The Dignity Digest

Issue # 150 August 15 , 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.**

Quotes

"Four or five to a room is not care with dignity. Many of these men and women had not been four or five to a room since basic training. Separate even from concerns about infection control, it's about dignity."

State Senator John Velis, a veteran who represents Holyoke and chairs the Joint Committee on Veterans and Federal Affairs, *State Breaks Ground on New Veterans Home in Holyoke,* **State House News,** August 14, 2023, New Veterans Home Holyoke

"Viewing disability through a social lens also meant acknowledging that a person is more disabled by their environment and the discrimination of others than their actual disability."

Jessica Smith, *How I Came to Love My Bionic Hand,* **Time,** August 14, 2023, My Bionic Hand

It is ironic that nursing home reform commissions and congressional hearings have ignored the plight of workers while extensively noodling with the industry over ever more complicated billing systems.

NAFTA & Nursing Home Wages in the Rio Grande Valley, **Tallgrass Economics,** August 12, 2023, NAFTA & Nursing Home Wages

[A] few of the medical staff members told me that they previously worked in community nursing homes and that the [Memory Disorder Unit] prisoners are probably receiving better care than they would on the outside, in whatever Medicaid-subsidized beds they were likely to find themselves.

I've Reported on Dementia for Years, and One Image of a Prisoner Keeps Haunting Me, **New York Times (free access),** August 11, 2023, Image of a Prisoner

"It's not like we are deep in a [Covid] wave. It's just

heading in a direction that's making us pay closer attention."

Caitlin Rivers, an epidemiologist at the Johns Hopkins Center for Health Security, An Unwelcome Visitor Returns This Summer. Hint: It's Covid. ***Wall Street Journal,** July 31, 2023, Unwelcome Visitor

The largest increases [in suicide] were seen in older adults. Deaths rose nearly 7% in people ages 45 to 64, and more than 8% in people 65 and older.

US suicides hit an all-time high last year, **AP News,** April 11, 2023, Suicides All Time High

Like senior citizens outside prison walls, older individuals in prison are more likely to experience dementia, impaired mobility, and loss of hearing and vision. In prisons, these ailments present special challenges and can necessitate increased staffing levels and enhanced officer training to accommodate those who have difficulty complying with orders from correctional officers. They can also require structural accessibility adaptations, such as special housing and wheelchair ramps.

Aging Prison Populations Drive Up Costs, **Pew,** February 20, 2018, Aging Prison Populations

Writing this list revealed to me the variety of ways I determine how really accessible places are — I usually just do it and don't often think about it. It reinforced what I already know; that the onus of responsibility is typically on the person with the disability to take the initiative of determining accessibility. Writing and seeing this list in black and white, stirred up a lot of emotions – frustrated, angry, exhausted – about the contortions that I and others with disabilities go through to participate in community life. These contortions sap our precious emotional and physical energy, which could be, and should be, used in more life-enhancing ways.

Marianne DiBlasi, *9 ways that I determine accessibility*, **Disability Issues,** Vol. 43, No. 3, Summer 2023, Disability Issues Vol. 43, No. 3, Summer 2023

	"The lie of Michael's adoption is one upon which Co-Conservators Leigh Anne Tuohy and Sean Tuohy have enriched themselves at the expense of their Ward, the undersigned Michael Oher, [retired NFL star]." 14-page petition, filed in Shelby County, Tennessee, probate court, *'Blind Side' subject Oher alleges Tuohys made millions off lie,* **ESPN,** August 14, 2023, Blind Side *The [Carney] hospital had a reputation for providing great care to Irish Catholics and not particularly good care to the Black and brown people who live in those communities now, and they painted the family medicine program as the cornerstone of an effort to rehabilitate this reputation. They said they were going to bring back inpatient pediatric care—they even had these big characters painted on the wall of what was supposed to be the peds unit—and they were going to have labor and delivery. When I interviewed, they made it seem like there was a lot of stuff that was still getting worked out because it was so new.* *By the time I moved to Boston, it was just clear that none of it was happening at all. The hospital was owned by the same private equity firm that owned the manufacturer of the AR-15, and they had no interest in restoring community hospitals.* Stephanie Arnold, MD, *My Life in Corporate Medicine,* **The American Prospect,** July 31, 2023, My Life in Corporate Medicine
Reports	**1. Centers for Disease Control and Prevention** August 10, 2023 *Suicide Data and Statistics* Suicide is one of the leading causes of death in the United States. This chart shows the number of suicide deaths by month and year, including the most recent provisional data available. You can access the full interactive chart by clicking on the image or the button Suicide Report
From Our Colleagues from Around the Country	**2. Tallgrass Economics** August 12, 2023 *NAFTA & Nursing Home Wages in the Rio Grande Valley* By Dave Kingsley **The Alta Vista Rehabilitation & Healthcare Center** . . . is owned and operated by

The Ensign Group – the largest (and rapidly expanding) American nursing home chain. This facility came to the attention of those of us working on a study of The Ensign Group (hereinafter referred to as Ensign) by The **Center for Healthcare Information and Policy** – a recently incorporated 501(C)(3) nonprofit dedicated to healthcare research.

In collecting data on Ensign's 2021 cost reports, we noticed that base CNA wages for this facility were excessively low at $10.82 per hour. Typically, 2021 CNA base wages (hourly wage excluding fringe benefits) average approximately $17.00 per hour with $13.00 at the very low end of the distribution.

Brownsville is in the Rio Grande Valley of Texas, connected by a bridge across the Rio Grande River to Matamoros, Mexico. The North American Free Trade Agreement liberalized the process of obtaining a work permit in the U.S. for Mexican citizens. Therefore, residents of Matamoros cross the bridge every day to work in Brownsville, Harlingen, and other Texas cities on the border. The minimum wage in Mexico is approximately 50 cents (U.S.) per hour.

Workers earn about $2.00 U.S. in the auto Maquiladora plants on the Mexican side of the border. Therefore, a wage of nearly $11 per hour is very attractive to Mexican citizens attempting to care for themselves and their families. It is in the best interests of the Mexican workers and the nursing home industry to garner CNA training and work permits for the border workforce. My interviews with workers in the U.S. nursing home system suggest that the Mexican culture and respect for elders lend themselves to a very capable and excellent immigrant workforce from Mexico.

However, the abject poverty of Mexico is an opportunity for exploitation of workers by the nursing home industry. It is important for U.S. legislators and regulators to take a serious look at this problem.

Why is Ensign Paying their Brownsville Workers Excessively Low Wages?

Why is Ensign Paying their workers less than a living U.S. wage? Because they can. Because the nursing home industry is financialized, protection and enhancement of shareholder value is the industry's moral and ethical summum bonum – the highest and guiding ethical value of the corporate culture.

Although the Brownsville facility netted $2,298,733 operating income on net patient revenue of $8,847,305 (26% net after expenses for interest, taxes, and depreciation), employees did not share in that financial success. The company expended $1,573,153 on nursing care. If they had increased that by 50%, their net would have been reduced to 17% – which would thrill the owners of any enterprise. The facility also reported nearly a million-dollar allocation to the Ensign home office and related parties. Furthermore, we usually note that CNA hours comprise around 60% of total nursing hours. At Alta Vista, 91,889 hours of the total 112,566 nursing hours were allocated to CNAs – 82%.

The labor mark up on the more than impressive earnings from this facility by a $3+ billion C corporation benefits investors but is not shared with workers. In other words, the labor market is determinative of wage rates while a price for the service is set by state governments at a level guaranteeing a robust return to shareholders and high executive pay.

The financial structures of corporations operating in the nursing home space are not a major factor in wages, hours, working conditions and staffing. Corporate type, e.g., REITs, private equity firms, C corporations, limited partnerships, LLCs, or any other type of corporation will not drive wages and staffing in this industry. Rather, an attitude toward labor and the perception of the value and worth of people doing the hands-on work with patients needing skillful and

empathetic care are the deciding factors in how we pay our care givers in nursing homes.
As long as the industry can use its political power to exploit workers, it will. It is ironic that nursing home reform commissions and congressional hearings have ignored the plight of workers while extensively noodling with the industry over ever more complicated billing systems. The industry will find plenty of techniques for leveraging billing systems to their advantage. What they won't do is invest in a loyal, experienced, and trained workforce.
NAFTA & Nursing Home Wages

Poem

Sandy Alissa Novack, MBA, MSW is a member of Dignity Alliance Massachusetts and the editorial board of *Disability Issues.*

Reflections was first published in *Disability Issues* (Vol. 43, No. 3, Summer 2023)

Commentary from the poet: There remain many vulnerable people in our communities who still need to wear face masks to protect themselves since Covid continues to circulate. If you are one of them, know that you are not alone. You have the right to ask your medical team to put on masks when you go in for medical appointments. You can also try asking for reasonable

3. Reflections

By Sandy Alissa Novack

Passing by the hallway mirror
I see I am
Wearing double pandemic face masks --
The three-ply all cotton Klimt's The Kiss art reproduction mask
Holding closer to my face
The standard medical mask which is way too big on me, and which
Could
Make me incognito

Even to myself.
No wonder I am not ready to shed even one of the masks
Like so many in my community
Shed as soon as the public health emergency ended.
I passed through the world these past three years

Invisible to others.
This includes the bank that put up
Barriers
To narrow the line to the tellers,
Which prevented me from passing through
With my rollator walker.
On my way out, I complained to an employee who
Shrugged.
My walker wears no face mask
Yet so many avert their eyes from it

And me.
The chain grocery store
Said elders and people who are immune-compromised
Could
Be prioritized
In line to enter the store
When they were counting
How many people
Would be allowed to enter at a time.
The customer service man
Could
Only see my walker

accommodations to be safe as you go about your business in the community. Please stay current with getting the Covid vaccine and other vaccinations you are eligible for. And always, take care of yourself.

