The Dignity Digest

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

*May require registration before accessing article.

Editor's Note

This is a special edition of *The Dignity Digest.*
We present the case for the necessity of independent, public audits of nursing homes and other providers of long-term services and care, full implementation of a meaningful Olmstead Plan, and the comprehensive reform of the long-term care system in Massachusetts.
We welcome commentary in response which can be sent to info@dignityAllianceMA.org.
The usual format and content of *The Dignity Digest* will resume with the next issue which will be distributed on Wednesday, September 21.

Call to Action

Transparency, Accountability, and Implementation of the Olmstead Plan
A Call to Action

Older adults and people with disabilities deserve and are legally entitled to long-term services and supports, affordable and accessible living options, and safe and quality care that respect choice and self-determination.

Critical to their dignity and well-being is a robust and comprehensive system of home and community-based services and care. Ninety-eight percent of adults favor living in their own home or that of a loved one or in a senior living community while receiving needed living support. Yet thousands of Massachusetts residents end up relegated to nursing facilities due to the lack of adequate home and community-based services and because of the state's anemically implemented Olmstead Plan.

In 2018, the Commonwealth updated its first Olmstead Plan, created in 2008. The Commonwealth's 2018 Olmstead Plan identifies four key goals:

(1) expansion of access to affordable, accessible housing with necessary supports
(2) enhancement of community-based long-term services and supports

(3) promotion of community-integrated employment of people with disabilities
(4) investment in accessible transportation for individuals with disabilities.

To fully realize the goals of the Olmstead Plan, the state must:

- Incorporate the goals into actionable and measurable requirements for the appropriate state agencies to pursue and to be accountable for. The plan can no longer sit on a shelf collecting dust; it must be taken seriously by the next Administration and be embraced and implemented to its fullest measure. Further, in the name of transparency and accountability, there must be a public-facing annual report that is clear and concise so that policy makers, advocates, and the general public understand what has been done and what remains to do.

- People with disabilities, older adults, their families, and their caregivers must be involved with all aspects of the plan's implementation. The governor should appoint an Olmstead Working Group consisting of persons with disabilities, older adults, advocates, cabinet level policy makers, legislators, providers, and others who have a stake in the process.

Without an effective Olmstead Plan to divert away or transition out older adults and people with disabilities from nursing facilities, thousands are at risk of inappropriate placement apart from their homes and communities.

Moreover, we must insist on greater transparency and accountability for the hundreds of millions of dollars of public funds Massachusetts nursing homes receive. Full transparency and ensured financial integrity of nursing homes are paramount to honoring the promise of quality care, to ensuring a life lived with dignity and self-determination for nursing home residents, and to providing safe working conditions and equitable compensation for their caregivers.

To achieve these goals, it is essential:

(1) To ensure that the fullest amount of funds is dedicated to direct resident care.
(2) To determine and document if there are inadequacies in MassHealth payment rates --- if so, establish equitable remedies that are linked directly to the provision of care.
(3) To identify any self-dealing/related party transactions detrimental to residents, including complex corporate transactions which syphon off or conceal profits. In 2018, the *New York Times* sounded the alarm: "…nursing

homes that outsourced to related parties tended to have fewer nurses and aides per patient, higher rates of patient injuries and unsafe practices…"[i] This situation leads to the overuse and misuse of antipsychotics to sedate residents, even though these drugs can be deadly to elders. Massachusetts nursing homes have one of the highest antipsychotic rates in the country.

The growth of ownership of nursing homes by private equity firms and real estate investment trusts (REITs) makes it clear that nursing homes are profitable businesses.[ii] Furthermore, a B*oston Globe* 2014 study of Massachusetts nursing home finances found that many nursing homes directed revenues to subsidiaries "…paying million-dollar rental fees and helping to pay executives' six-figure salaries…"[iii] These circumstances support the need for close scrutiny of nursing home finances, including biennial audits and public reporting, to ensure transparency and accountability.

In addition to audits of ongoing financial activity, a separate independent audit of Covid-19 related funding must be undertaken. Hundreds of millions of dollars of state and federal funds have been provided to Massachusetts nursing homes throughout the pandemic. There has been little to no analysis and accountability of the use of these funds. It is essential to provide public assurance that the funding was used as intended. A public report on the use of state appropriated, ARPA, and other Covid-19 special funding (2020 to current) must document how such funds have been used and to outline how best to utilize and monitor funds in response to any future health emergency or environmental disaster.

