The Dignity Digest

Issue # 146 July 17 , 2023

The Dignity Digest is information compiled by Dignity Alliance Massachusetts concerning long-term services, support, living options, and care issued each Monday.

***May require registration before accessing article.**

Spotlight

What's Hot? Older Adults!

Opinion by Richard T. Moore, former Massachusetts State Senator and Chair Dignity Alliance Massachusetts Legislative Workgroup

July 17, 2023

In the Pacific Northwest, "As records toppled, lives were lost. Early investigations suggest that nearly one thousand people died as a direct result of the Pacific Northwest heat wave. Most of them were older adults.

"In Oregon's Multnomah County, which includes Portland, the average age among those who perished was 70. People over 65 accounted for three-quarters of Washington's deaths,"[1]according to an article published in 2021 by Harvard Medical School.

As the National Institute on Aging reports, "Too much heat is not safe for anyone. It is even riskier if you are older or have health problems. It is important to be cautious and get relief quickly when you are overheated. Otherwise, you might start to feel sick or risk a heat-related illness that could cause serious health issues."[2]

"It's not your imagination: It really is hotter than when you were a kid. The nine years from 2013 to 2021 rank among the 10 warmest on record, according to the National Oceanic and Atmospheric Administration. Climate experts warn that bouts of extreme heat are only going to become more common as global temperatures continue to rise.

That's bad news for older adults, who are more likely to get sick from heat — even die from it, according to AARP.[3]

"Older adults can't adjust to sudden temperature changes as fast as younger people. This may happen because of certain medicines they take or chronic illnesses that affect their ability to regulate body temperature. When not treated properly, heat-related illnesses can lead to death. But you can take steps to stay cool during hot weather," CMS warns.[4]

[1] The Effects of Heat on Older Adults | Harvard Medicine Magazine
[2] Hot Weather Safety for Older Adults | National Institute on Aging (nih.gov)
[3] Extreme Heat Waves and Their Effect on Adults Over 50 (aarp.org)
[4] Older Adults and Extreme Heat (cdc.gov)

All these experts are telling us that during periods of extreme heat, older adults from age 50 and above, especially those with chronic health issues, need to be concerned. Even the Mass.Gov web site warns that "During prolonged periods of extreme heat, people spending time inside buildings that lack cooling systems (e.g., schools, workplaces, and homes), working outdoors, engaging in outdoor recreational activities, or experiencing homelessness, may all be at risk for excessive heat exposure. During a heat event, people may also be exposed to increased levels of harmful air pollutants such as ozone and particulate matter, and aeroallergens such as pollen."[5]

However, that list of facilities of buildings that lack cooling systems fails to mention building that lack cooling systems with significant concentrations of older adults – nursing homes and assisted living facilities. While the state has regulations requiring heating systems in such buildings,[6]only new, or substantially renovated, facilities are required to include air conditioning.[7] Massachusetts, by most accounts, is getting hotter.[8]
We need to be prepared for this situation to be a regular occurrence, not just the rare heat wave of the past.

While the state has laws and regulations to deal with cold weather, and even offers assistance to residents to improve insulation and help pay heating bills, there isn't a comparable requirement for dealing with hot weather. Why not require nursing homes, assisted living facilities and senior centers to have air conditioning? Why not provide help for residents of homes and apartments to deal with cooling costs? Why not work with our utilities to upgrade the electrical grid to accommodate increased demand during hot weather?

Only 19 state ban utility shut off during the summers.[9] Massachusetts is not one of them. The Commonwealth only requires new nursing homes or substantially renovated facilities to include air conditioning. A lot of people are talking about climate change, some are working to reduce the causes. However, older adults in, and out, of nursing homes need relief now! We can't wait for the global warming and climate change issues to be solved. Too many older adults, many from underserved communities, are going to get sick or die from extreme heat if we don't develop a strategy for protecting people now while we wait for resolving our serious climate issues.

[5] Extreme Heat and Poor Air Quality | Mass.gov

[6] 105 CMR 150.00: Standards for long-term care facilities | Mass.gov
[7] 105 CMR 150.700: Heating and Air Conditioning Systems
[8] Massachusetts is getting hotter. Our electricity system is not prepared. - Acadia Center
[9] https://www.washingtonpost.com/opinions/2023/07/13/heat-wave-utility-shutoff/

Quotes	*Nearly all facilities would meet a requirement of 2.5 or fewer HPRD [hours per resident day] and 85% of facilities would meet a requirement of 3.0 HPRD, but close to half (45%) of all nursing facilities would not meet a 3.5 HPRD requirements, and only 29% would meet an HPRD of 4.0.* *What Share of Nursing Facilities Would Meet Possible New Staffing Requirements?,* **Kaiser Family Foundation,** July 14, 2023, New Staffing Requirements *Ultimately the dead may teach the living, but it is the duty of the living to be the voice advocating for the dead.* *When it comes to donating bodies for research, the living must advocate for the dead*, ***Boston Globe,** July 15, 2023, Living must advocate for the dead *The risk of natural disasters is everywhere (even in the most resilient places). People will no longer just have to prepare for intensified versions of the natural disasters they know, but they will also have to consider the possibility of new types of disasters — floods, storms, heat waves, droughts, and fires — impacting their community.* *There's no such thing as a disaster-resistant place anymore,* **Vox,** July 13, 2023, No such thing as disaster-resistant place *"We are still relatively early on in the process and haven't yet seen the real steep increase in newly eligible people who are reaching their termination date with MassHealth, but we anticipate those more substantial waves are coming soon."* Massachusetts Health . Connector Executive Director Audrey Gasteier. *On MassHealth Shift, "Substantial Waves" Still In Distance*, **State House News,** July 13, 2023, Substantial Waves *"You can say with some kind of degree of confidence what the demographics will look like. What the society will look like depends enormously on policy choices and behavioral change."* Philip O'Keefe, Director of the Aging Asia Research Hub at the ARC Center of Excellence in Population Aging Research, *How a Vast Demographic Shift Will Reshape the World,* ***New York Times,** July 16, 2023, Vast Demographic Shift

[Prior to the passage of the Americans with Disabilities Act, h]aving a disability was considered a medical problem to be solved rather than an identity to be protected under non-discrimination laws.

How the Americans with Disabilities Act transformed a country, **National Geographic,** July 30, 2020, ADA Transformed a Country

"[The Americans with Disability Act] is the world's first declaration of equality for people with disabilities. It will proclaim to America and to the world that people with disabilities are fully human; that paternalistic, discriminatory, segregationist attitudes are no longer acceptable; and that henceforth people with disabilities must be accorded the same personal respect and the same social and economic opportunities as other people."

Justin Dart, vice chair of the National Council on Disability known as the "Godfather of the ADA", *How the Americans with Disabilities Act transformed a country,* **National Geographic,** July 30, 2020, ADA Transformed a Country

The history of wheelchair development "shows disabled people as active agents and directing their own lives,"—lives that are made more mobile and independent.

Nicholas Watson, Professor of Disability Studies and Director of the Centre for Disability Research at the University of Glasgow, *How the wheelchair opened up the world to millions of people,* ***National Geographic,** July 14, 2023, Wheelchair opened up the world

"As a user of the DOT and MBTA systems herself, Dr. [Lisa] Iezzoni will bring a critical perspective to [the Massachusetts Department of Transportation's] board [of directors] that will help us ensure that our transportation system is accessible for people with disabilities."

Gov. Maura Healey, *Healey Fills MassDOT Openings with Transpo Veterans,* ***State House News,** June 28, 2023, Healey Fills DOT Openings

"[Dr. Lisa Iezzoni] has done an enormous amount to put disability issues on the map, to uncover bias against our community. We are really lucky to have her."

Colin Killick, executive director, Disability Policy Consortium, *'We are really lucky*

	to have her': For disability community, historic MassDOT board hire Lisa Iezzoni inspires confidence, ***Boston Globe,** June 28, 2023, Lucky to Have Her
Life Well Lived **Anne Johansen** 	**1. BCIL Mourns the Passing of Disability Rights Champion** Anne Johansen, longtime disability rights champion, passed away unexpectedly at home on July 4th after having spent the day with friends. Her daughter Elizabeth Johansen noted it was poetic—a remarkable advocate for independence dying on Independence Day. BCIL assisted Anne about a decade ago to leave a suburban nursing home, where she had endured an absence of freedom, being restricted from even leaving the premises. She remarked often on nursing facilities' fundamental denial of her human dignity for seven years of her life, most recently at the June 27 meeting of the PCA Work Force Council, when she also spoke up for a pay raise for PCAs because of their essential role in supporting her and others to live in the community. Anne was an active participant and involved supporter of Dignity Alliance Massachusetts. Anne came to live independently in her own residences in Quincy and then Hanover, cherishing family, friends, and advocacy compatriots. She was frequently on the frontlines of BCIL's call for accessible MBTA services—she spearheaded access improvements for the Wollaston Station in Quincy—for affordable housing, and for PCA services. She served on the aforementioned PCA Work Force Council for a number of years, appointed by then State Auditor Suzanne Bump. Elizabeth invites all to learn about and celebrate the life of her mother along with her friends, family, and colleagues on Saturday, July 22, from 6:00-8:00 pm Eastern Time. You can register for this virtual event, hosted by Elizabeth and assisted by BCIL, here: https://us02web.zoom.us/meeting/register/tZArc-mrrzkrGtNLY_GEyB4plBR43YFE9VmB. Anyone needing an accommodation for the celebration of Anne's life should contact ssmith@bostoncil.org.
Dr. Lisa Iezzoni Appointed to the Massachusetts Department of Transportation board of directors Dr. Iezzoni is a member of Dignity Alliance Massachusetts. 	**2. *State House News** June 28, 2023 *Healey Fills MassDOT Openings with Transpo Veterans* By Michael P. Norton and Alison Kuznitz Gov. Maura Healey , , , turned back the clock and named a group of veterans of state transportation issues to help move Massachusetts beyond the congested highways, bottlenecked intersections, and slow train rides that it's become known for. While in Dublin on a trade trip, Healey announced she is appointing former senator and mayor Thomas McGee, A Better City President Emeritus Rick Dimino, and Ilyas Bhatti, former commissioner of the defunct Metropolitan District Commission, to the Massachusetts Department of Transportation Board. Dr. Lisa Iezzoni, a professor of medicine at Harvard Medical School, was also appointed and the Healey administration said she will provide representation from a member of the disability community on the board for the first time. Iezzoni's research for 25 years has centered on improving the "lived experience" and health care for adults with disability, with an emphasis on mobility disability, the governor's office said. . . Said Healey: "Our administration is committed to ensuring that our state's transportation system is safe, reliable and accessible for all, and we're confident

that this talented, diverse group of leaders will drive that work on the DOT Board of Directors. We are particularly proud to be appointing a member of the disability community for the first time in the board's history. As a user of the DOT and MBTA systems herself, Dr. Iezzoni will bring a critical perspective to this board that will help us ensure that our transportation system is accessible for people with disabilities."

