Joint Public Hearing: Residential Health Care Facilities and COVID-19

TESTIMONY OF

K Webster
Coordinator
Neighbors to Save Rivington House
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and Legislative Commissions on Administrative Regulations Review Commission
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Testimony:

Good morning. Thank you for the opportunity to testify.

My name is K Webster. I am the coordinator for Neighbors to Save Rivington House. We are an organization that arose spontaneously with the impending loss of Rivington House, once the largest skilled nursing home in the country dedicated solely to individuals trying to survive AIDS and the only such facility in New York City. The same year Rivington House opened its doors, the AIDS mortality rate in the US had reached an all-time high with 50,877 deaths. The NY State Dormitory Authority financed the state-of-the-art-infectious disease skilled nursing facility with $72 Million in bonds. It was staffed by trained skilled caring workers.

Bialystoker, Cabrini, St. Roses, were all nursing homes that had already been flipped here. A nursing home provider who was more interested in profits than care cashed in on the luxury condo market in the suddenly desirable Lower East Side of Manhattan abetted by poor state oversight. We and our elected officials pushed back and stopped the condos from being built in a many year effort to keep it as a neighborhood hub and site for skilled care housing to allow our elders to age in place in the community they built. Despite those efforts it was lost to us.

We focus on those who can't age in their current homes because: they don't have one, their housing is inaccessible or unaffordable, they require 24/7 skilled care due to medical conditions, they lack a trusted network to assist with care, they would endanger a partner's health with their care needs, or the person with guardianship decides their safely requires them to live in a government regulated care facility. We continue to work in coalitions with all advocates who insist on a continuum of care that respects the needs and wishes of those who need care, whether with viable supports for home care or reimagined, regulated congregate skilled care.

This is also personal for me. I cared for my mother in my home for a total of six years and, when late stage Alzheimer's made that unsafe for her, we relocated her to my sister's care in Baltimore as all nearby nursing homes were gone. Despite my sister's and a caring staff's best efforts in a typically understaffed home, she developed pressure ulcers and I went to

Baltimore for 6 weeks to live literally on a chair in her room to help nurse her back to health. We succeeded, and she lived for five more months delighting in small things.

I've supported another sister through a nine year battle to keep her husband alive who she cared for in her home. It was costly to her own health. Last week I argued with Lenox Hill Hospital to allow an 83 year old African American friend who has diabetes and congestive heart failure to remain in her hospital bed for the weekend while we sought a safe place for her to move to and get physical therapy. They would not. She is a powerful, smart woman but was too sick to continue to try to stay. She is now in a nursing home where no visitors are allowed. This is a nursing home that lost 93 people to COVID 19 (and that number is unreliable due to NYS not counting hospital deaths of recent nursing home admittances).

We have joined with the efforts of Community Voices for Health System Accountability and with individual advocates to ensure others are made aware of the egregious situation we have left our seniors to die in - too many of whom have no cognitive ability to know who they are much less the ability to fight for their lives. Their families have no strength for a larger effort while fighting to keep a beloved family member alive with dignity and care.

We also join with nursing home staff. Inadequate staffing, no sick leave or pay, poor pay and lack of infection control long before COVID 19 arrived, and *with* COVID 19 little or no PPE, meant the best of our caregivers were left alone to handle a crisis of biblical proportion.

Add to this that without visitation by entities with no conflict of interest - we have no idea what current conditions are or if the issues that exacerbated the virus' spread have been addressed or are still in play.

Unless you have lived under a rock none of this is news.

David Himmelstein in Public Health at Hunter: "we're spending $11,000+ on a per capita basis in the US on healthcare, with nearly $4000 per capita going for health administration. That's 4 times as much as is spent to administer the health system in Canada which is built on a non-profit basis and organized as a public service not as a market business.

My focus is on the linked issues of lax NY State Health Department oversight and the apparent strong correlation of for-profit nursing home ownership and reduced quality of care - including conditions prior to the pandemic that likely exacerbated deaths due to COVID-19.

