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Testimony of Secretary Elizabeth C. Chen, Ph.D., MBA, MPH
Massachusetts Executive Office of Elder Affairs
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Good afternoon Vice Chair Friedman, Vice Chair Donato, and distinguished members of the Committees on Ways and Means. Thank you for inviting me to speak before you today.

My name is Elizabeth Chen. It continues to be an honor to serve as your Secretary of Elder Affairs, particularly this year, which marks the 50th anniversary of the legislation that created the Commonwealth's Executive Office of Elder Affairs (EOEA). It is also a privilege and an immense responsibility to serve at this moment in history when older populations were some of the most impacted by the COVID-19 pandemic.

The backbone of the Aging Services Network in Massachusetts is comprised of two crucial partners: 350 municipal Councils on Aging and 25 regional Aging Services Access Points, also known as ASAPs. These two entities represent the core of community-based aging services and supports in the Commonwealth. This is a network that has been built and nurtured over a half century. Our Aging Services Network did not crack or buckle under the stress of the pandemic, but instead became stronger over the past 12 months.

Let me share with you how the EOEA $594 million budget proposal will continue to support services that enable 1.6 million adults age 60 and over to live and thrive in the community of their choosing.

Councils on Aging (9110-9002)

Councils on Aging are the front door to services for people age 60 and over and their families. While Senior Centers have been physically closed since the beginning of the pandemic, Councils on Aging stayed open and continued to provide services and shifted their programming to remote formats. Older people are resilient and many adapted by learning the language of Zoom, email, texts, and video chats. Not everyone has a computer or internet services or is inclined to use these remote formats. Councils on Aging have intensified outreach by organizing phone buddies, dropped off cards and gift bags, and patiently helped individuals adapt to new technology.

Never should we say again that older populations, as a group, are not comfortable with technology. As an example, one town is experiencing higher participation in exercise classes because people who are shy can now turn their cameras off and exercise with privacy. Transportation to a class or seminar is no longer a barrier if remote participation is enabled. We foresee program delivery both in-person and via remote technologies in post pandemic times.

This budget maintains $17.1[1] million, which allocates $12 per person age 60 and above, to local Councils on Aging so that they can continue programs that engage and support older populations in their cities and towns.

Senior Nutrition Program (9110-1900)

"*It's not just a meal. It's a wellness check*."

The Senior Nutrition Program provided 10.3 million meals in Federal Fiscal Year 2020, which is a 9.8% increase from the prior year. A year ago, ASAPs and Councils on Aging quickly pivoted to new COVID safety protocols that allowed for contact-free drop-off while maintaining the valuable "eyes on the consumer" wellness check. As the pandemic wore on, Councils on Aging and ASAPs shifted congregate dining to "grab and go," and devised creative ways in which older people can still participate safely in the traditions of every season – such as a 4th of July "grab and go" barbeque plus a parade of cars – and strengthened town relationships through "lunch and a book (from the library)."

When several regional kitchens were closed for two weeks at a time due to staff members contracting COVID-19, the consequences might have been catastrophic for consumers. But, *no one* missed a meal. EOEA had gradually increased emergency supplies of frozen and shelf-stable meals since the start of the pandemic to protect against this potential system failure.

Our Senior Nutrition Program was able to secure additional federal grants, not available to other states, because of the robust infrastructure already in place for many decades. The Senior Nutrition Program relies heavily on volunteer drivers, most of whom are over the age of 70. Undeterred by pandemic conditions, the Senior Nutrition Program delivered 9.2 million meals in Calendar Year 2020 and provided an additional 1 million meals in grab and go settings. The $9.7 million in our budget preserves our capabilities for maintaining nutritional and overall wellness for older residents.

[1] Based on 1.4 million population, and not adjusted to 2020 Census

The Role of Aging Services Access Points (ASAPs)

There are 25 Aging Services Access Points in the Commonwealth. Each is a private non-profit enterprise. Every zip code is served by an ASAP and there is no overlap. This design, in accordance with MGL ch. 19A, sec. 4B, should be celebrated as a stellar example of a productive and efficient public and private partnership.

EOEA contracts out part of the Senior Nutrition Program and all of the Home Care and Protective Services programs to ASAPs for implementation. EOEA's program staff monitors program integrity, overall ASAP financial stability, and engages in continuous quality improvement with this critical segment of our aging services network.