Healey Fills DOT Openings

3. ***Boston Globe**

June 28, 2023

'We are really lucky to have her': For disability community, historic MassDOT board hire Lisa Iezzoni inspires confidence

By Samantha J. Gross

Nationally renowned writer, researcher, and Harvard Medical School professor Dr. Lisa Iezzoni will represent MBTA riders on the state Department of Transportation board of directors, an announcement that drew cheers from the disability community who say her appointment represents "the voice of accessibility."

Governor Maura Healey appointed four new members Wednesday, including Iezzoni — the first member of the disability community to serve on the 11-member board, the governing authority for MassDOT.

Iezzoni, who has multiple sclerosis and uses a wheelchair, takes the Green Line to work and is widely regarded by her peers as a thoughtful researcher with the right lived experience for the role. . .

Those in the disability community say her presence will give voice to a sizable community that has long gone without an advocate in the transportation space. In 2019, nearly 800,000 people in Massachusetts had disabilities, according to a state factsheet.

And while a 2006 settlement agreement with the MBTA made a number of significant improvements to make the T accessible to riders with disabilities, the system is still imperfect. In Greater Boston, some accessible T stations are surrounded by inaccessible roadways or sidewalks. And The RIDE, an MBTA service that provides transportation to people who can't use the subway or bus, can be unreliable.

For those who do not drive, having accessible public transit is the difference between living independently and having to rely on others, said Monika Mitra, a fellow researcher who teaches disability policy at Brandeis University. The T has constant issues with poorly maintained wheelchair ramps, faulty elevators, malfunctioning audio announcements — all of which limit the ability of disabled people, Mitra said.

Lucky to Have Her

Americans with Disability Act Day 2023	**4. City of Boston Disability Commission** *ADA Day 2023: Thirty-third anniversary of the Americans with Disabilities Act* Saturday, July 18, 2023, 12:00 to 2:00 p.m. 1 City Hall Square, Boston Thirty-three years ago, in July of 1990, the Americans with Disabilities Act (ADA) was signed into law, enshrining and protecting the rights of people with disabilities throughout the country. The ADA has improved the lives of people with disabilities immensely, and that is worth celebrating! You are enthusiastically invited to join us for The Mayor's Commission for Persons with Disabilities annual ADA Day Celebration on Boston City Hall Plaza! Come to celebrate and honor the rights of people with disabilities. There will be a speaking program with City officials, a disability resource fair, food, music, and free t-shirts (while supplies last — so get there early!) Interpretation and translation services are available at no cost to you. The event will be wheelchair accessible, and. ASL and CART have been requested. To request additional accommodations or spoken language interpretation, please contact us at: disability@boston.gov Registration is optional, but please let us know you plan to attend if you would like! https://www.boston.gov/calendar/ada-day-2023
DignityMA Study Session	**5. DignityMA Study Session** *Older American Act Programs and New Rulemaking* Thursday, July 20, 2023, 4:00 to 5:00 p.m. The U.S. Administration for Community Living (ACL) is seeking input on proposed updates to the regulations for its Older Americans Act (OAA) programs. The proposed rule is the first substantial update to most OAA program regulations in 35 years. View an overview of the Update to ACL's Older Americans Act Regulations. Dignity Alliance Massachusetts has scheduled a Study Session about the OAA, its programs, and the rulemaking process. Lori Smetanka, Executive Director of The Consumer Voice and a national expert on aging and long term care policy, will lead the session. The session is scheduled for Thursday, July 20, 2023, from 4:00 to 5:00 p.m. via Zoom. The link is below. The session is free, open to all, and will be recorded. Pre-registration is not required. For more information contact, Dick Moore, Chair of DignityMA Legislative Workgroup (rmoore8743@charter.net), or Paul Lanzikos, DignityMA Coordinator(paul.lanzikos@gmail.com). Comments to the ACL must be received by the end of the day Tuesday, August 15. The federal Older Americans Act is scheduled for re-authorization in 2024. Join Zoom Meeting (No pre-registration needed.) https://us02web.zoom.us/j/89422936089?pwd=M1dwYzhpdnJDOWJ5aWNJQ1BqVyt4dz09 Meeting ID: 894 2293 6089 Passcode: 286131 One tap mobile +13126266799,,89422936089#,,,,*286131# US (Chicago) +16469313860,,89422936089#,,,,*286131# US Dial by your location • +1 646 931 3860 US • +1 305 224 1968 US • +1 309 205 3325 US

	• +1 689 278 1000 US • +1 719 359 4580 US • +1 253 205 0468 US • +1 360 209 5623 US • +1 386 347 5053 US • +1 507 473 4847 US • +1 564 217 2000 US • +1 669 444 9171 US Meeting ID: 894 2293 6089 Passcode: 286131 Find your local number: https://us02web.zoom.us/u/kbXe6CbJTA OAA Study Session
U. S. Senate Select Committee on Aging Hearing	**6. U. S. Senate Select Committee on Aging** Thursday, July 20, 2023, 9:30 a.m. *Laying the Foundation: Housing Accessibility and Affordability for Older Adults and People with Disabilities* Statement from U.S. Senator Robert Casey, Committee Chair: Next week, I am holding a hearing entitled, *"Laying the Foundation: Housing Accessibility and Affordability for Older Adults and People with Disabilities."* This hearing will focus on accessible and affordable housing for people with disabilities and older adults in urban and rural settings. . . At the hearing, I will focus on investments needed in the housing sector to make housing more accessible for people with disabilities and older adults. Stable, high-quality housing is an essential human need and the foundation to community well-being, leading to better outcomes in health, economic prosperity, and community integration. We must ensure that Americans with disabilities and older adults have housing that allows them to live safely and comfortably, and in their place of choice. I hope you will tune in. Note: US. Senator Elizabeth Warren is a member of the Committee. Link to live hearing: Laying the Foundation: Housing Accessibility and Affordability for Older Adults and People with Disabilities
Proposed regulatory amendments	**7. Massachusetts Department of Public Health** *Public Health Council* *Proposed Revisions to Health Care Facility and EMS Licensing Regulations* July 12, 2023 DPH proposes revisions to regulations governing health care facilities and emergency medical services, to provide high quality of care, industry standardization, and strong consumer protection to the residents of Massachusetts. Beginning in February 2022, the Centers for Medicare & Medicaid Services (CMS) required all CMS-certified providers (including personnel in healthcare facilities) to have completed the COVID-19 primary series vaccine. On May 31, 2023, CMS rescinded this requirement effective August 2023, and communicated that it will not be enforced in the interim. Currently, Department regulations require hospice and long-term care facilities to mandate that all personnel have received COVID-19 vaccination. • Exemptions have been allowed for individuals for whom the vaccination is

	medically contraindicated or against an individual's sincerely held religious belief. • Individuals receiving an exemption must be able to perform their essential job functions with reasonable accommodations that do not place an undue burden on the facility. • Guidance implementing this vaccination requirement requires personnel to receive only the primary series of the COVID-19 vaccine. See pages 49 through 63 of https://www.mass.gov/doc/phc-presentation-july-12-2023/download
Reports	**8. Centers for Medicare and Medicaid Services** *SNF Provider Preview Reports – Now Available* The Skilled Nursing Facility (SNF) Provider Preview Reports have been updated and are now available. These reports contain provider performance scores for quality measures, which will be published on Care Compare and Provider Data Catalog (PDC) during the **October 2023** refresh. The data contained within the Preview Reports are based on quality assessment data submitted by SNFs from **Quarter 1, 2022 through Quarter 4, 2022.** Additionally, the Centers for Disease Control and Prevention (CDC) COVID-19 Vaccination Coverage among Healthcare Personnel (HCP) measure reflects data from **Quarter 4, 2022**. The data for the claims-based measures will display data from **Quarter 4, 2020 through Quarter 3, 2022** for this refresh, and for the SNF Healthcare-Associated Infections (HAI) measure, from **Quarter 4, 2021 through Quarter 3, 2022**. Providers have until **August 14, 2023** to review their performance data. Only updates/corrections to the underlying assessment data before the final data submission deadline will be reflected in the publicly reported data on Care Compare. If a provider updates assessment data after the final data submission deadline, the updated data will only be reflected in the Facility-Level Quality Measure (QM) report and Patient-Level QM report. Updates submitted after the final data submission deadline will not be reflected in the Provider Preview Reports or on the Care Compare website. However, providers can request Centers for Medicare & Medicaid Services (CMS) review of their data during the preview period if they believe the quality measure scores that are displayed within their Preview Reports are inaccurate. SNF Provider Preview Reports can be retrieved by: 1. Select the CASPER Reporting link on the "Welcome to the CMS QIES Systems for Providers" webpage. **NOTE:** You must log into the CMS Network using your CMSNet user ID and password in order to access the "Welcome to the CMS QIES Systems for Providers" webpage. 2. Enter your QIES user ID and password on the QIES National System Login page. 3. Select the **Login** button, review the contents of the U.S. Government-Authorized Use Only Window pop-up message box and select the **OK** button to proceed to the "CASPER Home" webpage. 4. Select the **Folders** button from the menu bar. 5. Select your provider's shared folder from the Folders list on the CASPER Folders page. The folder will be named in the following manner: **[State Code] LTC or SB [Facility ID]** Where: **State Code** = your 2-character state code

