The Dignity Digest

Issue # 138 May 8, 2023
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.**

Spotlight

CMS eager to leverage new nursing home ownership data, leader confirms
McKnight's Long Term Care
By Kimberly Marselas
April 26, 2023
CMS Eager to Leverage

> A top Centers for Medicare & Medicaid Services enforcement official said Tuesday that the agency is eager to use data collected under a proposed ownership transparency rule to "scrutinize how certain ownership types correlate with quality of care and costs.", ,
> [Dara Corrigan, deputy CMS administrator and director of the agency's Center for Program Integrity,] noted that about 70% of nursing homes are owned by for-profit companies, and that there has been a recent increase in acquisitions by private equity companies and real estate investment trusts. Those were the targets of the new rule, which adds definitions for both owner types and triggers changes to CMS provider enrollment forms to capture more information. The agency also hopes the changes will lead to a better understanding of related party relationships... .
> The agency is currently reviewing formal comments on its ownership transparency rules; the submission period ended April 14. Several groups, including 18 states attorneys general [including Massachusetts], have submitted comments in favor of the rule, saying more transparency would improve their enforcement approaches.
> CMS Eager to Leverage

Quotes

Lawmakers must take a more critical look at what the state's powerful nursing home lobby legitimately needs and what guardrails, including audits, are needed to make sure taxpayer money doesn't just end up lining the pockets of for-profit nursing home operators. . .
And are the guardrails sufficient?
More money is tied into federal quality metrics. . . But will the state actually audit use of these monies? It should.
And why not use this spending to force improvements in nursing-home deficiencies, such as non-responsiveness to residents' needs, that drive a large proportion of

complaints in [the state].

Nursing-home budget largesse should reflect need, not lobbying clout: editorial, **Cleveland.com,** May 7, 2023, Reflect Need Not Lobbying Clout

The home care workforce grew from approximately 840,000 to 1.22 million workers between 2008 and 2013. After 2013, growth slowed, ultimately reaching 1.42 million workers in 2019. In contrast, the number of Medicaid HCBS participants grew continuously from 2008 to 2020, with accelerated growth between 2013 and 2020. As a consequence, the number of home care workers per 100 HCBS participants declined by 11.6 percent between 2013 and 2019.

The Home Care Workforce Has Not Kept Pace With Growth In Home And Community-Based Services, ***Health Affairs,** April 19, 2023, Home Care Workforce

"It's plain and simple: families deserve transparency when making decisions about hospice and home health care for their loved ones. . . Shining a light on ownership data is good for families, good for researchers, and good for enforcement agencies."

U.S. Department of Health and Human Services Secretary Xavier Becerra, *For the First Time, HHS Is Making Ownership Data for All Medicare-Certified,* **Centers for Medicare & Medicaid Services,** April 20, 2023, Home Health Agency Ownership Data

"We want to make sure that the nursing home industry is more transparent. . .Nursing homes frequently use other companies to provide various services. Generally, the public doesn't know what companies provide which services or [whether] companies might be contracted to nursing home owners. Making this information available publicly empowers nursing home residents and their families to make more informed decisions about their care."

Dara Corrigan, deputy CMS administrator and director of the agency's Center for Program Integrity, *CMS eager to leverage new nursing home ownership data, leader confirms,* **McKnight's Long Term Care News,** April 26, 2023,

CMS Eager to Leverage

We know that powerful forces in the nursing home industry, including private equity investors, vigorously oppose a minimum staffing standard. Private equity investors often turn a profit by manipulating personnel: hiring fewer workers and slashing pay and benefits at the cost of patient care. Setting a staffing standard would mean having to pay higher wages to attract more people to the industry; it would mean paying a living wage, so working in a nursing home would be a sustainable, family-supporting job.

In Recognition of Caregivers, White House Readies to Help Nursing Home Worker, **AFL-CIO,** May 1, 2023, in recognition of caregivers

"Older adults, in particular those with underlying health conditions, such as heart or lung disease or weakened immune systems, are at high risk for severe disease caused by RSV. Today's approval of the first RSV vaccine is an important public health achievement to prevent a disease which can be life-threatening."

Peter Marks, director of the FDA's Center for Biologics Evaluation and Research, *First vaccine targeting RSV wins FDA approval. More are coming.* ***Washington Post,** May 3, 2023 (updated), RSV Wins FDA Approval

Lawmakers must take a more critical look at what the state's powerful nursing home lobby legitimately needs and what guardrails, including audits, are needed to make sure taxpayer money doesn't just end up lining the pockets of for-profit nursing home operators. . .
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Nursing-home budget largesse should reflect need, not lobbying clout: editorial, **Cleveland.com,** May 7, 2023, Reflect Need Not Lobbying Clout

There continues to be a dire need for changes within the nursing home structure. If you have not visited a nursing home recently, it's an eye-opening experience! The lack of adequate staff along with inadequate training needs to be addressed.

Ruth Bensmiller-Reed, *Inadequate nursing home care must be addressed*, **The Gazette,** May 7, 2023, Inadequate Nursing Home Care

Visiting a hospital or clinic today feels like facing a firing squad, with rounds and rounds of bills coming from every direction. Fewer than half of Americans rate the quality of U.S. health care as excellent or good. . .
Patients are burned out. Nurses are leaving the profession. Doctors are demoralized. In the meantime, the people not sick or tending to sickness — the corporate middlemen in charge of insurance companies, private hospitals, doctor practices and pharmaceutical companies — are feasting. As Donald Berwick, a former administrator for the Centers for Medicare and Medicaid Services, noted, the "glorification of profit, salve lucrum, is harming both care and health."

Dr. Ricardo Nuila, *American Health Care Is Dying. This Hospital Could Cure It.,* **New York Times (free access),** March 9, 2023, American Health Care Is Dying

After listening to partisan rants on both sides that aim only to tweak rather than remake our system, I suggest we hold a national referendum on health care. Americans should vote yea or nay on a system that provides basic health care for all.
A federal ballot measure like this has never been held in our country. A referendum would ask Americans to focus on the proposal rather than on a candidate or political party. There's reason to believe that a direct vote could help us solve our health care quagmire.

Dr. Ricardo Nuila, *American Health Care Is Dying. This Hospital Could Cure It.*, **New York Times (free access),** March 9, 2023, American Health Care Is Dying

[A]s many as 30% of nurses at some Boston hospitals were fixed contract or traditional traveling nurses during the height of the pandemic. In addition to sapping hospitals of much-needed permanent nurses, the reliance on travel nurses has cost the industry $1.5 billion.

Newest 'State of Nursing in Massachusetts' Survey Reveals Unsafe Conditions and RN Burnout as True Causes of Statewide Staffing Crisis as Hospitals Overspend on Temporary Nurses and Patient Care Quality Drops, **Massachusetts Nurses Association,** March 29, 2023, MNA Survey

"After a time, we couldn't care for her ourselves. After all, we're all in our 60s, too."

Hua Ailing, a post office accountant in a small county in Anhui Province, China, *Deaths of Seniors in Hospital Fire Point to China's Elder Care Shortfall,* **New York Times (free access),** May 8, 2023, China's Elder Care Shortfall

[Ricardo Nuila, a practicing physician and associate professor at Baylor College of Medicine] asks a simple but profound question: "Why do some people benefit from health care in America, while others are excluded?" His answer is equally simple: Because the principal goal of the American health care system is to make money, period.

Made to Care For Those Left Behind, This Hospital Leads the Way, ***New York Times,** May 2, 2023 (updated), Made to Care

High-quality early care and education and long-term care are critical to our Nation's economic growth and economic security. Early care and education give young children a strong start in life, while long-term care helps older Americans and people with disabilities live, work, and participate in their communities with dignity. Access to both types of care is also critical to our national security because it helps ensure the recruitment, readiness, and retention of our military service members. . .

A sizeable majority of families and individuals in the United States who require care cannot access the

affordable, high-quality care they need. The markets for child care and long-term care for persons with disabilities and older adults who need support in their homes and communities fail to deliver enough high-quality care because of a persistent gap between the costs of providing this care and the prices families can pay.

Executive Order on Increasing Access to High-Quality Care and Supporting Caregivers, **The White House,** April 18, 2023, Increasing Access to High-Quality Care

"It's … with great hope that I declare Covid-19 over as a global health emergency. However, that does not mean Covid-19 is over as a global health threat."

WHO Director-General Tedros Adhanom Ghebreyesus, *WHO declares end to Covid global health emergency*, **STAT News**, May 5, 2023, WHO Declares End to Covid Emergency

"For 75 years, CDC and public health have been preparing for Covid-19, and in our big moment, our performance did not reliably meet expectations. My goal is a new, public health action-oriented culture at CDC that emphasizes accountability, collaboration, communication, and timeliness."

Dr. Rachel Walensky, CDC Director, in August 2022, *CDC Director Rochelle Walensky to step down,* **STAT News,** May 5, 2023, Walensky to Step Down

"This warehousing of children is beneath us. If we saw children being treated this way anywhere else, we would see it as a form of abuse or neglect. We choose to allow these children to languish. And that is morally unconscionable. It is willful and collective abuse."

