



MetroWest Healthy Aging Data Book



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This report is made possible by the MetroWest Community Health Care Foundation as part of its mission to promote a healthy MetroWest.

The MetroWest Community Health Care Foundation meets the health care needs of the region's residents by supporting community-based and community-driven programs. From preventative and responsive care, to programs that serve infants to elders, the Foundation provides over \$5 million in annual financial support that helps residents and their families lead healthier lives. In its work on issues such as youth substance abuse, nurse recruitment and retention, racial and ethnic disparities in health, and childhood obesity, the Foundation looks to develop and support programs that have a positive impact on the health of the twenty-five communities in the MetroWest area of Massachusetts.

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Analysis and opinions expressed are solely those of the author.

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TABLE OF CONTENTS

	Page Number
Executive Summary.....	7
Defining Elderly	8
Defining MetroWest Towns and Regions	9
Elderly Demographic Profiles and Projections.....	10
Mortality	21
Hospitalization.....	24
Hospital Observation Days.....	29
Emergency Visits.....	30
Cancer Incidence	34
Substance Abuse.....	36
Prevention	36
Access to Care and Services.....	38
Elder Services Agencies and Organizations	38
Appendix A: Elderly Housing and Household Definitions.....	45
Appendix B: U.S. Census 2000 Definition of Disability	45
Appendix C: Advocacy Organizations	53
Appendix D: State Agencies with Elder Health Agenda.....	56
End Notes	58

INDEX OF TABLES

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Table 1: MetroWest Towns, Regions, and Kinds of Communities.....	8
Table 2: Framingham Census of Population, 2000 and Population Estimates, 2005.....	9
Table 3: 2000 U.S. Census and Projected Population, elderly - 65 and Over.....	10
Table 4: 2000 U.S. Census and Projected Population, middle and late elderly: 75 and Over.....	11
Table 5: 2000 Census and Projected Population late elderly: 85 and Over	11
Table 6: Ages of MetroWest Elderly Residents, 2000.....	13
Table 7: Percentage of MetroWest Elderly Residents by Race and Ethnicity, 2000.....	14
Table 8: Living Situation of MetroWest and Massachusetts Elders, 65+, 2000	15
Table 9: Federal Poverty Limit by Size of Family Unit.....	16
Table 10: Average Yearly Counts of Selected Leading Causes of Elderly Death, MetroWest, 2003-2007	22
Table 11: Elderly Average Annual Death Counts, by Race and Ethnicity, MetroWest, 2003-2007	23
Table 12: Hospitalization: Average Counts by Cause, 2003-2008.....	25
Table 13: Median ages within age ranges	27
Table 14: Sources of payment for elderly hospital care: percentages, 2003-2008.....	28
Table 15: ER Visits by Cause, Residents Aged 65 and Over, 2002-2007	29
Table 16: ER Visits Compared with Hospitalizations for Falls, 2002-2007	32
Table 17: Cancer Incidence, by Type	34
Table 18: Admissions to publicly supported substance abuse treatment, Massachusetts, 2006-2008.....	35
Table 19: Elder Service Agencies and Access Points	37
Table 20: Elder Service Agencies and Units of Service for MetroWest Residents	38
Table 21: Publicly Supported Services for MetroWest Residents, July 1, 2008 -June 30, 2009	38
Table 22: Major Types of Service, by MetroWest Town, for July 1, 2008 to June 31, 2009	40
Table 23: Congregate Meals Served, by MetroWest Town of Residence, 2008.....	40
Table 24: Assisted Living and Specialized Care Units in MetroWest	41
Table 25: Nursing Home Facilities in MetroWest	42
Table 26: Group Housing in MetroWest	43

INDEX OF FIGURES

Figure 1: MetroWest Elderly Census and Population Projections, 2000-2030	12
Figure 2: MetroWest Population, Residents 65 and over, 2000	13
Figure 3: MetroWest Residents of Color, for Children (0-9) and Elderly (65+), 2000	14
Figure 4: Elderly Home Ownership	15
Figure 5: Percent of Elderly Householders below the Federal Poverty Limit.....	16
Figure 6: Count of elderly residents with any disability, civilian non-institutionalized population, 2000.....	17
Figure 7: Percentage of elderly residents with any disability, civilian non-institutionalized population, 2000.....	18
Figure 8: Elderly Persons with Two or More Disabilities	18
Figure 9: Persons with a single sensory disability	19
Figure 10: Residents with a single physical disability, 2000.....	19
Figure 11: Residents with a single "go-outside-the-home" disability	20
Figure 12: MetroWest Elderly Mortality Rates and Linear Trends, by Age Groups	21
Figure 13: Difference between MetroWest and Massachusetts Mortality Rates.....	21
Figure 14: Counts and trend line, annual mortality, 1994-2007	22
Figure 15: MetroWest Hospital Discharge Rates and Linear Trend Lines, per 100,000 Residents, 1989 – 2008.....	24
Figure 16: Hospitalization counts and trend line, persons age 85 and over, 1989 – 2008	24
Figure 17: All-Cause Hospitalization Rate per 100,000, 2003-2008	26
Figure 18: MetroWest and Massachusetts Hospitalization Rates for Falls, 2003-2008.....	27
Figure 19: Hospitalization for Diabetes-Related Complications, 2003-2008	28
Figure 20: Hospital Observation Day Rates per 100,000, 2002-2007	29
Figure 21: ER Visit Rate per 100,000, by Age Group, MetroWest 2002-2007	30
Figure 22: Emergency Visit Rates for Falls Throughout the Life-span, 2002-2007.....	31
Figure 23: Emergency Visits for Falls, 2002-2007	31
Figure 24: ER Visit Rates per 100,000 for Assault and Self-Inflicted Injury, 2002-2007	32
Figure 25: MetroWest Cancer Incidence Rates per 100,000, by Age, 1995-2006	33
Figure 26: MetroWest and Massachusetts Cancer Incidence - All Types, 2002-2006	33
Figure 27: Breast and Prostate Cancer Incidence Rate per 100,000 by Age Group	34
Figure 28: Percentage of MetroWest Elders Who Ever Had Pneumonia Vaccine.....	36
Figure 29: Percentage of MetroWest Elders Who Had Flu Shot in Past Year.....	36

Purpose

The purpose of this databook and report is to provide needed information about the elderly population for the MetroWest Community Health Care Foundation, its **MetroWest Healthy Aging Commission**, and other organizations and residents who are dedicated to improving the lives of elderly residents of the region. The report uses publicly available quantitative data to provide a firm ground for discussions among these groups and individuals.

Executive Summary

Breadth

The 2002 *MetroWest Health Data Book* and the 2005 *MetroWest Health Data Book and Atlas* each contained a limited amount of data specifically about the elderly population. This 2009 report examines the elderly population in depth, including:

- the age distribution of men and women by race, ethnicity, and origin, in order to better understand the demographic backgrounds of the elderly population;
- the social and health context of the elderly population, household and family living arrangements and disability;
- detailed analyses of mortality, emergency visits, hospital discharges, cancer incidence and preventive measures; and
- an account of services, including nursing homes, assisted living facilities and “portals” into other elder care services, advocacy organizations and relevant state agencies.

Summary of Findings

- There are a variety of definitions of the term elderly.
- Following the aging of the ‘baby boom’ cohort, there will be dramatic increases in the early elderly population through 2010, the middle elderly population starting in 2020 and in the late elderly population starting in 2030.
- Two thirds of MetroWest elders live in family households, either with their spouse or children or both.
- In contrast to the youth population, the MetroWest elder population is almost entirely White and non-Hispanic (96.3 per cent).
- The women to men ratio increases markedly with age, from 1.1:1 among persons 65-69 up to 9.3:1 for centenarians.

- MetroWest elders are more likely to own their own homes and less likely to be below the Federal poverty level, than are Massachusetts elders.
- Disability *counts* are high in the largest communities of Framingham, Natick and Marlborough, but disability *rates* are highest in the SouthWest region including Mendon, Milford, Hopedale, Bellingham and Franklin.
- Mortality rates have declined over the past two decades, for each elderly five-year age group examined: 65-69; 70-74; 75-79; and 80-84.
- Lung cancer and heart disease are the most frequent causes of death in MetroWest.
- MetroWest mortality rates are lower than those for Massachusetts in the age groups 65-69; 70-74; and 75-79. For age groups 80-84 and 85 and over, mortality rates are generally higher in MetroWest.
- MetroWest hospitalization rates for all causes are 4 percent lower than Massachusetts rates among 65-74 year olds, but 7 percent higher among 75-84 year olds and 9 percent higher among those 85 and over.
- MetroWest hospitalization rates for falls are 10 percent lower than Massachusetts rates among 65-74 year olds, but 9 percent higher among 75-84 year olds and 12 percent higher among those 85 and over.
- Hospital observation days for elders are significantly higher in MetroWest than in Massachusetts as a whole.
- Counts and population denominators for mortality, hospitalization and ER visits are too small for MetroWest elders of color to produce any reliable analysis.
- Few MetroWest elders enter publicly supported drug and alcohol treatment centers. The counts and rates for private treatment are unknown.
- The Massachusetts Executive Office of Elder Affairs provides data that 4,775 MetroWest elders received publicly supported services (1,499,375 units), through the “Points of Access,” during the period July 1, 2008 – June 30, 2009. There were 685,418 units of homemaker service, 322,423 units of personal care and 212,284 units of home delivered meals.
- There are numerous assisted living facilities (19) and nursing homes (35), and a variety of other group housing sites (14) in MetroWest.

Defining Elderly

Although in common language, this report is about the “elderly” population, there is no unanimity about what “elderly” really means.

Webster’s Revised Unabridged Dictionary (1913) defines: “Elderly, a. somewhat old; advanced beyond middle age; bordering on old age; as, elderly people.” This definition implies that elderly is *not* old age, but merely bordering on it.

MSN Encarta also provides an imprecise definition: past middle age and approaching the later stages of life (*sometimes considered offensive*).ⁿ

According to one researcher: “Conventionally, ‘elderly’ has been defined as a chronological age of 65 years old or older, while those from 65 through 74 years old are referred to as ‘early elderly’ and those over 75 years old as ‘late elderly’.”⁰

Gorman provides yet another definition, taking context into account: “The aging process is of course a biological reality which has its own dynamic, largely beyond human control. However, it is also subject to the constructions by which each society makes sense of old age. In the developed world, chronological time plays a paramount role. The age of 60 or 65, roughly equivalent to retirement ages in most developed countries is said to be the beginning of old age. In many parts of the developing world, chronological time has little or no importance in the meaning of old age. Other socially constructed meanings of age are more significant such as the roles assigned to older people; in some cases it is the loss of roles accompanying physical decline, which is significant in defining old age.”³

Other related concepts are “senior citizens,” “old age,” and “retirement age.” Thus, senior citizen discounts may begin as early as age 60. Social Security begins as early as age 62, but Medicare not until age 65. The American Association of Retired Persons (AARP) invites to membership all persons over age 50!

It has been asserted that the concept of elderly has been advancing upwards in chronological age, as the population itself ages, and as more “seniors” maintain good health into later years.

For the purposes of this report, elderly is defined as age 65. This criterion fits much of the available quantitative data. For some analyses, more detailed age breakdowns of the elderly population are possible, for example, early elderly: ages 65-74, middle elderly: ages 75-84 and late elderly: ages 85 and over.

Defining MetroWest Towns and Regions

MetroWest comprises 25 cities and towns, centered in the Framingham/Natick area. For analytic purposes, three sub-areas have been created: Eastern, NorthWest, and SouthWest. In addition, statistical analysis has revealed two kinds of communities that we have labeled as “more commercial versus more residential.” These groupings were defined by similarities between towns based on population, percent population change between 1990 and 2000, percent under 18, percent white, black, and Latino, population density, percent valuation in residential, commercial and industrial property, and equalized property valuation per capita. The communities are listed in Table 1. Some, but not all, of the quantitative data are analyzed with these distinctions in mind. Details on the methods used in creating the “kind of community” typology are available in the 2002 *MetroWest Health Data Book*.

Table 1: MetroWest Towns, Regions, and Kinds of Communities

City or Town	Sub-Region	Kind of Community
Dover	Eastern	More Residential
Medfield	Eastern	More Residential
Millis	Eastern	More Residential

City or Town	Sub-Region	Kind of Community
Natick	Eastern	More Commercial
Needham	Eastern	More Residential
Norfolk	Eastern	More Residential
Sherborn	Eastern	More Residential
Sudbury	Eastern	More Residential
Wayland	Eastern	More Residential
Wellesley	Eastern	More Residential
Framingham	NorthWest	More Commercial
Hudson	NorthWest	More Commercial
Marlborough	NorthWest	More Commercial
Northborough	NorthWest	More Residential
Southborough	NorthWest	More Residential
Westborough	NorthWest	More Commercial
Ashland	SouthWest	More Commercial
Bellingham	SouthWest	More Residential
Franklin	SouthWest	More Residential
Holliston	SouthWest	More Residential
Hopedale	SouthWest	More Residential
Hopkinton	SouthWest	More Residential
Medway	SouthWest	More Residential
Mendon	SouthWest	More Residential
Milford	SouthWest	More Commercial

Source: *MetroWest Health Data Book and Atlas*, 2005

Elderly Demographic Profiles and Projections

Population Estimation and Projection Methods

As of this writing, we are ten years beyond the Federal Census of 2000. A major question is: how much has the elderly population changed since that time. Unfortunately, there is not an easy answer to this question. There are several quite different, but related town-level population estimates and projections available for the MetroWest region. These have been developed by the U.S. Census Bureau, the Massachusetts Department of Public Health (MDPH), and the Metropolitan Area Planning Council (MAPC). A fourth set of projections is provided by the Massachusetts Executive Office of Elder Affairs (MEOEA), based on MISER 2002 projections. As an illustration, Table 2 contains a comparison of these estimates for the town of Framingham.

Table 2: Framingham Census of Population, 2000 and Population Estimates, 2005

Population Segment	Census 2000	ACS 2005 est.	Census 2005 est.	MDPH 2005 est.	MAPC 2005 est.	MEOEA 2005 est.
Total Pop.	66,913	58,161	65,060	65,651	67,987	
Pop. 65+	8,691			8,490	9,043	8,775

The 2005 estimates for MAPC and MEOEA are averages of the 2000 U.S. Census counts and their 2010 projections. It appears that the MAPC projections are higher than the other three estimates. One difference in method is that MAPC takes account of known birth and death rates, and in- and out-migration. In addition, the MAPC projections are taken out to 2030, which will be of help for planning purposes. For the purposes of analyzing health data currently available from MDPH, the MDPH population estimates will be used. For the purposes of population projection, the MAPC estimates will be presented.

Population Counts and Estimates

Table 3 contains projections of the total elderly population for 2010, 2020, and 2030. The 2005 figures are an average of 2000 and 2010 estimates.

Table 4 contains projections for the middle and late elderly only, and Table 5 for the late elderly only.

Table 3: 2000 U.S. Census and Projected Population, elderly - 65 and Over

Town	2000 Census	2005 (Average)	2010 Projection	2020 Projection	2030 Projection
Ashland	1,432	1,735	2,037	2,818	3,686
Bellingham	1,483	1,605	1,727	2,440	3,196
Dover	624	712	800	1,106	1,458
Framingham	8,691	9,043	9,394	12,004	15,092
Franklin	2,437	2,590	2,743	3,919	5,167
Holliston	1,228	1,283	1,337	2,043	2,718
Hopedale	913	921	929	1,264	1,656
Hopkinton	917	948	979	1,380	1,817
Hudson	2,214	2,520	2,826	3,790	4,859
Marlborough	4,190	4,297	4,404	5,707	7,203
Medfield	1,137	1,220	1,303	1,887	2,508
Medway	1,137	1,226	1,316	1,882	2,455
Mendon	443	540	637	993	1,440
Milford	3,448	3,659	3,870	4,938	6,374
Millis	743	813	883	1,280	1,685
Natick	4,608	4,834	5,060	6,652	8,454
Needham	5,190	5,350	5,510	7,080	8,909
Norfolk	577	615	653	977	1,293
Northborough	1,370	1,444	1,519	2,188	2,914
Sherborn	474	509	545	776	1,031
Southborough	731	851	970	1,338	1,767
Sudbury	1,653	1,827	2,001	3,087	4,243
Wayland	1,868	1,990	2,113	3,007	4,034
Wellesley	3,730	3,805	3,879	4,993	6,366
Westborough	2,085	2,127	2,169	2,810	3,555
MetroWest	53,325	56,465	59,605	80,358	103,876

Table 4: 2000 U.S. Census and Projected Population, middle and late elderly: 75 and Over

Town	2000 Census	2005 (Average)	2010 Projection	2020 Projection	2030 Projection
Ashland	576	817	885	953	1,388
Bellingham	580	618	672	726	1,083
Dover	236	271	290	309	470
Framingham	4,354	4,292	4,418	4,544	6,198
Franklin	1,082	1,026	1,101	1,175	1,700
Holliston	460	389	434	479	714
Hopedale	496	432	455	477	667
Hopkinton	431	403	440	477	707
Hudson	944	1,233	1,319	1,404	2,035
Marlborough	2,072	2,056	2,120	2,184	2,946
Medfield	496	486	540	594	903
Medway	501	487	523	558	809
Mendon	198	250	281	313	497
Milford	1,879	2,106	2,234	2,361	3,364
Millis	281	308	336	363	531
Natick	2,258	2,343	2,474	2,606	3,642
Needham	2,925	2,763	2,878	2,993	4,083
Norfolk	219	183	200	218	319
Northborough	537	524	573	621	933
Sherborn	200	209	228	248	370
Southborough	307	384	407	430	627
Sudbury	676	585	654	722	1,107
Wayland	831	806	898	989	1,550
Wellesley	1,918	1,823	1,875	1,926	2,641
Westborough	1,192	1,041	1,068	1,094	1,453
MetroWest	25,649	25,837	27,301	28,765	40,741

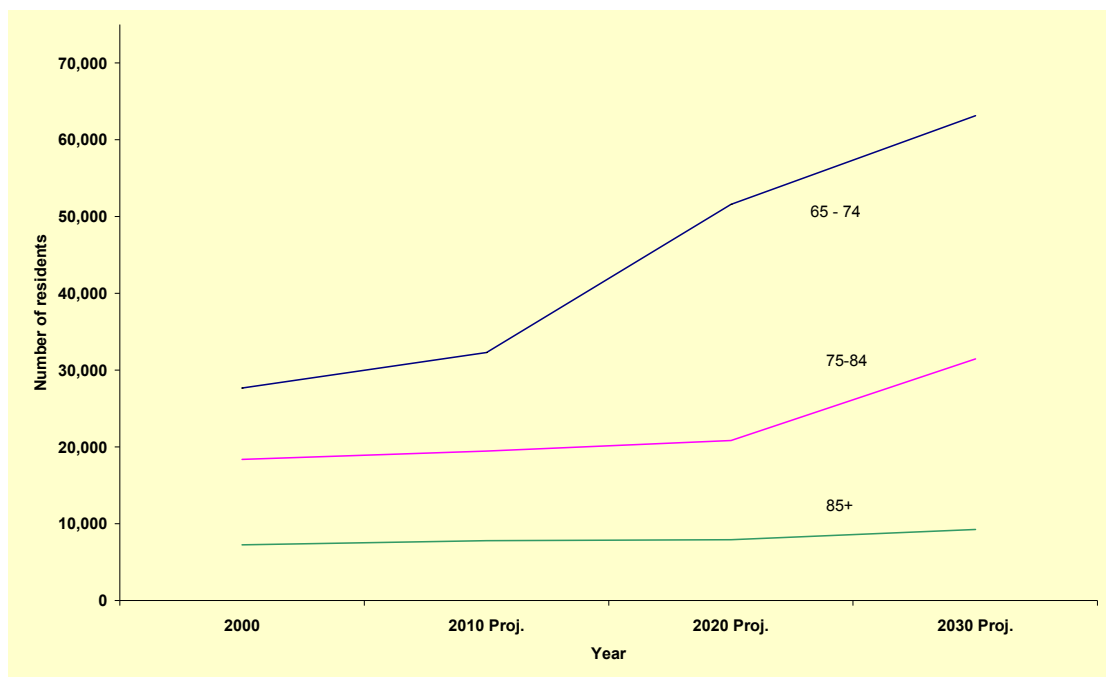
Table 5: 2000 Census and Projected Population late elderly: 85 and Over

Town	2000 Census	2005 (Average)	2010 Projection	2020 Projection	2030 Projection
Ashland	93	130	168	171	199
Bellingham	97	97	96	98	115
Dover	50	65	80	84	106
Framingham	1,353	1,364	1,374	1,320	1,488
Franklin	256	278	300	304	349
Holliston	99	103	107	123	165
Hopedale	142	136	130	131	146
Hopkinton	110	104	98	106	131
Hudson	184	257	329	349	423
Marlborough	629	644	660	633	688

Town	2000 Census	2005 (Average)	2010 Projection	2020 Projection	2030 Projection
Medfield	117	108	100	99	110
Medway	143	157	172	191	249
Mendon	54	66	77	91	123
Milford	516	568	621	659	795
Millis	59	67	74	77	90
Natick	608	620	631	635	724
Needham	1,040	1,033	1,027	1,025	1,167
Norfolk	47	48	48	47	55
Northborough	137	148	160	172	221
Sherborn	50	55	60	65	81
Southborough	65	84	103	108	129
Sudbury	214	206	197	220	285
Wayland	213	188	162	168	208
Wellesley	536	583	630	623	716
Westborough	453	435	416	419	494
MetroWest	7,265	7,544	7,823	7,919	9,254

Figure 1 shows the dramatic increase in the early elderly population, starting in 2010, followed by a similar increase in the middle elderly population in 2020. The number in the late elderly population will begin to rise in a more dramatic fashion starting in 2030. This “wave” pattern reflects the “baby boom” generation. The needs of this cohort will shift markedly over the next 30 years. With this information about the size of the future elderly population in mind, we turn to an examination of the characteristics of this group. The detailed population information about MetroWest elders is contained in the 2000 Census, so, to the extent that the MetroWest elderly population increases, the numbers in the detailed categories will increase as well.