And told me it isn't allowed in the store;

My “walker isn't sanitary.”
My walker is a big part of me.
I clean my walker
Every time I return from leaving home and
Often while still out and

About.
My walker is more sanitary than the feet of many of your
Other customers.
I will long remember
That your store referred to
Me
As unsanitary.
I

Do not want to shop your store.
For years and years I shopped a big-name pharmacy
But come the pandemic and shortages
Of products I needed and you sold me pre-pandemic,
You would not put aside some of your
Limited supply of what I continued to

Need.
“It is first come, first serve,” you said.
I remove my face masks when I come home and
Stare at the person in the mirror.
There are my eyes, my nose, my mouth.
I see my hair, my hair barrette, my glasses.
It is

I.
I remain myself when the face masks are removed.
That means

You do, too.
How can you forget
I am a human being
Who happens to have physical disabilities
When I don the face masks?

Oh. Now I understand better.
When I don the face masks I see

You.
I am protecting me from the covid that still circulates and sickens
That you don't care about protecting me from when you unmasked
Prematurely for me and people like me.
I

	Recognize you with and without your own face masks. Too bad, too bad. I recognize you As you have been and are. Ableist.
Profile 	**4. Time** August 14, 2023 *How I Came to Love My Bionic Hand* By Jessica Smith [Smith is a Paralympic swimmer, speaker, & children author of the *Just Jessica* series.] I was born missing my left arm. And while there really isn't anything I can't do; it took me a long time to feel comfortable with my appearance. For a long time, it felt like an obvious inadequacy in a world saturated with an obsessive desire for perfection. When I was born, the doctors told my parents they could fix me. I was fitted with a prosthetic device at 18 months, in order to blend in and develop "normally." Since medieval times there has been an obsessive interest in the development and engineering of prosthetic limbs, with each new design promising to be as capable and reliable as the human hand. One of the earliest records of a prosthetic hand was described in 77 AD by Roman scholar Pliny the Elder, he talked about how a Roman general had lost his hand during the Second Punic War and subsequently received a prosthesis, enabling him to return to battle. But there was nothing empowering about forcing a toddler to wear a heavy and at times painful device. To make matters worse, when I should have been able to rely on it most, it failed me in the cruelest way. One thing a prosthetic hand can't (yet) do is detect sensory feedback such as heat or cold. At 18 months of age, I reached up to grab a biscuit from the kitchen counter with my new hand and accidentally knocked over a pot of freshly boiled tea. Boiling water poured down onto my neck and chest, resulting in third degree burns to 15% of my body. The one thing that was supposed to make me whole nearly killed me. After an agonizingly traumatic recovery, I began to wear a prosthesis again, a decision made by my parents and the doctors. I wore myoelectric prosthetics, where muscle activity from the remaining detected by electrodes within the prosthesis and then processed to drive battery-powered motors that move the hand. In my lifetime, myoelectric hands have evolved from hideous claw contraptions to hands that are anatomically similar to that of the human hand. With durable materials and programmable multi-grip functions, impressive advancements in the design and development of artificial hands—such as varying grips and feeling of movement, action, and location—have been created to look like and replace what is "missing." In the past decade, in fact, there have been many discussions about how missing limbs might no longer be seen as a disability, with innovative advanced technologies making it impossible to distinguish between an artificial limb from a real one. This is a rhetoric I don't agree with. I *want* you to see my disability. I want you to

see me.
I was born into a world that wasn't designed or created for someone like me. And I spent my entire childhood and adolescence trying to conform and fit in. I did just about anything to ease the agonizing pains of the stares, verbal taunts, and pointed fingers. I wore long sleeves, I starved myself, I did whatever I needed to do to become invisible.
By the time I was eight years old, I had no self-confidence, and the hand I was wearing was making it harder and harder for me to fit in. So, I decided I was better off without one. I didn't need anyone to fix me. Because I wasn't broken.
After years of politely stating that I didn't need anyone's help (and I wasn't going to conform or force myself to fit in any longer), I learnt how to adapt and find my own way of doing things. From tying my shoes laces to learning to drive a car, there was nothing I couldn't do. And one of the most obvious ways for me to prove that I wasn't going to be limited by my disability or physical appearance, was through movement. I developed a love for all sports, in particular swimming. There was a sense of freedom and exhilaration powering through the water. I was selected onto my first Australian swimming team at age 13 and successfully represented my country for 8 years, culminating in my selection onto the 2004 Paralympic team. After I retired from swimming, I was able to draw parallels from my sporting career and apply them to the work I do today as an educator and activist for disability inclusion and children's author.
I realized I'd made a name for myself *because* of my disability—not in spite of it. I taught myself how to be comfortable in a society riddled with insecurities, and I set out to fight for the rights of people living with a disability. So, when I was first contacted in 2021 by Simon Pollard, whose company, COVVI, was on a mission to create the world's most advanced, powerful, and robust bionic hand, I was a bit surprised. He asked me to try the hand, and if I was comfortable with the idea, to become a patient advocate. Initially, I said no. I didn't need it. Then curiosity got the better of me.
For the past decade, I have been observing the unwavering interest in prosthetic hands from an industry and societal perspective. While I was busy advocating for disability rights, a new generation of advocates had made incredible progress. They'd elevated the discussion in ways I'd never imagined possible.
In 2015, Rebekah Marine (also known as "The Bionic Model") stunned audiences when she walked in the FTL Moda Runway show at New York Fashion Week wearing a prosthetic arm. For me, and so many others watching, it was a moment of elation and relief. At a time when the fashion industry's ideas of beauty were being questioned and the definition of diversity challenged, Marine was making a loud statement showing that disability could also be beautiful—and people were starting to notice.
While I used my platform to talk, people like Amy Purdy and Nick Vujicic harnessed the power of technology and social media to show just how far we've come. Posting selfies that displayed their wheelchairs, crutches, or artificial limbs without explanation. Social media was changing the way the world saw disability. People feared disability less and were more curious. Society was shifting from the outdated medical model and beginning to see a person first, and their disability second.
Viewing disability through a social lens also meant acknowledging that a person is more disabled by their environment and the discrimination of others than their actual disability. As those conversations began to shift, I realized that perhaps there was an opportunity to use technology to steer the narrative for

	future generations. In July 2022, I decided to trial the hand, and was blown away with not just the technology, but also the ease and comfort of the hand itself. Even still, it wasn't (and isn't) an easy process. I am developing neural pathways; I'm making movements for the first time that most people have embedded into their muscle memory. I'm learning to pick up utensils and how to hold a glass and actually drink from it without spilling any water. With my ego to the side, I realized the role of patient advocate was an enormous privilege, because through sharing my journey with advanced technology, I'm able to potentially reach thousands of other people living with upper limb differences who would benefit from its extraordinary capabilities. I wear a bionic hand not because I'm broken, but because I have an opportunity to enhance the human capabilities that already exist. My biggest motivations are my three children. My heart shattered knowing that they would see the pains of the stares, verbal taunts, and pointed fingers because their mom only has one hand. Instead, I want them to feel proud that their mom is actively embracing what makes her different. And in doing so, I might just also help create an easier path for people living with a disability to simply feel safe and accepted by their community and society. Now when I walk into a school , students are no longer afraid, but intrigued. They don't ask what happened to my missing hand; they ask where my bionic hand came from. "That's so cool, she is half human, half robot," shouted a student at a recent school visit. The excitement in his voice and the excited reactions from his classmates reassure me that working on disability inclusion is the right thing to do, and having these conversations with kids is exactly where I need to be. My Bionic Hand ***Read More:*** *What I Learned from the Generation of Disabled Activists Who Came After Me*
Disability Issues The ***Disability Issues*** newsletter is a free and independent publication. It is published quarterly and shares current information about the world of disability, new initiatives, and other helpful information to the disability community in MA. **To Subscribe:** The ***Disability Issues*** newsletter is available without charge to anyone who finds it useful and interesting. To subscribe, visit Disability Visibility.	**5. Disability Issues** Vol. 43. No. 3. Summer 2023 T A B L E O F C O N T E N T S • From the Editor | Marianne DiBlasi • Ready & Able: Coordinating Government Advocacy for Community with Disabilities | Tim Sullivan • Building Financial Security with Accessible and Affordable Housing | Sandy Alissa Novack • The PCA Corner: PCA Wage Increase Campaign and Programmatic Changes | Ray Glazier • Disability Ingenuity | Penelope Ann Shaw • The Poetry Corner: Reflections | Sandy Alissa Novack • Love & Intimacy: Are Relationships Possible If I Have a Disability? | Ms. Love • Information Briefs: • GBH Presents: August Press Play Saturdays • PBS Disability Pride Month Documentaries Current issue: Disability Issues Vol. 43, No. 3, Summer 2023
PBS Disability Pride Month Documentaries	**6. PBS** *Disability Pride Month Documentaries* In honor of Disability Pride Month to commemorate the passage of The Americans with Disabilities Act (ADA) that was signed into law on July 26, 1990,