New York State Oversight

The New York State Department of Health (NYS DOH) is responsible for regulatory oversight of nursing homes and decides who is awarded and allowed to maintain licenses for nursing homes.

The DOH leaves the particulars of vetting oversight to the Public Health and Health Planning Council (known as the PHHPC).

The council is an appointed body of officials, many from inside the health care industry. It is composed of those with expertise and many of whom have a very real potential conflict of interest in how healthcare is delivered in New York State. Apparently, there is but *one* consumer advocate on a council of 24. With two more seats approved by the NYS legislature

but never appointed by the Governor. I doubt that three members - whose sole focus is advocacy for the public (particular when public money funds nursing homes) is sufficient for a council whose job is the equitable delivery of good healthcare.

For instance, State law requires a "character and competence" review of buyers before a change in ownership can go through. Any other health care facilities associated with the buyers must have a record of high-quality care. The council has substantial leverage to press applicants to improve quality, but a 2015 examination by ProPublica showed that leverage was seldom used. The DOH prepares the character-and-competence recommendations for the council, but records showed the DOH doesn't report them all, therefore, the council hasn't always had complete information about all the violations and fines at nursing homes owned by or affiliated with applicants it reviewed. Too often ownership transfers are approved, especially transfers of struggling nursing homes, to operators with a history of poor or unknown performance which has been costly to the residents in their facility.

During the Certificate of Need (CON) process in the PHHPC the lack of transparency, lack of reasonable access for the public, limited public notice to submit meaningful comment leads to less than vigorous vetting on healthcare sites that the public depends on. Especially in fast-tracked nursing homes. There are closures with no time or consideration of resident needs. ("The Rivington Act" was offered as a possible fix but languishes as a bill).

Without the implementation of stricter vetting standards for nursing home owners and the elimination of an investor-focused industry there is the potential for a collapse into receivership as happened with Skyline Healthcare in New Jersey in 2018 and Kansas in 2019. The implosion of a major network left the state with 15 Skilled Nursing Facilities (SNFs) in receivership, accounting for the vast majority of the 22 statewide under third-party control due to financial pressures.

Adding to the problem, NYS doesn't impose sufficient fines to disincentivize mismanagement (of infection control for instance). Fines are considered merely the cost of doing business.

On NYS's grant of legal immunity: The public doesn't expect a profit-oriented sector (or those whose high salaries rely on money extracted from unclear funding sources) or those who donated heavily to political campaigns on behalf of that sector to be writing drafts of legislation on immunity from financial liability for negligence for that same sector. Immunity for staff was given by Executive Order 202.28 by Governor Cuomo on March 7, 2020. Wouldn't it have been simpler and uncontroversial to upgrade *that* coverage for the entire pandemic?

Under the State's oversight, the Ombudsman program relies too heavily on volunteers and underpaid staff who do not have the full independence and clout required to call out poor practices.

NYS does not require demographic information be kept on who live in nursing homes making it impossible to address any potential systemic discrimination.

Medicaid/Medicare Oversight

We will also want to be sure that what happened in California nursing homes didn't happen here. Incidents of Medicaid-funded residents being forced out of their nursing home to make a bed available for the far more profitable Medicare short term COVID19 releases from hospitals.

Who Owns Nursing Homes – Lack of Transparency and Accountability

The for-profit nursing home industry often claims it is hard to make money in the skilled nursing business, the "thin margin" hardship plea that apparently falls apart when those without conflicts of interest look at the data.

For Profit Ownership, LLCs, Hidden Financing and Assets, etc.

Over 70% of nursing homes in the US are now run for profit. With private-equity ownership on the rise since early in 2015 nearly 190 private-equity deals were made in the nursing-home industry "totaling about $5.3 billion…"

According to various studies ownership by entities set up with a for-profit motive has increased poorer care, less transparency and less accountability – and during this pandemic may have exacerbated the death of many.