Kenneth Goodman, who founded and directs the medical ethics program at the University of Miami Miller School of Medicine, *'Just another baby for them.' Parents, feds fight for kids stuck in Florida nursing homes,* **Miami Herald,** May 7, 2023 (updated), Just Another Baby for Them

OLDER AMERICANS MONTH
AGING UNBOUND: MAY 2023

1. **Administration on Community Living**
   Older Americans Month 2023
   Every May, the Administration for Community Living leads the nation's observance of Older Americans Month (OAM). The 2023 theme is ***Aging Unbound***, which offers an opportunity to explore diverse aging experiences and

	discuss how communities can combat stereotypes. Help promote flexible thinking about aging – and how we all benefit when older adults remain engaged, independent, and included. **Available now:** • Logos* • Posters* • Social media graphics* • Masthead • Activity ideas • Sample article and proclamation template *Available in English and Spanish https://acl.gov/oam/2023/older-americans-month-2023
Transitions	**2. STAT News** May 5, 2023 *CDC Director Rochelle Walensky to step down* A source told STAT that the decision to leave was Walensky's, and that the White House would have preferred that she remain in the job. . . In her time as CDC director, Walensky has tried to change the culture of the agency, pushing it to release data more quickly. Too often, she argued, scientists were holding onto information the public needed to know as they went through the process of releasing the data in scientific articles. . . She has also lobbied hard for authorities that would allow the agency to collect more and better data from states, tribes, and territories — a problem that has hamstrung the CDC at many points during the pandemic. Biden announced Walensky — an HIV expert who was previously chief of the infectious diseases division at Massachusetts General Hospital — was his choice to lead the CDC in December 2020, before he took office. Unlike the commissioner of the Food and Drug Administration or the director of the National Institutes of Health, the position of CDC director did not require Senate confirmation at that time. Walensky to Step Down
Webinars and Online Sessions	**3. Encore Boston Network** Wednesday, May 10, 2023, 2:00 to 3:30 p.m. *The Stigma Trap* Learn why millions of people get trapped in devastating long-term unemployment, including experienced workers with long careers. How is it possible for highly successful careers to suddenly go off the rails? Ofer Sharone, sociology professor at UMass Amherst, puts forward some answers and what to do about it in his new book, *The Stigma Trap*. Offered by 50+ Job Seekers in MA and co-presented by Encore Boston Network. **REGISTER HERE** **4. Administration on Community Living** Thursday, May 11, 2023, 4:00 to 5:30 p.m. *Turning Resources into Action: Increasing Integrated Housing Options for People with I/DD* Second webinar of a three-part series focused on improving community living options for people with I/DD. Safe, accessible, and affordable integrated housing options for people with intellectual and developmental disabilities (I/DD) are extremely limited. As a result, almost 70% of adults with I/DD live with their families, and most who live

outside the family home live in group settings.

To improve and expand community living options for people with I/DD, ACL is hosting a three-part webinar series that explores the housing needs of people with I/DD, barriers they face in securing housing (including limited inventory), and innovative strategies, resources, partners, and funding streams to help create more integrated housing options for people with I/DD. "Turning Resources into Action" is the second webinar in this series.

The series centers the perspectives and experiences of individuals with I/DD. It is intended for state and local disability, aging, health, and housing agencies; housing providers; disability and aging advocates; and researchers, as well as people with I/DD and their families.

"Turning Resources into Action" will feature speakers from the U.S. Department of Housing and Urban Development (HUD) and the Centers for Medicare & Medicaid Services, who will share information about federal resources and funding that can be used to support integrated housing options for people with I/DD. In addition, the Arizona Division of Developmental Disabilities (DDD) will talk about how they braided these resources to create community living options for people with I/DD, and Vicktor Gray, a person with I/DD who receives services from Arizona DDD, will share how he has benefitted.

During the webinar, you will learn about:

- Housing voucher programs
- HUD Continuums of Care
- Programs to develop affordable and accessible housing
- Programs to help people move from institutions like nursing homes into homes in the community
- Strategies that states are using to advance integrated community living for people with I/DD

After registration, you will receive a confirmation email with information about joining the webinar. Everyone who registers by 12:00 PM ET on Wednesday, May 10, 2023, will receive the slides in advance. A recording of the webinar and the slides will be available on the Housing and Services Resource Center website later this month.

The webinar will include real-time captioning and ASL interpretation. For additional accommodations or questions, please contact Allison Cruz.

Register for the webinar

5. **Bipartisan Policy Center**

Friday, May 19, 2023, 1:00 to 2:00 p.m.

Low-Income Housing Tax Credits and Long-Term Affordability

The Low-Income Housing Tax Credit (LIHTC) program is the largest and most significant affordable housing program in the United States. Since its inception in 1987, LIHTC has supported the construction or rehabilitation of about 110,000 affordable rental units per year, providing more than 3 million affordable units for low-income families. Since 1990, the federal government has required LIHTC developments to keep units affordable for a minimum of 30 years. Estimates find that nearly half a million current LIHTC units—representing nearly a quarter of the total stock—will reach their 30-year mark by the end of this decade.

With thousands of units across the country already phasing out of this standard, more resources will be needed to maintain and expand the number of affordable homes available to low-income renters. In this webinar, panelists will provide context on the scale of LIHTC affordability phaseouts in coming years,

	discuss strategies to preserve affordable units for longer time periods or in perpetuity, and highlight bipartisan proposals to strengthen LIHTC. SPEAKERS *Panel Discussion* • Emily Cadik | *CEO, Affordable Housing Tax Credit Coalition | @EmilyCadik* • Gerald Hunter | *President and Executive Director, IHFA | @IdahoHousing* • Chrystal Kornegay | *Executive Director, MassHousing | @MassHousing* • Francis Torres | *Senior Policy Analyst, BPC (Moderator) | @francis_to_go* **REGISTER NOW**
	Previously posted webinars and online sessions can be viewed at: https://dignityalliancema.org/webinars-and-online-sessions/
Nursing Homes	**6. Cleveland.com** May 7, 2023 *Nursing-home budget largesse should reflect need, not lobbying clout: editorial* Nursing home operators seem to be getting a pretty good return on their prior campaign contributions, if [Ohio's] pending two-year budget is any indication. That's not a positive. . . Lawmakers must take a more critical look at what the state's powerful nursing home lobby legitimately needs and what guardrails, including audits, are needed to make sure taxpayer money doesn't just end up lining the pockets of for-profit nursing home operators. . . Key examples of industry wins in the [Ohio] House, which passed its substitute budget bill on a bipartisan 78-19 vote April 26: -- "Rebasing": Increasing the frequency of how often the nursing home industry can boost nursing home rates in terms of inflation. According to the Legislative Service Commission, the cost of this House amendment is $607 million per fiscal year. Republican Gov. Mike DeWine's budget proposal didn't request the rebasing provision. -- High-occupancy premium: The House rewrite "reworks the state's quality incentive program, rewarding [nursing] homes with higher occupancy rates," Zuckerman reports. According to the LSC, the cost of this House amendment is $32 million per fiscal year. The governor didn't request this. -- Adds private-room payouts: The House rewrite "offers an add-on payment to facilities that put Medicaid patients in private rooms." According to the LSC, the cost of this House amendment is $82 million per fiscal year. The governor didn't request this, although Zuckerman notes it's widely supported as a way to improve patient dignity and for infection control. . . -- Pandemic bonus for six upscale facilities: The retroactive rewrite "would allow some of the $350 million pool in previously appropriated federal coronavirus relief [American Rescue Plan Act] dollars to flow to roughly six nursing homes that aren't enrolled in Medicaid. Those more upscale facilities cater to people with private insurance." LSC didn't estimate the additional cost. The governor didn't request either the appropriation or the retroactivity. Reflect Need Not Lobbying Clout **7. The Gazette** May 7, 2023 *Inadequate nursing home care must be addressed* By Ruth Bensmiller-Reed Once again, the topic of addressing issues within nursing home care is brought to light.

There continues to be a dire need for changes within the nursing home structure. If you have not visited a nursing home recently, it's an eye-opening experience! The lack of adequate staff along with inadequate training needs to be addressed.

During the past year, I have interacted with three different nursing homes and the experience went from bad to worse. We were assured and reassured our loved one would receive excellent care, sadly, that promise was not fulfilled. Our family obtained additional care givers (both being volunteers and paid out of pocket) with our hope proper care would be given. Even with this additional help, on numerous occasions staff did not respond to the needs of the patient nor follow instructions given or know the correct procedure/process.

Hopefully with higher wages and training a difference would be made. Each of us has a responsibility to be an advocate for those individuals who cannot speak for themselves but continue to tolerate being treated with no respect or dignity. Please express your concern to the governor and legislators in hopes of making a difference. Remember, it could be you waiting hours to be transferred from your wheelchair to your bed or being promised a necessary item to be brought to you. You wait but the person who promised to bring it never returns.

We need to do more! All residents deserve better!