Figure 1: MetroWest Elderly Census and Population Projections, 2000-2030



Gender

Women tend to outlive men in virtually all U.S. populations. In MetroWest, within each elderly age group, there exists a surplus of women over men, as shown in Figure 2. The surplus increases with increasing age. As Table 6 shows, in the 65-69 year old group, men and women are quite evenly balanced (1.1:1), whereas among centenarians, the ratio is 9.3:1. Of elders living alone, 23.1 percent are men, and 76.9 percent are women. This may have implications for the kinds of supports and activities afforded men and women in the different age ranges.

Figure 2: MetroWest Population, Residents 65 and over, 2000

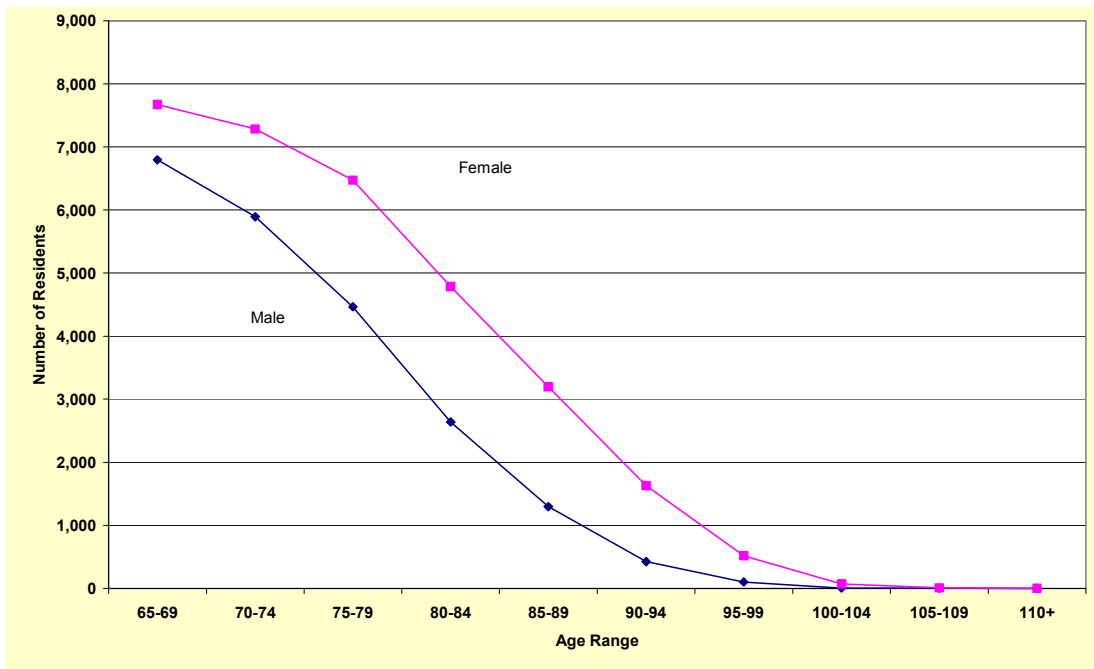


Table 6: Ages of MetroWest Elderly Residents, 2000

Age Range	Male	Female	Ratio of Women to Men
65-69	6,795	7,671	1.1
70-74	5,893	7,282	1.2
75-79	4,465	6,472	1.4
80-84	2,639	4,786	1.8
85-89	1,298	3,195	2.5
90-94	425	1,629	3.8
95-99	102	516	5.1
100+	9	84	9.3

Race and Ethnicity

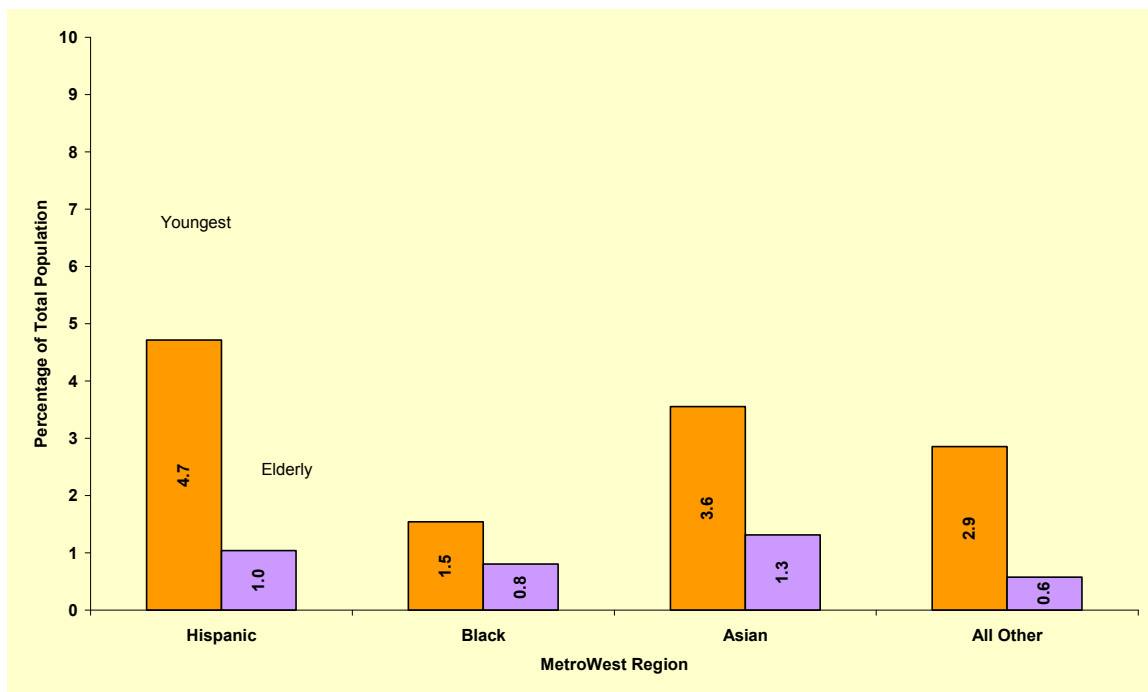
The elderly population in MetroWest is overwhelmingly white, non Hispanic, as shown in Table 7. Only 3.7 percent describe themselves otherwise. This number may have increased somewhat since the 2000 Census, but it is unlikely to have markedly changed. This contrasts with the child and youth populations where marked changes are occurring.

Table 7: Percentage of MetroWest Elderly Residents by Race and Ethnicity, 2000

Race/Ethnicity	MetroWest Elderly Residents	Percentage
Hispanic	554	1.0
Black, Not Hispanic	430	0.8
Asian, Not Hispanic	699	1.3
All Other, Not Hispanic	304	0.6
White, Not Hispanic	51,274	96.3
All	53,261	100.0

In the youngest age group (0-9 years old) 12.7 percent are “persons of color”⁹ or are multiracial, as shown in Figure 3. In addition, whereas the numerically dominant group among the elderly is Asian, among children the numerically dominant group is Hispanic. While quantitative health disparities analyses make sense for the younger age groups, there are too few persons of color among the elderly to produce reliable health estimates for separate racial and ethnicity groups in MetroWest.

Figure 3: MetroWest Residents of Color, for Children (0-9) and Elderly (65+), 2000



Living in Households, Institutions, or Alone

MetroWest elderly live in a variety of household settings recognized by the U.S. Census (see Table 8). Two thirds live in family households, either with a spouse or other relatives, while 26.5 percent live alone, and 7.2 percent live in an institution such as a nursing home. A small number (2.4 percent) of elders may be living in other environments, e.g., group homes. Single persons living in assisted living environments are likely counted under “living alone in a non-family household.” While the patterns for MetroWest are similar to those for the state as a whole, more MetroWest elders live in family households, and fewer live alone. The thousands who do live alone may need additional social supports as they age. Those living in family households may need additional part-time care themselves, or support for their families.

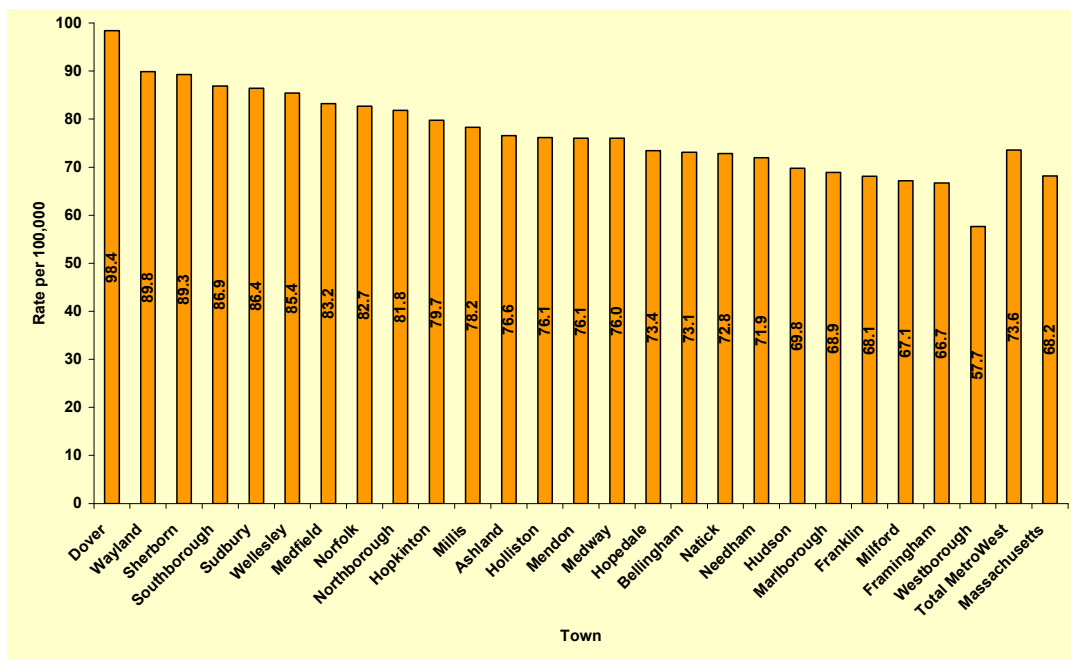
Table 8: Living Situation of MetroWest and Massachusetts Elders, 65+, 2000

Living Situation	MetroWest	MetroWest Percentage	Massachusetts Percentage
Living in a family household	34,018	63.9	61.2
Living alone in a non-family Household	14,113	26.5	29.8
Living in Institution, e.g., nursing home	3,857	7.2	6.2
All other	1,273	2.4	2.8
Total	53,261	100.0	100.0

Elderly Owners and Renters

The federal census classifies all householders according to ownership or rental status. The percentage of elderly ownership is high in MetroWest: 73.6 percent versus 68.2 percent for the state as a whole. Figure 4 illustrates the large variation in home ownership among MetroWest communities, from a high of 98.4 percent in Dover to a low of 57.7 percent in Westborough. This may reflect economic differences and the geographic distribution of assisted living facilities, whose residents are renting, non-institutionalized persons.

Figure 4: Elderly Home Ownership



Elders and Poverty Status

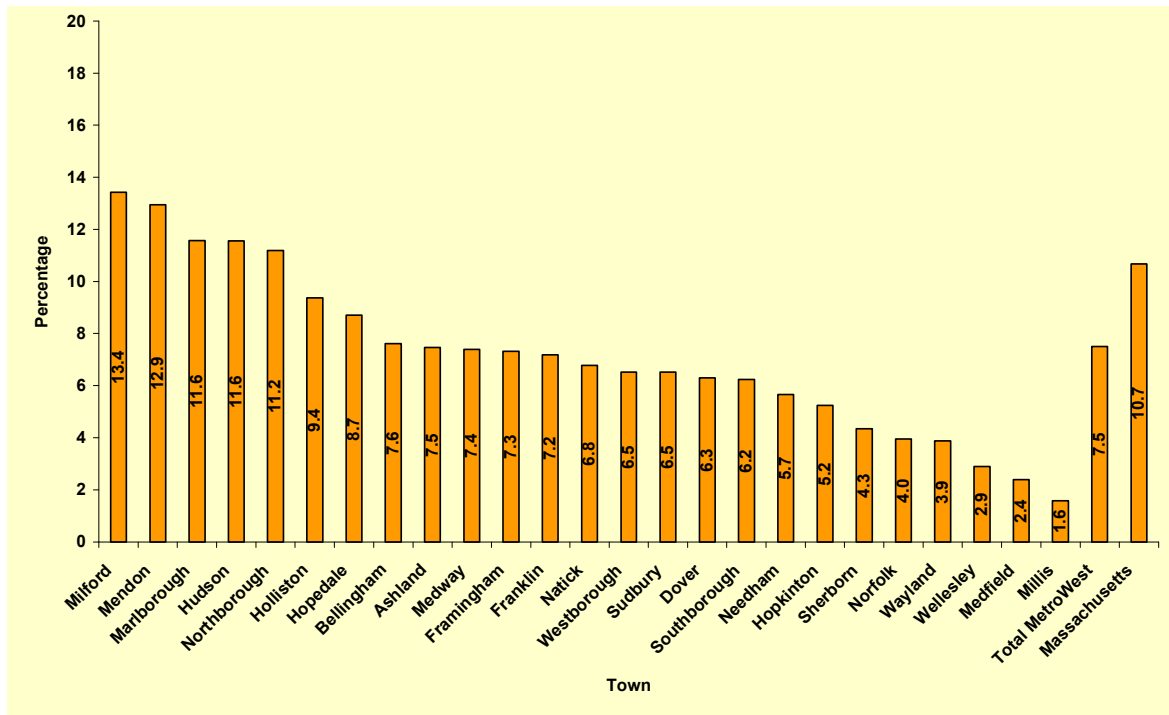
“Following the Office of Management and Budget's (OMB's) Directive 14, the Census Bureau uses a set of money income thresholds that vary by family size and composition to detect who is poor. If the total income for a family or unrelated individual falls below the relevant poverty threshold, then the family or unrelated individual is classified as being ‘below the poverty level.’”⁸ Table 9 shows the criteria used by the Federal census to classify households.

Table 9: Federal Poverty Limit by Size of Family Unit

Size of Family Unit	48 Contiguous States and D.C.
1	\$8,240
2	11,060
3	13,880
4	16,700
5	19,520
6	22,340
7	25,160
8	27,980
For each additional person, add	2,820

Figure 5 illustrates that MetroWest has a lower percent of elders in poverty than the state as a whole, and that there is a large variation between MetroWest communities.

Figure 5: Percent of Elderly Householders below the Federal Poverty Limit



Disability

For health care planning purposes, an important aspect of the elderly population is the extent of disability. The Census 2000 recognized several different types of disability in the elderly: what they defined as sensory, physical, self care and “go-out-side-the-home” disability. These terms are defined in Appendix B. While the use of 2000 data in May, 2010 is not ideal, as yet there are no other sources of town-by-town disability data.

Census 2000 contains tables for persons with “any disability” and those with one disability, by type of disability. Disability statistics are calculated for the “civilian non-institutionalized” elderly population rather than for the total elderly population. This is an important distinction because this definition *excludes* individuals residing in nursing homes (See Appendix A). The *numbers* disabled in the non-institutionalized population are largest in the largest communities, as can be ascertained in Figure 6. In contrast are the high *rates* of disability in the southwestern corner of the region: Mendon, Milford, Hopedale, Franklin and Bellingham, as shown in Figure 7. The reasons for this pattern are currently unknown. The wealthiest communities in the region tend to have the lowest rates of disability. Finally, great attention should be paid to those with multiple disabilities as shown in Figure 8. These are persons likely to need the greatest levels of support.