Not only have there been major changes in ownership structure and management, the degree of complexity has greatly increased with many levels of Limited Liability Corporation (LLC) ownership that make finding and holding accountable who maintains the ownership stake in a nursing home extremely difficult.

Dave Kingsley, University of Kansas Medical Center, "Private sector facilities are typically individually incorporated by parent corporations as Limited Liability Corporations (LLCs). Often one or more other subsidiaries or shell companies are in an ownership hierarchy, which serve as a cash pipeline to investors. Furthermore, parent corporations often own subsidiaries or LLCs that provide ancillary services such as management services, pharmacies, and physical therapy."

"The nursing home industry has become more of a real estate and finance industry than a skilled nursing industry."

The New York Times reported that "In many cases, investors created new companies to hold the real estate assets because the buildings were more valuable than the businesses themselves, especially with fewer nursing homes being built. Sometimes, investors would buy a nursing home from an operator only to lease back the building and charge the operator hefty management and consulting fees. Investors also pushed nursing homes to buy ambulance transports, drugs, ventilators and other products or services at above-market rates from other companies they owned." The practice of buying nursing home supplies at inflated cost from corporate entities tied to the owners/their families/stockholders of those nursing homes is not uncommon.

LLC structures typically exist to hide assets. William Murray, a plaintiff's lawyer with experience suing nursing homes: "The structure is designed to keep liability on the company

that has the fewest assets and the most debt". Though claims of not owning or operating any skilled nursing or other senior housing business is "a legal fiction" when they own the subsidiaries that own the operations.

Scotland's Centre for Health and Public Interest found that the property side of companies are often based in tax havens. Potential tax revenue is lost while hindering transparency and accountability of owners.

Executive Compensation

Executive compensation is among a large number of other finance-related techniques for extracting cash from the business of caring for patients in healthcare facilities. And although the salary of some executives may not have changed dramatically over time, some total compensations have increased exponentially such as with self -awarded bonuses under titles like "Non-Equity Incentive Plan Compensation" that executives/board members award to themselves.

Medicare and Medicaid

According to David Kingsley one of the major financial maneuvers that often "occur between the facility and the return earned by investors and executives" is the "extraction of cash from Medicare, Medicaid, and private pay reimbursements – through property leases, management contracts, and ancillary services (all of which are expenses on the operators' balance sheets, i.e. the LLC's balance sheet)".

Two US Senators were alarmed enough to write to four private equity firms particularly concerned about private-equity investment in "industries that affect vulnerable populations and rely primarily on taxpayer-funded programs such as Medicare and Medicaid, like the nursing-home industry."

It is even rumored that publicly financed Medicaid has been used to fund lobbyists for some owners under the guise of 'education'.

The public and the legislature need to know about *all* forms of financialization of the nursing home industry. The potential for abuse in the current system requires independent financially expert investigation.

Atul Gupta of the Wharton School's study noted that private equity investment often means increasing patients-per-bed occupancy rates while reducing nurse staffing. The study found an increase in patient volume and decrease in nurses' salaries was worth about $770,000 annually to the average private-equity-owned nursing home and that following private-equity buyouts, nursing homes' overall ratings on the five-star system decline by 8% of the average rating.

Scotland's Labor Party Health Spokesperson said it well: "[Nursing] homes conceal a shadowy world of billionaires, hedge fund operators and private equity firms yet they are staffed by some of the lowest paid workers in the country. A huge amount of public money goes through privately-owned care homes and we shouldn't continue to put up with this secrecy."

Impacts on Residents With For-Profit Ownership

For-profit nursing homes disproportionately lag behind their nonprofit counterparts across a broad array of measures for quality and are cited for violations at a higher rate than nonprofit facilities.

Staffing

Long-term care staffing is consistently reported in the literature as being an important difference between for-profit, nonprofit and publicly owned facilities.