Inadequate Nursing Home Care

8. **Miami Herald**

May 7, 2023 (updated)

'Just another baby for them.' Parents, feds fight for kids stuck in Florida nursing homes

At the Plantation Nursing and Rehabilitation Center on Northwest Fifth Street, frail men and women with wheelchairs, walkers, and hearing aids live out their last years in an institutional setting. Nearby, but in a world of their own, medically fragile youngsters at the start of life's journey spend day after day, year after year, confined to cribs. These children may spend the rest of their lives right here, with little to do but stare at a television, watched over by shift workers. They are the littlest residents of Florida nursing homes. And they occupy an institution within an institution, a place called The Kidz Korner.

Court records in a federal lawsuit set for trial on Monday before U.S. District Judge Donald M. Middlebrooks in West Palm Beach describe the above conditions. The complaint asserts that Florida's reliance on such institutions for the care of fragile children is a violation of their civil rights and an affront to federal laws that require the housing and treatment of disabled people in home-like settings whenever possible. The legal drama, a decade old, could result in a reckoning for Florida. The state likes to boast of its stellar finances — the $117 billion budget approved this month set a record. At the same time, it tightly rations funds for the care of children and others who require help. Regardless of need, lawmakers decide what they want to spend on Floridians with severe disabilities and medical needs. When the money runs out, that's it. And for those left out, it's sorry, maybe next year. It's why Floridians needing social services languish on waiting lists for years, even decades. Providing at-home nursing assistance and medical equipment might not cost much more than a nursing home bed, while allowing parents to nurture their fragile children at home. With Medicaid managed care plans dispensing the state's dollars, though, few families are approved for round-the-clock nursing care, children's advocates say. Those who are approved must cope with notoriously unreliable in-home nursing, a

byproduct of the state's penurious reimbursement rates.

And so, parents, many of whom cherish their children and want to show them love and affection, are forced to put them in nursing homes, sometimes hundreds of miles distant. Kidz Korner is one of three nursing homes in the state that currently house children. "This warehousing of children," said Kenneth Goodman, who founded and directs the medical ethics program at the University of Miami Miller School of Medicine, "is beneath us." "If we saw children being treated this way anywhere else, we would see it as a form of abuse or neglect," Goodman said. "We *choose* to allow these children to languish. And that is morally unconscionable. It is willful and collective abuse."

State health administrators long have insisted that the care children are given in nursing homes is superior to what parents can offer. But the state's own inspection records speak of children left for hours in diapers "soaked with urine," of children contracting dangerous respiratory infections from contaminated medical equipment, of a child losing nearly 50% of her body weight, of soiled, moldy buildings and piles of dirty laundry.

Mary L. Ehlenbach, the medical director of the Pediatric Complex Care Program at the University of Wisconsin in Madison, wrote in a report that parents often are held to a higher standard than the institutions that are being paid hundreds of thousands per year. Some parents, for example, said nursing home administrators told them their children couldn't go home until the family had a large private bedroom for the disabled child. At the nursing home, though, the children sometimes live three or four to a room. "Parents don't want their children exported to institutions 300 or 400 miles away to be warehoused," said Dr. Jeffrey Goldhagen, the division chief of community and societal pediatrics at the University of Florida College of Medicine in Jacksonville.

Brittany Hayes, the mother of a 5-year-old boy who has spent his entire life in nursing homes, told the Herald: "Most of the time he's in a crib. Every time I Facetime him, he's laying down in the crib." "If they'd just give me my child, I would make sure he meets his goals," Hayes said. "He's just another baby to them." Responding to "multiple complaints" about the institutionalization of disabled children, the Justice Department's civil rights division sued Florida health administrators a decade ago to put an end to such practices, saying they violate federal laws forbidding the institutionalization of disabled people, especially children.

Florida, an assistant U.S. attorney general wrote in a 2012 letter to the state, "has planned, structured and administered a system of care that has led to the unnecessary segregation and isolation of children, often for many years, in nursing facilities." While the confidentiality of state records, as well as the sealing and redaction of documents in the litigation, make it difficult to assess the toll of such isolation, a June 2022, inspection of a Pompano Beach facility for fragile children included this diagnosis for one resident who breathes with a respirator and suffers seizures: "major depressive disorder." The state insists that the federal government should mind its own business and allow Florida health regulators to provide care to disabled children as they see fit. The lawsuit, state lawyers say, cuts to the very "heart of its sovereignty: the weighing of competing healthcare policies."

"These children receive care in nursing homes not because the state violated [their civil rights], but because their parents or caregivers made, and continue to make, the emotionally difficult decision — under practical, complicated, and

individualized circumstances — that care in a nursing home is the best option for their children and families" the state wrote in a recent court filing.

In recent months, the Justice Department and the state filed thousands of pages of new records in the lawsuit, including reports and sworn statements from pediatricians, scholars and others who describe Florida's policies as archaic and cruel. The new records include statements from parents who say they would very much like to care for their kids at home — accounts that are at odds with the state's long-standing claims. Central to the litigation is Florida's perennially troubled Medicaid program, insurer of last resort for impoverished children and adults and Floridians with disabilities. Nearly 20% of the state's population is enrolled in Medicaid, records say, including almost 43% of all children — and a little more than half of children with special healthcare needs. The state set aside about $28 billion for Medicaid-funded healthcare, an arbitrary figure that is not nearly sufficient, forcing care to be rationed.

The result is that tens of thousands of disabled Floridians are on a wait list for community-based or in-home care, and many will die before they reach the top. Medical foster care, a separate program for frail children whose parents want to keep them out of institutions, also has a wait list. And, to access the program, a parent must relinquish custody of his or her child to the state — a requirement many parents find inhumane. With little hope of ever getting the in-home nursing or other services that could keep the medically complex children home, the Justice Department says, parents make the only choice they can: They leave their children in nursing homes, sometimes hundreds of miles away from those who love them. Dr. Walter F. Lambert, a pediatrician who is an associate professor of clinical medicine at the University of Miami, said children's well-being depends on far more than medicines, technology and nutrition.

"It's sad that health administrators don't consider the mental health of these children, and their need to be with their own family or in a family setting as an important part of their overall health, especially children with disabilities," Lambert said. When the lawsuit was filed, six nursing homes housed pediatric patients. By 2013, after the Miami Herald had written extensively about conditions in the homes, though, three of the facilities had shuttered, including the children's unit at Golden Glades Nursing & Rehabilitation, now called Sierra Lakes Nursing & Rehabilitation, a 180-bed facility near Miami Gardens where the Herald documented the deaths of two children. Among them was the plight of Marie Freyre, a 14-year-old afflicted with cerebral palsy and seizures who died within 24 hours of a long, bumpy ride from a Tampa hospital to the Golden Glades nursing home, ordered despite objections from her family. The girl arrived screaming in fear.

The same month as the Herald's reporting, December 2012, the Department of Children & Families quietly implemented a new policy that required high-level agency approval before any child in state care could be admitted to a nursing home or move from one institution to another. Only nine children in state care — that is, in the protective custody of DCF — now live in nursing homes, the state said in a court document. There are now three pediatric nursing homes in the state: Children's Comprehensive Care Center, with 36 licensed beds, in Pompano Beach; The Kidz Korner, with 100 licensed pediatric beds; and Sabal Palms Health & Rehabilitation, with 34 licensed pediatric beds, in Largo, a city in Pinellas County. Ian Trenchfield, Kidz Korner's administrator, acknowledged during a November 2022 deposition that an inability to secure in-home nursing

care sometimes keeps children from going home. One couple, he said, had to return their child to the facility after learning their private duty nurse quit the job before even starting.

"The state's efforts in this respect," wrote Sara S. Bachman, dean of Social Policy and Practice at the University of Pennsylvania, "fall woefully short."

Bachman and other experts from across the United States wrote in Justice Department reports filed in court that, by dint of a rigged funding system, health administrators and employees of the three nursing homes funnel children into institutions that they cannot leave. The state currently pays to house about 140 children in long-term care facilities. The Justice Department contends another 1,800 children are "at risk" of being institutionalized due to lack of community resources. Experts wrote in reports that some facility employees told parents several falsehoods that kept the children trapped in institutions: that the parents lacked adequate space to care for a disabled child; that they could not be trained to provide care themselves; and that their kids would perish without the specialized care only a nursing home could provide. "We would need to learn to care for her alone," one mother said she concluded after having her choices explained to her. "We were terrified."

Said another mother in a report filed in the litigation: "I didn't want him going into the facility…I wanted to bring him home." But, she added: "I was told the facility was the only option." And almost half of the 22,000 people on the state's wait list for state-funded community care — generally designed to ensure disabled Floridians are not segregated in isolated institutions — are children, Bachman wrote. She added that 800 of the 10,000 children waiting for services are considered medically complex. No matter where fragile children receive care, it is never inexpensive. One of the South Florida homes charges more than $235,000 per year to care for children considered the most "fragile," according to court records reviewed by the Herald. Medicaid currently pays $253.51 per day for elders in nursing homes, or $92,531 per year, according to the state's long-term care industry group.