Collectively, we, as residents of Massachusetts, owe older adults, people with disabilities, and their caregivers and family members the opportunity for the best quality of life possible. The Commonwealth of Massachusetts needs to be proactive and take full advantage of the financial and political capital it has to move toward equality and justice for all of its citizens. No longer should anyone be destined to live a life of poverty when the key to breaking this cycle literally lies in our hands through the effective implementation of a comprehensive Olmstead plan. No longer should nursing home residents be deprived of the highest practicable quality care and best possible quality of life they are due and deserve.[iv]

[See last page for footnotes.]

Dignity Alliance Massachusetts members Jeni Kaplan, Charles Carr, and Arlene Germain collaborated in the authoring of this statement.

Editor's note	**The postings below are a sampling of blogs, reports, and articles which support the Call to Action.**
Tall Grass Economics Blog posts by Dave Kingsley The blog posts by *Tall Grass Economics* present the case for how economies should best serve the needs of "the people" and not corporate interests	**Nursing Home History as Pablum: Creating a Comfortable Reality for the Powerful** Posted August 23, 2022 A commission to study the nursing home system, conducted under the auspices of the National Academies, of Science, Engineering, & Medicine (NASEM), recently released its report entitled The National Imperative to Improve Nursing Home Quality: Honoring Our Commitment to Residents, Families, and Staff.[1] The report included a very brief history of the nursing home system – a 400-year history reduced to a couple of pages. Furthermore, it is a history that will not upset officials, proprietors, investors, executives, politicians, and others who are benefitting from the status quo. Basically, the commission is feeding the public historical pablum. Left out of the multi-century account are such salient features as ongoing and intensifying financialization, and pivot points such as the 1950s-60s' development and codification of "the medically indigent," the role of states' rights, and the influence of racist, segregationists. Also excised were many significant changes of 1980s-90s such the transformation of macroeconomic and corporate philosophy from managerial capitalism into what is known as "agency theory," – basically meaning that shareholder value is not just the highest ethic of capitalist management but the only ethic. Between the late 1990s and early 2000s, capital markets and tax codes were conducive for the entry of real estate investment trusts (REITs), private equity (PE), and other corporate legal structures (e.g., limited liability companies or LLCs) into the senior housing market. Large pools of capital had been accumulating through pension, college endowment, sovereign wealth, and insurance funds that needed to flow into businesses that would provide desired yields and return on investment. These funds are managed by institutional investors such as Vanguard and BlackRock. The number and size of publicly listed companies have grown considerably over the past two decades as REITs have expanded their power and financial dominance in the senior housing market. To ignore these players in the industry is to ignore the proverbial 800-pound gorilla in the room. These changes have been accompanied by massive investments of cash into political campaigns and politicians' coffers by PACs, Corporations, and lobbying firms representing the medical-industrial complex, Wall Street, and real estate. What worthwhile history would tiptoe around the corruption wrought by money in politics? It is easy to become known as a radical and marginalized. Taking a hardnosed stand regarding the truth is an annoyance. History is written from a "point of view" of the powerful and their version of events. They choose the people, places, and things to include and exclude. Challenging those points of view will typically evoke hostility. This is currently noticeable in the backlash to "critical race theory." African Americans would benefit greatly from a factually accurate history of race in America, which would facilitate an honest look at institutional racism still pervasive in the

United States – including in the nursing home system. It would also be helpful to the elderly to have a movement that could be called critical elder theory – perhaps CET would be an appropriate acronym.

Unfortunately, humans are beset with psychological defense mechanisms that serve the avoidance of truth and lend support to the creation of a comfortable reality. There are many defense mechanisms recognized by psychoanalysts. However, four main defenses in history: denial, rationalization, repression, and fantasy are essential for understanding how official bodies such as commissions paper over reality and prevent real change.

Fantasy is seeing the world not as it is but as the way we would like it to be. No American wants to think that the elderly, as humans, are only worth what the treatment in a typical nursing home would suggest. We believe we are better than that. Our creed does not permit widespread shortening of life and suffering because of financial considerations. Somehow the incongruence between our creeds and our deeds must be reconciled. So, we retreat into a fantasy world in which medically fragile and frail elderly and disabled persons are living in as system with a few tweaks can be fully staffed and made into a "home-like culture" (a vague term if ever there was one).

