via info@DignityAllianceMA.org.</td></tr>
<tr><td>Support Dignity Alliance Massachusetts during May, Older Americans Month.

Please Donate!</td><td>Dignity Alliance Massachusetts is a grassroots, volunteer-run 501(c)(3) organization dedicated to transformative change to ensure the dignity of older adults, people with disabilities, and their caregivers. We are committed to advancing ways of providing long-term services, support, living options and care that respect individual choice and self-determination. Through education, legislation, regulatory reform, and legal strategies, this mission will become reality throughout the Commonwealth.

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Thank you for your consideration!</td></tr>
<tr><td>Spotlight

Editors note: See online text for the following charts and graphs:

Table 1: Population Aging United States and New England states 2010-2021

Figure 1: Number of Nursing Homes Indexed to FY 2010 United States, New England, and New England states FY 2010-2023</td><td>Nursing Home Closures in New England: Impact on Long-term Care, Labor Markets
Federal Reserve Bank of Boston
By Riley Sullivan
May 14, 2024
Key Takeaways
Nursing home closures in New England have outpaced closures in all other Medicaid regions despite the region’s outsized older population.
From 2011 to 2024, total patient counts and available beds in New England dropped sharply, some counties</td></tr>
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Table 2: Changes in Patient Counts *Medicaid Regions and New England States FY 2010 and FY 2023* *Figure 2: Nursing Home Closures since FY 2011* *New England States to January 2024* *Table 3: Medicaid Spending on Long Term* *United States and New England States 2022* *Table 4: Nursing Facility Finances* *New England States, 2018-2023* *Figure 3: Health-services employment* *Industries in New England, 2018:Q1-2023:Q1, Indexed*	now have fewer than half as many beds as they had a decade ago. • In the 2022-2023 fiscal year, the median nursing facility in each New England state operated at a loss. • Employment in the nursing home industry dropped sharply at the onset of the COVID-19 pandemic and has not rebounded. The US population, particularly in New England, is aging rapidly—both the median age and the share of the population aged 85 and older have increased and are projected to continue rising. This group of older adults is the segment of the population most likely to require long-term care, which encompasses a variety of formal and informal care options. The most intensive of these care options is provided in residential nursing facilities, better known as nursing homes. New England has seen a pattern of nursing home closures since at least 2011, and in some counties, the number of available beds has plummeted to less than half of what it was a decade ago. Due in part to increasing longevity, improvements in the health of older adults, and personal and family preferences, more older residents are remaining in their homes, or “aging in place.” Informal care and state programs designed to keep residents in their homes longer are also contributing to this trend. In recent years, nursing homes’ limitations on visitors and elevated rates of fatalities during the height of the COVID-19 pandemic may have played a role as well, though the trend predates the pandemic. The number of older adults aging in place may be increasing in the region, nevertheless nearly one-third of the New England states’ combined Medicaid spending is devoted to funding long-term care. In 2023, low reimbursement rates from Medicaid and Medicare and high operating costs resulted in most nursing homes in New England losing money, suggesting the region could see more closures unless significant changes occur. **An Older Population That Is Aging Rapidly** In the United States and New England, the 85-and-older cohort is the fastest growing segment of the population. This group is also the most likely to rely on long-term care options, including nursing homes (Gruber and McCrary 2023). The economic implications of an aging population range from reduced labor force productivity to increased spending on entitlement programs, including those that support long-term care. In each New England state, the share of the population that is aged 75 and older is greater than the 75-and-older share

of the US population (Table 1). From 2011 to 2022, the growth of this share was especially accelerated in the northern New England states of Maine, New Hampshire, and Vermont, which now have the three oldest median ages in the United States. Over the same period, the old-age-dependency ratio for New England grew even more rapidly, from 22.4 percent to 30.5 percent. This ratio measures the size of the population at or older than the typical retirement age (65) against the size of the typically working-age population (16 to 64). The increase in this ratio indicates that the number of working-age residents in the region is declining relative to the number of older residents. These younger residents often bear the responsibility of providing informal care to aging family members who require care but are not in nursing homes. As the older population continues to grow, pressures on informal caregivers and the region's long-term-care infrastructure will continue to increase.

Number of Nursing Homes Is Falling Fastest in New England

Nursing facilities across the country have garnered significant attention in recent years, particularly during the COVID-19 pandemic, for both quality and cost of care. Nationally, closures have accelerated, but this trend predated the pandemic, particularly in New England (Figure 1). From the start of fiscal year 2010 through the end of fiscal 2023, the number of nursing homes in New England decreased 15 percent. The six New England states each experienced declines greater than the national rate. The region has seen a net loss of more than 150 nursing facilities over the period considered. Maine, the state with the oldest population according to the metrics in Table 1, experienced the greatest decline in the number of nursing homes: 19 percent.

Considered jointly, the demographic and nursing home trends indicate that, compared with a decade ago, New England has more older residents and fewer facilities to provide care.

As the number of nursing facilities in New England has declined, so have patient counts. The Boston Medicaid Region, which encompasses the six New England states, saw a 23 percent decline in its patient count from fiscal years 2010 through 2023. This was the steepest drop among the country's 10 Medicaid Regions (Table 2). Informal care, home health care, and state programs to assist residents aging in their homes have plausibly provided alternatives to nursing facilities and contributed to the declining patient count. However, these alternatives can come with costs. For example, providing informal care may prevent prime-age workers from participating fully in the labor market. More

broadly, older adults staying in the homes they may have otherwise left affects the region's already-tight housing market.

Changes in the number of nursing homes can have differing effects on patient counts due to the wide variation in the number of beds at each facility and in the length of patients' stays. Figure 2 illustrates the locations of closures across the region and the change in the number of beds in each county. Some counties had less than half the number of beds in January 2024 than they had in fiscal year 2011. While Greater Boston was the area with the most closures, the counties that saw the greatest percentage declines in bed quantities were concentrated in Vermont, Connecticut, and Maine. This is because those counties had fewer facilities in 2011, and a substantial share of the facilities that closed were large.

Many counties have thus far avoided closures; however, nursing homes continue to face challenges, as indicated by the industry profitability trends examined in the next section.

Figure 2: Nursing Home Closures since FY:2011.

Medicaid Pays the Largest Share of Costs for Long-term Care

Long-term care (LTC) in the United States is funded through a mix of Medicaid, Medicare, private insurance, veterans' benefits, and out-of-pocket expenditures, but Medicaid provides the largest share of funding.[1] Although Medicare covers most of older adults' health-care expenses, it typically covers only short-term stays in LTC facilities following hospitalizations. For eligible patients, Medicaid is the designated funder of longer-term care. Many patients who do not have private LTC insurance must exhaust their personal savings through out-of-pocket spending before they become eligible for Medicaid.

Private LTC insurance premiums vary widely based on an individual's age, health status, level of coverage, and other factors. Policies provide coverage for expenses such as nursing home care, assisted living, and home-health services. Even though an estimated 70 percent of Americans 65 and older will need critical services before they die, only 3 to 4 percent of Americans aged 50 and older have LTC policies (Johnson 2019).

Due to this low rate of private insurance, the burden of financing long-term care falls primarily on individuals and their families, who have to pay out of pocket, or the government. Medicaid programs support long-term care for those who have minimal financial resources or who deplete their resources through paying for long-term care. Medicaid plans and coverage vary by state. Table 3 illustrates the

annual amount of funding that was dedicated to long-term care in the United States and in each New England state in 2022. Nationally, Medicaid programs spent more than $154 billion on long-term care, and in New England, one-third of the states' combined annual Medicaid spending went to funding LTC.

Despite these large expenditures, nursing homes' operating costs often exceed their Medicaid receipts. Table 4 shows the precarious financial position of most Medicaid-certified nursing facilities in the region. At the end of fiscal year 2023, the most recent year for which data are available, the median facility in each New England state was operating at a loss. If this trend continues, it is likely that more nursing homes will close. During the COVID-19 pandemic, the federal government provided financial support to nursing facilities to help offset revenue losses and high costs related to the crisis.[2] This Public Health Emergency (PHE) funding came from Provider Relief Funds (PRF), the Paycheck Protection Program (PPP), and other sources (Ochieng et al. 2022). While these infusions of funds for the 2020–2021 and 2021–2022 reporting periods yielded greater profitability for most facilities, by the most recent period, profitability had dipped back to or below the pre-pandemic levels (in the 2018–2019 and 2019–2020 periods).

Nursing Homes Facilitate Labor Force Participation

Nursing homes have a twofold impact on the labor market. Directly, they are major employers in some communities, providing jobs for more than 200,000 workers across New England. They also facilitate labor force participation by patients' family members who would otherwise need to forgo work or reduce their hours to care for their aging relatives. The role of nursing homes in facilitating labor force participation is particularly important among women (Lily, Laporte, and Coyte 2007) because older adults' informal caregivers are twice as likely to be female, typically a wife or daughter. The cost of this informal care, when measured as foregone wages, is estimated to be about one-third of the nearly 2 percent of US GDP that is spent on formal LTC (Gruber and McCrary 2023).

Nursing home closures can also have a direct impact on employment. Whereas most industries rebounded quickly from the spike in job losses at the onset of the COVID-19 pandemic, employment in nursing homes and residential care facilities has still not recovered. Figure 3 disaggregates the three industries comprising health services in New England. It shows that employment in nursing homes and residential care facilities was falling before the pandemic and has continued to flounder, while total employment in New

England and in the region's other two health-services industries has returned to 2018 levels. From the first quarter of 2018 through the first quarter of 2023, the number of workers employed in nursing homes in New England declined by 27,000. Nursing home employment fell in each New England state, ranging from a 7 percent drop in New Hampshire to a 19 percent drop in Rhode Island.3

Changes to Operations or Reimbursement of Nursing Homes May Be Needed

The current system for funding long-term care faces several challenges. These include the high cost of LTC, which can be a financial burden for individuals and families; the lack of affordable and accessible LTC insurance options; and the growing number of older adults who will need LTC services in the future.

Policymakers are exploring various options for addressing these challenges. In Rhode Island, for example, nursing homes are no longer fined when their staffing falls below the required levels. This policy change, which went into effect in December 2023, is intended to reduce facilities' cost burden and prevent additional closures.[4] However, on April 22, 2024, the Centers for Medicare and Medicaid Services (the federal agency that administers Medicare, Medicaid, and other health services) announced new minimum staffing standards, which will be phased in starting in two years. Interim staffing changes will go into effect in urban facilities by May 2026 and in rural facilities in May 2027. At their current staffing levels, less than one-fifth of facilities throughout the country would meet the new standards, meaning most facilities will be required to increase staffing in the coming years.[5]

States also have launched or continue to operate programs that support residents' ability to age in their homes. The Home Care Program in Massachusetts provides care management and in-home support services to residents. The cost of these services to the recipient is based on their income.[6] Other programs in Massachusetts include the Home Modification Loan Program, which provides loans with 0 percent interest and deferred payment options to homeowners who want to accommodate an older adult living in the home by, for example, installing a ramp or adapting a bathroom.[7]

Reduced capacity at nursing facilities spills over to the rest of the health-care system. Older patients who receive inpatient care at hospitals are often meant to receive further care at skilled nursing facilities, a subset of nursing facilities that are staffed by medical professionals and intended for shorter stays. In Massachusetts, 1,200 people a day on average are lying in hospital beds instead of recovering at skilled nursing

facilities due to closures and staffing shortages.[8] Hospital stays tend to be much more expensive than nursing home stays, and devoting resources to patients who would otherwise be in skilled nursing facilities could drive up a hospital's wait times and reduce its capacity to provide necessary treatments to other patients. In April 2024, Massachusetts committed to spending $1 billion over the next eight years on new housing and community-support programs that could enable 2,400 or more Medicaid recipients who require less intensive medical care to move out of nursing homes.[9]

The LTC industry's long-term challenges include the mismatch between Medicaid reimbursement rates and patient-related costs. In 2019, the median Medicaid reimbursement rate was 86 percent of facilities reported patient costs. For 29 percent of facilities, the reimbursement rate fell below 80 percent (Medicaid and CHIP Payment and Access Commission 2023). Due to the outsized role of Medicaid as the largest payer for nursing home services, this shortfall contributed, in most cases, to the operating losses that the region's facilities experienced last year. On April 17, 2024, Maine passed a budget allowing the state to issue one-time grants totaling more than $26 million to help nursing homes cover the gaps between reimbursement rates and care costs until higher reimbursement rates take effect. The higher rates will be phased in from 2025 to 2027.[10]

This report's analysis indicates that substantial changes to either how facilities operate or the level of reimbursement they receive will be necessary to stop the trend of nursing home closures. Alternatively, policymakers could innovate and expand programs that support aging in place, though such informal LTC solutions can have a negative effect on labor and housing markets. Other options may include promoting increased enrollments in LTC insurance, which may increase individuals' ability to fund long-term care at the full cost of the services to nursing facilities, without exhausting their resources.