Figure 6: Count of elderly residents with any disability, civilian non-institutionalized population, 2000

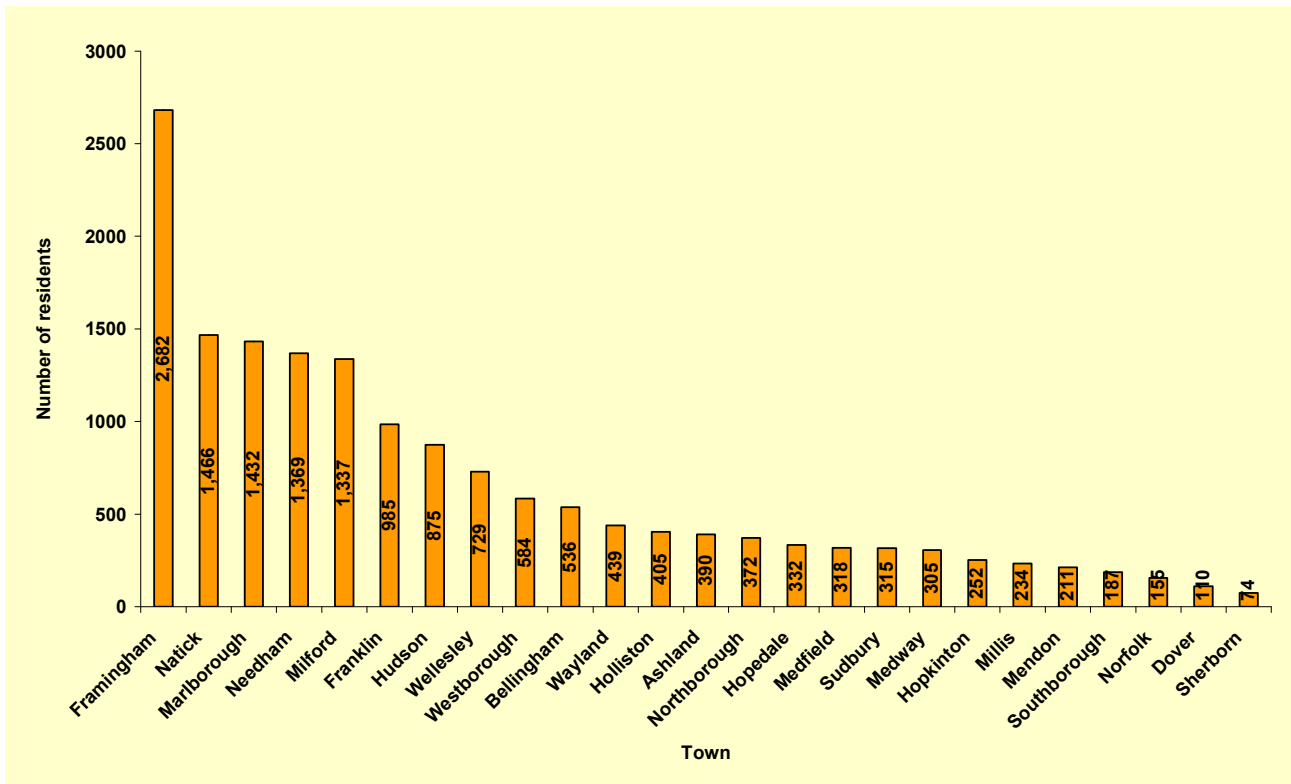


Figure 7: Percentage of elderly residents with any disability, civilian non-institutionalized population, 2000

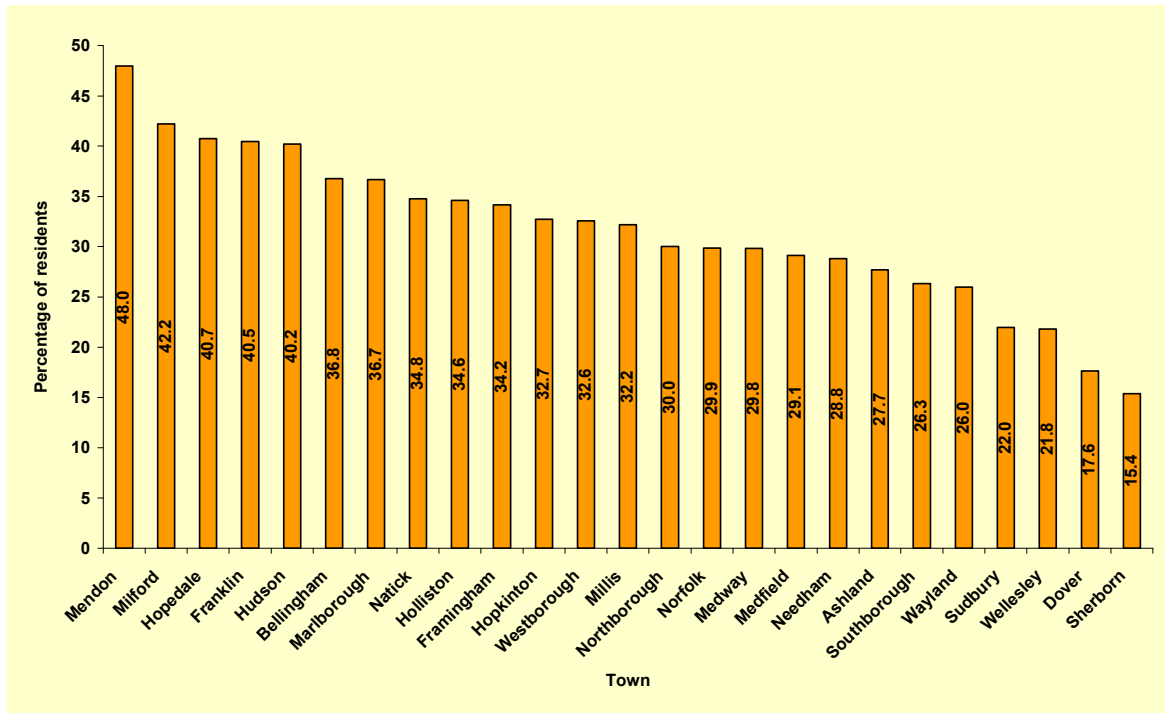


Figure 8: Elderly Persons with Two or More Disabilities

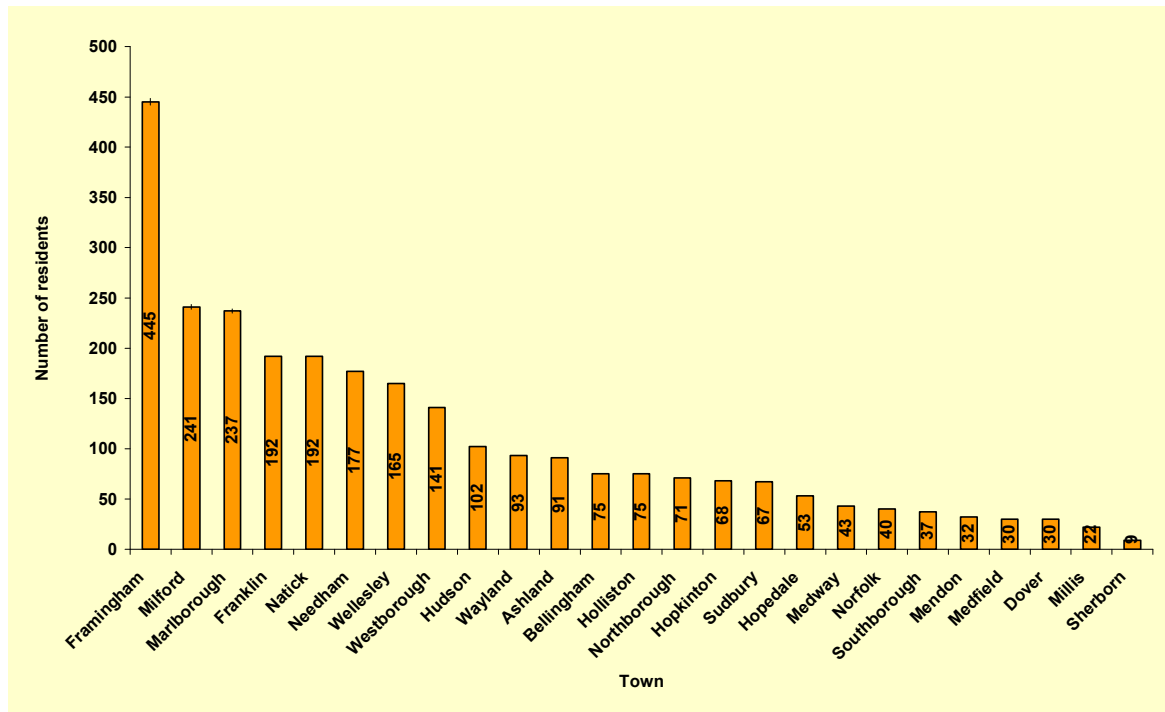


Figure 9: Persons with a single sensory disability

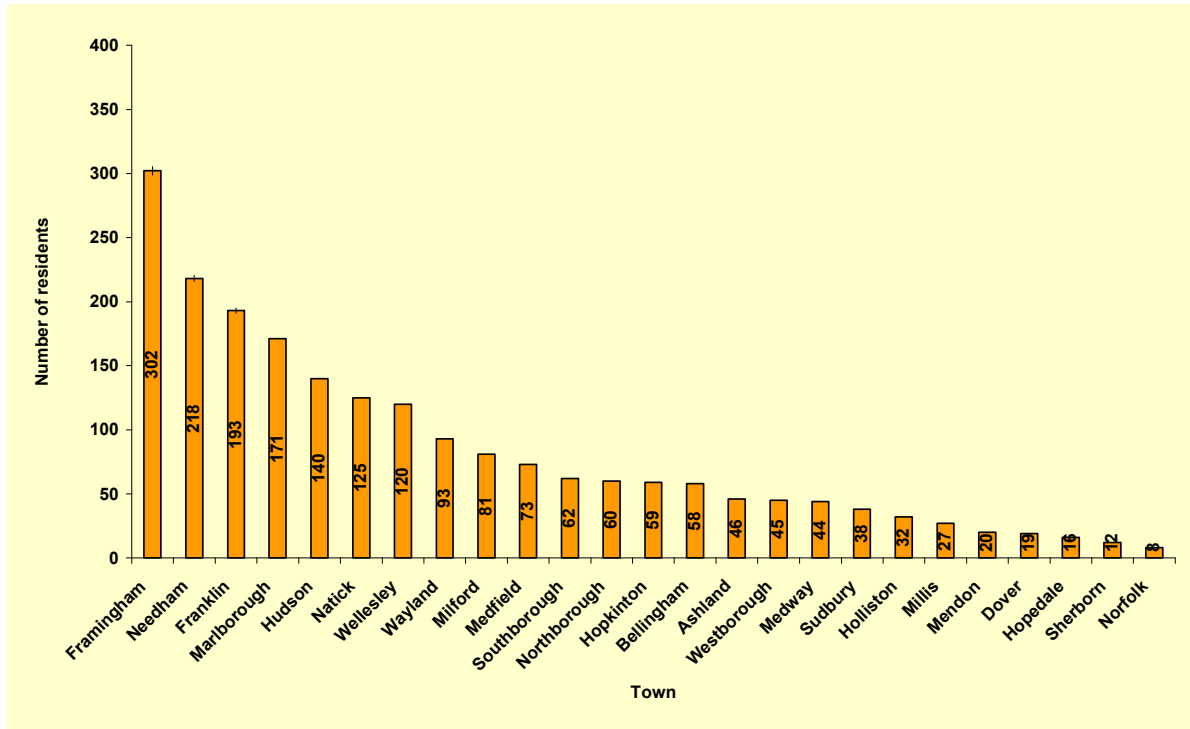


Figure 10: Residents with a single physical disability, 2000

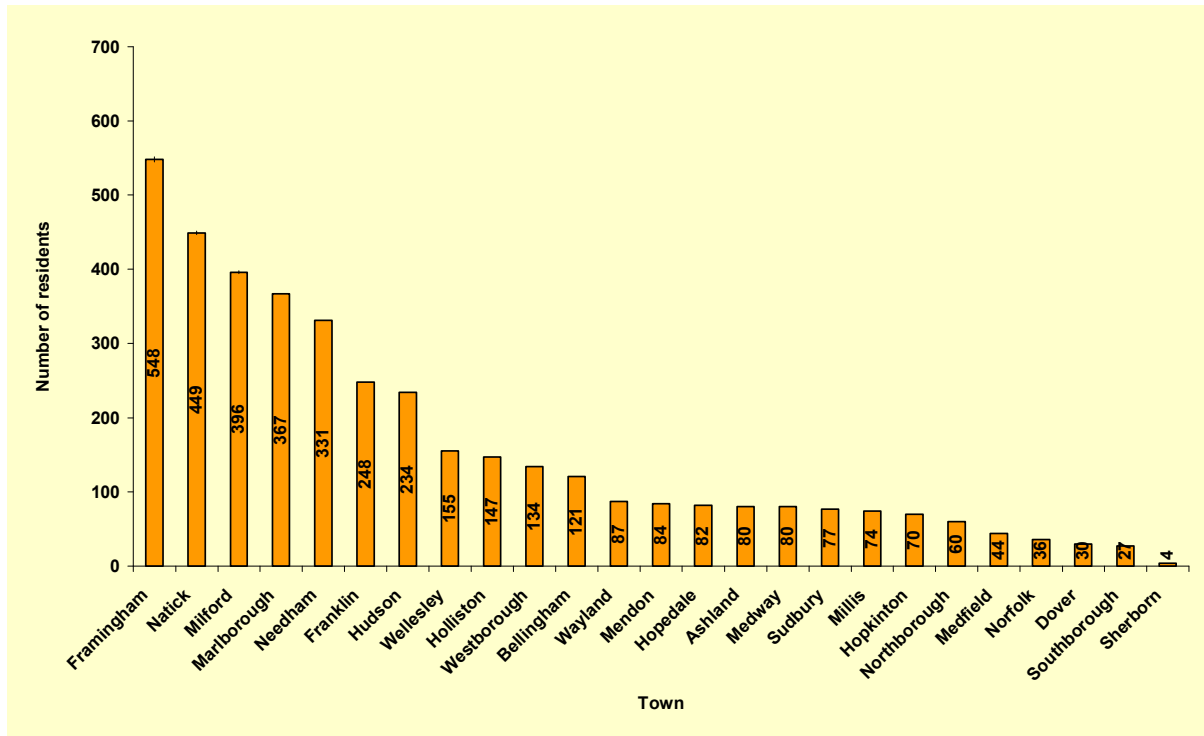
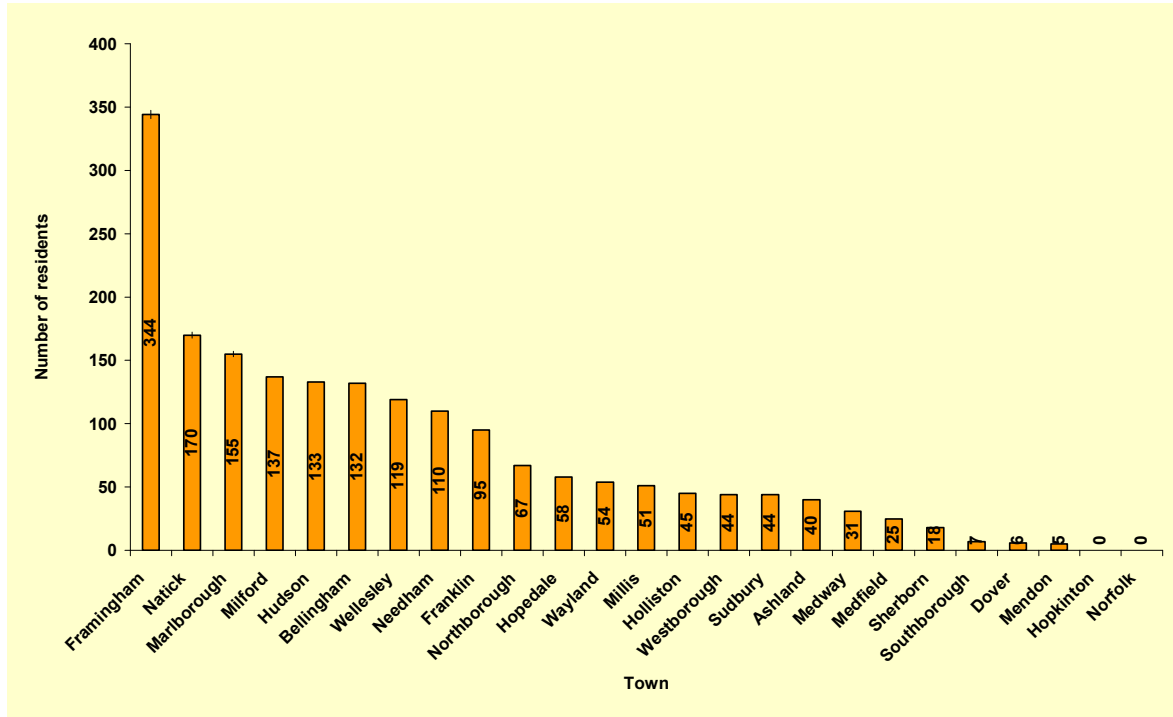


Figure 11: Residents with a single "go-outside-the-home" disability



Mortality

Mortality is a vital topic in any needs analysis prior to community health action for the elderly. If there are important disparities or trends in death rates, the causes or underlying conditions may become the subjects of focused public health responses.

Trends

It is clear from the data in Figure 12 that death rates are declining, for each key age group, since 1994. It is not clear, however, why the death rates for the late elderly, 85 and over, increased during the 1990s, and then fell. It is expected that the rates for this group would be more variable over time, since they are the smallest population group and subject to the largest random fluctuations. Further examination of the underlying population estimates used by MDPH to calculate rates indicates some sharp discontinuities for MetroWest population counts, producing the sharp changes in mortality rates, seen in Figure 13. Further examination of the counts for the 85 and over group as seen in Figure 14 indicates that the mortality count is steadily increasing, as would be expected with an increasing elderly population.

Figure 12: MetroWest Elderly Mortality Rates and Linear Trends, by Age Groups



Figure 13: Difference between MetroWest and Massachusetts Mortality Rates

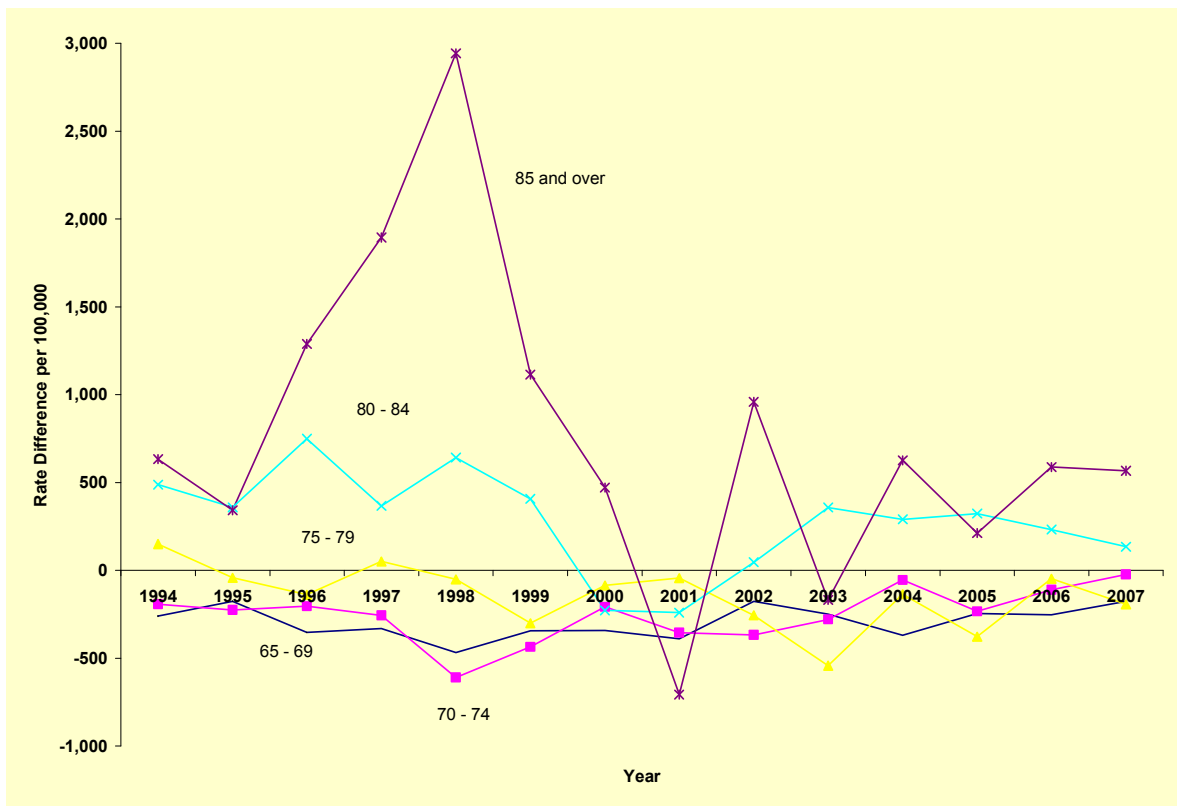


Figure 14: Counts and trend line, annual mortality, 1994-2007

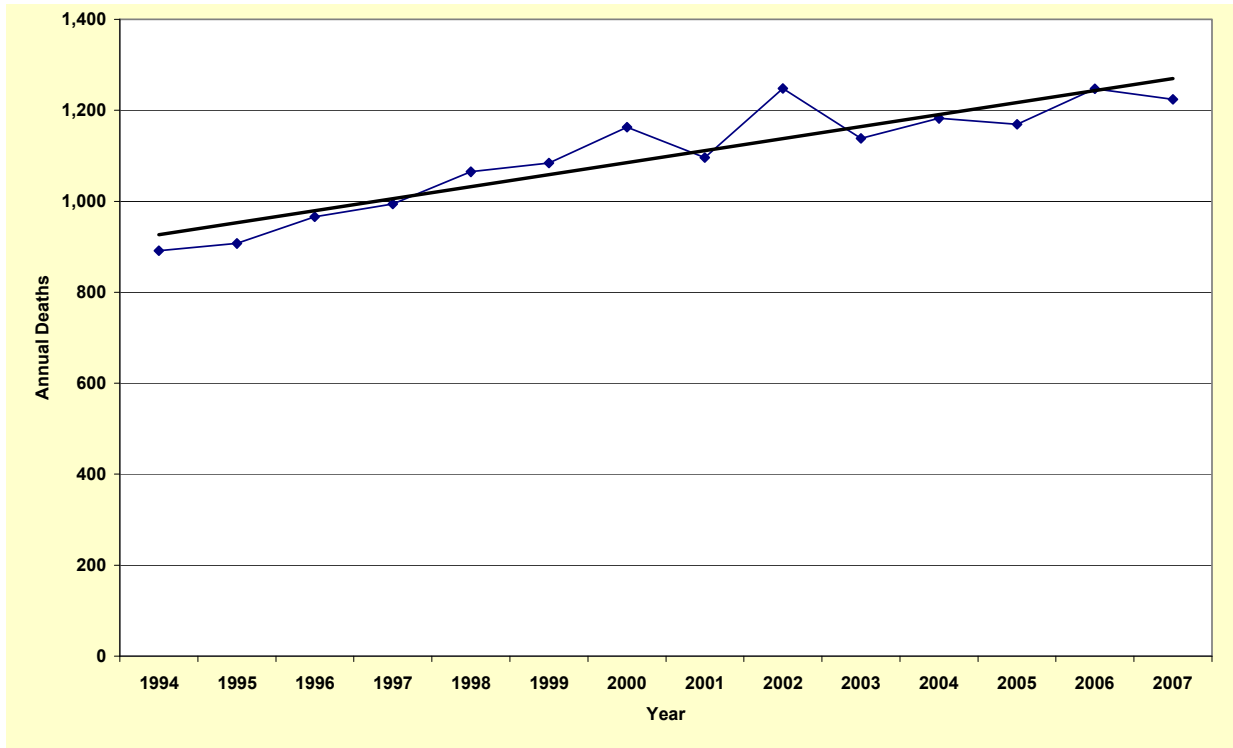


Table 10 shows selected leading causes of elderly death. The various forms of heart disease are the leading causes of death. Among cancers, lung cancer is the most frequent cause of death for MetroWest elderly.