ASAPs, as private non-profits, also receive grants and contracts from other state, federal, and private grantors. These additional capabilities build expertise and capacity, which are synergistic to EOEA programs in serving older populations - examples include deployment of local long-term care ombudsmen to help families with loved ones in nursing homes, support for family caregivers in the family caregiver support program, deployment of ASAP nurses to evaluate residents for placement when a nursing home or rest home closes; or providing on-site assistance for vaccination clinics held in senior affordable housing with Resident Care Coordinators funded by the Supportive Senior Housing (9110-1604) or Congregate Housing (9110-1660) programs.

Home Care (9110-0600; 9110-1630; 9110-1633)

The State Home Care Program serves individuals who need assistance with Activities of Daily Living[2] and/or Instrumental Activities of Daily Living [3] in order to remain at home. This program serves over 66,000 individuals of all income levels every year. In FY20, 24,177 individuals were eligible for nursing facility level of care but chose to remain at home and receive home care services. Expenditures for supportive care in the home are captured across three appropriations lines: Community Choices (9110-0600), Home Care Services (9110-1630), and Home Care Case Management and Administration (9110-1633).

When Governor Baker declared a state of emergency on March 10, 2020, EOEA immediately restructured home care services to allow for remote case management. While many services were offered remotely, there is no replacement when a consumer needs hands-on assistance. EOEA developed seven COVID-19 dedicated services to support COVID-19 positive consumers or consumers living in households with COVID-19 positive family members. Additionally, EOEA instituted several services and supplied devices where necessary to enable improved consumer/caregiver engagement and ability to connect remotely. More recently, the home care program developed an Alternate Setting Day Service so that individuals who need services

[2] Activities of Daily Living (ADLs). Tasks, including the ability to bathe, dress/undress, eat, toilet, transfer in and out of bed or chair, move while in bed, and ambulate inside the home, and management of incontinence which are used to measure the Functional Impairment Level (FIL) of an Applicant or Consumer.

[3] Instrumental Activities of Daily Living (IADLs). Basic tasks, including the ability to prepare meals, do housework, do laundry, go shopping, manage medication, ambulate outside the home, use transportation, manage money, and use the telephone, which are used to measure the Functional Impairment Level (FIL) of an Applicant or Consumer.

similar to Adult Day Health programs and Supportive Day Programs can receive these services in the home with a minimum of two-hour blocks of time.

Demand for home care services decreased during the first six months of the pandemic. However, demand is slowly returning, and we expect that it will return to pre-pandemic levels as vaccination rates continue to increase. The House 1 budget proposal for an increase of $16.7 million (3.4%) above FY21 for Home Care is due to higher demand, as more people are expected to choose to stay home instead of moving into long-term care settings.

Home Care Workforce (9110-1637)

The Home Care Workforce should be lauded and celebrated, particularly for their continued commitment to serving clients since the beginning of the pandemic. There are many residents of the Commonwealth with unmet home care needs. The Home Care Aide Training Grant allows EOEA to invest in efforts to reduce barriers to entry to this important workforce, and improve retention. This budget request allows EOEA to continue an effort initiated in FY20 to convert the Personal and Home Care Aide State Training (PHCAST) curriculum into a smartphone compatible, online format for on-demand, tuition-free access. Free access to training in this format will remove barriers for future aides interested in pursuing this work.

While the pandemic delayed our work, I am pleased to report that we have completed Phase I, which is the conversion of the first 37 hours of the 60-hour PHCAST curriculum. This course was made available to the public on February 18, 2021. As of February 22, more than two dozen learners have successfully completed the course. Completing these 37 hours enables individuals to be employed as professional Homemakers. Self-Directed workers and family caregivers are not required to complete the PHCAST curriculum but the format encourages anyone to participate and learn professional caregiving skills.

Over the next few months, this course will be translated into Spanish and Haitian Creole and we anticipate adding more languages in the future. We believe it is vital to work with a vendor that understands the learning needs of our target audience and has extensive experience with online course delivery. We are grateful that we found this dual expertise with our partners at the Institute for Community Inclusion at UMass Boston.

The next phase of our work will convert the remaining class-based learning of the curriculum to the same format as the first 37 hours. We expect converting the Personal Care Homemaker section of PHCAST to present new challenges as 10 of the 20 hours require hands-on, experiential instruction. When this next phase is completed, we anticipate that conversion of the PHCAST curriculum to online and tuition-free access will help attract new workers to the workforce and improve retention in the home care workforce, additionally the curriculum can be utilized as refresher training for the existing workforce. In response to the public health emergency, EOEA utilized the PHCAST platform to share an instructional video, demonstrating appropriate donning and doffing of personal protection equipment when caring for a person diagnosed with COVID-19 in the home.