The views expressed herein are solely those of the author and should not be reported as representing the views of the Federal Reserve Bank of Boston, the principals of the Board of Governors, or the Federal Reserve System.

Endnotes

1. See "Paying for Long-term Care," National Institutes of Health, National Institute on Aging (accessed April 21, 2024). https://www.nia.nih.gov/health/long-term-care/paying-long-term-care
2. The North Carolina Rural Health Program, which completed the analysis in Table 4 on our behalf, has found in previous studies that timing differences in recognition of PHE revenue versus PHE expenses on Medicare cost reports could distort reported profitability during the COVID-19 years. For this reason, it is important to clearly separate years without PHE funds (pre–COVID-19 years) and years with PHE funds (COVID-19 years). Therefore, the data include the profitability of nursing facilities during two pre–COVID-19 years and three COVID-19 years.

3. As of the first quarter of 2023, employment in the nursing home and residential care facilities industry stood at 88.4 percent of the 2018:Q1 level for New England. It was at 81.1 percent in Rhode Island, 87.1 percent in Connecticut, 89.2 percent in Massachusetts, 90 percent in Maine, 91 percent in Vermont, and 92.9 percent in New Hampshire.
4. See Antonia Noori Farzan, "RI Mandated the Highest Nursing Home Staffing in the US. Why the Governor Suspended Penalties," *Providence Journal*, December 29, 2023. https://www.providencejournal.com/story/news/politics/2023/12/29/fines-suspended-indefinitely-for-rhode-island-nursing-homes-that-violate-minimum-staffing-law/72061342007/
5. See Priya Chidambaram, Alice Burns, Tricia Neuman, and Robin Rudowitz, "With Current Staffing Levels, About 1 in 5 Nursing Facilities Would Meet Fully Implemented Minimum Staffing Standards in the Final Rule," KFF, April 22, 2024. https://www.kff.org/policy-watch/nursing-facilities-staffing-levels-standards-final-rule/
6. For more details, see In-Home Services, Executive Office of Elder Affairs. https://www.mass.gov/in-home-services
7. For more details, see Home Modification Loan Program (HMLP), Massachusetts Rehabilitation Commission. https://www.mass.gov/home-modification-loan-program-hmlp
8. See Jessica Bartless, "Over a Thousand Patients Have Been 'Stuck' in Hospitals Beds as Discharge Problems Persist," *Boston Globe*, June 12, 2023. https://www.bostonglobe.com/2023/06/12/metro/over-thousand-patients-stuck-hospital-beds-discharge-problems-persist/
9. See Jason Laughlin, "Massachusetts Commits $1 Billion to Move Thousands out of Nursing Homes in Wake of Lawsuit Settlement," *Boston Globe*, April 21, 2024 https://www.bostonglobe.com/2024/04/21/metro/nursing-home-settlement-disabled-massachusetts/
10. See Billy Kobin, "Maine Legislature Passes Budget Addition Again without Republican Support," *Bangor Daily News*, April 17, 2024 https://www.bangordailynews.com/2024/04/17/politics/state-politics/maine-house-2-year-budget-lacks-republican-support/

Data Sources and Acknowledgments

Data on patient counts and nursing facility closures come from the Centers for Medicare and Medicaid Services (CMS). Data on profit margins come from analysis completed by Dr. George H. Pink, senior research fellow at the Cecil G. Sheps Center for Health Services Research and deputy director of the North Carolina Rural Health Research Program at the University of North Carolina at Chapel Hill. Dr. Pink's analysis uses the CMS 2540-10 Cost Report files. We are grateful to Dr. Pink for completing the analysis for this report.

Data on industry employment come from the Quarterly Workforce Indicators (QWI). The QWI is a set of 32 economic indicators including employment, job creation/destruction, wages, hires, and other measures of employment flows.

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	Update." KFF. https://www.kff.org/coronavirus-covid-19/issue-brief/funding-for-health-care-providers-during-the-pandemic-an-update/
Your Opinion This essay was published in the Opinion section of the Sunday edition of the **New York Times.** **Commentary from readers of *The Dignity Digest* is welcomed.** Of particular interest is reaction to this proposal: *A better system for determining whether a patient should be treated over his or her objection would be a hospital hearing in which a committee of doctors, ethicists and other relevant experts — all of whom would be independent of the hospital and not involved in the care of the patient — engaged in conversation with the medical team and the patient and patient's family.* Responses may be offered via https://forms.gle/kpAs9zsarDq1yY13A Comments may be shared in future issues of *The Digest.*	***Doctors Need a Better Way to Treat Patients Without Their Consent*** **New York Times** By Sandeep Jauhar May 19, 2024 *Dr. Jauhar is a cardiologist in New York who writes frequently about medical care and public health.* Not long ago, I took care of a middle-aged man at my hospital who had severe heart failure requiring life support. When he was disconnected from machines after a few days of treatment, he began to display psychotic symptoms, including delusional thinking, tangential speech and paranoia. He had a long history of untreated schizophrenia, I learned, which had estranged him from family members and friends, with whom he had virtually no contact. My patient demanded to leave the hospital. However, sending him home was going to be a problem. He could not take care of himself. There was little chance he would take his medications, including a blood thinner to dissolve a clot in his heart before it caused a stroke. He was even less likely to take psychiatric drugs that he did not believe he needed. My colleagues and I didn't know what to do, so we called the treating psychiatrist. The psychiatrist immediately declared that our patient lacked the capacity to discharge himself from the hospital. The patient could not grasp the implications of this choice, for instance, or properly weigh its risks and benefits. The psychiatrist said the patient should remain in the hospital to receive psychiatric treatment, even against his will. The psychiatrist's opinion made sense to me. Patients with untreated schizophrenia have a higher rate of death than those who undergo treatment. Hopefully, treatment would restore my patient's judgment to the point where he would take his medications when he went home — or even decide not to take them, but to make that risky decision in the full appreciation of the likely consequences. (If autonomy means anything, it means that patients have the right to make bad decisions, too.) Treating him, even over his objections, seemed to be in his best interests. However, according to New York law — and the law of other states — such involuntary treatment would require a court order. As doctors, we would have to plead our case before a judge. But was a judge without medical or psychiatric expertise the best person to decide this man's fate? In this case and also more generally, I think the answer is no. The law ought to be changed to keep such decisions in hospitals — in the hands of doctors, medical ethicists and other relevant experts.

Doctors don't always have to resort to the courts to treat patients without their consent. There are some notable exceptions, such as during a life-threatening emergency (if a competent patient has not previously refused such treatment) or when there is a pressing societal interest (such as requiring patients with communicable tuberculosis to take antibiotics).

But judicial review has been the cornerstone of "treatment over objection," as it's known, for the past four decades or so.

Appellate courts in the 1980s ruled that judicial hearings in such cases are needed to safeguard patients' rights. For example, in 1983, in Rogers v. Commissioner of Department of Mental Health, the Massachusetts Supreme Judicial Court declared that a judge could override medical judgments favoring involuntary psychiatric treatment.

The underlying motivation behind judicial review was and remains laudable: to avoid the sort of paternalistic abuses that have characterized too much of medical history. Doctors often used to withhold bad news from patients, to cite just a small example. Involuntary treatment, even with benevolent intentions, reeks of such paternalism.

But though medical practice is by no means perfect, times have changed. The sort of abuse dramatized in the 1975 movie "One Flew Over the Cuckoo's Nest," with its harrowing depiction of forced electroconvulsive therapy, is far less common. Doctors today are trained in shared decision-making. Safeguards are now in place to prevent such maltreatment, including multidisciplinary teams in which nurses, social workers and bioethicists have a voice.

In addition to being less necessary to prevent abuse than they once were, courts are by nature poorly suited for making decisions about treatment over objection. For one thing, they are slow: Having to go to court often results in delays, sometimes up to a week or more, which can harm patients who need care urgently. Moreover, judges have neither the experience nor the expertise to properly evaluate psychological states, assess decision-making capacity or determine whether a proposed treatment's benefits outweigh its risks. It is no surprise that by some estimates 95 percent or more of requests for treatment over objection are approved by judges, who invariably haven't met the patient and must rely on information provided by the treating medical team.

A better system for determining whether a patient should be treated over his or her objection would be a hospital hearing in which a committee of doctors, ethicists and other relevant experts — all of whom would be independent of the hospital and not involved in the care of the patient — engaged in conversation with

	the medical team and the patient and patient's family. Having hearings on site would expedite decisions and minimize treatment delays. The committee would make the final decision. Of course, such a committee would have to be granted immunity from legal liability (as with judges in our current system), so that experts would be willing to serve and speak candidly. Patients' interests could be safeguarded by requiring the committee to publish its reasoning. Periodic audits by a regulatory body could ensure that the committee's deliberations were meeting medical and ethical standards. In the event that the committee could not reach a consensus on the best course of action (or if there were allegations of wrongdoing), then the parties involved could appeal to a judge. But that would be the exception rather than the rule. In the case of my patient with heart failure, the decision ultimately didn't have to go before a judge. Multiple discussions involving the patient, the hospital ethics and palliative care teams, social workers, nurses, psychiatrists and other doctors — discussions that in many respects served the function of a formal committee of the sort I'm proposing — yielded an agreement with the patient that his interests would be best served by sending him home with hospice care. Capacity must be judged relative to the decision being made, and it became clear over the course of hospitalization that our patient understood the terminal nature of his condition and had the capacity to choose hospice care. Forced treatment was unlikely to significantly improve his psychiatric symptoms before the natural progression of heart failure caused his death. So, he was discharged home. It was the best decision under the circumstances, one reached by expert deliberation, not legal procedure. He passed away a few weeks later without, fortunately, ever setting foot in court.
Quotes	*"Despite our best efforts to find a partner to redevelop the current location, we have been unable to create a plan that is financially viable given the challenges that all healthcare institutions currently face, including nursing shortages, skyrocketing real estate costs, inflation, and the growing demands for facility maintenance."* Statement of the Carmelite Sisters for the Aged and Infirm, sponsors of Marian Manor, *South Boston's Marian Manor to close this summer* (**Dorchester Reporter,** May 14, 2024)