In contrast, the Birth-Related Neurological Injury Compensation Association, a Florida program that oversees healthcare for children with profound brain injuries and disabilities, pays about $229,950 per child annually for around-the-clock in-home nursing by licensed practical nurses, said Melissa Jaacks, NICA's director. Of 235 participants in the NICA program, only two live in institutions at their parents' request, Jaacks said. The rest live with their families or in other community settings, most with varying amounts of in-home nursing support, or care provided by their parents.

"Having a kid like this can break you," said Jaacks, a former child welfare administrator who took over management of the NICA program last year as part of a massive reform. Many of the parents served by the program, she added, become remarkably skilled at caring for their medically complex children, and are paid by NICA to perform procedures — like suctioning a breathing tube or feeding a child by tube — generally done by nurses. "These parents are the experts in how to care for their kids," she said. The Agency for Health Care Administration, which oversees the state's Medicaid Program and regulates nursing homes, declined to discuss allegations in the court file. Bailey Smith, the department's communications director, replied to an email from the Herald: "The agency does not comment on pending litigation."

The state says that only a small number of children live in long-term care

facilities. Administrators say 99.8% of Florida children with complex medical needs live at home or in other community-type settings, with a price tag of $500 million per year. In recent weeks, the state has filed reports from experts who defend caring for children in congregate settings. One doctor suggested that many children with medical complexities are simply too impaired to benefit from living in a home environment. “Some children would derive no benefit from in-home care. Sadly, many of these children suffer from severe neurologic issues and are in chronic, deep comas with no chance for improvement,” wrote Dr. Allan Greissman, a critical care pediatrician at Joe DiMaggio Children’s Hospital in Hollywood.

“They have no cognition and do not interact or respond with the environment. They are fed by a tube and kept alive by a ventilator. They suffer with chronic issues causing ventilator dependency. They develop bed sores and have frequent infections. Their lives consist of laying on their backs, hooked up to a machine. Whether they are in the ICU, a chronic-care facility, or home, no socialization or nurturing can be done,” Greissman added. Ehlenbach, the federal government’s expert, described in her report meeting several children who were anything but comatose: “I observed institutionalized children who did not appear to have severe chronic medical conditions or significant functional limitations. At Sabal Palms I observed one who was sitting alone in a stroller at the edge of an open common area. “When I interacted with her, she tracked me with her eyes and smiled at me, clearly engaged with the interaction. One extroverted child approached our group by walking up to us and speaking. The child described our group as “an ensemble of eight.”

Previously, Liz Dudek, a former secretary of the state’s healthcare agency, insisted that the nursing homes were “warm, nurturing” places that offered a variety of enriching activities to their children — such as trips to farms where children can ride horses — a claim that is at odds with state experts, like Greissman, who suggested many, if not most, of the children could not safely leave the nursing home. Records from the Justice Department lawsuit — and from AHCA’s own inspections — portray a grim reality inside the homes. In 2016, Charles Nelson, a professor of pediatrics and neuroscience at Harvard Medical School, visited nursing homes housing the children and filed a report as part of the litigation. He wrote that youngsters “spent most of their time in bed, some with TV monitors to look at, others without… .As a rule, the children’s aides were rarely in the room with the child unless the child needed medical attention or was taking part in some programmed activity.”

A “classroom” activity at one nursing home, for example, consisted of children watching a movie. At another nursing home, Nelson wrote, “I did not observe any classroom instruction taking place.” Describing a 16-year-old at one nursing home, Nelson wrote that he “found [the boy] in his crib, completely hidden under his blanket, left entirely alone.” “What was common across all three institutions,” Nelson wrote, “was a profound sense of social isolation.”

It is difficult to glean from the litigation whether such practices persist. Though the Justice Department’s experts once again toured the remaining pediatric nursing homes, in May and June of 2022, records of their findings have been sealed or redacted in the court file. Agency for Health Care Administration records offer some insight into conditions within the pediatric wards of the three nursing homes. Two of the three homes — Sabal Palms and Children’s Comprehensive Care Center — have been on the state’s Watch List of homes

that "did not meet, or correct upon follow-up, minimum standards at the time of an inspection."

An attorney for Sabal Palms wrote in an email: "After reviewing this matter, Sabal [Palms] is going to decline the request for comment." Ian Trenchfield, the administrator of Kidz Korner, declined to discuss the litigation. In a short, emailed statement, Trenchfield wrote the facility "is meeting an important need: helping children who require complex medical care continue to thrive and if able, return back home. Our goal is always to provide the children we serve with the highest quality care and quality of life possible and help the families cope with the everyday challenges of caring for a child with a disability."

Marjorie Evans, CEO at Children's Comprehensive Care Center, spoke at length with a Miami Herald reporter. She defended the quality of care at her facility, but also strongly agreed with disability advocates who claim that nursing homes are poor substitutes for parents who have adequate resources to care for their children at home. "I don't think children should be in any skilled nursing facility long term," Evans said. "If I had my wish," she added, "I would not allow kids to be in a long-term care or skilled nursing facility."

Evans said Children's Comprehensive Care is unique among long-term care facilities in Florida that accept children: "We try to get them out." The Children's Comprehensive Care Center spent 80 days on the state's Watch List from June 20, 2022, until Sept. 8, 2022, for violating fire safety codes. A June 2021 state visit reported that one boy spent most of a day without having his diaper changed, despite repeated inquiries from an inspector. The report quoted a staff member: "She stated she has been busy."

At 4:14 p.m., when caregivers got around to changing the boy, the report said, his diaper "was soaked with urine" and reeked. As to the child's activities, the report noted he was sitting in a wheelchair, either playing with a toy or watching television, during five observations from 10:14 a.m. through 3:39 p.m. Last June, an inspector faulted the home after a child developed a pressure wound on his foot that was left untreated for two weeks. That same report described another child who was found wearing two diapers — one atop the other — while being "saturated in urine." In June of 2022, inspectors reported the interior of a medication refrigerator in the facility's nursery that was "heavily soiled and [had] large areas of brown dried matter," numerous holes on the walls, and ceiling tiles that were "heavily soiled and stained." The floor of a respiratory storage room was "heavily soiled and littered with trash." A clean linen storage room had what appeared to be yellow mold "with visible spores." The report said the facility failed to dispose of garbage properly.

That inspection also faulted the facility for failing to "provide enough food [or] fluids to maintain a resident's health." One resident told inspectors he ate only the macaroni and cheese and Ramen noodles his mom had delivered because "the food here is terrible." Said another child: "The food has been lousy for years." In May of 2021, AHCA inspectors reported the home failed to act when a child went from 34.8 to 27.9 pounds in one month. When asked about the weight loss, the home's dietician disputed the finding, saying she recorded the resident's correct "weight on papers that she kept in a folder in her bag that only she had access to."

The next day, the facility's nursing director produced a new weight chart in which some of the resident's weights had been "crossed out," a report said. The page with the alarming weights was later removed altogether, the report said. The

nursing director also showed an inspector a “nutrition progress note” for the child that had been back-dated by two weeks. The report said a second child lost 53% of his or her body weight, going from 52.9 pounds on April 6, 2021, to 24.6 pounds on May 2, 2021. The report said no efforts were made to address the “severe weight loss.” Sabal Palms in Largo, which is licensed for 244 beds, 34 of them pediatric, accrued 157 days on the Watch List since 2020, state health records say. In June 2022, for example, the home was placed on the list for failing to timely report the abuse or neglect of an elder who suffered a painful fracture when her right leg got stuck under a wheelchair.

“She stated it was two weeks before she was able to go to the hospital,” a report said. “She stated they [the facility staff] thought I was faking it.” In October of 2020, an inspector who had visited Sabal Palms’ pediatric unit reported that “the facility failed to ensure residents received adequate respiratory care” by, among other things, not assuring staffers used proper hygiene and infection-control precautions and not investigating properly when three children were found to have respiratory infections from “organisms found within contaminated water and soil.” One of the children, whose chart described him as “fragile,” had pneumonia. The inspector reported that a respiratory therapist donned a pair of gloves without first washing his hands before suctioning a child’s breathing machine. That same day, the inspector wrote, a different therapist “put on clean gloves without practicing hand hygiene,” and was later seen putting clean gloves atop dirty ones. In August of 2019, AHCA inspectors faulted the facility for performing life-saving measures on an unresponsive child, in contravention of a do-not-resuscitate order signed by the youngster’s mother and doctor. Sabal Palms’ risk manager told the state that, under the facility’s procedures, someone should have reviewed the child’s chart for instructions if he stopped breathing, “but nobody checked it.” Despite documentation of such conditions, state social service administrators and nursing home staff long have maintained that children with medical complexities are far better off in facilities than with family, and that parents are inherently less capable of being caregivers. “For many children, home is both a safe and a loving, nurturing environment. But for children with complex medical needs, that is often not the case,” wrote Greissman, the state’s expert. “With patients who have complex medical needs, ‘safety’ means anticipating the ‘what ifs’: what if something were to happen? For this reason, care for patients in the home can be fraught with risk.” Some parents, Ehlenbach wrote in her report, were told their children were too profoundly ill to survive outside of an institution, or were going to die soon no matter what. “We didn’t expect her to make it out of 2021, and now in 2022 she is doing better’,” one parent told her. Ehlenbach added: “Indeed, many of the staff members at the nursing facilities also shared stories of children who had unexpectedly survived and then became long-term institutionalized children.”