Listing courtesy of *Disability Issues*	PBS is showcasing a selection of documentaries that look at the history of the disability rights movement and activists. Additionally, there are documentaries about artists and storytellers whose works explore the diversity of disability experiences. Click here to access the following documentaries: **The Gang of 19**: Encouraged by civil rights movements of the 1960s, the Disability Rights Movement gained momentum leading to the passage of the Americans with Disabilities Act in 1990. Decades earlier in 1978, 19 individuals tossed aside their wheelchairs and blocked city buses deemed inaccessible for the physically disabled. Discover how this one act led to years of advocacy in Colorado and inspired the nation. **Wonderfully Made**: In this short film, Kashmiere Culberson is a recent college graduate who embodies strength and confidence. Kash does not allow her disability to limit her pursuit of happiness and self-love. **Eat Your Catfish**: Paralyzed by late-stage ALS and reliant on round-the-clock care, Kathryn clings to a mordant wit as she yearns to witness her daughter's wedding. Drawn from 930 hours of footage shot from her fixed point of view, Eat Your Catfish delivers a brutally frank and darkly humorous portrait of a family teetering on the brink, grappling with the daily demands of disability and in-home caregiving. **Creating an Inclusive Richard III**: In a July 2022 performance of Shakespeare's tragedy, Richard III, The Public Theater chose to stage a show that truly centered inclusivity and diversity. In a behind-the-scenes interview, Danai Gurira, Ali Stroker, and Monique Holt discuss how director Robert O'Hara prioritized diversity and inclusion in his production. **All Riders**: Visit public transportation from the perspective of disabled riders in this short film from Victor Dias Rodrigues. The subway makes New York City tick, but getting around is a constant battle for disabled New Yorkers. **The Beautiful Colors of Jeremy Sicile-Kira**: Jeremy Sicile-Kira uses painting to transcend his disability and communicate his dreams to others. **Sensorium**: The First Twenty: Visionary composer Paola Prestini explores the intersections of disability, artificial intelligence, and voice in an experimental multi-sensory opera with choreographer Jerron Herman and poet Brenda Shaughnessy. This version of the video includes ASL and captions. Click here to access the documentaries.
Funding Opportunity	7. **Blue Cross Blue Shield of Massachusetts' 2023 Health Justice Partnership and Grant Program** Blue Cross seeks to partner with organizations that share our commitment to help all Massachusetts community members lead healthy lives by creating more equitable and just communities across the state. This year, the focus is to partner with organizations that promote food justice and health equity throughout the community. The grant is a two-year financial contribution providing $35,000 in general operating support and up to $20,000 in pro bono support annually, with a total support of up to $110,000. Connect with BCBS of MA's team's **office hours** prior to applying. Applications are due Friday, September 1, 2023. **Apply here.**
Webinars and Online Sessions	**8. Alzheimer's Association Programming for August** The Alzheimer's Association of MA/NH is offering a wide array of programming in the month of August—as they do each month of the year. You can find educational programming for communities, caregivers and people living with dementia.

	https://www.alz.org/manh/helping_you/community_family_education
Previously posted webinars and online sessions	Previously posted webinars and online sessions can be viewed at: https://dignityalliancema.org/webinars-and-online-sessions/
Nursing Homes	**9. Skilled Nursing Homes** August 11, 2023 *Nursing Home Costs Jump 2.4% in July, Increase Not Seen Since 1997 BLS Data* By Amy Stulick Nursing home costs skyrocketed in July, up 2.4% compared to June, along with adult day services – it's the biggest monthly increase seen since 1997, while overall consumer prices were up 0.2% month over month. That's according to the latest Consumer Price Index (CPI) report from the Bureau of Labor Statistics. . . The July increase was preceded by three months of declines in April, May and June, and the monthly increase had averaged 0.3% per month for the first six months of 2023, according to BLS data. That's below the 0.5% pace seen in the first six months of 2022, Mace said. Average hourly earnings have been decelerating in recent months as well, she said. Production and nonsupervisory employee hourly earnings were up 4.3% on a year over year basis, but that's still down compared to March 2022, when increases in hourly earnings peaked at 11.9%. . . The nursing home workforce remains 11% below its pre-pandemic levels in February 2020, she said, while the overall job market and assisted living industries are past pre-pandemic job levels. NH Costs Jump 2.4%
Behavioral Health	**10. AP News** April 11, 2023 *US suicides hit an all-time high last year* By Mike Stobbe About 49,500 people took their own lives last year in the U.S., the highest number ever, according to new government data posted Thursday. The Centers for Disease Control and Prevention, which posted the numbers, has not yet calculated a suicide rate for the year, but available data suggests suicides are more common in the U.S. than at any time since the dawn of World War II. Experts caution that suicide is complicated, and that recent increases might be driven by a range of factors, including higher rates of depression and limited availability of mental health services. . . Suicide attempts involving guns end in death far more often than those with other means, and gun sales have boomed — placing firearms in more and more homes. . . U.S. suicides steadily rose from the early 2000s until 2018, when the national rate hit its highest level since 1941. That year saw about 48,300 suicide deaths — or 14.2 for every 100,000 Americans. The rate fell slightly in 2019. It dropped again in 2020, during the first year of the COVID-19 pandemic. Some experts tied that to a phenomenon seen in the early stages of wars and natural disasters, when people pull together and support each other. But in 2021, suicides rose 4%. Last year, according to the new data, the number jumped by more than 1,000, to 49,449 — about a 3% increase vs. the year before. The provisional data comes from U.S. death certificates and is considered almost complete, but it may change slightly as death information is reviewed in the months ahead. . .

	The largest increases were seen in older adults. Deaths rose nearly 7% in people ages 45 to 64, and more than 8% in people 65 and older. White men, in particular, have very high rates, the CDC said. Many middle-aged and elderly people experience problems like losing a job or losing a spouse, and it's important to reduce stigma and other obstacles to them getting assistance, said Dr. Debra Houry, the CDC's chief medical officer. Suicides All Time High
Private Equity	**11. The American Prospect** August 10, 2023 *The Great American Hospital Shell Game* by Maureen Tkacik Stock in Medical Properties Trust tanked 14 percent this week after a couple of eyebrow-raising disclosures. Medical Properties Trust owns some 444 hospitals and other health care facilities across four continents. That fact alone has kept the Birmingham, Alabama–based real estate investment trust (REIT) strangely buoyant in the face of years of scrutiny by the Maltese government, Iowa Republican Sen. Chuck Grassley, an international syndicate of short sellers, and this magazine, among others. While other REITs own dead malls and abandoned office buildings, "there is no scenario where a world exists without hospitals," CEO Edward Aldag reasoned on the company's second-quarter earnings call Tuesday, cheerily invoking a Centers for Medicare & Medicaid Services forecast that hospital spending would reach $1.5 trillion by 2023. . . MPT's single biggest tenant, representing about a quarter of its assets, is Steward Health, a struggling community hospital chain into which the REIT has plowed more than $5.5 billion since 2016. Steward's former owner Cerberus Capital Management had extracted at least $800 million from the hospital chain by the time it sold out in 2021 to Steward founder Ralph de la Torre. Along with some senior managers, de la Torre bought out the private equity firm's interest by taking out a $335 million loan with MPT, and shortly thereafter extracted their own nine-figure dividend from Steward. (Shortly after *that*, de la Torre bought a super-yacht.) . . . As a result of all these leasebacks and loans, Steward Health owes more than $400 million in annual rent to MPT. Unlike some of MPT's tenants, Steward pays its rent on time, largely because MPT has kept a constant stream of construction loans, promissory notes, joint venture investments, and other IOUs flowing to the company. But Steward has not kept up with other obligations. In a single Texas county, Steward has been sued by a linens provider, two staffing agencies, an HVAC contractor, a supplier of cadaver carriers, and a drug detoxification service for amounts totaling more than $13 million. The financial strain has taken a toll on Steward hospitals. Carney Hospital in Dorchester, Massachusetts, where family physician and essayist Stephanie Arnold spent a hellish stint as a medical resident back in 2015 that she wrote about for our August issue, has been on the brink of closure for a year. This spring, Steward abruptly closed a direly needed San Antonio hospital after the CEO blamed Steward's unmanageable "lease obligations" in an audio recording leaked to CBS News. Great American Hospital Shell Game **12. The American Prospect** July 31, 2023 *My Life in Corporate Medicine*