	"Jennifer [Benson's] impressive background and experience matches AARP's mission and our work at the local, state and national levels. We are excited to welcome her as leader of our talented and dedicated Massachusetts state staff and the scores of volunteers who make our work possible." AARP East and Caribbean Regional Vice-President Kelly A. Clark commenting on the appointment of Jennifer Benson as the Massachusetts State Director, *AARP Massachusetts Welcomes Jennifer Benson as New State Director*, **AARP,** May 14, 2024 *We are in a critical time, where nursing home residents are forced to live in facilities with inadequate staffing , and workers are confronted daily with myriad challenges, including poor wages and benefits, inadequate training, and few career advancement opportunities. The solution to these problems is not to make residents and workers less safe by decreasing training requirements.* From a letter to the U.S. House Committee on Energy & Commerce's Health Subcommittee voicing opposition to the Building America's Health Care Workforce Act (H.R. 468) and the Ensuring Seniors' Access to Quality Care Act (H.R. 3227) signed by twelve national advocacy groups, *Consumer Voice Sends Letter Opposing Bills that Would Weaken Nurse Aide Training Requirements in Nursing Homes*, **National Consumer Voice for Quality Long-Term Care,** May 15, 2024 *"It's just utterly meaningless. It's marketing."* Richard Mollot, executive director of the Long Term Care Community Coalition, commenting about the website, *A Place for Mom*, *Senior-care referral site 'A Place for Mom' stays mum on neglect* **(Washington Post (free access),** May 16, 2024) *"When I first saw A Place for Mom on the TV, I assumed it was a nonprofit. They were not forthcoming that they get a commission from anybody,"* Paula Anderson, of Minnesota, who 12 years ago found an assisted-living facility for her mother-in-law with help from the company, *Senior-care referral site 'A Place for Mom' stays mum on neglect* **(Washington Post (free access),** May 16, 2024)

	“It’s a pay-to-play model.” David Grabowski, Harvard professor of health-care policy who specializes in the economics of long-term care, commenting about the website, *A Place for Mom,* Senior-care referral site ‘A Place for Mom’ stays mum on neglect **(Washington Post (free access),** May 16, 2024) *Over the past five years, more than 2,000 elderly residents have walked away from assisted-living facilities in America or been left unattended outside, according to a Post investigation; nearly 100 have died. Some states have done little to recognize or measure the problem, much less prevent it, experts say.* How your state regulates assisted-living facilities **(Washington Post (free access),** December 17, 2023) *Nationally, [nursing home] closures have accelerated, but this trend predated the pandemic, particularly in New England . From the start of fiscal year 2010 through the end of fiscal 2023, the number of nursing homes in New England decreased 15 percent. . . Nursing home population in Massachusetts declined 23% from FY 2010 to FY 2023 (42,887 to 32,970).* Nursing Home Closures in New England: Impact on Long-term Care, Labor Markets, **Federal Reserve Bank of Boston,** May 14, 2024 *We need to improve care in nursing homes and lower the risks of neglect and abuse. That’s an imperative. Our national indifference to elder abuse and neglect is a scandal.* *But improving the situation means getting the best possible bang for every buck we spend. That’s also an imperative.* *And it also means working out who is going to pay for it, instead of the usual suspect: “someone else.”* The war over nursing homes is heating up **(MarketWatch,** May 18, 2024)

"I pulled up, and an ambulance was already here because somebody was overheated."

Houston City Councilmember Abbie Kamin commenting on the conditions in a 230 resident independent elder housing building that was without power for two days, *Senior living communities in the Heights had no power, no emergency plans after Houston storm* (**Houston Landing,** May 19, 2024)

"These are the perfect victims. Some of them were being physically assaulted. Some of them were being neglected."

Arlington, Texas Police Lt. Kimberly Harris commenting about the situation in five unlicensed assisted living residences, *'Held Against My Will': 20 Dead in Assisted Living Horror* (**Dallas Express,** May 19, 2024)

"Not only because it's right to have affordable housing, but because if we don't do that, our economy will suffer. And many of the people who don't want that housing in their community are going to feel the pain."

Barry Bluestone, founding dean of Northeastern's School of Public Policy and Urban Affairs, *The average Boston renter spends 47% of their income on housing. In Seattle, it's 28%. Why?* (**WGBH,** May 17, 2024)

"The vast majority of [nursing] homes were built in the 1960s and 1970s, when the then-new Medicare and Medicaid programs created government reimbursement streams for institutional nursing care services — and thus incentivized lenders and investors to put up the money for new construction based on the promise of steady, government-backed revenue for years to come. Once the market hit a critical mass of nursing homes, there was no more incentive to build new homes, and thus we have an infrastructure that's stuck in the Ford administration."

Alex Spanko, director of communications and marketing for the Center for Innovation, *Closure of historic nursing home reflects*

	sector's increasing infrastructure problems, **McKnights Long-Term Care News,** May 20, 2024 *"Nursing homes in New Jersey are entirely too large and not homelike. The report recognizes that New Jersey should follow the lead of other states and implement policy changes and investments to create smaller nursing homes with more person-centered models of care. These smaller, person-centered homes should become the norm."* Laurie Facciarossa Brewer, the state's Long-Term Care Ombudsman, *What NJ is doing to improve nursing home care*, **NJ Spotlight News,** May 20, 2024 *The question that has arisen in treating patients with costly medical care is "should we provide or withhold care based on age?"* *The "Budget Busting Baby Boomer Hypothesis:" Bogus Theories and Misguided Bioethicists*, **Tallgrass Economics,** May 18, 2024
Guide to news items in this week's *Dignity Digest*	**FY 2025 State Budget** **Nursing Homes** *The war over nursing homes is heating up* **(MarketWatch,** May 18, 2024) *Consumer Voice Sends Letter Opposing Bills that Would Weaken Nurse Aide Training Requirements in Nursing Homes* **(National Consumer Voice for Quality Long-Term Care,** May 15, 2024) *South Boston's Marian Manor to close this summer* **(Dorchester Reporter,** May 14, 2024) **Assisted Living** *Senior-care referral site 'A Place for Mom' stays mum on neglect* **(Washington Post (free access),** May 16, 2024) *How your state regulates assisted-living facilities* **(Washington Post (free access),** December 17, 2023) **Housing** *The average Boston renter spends 47% of their income on housing. In Seattle, it's 28%. Why?* **(WGBH,** May 17, 2024) *Healey-Driscoll Administration Announces Nearly $12 Million in Community Investment Tax Credits* **(Office of Governor Maura Healey and Lt. Governor Kim Driscoll,** May 17, 2024) **Disability Topics** *The Paralympics open in 100 days. Paris organizers are launching a campaign to boost ticket sales* **(AP News,** May 20, 2024) **Transportation** *All About Uber's New Transportation Service for Caregivers* **(Nice News,** May 20, 2024) **Elder Abuse**

[Rules for adult protective services could open door to more skilled nursing investigations, but also more cooperation](#) **(McKnights Long-Term Care News,** May 17, 2024)
[Elder Abuse](#) **(U.S. Department of Justice,** Undated)

From Our Colleagues Around the Country

[The "Budget Busting Baby Boomer Hypothesis:" Bogus Theories and Misguided Bioethicists](#) **(Tallgrass Economics,** May 18, 2024)

From Around the Country

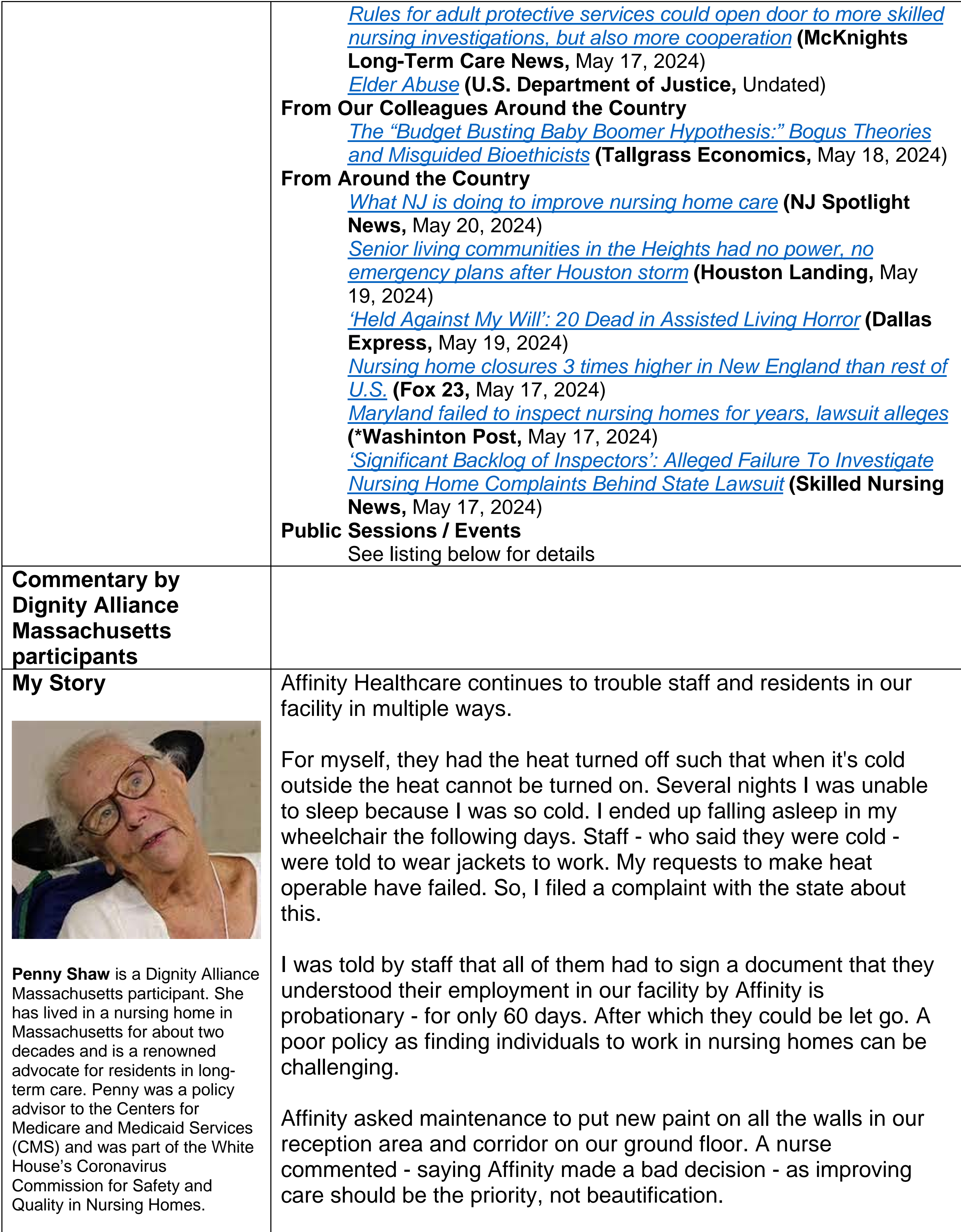
[What NJ is doing to improve nursing home care](#) **(NJ Spotlight News,** May 20, 2024)
[Senior living communities in the Heights had no power, no emergency plans after Houston storm](#) **(Houston Landing,** May 19, 2024)
['Held Against My Will': 20 Dead in Assisted Living Horror](#) **(Dallas Express,** May 19, 2024)
[Nursing home closures 3 times higher in New England than rest of U.S.](#) **(Fox 23,** May 17, 2024)
[Maryland failed to inspect nursing homes for years, lawsuit alleges](#) **(*Washinton Post,** May 17, 2024)
['Significant Backlog of Inspectors': Alleged Failure To Investigate Nursing Home Complaints Behind State Lawsuit](#) **(Skilled Nursing News,** May 17, 2024)

Public Sessions / Events

See listing below for details

Commentary by Dignity Alliance Massachusetts participants

My Story



Penny Shaw is a Dignity Alliance Massachusetts participant. She has lived in a nursing home in Massachusetts for about two decades and is a renowned advocate for residents in long-term care. Penny was a policy advisor to the Centers for Medicare and Medicaid Services (CMS) and was part of the White House's Coronavirus Commission for Safety and Quality in Nursing Homes.

Affinity Healthcare continues to trouble staff and residents in our facility in multiple ways.

For myself, they had the heat turned off such that when it's cold outside the heat cannot be turned on. Several nights I was unable to sleep because I was so cold. I ended up falling asleep in my wheelchair the following days. Staff - who said they were cold - were told to wear jackets to work. My requests to make heat operable have failed. So, I filed a complaint with the state about this.