Table 10: Average Yearly Counts of Selected Leading Causes of Elderly Death, MetroWest, 2003-2007

Diagnosis	Age 65-74	Age 75-84	Age 85+	Age 65+	Percent of Total Deaths for Metro-West	Percent of Total Deaths for Massachusetts
All Causes	455.8	938.2	1,192.0	2,586.0	100.0	100.0
Cancer: All Types	184.2	252.0	142.0	578.2	22.4	22.8
Breast (Female)	12.0	13.6	11.6	37.2	1.4	1.4
Colorectal	13.6	22.6	21.2	57.4	2.2	2.3
Lung	56.4	69.4	27.0	152.8	5.9	6.3
Pancreas	13.8	16.8	6.8	37.4	1.4	1.4
Prostate	7.2	16.0	10.8	34.0	1.3	1.5
Cerebrovascular Disease	16.2	59.4	80.6	156.2	6.0	6.6
Heart Failure	6.4	28.6	63.8	98.8	3.8	4.1
Ischemic Heart Disease	64.6	153.0	251.8	469.4	18.2	17.0
Myocardial Infarction, Acute	25.8	52.8	81.0	159.6	6.2	5.9
Diabetes Mellitus	12.4	20.0	20.4	52.8	2.0	2.3
Renal Failure	10.2	21.2	29.2	60.6	2.3	2.8
Septicemia	9.2	16.4	16.8	42.4	1.6	1.8

Diagnosis	Age 65-74	Age 75-84	Age 85+	Age 65+	Percent of Total Deaths for MetroWest	Percent of Total Deaths for Massachusetts
Injuries & Poisonings	11.0	18.6	21.2	50.8	2.0	1.8
Alzheimer's Disease	3.4	34.8	62.6	100.8	3.9	3.8
Chronic Lower Respiratory Diseases (CLRD), All	26.8	55.4	48.4	130.6	5.1	5.4
Pneumonia and Influenza	7.2	33.8	72.2	113.2	4.4	4.0

Disparities

Death counts for non-white elderly in MetroWest are too sparse to determine reliable death rates. This is illustrated in Table 11.

Table 11: Elderly Average Annual Death Counts, by Race and Ethnicity, MetroWest, 2003-2007

Age	White, Non-Hispanic	Black, Non-Hispanic	Hispanic	Asian / Pacific Islander, Non-Hispanic
65-69	174	3	2	1
70-74	264	4	3	4
75-79	381	3	2	2
80-84	539	4	4	4
85 and over	1,175	6	6	4
65 and over	2,533	21	16	15

Note rounding errors

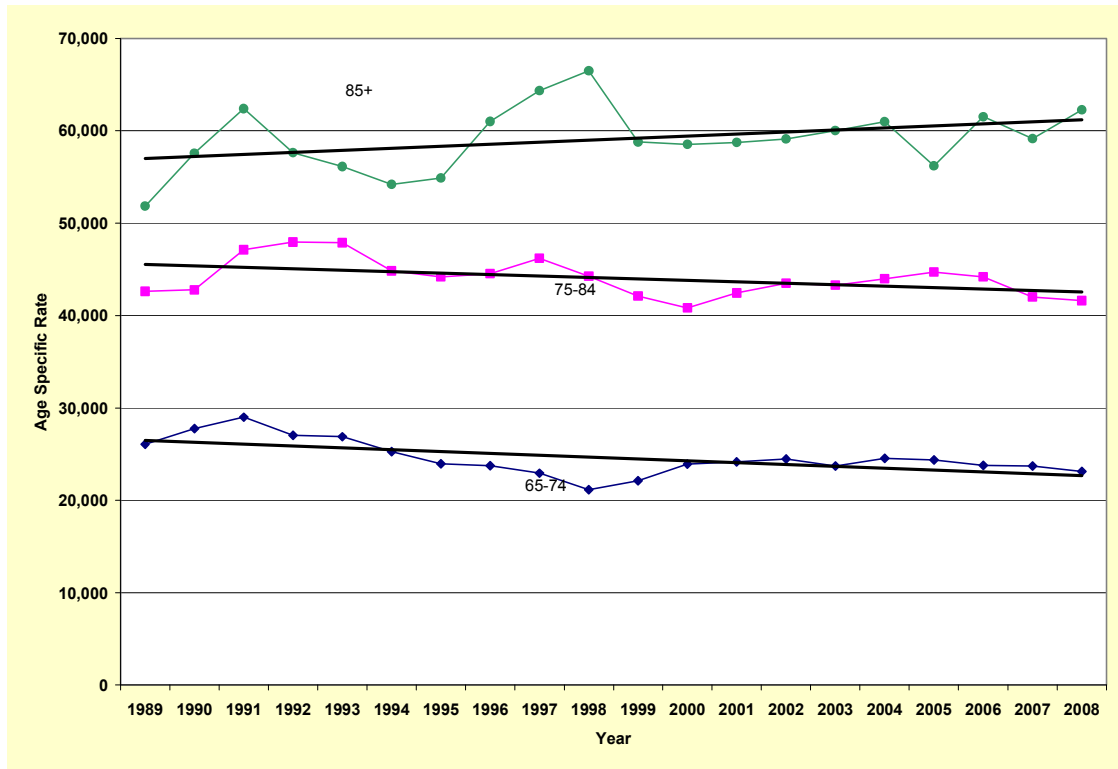
Conclusion

Mortality in MetroWest is comparable with Massachusetts as a whole. The leading type of cancer mortality is that of lung cancer – for which ending smoking in younger generations is virtually the only public health measure known. The other leading causes of death include those described as part of the metabolic syndrome discussed in the MetroWest Databook and Atlas published in 2006. These include heart disease and diabetes, both of which can be impacted in earlier years of life by diet and exercise, and in later years by careful medical follow-up and adherence to treatment.

Hospitalization

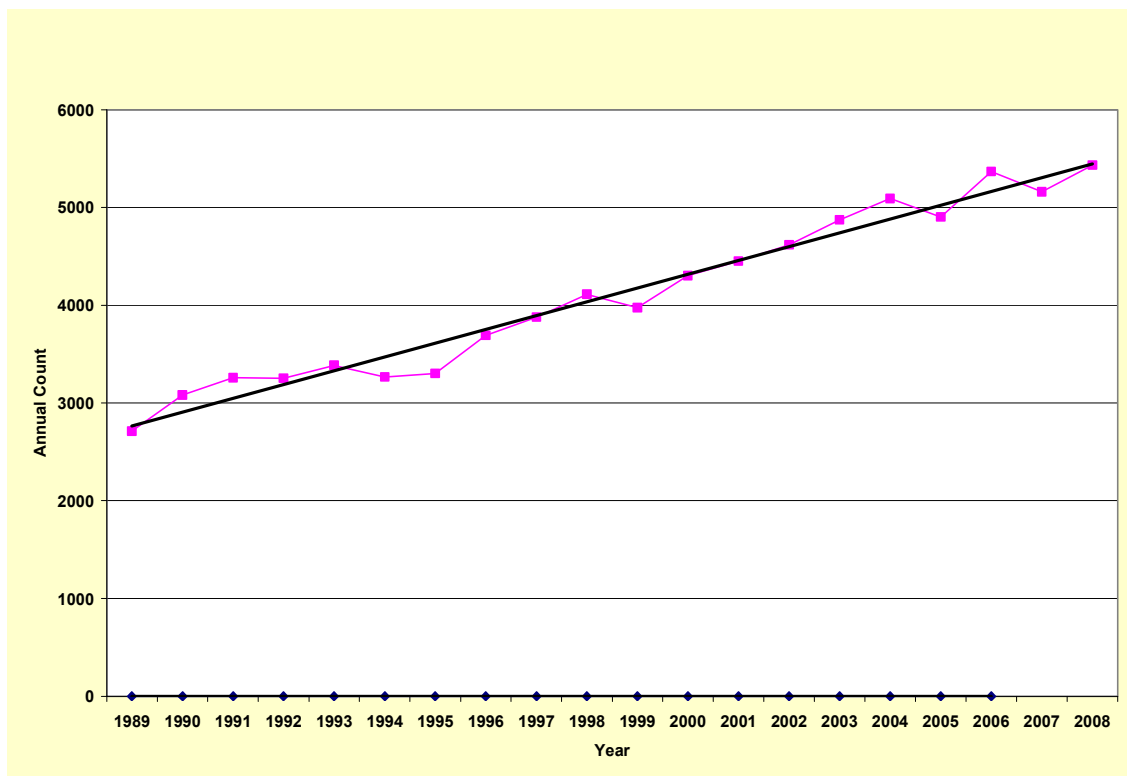
Hospital discharge data are available for MetroWest and Massachusetts from 1989 through 2006. The historical series shown in Figure 15 indicates a slight decline for the age group 65-74, an even smaller decline for the age group 75-84, and an increase for the age group 85 and over. The rates for the 65-74 age group are not significantly different from Massachusetts as a whole, but the MetroWest rates for the two older age groups are consistently higher than for Massachusetts (not shown). The MetroWest rates suggest that more than 1 in 2 residents age 85 and over are hospitalized each year, and/or that some residents in that age range suffer multiple hospitalizations. A further examination of this latter problem might be useful. As with mortality, the fluctuation

Figure 15: MetroWest Hospital Discharge Rates and Linear Trend Lines, per 100,000 Residents, 1989 – 2008



around the trend lines in rates for the age group 85 and over may be due to MDPH population estimation methods, rather than due to underlying disease or care processes. There are no significant deviations from the long-term upward trend in hospitalization counts, at least a portion of which is due to an increasing population, as shown in Figure 16.

Figure 16: Hospitalization counts and trend line, persons age 85 and over, 1989 – 2008



Hospitalization *Counts* by Age and Cause

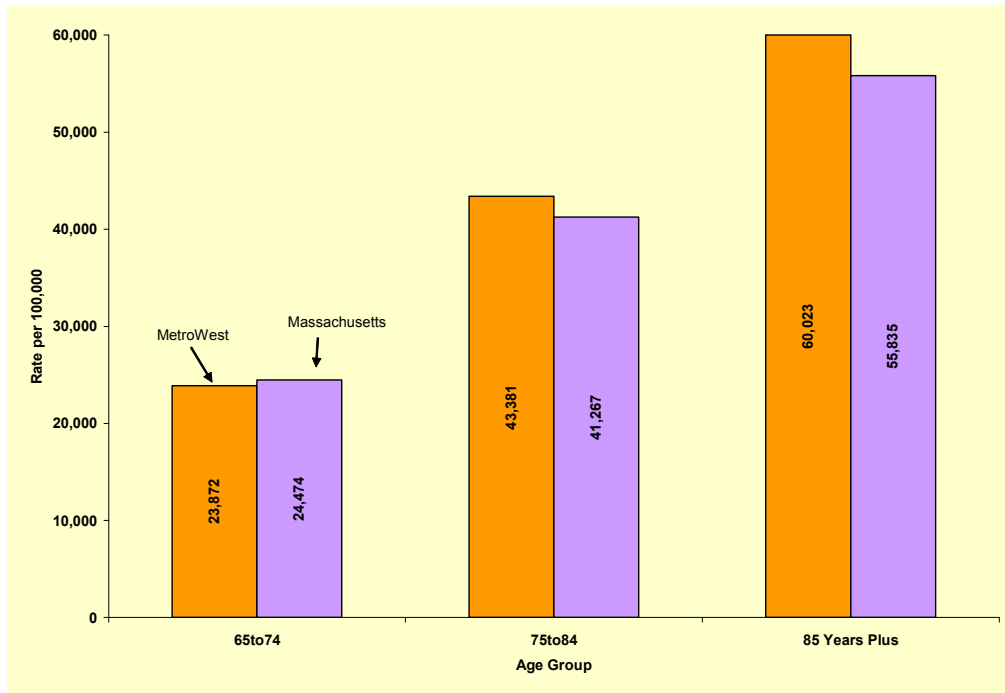
The basic counts of hospitalizations and their causes are an important factor in community health planning and these are presented in Table 12.

Table 12: Hospitalization: Average Counts by Cause, 2003-2008

Causes	Age			
	65 to 74	75 to 84	85 Years Plus	Total
All Causes	6,187	8,238	5,138	19,562
Alcohol / Substance Related	56	39	17	112
Cancer: All Types	462	431	148	1,040
Bladder	15	24	13	51
Breast (Female)	16	15	5	36
Colorectal	51	67	34	152
Kidney	14	14	3	31
Lung	75	65	13	153
Lymphoma, Non Hodgkins	13	17	5	36
Pancreas	14	15	5	35
Prostate	46	13	7	66
Uterine (Corpus Uteri)	14	10	2	25
Cerebrovascular Disease	209	329	210	747
Coronary Heart Disease	528	567	274	1,368
Heart Failure	230	452	448	1,129
Ischemic Heart Disease	525	559	264	1,347
Myocardial Infarction, Acute	200	255	180	635
Chronic Liver Disease	19	9	2	29
Diabetes, Complications of	276	389	216	880
Renal Failure & Disorders	85	150	115	350
Injuries & Poisonings: All	399	810	740	1,949
Falls	212	533	566	1,311
Traumatic Brain Injuries	35	72	63	170
Hip Fractures	52	163	214	429
Osteoarthritis	360	270	48	678
Asthma	50	45	23	118
Bacterial Pneumonia	225	385	343	953
Bronchitis / Chronic & Unspecified	177	231	84	492
Chronic Obstructive Pulmonary Disease (COPD)	239	297	116	651
COPD, All (Related)	1,493	1,972	1,018	4,483
Pneumonia and Influenza	256	430	372	1,058

MetroWest hospitalization rates for all causes are 4 percent lower than Massachusetts rates among 65-74 year olds, but 7 percent higher among 75-84 year olds and 9 percent higher among those 85 and over. Details are in Figure 17.

Figure 17: All-Cause Hospitalization Rate per 100,000, 2003-2008



Hospitalization *Rates*, by Age and Cause

Hospitalization rates are available for over 50 causes, by detailed age categories. A selection of these causes of hospitalization is presented in the following graphics. These causes include “all causes,” falls and diabetes-related complications. MetroWest hospitalization rates for falls are 10 percent lower than Massachusetts rates among 65-74 year olds, but 9 percent higher among 75-84 year olds and 12 percent higher among those 85 and over.

Differences between MetroWest and Massachusetts in elderly hospitalization cannot be explained by the agedness of each age group.

It is tempting to assume that the hospitalization rate differences for falls such as illustrated in Figure 18 are due to age differences within each age group. For example, if 75-84 year olds in MetroWest were markedly older than 75-84 year olds in Massachusetts, then that might explain the higher MetroWest hospitalization rate for falls. But this is not the case. A breakdown of median ages within age ranges for 2000 is detailed in Table 13 and analysis of these median ages (admittedly only an estimate of the median ages in 2003-2006) show marked consistency, except for females 85 and over, where MetroWest females are half a year older than for Massachusetts females as a whole. Thus, only a part of the difference in hospitalization rates could be due to age differences *within* the age groups.

Figure 18: MetroWest and Massachusetts Hospitalization Rates for Falls, 2003-2008

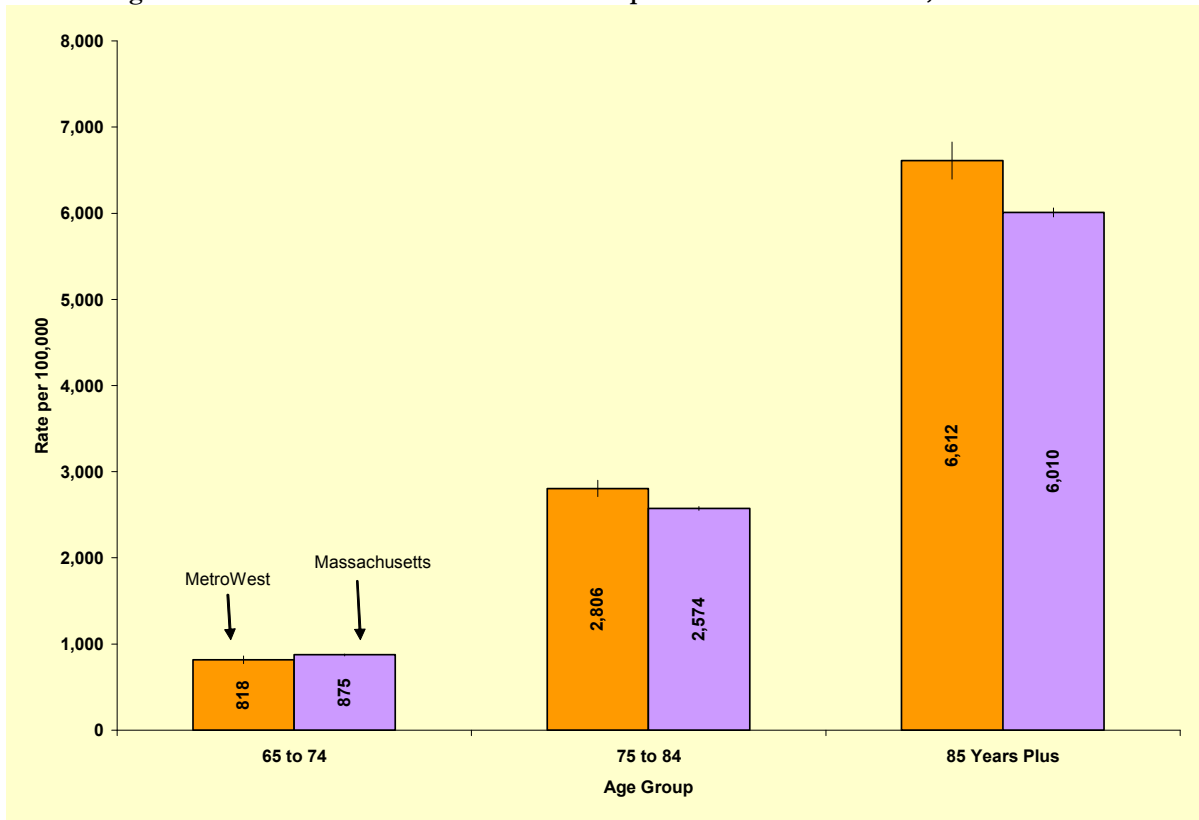
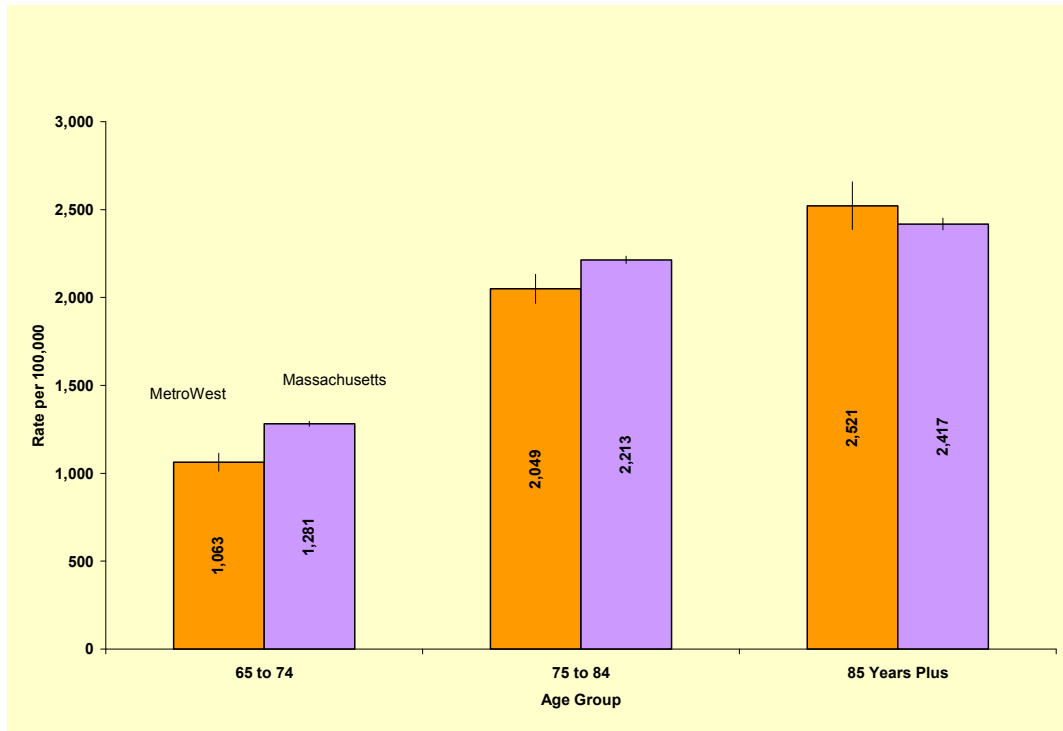


Table 13: Median ages within age ranges

Age	Male		Female	
	Massachusetts	MetroWest	Massachusetts	MetroWest
65-74	68.8	68.6	69.1	68.9
75-84	77.9	77.8	78.4	78.3
85 and Over	86.9	87.1	87.5	88.1

MetroWest differs little from Massachusetts in diabetes-related complications, except in the early elderly, 65-74 year old age group (See Figure 19). Here, MetroWest hospitalization rates are significantly lower than those for Massachusetts. These rates suggest a generally healthier early elderly population, or better primary care to help avoid hospitalization. Nevertheless, diabetes complications are a key area for improvement to avoid the quality of life decrements and costs associated with diabetes-related complications.