	by Stephanie Arnold, Maureen Tkacik The way medicine is corporatized in this country makes it extremely difficult and thankless to practice family medicine as it was intended. In fact, it's hard to even train a family physician, because community hospitals where physicians might do all those things under one roof or even in one neighborhood are bordering on extinction. There was a lot of media attention in the aftermath of Dobbs about abortion deserts, but in all those same areas you have maternity wards closing every few weeks, and now this vast effort to outlaw gender-affirming care. As a family doctor, it is difficult to separate the culture-war stuff from an ideological project to justify the deprivation of poor and working-class people of their right to health care, and the intimidation of doctors who advocate for them. My Life in Corporate Medicine
Disability Topics	**13. Social Security Administration** August 14, 2023 *Social Security Administration Expedites Decisions for People with Severe Disabilities* Kilolo Kijakazi, Acting Commissioner of Social Security, today announced 12 new Compassionate Allowances conditions. The Compassionate Allowances program quickly identifies claims where the applicant's medical condition or disease clearly meets Social Security's statutory standard for disability. Due to the severe nature of many of these conditions, these claims are often allowed based on medical confirmation of the diagnosis alone. For more information, please visit https://www.ssa.gov/news/press/releases/2023/#8-2023-1 **14. Disability Issues** Vol. 43, No. 3, Summer 2023 *9 ways that I determine accessibility* By Marianne DiBlasi This summer there were multiple incidents that heightened my awareness of the emotional and physical energy it takes to determine how really accessible a place is. I'll share one example with you, which I'm sure you can relate to, and add to, based on your own experiences. An able-bodied member of my local community sent me an email saying she wanted to write an article about how accessible our town was. She asked if I was willing to tell her how I determine how really accessible a place is. I was willing, and my response surprised me. I started writing one thing, then another, then another until I had quickly listed 9 ways that I determine accessibility. Here's my list: • Call the establishment, place, or home and ask about accessibility that meets my needs. If it's a home, sometimes I ask people to take photos and send them to me. • If it's local, I often drive by the location to check out the accessibility situation e.g., parking, ramps, how many stairs, is there's a railing. If it's outside, I check out the terrain e.g., is it asphalt, grass, gravel etc. and what is the slope. • Enter the address into google to see a photo of the street view to check out the accessibility situation. • If the establishment or place has a website, search for information on accessibility. • If it's local, sometimes I don't do any research. I go knowing in advance that if it's not accessible, I will turn around and leave.

	• Sometimes I decide to stay home because I don't want to go through the effort of asking about or researching accessibility to someplace new. • It's especially vexing when, after doing all the research and feeling excited about going someplace that I'm confident is accessible, only to discover that it really isn't. Almost accessible is not accessible. • It's rare, but greatly appreciated, when information about accessibility is proactively included in invitations to events at homes or other locations. • If I'm traveling someplace new e.g., on vacation, I google to learn about accessibility in the area. The google results are often huge and their usefulness is very mixed. If I can find a personal blog written by someone with a disability, that's often the best resource. Writing this list revealed to me the variety of ways I determine how really accessible places are — I usually just do it and don't often think about it. It reinforced what I already know; that the onus of responsibility is typically on the person with the disability to take the initiative of determining accessibility. Writing and seeing this list in black and white, stirred up a lot of emotions – frustrated, angry, exhausted – about the contortions that I and others with disabilities go through to participate in community life. These contortions sap our precious emotional and physical energy, which could be, and should be, used in more life-enhancing ways. On the positive side, an able-bodied member of the local community was taking the initiative to write about the accessibility of our town. I am grateful for her allyship and willingness to ask and be educated about the real-life experience of living with a physical disability. I ended my email to her by saying, "This is an important topic to raise awareness about determining accessibility. I'm grateful to you for writing about it, asking for input, and using what I share. I also appreciate that you didn't ask me to write the piece (as often happens), but you are willing to learn and share what you learn." Disability Issues Vol. 43, No. 3, Summer 2023 **15. United States Access Board** August 11, 2023 *U.S. Access Board Celebrates 55th Anniversary of the Architectural Barriers Act* On August 12, 1968, President Lyndon Johnson signed the Architectural Barriers Act (ABA) into law at his ranch in Stonewall, Texas, and remarked the next day "it is humane legislation—which had the unanimous support of both Houses of Congress. I am pleased and proud to sign it into law." Tomorrow marks the 55th anniversary of the ABA, one of the earliest measures by Congress to address access to the built environment by requiring federal and federally leased facilities to be accessible for people with disabilities. **Learn More**
Incarcerated Persons	**16. New York Times (free access)** August 11, 2023 *I've Reported on Dementia for Years, and One Image of a Prisoner Keeps Haunting Me* By Katie Engelhart At Federal Medical Center Devens, a federal prison in Massachusetts, there is a prisoner who thinks he is a warden. "I'm the boss. I'm going to fire you," Victor Orena, who is 89, will tell the prison staff. On some days, Mr. Orena is studiously aloof — as if he were simply too busy or important to deal with anybody else. On other days, he orders everyone around

in an overwrought Mafioso tone: a version of the voice that, perhaps, he used when he was a working New York City mob boss decades ago, browbeating members of his notorious crime family. This makes the real prison warden laugh.
On a recent morning, Mr. Orena sat in his wheelchair beside a man with bloodshot eyes. I asked them if they knew where they were.
“This is a prison,” Mr. Orena said, brightly.
“Why are you here?” I asked.
“I don’t remember,” he frowned. “I don’t know.”
Timothy Doherty, a senior officer specialist at F.M.C. Devens, which houses federal prisoners who require medical care, estimates that 90 percent of the men he oversees “don’t know what they did. Some of them don’t even know where they are.” Mr. Doherty helps to run the Memory Disorder Unit, the federal prison system’s first purpose-built facility for incarcerated people with Alzheimer’s disease and other forms of dementia.
Down the hall from where Mr. Orena was sitting — past the activity room with the fish tank, where a cluster of men were watching “King Kong” on TV — there is a cell belonging to another man who wakes every day to discover anew that he is in prison. Some mornings, the man packs up his belongings and waits at the door. He explains that his mother is coming to get him.
“She sure is,” a staff member might say, before slowly leading him back to his cell.
In recent years, I have reported on many aspects of life with dementia. One image has especially haunted me: that of a prisoner who, as a result of cognitive impairment, no longer remembers his crimes — but is still being punished for them.
We don’t know exactly how many people in American prisons have dementia because nobody is counting. By some estimates, there are already thousands, most of them languishing in the general inmate population.
Older adults represent one of the fastest-growing demographic groups within American correctional facilities. Between 1999 and 2016, the number of prisoners over 55 increased by 280 percent, according to a report by the Pew Charitable Trusts; over the same period, the number of incarcerated younger people grew by just 3 percent. This trend is largely attributed to “tough on crime” reforms in the 1980s and 1990s, which lengthened sentences and ensured that many more people would grow old and frail and then die behind prison walls.
Incarcerated life is also thought to accelerate the aging process, such that many longtime prisoners appear more than a decade older than their chronological ages — and are considered “elderly” at 50 or 55.
Early on, a prisoner’s dementia might go unnoticed. Federal prisons do not routinely screen older people for Alzheimer’s disease and other forms of dementia unless they exhibit symptoms. And the rigidity and monotony of institutional life can often mask them: A person can get by, for a while, just by following the man ahead of him.
But later, things will start to fall apart. At first, a person with dementia might struggle in the normal way that other aging prisoners do: to walk long distances for meals or medication, to get up from a low-lying toilet without a handrail, to climb a bunk bed on command. Over time, he might start to pace or repeat phrases over and over. He might have hallucinations or delusions or paranoia. He might fall. He might be incorrectly medicated by a doctor who does not understand his condition. He might struggle to distinguish between items of

similar color — mashed potatoes on a white plate, say — and so have trouble eating. Or forget to eat at all.

A prisoner with dementia might wear slippers outside his cell, even though this is against the rules. Or wander somewhere he is not supposed to go. He might have trouble judging the distance between things and bump into people who might, in turn, mistake the stumbles for deliberate affronts. He might begin to smell, because he can't remember how to wash his body — and he might expose his body to others, because his disease leaves him sexually disinhibited. He might get hurt by another prisoner who takes advantage of his impairment and then forget that he was hurt. He might hurt someone else. He might become incontinent. He might grow afraid of shadows because he perceives them to be holes in the ground.