Fantasies can only be maintained through denial of reality (out of sight-out of mind), repression (just don't think about it), and rationalization (Medicaid reimbursement is too low). Human nature being what it is, these defenses operate mostly at a subconscious level.

Window dressing called "home culture" as it has been conceived and implemented thus far will not substantively change the structure and function of the nursing home system as it has evolved. However, it will assuage our consciences.

The "medical industrial complex" is not capitalism, so let's change the narrative.

Posted August 28, 2022

Genuine Capitalist Enterprises are Not Operating in Anti-Competitive, Government Rigged, Systems.

As a proponent of capitalism, I resent the U.S. privatized, government-funded, health care system and the implication that it is a suitable representative of a capitalist system. It is not. The system of nursing homes, hospitals, and clinics through which patients pass for care is a financialized[1], corrupt, rigged, system. Furthermore, some services important to society should not be industrialized under the farcical notion that return on capital will drive quality care.

Reformers have failed to create a narrative to defeat the financiers' mantra that privatizing appropriate government services will increase quality and productivity. History has taught us a very clear lesson: industrialization and privatization of medical care and a host of other government services are unproductive and lead to

excess extraction of capital, lower productivity, and reduction of innovation and reinvestment.

You Can't Shame the Shameless

There is an unfounded belief that exposing bad operators in sensational mainstream media articles will force a change for the better in nursing homes and hospitals. The misguided view that the medical-industrial complex will be moved by horror stories reminds me of an old T-Shirt in my closet with the following silkscreened on it: "We Don't Care, We Don't Have to Care, We're EXON." You could substitute the words medical-industrial complex, The American Health Care Association (AHCA), Ensign Group," Welltower Corporation, Centene, United Health, and thousands of other corporate associations and entities for EXON on such a T-Shirt.

Nursing home and hospital corporations don't care about the shaming they deserve because politicians in federal and state legislatures have their backs. Furthermore, they have captured the agencies charged with regulating them. The Center for Medicare & Medicaid Services, and 50 state agencies are dominated by the industry and their well-financed lobbying organizations (not to mention the FDA, the FTC, the CFTC, etc.). You can shame private equity as a business model, scurrilous operators, low wages/salaries, understaffing, and other outrageous practices, but financiers in the healthcare business are, for the most part, shameless.

For at least a decade, I have been urging advocates to form a narrative and political strategy. Playing rope, a dope with an industry that has a very well devised, effective, and well-funded narrative will change nothing. The nursing home industry has a narrative based on falsehoods, which are comprised of frames related to the hardships endured by noble businessmen and investors. Frames in which the industry purports to be suffering from low Medicare/Medicaid reimbursement, and low net income (profits) are blatantly false and misleading. Regardless of how unbelievable the frames comprising industry propaganda, they are never seriously challenged by the constellation of nonprofit and government entities representing the elderly. Furthermore, do-gooder commissions charged with studies of nursing homes, hospitals, and other health care subsystems generally whitewash and paper over the unethical, inhumane, and anti-democratic nature of the entire medical-industrial complex.[2]

Let's Get Technical

I propose that advocates create frames that can be integrated into and support this narrative: "The privatized U.S. healthcare system is not fair, capitalistic, or ethical." Frames accusing industrialists of manipulation of markets, financial machinations, pay offs/bribes to legislators, and covering up corruption through well-funded lobbying entities such as the AHCA (nursing home lobby) are necessary but risky for professionals who want to go along to get along.

Industry moguls and their minions in government know from 70 years of history that their propagandistic efforts to convince the public that privatized, for profit, services are better than non-profit and government services are effective. This mantra has gained traction and is embedded deeply in the American zeitgeist. It will take a

concerted effort across a broad array of nonprofit advocacy organizations to destroy a narrative based on industry lies and complex financial maneuvers.

However, before advocates can suitably frame messages for the media and legislators, a considerable amount of research, data collection, and analysis must be undertaken. Data and evidence related to "rent seeking,"[3] "net operating income," and "cash flow," is necessary for debunking the "low net," "thin margins," and other hardship frames of the industry. The nursing home system must be unraveled and explained as a network of capital flows from taxpayers and other sources through Real Estate Investment Trusts (REITs), private equity firms, LLCs/LLPs, and C-Corporations.

It is necessary to show how excessive capital flows through nursing homes and hospitals to investors and executives. REITs have been existing under the radar and never discussed at legislative hearings (See my blog post: "Real Estate Investment Trusts (REITs) are Big Players in the Nursing Home Industry: That Should Concern All of Us" February 13, 2021). We must recognize how the entry of private equity and REITs around 2000 literally transformed the industry.