"Private-equity buyouts of nursing homes are linked with higher patient-to-nurse ratios, lower-quality care, declines in patient health outcomes and weaker performance on inspections" according to new research from the University of Pennsylvania's Wharton School, New York University's Stern School of Business and the University of Chicago Booth School of Business. The researchers found that after private equity stepped in, nursing staff hours per patient fell 2.4 percent, and staff quality as measured by federal regulators fell 3.6 percent.

A Kaiser Health News analysis of federal records showed that better-staffed nursing homes have fewer infection-control lapses. And that Government health inspectors have cited more nursing homes for failing to ensure that all workers follow prevention and control rules than for any other type of violation. In all, 9,697 nursing homes, or 63%, were cited for one or more infection-control deficiencies during the past two regular inspection periods, which go as far back as 2016 for some facilities. Simply put, violations were more common at homes with fewer nurses and aides than at facilities with higher staffing levels.

A 2011 study of nursing homes in the U.S. found that the largest for-profit chains had the lowest nursing hours.

Canada's National Library of Medicine published a report that concluded "Not-for-profit facility ownership is associated with higher staffing levels. This finding suggests that public money used to provide care to frail elderly people purchases significantly fewer direct-care and support staff hours per resident-day in for-profit long-term care facilities than in not-for-profit facilities. Specifically, government owned facilities provided 61 more minutes of staffing per resident day than for-profit facilities.

The Office of the British Columbia (BC) Seniors Advocate report states that care homes in the not-for-profit sector spent 10% more of their revenues on direct care compared with care homes in the for-profit sector. It found that with the same level of public funding, the for-

profit operators failed to deliver 207,000 hours of funded care while the not-for-profit sector delivered 80,000 more care hours than they were funded to deliver.

The Centers for Disease Control and Prevention (CDCP, 2020) analyzed the first COVID-19 outbreak. The report found several factors that contributed to the spread of the infection including failure to report a respiratory disease outbreak, staff members who worked while symptomatic and in more than one facility, inadequate familiarity and adherence to standard infection control practices, inadequate supplies of personal protective equipment (PPE) and hand sanitizers, delayed recognition of the virus based on signs and symptoms, and failure to hold consistent and effective quality assurance performance improvement meetings that could have identified issues earlier. **All measures that rely on sufficient staffing.**

Poor Staff Levels/ Worse COVID-19–Related Outcomes

One major factor in the spread of COVID-19 was previous violations of infection control regulations. The General Accountability Office found that infection control is the most common type of nursing home deficiency, as many as 40% of nursing homes with COVID-19-positive residents had been previously cited for infection-control infractions.

Recent research has shown an association between lower nurse staffing levels and worse COVID-19–related outcomes in LTC facilities.

The Canadian Medical Association Journal found "… facilities run on a for-profit basis had more extensive outbreaks and more [COVID19 related] deaths than facilities run on a nonprofit basis, with an even more marked effect when for-profit facilities were compared with facilities that were entirely municipally run.

A study by California on Policy, Politics, & Nursing Practice found that evidence supported findings that low staffing contributed to poor quality California nursing homes being more vulnerable to the COVID-19 pandemic. Specifically, that COVID-19 outbreaks occurred more in Long Term Care (LTC) facilities with total staffing levels of registered nurses (RNs) less than the recommended minimum standard (0.75 h per resident day) were twice as likely to have residents with infection of COVID-19 than adequately staffed facilities. They concluded that to prevent, delay, and manage nursing home infections such as has occurred during the COVID-19 pandemic, all States, and CMS need to adopt stronger minimum staffing requirements, particularly to increase RN and total nurse staffing levels in all nursing homes to address the fundamental underlying problem of low staffing in many U. S. nursing homes that jeopardizes the health and safety of residents.

The Office of the British Columbia (BC) Seniors Advocate determined that "Recognizing the importance of staffing characteristics was key to limiting COVID-19 outbreaks in long-term care in BC. Staff were quickly identified as an important vector of transmission, which led to the BC government limiting staff working across multiple sites by offering the same higher standard of wages and working conditions to all LTC workers."