I was told by staff that all of them had to sign a document that they understood their employment in our facility by Affinity is probationary - for only 60 days. After which they could be let go. A poor policy as finding individuals to work in nursing homes can be challenging.

Affinity asked maintenance to put new paint on all the walls in our reception area and corridor on our ground floor. A nurse commented - saying Affinity made a bad decision - as improving care should be the priority, not beautification.

Editor's note: Affinity Healthcare recently acquired the facility in which Penny resides.	Affinity intends to change the names of the units in which residents live on in spite of the fact this is part of our identity. They even have a box for suggestions. And a prize for the person who submits the winning names. I was told by two staff members that their offices lack proper ventilation. Wouldn't it be nice if this were a priority? Staff have commented that two individuals from Affinity's corporate office are in the facility frequently. But neither acknowledges either staff or residents. Neither nodding at them nor talking to them. These individuals just walk down the hall ignoring them. There is talk among staff and others that Affinity is the worst owner we've ever had. Resistance, not Affinity, is the name of our facility used by some of us.
Listening Sessions	1. **Massachusetts Department of Developmental Services Listening Session** Tuesday, May 28, 2024, 6:00 - 7:30 p.m. The Massachusetts Department of Developmental Services (DDS) wants to understand how to best deliver services to all adults with intellectual and developmental disabilities, including autism spectrum disorder. DDS hopes to deliver services in a way that meets people's needs no matter who they are or what their background is. The listening session will include: • Options for people to share information verbally and by writing comments in the chat and survey • Live American Sign Language interpretation and Spanish translation • Live translation in people's requested languages DDS is holding this listening session as part of the Health Equity Review Initiative. It will recommend ways to help DDS deliver the types of needed services in ways that do not leave people out **Already have a few ideas you want to share?** Please send them to us now using this survey: https://mathematica.questionprogov.com/DDSHealthEquitySurvey **Join the live listening session virtually on May 28 at 6:00 p.m. via this Zoom link:** https://mathematica-org.zoomgov.com/j/1613906979?pwd=bW93VHZhbmRnQzhnYXVkUlZjWCs0dz09 2. **Massachusetts Alliance for 21st Century Disability Policy (MA21)** *Advocacy for MA DDS Self-Directed Services as envisioned by the 2014 Real Lives Law* Join the conversation about Massachusetts Alliance for 21st Century Disability Policy (MA21) advocacy for changes to MA DDS Self-Directed Services to comply with the 2014 Real Lives Law. Help improve regulations and waivers at the Dept. of Developmental Services (DDS) to increase transparency, flexibility, and self-determination. You can choose to attend one or more of the following sessions. Tuesday, May 21, 2024, 1:30 p.m.

Tuesday, September 17, 2024,1:30 p.m.
Tuesday, November 19, 2024, 1:30 p.m.
Registration

3. **Massachusetts Executive Office of Housing and Livable Communities**
Statewide Housing Plan Regional Listening Sessions
Governor Healey has directed the Executive Office of Housing and Livable Communities (EOHLC) to develop a five-year strategic Statewide Housing Plan – the first in MA in over 40 years! To ensure the Plan captures the voices of MA constituents and housing stakeholders, EOHLC is holding several Regional Listening Sessions across MA to seek input on the Plan.
Regional Listening Sessions Agenda
- Brief overview of MA's housing environment
- Breakout groups for attendees to discuss top housing challenges and potential solutions
- Attendees reconvene for closing remarks

Schedule:

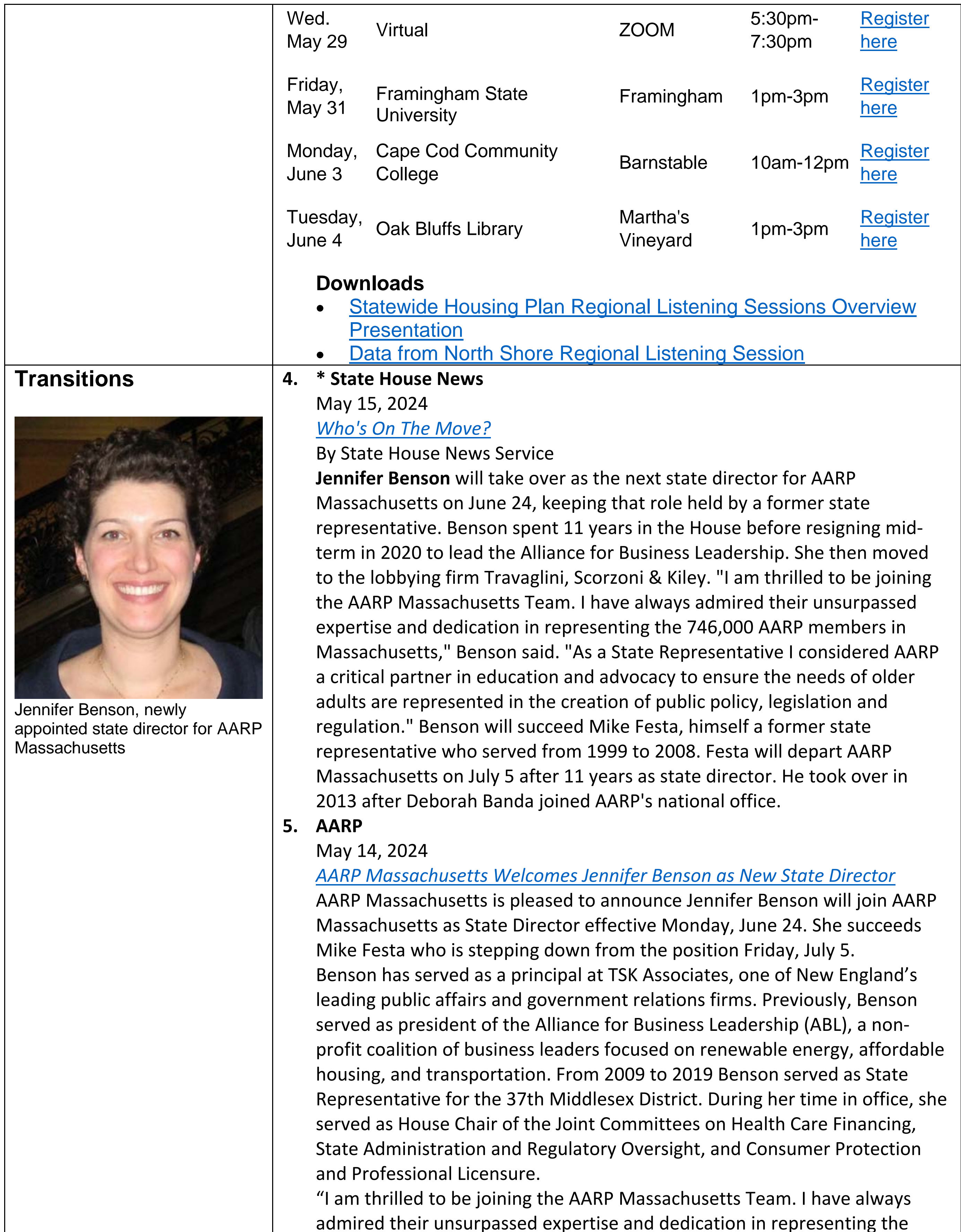
Date:	Location:	City:	Time:	RSVP:
Thursday, April 11	North Shore Community College	Lynn	1pm-3pm	Register here
Tuesday, April 23	Springfield Technical C.C.	Springfield	9am-11am	Register here
Tuesday, April 30	UMass Dartmouth	Dartmouth	11am-1pm	Register here
Friday, May 3	Massasoit Community College	Brockton	2pm-4pm	Register here
Thursday, May 9	UMass Boston	Boston	10am-12pm	Register here
Wed. May 15	Berkshire Community College	Pittsfield	2pm-4pm	Register here
Thursday, May 16	Greenfield Community College	Greenfield	2pm-4pm	Register here
Monday, May 20	Virtual	ZOOM	5:30pm-7:30pm	Register here
Tuesday, May 21	Blackstone Visitor Center	Worcester	10am-12pm	Register here
Thursday, May 23	United Teen Equality Center (UTEC)	Lowell	1pm-3pm	Register here

Wed. May 29	Virtual	ZOOM	5:30pm-7:30pm	Register here
Friday, May 31	Framingham State University	Framingham	1pm-3pm	Register here
Monday, June 3	Cape Cod Community College	Barnstable	10am-12pm	Register here
Tuesday, June 4	Oak Bluffs Library	Martha's Vineyard	1pm-3pm	Register here

Downloads

- Statewide Housing Plan Regional Listening Sessions Overview Presentation
- Data from North Shore Regional Listening Session

Transitions



Jennifer Benson, newly appointed state director for AARP Massachusetts

4. *** State House News**
   May 15, 2024
   Who's On The Move?
   By State House News Service
   Jennifer Benson will take over as the next state director for AARP Massachusetts on June 24, keeping that role held by a former state representative. Benson spent 11 years in the House before resigning mid-term in 2020 to lead the Alliance for Business Leadership. She then moved to the lobbying firm Travaglini, Scorzoni & Kiley. "I am thrilled to be joining the AARP Massachusetts Team. I have always admired their unsurpassed expertise and dedication in representing the 746,000 AARP members in Massachusetts," Benson said. "As a State Representative I considered AARP a critical partner in education and advocacy to ensure the needs of older adults are represented in the creation of public policy, legislation and regulation." Benson will succeed Mike Festa, himself a former state representative who served from 1999 to 2008. Festa will depart AARP Massachusetts on July 5 after 11 years as state director. He took over in 2013 after Deborah Banda joined AARP's national office.
5. **AARP**
   May 14, 2024
   AARP Massachusetts Welcomes Jennifer Benson as New State Director
   AARP Massachusetts is pleased to announce Jennifer Benson will join AARP Massachusetts as State Director effective Monday, June 24. She succeeds Mike Festa who is stepping down from the position Friday, July 5.
   Benson has served as a principal at TSK Associates, one of New England's leading public affairs and government relations firms. Previously, Benson served as president of the Alliance for Business Leadership (ABL), a non-profit coalition of business leaders focused on renewable energy, affordable housing, and transportation. From 2009 to 2019 Benson served as State Representative for the 37th Middlesex District. During her time in office, she served as House Chair of the Joint Committees on Health Care Financing, State Administration and Regulatory Oversight, and Consumer Protection and Professional Licensure.
   "I am thrilled to be joining the AARP Massachusetts Team. I have always admired their unsurpassed expertise and dedication in representing the

	746,000 AARP members in Massachusetts," said Benson. "As a State Representative I considered AARP a critical partner in education and advocacy to ensure the needs of older adults are represented in the creation of public policy, legislation and regulation. I am truly honored to join this highly respected organization and look forward to continuing their incredible work." While in the legislature, Benson championed legislation on the cutting edge including filing bills to grow the renewable energy economy, modernize our energy infrastructure, define biosimilar therapeutics, and to standardize step therapy practices to better serve patients. "Jennifer's impressive background and experience matches AARP's mission and our work at the local, state and national levels," said AARP East and Caribbean Regional Vice-President Kelly A. Clark. "We are excited to welcome her as leader of our talented and dedicated Massachusetts state staff and the scores of volunteers who make our work possible." Benson will take over the position from Mike Festa, who is leaving AARP after 11 years as State Director. "I am very pleased with the selection, and I know Jennifer will do an outstanding job," said Mike Festa, State Director, AARP Massachusetts. "There is no doubt that the best job I ever had was with AARP. I'm sure in no time at all Jennifer will feel the same." "Jen Benson joined us at a critical point as we reorganized TSK Associates. She was a significant contributor in that process and in the delivery of positive results for our clients," said Robert Travaglini, founder, TSK Associates and former President of the Massachusetts Senate. "Our loss is AARP's gain and we wish Jen and AARP nothing but the best." Jennifer earned a master's in public administration from Harvard University, Kennedy School of Government, and a B.A. in Art History from Florida Atlantic University. She and her husband, Brent, are the parents of three grown children and live in Watertown
Previously posted webinars and online sessions	Previously posted webinars and online sessions can be viewed at: https://dignityalliancema.org/webinars-and-online-sessions/