Advocacy research must include data from cost reports submitted by facilities to CMS and state agencies. Falsehoods in these reports are pervasive. Nevertheless, it is important to organize the data to make a case and support our frames pertaining to corruption and excessive extraction of capital at the expense of care.

We Are on It!

A team of people across the U.S. have come together to initiate solid, evidence-based, research. With some help from the LTCCC and a lot of volunteer work, a group of us have been organizing data from cost reports and digging into financial machinations, ownership, and the flow of capital from various sources (including taxpayers) to investors, executives, and family wealth.

We want to direct attention to more than horrendous examples of nursing home abuse and neglect. The industry justifies poor care with a well-honed, richly funded, propaganda campaign. We should not respond to their "woe is me pleas for increased funding." Rather we should follow the money and make the trail available to legislators and journalists that we know will utilize it (think Senator Elizabeth Warren). I don't want to engage them in their claim that investors in the nursing home industry are suffering. My only response to that is investors are not stupid. If returns were no good in public-funded, skilled nursing care, investors would be investing somewhere else.

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[1] By labeling the system "financialized," I mean that financial maneuvering for extracting cash takes precedence over increased productivity and quality of services. Shareholder value is the primary mission of most healthcare private corporations. Stakeholders are of secondary importance. Often stakeholders suffer for the sake of enhancing and protecting shareholders' interests.

	[2] While COVID was surging in the Spring of 2020, CMS convened an "independent" commission the management of which was outsourced to the Mitre Corporation. The report of this commission was a whitewash and papered over general neglect by the nursing home industry which resulted in 200,000 patient and employee deaths. Contrary to suggesting accountability for lack of infection control and no preparation for a pandemic that scientists had been warning about for decades, the final report recommended more financial assistance for the industry. Recently, a commission under the auspices of the National Academy of Sciences, Engineering, and Medicine (NASEM) in operation for a number of years entitled "National Imperative to Improve Nursing Home Quality" issued a report of their work. This commission tiptoed around the corruption, deceit, and excessive extraction of capital at the expense of quality care. [3] "Rent seeking" has evolved in the field of economics to describe corporate efforts to extract wealth without a correlative increase in the production of goods and services. The nursing home, finance, real estate, lobby is constantly hectoring legislators for an increase in reimbursement without any real, scientific, evidence that the cash flow and return on their investment is inadequate.
When Private Equity Tales Over a Nursing Home **The New Yorker**	***When Private Equity Takes Over a Nursing Home*** **The New Yorker**, August 25, 2022 By Yasmin Rafiei [Editor's note: This article is recommended to be read in its entirety. Click on title to access.] After an investment firm bought St. Joseph's Home for the Aged, in Richmond, Virginia, the company reduced staff, removed amenities, and set the stage for a deadly outbreak of COVID-19. When St. Joseph's Home for the Aged, a brown-brick nursing home in Richmond, Virginia, was put up for sale, in October 2019, the waiting list for a room was three years long. "People were *literally* dying to get in there," Debbie Davidson, the nursing home's administrator, said. The owners, the Little Sisters of the Poor, were the reason. For a hundred and forty-seven years, the nuns had lived at St. Joseph's with their residents, embodying a philosophy that defined their service: treat older people as family, in facilities that feel like a home. . . In the spring of 2021, an offer materialized from the Portopiccolo Group, a private-equity firm based in Englewood Cliffs, New Jersey, which then had a portfolio of more than a hundred facilities across the East Coast. "They said they like to keep things the way they are," Sister Mary John told me. The deal was finalized by June. Portopiccolo's management company, Accordius Health, was brought in to run the home's day-to-day operations. . . Since the turn of the century, private-equity investment in nursing homes has grown from five billion to a hundred billion dollars. The purpose of such investments—their so-called value proposition—is to increase efficiency. Management and administrative services can be centralized, and excess costs and staffing trimmed. In the autumn of 2019, Atul Gupta, an economist at the University of Pennsylvania, set out with a team of researchers to measure how these changes affected nursing-home residents. They sifted through more than a hundred private-equity deals that took place between 2004 and 2015, and linked each deal to categories of resident outcomes, such as mobility and self-reported pain intensity. The data revealed a troubling trend: when private-equity firms acquired nursing homes, deaths among residents increased by an average of ten per cent. "At first, we didn't believe it,"