Figure 19: Hospitalization for Diabetes-Related Complications, 2003-2008



Payment for Care

As might be expected for an elderly population, most hospital care is paid for by the Medicare program. A small amount is paid by private/HMOs, as is shown in Table 14.

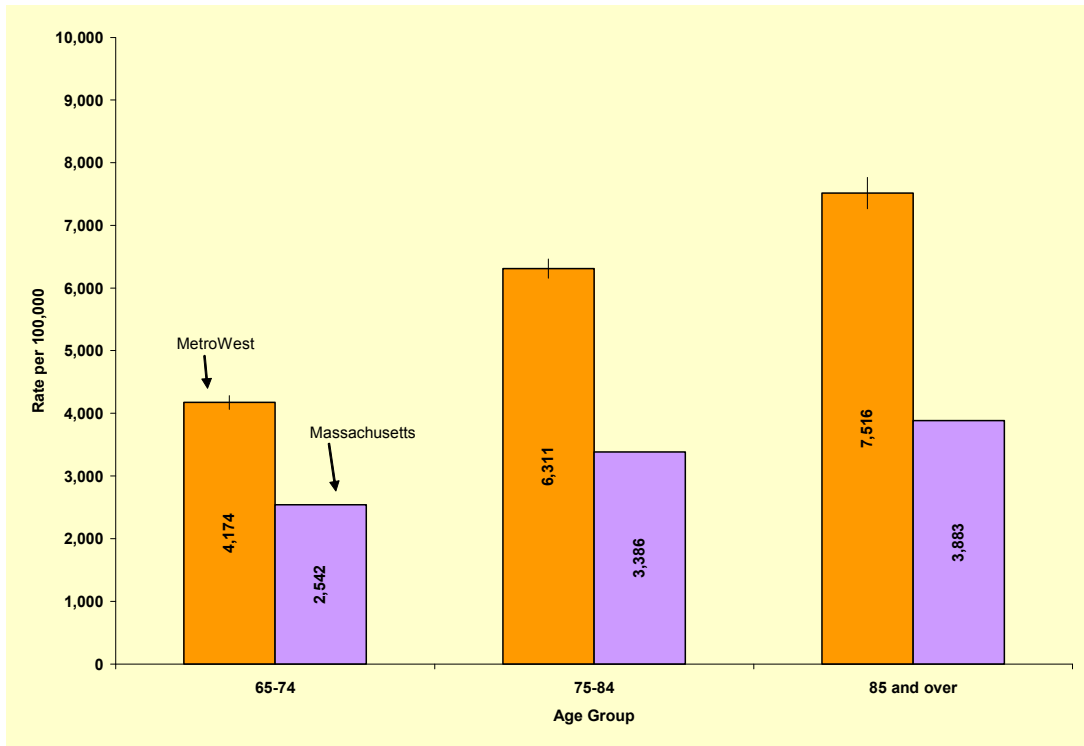
Table 14: Sources of payment for elderly hospital care: percentages, 2003-2008

Age Range	Public/Medicare	Public/Managed Care: Medicare	Private/HMO	All Other
65-74	64.1	16.9	7.1	11.9
75-84	77.6	15.4	4.1	2.9
85 and over	80.9	11.7	4.0	3.4

Hospital Observation Days

“Observation status is an administrative classification seen in hospital emergency rooms or outpatient clinics who have unstable or uncertain conditions potentially serious enough to warrant close observation, but usually not so serious to warrant admission to the hospital. These patients may be placed in beds usually for less than 24 hours without formal admission to the hospital. The designation of ‘observation status’ of patients by hospitals is not well understood. The coding of observation days has the potential to distort traditional measures of inpatient hospital utilization.”⁵⁵ The data indicate that MetroWest elderly patients are recorded for hospital observation days at a far higher rate than for the state as a whole (See Figure 20). It is not clear why this occurs, or whether this is a positive or negative finding. Further investigation is warranted.

Figure 20: Hospital Observation Day Rates per 100,000, 2002-2007



Emergency Visits

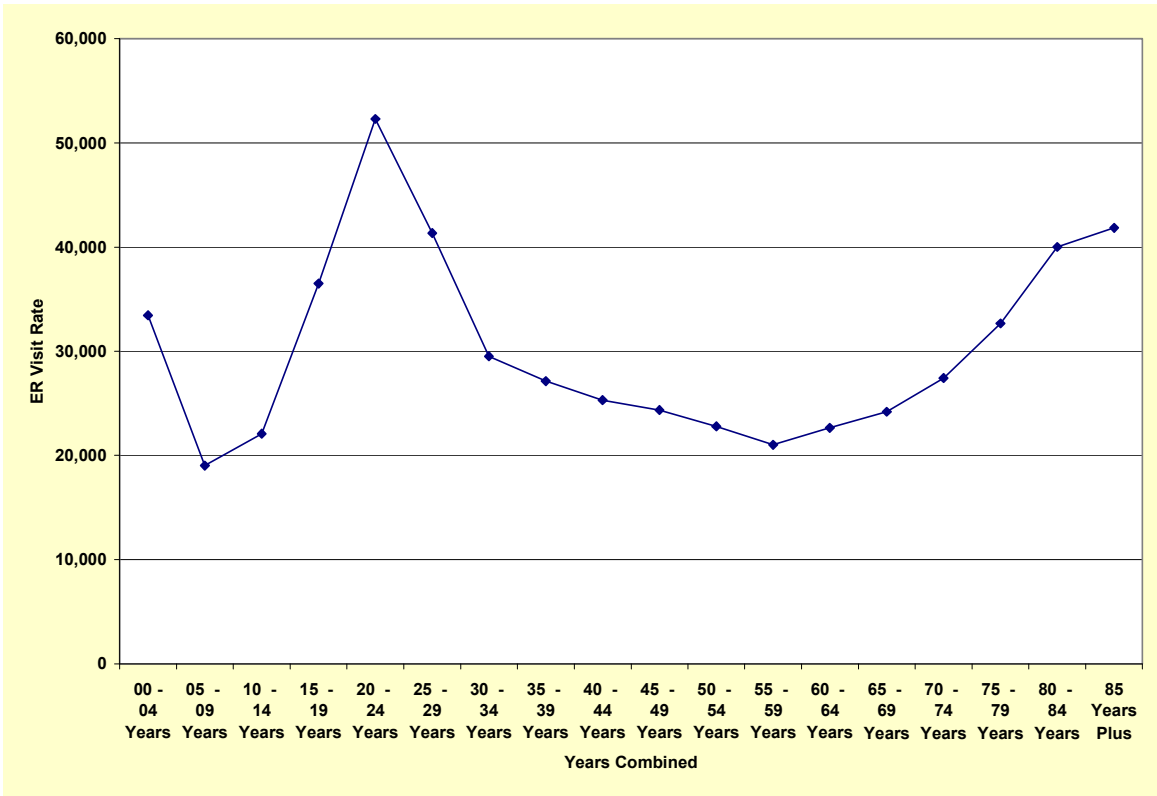
All Visits

Emergency visits are a significant life disruption for elderly persons, as well as being very costly. In addition, many emergency visits are thought to be avoidable. Figure 21 shows the overall emergency visit rate for MetroWest elders. Table 15 shows elderly Emergency Room visits by cause. The following figures and analyses examine specific causes of ER visits.

Table 15: ER Visits by Cause, Residents Aged 65 and Over, 2002-2007

Cause	Average Number of ER visits	Percentage of all ER visits
Falls	2,487	14.6
Diabetes related	1,853	10.9
Chronic obstructive pulmonary disease related	1,054	6.2
Major cardiovascular disease	916	5.4
All Diagnoses	17,016	

Figure 21: ER Visit Rate per 100,000, by Age Group, MetroWest 2002-2007



Falls

Falls are a significant avoidable cause of emergency room visits. There is considerable variation across the life span as is illustrated in Figure 22. Falls drop through age 30-34 and then begin an accelerating increase through the end of life. These data show a much more pronounced “age effect” than for all ER visits. The rapid increase of ER visits for falls clearly suggests the potential for increased fall prevention efforts. Figure 23 indicates that among the elderly, MetroWest has a higher falls ER rate than does Massachusetts as a whole.

Figure 22: Emergency Visit Rates for Falls Throughout the Life-span, 2002-2007

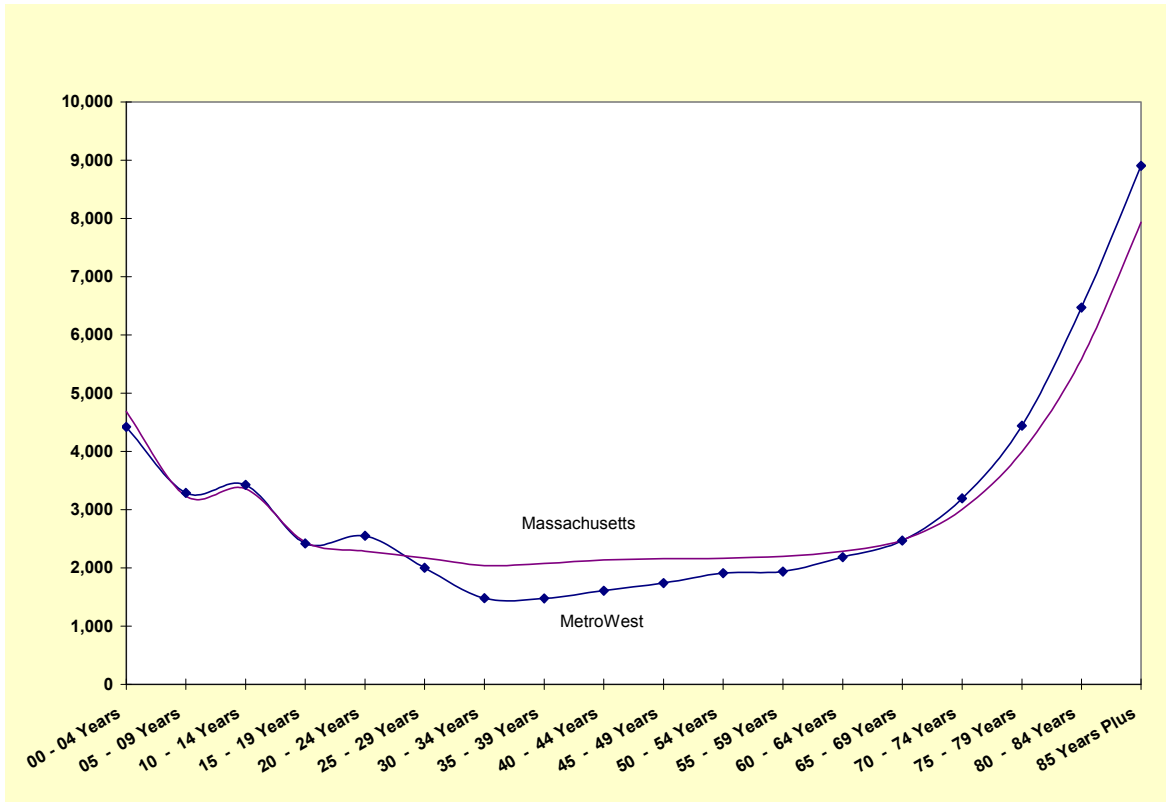
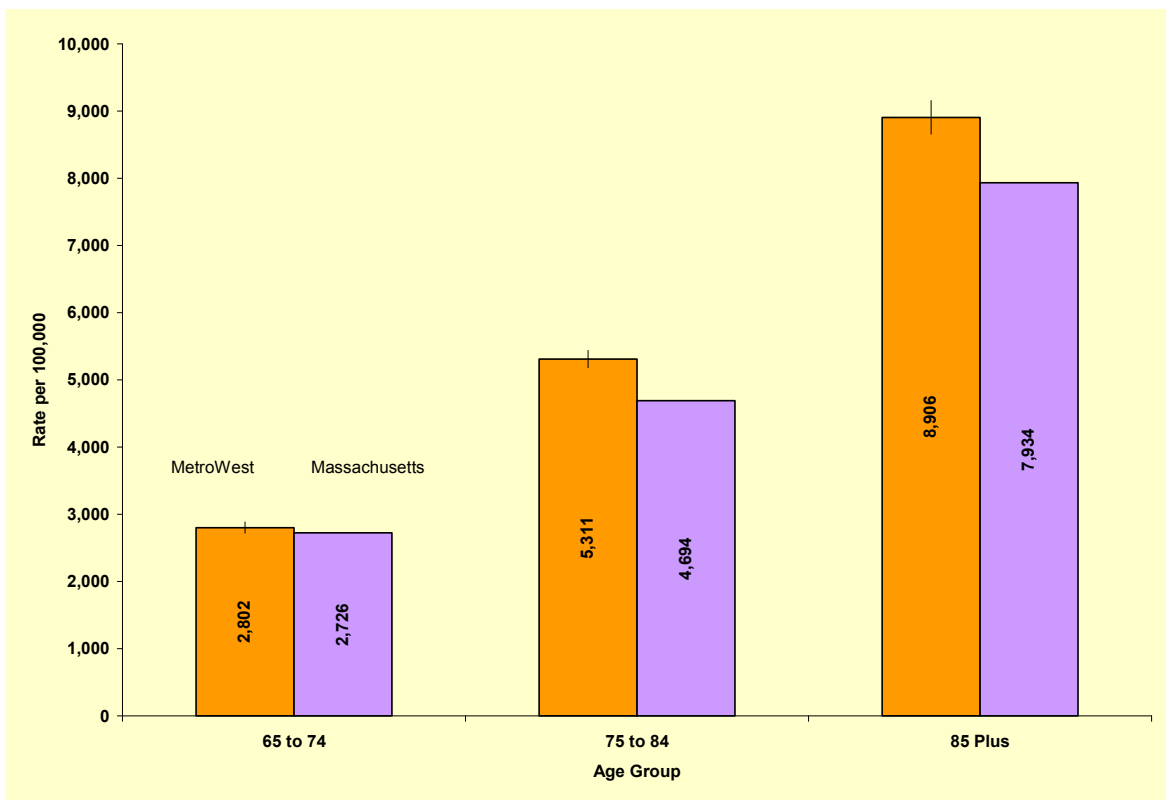


Figure 23: Emergency Visits for Falls, 2002-2007



Taken together, the hospitalization and ER data indicate an increase in severity of injuries from falls with increasing age (See Table 16). While only 28 percent of ER visits are estimated to be accompanied by hospitalization for the age group 65-74, almost three quarters (72 percent) of ER visits are estimated to be accompanied by hospitalization in the age group 85 and older.

Table 16: ER Visits Compared with Hospitalizations for Falls, 2002-2007

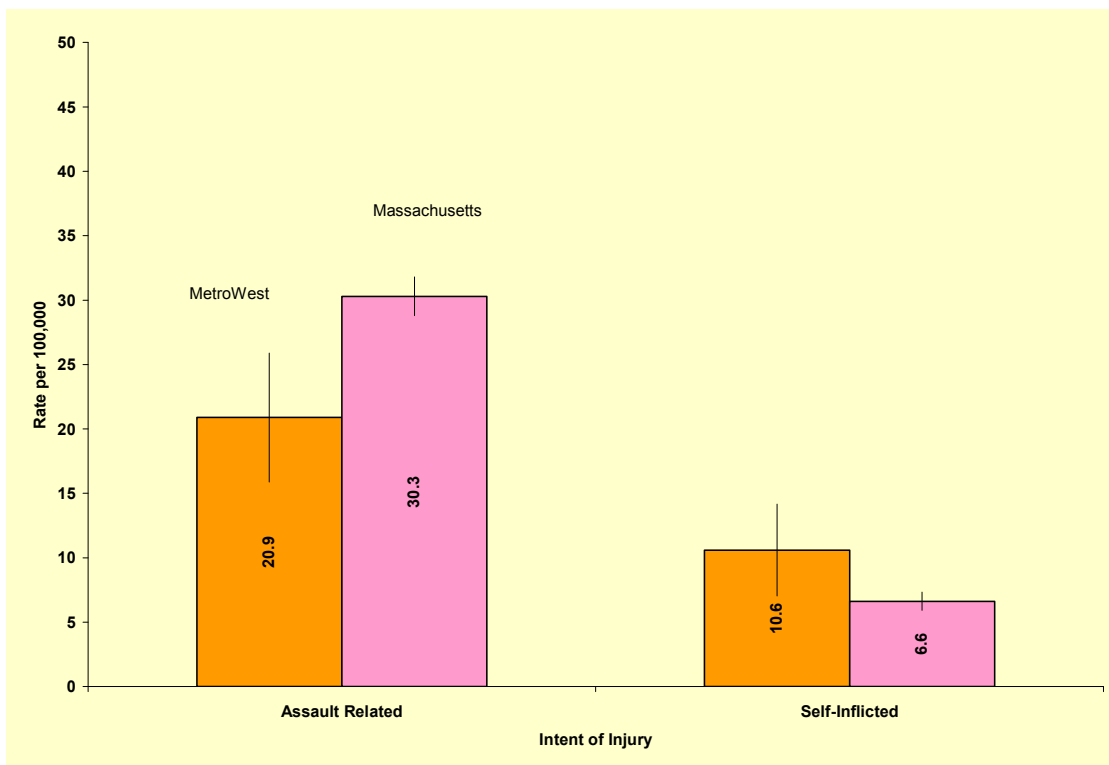
Age	ER Visits	Hospitalization	Ratio Hospitalization/ER
65-74	731	206	.28
75-84	1,008	528	.52
85+	749	552	.74

A further pattern emerges from the falls data. Falls account for a very large percentage of ER visits for the elderly. For example, ER visits for falls in 2002-2007 accounted for 10.9 percent of all ER visits for those aged 65-74, 14.8 percent for those 75-84 and 21.3 percent for those aged 85 and over. For all of those aged 65 and over, falls accounted for 14.6 percent of total ER visits, diabetes-related causes account for 10.9 percent of visits, chronic obstructive pulmonary disease accounts for 6.2 percent, and major cardiovascular disease accounts for 5.4 percent of all ER visits.