Medical staff at the nursing homes may encourage families to fear caring for their kids at home, experts wrote. But when children in the nursing homes experience an emergency, they generally are sent by ambulance to a nearby hospital, just as a parent would do, Ehlenbach wrote. In her report, Ehlenbach called a “myth” the contention of caregivers at one nursing home that the program was equivalent to a “mini-pediatric intensive care unit.” The three nursing homes Ehlenbach visited met few of the requirements of an intensive care unit, she wrote, including staffing: ICUs should have one nurse for every two patients; some of the nursing homes had 10 children for each nurse. Parents told

	experts that nursing homes made it nearly impossible for families to bring their children home, describing discharge planning as an endless series of moving goal posts. One parent expressed immense frustration at efforts to bring their child home from a nursing facility. "No matter who I scream at, nothing gets done," the parent told Ehlenbach. Wrote Ehlenbach in her report: "Several families described feeling desperate to be reunited with their children. One family member poignantly shared, 'Pretty much short of robbing a bank, we'll do what we can to bring him home'." Just Another Baby for Them **9. McKnight's Long Term Care** April 26, 2023 *CMS eager to leverage new nursing home ownership data, leader confirms* By Kimberly Marselas A top Centers for Medicare & Medicaid Services enforcement official said Tuesday that the agency is eager to use data collected under a proposed ownership transparency rule to "scrutinize how certain ownership types correlate with quality of care and costs.", , [Dara Corrigan, deputy CMS administrator and director of the agency's Center for Program Integrity,] noted that about 70% of nursing homes are owned by for-profit companies, and that there has been a recent increase in acquisitions by private equity companies and real estate investment trusts. Those were the targets of the new rule, which adds definitions for both owner types and triggers changes to CMS provider enrollment forms to capture more information. The agency also hopes the changes will lead to a better understanding of related party relationships... . The agency is currently reviewing formal comments on its ownership transparency rules; the submission period ended April 14. Several groups, including 18 states attorneys general [including Massachusetts], have submitted comments in favor of the rule, saying more transparency would improve their enforcement approaches. CMS Eager to Leverage
Home Care	**10. Centers for Medicare & Medicaid Services** April 20, 2023 *For the First Time, HHS Is Making Ownership Data for All Medicare-Certified Hospice and Home Health Agencies Publicly Available* The Biden-Harris Administration has made promoting competition and protecting consumers a top priority. Today, in support of the President's Executive Order on promoting competition and the Administration's commitment to transparency, the U.S. Department of Health and Human Services (HHS) is releasing ownership data for all Medicare-certified hospice and home health agencies. For the first time, anyone can now review detailed information on the ownership of more than 6,000 hospices and 11,000 home health agencies certified to participate in the Medicare program on the Centers for Medicare & Medicaid Services (CMS) website. "It's plain and simple: families deserve transparency when making decisions about hospice and home health care for their loved ones," said HHS Secretary Xavier Becerra. "President Biden has called for unprecedented action to increase transparency – and we are making more data publicly available than ever before. Shining a light on ownership data is good for families, good for researchers, and good for enforcement agencies. We will continue delivering on the President's

directive to promote competition and protect consumers."
Today's announcement builds on the Department's historic releases of data and unprecedented efforts to increase transparency:

- In April 2022, CMS released data publicly on mergers, acquisitions, consolidations, and changes of ownership from 2016-2022 for hospitals and nursing homes enrolled in Medicare.
- In September, CMS released additional data publicly on the ownership of approximately 15,000 nursing homes certified as a Medicare Skilled Nursing Facility, regardless of any change in ownership, including providing more detailed information about organizational owners of nursing homes.
- In December, CMS released detailed information on the ownership of more than 7,000 hospitals certified to participate in the Medicare program.

"Transitioning to hospice care is often an emotionally overwhelming time for many families," CMS Administrator Chiquita Brooks-LaSure said. "Making this data public increases transparency, giving families the information needed to help them identify the best care for their loved one. Providing information is a hallmark of this administration's efforts to improve care because we understand that having good information allows people to make the best choices possible."
The information posted today includes detailed information on the ownership of more than 6,000 hospices and 11,000 home health agencies certified to participate in the Medicare program, regardless of any change in ownership. The data elements include: enrollment information such as organization name, type, practice location addresses, National Provider Identifier (NPI), CMS Certification Number (CCN); detailed information about each owner such as whether it is an organization or an individual and whether it is a direct owner or indirect owner (that is, there is at least one subsidiary between it and the provider); and a numerical associate ID for each owner to enable linkage to the enrollment file. Additional files that include data on mergers, acquisitions, consolidations, and changes of ownership since 2016 for hospices and home health agencies enrolled in Medicare are also being made available as part of this release.
Making ownership information transparent benefits researchers and enforcement agencies by allowing them to identify common owners that have had histories of poor performance, analyze data and trends on how market consolidation impacts consumers with increased costs without necessarily improving quality of care, and evaluate the relationships between ownership and changes in health care costs and outcomes. Transparent ownership data benefits the public by assisting patients, and their loved ones, in making more informed decisions about care. HHS plans to analyze these data to identify ways to inform policy approaches that can improve competition in health care, a key priority for the Biden-Harris administration.
Review hospice enrollments and HHA enrollments on data.cms.gov.
CMS expects to release updated hospice and home health ownership data on a quarterly basis in a searchable format on data.cms.gov, in addition to a flat Excel file available for download to make it easier for researchers to use.
Home Health Agency Ownership Data

11. ***Health Affairs**
    April 19, 2023
    The Home Care Workforce Has Not Kept Pace with Growth In Home And Community-Based Services
    By Amanda R. Kreider and Rachel M. Werner

	Abstract Home and community-based services (HCBS) are the predominant approach to delivering long-term services and supports in the US, but there are growing numbers of reports of worker shortages in this industry. Medicaid, the primary payer for long-term services and supports, has expanded HCBS coverage, resulting in a shift in the services' provision out of institutions and into homes. Yet it is unknown whether home care workforce growth has kept up with the increased use of these services. Using data from the American Community Survey and the Henry J. Kaiser Family Foundation, we compared trends in the size of the home care workforce with data on Medicaid HCBS participation between 2008 and 2020. The home care workforce grew from approximately 840,000 to 1.22 million workers between 2008 and 2013. After 2013, growth slowed, ultimately reaching 1.42 million workers in 2019. In contrast, the number of Medicaid HCBS participants grew continuously from 2008 to 2020, with accelerated growth between 2013 and 2020. As a consequence, the number of home care workers per 100 HCBS participants declined by 11.6 percent between 2013 and 2019, with preliminary estimates suggesting that further declines occurred in 2020. Improving access to HCBS will require not just expanded insurance coverage but also new workforce investments. Home Care Workforce
Housing	**12. *New York Times** May 3, 2023 *Tiny Homes for the Formerly Homeless* A program that builds small energy-efficient houses in the backyards of Seattle residents is helping to address a persistent problem. Twelve people who had been living on the streets of Seattle are now snug in 12 tiny houses tucked into backyards throughout Washington's largest city. And each little dwelling is likely the most sustainable house on its block. . . These are the houses of the Block Project, as the home-building effort is called, with the goal of eventually putting one on every block in Seattle. The homes are constructed by volunteers working under the direction of Facing Homelessness, a local nonprofit. . . Seattle revamped its regulations governing ADUs in 2019, and since then construction has surged. Often the structures are quickly built of metal and cement board. But the Block Project homes are so carefully conceived and crafted that one has just been certified by the Living Building Challenge, a program administered by the International Living Future Institute that authenticates that a structure has attained high standards for sustainability. Excess power generated by the rooftop solar arrays is fed into the grid and offsets the host's utility costs — one way these houses for the homeless are giving back to the community. Tiny Homes for the Formerly Homeless
Public Policy	**13. The White House** April 18, 2023 *Executive Order on Increasing Access to High-Quality Care and Supporting Caregivers* By the authority vested in me as President by the Constitution and the laws of the United States of America, it is hereby ordered as follows: Section 1. Policy. High-quality early care and education and long-term care are critical to our Nation's economic growth and economic security. Early care

and education give young children a strong start in life, while long-term care helps older Americans and people with disabilities live, work, and participate in their communities with dignity. Access to both types of care is also critical to our national security because it helps ensure the recruitment, readiness, and retention of our military service members.

Throughout this order, early care and education are collectively referred to as "child care." References to "care" that do not specify the type of care refer to both childcare and long-term care. References to the "care workforce" refer to individuals and businesses working in the fields of child care and long-term care.