	Gupta told me. “We thought that there was a mistake.” His team reëxamined its models, testing the assumptions that informed them. “But the result was very robust,” Gupta said. Cost-cutting is to be expected in any business, but nursing homes are particularly vulnerable. Staffing often represents the largest operating cost on a nursing home’s ledger. So, when firms buy a home, they cut staff. However, this business model has a fatal flaw. “Nurse availability,” Gupta and his colleagues wrote, “is the most important determinant of quality of care.”. . The situation is growing more urgent. One in six Americans is sixty-five or older; by 2035, adults over sixty-five are expected to outnumber children for the first time in U.S. history. According to a report by IBISWorld, a market-research firm, this demographic shift—the “silver tsunami,” as it’s been called—will increase revenues in the United States’ nursing-home industry by twenty-five per cent in the next five years. Private-equity firms currently own only eleven per cent of facilities, as a federal report found. But about seventy per cent of the industry is now run for profit. “They all have the same operational approach, the same strategies for making money,” Harrington said. “It’s just that private equity tends to have higher expectations for profits.”. . There’s an active debate over whether nursing-home deterioration is caused by private-equity acquisition, as senior-care advocates contend, or if private-equity firms tend to acquire homes that are already deteriorating. . . Under the Little Sisters, the home had been lightsome and bustling. I could scarcely walk a few steps in the hallways without someone saying hello. “They came by to check on you, to see if there was anything you needed, how things could work better,” a resident told me. In the hallway, a television had blasted Dolly Parton’s “God Bless the U.S.A.,” and a nurse breezed by me, belting out the lyrics. I’d passed smiling women, their hair in curls from the salon, in the common area. When I’d told them they looked pretty, one had held a single finger to her mouth. She was watching television, and I was interrupting her. Now the home was dimly lit and startlingly vacant. Signs of neglect were everywhere: a collapsed ceiling in a common room, its fragments strewn across the carpet; detergent scattered across the laundry room; tools and machine parts littered near equipment in need of repair. The resident who had waited an hour and a half for oxygen last June had requested a repair for the call light outside her room. Staff gave her a Schwinn bicycle bell and instructed her to ring it if she needed help. (Portopiccolo’s spokesperson said that they have no records of this incident.) I asked the son if anything had improved in the past few weeks. “Nurse staffing is better now,” he said, “because people have died.”
How Nursing Homes Can Hide Profits While Claiming Losses and How This Impacts Residents Webinar	***How Nursing Homes Can Hide Profits While Claiming Losses and How This Impacts Residents*** The New Jersey Long Term Care Ombudsman program has produced a webinar with Ernest Tosh, an attorney and analyst who specializes in the relationship between nursing home finances and resident care. The video presentation contains easy-to-understand graphics and explanations. Attorney Tosh clearly describes how nursing homes are able to report financial losses to regulators while actually funneling substantial funds to parent companies and other related parties. He also explains how private equity is involved in some nursing homes’ operations and how all of these financial dynamics impact staffing and resident care. Finally, he summarizes

	existing financial reporting requirements and proposes changes to achieve real, needed fiscal transparency for this industry. View the Webinar on nursing homes hiding profits and claiming losses. It runs 1 hour 39 minutes. View the PowerPoint slides without narration on nursing homes hiding profits and claiming losses. Thanks to our colleagues at the *Long-Term Care Community Coalition* in New York for making this information known to us.
"Is state aid really helping the neediest hospitals? Better data analysis would help target funding to facilities that truly need it" *CommonWealth Magazine*	**Is state aid really helping the neediest hospitals?** **Better data analysis would help target funding to facilities that truly need it** By Nancy Kane and Paul Hattis *CommonWealth Magazine* August 27, 2022 AS LEGISLATORS ponder whether to resurrect a $350 million "relief" fund for Massachusetts hospitals, we suggest that they first step up the state's informational capacity to better assure that they are allocating funding to institutions truly in financial need. We worry that the proposed allocations in the 2022 relief package, as well as unanticipated and abrupt facility and service closures over the last decade or so, raise the concern that policymakers do not have clear criteria for determining which of our state's hospitals are truly in need and deserving of additional state support. Ideally, "distress" funding should go to hospitals whose primary cause of poor financial performance is due to a disproportionate commitment to serving low-income (high Medicaid) and/or underserved (behavioral health) populations, and not, for instance, due to over-expansion funded by excessive amounts of debt, or the strategic and financial priorities of out-of-state owners. Poor financial performance needs to be defined more broadly than simple operational measures of profitability. While the state collects and publishes a lot of financial data, primarily through the Center for Health Information and Analysis and, to a more limited extent, the attorney general's public charities division, improvements are needed to address important shortcomings of the state's financial oversight and monitoring approach. Here are the shortcomings as we see them: Too much focus on individual hospitals, not systems. While the state has made an effort to collect system-level audited financial statements, most of the data CHIA publishes is at the hospital level, even though at least two-thirds of our hospital beds are operated by multi-hospital systems. Systems often make strategic closure and service consolidation decisions reflecting system-level strategic and financial priorities that may not be apparent in any one member hospital's financial profile. Consider Steward Health System. While the Massachusetts hospitals owned by Steward appeared to be profitable in 2020 in aggregate, according to CHIA data, the system's operating losses (Steward owns 40 hospitals in nine states) have been