	LTC = Nursing Home Providers **SB = Swing Bed Units** **Facility ID** = CMS-assigned facility ID used for submitting Minimum Data Set (MDS) records **NOTE:** The SNF Provider Preview Reports will not be in your provider's Validation Report (VR) folder. 6. Select the desired SNF Provider Preview report link from the list of reports displayed on the right side of the CASPER Folders page and the report will display. **NOTE:** The SNF Provider Preview report links are titled "SNF Provider Preview Report." For questions related to accessing your facility's provider preview report, please reach out to the iQIES helpdesk **at** iqies@cms.hhs.gov **or call 1-877-201-4721.** **For questions about SNF Quality Reporting Program (QRP) Public Reporting, please email** SNFQRPPRQuestions@cms.hhs.gov**.** **9. *JAMA Network** April 17, 2023 *Novel Estimates of Mortality Associated with Poverty in the US* By David Brady, PhD; Ulrich Kohler, PhD; Hui Zheng, PhD The US perennially has a far higher poverty rate than peer-rich democracies.[1] This high poverty rate in the US presents an enormous challenge to population health given that considerable research demonstrates that being in poverty is bad for one's health.[2] Despite valuable contributions of prior research on income and mortality, the quantity of mortality associated with poverty in the US remains unknown. In this cohort study, we estimated the association between poverty and mortality and quantified the proportion and number of deaths associated with poverty. Novel Estimates of Mortality
Advocacy Use DignityMA's automated system to communicate with Senators Warren and Markey and your Congressperson easily and directly: TAKE ACTION	**10. Call to Action** *National Nursing Home Reforms* TAKE ACTION Last year, the Biden administration proposed critical nursing home reforms. Among the key proposals are a minimum staffing standard for nursing homes and increasing transparency and accountability around ownership and finances. These proposals (https://www.whitehouse.gov/briefing-room/statements-releases/2022/02/28/fact-sheet-protecting-seniors-and-people-with-disabilities-by-improving-safety-and-quality-of-care-in-the-nations-nursing-homes/) are essential for the safety and wellbeing of nursing home residents who all too often suffer daily neglect when their facilities are understaffed. Numerous studies document that without adequate staff, residents routinely sit in soiled clothes and dirty diapers, receive poor hygienic care , and fail to receive necessary medication. Their call bells go unanswered, even in emergencies. Poorly staffed nursing homes are more likely to be cited for abuse, have worse health inspections, and have the lowest quality ratings. It is imperative that we take steps to hold nursing home owners accountable for how they use taxpayer dollars. This includes ensuring all necessary funds go towards direct care. Nursing home residents cannot be left neglected and suffering in inadequate and unacceptable conditions. They fully deserve to be treated with competence, compassion, and with their dignity respected. **We are asking you to contact your Congressional Representative in**

	Washington, and ask them to urge the Office of Management and Budget Director, Shalanda Young (shalanda.d.young@omb.eop.gov), to immediately release strong CMS regulations establishing minimum staffing standards in nursing homes, and holding owners and operators accountable for the quality of care they provide and how they spend public dollars. This, plus the resources for meaningful enforcement is essential for ensuring that nursing home residents receive the care they need and deserve. TAKE ACTION
Webinars and Online Sessions	**11. The Consumer Voice** Thursday, July 27, 2023, 1:00 to 2:00 p.m. *Using the New Centers for Medicare & Medicaid Services Nursing Home Affiliation Data* On June 28, 2023, the Centers for Medicare & Medicaid Services (CMS) began to publish on its Nursing Home Care Compare website information regarding a facility's affiliation with other nursing homes under common ownership or control. In addition, CMS published a data set entitled "Nursing Home Affiliated Entity Performance Measures." For the first time, consumers will be able to see how nursing homes in a chain or under common ownership or control perform in various quality measures, including the Care Compare Five-Star rating system, staffing levels, regulatory violations, and many other performance measures. For nursing home residents and their families, making a decision about what facility to choose to reside in can be a daunting and frustrating process. Knowing who owns a nursing home can be a matter of life and death. For instance, research shows that residing in a nursing home owned by private-equity investment organizations raised resident mortality by 10%. However, for too long, it has been a labyrinthine and often fruitless endeavor to determine who actually owns a nursing home. CMS's new affiliation data is a critical and important step in ensuring increased transparency in nursing home ownership. On **July 27, 2023, at 1 p.m. ET**, Consumer Voice will hold a webinar to demonstrate how to use this newly available information. We will provide you with step-by-step guidance on how to access and interpret ownership and performance data. **REGISTER** **12. U. S. Census Bureau** Thursday, July 27, 2023, 4:00 p.m. *2030 Census Research, Testing and Timeline Webinar* **Presenters:** • Robert L. Santos, director, U.S. Census Bureau • Deborah Stempowski, associate director, Decennial Census Programs, U.S. Census Bureau • Daniel Doyle, deputy chief, Decennial Census Management Division, U.S. Census Bureau • Michael C. Cook, Sr., senior advisor for strategic communications, Office of the Director, U.S. Census Bureau, moderator **Access:** The virtual event will consist of a simultaneous audio conference and online presentation: WebEx Link • Webinar password (if requested): Census#1 • Webinar number (if requested): 2763 795 1508

	Audio: For telephone audio option (or to ask a question), please call by telephone to **1-888-469-0850** • **Passcode: 9659654** You can also watch this event on YouTube via the Census Live page. (Live captioning available) **13. MassHealth** Friday, July 28, 2023, 1:30 to 3:30 p.m. *EVV Implementation Updates: MassHealth PCA Listening Session* Where: https://zoom.us/j/94352357740?pwd=R3VHaU5lbTREOVNHOWNhNmZ1dC9FQT09 One tap mobile +13092053325,,94352357740#,,,,*982968# US +13126266799,,94352357740#,,,,*982968# US (Chicago) Dial by your location +1 301 715 8592 US (US Toll) +1 312 626 6799 US (US Toll) +1 646 876 9923 US (US Toll) Meeting ID: 943 5235 7740 Password: 982968 Live Spanish translation and ASL will be provided for this session
Previously posted webinars and online sessions	Previously posted webinars and online sessions can be viewed at: https://dignityalliancema.org/webinars-and-online-sessions/
Nursing Facilities	**14. Kaiser Family Foundation** July 14, 2023 *What Share of Nursing Facilities Would Meet Possible New Staffing Requirements?* Nursing facilities provided medical and personal care services for nearly 1.2 million Americans across 15,076 Medicare and Medicaid-certified facilities in 2022. While these facilities provide care to an older, frail, and disproportionately female population, there have been long-standing concerns about insufficient staffing in nursing facilities and its impact on quality. A recent report issued by the National Academy of Sciences, Engineering, and Medicine (NASEM) raised concerns about low nursing staff levels in nursing facilities across the country and the impact of inadequate staffing levels on the quality of care for nursing home residents. The high mortality rate in nursing facilities during the COVID-19 pandemic highlighted and intensified the consequences when staffing levels are low and quality suffers. A March 2023 report by GAO cited the need to improve staffing as a priority issue in nursing facilities, finding that inadequate staffing made it difficult for nursing homes to adhere to proper infection prevention and control practices. In light of these concerns, the Administration issued an executive order in April 2023 directing the Secretary of Health and Human Services to consider actions to promote adequate staffing at nursing homes and reduce staff turnover. The order also directed the Secretary of Labor to take actions that would improve the jobs of long-term care workers. This executive order followed the release of a fact sheet by the Biden Administration in February 2022 announcing forthcoming requirements for minimum nursing facility staffing levels. This data note explores the current state of nurse staffing levels at nursing facilities in anticipation of the forthcoming proposed rule on staffing regulations.

Specifically, we analyze the percentage and characteristics of facilities that would meet higher levels of nursing staff, if required under Medicare and Medicaid. The analysis includes data from 14,575 nursing facilities (97% of all facilities, serving 1.17 million or 98% of all residents) that reported staffing levels in June 2023. Staffing levels and requirements are often specified as direct care hours per resident day (HPRD), which equals the total number of hours worked by each type of nursing staff (nurse aides, registered nurses, and licensed practical nurses) divided by the total number of residents. Key takeaways include:

- Nearly all facilities would meet a requirement of 2.5 or fewer HPRD and 85% of facilities would meet a requirement of 3.0 HPRD, but close to half (45%) of all nursing facilities would not meet a 3.5 HPRD requirements, and only 29% would meet an HPRD of 4.0.
- Similarly, when looked at as a share of residents, 83% of residents live in a facility with staffing levels of at least 3.0 HPRD, but 50% of residents live in a facility that meet a 3.5 HRPD and only 23% live in a facility with staffing levels of 4.0 or greater.
- At any required staffing level above 2.5 HPRD, a lower percentage of for-profit nursing facilities would meet the requirement than non-profit or government nursing facilities.
- There is wide state variation in the share of facilities that would meet required HPRD levels of 3.0 or higher: At a level of 4 HPRD, the share of facilities meeting the requirement would range from 12% in Texas to 100% in Alaska.