In Connecticut The Journal of the American Geriatrics Society study found that "nursing homes with higher RN staffing and quality ratings have the potential to better control the spread of the novel coronavirus and reduce deaths. For LTC facilities with at least 1 confirmed case of COVID-19, every 20-minute (per resident day) increase in RN staffing

was associated with 22% fewer confirmed cases and in facilities with at least 1 death from COVID-19, every 20-minute increase in RN staffing significantly predicted 26% fewer deaths. They also found that nursing homes caring predominantly for Medicaid or racial and ethnic minority residents tend to have more confirmed cases.

The New York Times, “Covid-19 has been particularly virulent toward African-Americans and Latinos: Nursing homes where those groups make up a significant portion of the residents — no matter their location, no matter their size, no matter their government rating — have been twice as likely to get hit by the coronavirus as those where the population is overwhelmingly white.” If home had at least 25% Black and Latino there was a chance of 84% Coronavirus cases. If Home had less than 5% Black and Latino there was a 33% chance of Coronavirus. A 52% gap.

The Buffalo News noted that Medicaid pays nursing homes the lowest reimbursement, an average of $216 a day in Erie and Niagara counties. Medicare pays nursing homes more than double that, about $475 a day on average, according to estimates from Buffalo-area nursing home operators. State and federal regulations prohibit nursing homes from discriminating against individuals because of their payment source. But some families felt that is exactly what happened.

In terrible irony, in 2018 “nursing home industry lobbyists insisted that intensifying nursing home oversight wouldn’t help”. Analysis” …showed that one-fourth of nursing homes reported no registered nurse on duty for at least one day during a three month period — despite the Medicare requirement that an RN be on duty at least eight hours per day.”

Recommendations

Oversight

Public Health and Health Planning Council (PHHPC)

Public Health and Health Planning Council (PHHPC) immediately appoint a minimum of two consumer representatives, slots that are already in the legislative pipeline. Appointments should be clearly acknowledge advocates for residents of nursing homes, their families and the public (Justice in Aging, Long Term Care Coalition, etc.).

A reputable independent study to rapidly create a transition plan to create a PHHPC with an equitable ratio of relevant government representatives, independent financial experts, health care experts, industry advocates, nursing home/hospital consumer advocates and consumer representatives. Conflicts of interest transparent and made public.

Specifically, add independent legal and financial experts that can serve on PHHPC to assist with framing issues and developing competency to understand and elucidate arcane industry financials.

State planning around COVI-19 has occurred behind closed doors. The DOH and PHHPC need to be reoriented to provide guidance and planning in a transparent and inclusive manner. Add local disclosure and vetting processes to the current steps taken in rewarding licenses in

each region. The public, community-based organizations and advocates need to be given sufficient notice of CON proposals with realistic opportunities for input. The State should use the approach that the Public Service Commission follows to inform consumers about rate and utility ownership changes. Offer meetings nearby or in the affected community wherever possible.

Data:

NY State Department of Health performs the vital regulatory role in nursing home oversight and is in the best position to obtain ownership data from state licensure agencies. Use Kansas bipartisan laws enacted in 2019 as a possible template.

General issues

Staffing

In preparation for the next wave of COVID-19 mandate and enforce sufficient staffing ratios. Specifically staffing ratios that ensure care: RNs to residents, Skilled staff vs. Custodial, LPNs to Residents, Nursing aides to residents (do not include "staff" that are administrators, media and tour personnel, etc. a breakdown of specific staffing roles is necessary). The type of staffing levels guided by and based on the best available research and best practices to address resident care needs and to allow for added time required for safety-related tasks (handwashing, putting on/taking off personal protective equipment (PPE), and consistent compliance with infection control standards.