staggering for the last several years, contributing to a negative net worth of $1.5 billion as of 2020.

Income statements given too much weight. The CHIA annual hospital profiles show five metrics derived from income statements, two from balance sheets, and none derived from cash flow statements (such as investments in property, plant and equipment, and acquisitions). The only two balance sheet metrics are net assets (equivalent to net worth) and current ratio. The data books CHIA produces provide more balance sheet metrics, but are still short of a thorough analysis of financial health, which would involve looking at patterns of these ratios and cash flows to detect financial wealth, financial distress, and strategic investment priorities.

One of the most meaningful liquidity metrics is days of unrestricted cash on hand (current and noncurrent), a metric that can be used to identify accumulated wealth. For solvency, a metric that captures the impact of operating lease financial burdens (generally not classified as "long term debt") is increasingly important. Capital adequacy – how well is the hospital/system maintaining its historic investment in property plant and equipment — can be captured using metrics such as average plant age and capital expenditures over depreciation expense. A sources/uses analysis of cash over a longer period of time (5 – 7 years) can reveal where the cash of health systems/hospitals comes from (Is it operations or financing activities?) and where it is used (acquisitions, transfers to other entities, or investments in joint ventures) as another window into long-term strategic priorities and relative financial health.

Failure to explore strategic decisions. According to CHIA, Steward's Massachusetts hospitals in aggregate reported $63 million in profit in 2020. However, over the period 2016-2018, Steward sold most of its Massachusetts hospitals' buildings and land to Medical Properties Trust in sale/leaseback arrangements. Most of the sale proceeds went to pay off Cerberus, its private equity owner, and to acquire hospitals in other states., leaving Steward with very large future lease payment obligations. At the parent level, Steward Health reported $4 billion in long-term debt plus another $4 billion in future lease payments that Steward Health System as a whole owes Medical Properties Trust, and possibly other outside creditors, which puts the entire enterprise, including the Massachusetts hospitals, at grave financial risk. Steward's Massachusetts hospitals represent 10 percent of the state's hospital beds, and roughly 18 percent of its 2020 High Public Payer Community Hospital beds, a reference to facilities that receive a high percentage of funding from Medicaid and Medicare.

Too reactive, not pro-active. Current government agencies lack the resources to support active financial monitoring and evaluation. CHIA, the attorney general's office, the Executive Office of Health and Human Services, the Health Policy Commission, and the Department of Public Health each have ways of obtaining financial information, but typically only when a system is already in crisis. None of these agencies is officially charged with overseeing potentially risky financial transactions such as sale/leasebacks before they occur, nor do they have the regulatory authority to pro-actively intervene or prohibit major financial transactions that put health access, affordability, and/or equity among communities at risk.