HPRD is a relatively simple measure that does not account for what type of nursing staff are at the facility or the types of patients the facility serves. The measure also does not account for the number of non-nursing staff employed by a facility. The proposed rule is likely to strengthen the HPRD minimum requirement and could potentially include additional nurse staffing requirements. If the proposed rule includes requirements related to the types of nurses facilities must employ (and the hours they must work) or adjusts the number of required nurses based on patient health and frailty, fewer nursing facilities would meet a given requirement than are shown here. The rule may also require nursing facilities to employ additional staff beyond nurses, but such requirements are outside the scope of this analysis.

What are Current Staffing Requirements for Nursing Facilities?

The Act, established the first federal staffing minimums for nursing facilities. The Obama Administration issued an update to these regulations in 2016. The Obama Administration issued an update to these regulations in 2016. Federal regulations require facilities to provide licensed nursing services 24 hours a day, 7 days a week and to have a registered nurse on duty eight hours per day, seven days per week. Facilities must also appoint a director of nursing, have a full-time registered dietician on staff, and provide services that are "sufficient" to meet residents' needs. Combined, federal regulations have been interpreted as requiring the equivalent of 0.3 nursing HPRD for a 100-bed facility. Requirements are applied irrespective of facility size or resident census, with two exceptions: In facilities with daily occupancies of 60 or fewer, the director of nursing may serve as a charge nurse; and in facilities with greater than 120 beds, staff must include at least one-time full-time social worker.

For at least 20 years, a number of groups have suggested that federal

requirements for nursing staff levels (0.3 HPRD) are below the levels that would ensure patient safety and well-being. For example, in 2001, a report commissioned by the Centers for Medicare and Medicaid Services (CMS) recommended a minimum of 4.1 HPRD. In April 2022, the National Academies of Science, Engineering, and Medicine (NASEM) published a report with staffing recommendations that include: having RN on staff 24/7 with additional RN coverage as needed (current requirement of 8 hours per/day); a full-time social worker (currently this only applies to facilities over 120 beds); and an infection prevention and control specialist (no current requirement). The report also recommended funding research to identify optimum staffing levels for other direct care staff. A KFF June 2022 analysis of state policies on nursing facility staffing minimums found that most states require staffing standards above federal requirements.

What Share of Nursing Facilities Meet Varying Levels of Staffing Requirements That Could Be Included in the Forthcoming Proposed Rule?

As of June 2023, virtually all nursing facilities meet current staffing requirements (0.3 HPRD) and most would meet requirements of up to 3.0 HPRD, but if the new staffing requirements are 4.0 or greater, most facilities would need to hire new staff to comply (Figure 1). Because it is unknown what the new requirements might be, this analysis shows how many nursing facilities would meet required HPRD ranging from 1 to 5. Nearly all facilities would meet a requirement of 2.5 or fewer HPRD and 85% of facilities would meet a requirement of 3.0 HPRD, but close to half (45%) of all nursing facilities would not meet a 3.5 HPRD requirements, and only 29% would meet an HPRD of 4.0. Similarly, when looked at as a share of residents, 83% of residents live in a facility with staffing levels of at least 3.0 HPRD, but 50% of residents live in a facility that would meet a 3.5 HRPD and only 23% live in a facility with staffing levels of 4.0 or greater (Figure 1).

A small share of nursing facilities currently has staffing levels that would meet a requirement higher than 4 HPRD. Only 15% of facilities have staffing levels over 4.5 HPRD and just 8% have levels of 5.0. Only one in ten residents live in a facility with 4.5 or more HPRD and just 5% live in a facility with 5 or more HPRD.

If the required HPRD is adjusted for the health and frailty of residents in a nursing facility (case-mix), about 70% would meet a requirement of 3 HPRD, which is lower than the 85% that would meet an unadjusted requirement of 3 HPRD (Figure 2). Under current requirements, facilities do not have to adjust staffing based on the types of residents that live in the facility. However, federal data include staffing levels for facilities that are adjusted to reflect the health and frailty levels of facility residents. This adjustment is called “case-mix” and accounts for the fact that residents who have more health needs or are frailer are expected to require more assistance from nursing staff. For a given required HPRD, a smaller percentage of facilities would meet a “case-mix” adjusted requirement than would meet an unadjusted requirement.

At any required staffing level above 2.5 HPRD, a lower percentage of for-profit nursing facilities would meet proposed staffing levels than non-profit or government nursing facilities (Figure 3). If the level were set at 3 HPRD, 81% of for-profit nursing facilities would meet the requirement compared with 94% of non-profit facilities and 90% of government facilities. At 3.5 HPRD, differences by ownership type widen: a smaller share (47%) of all for-profit nursing facilities would meet requirements than non-profit facilities (75%) or government

facilities (68%). At 4.0 HPRD, just 20% of for-profit nursing facilities would meet requirements compared with about half of non-profit (52%) and government facilities (47%). About 72% of all facilities are for-profit (home to 74% of residents), 22% are non-profit (home to 20% of residents), and 6% are government-owned, (home to 6% of residents).

Differences by ownership status are smaller when using an HPRD adjusted for resident health and frailty. When using this adjusted HPRD, only about 12% of for-profit facilities, 8% of non-profit, and 8% of government facilities would meet a requirement of 3.5 HPRD. There is nearly no difference by ownership type in the percentage of facilities that would meet a case-mix adjusted requirement of 4 HPRD or higher.

If required staff levels exceed 3 HPRD, there would be wide variation across states in the share of facilities that would meet the requirements (Figure 4). There is minimal state variation across the states if the new requirements are 2 HPRD or fewer because over 90% of facilities would meet a required level of 2 HPRD in all states (Figure 4). If the requirement is 3 HPRD, the share of facilities in compliance would range from 58% in Missouri to 100% in five states and, if set at a level of 4 HPRD, the share of facilities in compliance would range from 12% in Texas to 100% in Alaska. Results are similar when looking at the percentage of nursing facility residents who live in a facility that would meet various staffing requirements (Appendix Table 1).

Staffing levels also vary within states, though some states generally have lower levels of staffing than others. For example, in Alaska, staffing levels range from 4.7 to 12.7 while in New Mexico, facilities range from 2.3 to 5.6 (Appendix Table 2).

What Happens to Nursing Facilities When They Do Not Meet Required Staffing Levels?

For facilities determined out of compliance with federal staffing requirements, penalties vary depending on a deficiency's severity and how long it takes for a nursing facility to reach substantial compliance. Substantial compliance is a level of compliance with the requirements such the deficiency no longer poses a substantial risk to resident health or safety. For deficiencies that do not result in immediate jeopardy, facilities are given up to six months to correct deficiencies. If a facility does not come into substantial compliance within three months, Medicare and Medicaid will not pay the costs for individuals admitted after the deficiency finding date. If a facility that does not come into substantial compliance within six months, Medicare and Medicaid will not pay the costs for any individuals in the facility. For deficiencies that result in immediate jeopardy, CMS or the State Medicaid Agency may either: 1) appoint temporary management to oversee operations while deficiencies are corrected or 2) end the facility's participation in the Medicare and/or Medicaid programs and transition residents to another facility or community setting.

Between July 2021 and July 2022, about 19% of nursing facilities received deficiencies for "Nursing Services", meaning that they failed to have "sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety". This grouping of deficiencies captures more than just failing to meet the 0.3 HPRD requirement and includes other deficiencies such as the failure to ensure proper training for nurse aides. The vast majority of these deficiencies were not associated with harm to patients.

What are Key Issues to Watch?

Looking ahead, if a proposed rule is issued and finalized, many nursing facilities may need to hire new staff to meet the proposed staffing levels, but the extent of the challenge will depend on the specifics of the new requirements. Key considerations for evaluating new requirements, beyond the level of the minimum staffing requirement, include the following.

- How long do nursing facilities have to comply with the new requirements and are they phased in over time? Implementation periods of several years and phased-in requirements give nursing facilities more time to come into compliance.
- Do the new requirements include a total number of HPRD or do they include specific requirements for different types of nursing staff? Requirements for overall staffing levels will be easier for nursing facilities to meet than requirements that are specific to each type of nursing staff.
- Do the new requirements include requirements for non-nursing staff such as social workers, nutritionists, and infection control specialists? Requirements for non-nursing staff could make it harder for some facilities to comply.
- Are the new requirements adjusted for patients' characteristics such that facilities with higher-risk residents need to have more staff or more highly trained staff? It may be more difficult for nursing facilities to meet requirements that vary based on patient characteristics.

Compounding the compliance challenge are workforce shortages in the long-term services and supports (LTSS) sector, which reflect demanding working conditions and relatively low wages. The COVID-19 pandemic affected health care workers in all settings but particularly for direct care workers who provide LTSS. As of December 2022, employment levels were still over 13% below pre-pandemic levels for nursing care facilities and 7% below pre-pandemic levels for community care facilities for the elderly. Immigrants could help fill some of those positions, but a backlog of green card petitions is expected to further exacerbate nursing shortages across both health and long-term care sectors. Nationwide, there is "a growing crisis of unfilled job openings and high staff turnover" in the long-term care sector. Recognizing these shortages, most states have moved forward to increase Medicaid payment rates to LTSS providers. In a recent survey of Medicaid directors, 44 states reported increasing Medicaid rates for nursing facilities in 2022, and a survey of HCBS programs found that 48 states increased rates for home- and community based LTSS providers. Despite those pay increases, workforce shortages persist.