Assaults and Self-Inflicted Injuries

ER visits for assault on persons 65 and over are rare in MetroWest and lower than for Massachusetts as a whole. ER visits for self-inflicted injury are low, but slightly higher than for Massachusetts as a whole. (See Figure 24)

Figure 24: ER Visit Rates per 100,000 for Assault and Self-Inflicted Injury, 2002-2007



Cancer Incidence

Cancer is a reportable disease and is tracked by the Cancer Incidence Registry of the Massachusetts Department of Public Health. Reports are generated by local hospital tumor registries, doctors, and laboratories. Typically, cancer incidence data lag several years behind “real time,” to allow the time to do the requisite data quality control. For this report, data through 2006 are available. There has been remarkably little change in cancer incidence in MetroWest in the period 1995-2006, the latest year for which incidence data are available (See Figure 25). Cancer incidence in the elderly is remarkably similar in MetroWest and Massachusetts, as is illustrated in Figure 26.

Figure 25: MetroWest Cancer Incidence Rates per 100,000, by Age, 1995-2006

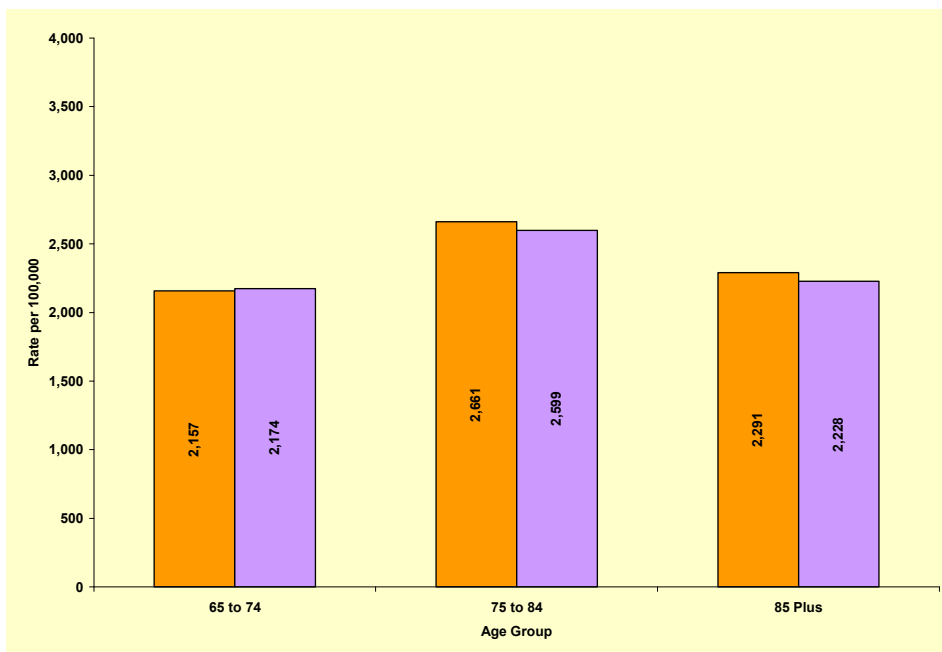
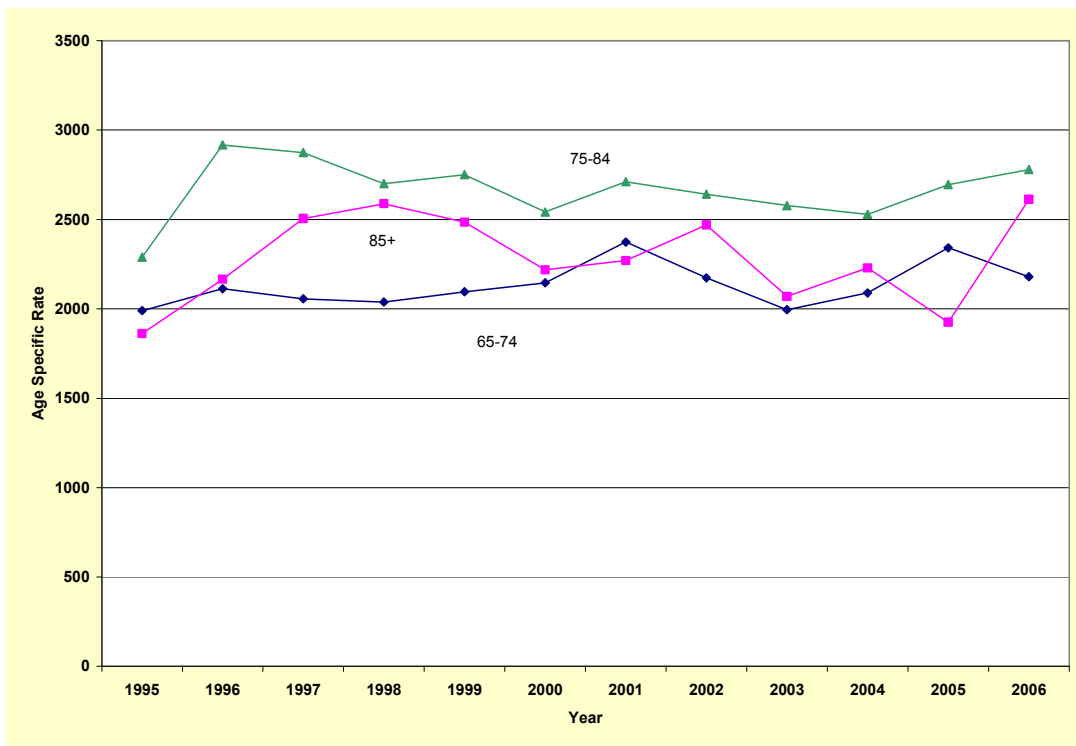


Figure 26: MetroWest and Massachusetts Cancer Incidence - All Types, 2002-2006

Table 17 includes all major invasive cancers. None of the rates are significantly different from Massachusetts cancer incidence rates. The major cancers in MetroWest elderly are prostate, breast, lung and colorectal.

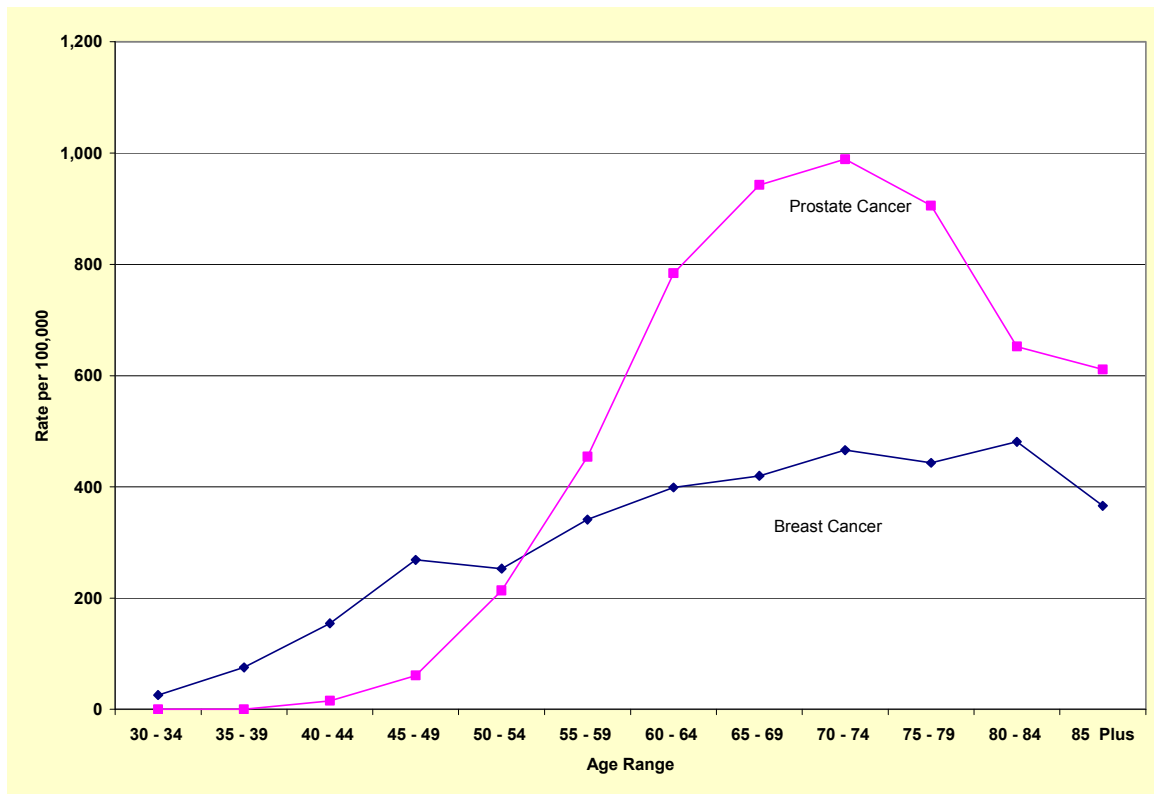
Table 17: Cancer Incidence, by Type

Type of Invasive Cancer	MetroWest Cancer Rate per 100,000, 2002-2006		
	Age		
	65 to 74	75 to 84	85 Plus
All Types	2157.3	2660.6	2291.3
Breast (female)	441.7	460.1	366.1
Colorectal	212.0	376.5	455.4
Lung	358.2	469.3	314.0
Melanoma / Skin	76.5	92.8	79.1
Pancreas	57.4	85.4	81.5
Prostate (male)	963.5	805.7	611.0
Uterine (Corpus Uteri)	121.5	67.0	33.6

Gender Related Cancers

Breast and prostate cancers are the two principal invasive cancers that are gender related. The data show a very different age pattern in MetroWest, as shown in Figure 27. Breast cancer incidence in women rises continuously throughout the lifespan, until age 85. Prostate cancer, on the other hand, is virtually non-existent until age 40-44, then rises rapidly through age 60-64 and declines in the elder years. Prostate cancer therefore has a much higher incidence rate than breast cancer, among the elderly.

Figure 27: Breast and Prostate Cancer Incidence Rate per 100,000 by Age Group



Substance Abuse

The data on substance abuse among the elderly is very weak. The MDPH tracks publicly supported substance abuse admissions. The numbers for Massachusetts as a whole are very small among the elderly, as shown in Table 18 and the numbers for MetroWest are all suppressed for confidentiality concerns. One interesting state-wide pattern is that the percentage alcohol-related cases decreased with age. The other source of alcohol abuse data, the Behavioral Risk Factor Surveillance System survey done each year on the population 18 and over is not available for the elderly population in MetroWest. The best estimate available in terms of demographic similarity to MetroWest is on the “balance of the state” of Massachusetts after taking out the major cities.⁸ For this grouping, 3.4 percent of the elderly admitted to binge drinking and 4.0 percent admitted to heavy drinking.” These rates are almost identical to those for Massachusetts as a whole.

Table 18: Admissions to publicly supported substance abuse treatment, Massachusetts, 2006-2008

Age Range	Average Annual Cases 2006-2007	Percent Alcohol Related
65-69	339	87.6
70-74	123	87.3
75-79	53	84.9
80-84	18	77.8
85+	16	68.5

Similarly, the average annual hospital discharges 2003-2006 for MetroWest residents for alcohol and substance causes is very small: 52 for residents 65-74, 43 for residents 75-84 and only 16 for residents 85 and over.

Prevention

The Behavioral Risk Factor Surveillance System is an annual telephone survey carried out as a partnership between the U.S. Centers for Disease Control and Prevention, and the Massachusetts Department of Public Health. This is a “random digit dialing” survey, so that each resident has an equal chance of participating, unless there are special designs, e.g., to over-sample in certain geographic areas. It should be noted that persons with “cell phones only” are not part of the sample. This is less of an issue for elderly residents than for younger residents. Several of the reports focus particularly on the 65 and over populations, such as for information on flu and pneumonia shots. These items have been reported on the MetroWest Databook website, and are repeated here (See Figure 28 and Figure 29). For flu shots, 77.6 percent of MetroWest elders have received one in the past year, compared with 71.3 of all Massachusetts elders. This is a statistically significant difference. Regarding pneumonia vaccine, 64.4 percent of MetroWest elders have ever received one, as compared with 67.0 percent of Massachusetts elders. This difference is not statistically significant.

MetroWest elderly Black and Asian residents are less likely than are MetroWest white residents to report ever having had pneumonia vaccine. MetroWest Black residents are also less likely than White residents to report having had a flu shot in the past year.

Figure 28: Percentage of MetroWest Elders Who Ever Had Pneumonia Vaccine

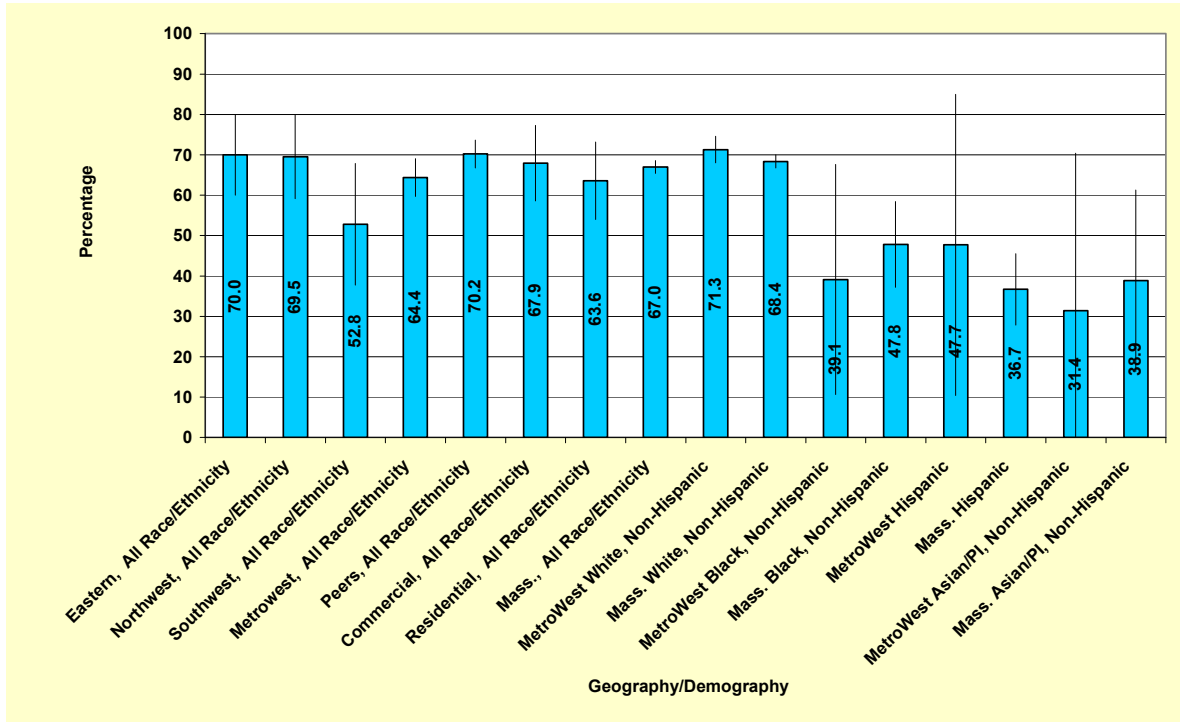
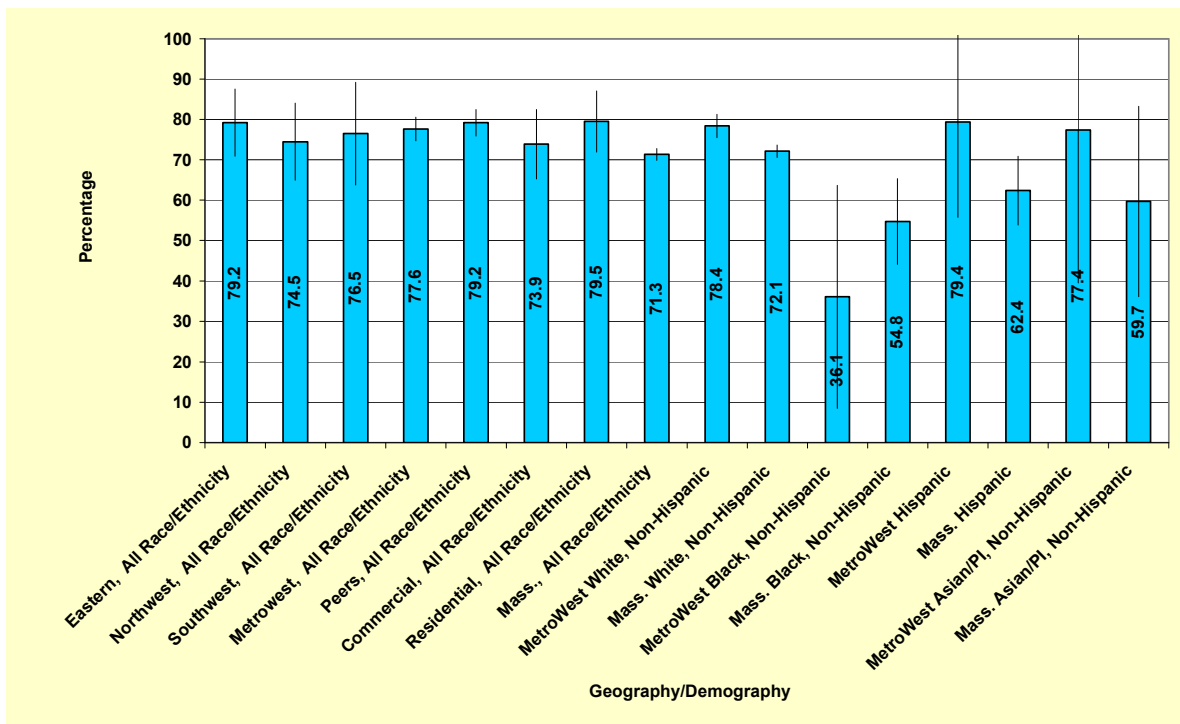


Figure 29: Percentage of MetroWest Elders Who Had Flu Shot in Past Year



Access to Care and Services

Insurance

Only a negligible percentage (0.7 percent) of elders lack health insurance. This is because almost all are on the Medicare program or are Medicare-eligible. The most recent data on the topic of insurance comes from the 2008 American Community Survey of the Federal Census. Most Massachusetts elders claim to have private insurance (74.5 percent) while 80.1 percent of them have public health insurance, presumably Medicare. Thus, many elders claim both private and Medicare coverage.^v MetroWest-specific data are not available.

Elder Services Data and Agencies

No one state agency collects all of the data on elder services provided in the Commonwealth. The Massachusetts Executive Office of Elder Affairs (MEOEA) operates the only database in existence, the Senior Information Management System (SIMS), and it only includes publicly supported services. Therefore, if residents pay for private services, these will not be reported to SIMS. Within these limitations, we can report on several types of services reported to MEOEA.

Elder Services Agencies and Organizations

In this section, we review several types of elder services, including aging service access points (“portals”) that operate to connect elders with appropriate services, nursing home facilities, assisted living and specialized services. The four agencies named as “Access Points” for the towns in MetroWest provide the dominant share of service (99.6 percent). The total number of service units was 1,499,375, delivered to 4,775 individuals for an average of 314 services to individuals for the period July 1, 2008 to June 30, 2009. The agencies listed in Table 19 provide an access point to a wide variety of publicly supported services to elders. The units of service for each agency are listed in Table 20. The types of service, units and costs are listed in Table 21.