Finances

Institute a medical loss ratio (MLR)—requiring providers to use designated percentages of reimbursement on resident care—serves as a check to the poor use of public and private money. Federal law already places an MLR on health insurance companies under the Affordable Care Act, requiring them to spend at least 80 to 85% of premium dollars on medical care. The nursing home industry itself has come out in support of MLRs.

Licensing

Make mandatory retroactively:

a) Ownership disclosure and financial accounting of assets and funding and expense data of all currently licensed facilities. Full disclosure of all financial connections to other businesses regardless of how distanced by legal maneuvers. No licenses renewed to any licensee that won't disclose. Require updates if there is a change

b) Require ratios for CEO compensation (including stock options) that are proportionate to their funding sources and have their compensation proportional to their skilled care workers.

New Licenses

A moratorium on new licenses, transfers or sales of facilities to for-profit, private equity backed or LLC entities. Research and studies have shown that this kind of ownership has resulted in poorer quality care in the crucial areas which appear to be the exact vulnerabilities which loomed large in the pandemic. Until we know causality, we cannot in good conscience allow further inroads from that quarter.

Or

A ban on future licenses to for-profit, private equity backed or LLC entities. Especially given that NYS granted immunity to providers and the looming possibility of Federally granted immunity, these entities are no longer answerable to the public who funds them.

Transition away from current for-profit owners to public ownership or not-for-profit ownership with caveats that management salaries are proportionate to skilled staff salaries and proportionate to the public funding streams with full transparent, easily accessed accounting required.

Prospective buyers of any licensed facility must further provide a 12-month operating budget for the facility, along with proof that they have sufficient funds to make that plan a reality.

Losing Licenses

Revoke or suspend or deny licenses to any entity (whether for-profit or non-profit) that has "x" number of infractions not following through on infection control guidelines – including staffing ratios.

Other oversight

Fund and increase Ombudsmen in those programs with iron-clad independence and clout to enforce infractions. The National Institute of Medicine has recommends there should be one full-time paid Ombudsman Coordinator for every 2,000 LTC facility beds. The report showed that NY only ranks 39th in the number of ombudsman staff per 2,000 beds.

Significant fines for serious infractions of infectious disease protocols, require "x" months of PPE on hand. For repetitive infractions – loss of license.

Keep records on the demographics of who lives in nursing homes so that we may effectively monitor them for any violations of the NYS Human Rights Law.

Advocate to reform the Long Term Services and Supports (LTSS) financing system to protect consumers from poverty when accessing care. The U.S. approach to long-term care financing requires consumers to spend all their savings and assets paying for care out- of-pocket before they become eligible for Medicaid, the largest payer of LTSS. In theory, Medicaid serves as a safe net for those who qualify, in practice, its services are limited by eligibility requirements, inadequate funding, and workforce shortages.

Future of Care in Congregate Nursing Homes and In-Home Care

Fund sturdy supports for in-home care.

Legislature fund a study on how to refinance and reimagine care facilities and to make them less segregated, more human centered, with community and experts and advocates input. Multi-bed room designs vulnerabilities to virus transmission require building upgrades as an important part of addressing the problems in the LTC sector.

Closing

We have the expertise and knowledge to completely overhaul our care and oversight systems. We have the ability to find and restructure funding with the help of foundations and public money to refinance and reimagine how we deliver skilled care as a state whether in congregate settings or in private homes. We have enough information on what went wrong to act *immediately* to rectify past mistakes.

"There were many, many, many nursing homes throughout the country that got no infections. Just because you are a nursing home doesn't mean you're going to get an outbreak. It's how you have your staff and the actual structure and the standard operating procedures that have made certain nursing homes highly vulnerable. You got to fix that and fix that fast.
Or you don't wind up getting money.
- Dr. Fauci CDC

All of the issues that worsened in this pandemic have existed in nursing homes long before this event. The Canadian Health Care System:

"If requirements to fund adequate levels of staffing affect the bottom lines of for-profit facilities, then it might be time for this care to be turned over to public and truly nonprofit entities. If increasing quality raises costs more quickly than it does revenues, profits must fall as quality improves. That is, a trade-off between profit and quality would exist. Public policy needs to come to terms with this trade-off and intervene on behalf of our most vulnerable seniors."