Potential increases in nursing home staffing requirements could increase costs, which may be difficult for some states' Medicaid programs to absorb without additional federal funding. The American Health Care Association, a group representing both for-profit and not-for-profit long-term care facilities, commissioned a study in anticipation of the proposed rule and estimated that a minimum staffing requirement could cost anywhere from 3 billion to 10 billion dollars in a single year and require hiring more than 187,000 nurses and nurse aides. It is not clear how these costs will be financed, but they are likely to be passed on to public and private payers for nursing facility services, including residents and their family members who paid $45 billion in out-of-pocket costs for care in nursing homes and other institutional LTSS settings in 2020. Medicaid spent nearly $53 billion dollars in that year, about twice the amount ($26 billion) that traditional Medicare spent on skilled nursing facilities (SNFs) in 2020.

	Medicaid financing is shared by the states and the federal government. However, unlike the federal government, states must meet balanced budget requirements, and therefore, may need to cut other spending or raise taxes to pay for the state share of additional nursing home costs. In addition to potential costs to meet nursing facility staffing requirements, a recent proposed rule on Medicaid access would require states to demonstrate that their payment rates for home and community-based LTSS are "adequate to ensure a sufficient direct care workforce to meet the needs of beneficiaries and provide access to services in the amount, duration, and scope specified in the person-centered plan" Together these rules could require significant Medicaid investments in LTSS. **Topics** • Medicaid **Tags** • Nursing Facilities • Long-Term Care • Seniors • Disability **news release** Jul 2023 • Will Nursing Facilities Have to Hire to Comply with Potential New Staffing Requirements? **Also of Interest** • 10 Things About Long-Term Services and Supports (LTSS) • Nursing Facility Staffing Shortages During the COVID-19 Pandemic • State Actions to Address Nursing Home Staffing During COVID-19 • A Look at Nursing Facility Characteristics Through July 2022 New Staffing Requirements
Housing	**15. Pro Publica** July 14, 2023 *LA Promised to Preserve Low-Cost Housing. These Tenants' Homes Were Turned into Hotel Rooms Anyway.* By Robin Urevich, Capital & Main, and Gabriel Sandoval When the American Hotel converted into a tourist hotel, its long-term residents lost not just their affordable housing but the creative community that long thrived in the iconic building. Jaime Colindres' third-floor room at the American Hotel in Los Angeles was tiny, but in it he painted expansive scenes of the American West on salvaged pieces of wood. . . That was 10 years ago. The American is now a boutique tourist hotel in LA's downtown Arts District. Nearly all of its longtime residents have been replaced. But the culprit is not gentrification. It's the city's failure to enforce its own laws to preserve affordable housing. A 2008 city ordinance sought to protect residential hotels like the American. Residential hotels often offer single-room dwellings and are sometimes the only housing that elderly, disabled and low-income people can afford. But Capital & Main and ProPublica found 21 such buildings, including the American, offering rooms to travelers. Under the ordinance, owners who convert or demolish residential hotel rooms

	must either build new units or pay into a city housing fund. None of the 21 have received clearances from the city showing that they've done either, according to Housing Department records. But the agency has cited only four of the hotels for residential hotel violations, even as some buildings went through obvious transformations and publicly advertise rooms on travel websites, the news organizations found. The American wasn't one of the hotels cited. . . In the years since the hotel's conversion, it's arguably become even harder for the former residents to find a replacement for the housing they had at the American. Several former residents left the state to be closer to family or to find more affordable housing. Turned Into Hotel Rooms Related articles: • Checked Out: How LA Failed to Stop Landlords from Turning Low-Cost Housing Into Tourist Hotels • Los Angeles Housing Department Will Investigate Residential Hotels
Medicaid	**16. State House News** July 13, 2023 *On MassHealth Shift, "Substantial Waves" Still in Distance* By Chris Lisinski Three months into a year-long campaign to reassess eligibility for all 2.4 million MassHealth members, officials are still waiting for the ripples of disruption to turn into the waves they expected. . . The Massachusetts Health Connector has seen an influx of people who formerly received publicly funded insurance from MassHealth enrolling in plans offered through the state-run marketplace, but so far, the volume has been fairly small. More than 16,000 people who lost MassHealth coverage since April 1 have transitioned onto a plan available from the Massachusetts Health Connector, according to Marissa Woltmann, the Connector's chief of policy. That reflects about 22 percent of people who were deemed no longer eligible for MassHealth but qualify for a plan through the Connector, which Woltmann said is "higher than some of the preliminary data we've seen coming out of other states as well as an assessment of our own data on pre-COVID transitions." Still, three-quarters of people who lost MassHealth and are now eligible for the Connector have not yet selected an insurance plan offered through the state-run marketplace, according to Woltmann's presentation at a Connector board meeting. Four out of 10 people in that subset do not qualify for any subsidies to offset the cost of insurance through the Connector, and many of those people have access to coverage through other avenues like an employer-sponsored health plan, officials said. . . Like many other states, Massachusetts saw enrollment in MassHealth -- which combines Medicaid and the Children's Health Insurance Program under one umbrella -- swell during the COVID-19 emergency. . . The state has also partnered with groups like Health Care for All to launch a communications and outreach blitz. Canvassers have knocked on more than 320,000 doors, and community-based organizations have held more than 500 events in the communities, most at risk of residents losing MassHealth coverage, according to LaMontagne. Substantial Waves

17. Administration on Community Living

July 13, 2023

All Hands on Deck: Medicaid Beneficiaries Must Take Action to Keep Their Coverage

By Alison Barkoff, Acting Administrator and Assistant Secretary for Aging

We need your help get the word out to people enrolled in Medicaid that they may have to take action to remain covered and that there are steps they can take if they lose Medicaid.

As we've discussed on this blog before (on 3/22 and 5/15), at the beginning of the COVID-19 pandemic, significant changes were made to Medicaid enrollment and eligibility rules to prevent people from losing Medicaid coverage during the pandemic. With the end of the federal Public Health Emergency on May 11, 2023, those flexibilities have ended, and all states are resuming their regular processes for renewing individuals' Medicaid coverage.

Based on data from 28 states and the District of Columbia, Kaiser Family Foundation reports that more than 1.6 million people have been disenrolled from Medicaid as of July 5, 2023. Many of these people may still be eligible for Medicaid but lost coverage because they didn't return forms (or either they or the state made other mistakes).

It is crucial to make sure everyone covered by Medicaid knows:

- Over the next 12 months, everyone with health care coverage through Medicaid or the Children's Health Insurance Program (CHIP) will need to renew their coverage.
- What they need to do to avoid losing coverage if they are still eligible.
- Other options for coverage if they are no longer eligible for Medicaid or CHIP (such as the Affordable Care Act (ACA) Marketplace or employer-sponsored coverage), and how to find help navigating them.

If you're reading this blog, we need your help to spread the word. If you're part of the aging and disability networks, your help is particularly important — no one else has your ability to reach disabled people and older adults!

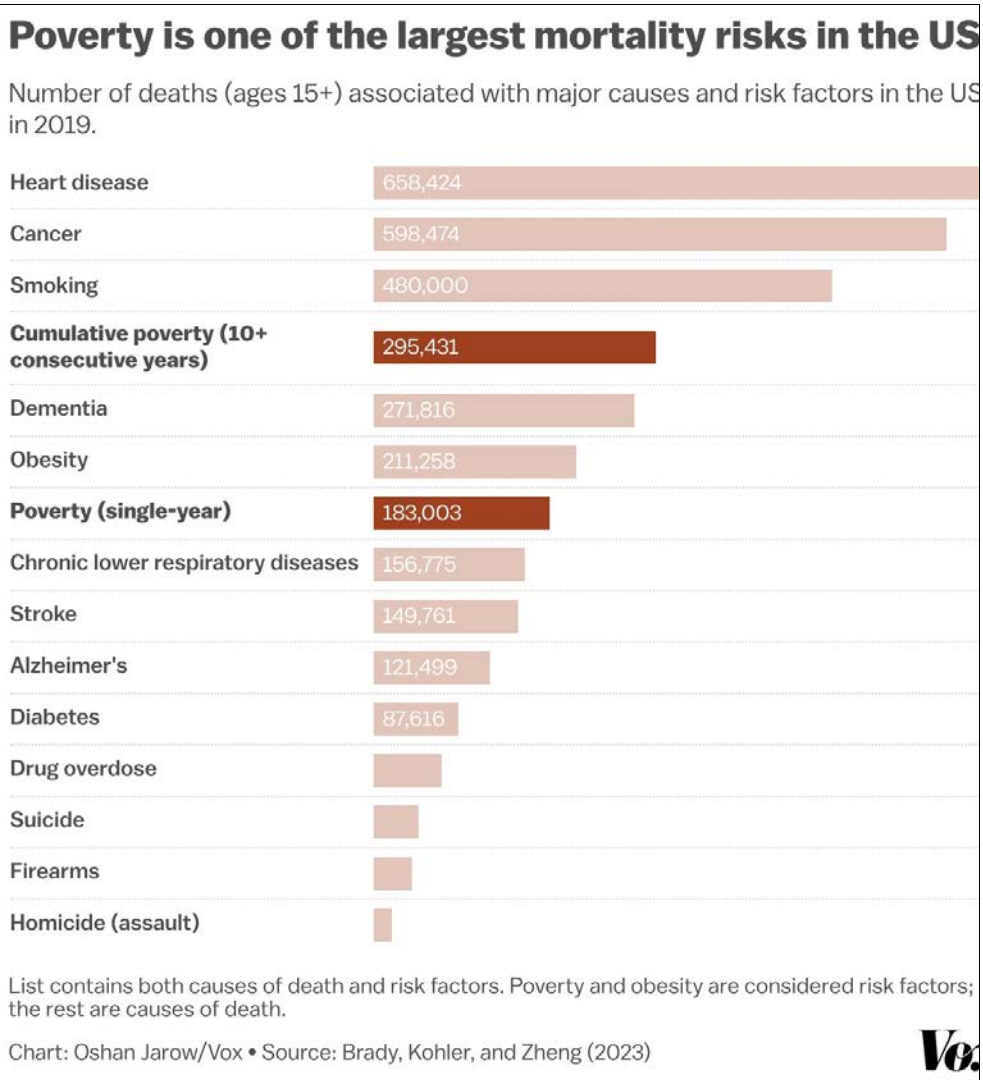
Every Medicaid beneficiary needs to receive these important messages:

- UPDATE your contact information with your state Medicaid agency NOW.
- RESPOND to the Medicaid renewal form when it comes in the mail. If you don't, you may lose your coverage even if you are still eligible.
- PARENTS should respond even if you are not eligible or are enrolled in other coverage. Your children could still be eligible for coverage.
- CONNECT WITH RESOURCES THAT CAN HELP: If you lose Medicaid coverage and think you may still be eligible, there are programs that may be able to help you appeal the denial of Medicaid coverage or find other insurance. State protection and advocacy systems and legal advocacy organizations funded under the Older Americans Act may be able to help with appeals. Disabled people of all ages can also contact the Disability Information and Access Line (DIAL) for assistance, and older adults can contact the Eldercare Locator to find local assistance.
- CHECK OTHER OPTIONS: If you are no longer eligible for Medicaid, you should check to see if you can get coverage through your employer or through the Affordable Care Act Marketplace at healthcare.gov. Older adults and people with disabilities who are eligible for Medicare can also find assistance through their State Health Insurance Assistance Program (SHIP). SHIP is a national program that offers one-on-one assistance, counseling,

	and education to Medicare beneficiaries of all ages, their families, and caregivers to help them make informed decisions about their care and benefits. Please look for ways to share these messages widely. Include them in your newsletters, add them to flyers packaged with home-delivered meals, share on social media, post on bulletin boards — you get the idea. Be sure to include the name of your state's Medicaid program and ACA Marketplace — many people don't realize they have Medicaid coverage if it goes by another name in their state, and they may not realize that they need to look for renewal information. Find links to your state Medicaid agency. The Centers for Medicare & Medicaid Services (CMS) has developed a variety of materials that you can use to ensure your communities and networks have this important information. For example, their communications toolkit — available in English, Spanish, Chinese, Hindi, Korean, Tagalog, and Vietnamese — contains important messages and sample materials (like drop-in articles, social media messages, and flyers) for states and other partners to use. CMS has also created a variety of fact sheets, including one with a variety of suggestions for things you can do to help keep people covered. Finally, in a recent letter to U.S. governors, Health and Human Services Secretary Xavier Becerra urged states to adopt all options HHS has offered to help eligible individuals and families maintain their health coverage during unwinding. Your advocacy can play an important role in implementing these options. Making sure people stay covered will take an "all hands on deck" effort, but together, we can make sure every American has access to quality, affordable health coverage. *For additional information and the latest resources, visit the "Unwinding" page on ACL.gov.* All Hands on Deck
Alzheimer's Disease and Other Dementia	**18. AP News** July 17, 2023 *Second Alzheimer's drug in the pipeline promises to slow worsening but with safety concern* By Lauran Neergaard Another experimental Alzheimer's drug can modestly slow patients' inevitable worsening — by about four to seven months, researchers reported Monday. Eli Lilly and Co. is seeking Food and Drug Administration approval of donanemab. If cleared, it would be only the second Alzheimer's treatment convincingly shown to delay the mind-robbing disease — after the recently approved Leqembi from Japanese drugmaker Eisai. . . Both donanemab and Leqembi are lab-made antibodies, administered by IV, that target one Alzheimer's culprit, sticky amyloid buildup in the brain. And both drugs come with a serious safety concern — brain swelling or bleeding that in the Lilly study was linked to three deaths. Scientists say while these drugs may mark a new era in Alzheimer's therapy, huge questions remain about which patients should try them and how much benefit they'll really notice. . . The study had a few twists. Patients were switched to dummy infusions if enough amyloid cleared out — something that happened to about half within a year. And because amyloid alone doesn't cause Alzheimer's, researchers also tracked levels of another culprit in the brain — abnormal tau. More tau signals

	more advanced disease. The results: Both groups declined during the 18-month study but overall those given donanemab worsened about 22% more slowly. Some patients fared better — those with low to medium tau levels saw a 35% slower decline, reflecting that the drug appears to work better in earlier stages of the disease. . . It's too soon to know if some patients might need to resume donanemab, said Lilly's Dr. Mark Mintun. But the amyloid "doesn't come back with any sort of vengeance," he said, speculating that might take several years. Another concern: More than 90% of the study's participants were white, leaving little data about how other populations might respond, Alzheimer's specialist Jennifer Manly of Columbia University wrote in JAMA. Second Alzheimer's Drug
Public Health	**19. Vox** July 14, 2023 *Poverty is a major public health crisis. Let's treat it like one.* By Oshan Jarow Poverty contributes to hundreds of thousands of American deaths a year, a recent study finds. . . It's well established that poverty is bad for your health. But as a public health issue, the US knows less about the direct link between poverty and death than we know about, say, the link between smoking and death. Current estimates suggest smoking kills 480,000 Americans per year. Obesity kills 280,000, and drug overdoses claimed 106,000 American lives in 2021. Together, risk factors and their mortality estimates help motivate public health campaigns and government-funded efforts to save lives. But how many Americans does poverty actually kill? The question has received little attention compared to other mortality risks, and meanwhile, poverty remains prevalent across the country. . . Amelia Karraker, a health scientist administrator at the National Institute on Aging, explains that research has shown a variety of pathways that connect poverty and mortality. These range from neighborhood amenities and nutrition down to the impacts of stress on the body: "Being poor is really stressful, which we know from NIH-supported research has implications for what's actually happening in the body at the cellular level, which ultimately impacts health and mortality," she said. Crucially, that doesn't mean you'll find "poverty" written as the cause on anyone's death certificate. Risk factors are only correlations that imply an association but not necessarily causation (although new research found that cash transfers to women in low- and middle-income countries cut mortality rates by 20 percent). But proving an association is a necessary step toward deciphering whether poverty might be more than an association. For example, there is an association between the number of Nicolas Cage movies released and the number of people who drown in swimming pools that year. No one is arguing that we should dissuade Cage from releasing films in order to combat drowning. But there is also an association between cigarette smoking and lung cancer. Here, we do believe one causes the other, so we do try and dissuade people from smoking to combat lung cancer deaths. . . Measured in relative terms, poverty in the US is significantly worse than in similarly wealthy countries. Meanwhile, US citizens face a higher mortality rate at almost every age than residents of peer countries, and that disparity is growing. Even according to the US Census Bureau's supplemental poverty

	measure (an approach that tries to blend relative methods with absolute ones, while accounting for government programs like SNAP benefits and tax credits), nearly 26 million Americans remained in poverty in 2021. . . While the use of social determinants of health as a framework is gaining significant traction among physicians, companies, and even the WHO, Lucy Marcil, a pediatrician and associate director for economic mobility in the Center for the Urban Child and Healthy Family at Boston Medical Center, feels they don't go far enough. She helped coin the idea of anti-poverty medicine in 2021. She explained that "anti-poverty medicine is one step further upstream to the root cause. Social determinants of health are important, but getting someone access to a food pantry doesn't really address why they're hungry in the first place." . . Relative to similarly rich countries, the US has high poverty rates, high mortality rates, and a confusing welfare state. It has the second largest welfare state in the world if you include things like subsidies for employer-based health insurance, tax-favored retirement accounts, and homeowner subsidies. These mostly benefit those who are already well-off. Instead, if you judge the American safety net based on the share of GDP spent on programs that benefit low-income citizens, it falls well below the average among other rich nations. In other words, poverty is a policy choice, and the US has yet to choose otherwise. As the sociologist Matthew Desmond put it in his recent call for poverty abolitionism, "Ending poverty in America will require both short- and long-term solutions: strategies that stem the bleeding now, alongside more enduring interventions that target the disease and don't just treat the symptoms." Poverty is a major public health policy



Health Policy

20. *Boston Globe
July 15, 2023
When it comes to donating bodies for research, the living must advocate for the dead
By Christine M. Pink, the director of the Body Donation Program at the Western Michigan University Homer Stryker M.D. School of Medicine
Although there is no specific accreditation or licensing for anatomic body donation programs in the United States, the majority are run professionally and in good faith with respect for the donors and their loved ones.
"Mortui vivos docent," or "the dead teach the living," is a Latin phrase used for hundreds of years to justify the dissection of human bodies for medical education and research. As the need for physicians grows, so too does the demand for cadavers to support their education.
Yet the indictment of the former Harvard Medical School morgue manager for allegedly stealing and selling body parts from anatomical donors has shaken medical school body donation programs like my own at the Western Michigan University Homer Stryker M.D. School of Medicine. The allegations show the need for more regulation and oversight of medical school body donation programs. They also make clear the need for better public understanding about the harrowed history of medical education and cadaver dissection.