	With the creation of the Health Policy Commission in 2012, a merger or acquisition triggered the provision of more extensive financial data by the involved providers, followed by detailed analysis by Health Policy Commission staff of proposed market transactions before they happen and often extensive community engagement regarding the perceived impact. When this level of state scrutiny and public participation occurs, the process can be consequential as to whether the transaction goes forward or not, and the financial and equity impact of the transaction can be mitigated. This depth of financial understanding and policy intervention roles tied to mergers and acquisitions should be mirrored by government agency oversight over routine financial data, analysis, and oversight. The state needs to be better prepared to support new legislative funding initiatives or decision-making by state agencies with timely, relevant financial information. While we have a public repository of comprehensive financial data at CHIA, what is lacking is the investment in staff capabilities to analyze and interpret for public policy purposes what the data tells us. Additional resources should be provided to CHIA to carry out more comprehensive oversight and monitoring activities, with the capacity to call on appropriate sister agencies to intervene before a crisis occurs. This would be a valuable investment of public dollars in a state like ours that depends greatly on our health care providers to meet basic care needs and drive the overall economy of our state. *Nancy Kane is a retired professor of management at the T.H. Chan School of Public Health at Harvard University and a board member of the UMass Memorial Health system. Paul A. Hattis is a senior fellow at the Lown Institute.*
Long Term Care Community Coalition The Long Term Care Community Coalition (LTCCC) is a nonprofit organization dedicated to improving quality of care, quality of life, and dignity for elderly and disabled people in nursing homes, assisted living, and other residential settings. LTCCC focuses on systemic advocacy, researching national and state policies, laws, and regulations in order to identify relevant issues and develop meaningful recommendations to improve quality, efficiency, and accountability. In addition to providing a foundation for advocacy, LTCCC uses this research and the resulting recommendations to educate policymakers, consumers, and	**LTCCC Alert: Nursing Home Staff Turnover Above 50%** *The following is an alert for the Q1 2022 staffing report. To access the report, **click here**.* **August 24, 2022** – Staff retention is essential for nursing homes to provide quality care for their residents. Unfortunately, turnover continues to be a major problem for many of the nation's 15,000-plus facilities. The average nursing home turns over more than half (53.3%) of its nursing staff within a year, according to the latest federal data. **Today, LTCCC announces the publication of the latest staffing data for every US nursing home** (in compliance with mandatory reporting requirements) during the first quarter of 2022. This staffing report includes information for every nurse and non-nurse staff position, facilities' use of contract (agency) staffing, and, for the first time, turnover and weekend staffing levels (the Centers for Medicare & Medicaid Services began publishing turnover and weekend staffing levels in 2022). The federal data show that average nursing home staffing (3.62 Total Nurse Staff Hours Per Resident Day, incl. 0.61 RN Staff HPRD) is far below the levels needed to meet basic care needs for the nation's 1.1 million nursing home residents. **Staffing Facts for Q1 2022**

the general public. Consumer, family, and LTC ombudsman empowerment are fundamental to its mission.	• Nationwide, **the average nursing home reported a nursing staff turnover rate of 53.3%** and **RN staff turnover rate of 51.9%.** (Note: 17.7% of nursing homes either submitted data that did not meet the criteria required to calculate nurse staff turnover or did not submit staffing data; 23.9% of nursing homes did not meet the RN staff turnover criteria or submit RN staffing data). • Contract employees accounted for **9.7% of all nurse staff hours in Q1 2022**, nearly double the rate from Q1 2021 (5.0%). • Total RN Staff HPRD (0.61) **is down more than 10%** since the first quarter of 2021 while total staffing levels have decreased about **8% in that period**. • **Staffing levels are significantly lower on weekends**. The median nursing home provided 3.06 total nurse staff HPRD on weekends, about 15% lower than the overall staffing level. • **Roughly one in four (26.8%) nursing homes met the essential total care staff threshold** (4.10 HPRD), as determined by a landmark 2001 federal study. Though recent studies have found that adequate RN staffing is essential, only **30.5% of nursing homes met the RN staff threshold (0.75 HPRD)** indicated by the study. LTCCC's Q1 2022 report can help the public, media, and policymakers identify and assess the extent to which nursing homes in their communities provided sufficient staffing to meet basic clinical and quality of life needs. The report is based on the most recent payroll-based journal (PBJ) data reported by the federal Centers for Medicare & Medicaid Services (CMS). **(See: PBJ Daily Nurse Staffing, PBJ Daily Non-Nurse Staffing, and Provider Information). Visit the NursingHome411 Data Center for more information on staffing, five-star ratings, and other important nursing home data.**
Dignity Alliance Massachusetts Request for strategic input	**Request for Strategic Input** Dignity Alliance Massachusetts is engaged in a process to determine the strategic direction and a set of priorities to pursue throughout 2023. A Google form has been designed to collect input: https://forms.gle/fqLWJkCxcmqW71Lq9 We are distributing the form through DignityMA's distribution list. Even if you don't regularly participate in any Zoom sessions or other DignityMA activities, but follow and support our mission and work, we welcome your input. We would appreciate submissions by Thursday, September 15.
Access to Dignity Alliance social media	Email: info@DignityAllianceMA.org Facebook: https://www.facebook.com/DignityAllianceMA/ Instagram: https://www.instagram.com/dignityalliance/ LinkedIn: https://www.linkedin.com/company/dignity-alliance-massachusetts Twitter: https://twitter.com/dignity_ma?s=21 Website: www.DignityAllianceMA.org