Table 19: Elder Service Agencies and Access Points

Aging Services Access Points and MetroWest Towns			
Central Mass Agency on Aging, Inc.	BayPath Elder Services	Springwell, Inc.	HESSCO Elder Services
Bellingham Franklin Hopedale Medway Mendon Milford	Ashland Dover Framingham Holliston Hopkinton Hudson Marlborough Natick Northborough Sherborn Southborough Sudbury Wayland Westborough	Needham Wellesley	Medfield Millis Norfolk

Table 20: Elder Service Agencies and Units of Service for MetroWest Residents

Agency Name	Units of Service
BayPath Elder Services	824,187
Tri-Valley, Inc.	492,249
Springwell, Inc.	105,243
HESSCO Elder Services	71,263
Old Colony Elderly Services, Inc.	1,744
South Shore Elder Services, Inc.	1,236
Greater Lynn Senior Services, Inc.	1,068
SeniorCare, Inc.	568
Bristol Elder Services, Inc	550
Elder Services of Worcester Area, Inc.	420
Mystic Valley Elder Services, Inc.	379
Elder Services of Cape Cod and the Islands	236
Chelsea/Revere/Winthrop Home Care Center	168
Minuteman Senior Services	19
Executive Office of Elder Affairs	17
Boston ElderINFO (Information & Referral)	6
Central Mass Agency on Aging, Inc. (AAA)	5
Boston Senior Home Care	4
Elder Services of Merrimack Valley, Inc.	3
City of Boston, Comm. on Affairs of the Elderly	2
Franklin County Home Care Corporation	2
Greater Springfield Senior Services, Inc	2
Montachusett Home Care Corporation	2
Elder Services of Berkshire County, Inc.	1
North Shore Elder Services, Inc.	1
Somerville/Cambridge Elder Services, Inc	1
Total	1,499,375

Table 21: Publicly Supported Services for MetroWest Residents, July 1, 2008 -June 30, 2009

Type of Service	Units of service	Cost
Administrative Task Fee	1	\$53
Adult Day Health - Basic	1,916	\$102,908
Adult Day Health - Complex	1,047	\$71,686
Assisted Transportation	112	\$0
Bill / Rep Payee (Protective)	131	\$0
Case Management	5	\$0
Chore - Heavy	5,937	\$36,972
Chore - Light	368	\$2,965
Companion	61,845	\$247,902
Congregate Meal Lunch Basic Cold	57	\$257
Congregate Meal Lunch Basic Hot	21,373	\$77,264
Consumer Directed Services	47	\$329

Type of Service	Units of service	Cost
Emergency Shelter	8	\$1,512
Enhanced Personal Life Line	108	\$4,149
Environmental Accessibility Adaptations	100	\$14,718
Friendly Visiting	91	\$0
Grocery Shopping & Delivery	296	\$6,120
HDM Meal Breakfast Weekday Cold	33	\$107
HDM Meal Emergency Meal	2	\$12
HDM Meal Emergency Meal - RDA	10	\$51
HDM Meal Holiday Frozen	257	\$1,505
HDM Meal Holiday Hot	1	\$8
HDM Meal Hot Cultural Weekday Kosher	427	\$2,420
HDM Meal Lunch Weekday Cold	168	\$960
HDM Meal Lunch Weekday Cold/Frozen Therapeutic	64	\$416
HDM Meal Lunch Weekday Frozen	6,346	\$32,948
HDM Meal Lunch Weekday Hot	171,703	\$926,888
HDM Meal Lunch Weekday Hot Therapeutic	9,806	\$50,387
HDM Meal Supper Weekday Cold	16,133	\$93,779
HDM Meal Supper Weekday Frozen	235	\$1,410
HDM Meal Weekend Frozen	7,013	\$38,093
HDM Meal Weekend or Holiday Cold/Frozen	2	\$13
HDM Meal Weekend or Holiday Frozen	84	\$462
Health Insurance Benefits Counseling	4	\$0
Home Health Aide	66,631	\$406,429
Homemaker	685,418	\$3,760,564
Information and Assistance	2,819	\$19
Laundry Services	3,521	\$69,853
Legal Services (Protective)	1	\$180
Medication Dispensing System (Monthly)	309	\$15,373
Nutrition Counseling	16	\$0
Nutrition Education	37	\$0
Nutritional Assessment (Hourly)	7	\$525
Personal Care	322,423	\$1,773,528
Personal Emergency Response Sys (Install)	85	\$3,275
Personal Emergency Response Sys (Monthly)	9,435	\$238,146
Respite - Nursing Facility	21	\$4,585
Skilled Nursing Services	927	\$80,622
Supportive Day Care	1,060	\$18,550
Supportive Home Care Aide	2,487	\$16,998
Telephone Reassurance	44	\$0
Transportation (per Mile)	5,471	\$16,066
Transportation Chair Car Rate 1 (1 way)	1,995	\$23,629
Transportation Rate 1 (1-way trip)	90,931	\$191,105
Wanderer/Locator (Annual service fee)	1	\$25
Wanderer/Locator (one-time registration)	8	\$419
Total	1,499,377	\$8,336,184

Source: Executive Office of Elder Affairs, October 1, 2009

The three most frequent types of in-home publicly supported services are: personal care, homemaker services and home delivered meals. These are reported by town in Table 22.

Table 22: Major Types of Service, by MetroWest Town, for July 1, 2008 to June 31, 2009

Town	Homemaker Units of Service	Personal Care Units of Service	Home Delivered Meals Units of Service	All Units of Service
Ashland	17,692	7,347	5,222	35,544
Bellingham	24,393	13,029	9,200	74,143
Dover	1,059	5,473	42	6,744
Framingham	160,547	70,291	40,029	296,354
Franklin	40,038	17,986	15,413	115,826
Holliston	17,855	7,932	4,455	32,048
Hopedale	15,114	5,032	6,469	29,190
Hopkinton	11,849	3,040	2,919	18,694
Hudson	41,533	34,279	10,939	92,256
Marlborough	50,882	23,727	18,106	117,561
Medfield	13,108	2,230	4,027	32,617
Medway	20,424	4,080	7,489	63,589
Mendon	5,176	1,564	4,744	20,810
Milford	77,515	36,871	32,781	189,030
Millis	13,216	1,484	4,364	25,317
Natick	62,072	27,852	12,869	109,906
Needham	32,212	23,703	4,280	71,257
Norfolk	5,969	1,736	2,366	11,197
Northborough	13,662	5,554	3,775	28,909
Sherborn	2,022	202	11	2,361
Southborough	6,021	7,052	2,732	17,889
Sudbury	11,756	3,864	4,963	25,077
Wayland	12,049	3,425	3,238	19,021
Wellesley	16,121	7,309	5,772	35,367
Westborough	13,133	7,361	6,079	28,670
Total	685,418	322,423	212,284	1,499,375

Congregate meals combine nutrition and the socialization that may be important to elders who are otherwise isolated. The numbers of congregate meals served by town are shown in Table 23.

Table 23: Congregate Meals Served, by MetroWest Town of Residence, 2008

Town	Persons or Consumer Groups	Units of Service
Ashland	2	76
Bellingham	9	145
Dover	1	138
Framingham	26	721
Franklin	5	72
Holliston	4	101
Hopedale	35	380
Hopkinton	1	4
Hudson	13	325

Town	Persons or Consumer Groups	Units of Service
Marlborough	23	355
Medfield	46	4,162
Medway	34	972
Mendon	82	1,537
Milford	55	1,547
Millis	51	3,353
Natick	8	108
Needham	82	4,255
Norfolk	24	676
Northborough	4	80
Sherborn	1	81
Southborough	5	132
Sudbury	18	230
Wayland	2	2
Wellesley	50	1,256
Westborough	28	722
Total	609	21,430

The foregoing data are principally for persons living in “traditional” housing. For those who have a need to move to more supportive environments, there are many possibilities, including assisted living and nursing homes, and a wide variety of other care settings. These are detailed in Tables 24-26. An examination of the data shows a large concentration of facilities in the Natick, Framingham and Westborough area, presumably drawing residents from the smaller towns in the region. It is unknown how many MetroWest residents use facilities in neighboring towns outside of the MetroWest region, or further afield.

Table 24: Assisted Living and Specialized Care Units in MetroWest

Assisted Living and Specialized Care Units in MetroWest				
Name of Residence	Town	Assisted Living	Specialized Care	Total
Atria Draper Place	Hopedale	68	18	86
Avery Crossing	Needham	60		60
Carmel Terrace	Framingham	69		69
Christopher Heights	Marlborough	83		83
Coleman House	Northborough		11	11
Forge Hill	Franklin	65	19	84
Golden Pond	Hopkinton	122	46	168
Hearthstone Alzheimer Care	Hopkinton		25	25
Hearthstone Alzheimer Care	Marlborough		45	45
Heritage at Framingham	Framingham	58	40	98
New Horizons???	Marlborough			0
Orchard Hill at Sudbury	Sudbury	45		45
Robbie's Place	Marlborough		22	22
Summerville at Farm Pond	Framingham	78	22	100
Traditions of Wayland	Wayland	76		76
Whitcomb House	Milford	68		68
Whitney Place at Natick	Natick	39	49	88
Whitney Place at Northborough	Northborough	75	28	103
Whitney Place at Westborough	Westborough	60	46	106
Total		966	371	1337

Table 25: Nursing Home Facilities in MetroWest

Nursing Home Facilities in MetroWest		
Facility Name	Town	Beds
St. Patrick's Manor	Framingham	333
Countryside Nursing Home Inc	Framingham	30
Carlyle House	Framingham	55
Oak Knoll Healthcare Center	Framingham	123
Resident Care Rehabilitation & Nursing	Framingham	91
Bethany Skilled Nursing Facility	Framingham	101
Kathleen Daniel	Framingham	124
Franklin Skilled Nursing & Rehabilitation Center	Franklin	82
Timothy Daniels House	Holliston	40
Continuing Care Center At Hopedale	Hopedale	70
Marie Esther Health Center Inc	Marlborough	29
Bolton Manor Nursing & Rehabilitation Center	Marlborough	149
Marlborough Hills Healthcare Center	Marlborough	196
Thomas Upham House	Medfield	42
Medway Country Manor Skilled Nursing & Rehabilitation	Medway	123
Geriatric Authority Of Milford	Milford	85
Milford Care And Rehabilitation Center	Milford	135
Blaire House Of Milford	Milford	73
Eliot Healthcare Center	Natick	126
Beaumont Rehabilitation & Skilled Nursing Center - Natick	Natick	53
Mary Ann Morse Nursing & Rehabilitation	Natick	123
Avery Manor	Needham	142
Wingate At Needham Rehabilitation & Skilled Nursing Residence	Needham	142
Skilled Nursing Facility At North Hill	Needham	72
Briarwood Healthcare And Nursing Center	Needham	120
Coleman House	Northborough	45
Beaumont Rehabilitation & Skilled Nursing Center - Northborough	Northborough	96
Riverbend Of South Natick	Natick	55
Sudbury Pines Extended Care	Sudbury	92
Wingate At Sudbury Rehabilitation & Skilled Nursing Residence	Sudbury	142
Wayland Nursing & Rehabilitation Center	Wayland	40
Newton And Wellesley Alzheimer	Wellesley	110
Elizabeth Seton	Wellesley	84
Beaumont Rehab & Skilled Nursing Center - Westborough	Westborough	152
Westborough Health Care Center	Westborough	123
Total		3,598

Table 26: Group Housing in MetroWest

Continuing Care Retirement Communities		
North Hill	Needham	
Willows at Westborough	Westborough	
Rest Homes		
Mill Pond Rest Home	Ashland	
Vernon House	Framingham	
Willowbrook Manor Rest Home	Millis	
Hospice		
Care Alternatives Hospice	Marlborough	
Aseracare Hospice	Wellesley	
Beacon Hospice	Framingham	
Framingham		
Wayside Hospice	Wayland	
Congregate Housing		
Memorial House	Framingham	66 units
William Coolidge	Natick	20 units
Supportive Housing		
Linden-Chambers	Needham	112 units
Memorial Housing	Framingham	See congregate

Summary of Findings

A summary of findings for this report is presented on pages 7-8, as part of the Executive Summary.

Appendix A: Elderly Housing and Household Definitions

Group Quarters – U.S. Census Definition

“The group quarters population includes all people not living in households. This term includes those people residing in group quarters as of the date on which a particular survey was conducted. Two general categories of people in group quarters are recognized: 1) the institutionalized population which includes people under formally authorized supervised care or custody in institutions at the time of enumeration (such as correctional institutions, nursing homes, and juvenile institutions) and 2) the non-institutionalized population, which includes all people who live in group quarters other than institutions (such as college dormitories, military quarters, and group homes). The non-institutionalized population includes all people who live in group quarters other than institutions.”¹⁰

Nursing Homes and Assisted Living Facilities

The U.S. Census makes an important distinction between nursing homes and assisted living facilities. Nursing homes are considered part of the institutionalized population. Assisted living facilities are considered part of the non-institutionalized population. Thus, elderly residing in nursing homes are not included in the tables for disability, whereas residents of assisted living facilities are included in these tables.

Nursing Homes

“Nursing homes are residences for people who need skilled nursing care. Nursing homes are also called skilled nursing facilities. Nursing homes offer long-term care and short-term care. Long-term care is for people who can no longer live independently because of physical, emotional, or mental problems. Short-term care is for people who need rehabilitation to be able to live independently again.

Nursing homes provide shelter, meals, social activities, and assistance with activities of daily living. They also provide 24-hour skilled nursing care and rehabilitative services. Some nursing homes have special sections for people with specific conditions such as Alzheimer's disease.

Nursing homes can be non-profit or for-profit organizations. Some non-profit nursing homes have religious affiliations. All nursing homes are licensed by the Department of Public Health.”¹¹

Assisted Living Facilities

“Assisted living residences are a special combination of housing and personalized support services designed to meet the needs--both scheduled and unscheduled--of those who require help with activities of daily living (ADL's). Activities of daily living include tasks related to bathing, dressing, grooming, eating, and other similar personal care needs. Most assisted living residents are in their mid-80's and need assistance with basic activities such as bathing and dressing, meal preparation, housekeeping, shopping and transportation. Often, residents move to assisted living when they can no longer safely live alone.”¹²

Nursing Home – Assisted Living – Congregate Housing Continuum

“Assisted living fits in the continuum between shared living arrangements such as congregate housing and the more intensive medical and skilled nursing services provided by nursing facilities. One of assisted living's defining features is the individualized personal care provided to residents who need assistance with activities of daily living or help (such as reminders) with medications. Personal care services offered in assisted living cover a broad range of activities of daily life to assist the resident in maintaining the highest level of dignity and independence possible. An individualized service plan is developed for each resident and is revised as new needs arise. The service plan identifies resident needs and implements plans to meet those needs. Assisted living also can provide a structured setting for residents who are experiencing memory loss.”¹³

Congregate Housing

“Congregate Housing is a shared living environment designed to integrate the housing and services needs of elders and younger disabled individuals. The goal of Congregate Housing is to increase self-sufficiency through the provision of supportive services in a residential setting. Congregate Housing is neither a nursing home nor a medical care facility. It does not offer 24-hour care and supervision. Services are made available to aid residents in managing Activities of Daily Living in a supportive, but not custodial environment. Each resident has a private bedroom, but shares one or more of the following: kitchen facilities, dining facilities, and/or bathing facilities. Throughout the state there are many variations in size and design.”¹⁴

Supportive Housing

“Supportive housing is public housing for seniors, with on-site support services. Residents have 24-hour access to services in their homes, similar to an assisted living facility.

Depending on income and need, residents may qualify for free case management and support services through the Massachusetts Home Care Program. Residents not eligible for the Home Care program may purchase a service package, or pay for services as needed.”¹⁵

Adult Family Care (AFC)

“Adult Family Care (AFC), also called Adult Foster Care, is a program for frail elderly adults and adults with disabilities who cannot live alone safely. AFC adults live with trained paid caregivers who provide daily care. Caregivers may be family members (except legally responsible relatives), or non-family members.

The program is for adults who need daily help with personal care, but want to live in a family setting rather than in a nursing home or other facility. The caregiver provides meals, companionship, personal care assistance, and 24-hour supervision. Caregivers may be individuals, couples, or larger families.

Caregivers receive up to \$18,000 per year from MassHealth to provide care to MassHealth members who otherwise would need institutional care. Service providers, including a social worker and registered nurse, train the caregiver and provide ongoing support.

Note: Adult Family Care (AFC) now includes the pilot project, Enhanced Adult Family Care (EAFC).”¹⁶

Selected Definitions used by the Massachusetts Executive Office of Elder Affairs

- Activities of Daily Living (ADLs) - Tasks, including the ability to bathe, dress/undress, eat, toilet, transfer in and out of bed or chair, get around inside the home, and manage incontinence, which are used to measure the Functional Impairment Level of an Applicant or Client.
- ASAPs - Aging Services Access Points
- Applicant - An individual who has applied for Home Care Program services by entering into an intake process by telephone, mail or in person as documented by the ASAP.
- Assisted Living Residence - An entity certified by Elder Affairs under 651 CMR 12.03 defined in 651 CMR 12.02 which provides room, board, and personal care services to residents.
- At Risk - Elders who are experiencing substance abuse, mental health problems or cultural or linguistic barriers to care.
- Caregiver - A family member regardless of place of residence, or a non-family member living in the same residence as a Client receiving Respite Services, who is 18 years of age or older and who is providing Daily Care to the Client without receiving payment for providing such care.
- Certified Home Health Agency - An agency certified by the Department of Public Health that has met the Medicaid and Medicare Conditions of Participation.
- Client - An individual who is eligible for and receiving Home Care Program Services.
- Client Record - One record maintained by the ASAP for a Client, which contains all required documentation in compliance with Elder Affairs' Documentation Standards.
- Congregate Housing - A joint program between Elder Affairs and the Department of Housing and Community Development that offers a shared living environment and integrates housing and support services.
- Congregate Meals - A nutrition program for elders where meals are provided at a congregate meal site such as a church, senior center, or other community center.
- Co-payment - A monthly dollar amount billed to a Client for Home Care Program services based on the Client's income.
- Critical Unmet Needs - A Client's Unmet Needs, which include one or more of the following: any Activity of Daily Living (ADL), meal preparation, food shopping, and transportation for medical treatments, Respite Care, and Home Health Services.
- Daily Care - Assistance with Activities of Daily Living and Instrumental Activities of Daily Living.
- Supervision and social and emotional support as required by the Client for part of each day.
- Division of Medical Assistance (DMA) - The Division of Medical Assistance of the Massachusetts Executive Office of Health and Human Services is a governmental agency responsible for the administration of the Title XIX (Medicaid) Program.
- Documentation Standards - Standards issued by Elder Affairs regarding the documentation procedures for gathering and maintaining client information.
- Elder at Risk Program (EAR) - The EAR Program provides services to persons age 60 and older who, because of mental or physical impairments, substance abuse, or language or cultural barriers, are unable to meet essential needs and can no longer remain safely in the community without assistance.

- Elder Affairs - The Executive Office of Elder Affairs of the Commonwealth of Massachusetts.
- Enhanced Community Options Program (ECOP) - A program administered by ASAPs for frail elders who are clinically eligible for Nursing Facility services under MassHealth and meet certain criteria set forth by Elder Affairs. ECOP provides a broad range of community services for these elders to remain in the community that includes services available under the Home Care Program.
- Family – An adult and his or her spouse.
- Functional Impairment Level (FIL) - The degree of functional impairment experienced by an Applicant or Client determined by an inability to complete Activities of Daily Living and Instrumental Activities of Daily Living. Each FIL is defined by the number of tasks an individual is unable to perform.
- Home and Community-Based Waiver (Waiver) - A waiver of federal requirements granted to the Commonwealth, by the U.S. Department of Health and Human Services under 42 U.S.C. #1396n (d), which allows DMA to pay for home and community-based services for MassHealth members who meet MassHealth criteria for Nursing Facility services but reside in the community.
- Home Care Program Services - Home Care Program Services include:
 - Adaptive Housing - Home adaptations, modifications or adaptive equipment for Clients who require these adaptations in order to remain independent or to improve independence in the community.
 - Adult Day Health (ADH) - Services provided by an Adult Day Health program approved for operation by the Division of Medical Assistance and operating in accordance with 130 CMR 404.000 et seq. ADH services provide health care, supervision, restorative services, and socialization.
 - Chore - Services to help Clients maintain their homes and/or to correct or prevent environmental defects that are hazardous to a Client's health and safety. Light chores include vacuuming, dusting, dry mopping, cleaning bathrooms and kitchens. Heavy chores include washing floors and walls, defrosting freezers, cleaning ovens, cleaning attics and basements to remove fire and health hazards, woodcutting, changing storm windows, heavy yard work and snow shoveling.
 - Companion - Services include: socialization; help with shopping and errands; escort to doctor's appointments, to nutrition sites, walks; recreational activities such as playing cards; and assistance with the preparation and serving of light snacks.
 - Dementia Day Care - Services provided by a Dementia Day Care Program operating in accordance with Dementia Day Care Standards issued by Elder Affairs. Dementia Day Care provides a structured, secure environment for individuals with cognitive disabilities to maximize the individual's functional capacity, reduce agitation, disruptive behavior, and the need for psychoactive medication, and to enhance cognitive functioning.
 - Emergency Shelter - Services designed to provide temporary (for no more than 14 calendar days in a six month period) overnight shelter for a Client, or a Client and the Client's household who are without a home.
 - Grocery Shopping/Delivery Services - Includes obtaining grocery order(s), grocery shopping, grocery delivery and assistance as needed with storage and packaging; and may include nutritional information and education.

