Chris Dempsey for State Auditor
Dignity Alliance Massachusetts
Questionnaire Responses

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1. **Most Massachusetts residents know someone who has needed long-term services or care due to issues related to aging or disabilities or experienced it themselves. Has anyone close to you needed nursing home care, congregate living arrangements, or home and community-based services? What implications for public policy and regulatory enforcement do you draw from this experience?**

   I'm no different from most Massachusetts residents: I have close family members and loved ones who have required long-term care, who have struggled to find care that is affordable, who have benefited greatly from the compassionate care of providers, and who have faced the shortcomings of a system that is complex and difficult to navigate. We need long-term care options that are less expensive, easier to access, more stable, and which treat care-recipients and care providers with dignity, respect, and compassion.

2. **Hundreds of million dollars of state and federal funds have been provided to Massachusetts nursing homes during the pandemic. There has been little to no analysis and accountability of the use of these funds. It is important to know if these expenditures were effective in order to direct future allocation decisions. It is equally essential to provide public assurance that the funding was used as intended. As the state auditor, will you undertake a comprehensive public audit of the use of pandemic-related spending as an early priority?**

   I was the first candidate in this race to put forward a plan for oversight of federal stimulus funds. I released a paper on oversight of ARPA funds, and that will be a Day 1 priority in office. The plan includes, but is not limited to: 1) Monitoring and tracking ARPA funds in real time, 2) Adopting many of the recommendations of the Racial Equity Scorecard that was developed by the NAACP, the Black Economic Council, the Massachusetts Public Health Association, and many other groups, and 3) Working with state and local partners to ensure comprehensive oversight. I strongly encourage all to read the full paper on our website, as it leaves no doubt that our agenda for oversight of federal stimulus funding is the strongest, most comprehensive, and most equitable in the race.

3. **The ownership of nursing homes is increasingly under the control of out-of-state, investor groups. The organizational structure has been segmented into many components, often under common ownership, e.g., a real estate entity, management company, therapy services, and more. This make it difficult to determine who is controlling major staffing, operational and business decisions and who has responsibility and accountability. Consequently, it is critical to analyze how MassHealth funds are being used. Periodic, independent, comprehensive, and transparent public audits are necessary to assess how nursing homes operate and public funding is spent. As the state auditor, will you undertake this type of audit on an ongoing basis? Would you support legislation to ensure transparency and accountability of nursing home ownership interests and control?**

   Yes. The Auditor's Office must have a complete understanding of how and where MassHealth funds are used. I would support legislation to improve transparency of nursing home ownership and control. We need to understand where our public dollars are going, and we owe it to MassHealth recipients and to taxpayers to track these dollars and eliminate waste, so that recipients receive the best possible care. We also need to make sure that when MassHealth is paying the benefits are going to a local workforce, not out of state owners.

4. **Under state law and federal requirements, the Massachusetts Department of Public Health (DPH) has the primary responsibility for ensuring the safety, well-being, and effectiveness of care for all nursing home residents including adherence to resident's rights. Over the past few years, DPH's performance has come under criticism in several state and federal studies. Additionally, nursing homes with recent state-approved changes of ownership experienced significant care giving failures. There also have been changes in DPH's key staffing. All put into question the adequacy and efficacy of nursing home oversight, licensure adherence, and quality of operations within the Department. As the state auditor, what steps would you take to ensure that strong and comprehensive nursing home oversight and a thorough and transparent nursing home licensure process are vital responsibilities for the Department?**

   Auditor Bump conducted an audit of the DPH in 2019 that identified significant issues in the licensure and oversight of healthcare facilities, including nursing homes. The first step must be to follow-up on that audit, tracking progress on previous recommendations, adjusting recommendations to reflect the new challenges presented by COVID, and advising on and additional steps that must be taken based on any other new information.

   We know that additional administrative actions are necessary. I will spotlight those issues with the next gubernatorial administration and with other stakeholders, including the media and advocates. I strongly support the creation of a long-term care ombudsman who can help support training and response to exploitation, elder abuse, and neglect. Should additional legislative changes be needed, I look forward to being a strong ally and partner to the Dignity Alliance in working with the Legislature to enact these changes.

5. **In recent years, there have been targeted MassHealth rate enhancements for nursing homes. Their efficacy has not been analyzed and reported publicly. What can the state auditor do to ensure that current and future rate increases are effective and they accomplish intended goals?**

   For all of our actions as a Commonwealth, it is important that each program be fairly evaluated for efficacy. Providing rate enhancements during this very difficult time in health provision is an understandable reaction to staffing difficulties but reasonable reactions made in good faith are not enough to be good long-term policy.

   This and other future responses must come with a clear definition of success, metrics that would enable measurement against those definitions, and a willingness to adjust or discontinue programs that are not meeting our needs.

   To this end, as Auditor, I intend for my office to be a resource for State agencies looking to conduct self-evaluations in addition to the office's official audits. This is an important cultural change as it requires an open mind to change course and to abandon instincts to treat a "failed" program as a personal or professional failure. When we can acknowledge these are difficult problems to solve and that many of our attempts may not succeed, no matter how well-intentioned, we can work together to improve the efficacy of state programs and deliver the greatest benefit to the public.