Eventually, the man will find himself living inside an unyielding system whose boundaries and principles he can no longer see or interpret or remember. And because he can't stop breaking the rules, he might be punished — in some cases, with solitary housing. There, his condition might worsen. "Noncompliance with correctional rules and directions is often treated as a disciplinary issue rather than a medical issue," explains a 2022 report, "Persons Living With Dementia in the Criminal Legal System," copublished by the American Bar Association Commission on Law and Aging. Because the prisoner has nowhere else to go, he might muddle along as best as he can until he becomes so impaired that he is transferred to a medical center, where he will spend the rest of his incarcerated days lying in bed.

The Memory Disorder Unit at F.M.C. Devens, which opened in 2019 and was designed to resemble a memory care facility, offers an alternative path for such a prisoner. Its correctional officers have received training from the National Council of Certified Dementia Practitioners and currently supervise around two dozen men with an average age of 72. These officers have been given a tall task: to bend an institution designed to punish and sequester into a place that can provide care to some of the most vulnerable people in the system.

In the end, they are proud of what they have built. Why else would they let a journalist come to see it? And still, the M.D.U. seems to challenge several of the classic justifications for the prison system itself: to segregate the dangerous, for instance (many M.D.U. residents are weak and unthreatening), or to reform the morally corrupt (many M.D.U. prisoners don't remember doing wrong).

Amy Boncher, who was the warden of F.M.C. Devens when I visited in May (she is now the Bureau of Prisons' Northeast regional director), told me that when she first met the residents of the unit, it was hard to make sense of the entire project. "I looked at them. And I'm thinking: Why haven't we released all of them?"

"Do you know history?" An M.D.U. resident shuffled toward me. I could only make out bits of speech: "Fidel Castro" and "revolution" and "United States took over Cuba." This man was born in Cuba and now spends his days reliving its past. As he moved closer, I noticed the smell; since arriving at the M.D.U., he has generally refused to brush his teeth.

I'm told that he's a "big teddy bear" — though he can get agitated if, say, another prisoner gets annoyed by his revolutionary babble and tells him that Fidel Castro is dead and that nobody liked him. When this happens, a staff member will play the man some old Cuban music, and he will weep as he listens to it.

Most days, he doesn't seem to know why he is in prison, though sometimes he

will allude to a past transgression. “I was a young man,” he will insist. “I told them who did it.”

After a few minutes, an “inmate companion” named Oswaldo Ornelas put his arm around the Cuban man’s shoulders and led him down the hallway. Mr. Ornelas is one of four cognitively healthy prisoners, men without dementia, who are trained to live and work in the M.D.U. in exchange for $30 to $100 a month in wages and, possibly, time off their sentences. The companions are selected based on criminal history — they can’t have been convicted of a sex crime or another violent crime — and temperament. “You’ve got to make sure they won’t take advantage of the men in any way,” Mr. Doherty, the senior officer specialist, said.

Mr. Ornelas told me that a few years ago, while incarcerated, he received a kidney transplant and that he wanted to work in the M.D.U. “to give my life back.”

When I arrived at the unit, Mr. Ornelas was on duty with another companion, Richard Lotito, and the two men had just spent three hours waking, showering, and dressing the other prisoners. Their work is physically demanding and exquisitely intimate. Several of the men need help with the toilet and wear diapers. Over many months, the companions have learned their individual needs and tempos. “One guy poops every other day, another poops all day,” Mr. Lotito said. Another gets confused and urinates in the trash cans. “The key to this job is patience.” (Mr. Lotito and Mr. Ornelas were both released in July.)

The M.D.U. is made up of two long hallways that are lined with cells and several common rooms. Unlike standard prison units, the M.D.U. has a kitchen filled with snacks, because sometimes the men forget that they have just eaten and insist that they are starving — and then one of the companions can make them peanut butter sandwiches.

Across most of the unit, the walls are painted a pale pink. In the world of dementia care, pink is sometimes thought to be a calming color that reduces combative behavior. Two officers and one nurse are walking the floors at any given moment, but they do not carry guns, and they are not everywhere. Near the entryway, the prisoners’ artwork is displayed on the wall: paper lanterns, painted tiles, flowers made of pipe cleaners. On the doors to the cells are pictures of favorite objects that help the men to locate their rooms: a Cadillac, the Red Sox logo, an umbrella. Most of the time, the doors inside the unit are unlocked, and the prisoners can come and go as they please. If the whole place weren’t locked down and made of windowless concrete, it would almost look like a day care center.

During the day, there are activities. Trivia, with questions about events from the ’50s and ’60s. Bocce ball. Music therapy. Outside of scheduled time, the men are encouraged to be active. One folds laundry. One sits on the patio on a metal rocking chair and watches birds fly by. Another is given a paintbrush and a can of washable paint so that he can paint the walls all day — “because he gets upset when he’s bored and doesn’t know what to do with himself,” Mr. Doherty said.

As I was led around the unit, I heard screaming. I was told that the screaming man had suffered a brain injury and that he screams often, sometimes because of pain from the spots on his legs where he has rubbed the skin raw. Alexandra Kimball, an occupational therapist, rushed to his side. “Do you like Tom Brady?” she asked gently, referring to the former N.F.L. quarterback.

The screaming stopped. “I love Tom Brady.”

The staff members of the M.D.U. maintain a binder with profiles of the

prisoners, including information on how to soothe them. The binder entry for the screaming man advises officers to reference Tom Brady.

Compared to officers in the rest of the prison, M.D.U. staff members can exercise a bit more discretion when it comes to rule breaking. Ms. Boncher, the former warden, told me that the M.D.U. has its own unique "disciplinary procedures." Her staff members, she explained, are skilled at deciding which prisoners should be disciplined for bad behavior, which she says involves a psychological determination about whether the offending man knew that he was doing something wrong and did it anyway and is therefore responsible and worthy of punishment or was simply acting on impulse, a victim of his own damaged mind. This approach assumes that it is even possible to deduce the mental state of a man who only sometimes or partially understands himself.

But sometimes the M.D.U. residents will fight in the TV room. Or someone will spit on someone else — or walk into the wrong cell and get punched in the face. In most cases, a man who acts out will be "redirected" to a new activity. In other cases, he will lose his commissary or phone privileges for a few days. In rarer cases, he will be locked alone in his room until he calms down, an approach that would not be used in a typical nursing home.

A few men are only allowed out of their cells for two hours each day, with supervision. This includes someone whom Mr. Doherty describes as "absolutely the nicest of inmates" until he starts hearing voices. Some of the men understand that they are being punished and some don't, and some understand but then forget.

"All the prisons need this," Mr. Doherty told me, gesturing around him. "What do other places do with these guys?"

On the day I visited the unit, a few of the medical staff members told me that they previously worked in community nursing homes and that the M.D.U. prisoners are probably receiving better care than they would on the outside, in whatever Medicaid-subsidized beds they were likely to find themselves. Behind bars, the men have easy access to psychologists, social workers, and a pharmacist with a specialty in geriatrics. Perhaps that's true. And yet, the existence of the M.D.U. seems to impugn the basic logic of the carceral system or at least its classic rationales.

For some, the point of prison is chiefly to incapacitate dangerous people. The men inside the M.D.U. vary in their physical abilities, but many are very sick and confused and use wheelchairs or walkers, and they probably couldn't hurt anyone if they wanted to. With them, appeals to public safety fall short. More broadly, the Department of Justice has concluded that "aging inmates are generally less of a public safety threat." And researchers have found that recidivism rates drop to nearly zero for people over 65.

For others, prison is meant to offer retribution for wrongdoing. In this view, if a person does something wrong, he deserves to be punished in proportion to his crime — and justice depends on it. Dementia tests this logic in different ways. Proponents of this view might decide that even a just act of punishment becomes unjust if the offender no longer understands why he is being condemned. Alternatively, they might conclude that those who are ailing and weak deserve mercy. Many of the M.D.U. residents have already served several years of their sentences.

Some believe that incarceration is an opportunity for rehabilitation. "But with dementia, there is no rehabilitation," says Lynn Biot-Gordon, of the National Council of Certified Dementia Practitioners, the organization that provided

training to M.D.U. staff. Moral education is impossible for a person who cannot be educated. And a prisoner cannot reflect on his crimes — and then maybe regret them or feel ashamed of them or be repulsed by them or resolve to do better in the future — if he does not even remember them or feel responsible for them.

Kelly Fricker, a psychologist at F.M.C. Devens, told me that she can't do much in the way of talk therapy for her M.D.U. patients. "An inherent part of mental health therapy would be to remember from session to session. Many guys here don't even know who I am."

But what if the point of imprisoning people for decades is to deter others from committing crimes? Arguably, this rationale survives. Letting the M.D.U.'s prisoners go would, in this view, weaken the overall deterrent effect of criminal law. To hold this view, however, you would have to hold the unlikely belief that a person's decision to commit a crime would be affected by the knowledge that prisoners with advanced dementia are sometimes released from prison early.

Of course, dementia is not the only medical condition that casts doubt on the principles of incarceration. A prisoner who is very old but cognitively healthy might be similarly frail and unthreatening — or might have changed in drastic ways since his incarceration. A person with a severe mental illness might similarly forget his crimes — or feel psychically disconnected from them or be incapable of thoughtfully reflecting on them later. But dementia might pose the paradigmatic challenge.