- Home-delivered Meals - The provision of well balanced meals, which meet Elder Affairs' Nutrition Standards and the Client's dietary needs, delivered to Clients who are unable to prepare nutritionally adequate meals or attend a congregate meal site.
- Home Health Services - Those services defined in DMA regulations in 130 CMR 403.000 which include Skilled Nursing Care; Physical, Occupational, and Speech Therapy; and Home Health Aide.
- Home Health Aide - Services provided to Clients under the supervision of a registered nurse, or a speech, occupational, or physical therapist. This includes personal care; simple dressing changes that do not require the skills of a registered nurse; assistance with medications that are ordinarily self-administered and that do not require the skills of a registered or licensed nurse; activities that support the skilled therapies; and routine care of prosthetic and orthotic devices. These services comply with the definitions included in Division of Medical Assistance regulations in 130 CMR 403.000, et seq.
- Homemaker - Services to assist a client with Activities of Daily Living and Instrumental Activities of Daily Living which includes shopping, menu planning, and meal preparation, including special diets, laundry, and light housekeeping. These Services comply with the Homemaker Standards issued by Elder Affairs.
- Laundry - Cleaning services provided by a laundry company.
- Nutritional Assessment - A comprehensive nutritional assessment conducted by a qualified nutritionist. A nutritional plan of care is developed based on the results of the assessment.
- On-Call - The provision of an on-call capacity to respond to client needs either during or after regular business hours.
- Personal Care - Activities include: bathing, dressing, and grooming (hair shampooing and combing); foot care (excluding nail cutting); assistance with dentures; shaving (limited to shaving with an electric razor); assisting with bedpan routines; assisting with eating; assisting with ambulating; and assisting with transfers (excluding transfers if the Client is totally dependent). These services comply with the Personal Care Guidelines issued by Elder Affairs.
- Personal Emergency Response System - A medical communications alerting system that allows a Client experiencing a medical emergency at home to activate electronic components which transmit a coded signal via digital equipment over telephone lines to a central monitoring station. The central monitoring station is staffed 24 hours a day, seven days a week by trained attendants who receive and process the emergency call and ensure the timely notification needed to dispatch appropriate individuals and/or emergency services to the person in need.
- Social Day Care Services - Individualized programs of social activity provided to Clients who require daytime supervision at sites other than their homes. Activities include: assistance with walking, grooming, and eating; provision of one meal and two snacks per day; planned recreational and social activities suited to the needs of the participants and designed to encourage physical and mental exercise and stimulate social interaction.
- Supportive Home Care Aide - Services provided to clients with emotional or behavioral problems to assist with Activities of Daily Living and Instrumental Activities of Daily Living. These services include Personal Care (as defined in the Personal Care Guidelines issued by Elder Affairs), shopping, menu planning, meal preparation including special diets, laundry,

light housekeeping, escort, and socialization/emotional support. These Services comply with the Supportive Home Care Aide Standards issued by Elder Affairs.

- Translation Services - Translation/interpreting provided to clients in need of such assistance in order to receive services.
- Transportation - Provision of transportation to and from community facilities or services.
- Additional Services - The Secretary may issue Program Instructions to define and approve additional Home Care Program Services available to Clients to secure and maintain maximum independence.
- Home Care Management Information System (HOMIS) - The management information system established by Elder Affairs and used by ASAPs to maintain Client demographic and assessment data, service authorization and utilization data and to manage ASAP expenditures.
- Information and Referral Services - Activities related to the maintenance of current information with respect to services available to Clients, assessments of the type of assistance needed by an elder requesting information, referral to appropriate services, and follow-up to determine if needed services were received. Information and Referral services may be conducted by mail, by telephone, electronically, or in person.
- Instrumental Activities of Daily Living (IADLs) - Basic environmental tasks, including the ability to prepare meals, do housework, do laundry, go shopping, take medicine, get around outside, use transportation, manage money, and use the telephone, which are used to measure the Functional Impairment Level of an Applicant or Client.
- Interdisciplinary Case Management - A client centered approach to assessment, service acquisition, reassessment, and monitoring of services provided to assist elders to live independently in the community. It includes working cooperatively, coordinating service plans and maintaining ongoing communication with the elder, family members, informal supports and formal supports, as necessary. It is provided by registered nurses and case managers working in consultation with physicians, nurses and therapists from home health agencies, hospice providers, nutritionists, housing managers, mental health professionals, and other home and health care professionals. These services comply with the Interdisciplinary Case Management Standards issued by Elder Affairs.
- LTC Assessment - The Long Term Care Assessment procedure specified by Elder Affairs to determine eligibility for Home Care Program Services, Community-Based Long Term Care Services and Nursing Facility Services.
- LTC Assessment Tool - An instrument designated by Elder Affairs used to conduct a LTC Assessment.
- MassHealth - The Medical Assistance Program administered by the Division of Medical Assistance pursuant to M.G.L. c. 11 8E and Title XIX of the Social Security Act. MassHealth is the name the Commonwealth uses for the Medicaid Program.
- MassHealth Member - An individual who has been determined eligible to receive benefits under the Medical Assistance Program (MassHealth).
- Medicaid - See MassHealth.
- Non-Critical Unmet Needs - Unmet needs, which include one or more of the following: laundry, housework, shopping other than food shopping, transportation other than transportation for medical treatment and socialization.

- Nursing Facility - A facility that is licensed to provide skilled nursing care to residents, which meets the provider eligibility and certification requirements as specified in Division of Medical Assistance regulations, 130 CMR 456.000 et seq.
- Peer Review - A process by which ASAPs convene in groups to review Client Records for the purpose of providing feedback to one another regarding how cases were handled and to ensure a more consistent approach among providers. The Peer Review process must be implemented according to the Peer Review Program Instructions issued by Elder Affairs.
- Program Instruction - A document issued by Elder Affairs that sets forth required procedures and protocols.
- Protective Services - Services provided by an Elder Protective Services Program in accordance with M.G.L. c. 19A, §§ 14 through 26 and regulations at 651 CMR 5.00, which are necessary to prevent, eliminate or remedy the effects of abuse to an elder.
- Respite Care - The provision of one or more Home Care Program services to temporarily relieve the Client's caregiver -- in emergencies, or in planned circumstances-- of the daily stresses and demands of caring for a Client in efforts to strengthen or support the Client's informal support system. In addition to services available under the Home Care Program, Respite Care services may include short term placements in Adult Foster Care, Nursing Facilities, Rest Homes, or Hospitals.
- Service Plan - A plan of care that delineates all services from all funding sources to be provided to a Client, developed in conjunction with the Client and/or the Client's designated representative.
- Service Priority Matrix - The method used to prioritize Applicants to the Home Care Program which is based on an assessment of Critical Unmet Needs and Non-critical Unmet Needs.
- Subcontract - A contract between the ASAP and an organization to provide one or more Home Care Program Services. The subcontracting organization shall not deliver any services to a Client without the authorization of the ASAP.
- Suspension - The temporary cessation of Home Care Program services as a result of the Client's unavailability to receive such services for a time period not to exceed 90 calendar days. At the time of suspension, there must be an expectation that services will be resumed on or before the end of 90 calendar days.
- Termination - The termination of all Home Care Program Services which results in the closing of a case.
- Transitional Assistance – The provision of services to assist elders in returning to a community setting following discharge from a nursing facility, which may include financial assistance for security deposits, essential furnishings, cooking supplies, moving expenses, and setup fees and deposits for utility services, telephone, etc. Services may also be provided to correct safety or code violations, architectural barriers; or to address health and safety issues related to the home environment.
- Uniform Intake - The intake policy and procedures for eligibility for Home Care Program Services as established by Elder Affairs. The Uniform Intake Policy is subject to change by Elder Affairs and the eligibility of an individual under such policy is subject to appropriation of state funds to Elder Affairs.
- Unmet Need(s) - The Applicant or Client's identified care needs which are not being met by other sources available to the Client or Applicant as determined by the LTC Assessment.

- Vendor - An entity which has entered into a contract with an ASAP to provide one or more Home Care Program Services.
- Voluntary Co-payment - A dollar amount which may be donated by a Client whose annual gross income falls at or below the annual gross income levels set forth in 651 CMR 3.03(3)(e).^m

Appendix B. U.S. Census 2000 Definition of Disability

“The data on disability status were derived from answers to long-form questionnaire Items 16 and 17. Item 16 was a two-part question that asked about the existence of the following long-lasting conditions:

- (a) blindness, deafness, or a severe vision or hearing impairment (sensory disability); and
- (b) a condition that substantially limits one or more basic physical activities, such as walking, climbing stairs, reaching, lifting, or carrying (physical disability). Item 16 was asked of a sample of the population 5 years old and over.

Item 17 was a four-part question that asked if the individual had a physical, mental, or emotional condition lasting 6 months or more that made it difficult to perform certain activities. The four activity categories were:

- (a) learning, remembering, or concentrating (mental disability);
- (b) dressing, bathing, or getting around inside the home (self-care disability);
- (c) going outside the home alone to shop or visit a doctor's office (going outside the home disability); and
- (d) working at a job or business (employment disability).

Categories 17a and 17b were asked of a sample of the population 5 years old and over; 17c and 17d were asked of a sample of the population 16 years old and over.

For data products that use the items individually, the following terms are used:

- sensory disability for 16a
- physical disability for 16b
- mental disability for 17a
- self-care disability for 17b
- going outside the home disability for 17c
- employment disability for 17d

For data products that use a disability status indicator, individuals were classified as having a disability if any of the following three conditions were true:

- (1) they were 5 years old and over and had a response of "yes" to a sensory, physical, mental or self-care disability;
- (2) they were 16 years old and over and had a response of "yes" to going outside the home disability; or
- (3) they were 16 to 64 years old and had a response of "yes" to employment disability.”

Appendix C. Advocacy Organizations

In the following section, we present the Massachusetts based advocacy organizations, as they describe themselves.

Massachusetts Association of Older Americans

“Today, MAOA leads the fight against the dual stigma of being old and mentally ill. The fights to preserve Medicare and Social Security, to ensure access to community-based long term care and to obtain mental health care for elders suffering from depression and other brain disorders are high on MAOA’s agenda. Continuing its long tradition of providing educational opportunities, MAOA organizes regular conferences on important issues throughout the state; sponsors a SeniorNet computer training program and collaborates with Councils on Aging to hold training sessions for senior advocates.

MAOA continues its collaborative, educational and coalition-building efforts on a statewide basis, reaching thousands of the 360,000 seniors throughout the Commonwealth. MAOA works closely with the Boston Partnership for Older Adults (**BPOA**), the Mature Workers Coalition, SAGE-Boston Collaborative, the Senior Housing Coalition, the Senior Pharmacy Coalition, and Action for Boston Community Development, Mass Home Care and MA Councils on Aging and Senior Center Directors (MCOA) to accomplish our educational and advocacy goals.”¹⁸

Massachusetts Senior Care Association

“We are the Massachusetts Senior Care Association, the state's oldest and largest long term care provider organization representing more than 550 skilled nursing facilities, assisted living residences and continuing care retirement communities.

Here are a few highlights of our work:

- Mass Senior Care member facilities provide health care, housing and support services to nearly 50,000 people in Massachusetts.
- Mass Senior Care's membership includes nonprofit, proprietary and municipally-owned facilities that employ approximately 50,000 people, and contribute nearly \$3 billion annually to the Massachusetts economy.
- Mass Senior Care provides education and professional development services to provide long term care employees with access to the latest innovations in caregiving.
- The Massachusetts Senior Care Foundation, the non-profit research and education arm of MECF, has provided \$1.5 million in scholarships to nearly 1,000 long term care employees since its inception in 1985.
- Massachusetts Senior Care Association is home to the Massachusetts Center for Assisted Living (MCAL), providing advocacy and representation for Mass Senior Care's assisted living and retirement housing members.”¹⁹

Massachusetts Aging Services Association

“The Massachusetts Aging Services Association (MassAging) is the only Massachusetts membership association representing the full continuum of not-for-profit providers of aging services including nursing facilities, residential care communities, assisted living residences, housing providers, continuing care retirement communities, and community based service providers. Sponsored by religious, fraternal, and other not-for profit groups, MassAging members serve more than 25,000 older persons and employ more than 17,000 people.”^{OM}

Massachusetts Assisted Living Facilities Association

“The Massachusetts Assisted Living Facilities Association (Mass-ALFA) is a non-profit association devoted to supporting the establishment and operation of quality assisted living residences in Massachusetts that provide appropriate supportive housing and services for individuals with varied needs and income levels. Established in 1990 as a state affiliate of the Assisted Living Federation of America (ALFA), Mass-ALFA has grown to hundreds of members including assisted living providers and associated professionals. Mass-ALFA provides information, advocacy and support to the assisted living community. Mass-ALFA promotes the philosophy of assisted living which includes offering cost-effective quality care tailored to the individual’s needs; fostering independence, dignity and the right to privacy for each resident; allowing each resident choice of care and lifestyle; providing a safe, residential environment and making the assisted living residence a valuable community asset.”^{ON}

Appendix D. State Agencies with Elder Health Agenda

The principal agencies involved with elder health issues are the Massachusetts Executive Office of Elder Affairs and the Massachusetts Department of Public Health. We present below their program descriptions, as they describe themselves.

Massachusetts Executive Office of Elder Affairs

“The Massachusetts Executive Office of Elder Affairs (Elder Affairs) became one of the nation’s first cabinet-level agencies responsible for addressing the needs of elders in 1971.

Originally a small advocacy agency, Elder Affairs assumed its mandate to fund services in 1973 with the passage of legislation creating the Office. Today, Elder Affairs directs services to thousands of elders across the Commonwealth through state and federally funded programs.

Elder Affairs is responsible for the administration and oversight of programs and services on behalf of the Commonwealth’s plus-million elder population. Its mission is to promote the dignity, independence, and right of Massachusetts elders, and to support their families through advocacy and the development and management of community-based programs and services.

Through the statewide elder network, Elder Affairs provides services locally via Aging Services Access Points (ASAPs), Councils on Aging (COA), and senior centers in communities across the Commonwealth. This network reaches out to elders in need of services that include home care and caregiver support, nutrition programs, long term care, protective services, housing options, and SHINE counseling.”²²

Department of Public Health Healthy Aging and Disability Unit (HADU)

“The Healthy Aging and Disability Unit (HADU) encompasses the Office of Healthy Aging and the Office on Health and Disability. The unit promotes the health and well being of older adults and people with disabilities across the lifespan in Massachusetts.

HADU coordinates and supports program and policy development that assures access to quality health care. HADU provides opportunities for older adults and people with disabilities to learn about and manage their health. Activities essential to the unit’s mission are:

- Supporting the availability and accessibility of quality health promotion opportunities for older adults and people with disabilities across the lifespan;
- Collecting and disseminating data related to aging and disability in Massachusetts;
- Improving accessibility and quality of health services, activities, and programs for older adults and people with disabilities; and
- Building and expanding aging and disability constituencies that foster individual and organizational awareness and promote health, well-being, and independent living.

Healthy Aging and Disability Unit Activities

- Americans with Disabilities Act (ADA) Compliance Coordination: provides technical assistance to promote compliance of health programs with the ADA and other disability-related non-discrimination laws.
- Data Collection and Research: provides the knowledge-base needed to design programs related to healthy aging, health and disability, and secondary health conditions.
- Disease Prevention and Health Promotion: works with state agencies and community partners to identify, implement, and evaluate evidence-based health promotion programs among older adults and people with disabilities.
- Education: provides materials and information on health promotion and disease prevention related to health needs and concerns of older adults and people with disabilities.
- [Keep Moving Program](#): facilitates the development of senior walking clubs across Massachusetts.
- The Massachusetts Partnership on Substance Use in Older Adults: A Resource Network on Prevention and Addictions - provides awareness, education and collaboration on substance abuse and misuse among older adults.
- [Stanford University Chronic Disease Self-Management Program \(CDSMP\)](#): helps people gain self-confidence in their ability to control their symptoms and understand how their health problems affect their lives through an evidenced-based program to promote the health and well-being of those affected by chronic illnesses.
- Technical Assistance and Training: designs and implements training and technical assistance for health care providers and public health programs on the Americans with Disabilities Act to ensure inclusion of persons with disabilities in state funded programs, services, and activities.
- Policy, Systems Development, and Planning: supports the development of policies, systems and resources to improve access to quality healthcare for people with disabilities.^{20P}

End Notes

Except as otherwise noted, the sources of all data are:

- (1) U.S. Census 2000
- (2) Mass-CHIP, v 3 r 324, Massachusetts Department of Public Health.

ⁿ http://encarta.msn.com/dictionary_1861607746/elderly.html/ Accessed August 27, 2009.

² Sawabe M. Reviewing the definition of "elderly" *Geriatrics and Gerontology International* 6(3) 149-158, 2006

³ Gorman M. Development and the rights of older people. In: Randel J, et al., eds. *The ageing and development report: poverty, independence and the world's older people*. London, Earthscan Publications Ltd., 1999:3-21.

⁴ This term has been used increasingly since the 1970s to move "understandings of race beyond the black-white binary then prevalent."

⁵ *Federal Register*, Vol. 64, No. 52, March 18, 1999, pp. 13428-13430

⁶ U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, HCUP [Healthcare Cost and Utilization Project] Methods Series: Observation status related to U.S. Hospital Records Report #2002-3 http://www.hcup-us.ahrq.gov/reports/FinalReportonObservationStatus_v2Final.pdf

⁷ Self-injury, self-inflicted violence, self-injurious behavior or self-mutilation is defined as a deliberate, intentional injury to one's own body that causes tissue damage or leaves marks for more than a few minutes which is done to cope with an overwhelming or distressing situation. See http://www.helpguide.org/mental/self_injury.htm#

⁸ The major cities are considered to be: Boston, Fall River, New Bedford, Lowell, Lawrence, Springfield, and Worcester.

⁹ Table B27001: Health Insurance Coverage Status by Age for the Civilian Non-Institutionalized Population. 2008 American Community Survey 1-Year Estimates. United States Bureau of the Census.

¹⁰ U.S. Census definitions, 2000.

¹¹ Excerpted from:

<http://www.massresources.org/pages.cfm?contentID=8&pageID=2&subpages=yes&dynamicID=449#whatis>

¹² Excerpted from <http://www.massalfa.org/docs/fastfactinfo.htm>

¹³ Excerpted from <http://www.massalfa.org/docs/fastfactinfo.htm>

¹⁴ Massachusetts Executive Office of Elder Affairs.

http://www.mass.gov/?pageID=eldersterminal&L=3&L0=Home&L1=Housing&L2=Congregate+Housing&sid=Eelders&b=terminalcontent&f=congregate_overview&csid=Eelders Accessed October 9, 2009.

¹⁵ Excerpted from

<http://www.massresources.org/pages.cfm?dynamicID=444&subpages=yes&contentID=8&pageID=2>

¹⁶ Excerpted from

<http://www.massresources.org/pages.cfm?dynamicID=437&subpages=yes&contentID=8&pageID=2>

¹⁷ Excerpted from file provided by Wey Hsiao, Executive Office of Elder Affairs, October 13, 2009.

¹⁸ Excerpted from <http://www.maoamass.org/history.htm>

¹⁹ Excerpted from http://www.masslongtermcare.org/index.php?option=com_content&task=view&id=14&Itemid=58

²⁰ Excerpted from <http://www.massaging.org/i4a/pages/index.cfm?pageid=1>

²¹ See <http://www.massalfa.org/docs/about.htm>

²² Massachusetts Executive Office of Elder Affairs

http://www.mass.gov/?pageID=eldersutilities&L=1&sid=Eelders&U=agency_history

²³ Excerpted from

http://www.mass.gov/?pageID=eohhs2terminal&L=5&L0=Home&L1=Government&L2=Departments+and+Divisions&L3=Department+of+Public+Health&L4=Programs+and+Services+A+-+J&sid=Eeohhs2&b=terminalcontent&f=dph_com_health_health_disability_c_about&csid=Eeohhs2