Thank you for listening.

Yours,

K Webster
Neighbors to Save Rivington House

Sources:

Lower Manhattan Hit Hardest by Nursing Home Decline, Stats Show
https://www.dnainfo.com/new-york/20161010/lower-east-side/nursing-care-facility-closures-department-of-health-data-rivington-house/

Seniors and staff caught in the middle of nursing homes' quest for profit
https://www.theguardian.com/us-news/2020/jul/30/care-homes-seniors-nursing-homes-flipping-profit
CMAJ: “COVID-19 and long-term care facilities: Does ownership matter?”
https://www.cmaj.ca/content/cmaj/early/2020/07/22/cmaj.201714.full.pdf

Kansas Cracks Down on Nursing Home Owners’ Finances in Wake of Skyline Collapse
https://skillednursingnews.com/2019/04/kansas-cracks-down-on-nursing-home-owners-finances-in-wake-of-skyline-collapse/

ProPublica “How N.Y.’s Biggest For-Profit Nursing Home Group Flourishes Despite a Record of Patient Harm”
https://www.propublica.org/article/new-york-for-profit-nursing-home-group-flourishes-despite-patient-harm

Health Care for All New York
https://hcfany.org/hcfany-urges-governor-to-sign-bill-adding-more-consumer-reps-to-state-health-provider-review-panel/

Market Watch Private Equity Takeover of Nursing Homes Has Reduced Quality of Care at Critical Moment Report Suggests
https://www.marketwatch.com/story/coronavirus-pandemic-puts-private-equity-ownership-of-nursing-homes-under-microscope-2020-03-14

After Hospitals’ Donation to New York Democrats, a $140 Million Payout
https://www.nytimes.com/2019/10/03/nyregion/medicaid-donation-hospitals-cuomo.html

Health Care Lobbyists Are Donating Large Amounts to Democrats. They Want Execs’ Immunity From COVID-19 Lawsuits
https://jacobinmag.com/2020/07/health-care-lobby-democrats-execs-covid-immunity

Buffalo News “$5000 Nursing Home Investigations Delayed Thanks to COVID-19”
https://buffalonews.com/news/state-and-regional/5-000-nursing-home-investigations-delayed-thanks-to-covid-19/article_abaa7896-c205-11ea-8c7b-4f2c25860c00.html#tracking-source=home-top-story-1

The Gathering Storm: How the State Seized Control of Two Troubled Nursing Homes Coronavirus Crisis Loomed
https://calmatters.org/health/coronavirus/2020/07/coronavirus-california-nursing-homes-pasadena/

Residents: Don't privatize Sullivan County nursing home
https://www.recordonline.com/story/news/2020/07/14/residents-say-dont-put-sullivan-county-nursing-home-private-hands/5433931002/

Coronavirus squeezes the "sandwich generation"
https://www.axios.com/coronavirus-sandwich-generation-3527e6de-66da-4a9a-b65f-a5b2610bbeeb.html?utm_source=linkedin&utm_medium=social&utm_campaign=organic&utm_content=1100

Money Flowed Into Campaign Coffers as NY Lawmakers Passed Immunity Protection for Hospitals, Nursing Homes
https://www.law.com/newyorklawjournal/2020/07/16/money-flowed-into-campaign-coffers-as-ny-lawmakers-passed-immunity-protection-for-hospitals-nursing-homes/

2016 “SNF Companies Exiting a ‘Deteriorating Industry’
https://seniorhousingnews.com/2016/11/21/snf-companies-exiting-deteriorating-industry/

From 2018 McKnight’s “CMS intensifying nursing home staffing oversight; providers say it won’t help”

https://www.mcknights.com/news/cms-intensifying-nursing-home-staffing-oversight-providers-say-it-wont-help/?platform=hootsuite