Geriatric Mental Health Services (9110-1640)

The need for mental and behavioral health services can change over one's life course, and the aging process requires constant adaptation as physical and cognitive abilities shift. Pandemic constraints have added additional needs due to coping with isolation from friends and family, accelerated physical and cognitive deconditioning, loss of loved ones, and constant fear and anxiety over an invisible, but real existential threat.

In FY16, EOEA piloted the concept of Elder Mental Health Outreach Teams (EMHOT), and now there are seven EMHOTs which serve residents in 81 cities and towns across the Commonwealth. EMHOTs are multi-disciplinary teams based at ASAPs and COAs that provide a variety of social and clinical services to meet the behavioral health needs of older adults. They connect older adults to vital community supports, resources and services needed to address broader factors associated with behavioral health conditions, such as housing insecurity, loss of social connectedness, and financial challenges.

From January 2020 to July 2020 (latest reporting period), EMHOTs served 445 consumers. Nearly one-half (N=216) were new to the program. This rapid growth suggests significant need for these services, especially during the public health emergency. Approximately one-half of EMHOT consumers experienced depression, while approximately one-quarter experienced general anxiety disorder.

Each EMHOT provided an average of 724 hours of individual counseling in the first six months of FY20 (more than double the previous reporting period). After receiving EMHOT services, 87.6% of surveyed older adults reported they were more aware of community resources and 80.5% reported being better able to deal with crisis situations. Additionally, the Department of Public Health funds a set of similar programs through their suicide prevention line item. The DPH and EOEA programs meet to share best practices and ensure the behavioral and mental health needs of older adults are being met throughout the state.

Protective Services (9110-1636)

Adult Protective Services supports the most vulnerable adults in our communities by responding to reports of abuse and neglect. In FY2020, 34,813 cases were referred by mandated reporters, friends, neighbors and family to Adult Protective Services; 10,177 cases were substantiated after investigation. Over two-thirds of the cases were due to neglect or self-neglect. Untreated mental health conditions and cognitive impairment are often key underlying causes of neglect by a caregiver or self-neglect for an older person. The average time to investigate a case is approximately 35 days, and program specialists spend as long as 120 days or several months to put remedial services and supports in place to improve the safety of the living situation.

Assisted Living Residences

EOEA certifies 270 Assisted Living Residences (ALR), which house approximately 17,000 older individuals across the Commonwealth. The average age of residents is 86. EOEA put in place a waiver at the beginning of the pandemic, which allows Assisted Living Residences to administer limited skilled nursing services. Skilled care to be provided, may include, but is not necessarily

limited to, the application or replacement of simple nonsterile dressings, the application of eye drops, the application of ointments, and the management of oxygen on a regular and continuing basis, and injections. This waiver is allowed in regulations 651 CMR 12.00 and expires at the end of the State of Emergency.

Since the beginning of the pandemic, the EOEA Assisted Living Program worked closely with the Department of Public Health, issued pandemic-specific guidance, provided technical assistance, and facilitated interactions between Assisted Living management, Local Boards of Health, and the Department of Public Health with protective equipment, infection prevention and control, COVID-19 testing, and COVID-19 vaccinations.

The expenditures for the certification team of three field staff and one director are incorporated in the Elder Affairs Administration line (9110-0100).

The COVID-19 Vaccine on-site clinics operated under the Federal Pharmacy Partnership Program (FPPP) started in mid-January for Assisted Living Residences. In six weeks, as of February 24th, 100% of ALRs have completed their first vaccine clinic and 96% have completed their second of three clinics. As of late February, uptake of the COVID-19 vaccine amongst residents is 95% and 75% in staff.

Age-Friendly Communities and Closing

The Executive Office of Elder Affairs and our partners in the aging services network have adapted, pivoted, and found innovative solutions to meet the needs of older residents and their families throughout this challenging year. Massachusetts has been a national leader in the Age and Dementia Friendly movement, and communities across the Commonwealth are engaged in this work. I am pleased to report that not only did this work continue throughout this difficult year, but this work served as a foundation for a collaborative, flexible, and creative pandemic response.

As I think about this past year, in all its hardship, challenges, sorrow, and struggle, I know there will come a time when we look back on these days to reflect on how we coped, and to celebrate our collective resilience.

I want to close by thanking you for the opportunity to testify today and thank you for your support of older people and their families and the organizations that serve them throughout the Commonwealth.