A sizeable majority of families and individuals in the United States who require care cannot access the affordable, high-quality care they need. The markets for child care and long-term care for persons with disabilities and older adults who need support in their homes and communities fail to deliver enough high-quality care because of a persistent gap between the costs of providing this care and the prices families can pay. High-quality care is labor intensive and requires skilled workers, and providers have limited ability to reduce costs. As a result, even when high-quality care is available, it costs far more than many families and individuals can afford, causing them to forgo care altogether, seek lower-quality care options, juggle unconventional shifts at work, reduce their own paid work hours, drop out of the labor force, or make other arrangements. Care expenditures represent a significant and increasing share of families' budgets, with childcare prices growing by approximately 26 percent and some types of long-term care costs growing by over 40 percent in the last decade. Inadequate supply is exacerbated by high turnover in the care workforce. Care workers — disproportionately women of color — are among the lowest-paid in the country and often have to rely on public benefits despite working complex and demanding jobs. Investments in the care workforce are foundational to helping to retain care workers and improving health and educational outcomes. In recent years, more than half of the long-term care workforce and nearly 20 percent of the child care workforce turned over each year. And the workforce remains 8 percent smaller than before the COVID-19 pandemic.

In 2019, more than three in four United States households that searched for care reported difficulty finding adequate care for their young children, and roughly the same share of center-based child care providers turned families away because they lacked enough child care slots. Similarly, more than three in four long-term care service providers have reported not being able to accept new clients, making it harder for older Americans and people with disabilities to find the care they need. Military families consistently cite access to high-quality childcare as an impediment to military spouse employment and family economic security. Difficulty accessing care also poses a challenge for both spouses — and, as data shows, particularly for women in dual military couples — to continuing their service if they have caregiving responsibilities. The need for long-term care is likely to become more acute as our Nation's population ages. By 2060, there will be approximately twice as many adults over the age of 65 than in 2016, and projections indicate that there will be around 8 million long-term care job openings over the next decade.

Family caregivers provide informal, often unpaid, care to help loved ones live in their homes and communities, including caring for aging family members, people with disabilities, and children. At least 53 million people are family caregivers in the United States — including 5.5 million who are caring for

wounded, ill, and injured service members and veterans — and many face challenges due to lack of support, training, and opportunities for rest. Family caregivers include spouses, parents, siblings, adult and minor children, grandparents, and other relatives. Family caregivers reflect the diversity of America's communities, and people can assume family caregiving responsibilities at any stage of life. Without adequate resources, family caregiving can affect caregivers' own physical and emotional health and well-being and contribute to financial strain. These negative consequences are felt most acutely by women, who make up nearly two-thirds of family caregivers and drop out of the workforce at a rate three times higher than men.

It is the policy of my Administration to enable families — including our military and veteran families — to have access to affordable, high-quality care and to have support and resources as caregivers themselves. It is also the policy of my Administration to ensure that the care workforce is supported, valued, and paid well. Additionally, care workers should have the free and fair choice to join a union.

The Congress must provide the transformative investments necessary to increase access to high-quality child care — including preschool and Head Start — and long-term care services, as well as high-quality, well-paying jobs that reflect the value the care workforce provides to families and communities. Such investments include removing barriers and providing the funding needed for Tribal Nations to effectively provide high-quality child care and long-term care.

Nearly every other advanced country makes greater public investments in care than the United States. Investing in care is an investment in the future of America's families, workforce, and economy.

While the Congress must make significant new investments to give families in this country more breathing room when it comes to care, executive departments and agencies (agencies) must do what they can within their existing authorities to boost the supply of high-quality early care and education and long-term care and to provide support for family caregivers. Through this order, I direct agencies to make all efforts to improve jobs and support for caregivers, increase access to affordable care for families, and provide more care options for families.

Sec. 2. Increasing Compensation and Improving Job Quality for Family Caregivers, Early Educators, and Long-Term Care Workers. (a) To increase compensation and benefits for early childhood educators and long-term care professionals who are providing federally funded services:

(i) the Secretary of Health and Human Services, through the Administrator for the Centers for Medicare and Medicaid Services (CMS), shall issue guidance to States on ways to use enhanced funding to better connect home- and community-based workers who provide services to Medicaid beneficiaries;

(ii) the Secretary of Health and Human Services shall implement strategies to encourage comparability of compensation and benefits between staff employed by Head Start grant recipients and elementary school teachers;

(iii) the Secretary of Health and Human Services shall expand efforts to improve care workers' access to health insurance; and

(iv) the Secretary of Education shall use grant notices for the Child Care Access Means Parents in School (CCAMPIS) program to encourage grantees to improve quality in funded programs, including by increasing compensation and

providing support services for early childhood educators who serve children of students at CCAMPIS colleges using Federal and non-Federal funding as appropriate;

(v) the Department of the Treasury shall conduct outreach on the Saver's Match credit, and the Department of Commerce shall conduct — and the Small Business Administration is encouraged to consider conducting — outreach on potential Federal resources available to assist small businesses in offering retirement plans, including a per-employee credit of up to $1,000, as provided in the SECURE 2.0 Act of 2022 (Division T of Public Law 117-328), in order to ensure that the care workforce, including individuals and small businesses, are aware of Federal retirement assistance for which they may be eligible.

(b) To improve working conditions and job quality in federally assisted child care and long-term care programs, encourage providers to establish incentives to recruit and retain workers, help prevent burnout, make it as easy as possible for care workers to access behavioral health services, and thereby improve the care that individuals receive, the Secretary of Health and Human Services shall:

(i) consider additional actions — such as providing guidance, technical assistance, and provider and resident education — and rulemaking on nursing home staffing transparency to promote adequate staffing at nursing homes, building on the Department of Health and Human Services' efforts to propose minimum standards for staffing adequacy at nursing homes;

(ii) consider additional actions to reduce nursing staff turnover in nursing facilities and improve retention of those staff, advancing the Department of Health and Human Services' efforts to measure and adjust payments based on staff turnover; and

(iii) implement strategies to expand mental health support for the care workforce, including early childhood providers supported through the Child Care and Development Fund (CCDF) and Head Start.

(c) To expand training pathways and professional learning opportunities to increase job quality, improve quality of care, and attract new entrants into the care workforce, the Secretary of Labor and the Secretary of Education, in consultation with the Secretary of Health and Human Services, shall:

(i) encourage recipients of Federal financial assistance to expand opportunities for early childhood educators and long-term care professionals through community college programming, career and technical education, Registered Apprenticeship, pre-apprenticeships leading to Registered Apprenticeship, and other job training and professional development;

(ii) make available innovative funding opportunities, develop and evaluate demonstration projects for care training and educational attainment, and provide technical assistance to State, local, and Tribal partners to improve job quality for care occupations; and

(iii) develop partnerships with key stakeholders, including State, local, Tribal, and territorial governments; unions and labor organizations; State and local workforce development boards; institutions of higher education (including community colleges, Historically Black Colleges and Universities, Tribal Colleges and Universities, and Minority Serving Institutions); aging and disability networks; and national- and community-based organizations that focus on care (including professional membership organizations).

(d) To support family caregivers of beneficiaries of Federal health care programs and services, and in conjunction with implementing the 2022 National

	Strategy to Support Family Caregivers: (i) the Secretary of Health and Human Services shall, consistent with the criteria set out in section 1115A(b)(2) of the Social Security Act (42 U.S.C. 1315a(b)(2)), consider whether to select for testing by the Center for Medicare and Medicaid Innovation an innovative new health care payment and service delivery model focused on dementia care that would include family caregiver supports such as respite care; (ii) the Secretary of Health and Human Services shall consider how better to evaluate and clearly set expectations for family caregivers in the Acute Hospital Care at Home program, which allows hospitals to treat in their homes those who would otherwise be hospital inpatients; (iii) the Secretary of Health and Human Services shall take steps to ensure that hospitals are actively involving family caregivers in the discharge planning process, consistent with CMS condition of participation discharge planning requirements, including by promoting best practices such as partnerships with community-based organizations and using resources from the Administration for Community Living and the Agency for Healthcare Research and Quality; (iv) the Secretary of Health and Human Services shall increase beneficiary communications and support family caregivers by increasing promotion of the option for Medicare beneficiaries to choose to give family caregivers access to their Medicare information via 1-800-MEDICARE and the State health insurance assistance program networks; (v) the Secretary of Veterans Affairs shall consider issuing a notice of proposed rulemaking by the end of this fiscal year that would make any appropriate modifications to eligibility criteria for the Program of Comprehensive Assistance for Family Caregivers, which provides services and benefits, including a monthly stipend, for eligible caregivers of veterans who sustained a serious injury or illness in the line of duty; and (vi) the Secretary of Veterans Affairs shall develop and implement a pilot program to offer psychotherapy via video telehealth to family caregivers within the Program of Comprehensive Assistance for Family Caregivers to improve their access to mental health services. (e) To improve and expand opportunities through AmeriCorps to encourage more individuals to enter early learning careers, the Chief Executive Officer of AmeriCorps is encouraged to consider: (i) expanding access to Segal AmeriCorps Education Awards, which AmeriCorps members can use to pay for education and training or reduce their student debt; providing loan forbearance for AmeriCorps members involved in early learning; and providing other benefits to supplement national service activities that support early learning; and (ii) prioritizing applications that propose to implement or expand high-quality programs focused on early learning and prioritizing projects intended to prepare AmeriCorps members and AmeriCorps Seniors volunteers to enter early learning careers. (f) To improve jobs of domestic child care and long-term care workers: (i) the Secretary of Labor shall create and publish in multiple languages, as appropriate, compliance assistance and best practices materials — such as sample employment agreements for domestic child care and long-term care workers and their employers — to promote fair workplaces and ensure the parties know their rights and responsibilities, and shall identify other means to

promote employers' adoption of best practices;

(ii) the Secretary of Labor shall work with community and other local partners to expand culturally and linguistically appropriate community outreach and education efforts to domestic child care and long-term care workers in order to combat their exploitation; and

(iii) the Chair of the Equal Employment Opportunity Commission is encouraged to work with the Attorney General, the Secretary of Labor, and the Secretary of Homeland Security to develop materials addressing the employment rights of non-citizen domestic child care and long-term care workers who are legally eligible to work.