	In the present day, we accept that examination of a body after death can provide important information. Forensic pathologists routinely perform autopsies to determine cause and manner of death. Anatomy education comprises foundational training in the first two years of medical school. It is considered so important that the Association of American Medical Colleges shares information on its website about available anatomy resources broken down by specialty. However, the regular use of human cadavers for medical education, and their procurement, receives far less media attention. . . The history of medical cadaver use is a tainted one that is particularly horrible for disenfranchised groups. As medical schools strive to address health inequities through recruiting diverse students, faculty, and staff, they ought to think about the first human bodies their students see. Many people, but especially those belonging to minority groups, are understandably uneasy about donating their body or a loved one's to a medical school. It is the responsibility of the medical education community to demystify body donation and gain the public's trust. In addition to transparency about donation, medical educators should advocate for legislation that more clearly addresses whole-body donation for medical education purposes. There must also be an oversight mechanism to enforce these laws. There is a model that works in the UK's Anatomy Act of 2004, which regulates any organization that stores and uses human tissue for medical education and research, as well as many other agencies. Most body donation programs today would meet those standards. Opposition to these measures would only serve to increase public mistrust. Ultimately the dead may teach the living, but it is the duty of the living to be the voice advocating for the dead. Living must advocate for the dead
Covid 19	**21. The Weather Channel** July 12, 2023 *Monitor Can Detect COVID-19 In Air We Breathe* Scientists at Washington University in St. Louis say they have developed a new type of air monitor that can detect COVID-19 in the air in real time. Detect Covid 19
U. S. Census	**22. 2030 U. S. Census** July 13, 2023 *2030 Census Webinar Series Set to Begin* The U.S. Census Bureau today announced a series of webinars to share updates and lay the groundwork for key components of preparations for the 2030 Census. The upcoming webinars will provide important details about the Census Bureau's 2030 Census research, plans for testing, the 2030 Census timeline and the findings of the public comments submitted in response to a Federal Register Notice. Attempting to count every person living in the United States is an incredibly complex undertaking that the Census Bureau takes seriously and uses research, input, and expertise to inform decisions. The Census Bureau will continue to engage stakeholders and provide updates throughout the process. **Read More** **2030 Census Webinar Schedule** • **Research, Testing and Timeline** (Scheduled for July 27)

	○ This webinar will give an overview of dozens of research projects already underway that can be classified in five focus areas that the Census Bureau terms "Enhancement Areas." ○ The Census Bureau will share its 2030 Census testing strategy. ○ The Census Bureau will also provide a more detailed timeline for 2030 Census planning, operational design, and development. • **Federal Register Notice (FRN) Findings** (Tentatively scheduled for October) ○ The Census Bureau received over 8,000 comments in response to the 2030 Census Federal Register Notice which was posted last year. This webinar will share the findings of those comments and how the Census Bureau is incorporating feedback into the 2030 Census research agenda. Census Bureau officials will present information during the virtual events. A question-and-answer session will immediately follow each presentation. **Continue reading** for additional webinar details. • **Press Kit**: 2030 Census • **Webpage**: 2030 Census
Scams and Financial Fraud	**23. Federal Trade Commission** July 13, 2023 *Have a disability? What to know about Medicaid and scams* By Carol Kando-Pineda, Attorney, FTC's Division of Consumer and Business Education Every July, Disability Pride Month is a powerful reminder about the importance of disability rights. This July, it's also a time to talk about Medicaid renewal scams that could affect millions of people with disabilities. To make sure people had insurance during the pandemic, states had to keep people enrolled in Medicaid — but that requirement has been phased out. So where do scams come in? Well, people eligible for Medicaid now have to re-enroll. If they're not eligible for Medicaid, they need to find new insurance. And **that** means scammers will start targeting those people — including people with disabilities. To avoid the scams, here's what to know: • **Medicaid won't charge you to renew or enroll.** Your state Medicaid agency may call, text, or email you to renew. But it won't ask for money or information like your credit card or bank account number. Learn about eligibility at Medicaid.gov/renewals. • **Start at HealthCare.gov if you need new insurance.** HealthCare.gov compares insurance plans, coverage, prices, and your eligibility. It only asks for your monthly income and age to give you a price quote. Don't share your bank account or credit card number to get a quote for health insurance. That's a scam. • **Scammers try to sell medical discount plans that are not medical insurance.** Medical discount plans charge a monthly fee for supposed discounts on some medical services or products from a list of providers. They're not a substitute for health insurance. Some plans just take your money for little or nothing in return. If anyone pressures you to sign up quickly for a medical discount plan, that's a red flag. If you spot a scam, tell the FTC at ReportFraud.ftc.gov.
Emergency Preparedness	**24. Vox**

	July 13, 2023 *There's no such thing as a disaster-resistant place anymore* By Rachel DuRose An estimated 11 million people across the northeastern US are under flood risks or warnings this week after historic levels of rainfall — 1-in-1,000-year events — swept through New England, with rivers in Vermont and New York's Hudson Valley overflowing and turning town streets into waterways. . . Learning from Irene over a decade ago, Vermont knew it did not have the resources alone to handle its current flash floods, and called in aid from North Carolina, Massachusetts, Michigan, and Connecticut before the storm struck. The region's lack of preparedness for these extreme events also makes sense when taking into consideration the area's history with natural disasters. Vermont was once considered one of the most natural disaster-resistant states in the country, and a local Vermont news station reported people were moving to the state for the purpose of avoiding worsening wildfires, droughts, and floods elsewhere in the US. "Vermont is one of the few places in the world that is likely to get more habitable," Chris Koliba, a professor of community development and applied economics at the University of Vermont, told Boston's NPR news station, WBUR, in 2021. . . Scenarios like Winter Storm Uri and this week's flooding in the Northeast will become more and more common. Places with a history of natural disasters have the community knowledge and infrastructure to weather these events, but those that have never or rarely handled them before will need to upgrade and build new infrastructure quickly. . . The risk of natural disasters is everywhere (even in the most resilient places). People will no longer just have to prepare for intensified versions of the natural disasters they know, but they will also have to consider the possibility of new types of disasters — floods, storms, heat waves, droughts, and fires — impacting their community. No such thing as disaster-resistant place
Aging Topics	**25. *New York Times** July 16, 2023 *How a Vast Demographic Shift Will Reshape the World* By Lauren Leatherby The world's demographics have already been transformed. Europe is shrinking. China is shrinking, with India, a much younger country, overtaking it this year as the world's most populous nation. But what we've seen so far is just the beginning. The projections are reliable, and stark: By 2050, people age 65 and older will make up nearly 40 percent of the population in some parts of East Asia and Europe. That's almost twice the share of older adults in Florida, America's retirement capital. Extraordinary numbers of retirees will be dependent on a shrinking number of working-age people to support them. In all of recorded history, no country has ever been as old as these nations are expected to get. As a result, experts predict, things many wealthier countries take for granted — like pensions, retirement ages and strict immigration policies — will need overhauls to be sustainable. And today's wealthier countries will almost inevitably make up a smaller share of global G.D.P., economists say. This is a sea change for Europe, the United States, China, and other top

	economies, which have had some of the most working-age people in the world, adjusted for their populations. Their large work forces have helped to drive their economic growth. Those countries are already aging off the list. Soon, the best-balanced work forces will mostly be in South and Southeast Asia, Africa, and the Middle East, according to U.N. projections. The shift could reshape economic growth and geopolitical power balances, experts say. . . Demography isn't destiny, and the dividend isn't automatic. Without jobs, having a lot of working-age people can drive instability rather than growth. And even as they age, rich countries will enjoy economic advantages and a high standard of living for a long time. . . Many of these demographic changes are already baked in: Most people who will be alive in 2050 have already been born. . . To cope, experts say, aging rich countries will need to rethink pensions, immigration policies and what life in old age looks like. Change will not come easy. More than a million people have taken to the streets in France to protest raising the retirement age to 64 from 62, highlighting the difficult politics of adjusting. Immigration fears have fueled support for right-wing candidates across aging countries in the West and East Asia. . . "We've managed to increase the length of life," Dr. Myrskylä said. "We have reduced premature mortality. We have reached a state in which having children is a choice that people make instead of somehow being coerced, forced by societal structures into having whatever number of children." People aren't just living longer; they are also living healthier, more active lives. And aging countries' high level of development means they will continue to enjoy prosperity for a long time. But behavioral and governmental policy choices loom large. Vast Demographic Shift
Disability Topics	**26. *National Geographic** July 14, 2023 *How the wheelchair opened up the world to millions of people* By Erin Blakemore Wheeled seats have existed since the invention of the wheel, but it took centuries for the devices to gain traction with the masses. At first, people with mobility issues were pushed in wheelbarrow-like devices or wheeled furniture pushed by medical attendants or servants. When Philip II of Spain, who suffered from gout and arthritis, commissioned a wheeled chair in the late 16th century, it was known as an "invalid's chair." . . . It would take until 1655 for the first self-propelled wheelchair to emerge. Stephan Farffler, a clockmaker who lost the use of his legs in a childhood accident, created the device so he could propel himself to and from church in Nuremberg, Germany. His invention resembled a modern recumbent bike, relying on a hand crank to propel himself forward. Today, it's considered a forerunner of the tricycle, but at the time, the unique invention hinted at the potential uses of self-powered, wheeled devices. . . Farffler's design pushed wheelchair technology forward, and a number of inventors created similar devices. One of them, Belgian impresario John Joseph Merlin, created a "gouty chair" that relied on gears and cranks to propel users. The design became so popular that wheelchairs were called "Merlin chairs" for more than a century afterward. . .

Wheelchairs became more ubiquitous as years went by, especially in the wake of the Civil War and both World Wars, which left hundreds of thousands of veterans with compromised mobility. But wheelchairs were seen as medical devices, not accessories for independent living, in part due to their size and cost. Wheelchair use skyrocketed with the polio pandemic of the 1940s and the increasing toll of modern warfare—plus the development of antibiotics that allowed more people to survive spinal cord injuries. . .

Meanwhile, powered wheelchairs, first introduced in Canada in the 1950s, were increasingly available, too, allowing people with arm mobility limitations to use wheelchairs, too. . .