	Workgroup	**Workgroup lead**	**Email**
	General Membership	Bill Henning	bhenning@bostoncil.org

<table>
<tr><td rowspan="9">Participation opportunities with Dignity Alliance Massachusetts

Most workgroups meet bi-weekly via Zoom.

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<tr><td>The Dignity Digest</td><td colspan="3">For a free weekly subscription to The Dignity Digest:
https://dignityalliancema.org/contact/sign-up-for-emails/
Editor: Paul Lanzikos
Primary contributor: Sandy Novack
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<tr><td>Note of thanks</td><td colspan="3">Thanks to the contributors to this issue of The Dignity Digest
Charles Carr
Arlene Germain
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Special thanks to Paul Spooner with the MetroWest Center for Independent Living for assistance with the website and MailChimp versions of The Dignity Digest.
If you have submissions for inclusion in The Dignity Digest or have questions or comments, please submit them to paul.lanzikos@gmail.com.</td></tr>
<tr><td colspan="4">Dignity Alliance Massachusetts is a broad-based coalition of organizations and individuals pursuing fundamental changes in the provision of long-term services, support, and care for older adults and persons with disabilities.
Our guiding principle is the assurance of dignity for those receiving the services as well as for those providing them.
The information presented in "The Dignity Digest" is obtained from publicly available sources and does not necessarily represent positions held by Dignity Alliance Massachusetts.
Previous issues of The Tuesday Digest and The Dignity Digest are available at: https://dignityalliancema.org/dignity-digest/
For more information about Dignity Alliance Massachusetts, please visit www.DignityAllianceMA.org.</td></tr>
</table>

[i] Also, New York Times, *Care Suffers as More Nursing Homes Feed Money Into Corporate Webs*, Gordon Rau, 1/2/2018, https://www.nytimes.com/2018/01/02/business/nursing-homes-care-corporate.html?_r=0.

[ii] *NURSING HOME MEDICAID FUNDING: SEPARATING FACT FROM FICTION*, Long-Term Care Community Coalition, 1/10/21, page 3, https://nursinghome411.org/wp-content/uploads/2021/01/LTCCC-Policy-Brief-Medicaid-Funding-Facts-vs-Fiction.pdf

[iii] Boston Globe, *A pattern of profit and subpar care at Mass. nursing homes*, Kay Lazar, 3/27/16, http://www.bostonglobe.com/metro/2016/03/26/profit-and-care-massachusetts-nursing-homes/JfpOM6rwcFAObDi2JLcAnN/story.htm.

> " In a 2014 study, 44% of MA nursing homes paid rental fees to themselves or a related company (20% paid more than $1M). The review also found that some nursing home owners were paying themselves salaries in excess of $1M…"
> "…for-profit nursing homes, which constitute 70% of facilities in the state, frequently devote less money to nursing care compared to nonprofit homes, and often have more health and safety violations. The review also found that some nursing home owners were paying themselves salaries in excess of $1 million…"

Also, New York Times, *Care Suffers as More Nursing Homes Feed Money Into Corporate Webs*, Gordon Rau, 1/2/2018, https://www.nytimes.com/2018/01/02/business/nursing-homes-care-corporate.html?_r=0.

Additional quotes from 3/27/16 Boston Globe, footnote 2:

"…For-profit nursing homes were far more likely to pay rental fees to a company they also owned, providing a prime avenue for owners to keep more money.

- Among for-profit nursing homes, 163 paid rental fees to themselves or a related company**.** Just 11 nonprofit homes reported such payments…" [174 in total, or 44% of all MA nursing homes.]

"… 80 Massachusetts nursing homes [20% of MA nursing homes] each paid more than $1 million in rental fees, with the money often directed to property companies they also own. Among these nursing homes, the health and safety problems found by state inspectors were 42 percent higher than for the facilities that spent less than $1 million. All but one of those that spent more than $1 million in rental fees was for-profit…"

[iv]