(g) To improve data and information on the care workforce:

(i) the Secretary of Labor shall conduct and publish an analysis of early childhood and home care workers' pay in comparison to the pay of other workers with similar levels of training and skill;

(ii) the Secretary of Labor shall issue guidance to help States and localities conduct their own analyses of comparable pay rates for care workers in their respective jurisdictions; and

(iii) the Secretary of Labor and the Secretary of Health and Human Services shall, in consultation with relevant agencies and external experts and organizations, jointly conduct a review to identify gaps in knowledge about the home- and community-based workforce serving people with disabilities and older adults; identify and evaluate existing data sources; and identify opportunities to expand analyses, supplement data, or launch new efforts to provide important data on the home- and community-based care workforce and ensure equity for people with disabilities and older adults. The Secretaries shall publicly release the findings and recommendations of this review no later than April 2024.

Sec. 3. Making Care More Accessible and Affordable for Families. (a) To increase access to affordable, high-quality child care and long-term care for workers delivering federally assisted projects:

(i) Agencies shall identify and issue guidance on which agency discretionary, formula, and program-specific funds can be used for child care and long-term care as a supportive service for workers who are being trained for and working on federally funded projects, and in doing so shall consider agency funds made available by the bipartisan Infrastructure Investment and Jobs Act (Public Law 117-58); Public Law 117-169, commonly referred to as the Inflation Reduction Act of 2022; and division A of Public Law 117-167, known as the Creating Helpful Incentives to Produce Semiconductors (CHIPS) Act of 2022.

(ii) With respect to the agency funds identified in subsection (a)(i) of this section:

(A) Agencies shall consider requiring, where appropriate, applicants for Federal job-creation or workforce development funds to provide affordable, accessible, safe, and reliable child care and long-term care for workers carrying out federally assisted projects (including both construction and operating phases where applicable), or shall consider preferencing applicants that use the funds for this purpose or encouraging applicants to use funds for this purpose. Agencies shall provide implementation guidance to relevant program staff and collaborate with the Department of Labor to identify potential support for these actions, including technical assistance for guidance and funding opportunities.

(B) Agencies shall consider providing technical assistance to help

funding recipients provide access to child care and long-term care as a supportive service and to connect funding recipients with potential partners, including care associations, community-based organizations, Registered Apprenticeship and pre-apprenticeship programs, and labor unions.

(C) In cases where child care or long-term care is required or encouraged, agencies shall consider collecting information from funding recipients on whether and how they will provide access to child care and long-term care, and how many workers (including apprentices and pre-apprentices) would be affected.

(iii) The Secretary of Labor and the Secretary of Health and Human Services, in consultation with the Secretary of Commerce, shall support the efforts outlined in subsection (a) of this section by issuing guidance and providing technical assistance with best practices and models for how to provide supportive services, including child care and long-term care.

(b) To lower child care costs for families eligible for Federal programs, the Secretary of Health and Human Services shall:

(i) consider issuing regulations to pursue policies to reduce child care costs for families benefiting from CCDF;

(ii) identify potential opportunities to reduce barriers to eligibility for Head Start and CCDF;

(iii) encourage States, through all available avenues, to increase the use of Temporary Assistance for Needy Families funds for basic assistance and work supports for families — including access to child care — and to spend more funds on cash assistance for families; and

(iv) identify other potential strategies to make child care and Head Start more accessible for those families most in need.

(c) To help more Federal employees access affordable care:

(i) the Director of the Office of Personnel Management shall consider establishing criteria that support equitable and accessible employee participation in child care programs, to include agencies' adoption of income thresholds that are aligned with increasing costs of child care;

(ii) the Director of the Office of Personnel Management shall conduct a review of child care subsidy policy and agency program data to determine the effectiveness of current child care subsidies within the Federal Government;

(iii) the heads of agencies are encouraged to expand employee access to child care services through Federal child care centers, child care subsidies, or contracted care providers; and

(iv) the Department of Defense shall take steps to enhance recruitment and retention of the Department's child development program workers and to improve the affordability of child care for service members by September 2023, in addition to its ongoing efforts as part of the Fourteenth Quadrennial Review of Military Compensation to assess how child care costs impact the ability of the military to attract and retain its workforce.

Sec. 4. Expanding Options for Families by Building the Supply of Care. (a) To provide families with more options for high-quality long-term, home-, and community-based care and early learning services:

(i) The Secretary of Health and Human Services shall consider rulemaking to improve access to home- and community-based services under Medicaid. As part of any such rulemaking, the Secretary shall consider taking steps to support provider participation in Medicaid home- and community-based programs.

(ii) The Secretary of Health and Human Services shall issue policies that would support child care providers to give families more options to access high-quality child care providers, and shall update payment practices to improve provider stability and supply.

(iii) The Secretary of Education shall update a guide for schools and districts to expand high-quality early learning programming using Federal funds so that more preschoolers are fully prepared to succeed in school.

(iv) The Secretary of Education and the Secretary of Health and Human Services shall identify and disseminate evidence-based practices for serving children with disabilities and their families in high-quality early childhood education programs, including Head Start. The Secretaries shall also take steps to ensure that services are inclusive of children with disabilities and their families; highlight any resources that are available to aid in that effort, including for preschool-aged children with disabilities under section 619 of the Individuals with Disabilities Education Act (IDEA) and for infants and toddlers with disabilities and their families under Part C of the IDEA; and provide information to support all early childhood programs in meeting their obligations under section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990.

(v) The Director of the Bureau of Consumer Financial Protection is encouraged to consider developing financial guidance resources that support families during their care planning.

(vi) The Secretary of Health and Human Services shall take steps to streamline processes for Tribes to use CCDF and Head Start funding to construct and improve facilities, including facilities that are jointly funded.

(vii) The 12 agencies that signed the October 2022 Memorandum of Agreement to implement Public Law 102-477 (the "Tribal 477 Program") shall increase the effectiveness of Tribal employment and training programs to ensure child care can be used as a support for families by reducing and streamlining administrative requirements, including through consolidation of budgeting, reporting, and auditing systems.

(b) To expand options for quality home- and community-based services to veterans:

(i) The Secretary of Veterans Affairs shall consider expanding the existing Veteran Directed Care Program — which provides veterans who need help with daily living with a budget to spend on home- and community-based services including personal care services — to all Department of Veterans Affairs Medical Centers by the end of Fiscal Year 2024, and shall consider developing an implementation plan for this expansion by June 2023.

(ii) The Secretary of Veterans Affairs shall consider designing and evaluating a pilot program in no fewer than five veteran sites or in five States for a new Co-Employer Option for delivering veteran home health services. Features of the program may include allowing veterans to choose who provides their care and to determine when and how that care is delivered, and connecting veterans with a third-party agency that would help coordinate administrative tasks and act as an intermediary between veterans and their home health workers. Should the Department of Veterans Affairs implement this pilot program, it shall provide an implementation plan — including cost estimates and evaluation strategy — to the President, through the Assistant to the President for Domestic Policy, before August 31, 2023.

(iii) The Secretary of Veterans Affairs shall consider expanding the Home-Based Primary Care program by adding 75 new interdisciplinary teams to provide care to veterans in their homes.

(c) To increase the supply of providers and options for families by encouraging greater private financial protection, support, and technical assistance for care providers:

(i) the Secretary of the Treasury shall consider providing information to and sharing industry best practices with Community Development Financial Institutions to facilitate capital flows and support to care providers;

(ii) the Administrator of the Small Business Administration is encouraged to consider publishing a guide on how individuals in the care workforce may start and sustainably operate care businesses locally and through Small Business Administration programming; and

(iii) the Director of the Bureau of Consumer Financial Protection is encouraged to consider issuing guidance addressing financial institution practices that may increase the burden on the care workforce, discourage their work, and harm their financial well-being.