6. **In efforts to "rebalance" the provision of long-term services and care, Massachusetts has secured various Medicaid waivers from the federal government to expand eligibility for and availability of home and community-based alternatives to institutional care for older adults and persons with disabilities. As the state auditor, what role do you have in analyzing the effectiveness of these waiver programs which have been implemented in Massachusetts?**

   Our state government should be trying various methods to improve the delivery of needed services and taking advantage of Federal flexibilities to deploy them. However, innovation for its own sake is insufficient to improve health outcomes. Evaluation of these programs is necessary to understand what works and what does not, to understand why things succeed, what changes we can make to improve programs not meeting their goals, and to know when a good idea is not good enough in practice. We also must ensure that proper services are being provided to the individuals on the waivers, services like: mental health outreach and crisis response, as well as personal care, home health aid, transportation services, and more. The rapid expansion of 1915(c) waiver programs throughout the 21st century means that we are in an opportune time to compare programs and outcomes across states, across time, and against concrete criteria to ensure we are delivering the best possible care in the least restrictive environment.

7. **The quality of care in nursing homes is directly correlated with the adequacy of staffing, namely certified nursing assistants (CNAs), registered nurses (RNs), and licensed practical nurses (LPNs). Yet the majority of MA nursing homes do not meet a newly established MA hourly standard of care. Strong oversight is necessary to ensure safe staffing levels to protect nursing home residents. In your role as state auditor, what would be done to assure compliance with staffing requirements?**

   The quality care and safety of patients should always be the number one priority of nursing homes, and to ensure that safety is a priority, nursing homes have to be fully and properly staffed.

   As State Auditor, I will work with DPH to make sure they are properly enforcing their new staffing requirements for nursing homes.

   As our population continues to age, the demand on nursing homes will only continue to grow, if we don't work to address staffing shortages now we will only see the quality of care continue to drop. I strongly support increasing the Registered Nurse coverage in nursing homes to reduce the misuse in antipsychotics and provide increased overall quality of care. I also believe there should be an increase in the amount of training CNAs required to be inline with the recommendations from the National Academy of Medicine.

   This is why as State Auditor I will also support legislation that will provide solutions to nursing homes that are struggling to meet the new safe staffing levels so that patients are receiving the best quality of care and so that staff are receiving livable wages.

8. **About one of four nursing home residents in Massachusetts is administered antipsychotic medications, one of the highest nursing home antipsychotic usage rates in the country. Massachusetts requires informed written consent of a patient or a patient's representative's representative prior to the administration of antipsychotics and other psychotropics to nursing home residents. Additionally, about 10% of Massachusetts nursing home residents have a diagnosis of schizophrenia, many of recent determination. This is a rate ten times greater than that of the general population. As state auditor, what can be done to reduce the usage of antipsychotic medications as well as ensure meaningful compliance with existing requirements?**

   Currently, less than 1% of the US population is diagnosed with schizophrenia, yet in Massachusetts nursing homes 10% of patients are diagnosed, making it one of the highest in the nation. Psychotropics can be important in providing comprehensive care for illnesses like schizophrenia, but have deleterious impacts when administered as chemical restraints for nursing home residents, especially those with dementia where psychotropics have a black box warning for mortality. With an already disproportionately high rate of diagnosis, it is crucial for nursing homes to work through less drastic alternative forms of treatment before utilizing psychotropics. A targeted audit of the informed consent process may be a prudent outcome of this collaboration. This can support a drive for increased clarity and regulations around the Informed Written Consent process and form to protect patients from excessive and undesired antipsychotic medication administration. The audit should also identify where best practices can be adopted in certification for nursing home staff to better equip the workforce to provide non-pharmacological care when appropriate and reduce potential misdiagnosis of schizophrenia.

9. The Massachusetts Inspector General (IG) recently issued a report about the Holyoke Soldiers' Home with a set of recommendations. The report noted that the Executive Office of Health and Human Services (EOHHS) is responsible for approximately one-third of the state's annual budget. Among a number of observations, the IG recommended that EOHHS improve its oversight of each EOHHS subsidiary agency by ensuring direct reporting structures and clear chains of command and regularly evaluating the performance of agency heads through mandatory, structured, independent performance evaluations. Do you concur with the Inspector General's recommendations? Why or why not?

As the most extreme moments of crisis recede, we must get a better understanding of our failures in congregate care settings, at the Soldiers' Homes, in other public facilities, and in private facilities. Even in the early days of the pandemic, when we were not yet aware of all of the information about COVID and when PPE was hard to find, our facilities were consistently failing at basic infection control. What happened at the Holyoke Soldiers' Home was a preventable tragedy, one that reflects some of the failures in our facilities that predate COVID-19. The fact that these problems predated COVID also shows that there were early warning signs. By understanding how these sub-par practices came to become standard and how failures of inspections did not lead to change pre-COVID, we can understand how we tragically failed residents and family members. I have met with families of the victims of the Holyoke Soldiers' Home tragedy, and those families have told me that they are not seeking revenge or retribution, but only respect, awareness, and the improvement of facilities and practices so that other families need not suffer in the way they did. My investigation into the tragedy will be about collaboration and compassion, not finger-pointing and Monday Morning quarterbacking.

A whistleblower complaint triggered the IG report of the Holyoke Soldiers' Home on the eve of the COVID pandemic -- and the tragic death of 77 veterans in Holyoke exposed how poorly that facility was prepared for a pandemic. Earlier investigation may have prevented significant tragedy but the attention of the IGs office in real-time to the calamity that came will hopefully help to provide a significant imperative to fix long-standing problems and drive real improvement to the lives of Veterans.

The IG recommendations to the Legislature, the DVS, and EOHHS represent a base to improve the administrative functioning and operation of the Soldiers' Home. I agree that there needs to be a clear chain of command, and that administrators should be experienced and certified. We cannot afford to have such critical facilities be led by unqualified political appointees. I also think there is an important role for an advisory group of veterans, families, and other stakeholders to improve operations and the quality of care. Moving forward, fundamental care values and practices must be paramount. Residents deserve to be treated with dignity, have self-determination and choice, and equitable access to care.