Independent Assessment Entity ***Request for Information*** **Responses must be submitted electronically no later than 3:00 p.m. May 28th, 2024.**	**6. COMMBUYS** *Executive Office of Health and Human Services* ***Independent Assessment Entity Request for Information*** MassHealth is exploring whether an Independent Assessment Entity (IAE) can improve the MassHealth member experience by simplifying and streamlining the clinical assessment process for certain long-term services and supports. The IAE would conduct required assessments for personal care attendant services (PCA), Adult Day Health (ADH), Group Adult Foster Care (GAFC), Adult Foster Care (AFC), Day Habilitation, Senior Care Options (SCO), PACE, and One Care. Currently, more than 400 entities administer clinical eligibility assessments and/or rating category assessments for these LTSS programs. **Responses must be submitted electronically.** Questions should be answered in order of appearance and numbered according to the RFI question number. Respondents are invited to respond to a subset or all the RFI questions; please respond to as many as you feel are appropriate. Questions regarding COMMBUYS should be directed to the OSD Help Desk at OSDHelpDesk@mass.gov.
Nursing Homes	**7. McKnights Long-Term Care News** May 20, 2024 *Closure of historic nursing home reflects sector's increasing infrastructure problems* By Kimberly Marselas **Marian Manor to Close After Failing to Secure Funding for Upgrades** **Summary:** • Marian Manor, a historic nursing home in South Boston, will close this summer due to financial difficulties. • The 70-year-old facility, owned by the Carmelite Sisters for the Aged and Infirm, couldn't find a partner to help pay for necessary renovations. • Rising costs, nursing shortages, and an aging building made it impossible to keep Marian Manor operational. **Challenges Facing Nursing Homes:** • Many nursing homes built in the 1960s and 1970s are nearing the end of their useful life and require significant upgrades. • Pandemic-related financial strain makes it difficult for facilities to secure loans or financing for renovations. • Traditional bank loans are scarce, and alternative financing options are often expensive or risky. **Possible Solutions:** • Government incentives like grants or Medicaid rate increases could support modernization efforts. • Construction of smaller, more modern facilities with private rooms might attract new revenue streams. • Policies that encourage patient-centered improvements could make facilities more attractive to lenders. **Looking Ahead:**

- Marian Manor's closure might be a sign of things to come for older nursing homes.
- The industry needs innovative solutions to address funding shortfalls and outdated infrastructure.
- Government support and policy changes might be necessary to ensure the future of quality nursing care.

8. **MarketWatch**
   May 18, 2024
   The war over nursing homes is heating up
   By Brett Arends
   Staffing mandates are just the beginning
   The Nursing Home Care Debate: Balancing Costs and Quality
   The article discusses the debate surrounding new federal regulations that aim to increase staffing levels in nursing homes. While acknowledging the need for better care, it raises concerns about the potential costs and unintended consequences.
   Key Points:
   - **New Regulations:** The Biden administration proposes increased staffing, requiring more nurses and aides.
   - **Industry Concerns:** Nursing home operators argue the regulations will force closures, especially in rural areas, due to a projected $4.5 billion to $6.5 billion annual cost increase.
   - **Potential Benefits:** Studies show facilities with higher staffing have better patient outcomes. AARP supports the mandates.
   - **Hidden Costs:** Increased staffing could lead to higher prices for Medicaid, Medicare, and private long-term care.
   - **Cost-Effectiveness:** The author questions whether simply adding staff is the best use of funds. He proposes investing in technology like wearable health monitors and hidden cameras to improve care and reduce abuse.
   - **Technological Advancements:** The article argues that older studies linking staffing to outcomes may not consider recent technological advancements.
   - **Political Implications:** The nursing home industry may lobby Congress to block the mandates.
   - **The Bottom Line:** The article calls for a nuanced discussion on improving nursing home care. We need to find the most efficient ways to deliver better care while considering who will pay the additional costs.

   The article avoids taking sides but encourages critical thinking about the issue. It highlights the need for:
   - **Balanced Approach:** Combining technological advancements with adequate staffing.
   - **Addressing Abuse:** Taking national action against elder abuse and neglect.
   - **Transparency in Costs:** Understanding who will bear the financial burden of increased regulations.
9. **National Consumer Voice for Quality Long-Term Care**
   May 15, 2024
   Consumer Voice Sends Letter Opposing Bills that Would Weaken Nurse Aide Training Requirements in Nursing Homes

	[On May 14,] Consumer Voice, along with other advocates on behalf of our nation's 1.2 million nursing home residents and half a million nursing home workers, sent a letter to the House Committee on Energy & Commerce's Health Subcommittee voicing opposition to the Building America's Health Care Workforce Act (H.R. 468) and the Ensuring Seniors' Access to Quality Care Act (H.R. 3227). Both bills would significantly weaken training requirements for nurse aides in nursing homes. • H.R 468 would reinstitute a pandemic-era regulatory waiver allowing untrained aides to work in nursing homes for longer than four months without meeting training and certification requirements. The Centers for Medicare & Medicaid Services (CMS), when rescinding this waiver, stated that it had likely contributed to resident harm, including weight loss, resident abuse, improper transferring, and other negative health outcomes. • H.R. 3227 would allow nursing homes cited for egregious violations, such as medical record falsification or failing to report resident abuse, to continue to operate their own nurse aid training programs. **Read the full letter.** **10. Dorchester Reporter** May 14, 2024 *South Boston's Marian Manor to close this summer* By Staff Marian Manor, the nursing and rehabilitation facility in South Boston run by the Carmelite Sisters for the Aged and Infirm since 1954, will close this summer. In a statement to the Reporter today, the Sisters say: "Despite our best efforts to find a partner to redevelop the current location, we have been unable to create a plan that is financially viable given the challenges that all healthcare institutions currently face, including nursing shortages, skyrocketing real estate costs, inflation, and the growing demands for facility maintenance. "In addition, there is not sufficient public funding or grants available at this time that would allow us to move forward with any of the redevelopment proposals considered for the current location.... Having exhausted every practical option, we have made the difficult decision to close Marian Manor as the aging building has come to the end of its useful life." The closure is expected to take effect in 120 days and the facility says "we are committed to our residents, their families, and our staff. Prior to the closure of the facility, we will ensure that all our current residents are relocated to another location of their choosing – including a nearby facility sponsored by the Carmelite Sisters, or another nursing and long-term care facility."
Assisted Living	**11. PubMed** May 2024 *Serious Mental Illness in Assisted Living Communities: Association with Nursing Home Placement* By Helena Temkin-Greener, Wenhan Guo , Brian McGarry, Shubing Cai

Results: More than half (55.65%) of AL residents had a diagnosis of SMI, among them 93.2% had major depression, 28.5% schizophrenia, and 22.2% bipolar disorder. Individuals with schizophrenia and bipolar disorder had a significantly lower probability of NH placement, a 32% and a 15% decrease relative to the cohort mean, respectively. Placement risk was significantly greater for residents with ADRD compared to those without, increasing for those who also had schizophrenia or bipolar disorder, 12.9% and 1.5% relative to the sample mean, respectively.
Conclusion and implications: Presence of schizophrenia and bipolar disorder, in conjunction with ADRD, significantly increases the risk of long-term NH placement, suggesting that ALs may not be well prepared to care for these residents.

12. **Washington Post (free access)**
May 16, 2024
Senior-care referral site 'A Place for Mom' stays mum on neglect
By Christopher Rowland, Steven Rich, Todd C. Frankel, and Douglas MacMillan
In some states, more than a third of the popular website's most highly recommended facilities have been cited for substandard care, The Washington Post found.
A Place for Mom: Misleading Ratings and Assisted Living Concerns
This article exposes how A Place for Mom, a seemingly helpful referral service for senior living facilities, may be misleading families. Here are the key takeaways:
It calls itself the nation's leading "trusted advisory service," but in reality A Place for Mom is a referral service that is paid large fees by assisted-living facilities and does not independently assess their records. More than a third of its most highly recommended facilities in 28 states were cited for neglect or substandard care in the past two years, many of them repeatedly. . .
Founded by an entrepreneurial married couple in Seattle in 2000, A Place for Mom is now owned by private equity firms Silver Lake Partners and General Atlantic. As a privately held company, it is not required to disclose such key information as annual revenue and marketing budgets.
   - **A Place for Mom is a paid referral service, not a watchdog.** Assisted living facilities pay A Place for Mom when a resident moves in through their service.
   - **"Best of Senior Living" awards lack transparency.** These awards are based on user reviews, which can be manipulated, and don't consider inspection reports that reveal neglect or substandard care.
   - **State inspection reports are not readily available.** A Place for Mom doesn't include crucial information from state inspections on their website, even when violations put residents at risk.
   - **Consumer reviews may not be reliable.** Facilities are incentivized to get positive reviews, and some may solicit fake ones or pressure residents and families to write them.
   - **Limited regulations and lack of transparency make it difficult to choose safe facilities.** There are no federal regulations or

	national report cards for assisted living facilities, making it challenging for families to find reliable information. **The article highlights the following concerns:** • **Safety of residents:** Neglectful care, medication errors, bedsores, and inadequate staffing are some of the issues identified in inspection reports for facilities receiving "Best of Senior Living" awards. • **Financial burden on families:** Assisted living can be expensive, and misleading information can lead families to choose a facility that doesn't meet their loved one's needs. • **Difficulties for families seeking senior care:** The lack of clear information makes it hard for families to compare facilities and find safe, quality care for their loved ones. **What to consider when choosing an assisted living facility:** • **Research state inspection reports.** These reports can reveal violations and provide valuable information about a facility's care standards. • **Visit facilities in person.** Tour the facility, meet the staff, and observe how residents are cared for. • **Talk to residents and families.** Get firsthand accounts of the living environment and care quality. • **Consider alternatives.** Depending on the needs of your loved one, there might be other options like in-home care or adult day programs. **13. Washington Post (free access)** December 17, 2023 *How your state regulates assisted-living facilities* By Julie Zauzmer Weil and Steven Rich *With no federal oversight, the industry is governed by a patchwork of state laws, few of which meet expert recommendations* The federal government does not regulate the nation's roughly 30,000 assisted-living facilities. Instead, oversight is left to the states, where a patchwork of rules often falls far short of expert recommendations, a Washington Post analysis has found. Advocates point to three requirements that could improve safety and transparency: • Mandating a minimum number of on-duty staffers for each resident. • Requiring that all caretakers receive at least six hours of training on dementia. • Providing online access to complaints and inspection reports for families trying to choose a facility. Only two states — Alabama and Indiana — impose all three requirements, according to The Post's analysis. Thirteen states and D.C. — home to more than 1 in 5 assisted living beds — require none of them.
Housing	**14. WGBH** May 17, 2024 *The average Boston renter spends 47% of their income on housing. In Seattle, it's 28%. Why?* By Kana Ruhalter and Arun Rath

	Rents have grown 1.5 times faster than wages nationwide. That means that rents have outpaced wages in nearly 9 out of 10 major metros since 2019. Here in Boston, rents grew by almost 6% while wages decreased by 1%. Gov. Maura Healey has said housing and affordable housing are serious priorities for her and for the state. Are there solutions in the works — or are there solutions *not* in the works that could do something about this? There are actually quite a number. The one that our governor has been talking about, Gov. Healey, is to make it easier for families who have a home with a backyard or something to have an accessory dwelling unit, or an ADU. . . Number two: We have to put more pressure on towns and cities to allow housing. . . There are some interesting ways to deal with these issues, and we have to come up with ideas that somehow circumvent the NIMBYism — Not In My Backyard — because we absolutely have to do that. Not only because it's right to have affordable housing, but because if we don't do that, our economy will suffer. And many of the people who don't want that housing in their community are going to feel the pain. **15. Office of Governor Maura Healey and Lt. Governor Kim Driscoll** May 17, 2024 *Healey-Driscoll Administration Announces Nearly $12 Million in Community Investment Tax Credits* Lieutenant Governor Kim Driscoll and Housing and Livable Communities Secretary Ed Augustus joined Community Development Corporations (CDCs) from across the state to announce nearly $12 million in Community Investment Tax Credits (CITC). The CITC Program was created by the Legislature in 2012. It was designed to improve economic opportunities for low- and moderate-income households and other residents in urban, rural, and suburban communities across the commonwealth. The program works through Community Development Corporations (CDCs) partnering with nonprofit, public and private entities to accomplish these objectives. This is the 11th year of program funding, and today's announcement will support 54 CDCs. . . In addition to these grants, Governor Healey has proposed to make permanent and expand the statewide cap on allocations under the Community Investment Tax Credits from $12 million to $15 million with the Affordable Homes Act. This change would mean CITC funding could be used to attract $30 million in investments, from the existing $24 million cap.
Disability Topics	**16. AP News** May 20, 2024 *The Paralympics open in 100 days. Paris organizers are launching a campaign to boost ticket sales* By Jerome Pugmire A total of 4,400 athletes will take part in the Paralympics. Tickets are available from 15 euros ($16) for track and field sessions at Stade de France, wheelchair tennis at Roland Garros, or blind soccer at the foot of the Eiffel Tower. . .