"Running on a Thin Margin is not a valid argument for low quality nursing home care: we need to debunk it."
https://kanmograypanthers.com/running-on-a-thin-margin-is-not-a-valid-argument-for-low-quality-nursing-home-care-we-need-to-debunk-it/

Governor Cuomo Executive Order No.202.28
https://www.governor.ny.gov/news/no-20228-continuing-temporary-suspension-and-modification-laws-relating-disaster-emergency

Push for Profits Left Nursing Homes Struggling to Provide Care
https://www.nytimes.com/2020/05/07/business/coronavirus-nursing-homes.html

The Striking Racial Divide in How Covid-19 Has Hit Nursing Homes
https://www.nytimes.com/article/coronavirus-nursing-homes-racial-disparity.html

Cuomo Executive Order Grants Immunity to Healthcare Providers During COVID-19 Emergency
https://www.mlmic.com/blog/physicians/new-york-physician-immunity-during-pandemic

Does Private Equity Investment in Healthcare Benefit Patients? Evidence from Nursing Homes
NYU Stern School of Business
https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3537612

Scotland's Care Homes Owned by Chinese (and US) In Tax Havens
https://theferret.scot/scottish-care-homes-chinese-state-tax-havens/

Poverty wages in nursing homes accelerated coronavirus outbreak
https://www.bostonglobe.com/2020/04/25/opinion/poverty-wages-nursing-homes-have-accelerated-coronavirus-outbreak/?event=event25

Private-equity takeover of nursing homes has reduced quality of care at critical moment, research suggests
https://www.marketwatch.com/story/coronavirus-pandemic-puts-private-equity-ownership-of-nursing-homes-under-microscope-2020-03-14

The Reality of Coronavirus Pandemic for the American Medical System with David Himmelstein and Steffie Woolhandler: Distinguished professors of Public Health.
Philip Alcabes: Professor and former infectious-disease epidemiologist.
http://www.roosevelthouse.hunter.cuny.edu/events/reality-coronavirus-pandemic-american-medical-system-online-event/

Nurse Staffing and Coronavirus Infections in California Nursing Homes
https://theconsumervoice.org/uploads/files/issues/Harrington,_Ross_et_al._Nurse_Staffing_and_Coronavirus_Infections_in_NHs_July_2020.pdf

Trends in long-term care staffing by facility ownership in British Columbia, 1996 to 2006
https://pubmed.ncbi.nlm.nih.gov/21269009/

COVID -19 Infections and Deaths among Connecticut Nursing Home Residents: Facility Correlates
https://onlinelibrary.wiley.com/doi/10.1111/jgs.16689

How N.Y.'s Biggest For-Profit Nursing Home Group Flourishes Despite a Record of Patient Harm
https://www.propublica.org/article/new-york-for-profit-nursing-home-group-flourishes-despite-patient-harm

Coronavirus Stress Test: Many 5-Star Nursing Homes Have Infection-Control Lapses
https://khn.org/news/coronavirus-preparedness-infection-control-lapses-at-top-rated-nursing-homes/

Nurse staffing and deficiencies in the largest for-profit nursing home chains and chains owned by private equity companies
https://pubmed.ncbi.nlm.nih.gov/22091627/

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https://pubmed.ncbi.nlm.nih.gov/22091627/

Staffing levels in not-for-profit and for-profit long-term care facilities: does type of ownership matter?
https://pubmed.ncbi.nlm.nih.gov/15738489/

Less spent on residents and care staff underpaid at for-profit seniors' homes: B.C. report
https://www.theglobeandmail.com/canada/british-columbia/article-for-profit-senior-care-homes-spend-less-on-residents-than-non-profit/

Medical Loss Ratios for Nursing Homes: Protecting Residents and Public Funds
https://medicareadvocacy.org/medical-loss-ratios-for-nursing-homes-protecting-residents-and-public-funds/