Within the philosophical literature on cognitive impairment, there is a debate about whether a person with advanced dementia is even the same person as he was before it. If he cannot be considered the same person, then the men of the M.D.U. are, in an important sense, being punished for someone else's crimes.

At one point during my visit, I spoke with a white-haired man who had a large nose and reddish skin. "I want to go home like anything," he told me softly.

"What brought you here?" I asked.

"What brought me here?" The man paused. "Hmm. I don't know."

As we walked away, Mr. Doherty shook his head. "He remembers," he said. Then he told me that the white-haired man had raped his granddaughter.

Later, I wondered how much it should matter whether the old man remembered what he did. And what if he remembered sometimes but not other times? Many people with dementia exist in a kind of middle ground of partial comprehension or have memories that surface and then disappear.

"We get into difficult metaphysical questions about personhood here," said Jeffrey Howard, a professor of political philosophy and public policy at University College London, when I told him about my conversation with the white-haired man. "But you might think that there are two versions of the man: One of them deserves the punishment, and the other doesn't. In order to punish the version of him that deserves it, you have to take along this hostage for the ride. It's hard to see how that sort of collateral damage could be justified."

There is, technically, a way out. A few of the M.D.U.'s residents have received so-called compassionate release, which allows prisoners with extraordinary or compelling reasons, such as severe illness, to be released early from their sentences. The Federal Bureau of Prisons and most state systems have a version of it. But compassionate release, according to the 2022 American Bar Association report, is "rarely used," and many prisoners die over the months it takes for their applications to be reviewed. Release is especially rare for people with dementia, because the Bureau of Prisons has historically misinterpreted the

federal statute to mean that only prisoners who are terminally ill and very close to death are eligible.

State programs are also limited. Lilli Paratore, the director of legal services at UnCommon Law, which offers pro bono legal representation to incarcerated people in California, told me about representing a woman with Parkinson's disease and dementia who applied for medical parole. Parole board members looked at her client's memory gaps with suspicion, Ms. Paratore told me. "Your lack of memory appears to be selective," one commissioner said. (The client was eventually released.)

Even people with dementia who do obtain early release can find themselves stuck in prison, because they can't be released without a plan and there is nowhere else for them to go. Some have lost contact with family members. They don't have anyone on the outside who is able to provide or fund round-the-clock care. And nursing homes usually won't take them, particularly if they have violent histories — which some but not all of the M.D.U. residents do. "Some people get released but we can't find them a spot," Christina Cozza, a social worker in the unit, said.

Within the medical field, there has been very little research on how a history of violence might present itself in the context of dementia. Would a violent impulse be heightened or diminished as the brain it dwells in grows more impaired?

Patricia Ruze, the clinical director of F.M.C. Devens, does not believe that the men of the M.D.U. pose a threat to anyone. "They are probably better behaved than most patients in dementia units generally, because a lot of them have spent many, many, many years in custody and so are rule followers." Dr. Ruze thinks it would be "totally appropriate" to release the whole unit on compassionate grounds and relocate the men to community nursing homes, which already have experience dealing with aggressive behaviors brought on by cognitive impairment — and which cost much less than operating a prison unit. "It doesn't make sense for our country to pay so much to house 15, 20 guys," Dr. Ruze said.

Ms. Boncher, the former warden, is now equivocal. "They've done some horrific things. They've been abusive to other humans." Collectively, the men of the M.D.U. have murdered, attempted to murder, stabbed, kidnapped, extorted, swindled, and brought fear to entire cities. There were victims of these crimes, and some of them are still living. They will have their own opinions about the need, or not, for mercy.

Within the M.D.U., staff members believe that the future of the correctional system lies in more M.D.U.s. "This is the future," one unit nurse told me.

"Have people from other institutions visited, to learn about the model?" I asked.

"Yes," Mr. Doherty said. Then he turned to his colleagues. "Didn't we have people from Guantánamo?"

In the meantime, some researchers are proposing a more modest approach: building more "dementia-friendly prisons." Such prisons might have cell doors painted in different colors to help confused inmates orient themselves — and handrails, nonslip floors, and accessible showers. They might guarantee that prisoners with dementia get bottom bunks and a bit more time to drop to the floor during drills. They might have pictures above the sinks to remind prisoners how hand-washing works and "scheduled toileting" for people who are incontinent. They might permit a person to wear Velcro clothing if he can no longer manage buttons or clasps. They could give him longer to finish his dinner.

Dr. Ruze, the clinical director, is skeptical of all of it. “In this country, we incarcerate way too many people for way too long. We give people life sentences. And then they turn 90, they’re in diapers, they get demented. We have to ask ourselves, what are we accomplishing?”

Whatever we are currently accomplishing or mean to accomplish, it seems to require that America’s prisons undergo a strange and maybe absurd conversion: into something that more closely resembles a locked-down, fenced-off, barbed-wire-enclosed nursing home.

As I left the M.D.U., a man was moving slowly down the hallway in a wheelchair, his head wrapped in a thick bandage — because, I was told, he bangs his head on the concrete walls when he gets frustrated. In the common room, another man was helping the person beside him to open a plastic container holding his lunch, a hamburger. Another man sat to the side.

“Do you like it here?” I asked him.

“Yeah, it’s fine,” he said. “But I’d rather be in … oh, what’s it …?” Then he forgot where he wished he could go.

Image of a Prisoner

17. **Pew**

February 20, 2018

Aging Prison Populations Drive Up Costs

By: Matt McKillop & Alex Boucher

Prison populations are shrinking, reflecting a decade-long movement by states to enact policies that reverse corrections growth, contain costs, and keep crime rates low. At the end of 2016, fewer people were held in state and federal prisons than in any year since 2004.

But despite this overall reduction, one group in prisons is surging: older individuals. From 1999 to 2016, the number of people 55 or older in state and federal prisons increased 280 percent. During the same period, the number of younger adults grew merely 3 percent. As a result, older inmates swelled from 3 percent of the total prison population to 11 percent. . .

Like senior citizens outside prison walls, older individuals in prison are more likely to experience dementia, impaired mobility, and loss of hearing and vision. In prisons, these ailments present special challenges and can necessitate increased staffing levels and enhanced officer training to accommodate those who have difficulty complying with orders from correctional officers. They can also require structural accessibility adaptations, such as special housing and wheelchair ramps.

Additionally, as the Bureau of Justice Statistics found, older inmates are more susceptible to costly chronic medical conditions. They typically experience the effects of age sooner than people outside prison because of issues such as substance use disorder, inadequate preventive and primary care before incarceration, and stress linked to the isolation and sometimes violent environment of prison life.

For these reasons, older individuals have a deepening impact on prison budgets. Estimates of the increased cost vary. The National Institute of Corrections pegged the annual cost of incarcerating those 55 or older who have chronic and terminal illnesses at two to three times that for all others on average. More recently, other researchers have found that the cost differential may be wider.

At the federal level, an assessment by the Justice Department’s inspector general found that, within the Federal Bureau of Prisons, institutions with the highest percentages of aging individuals spent five times more per inmate on

	medical care—and 14 times more per inmate on medication—than those with the lowest percentages. **Why state prison populations are aging** The graying of state prisons stems from an increase in admissions of older people to prison and the use of longer sentences as a public safety strategy. From 2003 to 2013, admissions of those 55 or older increased by 82 percent—higher than the overall population growth for that age bracket—even as they declined for the younger group. A majority of these admissions were for new court commitments, which generally carry longer sentences than parole violations. *This is the sixth analysis in a series examining how health care is funded and delivered in state-run prisons, as well as how care continuity is facilitated upon release.* Aging Prison Populations
Alzheimer's and Dementia	**18. *The Washington Post** August 10, 2023 *Some dementia patients begin to create art. We may now know why.* By Sam Jones A study has identified the potential brain structures and their connections that lead some frontotemporal dementia patients to start painting or producing other forms of art The man in behavioral neurologist Adit Friedberg's office could not speak. "He could not even utter a single word," Friedberg said. The man had lost his ability to understand or produce words, and had been diagnosed with primary progressive aphasia, a form of frontotemporal dementia (FTD). He was, however, painting — and often. His wife placed a pile of his work on Friedberg's desk and asked, "What is he trying to tell me?" Some people with dementia such as this patient develop or experience increased visual creativity even as their brains degenerate. The underlying mechanism, though, was unknown until a recent study led by Friedberg and others, which uncovered the potential brain structures involved and the connections between them. . . An increase in visual artistic creativity is relatively unique in neurodegenerative diseases. . . To tease out other possible reasons for visual artistic creativity in only some FTD patients, Friedberg decided to look at changes in brain tissue. She found that the brain's left hemisphere primary motor cortex — a region that controls right-hand movement — increases in volume in visual artistic creativity patients, in connection with an increase in volume in the dorsomedial occipital region. Even as the tissue around it is dying, Miller said, "the one area in the left hemisphere that isn't down in volume is the part of the motor strip involved with painting itself." Dementia Patients Create Art
Guardianship	**19. ESPN** August 14, 2023 *'Blind Side' subject Oher alleges Tuohys made millions off lie* By Michael A. Fletcher Retired NFL star Michael Oher, whose supposed adoption out of grinding poverty by a wealthy, white family was immortalized in the 2009 movie "The Blind Side," petitioned a Tennessee court Monday with allegations that a central element of the story was a lie concocted by the family to enrich itself at his