	The Paralympics will have a record 164 broadcasters worldwide covering 549 events across 22 sports. The 12-day event follows the July 26-Aug. 11 Olympics in Paris.
Transportation	**17. Nice News** May 20, 2024 *All About Uber's New Transportation Service for Caregivers* Whether you're a current caregiver or looking to support someone who is, a new resource from Uber should be on your radar as a tool that could make navigating logistics a little easier. Meet Uber Caregiver: a service launching this summer that will allow caregivers to coordinate rides to doctor's appointments for their care recipient and use health insurance benefits to pay. Uber Health lead engineer Jeremy Hintz was inspired to create the app feature based on personal experience, as his mother stepped in as his grandparents' primary caregiver. "All this actually came out of a phone conversation I was having with my mom about the things she needed help with day-to-day," Hintz told *Today*. "We have Uber and Uber Eats; why can't we tap into health care benefits, too?" Find out more about how the service works and the up-and-coming plans to expand it, which include allowing caregivers to manage deliveries of groceries and over-the-counter items.
Elder Abuse	**18. McKnights Long-Term Care News** May 17, 2024 *Rules for adult protective services could open door to more skilled nursing investigations, but also more cooperation* By Kimberly Marselas Here's a summary of the new federal rule for Adult Protective Services (APS): **What it does:** Establishes the first national standards for APS programs. Strengthens protections for vulnerable adults, including those facing guardianship. Requires faster response times for critical cases. Encourages coordination between APS and other agencies involved in elder care. **Impact on nursing homes:** Doesn't directly require investigations in nursing homes, but states can choose to include them. Potential for duplicate investigations in some states. May be helpful for nursing homes in complex situations involving guardianship or family conflict. Encourages APS to be a last resort for guardianship and seek other solutions first. **Overall:** Expected to improve consistency and professionalism in APS services. May have the biggest impact on protecting older adults living outside of nursing homes. Takes effect in June 2024, with full compliance required within 4 years. **19. U.S. Department of Justice** Undated

	Elder Abuse Data on elder abuse rural communities.
From Our Colleagues Around the Country	**20. Tallgrass Economics** May 18, 2024 *The "Budget Busting Baby Boomer Hypothesis:" Bogus Theories and Misguided Bioethicists* By Dave Kinglsey *Yes We Can Afford to Care for Babies and the Elderly* A mere thirty years ago, babies born at 24 weeks weighing 750 grams rarely survived. Today, 70% of these children survive, thrive, and go home to continue their development as healthy human beings.[1] That is the wonderful side of medical technology. Keeping pre-term babies alive is expensive – these are the rare multi-million-dollar hospital cases. No doubt, the 0- to 5-year age category includes a large proportion of the highest cost acute care patients.[2] But I believe it is fantastic that medical technology can accomplish that. I also believe that it is the moral and medically ethical thing to do. The 65 to 70 age cohort is the other group with the most expensive hospital charges. Most of the exceedingly high hospital charges for this age-group are related to heart disease. After age 70, hospital charges drop precipitously. I discovered this phenomenon while doing research and teaching at Kansas University Medical School and discussed it with famed cardiologist Caldwell Esselstyne at the Cleveland Clinic. Dr. Esselstyne explained that we were seeing the natural history of a disease – namely atherosclerosis. Autopsies on soldiers during the Korean War revealed that this disease was well developed in a large number of young adults, which was a revelation to the U.S. medical profession. Typically, it progresses untreated and results in a crisis by a person's mid to late 60s. [3] The question that has arisen in treating patients with costly medical care is "should we provide or withhold care based on age?" Treating complicated diseases with advanced medical technologies is expensive, but the United States with the most abundant financial resources in the world can easily afford to save pre-term babies and 65- to 70-year-old patients with heart disease. If provided with necessary information regarding the realities of public finance and medical necessity and outcomes, the American people, would, I believe, want to spend whatever is possible, reasonable, and feasible to save and extend life regardless of disease and age. **The Dominant Bioethicist View in Scholarly Debate about Healthcare Justice: Depriving the Elderly of Beneficial Care is Justified** In the past few decades, a consensus has formed among the most influential American bioethicists that the escalating cost of healthcare in the United States is unsustainable and, therefore, bioethics demands rationing of ***beneficial*** medical care. Rationing of medical care should, in their view, be justified primarily by an individual's years of future economic productivity and contributions to society. It is a chilling and horrifying mantra within a constricted context of neoliberal economics, erroneous conventional wisdom about public finance, and medical-industrial (Wall Street) narratives.

Not surprisingly, in the grand theories and scheme of the poohbahs of bioethics, the elderly and Medicare are primarily blamed for running up the cost of cost of medical care. In an article titled "Rationing Just Medical Care," [4] Lawrence Schneiderman, a proponent of medical care rationing, has incorporated and summarized the rationale of the rationing movement. Schneiderman states that a "decent minimum of care" would be at a level that "enables a person to acquire an education, seek or hold a job, or raise a family." [5]

In Schneiderman's system, group membership based on age and productivity are criteria for providing or withholding care rather than an individual's medical diagnosis and prognosis. The nature of care for persons with impaired health, unable to meet the three goals for qualifying for expensive, lifesaving, life extending care would receive "a reasonable level of comfort, whether it be from pain or other forms of suffering."[6] A person not acquiring an education, seeking or holding a job, or raising a family would be provided "a reasonable level of function within the person's limits that is respectful of the person's dignity, as well as a reasonable level of comfort, whether it be from pain or other forms of suffering.[7]

Schneiderman is speaking for America's preeminent bioethicists such as Peter Singer, Daniel Callahan, Zeke Emmanuel, and Norman Daniels – to name the top few. Their utilitarian philosophy is compatible with neoliberal economics and Wall Street claims that Medicare plus an aging population is a major threat to the economic wellbeing of the United States. Utilitarian ethicists consider individuals and their treatment in the medical system as "means to an end" rather than ends in themselves. This utilitarian position is illustrated by the quote Schneiderman borrows from economist Paul Krugman: "America has a long-run budget problem. Dealing with this problem will require, first and foremost, a real effort to bring healthcare costs under control – without that, nothing will work."[8]

This is an accurate quote, but one taken out of context. Krugman also emphasized a flawed tax code, which has become even more obscenely tilted in favor of the wealthy and against the working classes since 2010 when he wrote the opinion piece in the *New York Times*. He also refrained from blaming Medicare and the elderly for excessive healthcare spending. If Krugman were engaged in a serious budget discussion today, he would probably agree that waste, fraud, and inefficiencies in privatized healthcare, defense, and other government programs turned over to industrial complexes are major contributors to federal deficits and debt.

Cruel Capitalism and Wall Street Hegemony over the U.S. Healthcare System: The Elderly Can be Sacrificed for the Sake of Money

The bioethics enterprise is dominated by a handful of white male neoconservatives. As their theoretical framework and publications make clear, their views are compatible with the white male financiers dominant on Wall Street.[9] These doyens of neoliberal economic bioethics attack Medicare and fall in line with superrich financiers' misinformation regarding "entitlements caused" deficits and debt white at the same time they ignore the ravages of privatization on the U.S. healthcare system.

Financiers at the top of the wealth pyramid want to distract attention from an obscene tax code, which is fueling deficit spending and draining resources from public health, education, and other major institutions that enhance the quality of a society. Mainstream bioethicists are a perfect ancillary to their strategy. Although, the real out of control costs in the U.S. healthcare system is due to the amount of the public treasure funneled into dividends, stock buybacks, and executive/board compensation. Nevertheless, this incontrovertible fact is nowhere to be found in the writings of the leaders in the bioethics enterprise.

Bioethicists like Peter Singer,[10] Zeke Emmanuel,[11] Norman Daniels,[12] and Daniel Callahan [13] have shown a shocking disregard for scientific thinking and science in general. They have failed to seriously examine their basic assumptions, nor have they engaged in serious data analysis based on medical care data and public finance – they accept the Wall Street narrative at face value.

One would think that the role of ethicists is philosophical and moral rather than budgetary and macroeconomic. But that is not the role they are playing. They have joined forces with conservative deficit and debt hawks by taking up the invalid argument that Medicare is not affordable; that given the continuing growth of the elderly population and costs of medical technology, the only means of sustaining the healthcare system is rationing – essentially shortening human life for the purpose of reducing costs.

Daniels, Emanual, Daniels, Callahan, and other economic-oriented bioethicists have no original scientific studies of their own to support their claim that a condition of growing elderly cohorts (65+ and 80+), advancing medical technology, and the constraints of limited U.S. wealth on government expenditures is unsustainable. They rely solely on the Wall Street generated budget busting Medicare myth to make the case that beneficial medical care should be withheld from frail older Americans. Hence, their one solution and primary proposal are buttressed through confirmation bias.

Callahan, founder of the prestigious and powerful Hastings Center on Bioethics, states that he believes the “only reasonable approaches are to concede the greater importance of children and younger age groups for the future than for the elderly and to make certain the economic imbalance does not increase.” [14] This arbitrary ingroup-outgroup construction typifies ordinary prejudice, stereotyping, scapegoating and discrimination that it generates. [15]

We cannot ignore the relationship between the cavalier attitude toward medical ethics in the warehousing and neglect of elderly and disabled “nursing home” patients and the ageism/physicalism of the bioethicists.

There is no scientific evidence that the elderly are responsible for causing budget deficits and debts. Conversely, considerable evidence is available to debunk the baby boomer budget busting narrative,[16] which has been ignored by policymakers, the media, and advocacy groups.

Right wing narratives and political strategies for reducing Medicare and Social Security benefits have been effective and harmful to the well-being of older age groups in the United States. The harm extends

beyond Medicare and Social Security. It is difficult to claim that patients in so-called "nursing homes" should receive better care than the pervasive neglect, abuse, and warehousing characteristic of the current profit-oriented system when the leading bioethicists are pushing Wall Street narratives. The elderly have no powerful lobby with the mission of pushing back on the reduction of healthcare to money and the deserving.

Unfortunately, the public is led to believe that the AARP is an advocacy group for "retirees," when in fact over $1 billion of their revenue is from royalties for selling their brand to corporations preying on the elderly while $2 hundred million is from selling memberships. They need to walk that fine line by burnishing their false image as a pro-senior organization.