So, what's next for wheelchair design? Watson predicts that artificial intelligence will be increasingly used in wheelchair navigation. Engineers are also working on ways to prevent dangerous wheelchair tips, even bringing tech like radar and cameras on board. These days, everything from sit/stand wheelchairs to personalized rim design and custom wheels support users' individual needs while adding a bit of flair to their ride.

Wheelchair opened up the world

27. *National Geographic

July 30, 2020

How the Americans with Disabilities Act transformed a country

By Amy McKeever

More than 2,000 disability rights advocates gathered on the South Lawn of the White House in Washington, D.C., on a hot summer day. It was July 26, 1990, and they'd come together to witness one of the most momentous civil rights victories in decades: President George H.W. Bush signing the Americans with Disabilities Act (ADA) into law.

During the signing ceremony—days after the Fourth of July—Bush admitted that the United States hadn't always lived up to its founding principles of freedom and equality. "[T]ragically, for too many Americans, the blessings of liberty have been limited or even denied," he said. "Today's legislation brings us closer to that day when no Americans will ever again be deprived of their basic guarantee of life, liberty, and the pursuit of happiness."

The ADA not only provided comprehensive civil rights protections for people with disabilities for the first time in the nation's history, but it also marked a sea change in the nation's attitudes toward disability rights. . .

The disability rights movement gains steam

Throughout history, people with disabilities were feared and ridiculed for their perceived defects and pushed to the margins of society. By the 1960s, that discrimination had been codified. People with disabilities were excluded from public schools, involuntarily sterilized, sent to live in state-run institutions, and even denied the right to vote. Some U.S. municipalities even had so-called "ugly laws" prohibiting people with "unsightly or disgusting" deformities in public places.

It was a world designed not to include people with disabilities. Government buildings and private businesses alike lacked ramps and elevators, while public transportation rarely provided accommodations for people with mobility or visual impairments. Having a disability was considered a medical problem to be solved rather than an identity to be protected under non-discrimination laws. . .

The need for a comprehensive civil rights law

With Section 504, the American public began to understand that making

	accommodations for people with disabilities was a civil right rather than a welfare benefit. It also galvanized a growing disability rights movement that won several other important victories in the 1970s and 1980s—including legislation that guaranteed a free public education to children with impairments and prohibited housing discrimination on the basis of disabilities. Yet discrimination persisted. In 1979, the Supreme Court ruled that the nursing school at Southeastern Community College in Whiteville, North Carolina, was not required by Section 504 to accommodate a hearing-impaired applicant. In other circumstances, regulations were simply not well enforced. For example, transit authorities were left to decide for themselves how accessible they needed to be. . . **Why the ADA matters** The Americans with Disabilities Act was a sweeping piece of legislation that banned discrimination on the basis of disability in employment, public accommodations, public services, transportation, and telecommunication. It finally afforded people with disabilities the same protections that the Civil Rights Act of 1964 had provided on the basis of race, color, religion, sex, and national origin. . . The ADA launched the process of building a more accessible world by ensuring that buildings, schools, and public spaces were equipped with ramps, elevators, and curb cuts. It made travel easier by requiring operators to make accommodations, such as offering wheelchair lifts, airport shuttle service, and rental cars with hand controls. It also led to the rise of interpreters and closed captioning in public communications.
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	**Federal Trade Commission** **https://www.ftc.gov/** Report fraud https://reportfraud.ftc.gov/#/ **U. S. Census** **https://www.census.gov/** o Planning for the 2030 Census is underway. o Learn what's next for 2030 Census planning. o Read public feedback about the 2030 Census. o Check out the 2030 Census timeline. **Memory Loss: How to Improve Your Memory** **https://www.remindercall.com/resources/thanks-for-the-memories-brain/** A new study released in November of 2021 found it's best to mix it up when it comes to stimulating activities that stimulate the brain. The recent study at Simon Fraser University pulled data from the National Institute of Aging's Health and Retirement Study.
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	For open funding opportunities previously posted in *The Tuesday Digest* please see https://dignityalliancema.org/funding-opportunities/.

<table>
<tr><td>opportunities</td><td></td></tr>
<tr><td>Websites of Dignity Alliance Massachusetts Members</td><td>See: https://dignityalliancema.org/about/organizations/</td></tr>
<tr><td>Nursing homes with admission freezes</td><td>Massachusetts Department of Public Health
Temporary admissions freeze
On November 6, 2021 the state announced that it would require certain high risk nursing homes and rest homes to temporarily stop all new admissions to protect the health and safety of residents and prevent further COVID-19 transmission. Stopping admissions enables homes to focus resources such as staff and PPE on the health and safety of its current residents and enables the home to stabilize before taking on new residents. Homes that meet certain criteria will be required to stop any new admissions until the Department of Public Health has determined that conditions have improved, and the facility is ready to safely care for new residents. The Commonwealth will work closely with homes during this time and provide supports as needed to ensure resident health and safety.
• There are a number of reasons why a facility may be required to stop admissions, and the situation in each facility is different. Some of the factors the state uses to make this decision include:
• Number of new COVID-19 cases within the facility
• Staffing levels
• Failure to report a lack of adequate PPE, supplies, or staff
• Infection control survey results
• Surveillance testing non-compliance
Facilities are required to notify residents' designated family members and/or representatives when the facility is subject to an admissions freeze. In addition, a list of facilities that are currently required to stop new admissions and the reason for this admissions freeze will be updated on Friday afternoons, and as needed when the Department of Public of Health determines a facility can be removed from the list.
Updated on May 10 , 2023. Red font – newly added
<table>
<tr><th>Name of Facility</th><th>City/Town</th><th>Date of Freeze</th><th>Qualifying Factor</th><th>Star Rating</th></tr>
<tr><td>Hillside Rest Home</td><td>Amesbury</td><td>5/2/2023</td><td>Cases</td><td>N/A</td></tr>
</table></td></tr>
<tr><td>Massachusetts Department of Public Health Determination of Need Projects</td><td>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</td></tr>
</table>

	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

<table>
<tr><td></td><td>this contributes to the quality-of-care residents receive and their quality of life.
https://tinyurl.com/NursingHomeCompareWebsite</td></tr>
<tr><td>Data on Ownership of Nursing Homes</td><td>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.</td></tr>
<tr><td>Long-Term Care Facilities Specific COVID-19 Data</td><td>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</td></tr>
<tr><td>DignityMA Call Action</td><td>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</td></tr>
<tr><td>Access to Dignity Alliance social media</td><td>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</td></tr>
<tr><td>Participation opportunities with Dignity Alliance Massachusetts

Most workgroups meet bi-weekly via Zoom.</td><td colspan="2"><table>
<tr><th>Workgroup</th><th>Workgroup lead</th><th>Email</th></tr>
<tr><td>General Membership</td><td>Bill Henning
Paul Lanzikos</td><td>bhenning@bostoncil.org
paul.lanzikos@gmail.com</td></tr>
<tr><td>Behavioral Health</td><td>Frank Baskin</td><td>baskinfrank19@gmail.com</td></tr>
<tr><td>Communications</td><td>Pricilla O’Reilly
Lachlan Forrow</td><td>prisoreilly@gmail.com
lforrow@bidmc.harvard.edu</td></tr>
<tr><td>Facilities (Nursing homes)</td><td>Arlene Germain</td><td>agermain@manhr.org</td></tr>
<tr><td>Home and Community Based Services</td><td>Meg Coffin</td><td>mcoffin@centerlw.org</td></tr>
<tr><td>Legislative</td><td>Richard Moore</td><td>rmoore8743@charter.net</td></tr>
<tr><td>Legal Issues</td><td>Jeni Kaplan</td><td>jkaplan@cpr-ma.org</td></tr>
<tr><th>Interest Group</th><th>Group lead</th><th>Email</th></tr>
<tr><td>Assisted Living and Rest</td><td>In formation</td><td></td></tr>
</table></td></tr>
</table>

<table>
<tr><td rowspan="6">Interest Groups meet periodically (monthly, bi-monthly, or quarterly).

Please contact group lead for more information.</td><td>Homes</td><td></td><td></td></tr>
<tr><td>Housing</td><td>Bill Henning</td><td>bhenning@bostoncil.org</td></tr>
<tr><td>Veteran Services</td><td>James Lomastro</td><td>jimlomastro@comcast.net</td></tr>
<tr><td>Transportation</td><td>Frank Baskin
Chris Hoeh</td><td>baskinfrank19@gmail.com
cdhoeh@gmail.com</td></tr>
<tr><td>Covid / Long Covid</td><td>James Lomastro</td><td>jimlomastro@comcast.net</td></tr>
<tr><td>Incarcerated Persons</td><td>TBD</td><td>info@DignityAllianceMA.org</td></tr>
<tr><td>The Dignity Digest</td><td colspan="3">For a free weekly subscription to The Dignity Digest:
https://dignityalliancema.org/contact/sign-up-for-emails/
Editor: Paul Lanzikos
Primary contributor: Sandy Novack
MailChimp Specialist: Sue Rorke</td></tr>
<tr><td>Note of thanks</td><td colspan="3">Thanks to the contributors to this issue of The Dignity Digest
Dick Moore
Heather Watkins
Special thanks to the MetroWest Center for Independent Living for assistance with the website and MailChimp versions of The Dignity Digest.
If you have submissions for inclusion in The Dignity Digest or have questions or comments, please submit them to Digest@DignityAllianceMA.org.</td></tr>
<tr><td colspan="4">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.
Previous issues of The Tuesday Digest and The Dignity Digest are available at: https://dignityalliancema.org/dignity-digest/
For more information about Dignity Alliance Massachusetts, please visit www.DignityAllianceMA.org.</td></tr>
</table>