	expense. The 14-page petition, filed in Shelby County, Tennessee, probate court, alleges that Sean and Leigh Anne Tuohy, who took Oher into their home as a high school student, never adopted him. Instead, less than three months after Oher turned 18 in 2004, the petition says, the couple tricked him into signing a document making them his conservators, which gave them legal authority to make business deals in his name. The petition further alleges that the Tuohys used their power as conservators to strike a deal that paid them and their two birth children millions of dollars in royalties from an Oscar-winning film that earned more than $300 million, while Oher got nothing for a story "that would not have existed without him." In the years since, the Tuohys have continued calling the 37-year-old Oher their adopted son and have used that assertion to promote their foundation as well as Leigh Anne Tuohy's work as an author and motivational speaker. . . Under the conservatorship, Oher surrendered that authority to the Tuohys, even though he was a legal adult with no known physical or psychological disabilities. Blind Side
Emergency Preparedness / Climate Change	**20. The White House** August 11, 2023 *Biden-Harris Administration Launches National Dashboard to Track Heat-Related Illness* *New tool will help target heat-related health resources and prioritize life-saving interventions for communities most impacted by extreme heat* This week the U.S. Department of Health and Human Services (HHS) Office of Climate Change and Health Equity (OCCHE), in partnership with the National Highway Traffic Safety Administration (NHTSA), launched a first-of-its-kind online information portal called the Heat-Related Illness EMS Activation Surveillance Dashboard ("EMS HeatTracker"), which maps emergency medical services responses to heat-related illness across the country. The tracker will help public health officials ensure that outreach and medical aid reach the people who need it most and help decision-makers prioritize community resilience investments. This tool is being published as the climate crisis makes heat waves more extreme and more frequent around the country. It is the latest step by the Biden-Harris Administration to provide communities with the support and resources they need to stay safe from the worsening effects of extreme heat. The EMS HeatTracker will be used to help state, regional, and local government officials, such as city and regional planners, determine where to prioritize heat mitigation strategies, like street trees, parks, and cool roofs. It will also be used to help mayors and public health officials prioritize interventions like cooling centers and outreach to at-risk populations during periods of extreme heat. In addition to showing state and county-level heat-related EMS activations, the dashboard breaks down patient characteristics by age, race, gender, and urbanicity (e.g., urban, suburban, rural, and frontier). These data underscore which populations experience heat-related health risks most severely. The EMS HeatTracker, which will also be available through the heat.gov portal, is part of ongoing collaborations across the Administration through the National Integrated Heat Health Information System and the Interagency Working Group on Extreme Heat. The dashboard will be updated weekly to show data on a

	rolling basis. To view the EMS HeatTracker, click HERE . Heat Related Dashboard **21. *New York Times** July 20, 2023 *Is It Safe to Go Outside? How to Navigate This Cruel Summer.* By Alisha Haridasani Gupta Heat, flooding, and wildfire smoke have made for treacherous conditions. Use this guide to determine when it's safe to head out and when you should stay home. Excessive rain and flooding in the Northeast, a dangerous heat wave with triple-digit temperatures across the South, West and Midwest, and smoke from wildfires in Canada have all come together to make this a summer of weather extremes in the United States, in which going outside can be riddled with perils. So how do you know when it's safe to venture out? "No matter what the extreme weather situation is, there are usually a few practical steps you can take" to reduce your risk, said Alex Lamers, an extreme weather expert at the National Oceanic and Atmospheric Administration. Here are the things to consider before you head out the door. **Extreme heat** If the heat index is 103 degrees or above, avoid vigorous activity outdoors and limit your exposure to the heat. . . If you are pregnant, over 65 or have an underlying health condition, you may need to be cautious even at lower heat index temperatures. **Excessive rainfall** If there's a flood watch alert in your area, be prepared to change your plans or even evacuate, . . . especially if you live in a flood-prone area — one close to a body of water or in a low-lying region — or if you live in a basement-level apartment. **Poor air quality** If the air quality is poor, plan to stay indoors as much as possible with the windows closed. If you must be outdoors, consider wearing an N95 mask to help reduce your exposure to toxins. Navigate Cruel Summer
Covid	**22. *Wall Street Journal** July 31, 2023 *An Unwelcome Visitor Returns This Summer. Hint: It's Covid.* By Sumathi Reddy Summer is bringing us hot days, vacations—and a Covid bump. If you are surprised to learn that your neighbor, co-worker, or kid's best friend just tested positive for Covid-19, don't be. Measures of Covid rates including virus levels in wastewater, ER visits, test positivity and hospital admissions are increasing nationally, according to the most recent Centers for Disease Control and Prevention data. The good news is that we are starting from very low rates. Doctors are watching the current trends for clues to Covid's yearly pattern going forward. Other respiratory viruses such as flu and RSV typically start spreading in the fall and peak in the winter. Covid, a much newer virus that has mutated a lot since emerging a few years ago, so far has had winter surges as well as summer bumps, like we're seeing again this year. One possible factor: Heat waves are sending people fleeing for air-conditioned indoor spaces, where Covid transmits more easily compared with outside. Summer travel might also play a role, as people crowd into airports and bring

their germs along with them crisscrossing the world. . .
Covid-19 hospitalizations as of July 15 are up 10.3% from the previous week, according to CDC data. Emergency department visits are up 7% and test positivity rose to 6.3% from 5.8%. Hospital admissions include both people hospitalized for Covid as well as those who test positive when they come in to be treated for something else. Deaths remain low. . .
Since the federal government formally declared the end of the pandemic as a public health emergency in May, labs no longer are required to submit data on Covid-19 testing. Instead, the CDC testing positivity data comes from more than 400 labs that voluntarily submit data. . .
Already, the hospital and clinic have seen roughly double the number of people testing positive for Covid-19 over the past two to three weeks, Ostrosky says.
The most recent data from Biobot, a Cambridge, Mass., wastewater epidemiology company, shows a 17% increase nationally in the level of the virus that causes Covid for the week ending July 26 compared with the prior week.
Unwelcome Visitor

Veterans

Rendering of the Holyoke Veterans Home. [Courtesy EOVS]

23. State House News
August 14, 2023
State Breaks Ground on New Veterans Home in Holyoke
By Sam Drysdale
Senator Eyeing Veterans Facilities Beyond Just Holyoke and Chelsea.
Three years after a COVID-19 outbreak at the Holyoke Soldiers' Home resulted in at least 76 veterans' deaths, and several investigations, lawsuits, and an oversight reform law later, shovels broke ground Monday on a new Holyoke Veterans Home.
The $483 million facility will house 234 long-term care beds for the state's medically vulnerable veteran population, according to Gov. Maura Healey's office. The new home is expected to be completed in the summer of 2028.
The project to replace the Holyoke home will be funded by a combination of $263.5 million in federal funds through the U.S. Department of Veterans Affairs State Home Construction Grant Program, and a state bond bill passed in 2021 which sent $400 million to finance the project's design and construction. . .
The new 234-bed facility will be eight stories, and each floor will have three "houses" with 12 beds each, communal spaces, and nursing support. This includes a 30-bed memory care floor, and the home will also host a 40-person adult day health program for veterans who live in the community. . .
The COVID-19 outbreak that killed dozens of veterans was found to be connected to operational and governance shortcomings at the state-run facility. An independent report found an "abject failure of leadership" at the home. . .
With the Holyoke project underway, the state's other newly-constructed Veterans' Home in Chelsea is set to open its doors for veterans in the late summer or early fall, according to EOVS.
Chelsea's 136-bed long-term care Quigley Building was phased out in May and replaced by a new Community Living Center, a $200 million project reimbursed at 65 percent by the federal government.
Velis said he is hopeful that another $200 million in the bond bill that sent $400 million toward the Holyoke replacement will be used to open more veterans' facilities.
"There are pockets of veterans all over this commonwealth. We're asking their families to send their loved ones to Chelsea or Holyoke right now," Velis said.
"There's that extra $200 million for other veterans' projects that come up. A