Other aging enterprises such as the National Council on Aging, National Institute of Aging, Area Agencies on Aging, and a plethora of other advocacy groups and organizations spawned by the Older Americans Act have been tepid at best in the fight against excess extraction of Medicare funds by mammoth insurance corporations, medical device manufacturers, pharmaceutical companies, and a host of financial intermediaries.

Commissions and think tanks on nursing homes have shown no interest in a public discussion regarding medical ethics or the lack thereof in the outrageously poor care of patients. Instead, I see an implicit sympathy with industry financial hardship disinformation. Consequently, the elderly are vulnerable to euthanasia by neglect – not just in nursing homes but throughout the healthcare system. Indeed, the categorization of human beings as more or less worthy of medical care is eerily similar to the 1930s eugenics movement in the United States – adopted and utilized in Nazi-era Germany as justification for extermination of seriously frail and physically limited people.

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[1] Sandra Lane (2015) *Why are Our Babies Dying*. New York: Imprint Routledge.
[2] David Kingsley (2015) "Aging & Healthcare Costs: Narrative Versus Reality," *Poverty & Public Policy, 7:1,* 9-15.
[3] Jack P. Strong (1986) "Coronary Atherosclerosis in Solders: A Clue to the Natural History of Atherosclerosis in the Young." *JAMA, 256(20)* 2863-2866; Young Mi Hong (2010) "Atherosclerosis Cardiovascular Disease Beginning in Childhood," *Korean Circ J 40,* 1-9.It may very well be that playgrounds and "happy meals" along with double patty, cheese, bacon, hamburgers are a bigger threat to healthcare expenditures than health per se at any age.
[4] Lawrence Schneiderman (2011), "Rationing Just Medical Care," *American Journal of Bioethics, 11-7*, pp. 7-14.
[5] Ibid., page 8.
[6] Ibid., page 8.
[7] Ibid., page 9.
[8] Opinion | Budget Deficits: Spend Now, Save Later – The New York Times (nytimes.com)
[9] The late Peter G. Peterson, multi-billionaire co-founder of Blackstone committed over a billion dollars to funding an anti-Medicare and anti-Social Security lobby in Washington, which includes the Concord Coalition, the Committee for a Responsible Budget, and other projects for providing disinformation and misinformation about programs for the elderly. His lobbying organizations have been effective in injecting a political narrative into the mainstream media. In his book *Running on Empty* (2004, New York: Picador), he states that, "whatever reforms talked about – be they more use of information technology or medical malpractice reform – we are going to have to give up some medical care that may be of some benefit," p. xvii.

	[10]Peter Singer, "Why We Must Ration Health Care" *New York Times*, July 19, 2009. [11] Zeke Emmanuel, "Why I Hope to Die at 75," *The Atlantic*, October 2014. [12] Norman Daniels (2013) "Global Aging and the Allocation of Health Care Across the Life Span," *American Journal of Bioethics. 13(8)*: 1-2. [13] Daniel Callahan (2009) *Taming the Beloved Beast: How Medical Technology Costs are Destroying Our Health Care System*. Princeton, NJ: Princeton University Press. [14] Callahan, Ibid., p. 218. [15] On prejudice, discrimination, & scapegoating, see: Gordon Allport (1989), *The Nature of Prejudice*. New York: Addison-Wesley, 243-260. [16] Kingsley, (2015), Op. Cit.

From Around the Country	**21. NJ Spotlight News**
	May 20, 2024
	What NJ is doing to improve nursing home care
	By Lilo H. Stainton
	State task force commends some reforms but reiterates concerns about long-standing problems
	New Jersey Overhauls Nursing Home Care After COVID-19 Exposed Problems
	New Jersey is making significant changes to how it regulates and funds long-term care, following a task force report that identified longstanding issues exacerbated by the pandemic. Here's a breakdown of the key points:
	Problems Identified:
	• High death rates in nursing homes during COVID-19.
	• Understaffing and low wages for nursing home workers.
	• Overreliance on large, institutional nursing homes.
	• Lack of affordable housing for seniors who want to age at home.
	• Inadequate state funding and oversight.
	Key Reforms:
	• **Increased funding:**
	  ○ $50 million to incentivize better staffing and resident care.
	  ○ $5 million to support struggling nursing homes.
	  ○ More funding for home and community-based services.
	• **Stricter oversight:**
	  ○ More frequent inspections.
	  ○ Tougher penalties for repeat violations.
	  ○ Increased staffing levels at the Department of Health for inspections.
	• **Focus on home care:**
	  ○ Goal to move more Medicaid recipients to home and community care.
	  ○ Investment in workforce training for home care providers.
	• **Nursing home improvements:**
	  ○ Requirement for all new facilities to have single rooms.
	  ○ Encouragement of smaller, more home-like settings.
	Challenges Remain:
	• Nursing homes say low Medicaid payments make it difficult to improve staffing and care.
	• New Jersey faces a shortage of affordable housing for seniors.
	• Effectively enforcing stricter regulations requires sufficient staffing at the Department of Health.
	Overall, New Jersey is taking a multi-pronged approach to improve long-term care. The success of these reforms will depend on

adequate funding, effective enforcement, and addressing the housing needs of seniors.

22. **Houston Landing**
May 19, 2024
Senior living communities in the Heights had no power, no emergency plans after Houston storm
By John Tedesco and Michael Murney
Ever since the power went out Thursday night from the devastating storm that hit Houston, Brian Cotten has been living on water and peanut-butter sandwiches in his sweltering apartment at a senior living center in the Heights. . .
For two days, no one at the city was aware of the residents' plight. Cotten was worried about his neighbors, many of whom are on oxygen or use wheelchairs. The building's landlord, the nonprofit Housing Corporation, had few employees on hand during the outage. . .
None of the Housing Corporation's Houston properties are licensed or monitored by the state of Texas to provide care for seniors. Unlike nursing homes and other assisted living facilities that provide higher levels of care, Texas does not require independent living facilities to maintain licensure and are not inspected by the state.

23. **Dallas Express**
May 19, 2024
'Held Against My Will': 20 Dead in Assisted Living Horror
By Sydney Asher
As many as 20 deaths have been reported in an assisted living facility scheme, where reports of severe abuse, neglect, fraud, and theft were made against the operator of the homes. . . Throughout the investigation, the death toll of residents has continued to rise.

24. **Fox 23**
May 17, 2024
Nursing home closures 3 times higher in New England than rest of U.S.
By WGME Staff
While Maine has the oldest population in the nation, over the past 24 years more nursing homes have closed in New England than anywhere else in the country.
According to a report from the Boston Federal Reserve, since 2010, the number of nursing homes in New England has dropped by 15 percent.
That drop is three times higher than the rest of the United States.

25. ***Washinton Post**
May 17, 2024
Maryland failed to inspect nursing homes for years, lawsuit alleges
By Katie Shepherd
Maryland has the second highest percentage of late inspections of any state, according to federal data.
Disabled residents in nursing homes are suing the Maryland Department of Health, claiming neglect and unsafe conditions.
The lawsuit alleges the department failed to properly inspect facilities or investigate complaints, putting residents at risk.
Key points:

	Residents with mobility issues say they've been left in soiled linens, waited long for help, and developed bed sores. The lawsuit claims Maryland has the second-highest rate of overdue nursing home inspections nationwide. The lawsuit argues these lapses violate federal and state laws. Lawsuit seeks change for all Maryland nursing home residents. Lawyers say neglect disproportionately affects minority communities. They hope this lawsuit will improve conditions for all residents in Maryland nursing homes. **26. Skilled Nursing News** May 17, 2024 *'Significant Backlog of Inspectors': Alleged Failure To Investigate Nursing Home Complaints Behind State Lawsuit* By Shelby Grebbin A recent lawsuit filed in federal court accuses the Maryland Department of Health (MDH) of failing to adequately inspect and investigate complaints in the state's nursing facilities, leading to significant instances of abuse and neglect. The lawsuit, representing five anonymous residents with mobility impairments and complex health needs, claims MDH's inaction disproportionately harms residents with disabilities who are especially vulnerable to poor care, as reported in The Baltimore Sun. . . Seeking class-action status, the lawsuit aims for judicial enforcement of annual facility inspections and timely complaint investigations. According to the lawsuit, Maryland failed to inspect over 100 of its 225 licensed nursing facilities in the past four years and has a large backlog of unresolved complaints.
Public Sessions / Events	**27. Caring Force Rally** Wednesday, May 22, 2024, 10:30 a.m. Great Hall, State House *Human Services Providers Council* Senate President Spilka addresses hundreds of human services workers and advocates expected to attend The Caring Force's 12th annual State House rally and advocacy day. The event is held to advocate for the Providers' Council's pro-human services workforce agenda, call attention to the workforce crisis and honor legislators (Rep. Mindy Domb and Sen. Joan Lovely) with the "Caring Bear Award." Priority legislation deals with sector wages and student loan repayment programs. **28. Arc of Massachusetts Celebration** Thursday, May 23, 2024, 2:30 p.m. Verve Hotel Boston Natick The Arc of Massachusetts celebrates its seven decades of work through a program focused on the history of disability policy and advocacy. The event, called "70 Years of Progress: Advocacy, Empowerment, and The Arc of Massachusetts," includes a panel discussion with former House speaker Robert DeLeo and former Arc board members Cynthia Haddad and Roger Walsh. The program is followed by The Arc's annual meeting and dinner.| More Info and Register) **29. PCA Workforce Council** Friday, May 24, 2024, 2:30 p.m.

	PCA Workforce Council and MassHealth meet. More Info)
Dignity Alliance Massachusetts Legislative Endorsements	Information about the legislative bills which have been endorsed by Dignity Alliance Massachusetts, including the text of the bills, can be viewed at: https://tinyurl.com/DignityLegislativeEndorsements Questions or comments can be directed to Legislative Work Group Chair Richard (Dick) Moore at rmoore8473@charter.net.
Websites	
Blogs	
Podcasts	The Consumer Voice maintains an extensive library of podcasts covering an array of long-term care topics. **Consumer Voice Podcast Library**
Previously recommended websites	The comprehensive list of recommended websites has migrated to the Dignity Alliance MA website: https://dignityalliancema.org/resources/. Only new recommendations will be listed in *The Dignity Digest.*
Previously posted funding opportunities	For open funding opportunities previously posted in *The Tuesday Digest* please see https://dignityalliancema.org/funding-opportunities/.
Websites of Dignity Alliance Massachusetts Members	See: https://dignityalliancema.org/about/organizations/
Contact information for reporting complaints and concerns	**Nursing home** — Department of Public Health 1. Print and complete the Consumer/Resident/Patient Complaint Form 2. Fax completed form to (617) 753-8165 Or Mail to 67 Forest Street, Marlborough, MA 01752 Ombudsman Program
Nursing Home Closures (pending)	**Massachusetts Department of Public Health** *Marian Manor, Dorchester* Closure date: September 11, 2024 Notice has not been posted. Hearing has not been scheduled. *Benjamin Healthcare Center, Roxbury* Closure date: July 1, 2024 • Notice of Intent to Close (PDF) | (DOCX) • Draft of Closure and Relocation Plan (PDF) | (DOCX) *Bridgewater Nursing & Rehab, Bridgewater* Closure date: May 24, 2024 • Notice of Intent to Close (PDF) | (DOCX) • Draft of Closure and Relocation Plan (PDF) | (DOCX) For more information about each individual facility, please use the Massachusetts Nursing Home Survey Performance Tool and the CMS Nursing Home Compare website.
Nursing Home Closures	**Massachusetts Department of Public Health** *Savoy Nursing and Rehabilitation Center,* New Bedford Closure date: April 3, 2024 *New England Sinai Hospital Transitional Care Unit* Closure date: April 2, 2024 *South Dennis Health Care*, Dennis Closure date: January 30, 2024 *Arnold House Nursing Home*, Stoneham

	Closure date: September 22, 2023 *Willimansett East,* Chicopee Closure date: June 6, 2023 *Willimansett West,* Chicopee Closure date: June 6, 2023 Chapin Center Springfield Closure date: June 6, 2023 *Governors Center*, Westfield Closure date: June 6, 2023 *Stonehedge Rehabilitation and Skilled Care Center*, West Roxbury Closure February 10, 2022 *Heathwood Healthcare*, Newton Closure date: January 5, 2022 *Mt. Ida Rest Home*, Newton Closure date: December 31, 2021 *Wingate at Chestnut Hill,* Newton, MA Closure date: October 1, 2021 *Halcyon House*, Methuen Closure date: July 16, 2021 *Agawam HealthCare*, Agawam Closure date: July 27, 2021 *Wareham HealthCare*, Wareham Closure date: July 28, 2021 *Town & Country Health Care Center*, Lowell Closure date: July 31, 2021
Nursing homes with admission freezes	**Massachusetts Department of Public Health** *Temporary admissions freeze* There have been no new postings on the DPH website since May 10, 2023.
Massachusetts Department of Public Health Determination of Need Projects	**Massachusetts Department of Public Health** ***Determination of Need Projects: Long Term Care*** **2023** **Navigator Homes of Martha's Vineyard, Inc. – Long Term Care Substantial Capital Expenditure** **Royal Wayland Nursing Home, LLC – Conservation Long Term Care Project** **2022** **Ascentria Care Alliance – Laurel Ridge** **Ascentria Care Alliance – Lutheran Housing** **Ascentria Care Alliance – Quaboag** **Berkshire Healthcare Systems, Inc. – Windsor Long Term Care Conservation** **Fairlawn Rehabilitation Hospital-Hospital/Clinic Substantial Capital Expenditure** **Long Term Centers of Lexington – Pine Knoll – Long Term Care Conservation** **Long Term Centers of Wrentham – Serenity Hill – Long Term Care Conservation** **Next Step Healthcare LLC-Conservation Long Term Care Project** **Royal Falmouth – Conservation Long Term Care**

	Royal Norwell – Long Term Care Conservation **Wellman Healthcare Group, Inc** **2020** **Advocate Healthcare, LLC Amendment** **Campion Health & Wellness, Inc. – LTC - Substantial Change in Service** **Heywood Healthcare, Inc. – Hospital/Clinic Substantial Capital Expenditure** **Notre Dame Health Care Center, Inc. – LTC Conservation** **2020** **Advocate Healthcare of East Boston, LLC.** **Belmont Manor Nursing Home, Inc.**
List of Special Focus Facilities	**Centers for Medicare and Medicaid Services** *List of Special Focus Facilities and Candidates* https://tinyurl.com/SpeciialFocusFacilityProgram Updated March 29, 2023 CMS has published a new list of Special Focus Facilities (SFF). SFFs are nursing homes with serious quality issues based on a calculation of deficiencies cited during inspections and the scope and severity level of those citations. CMS publicly discloses the names of the facilities chosen to participate in this program and candidate nursing homes. To be considered for the SFF program, a facility must have a history (at least 3 years) of serious quality issues. These nursing facilities generally have more deficiencies than the average facility, and more serious problems such as harm or injury to residents. Special Focus Facilities have more frequent surveys and are subject to progressive enforcement until it either graduates from the program or is terminated from Medicare and/or Medicaid. This is important information for consumers – particularly as they consider a nursing home. **What can advocates do with this information?** • Include the list of facilities in your area/state when providing information to consumers who are looking for a nursing home. Include an explanation of the SFF program and the candidate list. • Post the list on your program's/organization's website (along with the explanation noted above). • Encourage current residents and families to check the list to see if their facility is included. • Urge residents and families in a candidate facility to ask the administrator what is being done to improve care. • Suggest that resident and family councils invite the administrator to a council meeting to talk about what the facility is doing to improve care, ask for ongoing updates, and share any council concerns. • For long-term care ombudsmen representatives: Meet with the administrator to discuss what the facility is doing to address problems and share any resources that might be helpful. **Massachusetts facilities listed (updated March 29, 2023)** **Newly added to the listing** • Somerset Ridge Center, Somerset https://somersetridgerehab.com/ Nursing home inspect information: https://projects.propublica.org/nursing-homes/homes/h-225747 • South Dennis Healthcare https://www.nextstephc.com/southdennis

	Nursing home inspect information: https://projects.propublica.org/nursing-homes/homes/h-225320 **Massachusetts facilities not improved** • None **Massachusetts facilities which showed improvement** • Marlborough Hills Rehabilitation and Health Care Center, Marlborough https://tinyurl.com/MarlboroughHills Nursing home inspect information: https://projects.propublica.org/nursing-homes/homes/h-225063 **Massachusetts facilities which have graduated from the program** • The Oxford Rehabilitation & Health Care Center, Haverhill https://theoxfordrehabhealth.com/ Nursing home inspect information: https://projects.propublica.org/nursing-homes/homes/h-225218 • Worcester Rehabilitation and Health Care Center, Worcester https://worcesterrehabcare.com/ Nursing home inspect information: https://projects.propublica.org/nursing-homes/homes/h-225199 **Massachusetts facilities that are candidates for listing (months on list)** • Charwell House Health and Rehabilitation, Norwood (15) https://tinyurl.com/Charwell Nursing home inspect information: https://projects.propublica.org/nursing-homes/homes/h-225208 • Glen Ridge Nursing Care Center (1) https://www.genesishcc.com/glenridge Nursing home inspect information: https://projects.propublica.org/nursing-homes/homes/h-225523 • Hathaway Manor Extended Care (1) https://hathawaymanor.org/ Nursing home inspect information: https://projects.propublica.org/nursing-homes/homes/h-225366 • Medway Country Manor Skilled Nursing and Rehabilitation, Medway (1) https://www.medwaymanor.com/ Nursing home inspect information: https://projects.propublica.org/nursing-homes/homes/h-225412 • Mill Town Health and Rehabilitation, Amesbury (14) No website Nursing home inspect information: https://projects.propublica.org/nursing-homes/homes/h-225318 • Plymouth Rehabilitation and Health Care Center (10) https://plymouthrehab.com/ Nursing home inspect information: https://projects.propublica.org/nursing-homes/homes/h-225207 • Tremont Health Care Center, Wareham (10) https://thetremontrehabcare.com/ Nursing home inspect information: https://projects.propublica.org/nursing-homes/homes/h-225488 • Vantage at Wilbraham (5) No website Nursing home inspect information: https://projects.propublica.org/nursing-homes/homes/h-225295

	• Vantage at South Hadley (12) No website Nursing home inspect information: https://projects.propublica.org/nursing-homes/homes/h-225757 https://tinyurl.com/SpeciialFocusFacilityProgram
Nursing Home Inspect	**ProPublica** ***Nursing Home Inspect*** Data updated November 2022 This app uses data from the U.S. Centers for Medicare and Medicaid Services. Fines are listed for the past three years if a home has made partial or full payment (fines under appeal are not included). Information on deficiencies comes from a home's last three inspection cycles, or roughly three years in total. The number of COVID-19 cases is since May 8, 2020, when homes were required to begin reporting this information to the federal government (some homes may have included data on earlier cases). Massachusetts listing: https://projects.propublica.org/nursing-homes/state/MA **Deficiencies By Severity in Massachusetts** (What do the severity ratings mean?) # reported Deficiency Tag 250 **B** 82 **C** 7,056 **D** 1,850 **E** 546 **F** 487 **G** 31 **H** 1 I 40 **J** 7 **K** 2 L
Nursing Home Compare	**Centers for Medicare and Medicaid Services (CMS)** *Nursing Home Compare Website* Beginning January 26, 2022, the Centers for Medicare and Medicaid Services (CMS) is posting new information that will help consumers have a better understanding of certain staffing information and concerns at facilities. This information will be posted for each facility and includes: • **Staff turnover:** The percentage of nursing staff as well as the number of administrators who have stopped working at a nursing home over the past 12-month period. • **Weekend staff**: The level of weekend staffing for nurses and registered nurses at a nursing home over a three-month period. Posting this information was required as part of the Affordable Care Act, which was passed in 2010. In many facilities, staffing is lower on weekends, often meaning residents have to wait longer or may not receive all the care they need. High turnover means that staff are less likely to know the residents, recognize changes in condition, or implement preferred methods of providing care. All of this contributes to the quality-of-care residents receive and their quality of life. https://tinyurl.com/NursingHomeCompareWebsite

Data on Ownership of Nursing Homes	**Centers for Medicare and Medicaid Services** *Data on Ownership of Nursing Homes* CMS has released data giving state licensing officials, state and federal law enforcement, researchers, and the public an enhanced ability to identify common owners of nursing homes across nursing home locations. This information can be linked to other data sources to identify the performance of facilities under common ownership, such as owners affiliated with multiple nursing homes with a record of poor performance. The data is available on nursing home ownership will be posted to data.cms.gov and updated monthly.
Long-Term Care Facilities Specific COVID-19 Data	**Massachusetts Department of Public Health** *Long-Term Care Facilities Specific COVID-19 Data* *Coronavirus Disease 2019 (COVID-19) reports related to long-term care facilities in Massachusetts.* **Table of Contents** • COVID-19 Daily Dashboard • COVID-19 Weekly Public Health Report • Additional COVID-19 Data • CMS COVID-19 Nursing Home Data
DignityMA Call Action	• The MA Senate released a report in response to COVID-19. **Download the DignityMA Response to Reimagining the Future of MA**. • **Advocate** for state bills that advance the Dignity Alliance Massachusetts' Mission and Goals **– State Legislative Endorsements**. • **Support** relevant bills in Washington **– Federal Legislative Endorsements**. • **Join** our **Work Groups.** • **Learn** to use and leverage social media at our workshops: **Engaging Everyone: Creating Accessible, Powerful Social Media Content**
Access to Dignity Alliance social media	Email: info@DignityAllianceMA.org Facebook: https://www.facebook.com/DignityAllianceMA/ Instagram: https://www.instagram.com/dignityalliance/ LinkedIn: https://www.linkedin.com/company/dignity-alliance-massachusetts Twitter: https://twitter.com/dignity_ma?s=21 Website: www.DignityAllianceMA.org

Participation opportunities with Dignity Alliance Massachusetts

Most workgroups meet bi-weekly via Zoom.

Workgroup	**Workgroup lead**	**Email**
General Membership	Bill Henning Paul Lanzikos	bhenning@bostoncil.org paul.lanzikos@gmail.com
Assisted Living	John Ford	jford@njc-ma.org
Behavioral Health	Frank Baskin	baskinfrank19@gmail.com
Communications	Lachlan Forrow	lforrow@bidmc.harvard.edu
Facilities (Nursing homes and rest homes)	Arlene Germain	agermain@manhr.org
Home and Community Based Services	Meg Coffin	mcoffin@centerlw.org
Legislative	Richard Moore	rmoore8743@charter.net
Legal Issues	Jeni Kaplan	jkaplan@cpr-ma.org
Interest Group	**Group lead**	**Email**
Housing	Bill Henning	bhenning@bostoncil.org
Veteran Services	James Lomastro	jimlomastro@comcast.net

Interest Groups meet periodically (monthly, bi-monthly, or quarterly). Please contact group lead for more information.	Transportation	Frank Baskin Chris Hoeh	baskinfrank19@gmail.com cdhoeh@gmail.com
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Dignity Alliance Massachusetts is a broad-based coalition of organizations and individuals pursuing fundamental changes in the provision of long-term services, support, and care for older adults and persons with disabilities.
Our guiding principle is the assurance of dignity for those receiving the services as well as for those providing them.
The information presented in "The Dignity Digest" is obtained from publicly available sources and does not necessarily represent positions held by Dignity Alliance Massachusetts.
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