	veteran is a veteran is a veteran, no matter where they call home, and those conversations are happening." New Veterans Home Holyoke
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	**Heat-Related EMS Activation Surveillance Dashboard** **https://nemsis.org/heat-related-ems-activation-surveillance-dashboard/** The Heat-Related EMS Activation Surveillance Dashboard, created in partnership between the HHS Office of Climate Change and Health Equity and the DOT National Highway Traffic Safety Administration, uses nationally submitted Emergency Medical Services (EMS) data to track EMS responses to people experiencing heat-related emergencies in the pre-hospital setting.
Previously recommended websites	The comprehensive list of recommended websites has migrated to the Dignity Alliance MA website: https://dignityalliancema.org/resources/. Only new recommendations will be listed in *The Dignity Digest.*
Previously posted funding opportunities	For open funding opportunities previously posted in *The Tuesday Digest* please see https://dignityalliancema.org/funding-opportunities/.
Websites of Dignity Alliance Massachusetts Members	See: https://dignityalliancema.org/about/organizations/
Nursing homes with admission freezes	**Massachusetts Department of Public Health** *Temporary admissions freeze* There have been no new postings on the DPH website since May 10, 2023.
Massachusetts Department of Public Health Determination of Need Projects	**Massachusetts Department of Public Health** ***Determination of Need Projects: Long Term Care*** **2023** **Navigator Homes of Martha's Vineyard, Inc. – Long Term Care Substantial Capital Expenditure** **Royal Wayland Nursing Home, LLC – Conservation Long Term Care Project** **2022** **Ascentria Care Alliance – Laurel Ridge** **Ascentria Care Alliance – Lutheran Housing** **Ascentria Care Alliance – Quaboag** **Berkshire Healthcare Systems, Inc. – Windsor Long Term Care Conservation** **Fairlawn Rehabilitation Hospital-Hospital/Clinic Substantial Capital Expenditure** **Long Term Centers of Lexington – Pine Knoll – Long Term Care Conservation** **Long Term Centers of Wrentham – Serenity Hill – Long Term Care Conservation** **Next Step Healthcare LLC-Conservation Long Term Care Project** **Royal Falmouth – Conservation Long Term Care** **Royal Norwell – Long Term Care Conservation** **Wellman Healthcare Group, Inc** **2020** **Advocate Healthcare, LLC Amendment** **Campion Health & Wellness, Inc. – LTC - Substantial Change in Service** **Heywood Healthcare, Inc. – Hospital/Clinic Substantial Capital Expenditure Notre Dame Health Care Center, Inc. – LTC Conservation** **2020**

	Advocate Healthcare of East Boston, LLC. **Belmont Manor Nursing Home, Inc.**
List of Special Focus Facilities	**Centers for Medicare and Medicaid Services** *List of Special Focus Facilities and Candidates* https://tinyurl.com/SpeciialFocusFacilityProgram Updated March 29, 2023 CMS has published a new list of Special Focus Facilities (SFF). SFFs are nursing homes with serious quality issues based on a calculation of deficiencies cited during inspections and the scope and severity level of those citations. CMS publicly discloses the names of the facilities chosen to participate in this program and candidate nursing homes. To be considered for the SFF program, a facility must have a history (at least 3 years) of serious quality issues. These nursing facilities generally have more deficiencies than the average facility, and more serious problems such as harm or injury to residents. Special Focus Facilities have more frequent surveys and are subject to progressive enforcement until it either graduates from the program or is terminated from Medicare and/or Medicaid. This is important information for consumers – particularly as they consider a nursing home. **What can advocates do with this information?** • Include the list of facilities in your area/state when providing information to consumers who are looking for a nursing home. Include an explanation of the SFF program and the candidate list. • Post the list on your program's/organization's website (along with the explanation noted above). • Encourage current residents and families to check the list to see if their facility is included. • Urge residents and families in a candidate facility to ask the administrator what is being done to improve care. • Suggest that resident and family councils invite the administrator to a council meeting to talk about what the facility is doing to improve care, ask for ongoing updates, and share any council concerns. • For long-term care ombudsmen representatives: Meet with the administrator to discuss what the facility is doing to address problems and share any resources that might be helpful. **Massachusetts facilities listed (updated July 26, 2023)** • 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** • None **Massachusetts facilities which have graduated from the program** • 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 • The Oxford Rehabilitation & Health Care Center, Haverhill https://theoxfordrehabhealth.com/ Nursing home inspect information: https://projects.propublica.org/nursing-homes/homes/h-225218 **Massachusetts facilities that are candidates for listing (months on list)** • Highview of Northampton, Northampton ((1) https://highviewnorthampton.com/ https://projects.propublica.org/nursing-homes/homes/h-225466/ • Fall River Healthcare (1) https://www.nextstephc.com/fallriver https://projects.propublica.org/nursing-homes/homes/h-225723/ • Charwell House Health and Rehabilitation, Norwood (19) https://tinyurl.com/Charwell Nursing home inspect information: https://projects.propublica.org/nursing-homes/homes/h-225208 • Glen Ridge Nursing Care Center (5) https://www.genesishcc.com/glenridge Nursing home inspect information: https://projects.propublica.org/nursing-homes/homes/h-225523 • Medway Country Manor Skilled Nursing and Rehabilitation, Medway (5) https://www.medwaymanor.com/ Nursing home inspect information: https://projects.propublica.org/nursing-homes/homes/h-225412 • Mill Town Health and Rehabilitation, Amesbury (18) No website Nursing home inspect information: https://projects.propublica.org/nursing-homes/homes/h-225318 • Plymouth Rehabilitation and Health Care Center (14) https://plymouthrehab.com/ Nursing home inspect information: https://projects.propublica.org/nursing-homes/homes/h-225207 • Tremont Health Care Center, Wareham (14) https://thetremontrehabcare.com/ Nursing home inspect information: https://projects.propublica.org/nursing-homes/homes/h-225488 • Vantage at Wilbraham (9) No website Nursing home inspect information: https://projects.propublica.org/nursing-homes/homes/h-225295 • Vantage at South Hadley (16) No website Nursing home inspect information: https://projects.propublica.org/nursing-homes/homes/h-225757 https://tinyurl.com/SpeciialFocusFacilityProgram
Nursing Home Inspect	**ProPublica** ***Nursing Home Inspect*** Data updated November 2022 This app uses data from the U.S. Centers for Medicare and Medicaid Services.

	Fines are listed for the past three years if a home has made partial or full payment (fines under appeal are not included). Information on deficiencies comes from a home's last three inspection cycles, or roughly three years in total. The number of COVID-19 cases is since May 8, 2020, when homes were required to begin reporting this information to the federal government (some homes may have included data on earlier cases). Massachusetts listing: https://projects.propublica.org/nursing-homes/state/MA **Deficiencies By Severity in Massachusetts** (What do the severity ratings mean?) # reported Deficiency Tag 250 **B** 82 **C** 7,056 **D** 1,850 **E** 546 **F** 487 **G** 31 **H** 1 I 40 **J** 7 **K** 2 L
Nursing Home Compare	**Centers for Medicare and Medicaid Services (CMS)** *Nursing Home Compare Website* Beginning January 26, 2022, the Centers for Medicare and Medicaid Services (CMS) is posting new information that will help consumers have a better understanding of certain staffing information and concerns at facilities. This information will be posted for each facility and includes: • **Staff turnover:** The percentage of nursing staff as well as the number of administrators who have stopped working at a nursing home over the past 12-month period. • **Weekend staff**: The level of weekend staffing for nurses and registered nurses at a nursing home over a three-month period. Posting this information was required as part of the Affordable Care Act, which was passed in 2010. In many facilities, staffing is lower on weekends, often meaning residents have to wait longer or may not receive all the care they need. High turnover means that staff are less likely to know the residents, recognize changes in condition, or implement preferred methods of providing care. All of this contributes to the quality-of-care residents receive and their quality of life. https://tinyurl.com/NursingHomeCompareWebsite
Data on Ownership of Nursing Homes	**Centers for Medicare and Medicaid Services** *Data on Ownership of Nursing Homes* CMS has released data giving state licensing officials, state and federal law enforcement, researchers, and the public an enhanced ability to identify common owners of nursing homes across nursing home locations. This information can be linked to other data sources to identify the performance of facilities under common ownership, such as owners affiliated with multiple nursing homes with a record of poor performance. The data is available on nursing home ownership will be posted to data.cms.gov and updated monthly.

<table>
<tr><td>Long-Term Care Facilities Specific COVID-19 Data</td><td colspan="3">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 colspan="3">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 colspan="3">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 rowspan="13">Participation opportunities with Dignity Alliance Massachusetts

Most workgroups meet bi-weekly via Zoom.

Interest Groups meet periodically (monthly, bi-monthly, or quarterly).

Please contact group lead for more information.</td><td>Workgroup</td><td>Workgroup lead</td><td>Email</td></tr>
<tr><td>General Membership</td><td>Bill Henning
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<tr><td>Legal Issues</td><td>Jeni Kaplan</td><td>jkaplan@cpr-ma.org</td></tr>
<tr><td>Interest Group</td><td>Group lead</td><td>Email</td></tr>
<tr><td>Assisted Living and Rest Homes</td><td>In formation</td><td></td></tr>
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<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
Marianne DiBlasi</td></tr>
</table>

	• Brian Kremer • Dick Moore 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.*

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.