(d) To build the capacity of local communities to better coordinate and deliver care:

(i) the Secretary of Health and Human Services shall review existing policies to identify opportunities — including among Tribal communities — to increase the capacity of community care entities by providing operational support to these networks of providers; and

(ii) the Secretary of Agriculture shall use the Rural Partners Network and issue guidance developed in partnership with the Secretary of Health and Human Services to promote opportunities — including by hosting workshops — to increase access to child care and long-term care in rural and Tribal communities.

(e) To make the delivery and design of Federal care assistance and programs work better for families, the care workforce, and people seeking care, the Secretaries of the Treasury, Defense, Agriculture, Labor, Health and Human Services, Education, and Veterans Affairs shall consider — and the Administrator of the Small Business Administration is encouraged to consider — prioritizing engagement with parents, guardians, and other relatives with care responsibilities; individuals receiving long-term care; State and local care experts; care providers and workers; employers; and labor unions.

Sec. 5. General Provisions. (a) Nothing in this order shall be construed to impair or otherwise affect:

(i) the authority granted by law to an executive department or agency, or the head thereof; or

(ii) the functions of the Director of the Office of Management and Budget relating to budgetary, administrative, or legislative proposals.

(b) This order shall be implemented consistent with applicable law and subject to the availability of appropriations.

(c) Where not already specified, independent agencies are encouraged to comply with the requirements of this order.

(d) This order is not intended to, and does not, create any right or benefit, substantive or procedural, enforceable at law or in equity by any party against the United States, its departments, agencies, or entities, its officers, employees, or agents, or any other person.

	Increasing Access to High-Quality Care
Alzheimer's and Other Dementia	**14. *STAT+ News** May 5, 2023 *Clinical trials for Alzheimer's treatments need to include people with Down syndrome* Alzheimer's and People with Down Syndrome
Integrated Care Programs	**15. *Health Affairs** May 2023 *Enrollment And Characteristics of Dual-Eligible Medicare and Medicaid Beneficiaries in Integrated Care Programs* Integrated care programs (ICPs) are meant to make Medicare and Medicaid coverage for dual-eligible beneficiaries work more seamlessly. Evidence is limited on ICP enrollment trends and the characteristics of dual-eligible beneficiaries who enroll in these programs—specifically, the Program of All-Inclusive Care for the Elderly, Medicare Advantage (MA) Fully Integrated Dual-Eligible Special Needs Plans, and state demonstration Medicare-Medicaid plans. Using national data, we evaluated changes in ICP enrollment between 2013 and 2020 and compared the demographic characteristics of beneficiaries in these programs relative to the characteristics of beneficiaries not in them. The proportion of dual-eligible beneficiaries in ICPs increased from 2.0 percent in 2013 to 9.4 percent in 2020. However, nonintegrated or partially integrated coordination-only MA plans experienced the plurality of growth in enrollment of dual-eligible beneficiaries. Relative to non-ICP fee-for-service Medicare, beneficiaries in ICPs were more likely to be Black and Hispanic versus White and were less likely to be rural, younger, or disabled. Policy makers should diligently monitor growth in ICPs and less integrated dual-eligible plans in MA while also evaluating their impact on equity, spending, and quality of care. https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2022.01321
Covid	**16. STAT News** May 5, 2023 *WHO declares end to Covid global health emergency* The World Health Organization ended the Covid-19 global health emergency on Friday, saying it was time for countries to transition from treating Covid as an emergency to dealing with it as a disease that is here to stay. The decision was made on the advice of a panel of independent experts, the so-called Covid-19 emergency committee, which met Thursday. Though a couple of members of the committee were reportedly hesitant about the move, the majority agreed Covid no longer meets the criteria of a Public Health Emergency of International Concern. . . The Covid-19 PHEIC has been in effect since Jan. 30, 2020. Since the start of the pandemic, the WHO estimates that at least 20 million people around the world have died from the new disease, though the official death toll is about 7 million. WHO Declares End to Covid Emergency
Veteran Services	**17. The White House** April 18, 2023 *Executive Order on Increasing Access to High-Quality Care and Supporting Caregivers* (b) To expand options for quality home- and community-based services to veterans: (i) The Secretary of Veterans Affairs shall consider expanding the existing

	Veteran Directed Care Program — which provides veterans who need help with daily living with a budget to spend on home- and community-based services including personal care services — to all Department of Veterans Affairs Medical Centers by the end of Fiscal Year 2024, and shall consider developing an implementation plan for this expansion by June 2023. (ii) The Secretary of Veterans Affairs shall consider designing and evaluating a pilot program in no fewer than five veteran sites or in five States for a new Co-Employer Option for delivering veteran home health services. Features of the program may include allowing veterans to choose who provides their care and to determine when and how that care is delivered, and connecting veterans with a third-party agency that would help coordinate administrative tasks and act as an intermediary between veterans and their home health workers. Should the Department of Veterans Affairs implement this pilot program, it shall provide an implementation plan — including cost estimates and evaluation strategy — to the President, through the Assistant to the President for Domestic Policy, before August 31, 2023. (iii) The Secretary of Veterans Affairs shall consider expanding the Home-Based Primary Care program by adding 75 new interdisciplinary teams to provide care to veterans in their homes. Increasing Access to High-Quality Care
Workforce	**18. AFL-CIO** May 1, 2023 *In Recognition of Caregivers, White House Readies to Help Nursing Home Workers* Last month, President Biden announced comprehensive government actions to improve access to quality childcare and long-term care. The executive order, signed by the president, directed an array of federal programs at the departments of Health and Human Services and Veterans Affairs, and other departments to do more to meet the care needs of working families who rely on either paid or unpaid caregivers to participate in our economy and our society. The president's announcement, which comes during Care Workers Recognition Month, is a landmark effort to highlight the role of care work in our economy. As the president noted, one in five Americans is a caregiver, helping raise a child or caring for a person with a disability, either at home or in a nursing home. The attention on caregiving comes naturally for this president. During his remarks at the signing event, he recalled the help he needed raising his sons after his first wife and daughter died in a car crash and the care he and the first lady provided to their parents near the end of their lives. For many people, however, the hardest part is finding a caregiver. We will need millions of new caregivers to meet the needs of our aging society. How do we get more people to do this physically demanding and often emotionally draining work? Recruitment and retention are challenging because this important work is routinely undercompensated. The median annual income for a certified nurse assistant in a nursing home is $24,200—so low that one-third are on some public assistance. The median annual income for a home care worker is even less. One way to ensure caregivers are paid more is to make it easier for workers who want to join a union. We know labor law is fundamentally broken—it is simply too hard for workers to exercise our right to collective action. To support the needs of America's families and our economy, we need to make sure caregivers

have a voice at work.

When it comes to nursing homes, there is an immediate opportunity to address the quality of care for residents. The Biden administration can follow through on its promise to do what previous administrations lacked the political courage to do: set a science-based, national minimum staffing standard for nursing homes that participate in Medicare and Medicaid.

We know that powerful forces in the nursing home industry, including private equity investors, vigorously oppose a minimum staffing standard. Private equity investors often turn a profit by manipulating personnel: hiring fewer workers and slashing pay and benefits at the cost of patient care. Setting a staffing standard would mean having to pay higher wages to attract more people to the industry; it would mean paying a living wage, so working in a nursing home would be a sustainable, family-supporting job.

Nursing home experts across the board agree that current staffing at most nursing homes is inadequate, and that poor staffing puts residents at risk for ulcers, falls, and other adverse medical events. One has to look no further than Health and Human Services' findings in 2001 for the bare minimum staffing levels needed to avoid harming patients. Yet too many nursing operators want to compromise this medically based standard of care. We are glad to work with the industry to address issues around implementation of a staffing standard, but there should be no doubt about what experts say is the best way to improve nursing home care: stop the understaffing that compromises resident care and makes caregivers pursue other work.

in recognition of caregivers

19. **Massachusetts Nurses Association**

March 29, 2023

Newest 'State of Nursing in Massachusetts' Survey Reveals Unsafe Conditions and RN Burnout as True Causes of Statewide Staffing Crisis as Hospitals Overspend on Temporary Nurses and Patient Care Quality Drops

85% of nurses say hospital care quality has deteriorated over the past two years; 53% say hospitals that rely on travel nurses have worse care.

71% of nurses say their biggest obstacle to delivering quality care is understaffing and/or having too many patients at one time.

88% of nurses (and 98% of new nurses) support legislation limiting the number of patients assigned to a nurse at one time. . .

"The hospital staffing crisis and nurses' struggle to provide safe, high-quality patient care has been driven by corporate greed and persists because of the hospital industry's refusal to listen to nurses and implement our solutions," said Katie Murphy, a practicing ICU nurse and president of the MNA. "Rather than the cause of this crisis, the COVID-19 pandemic has simply laid bare a system already broken by hospital executives. The industry claims it cannot find nurses, but the data shows there are more nurses than ever. There is not a shortage of nurses, but rather a shortage of nurses willing to work in these unsafe conditions.". . .

The Boston Globe reported this month that during the height of the pandemic, the Baker administration created a new classification of traveling nurses with no salary caps and no requirements that they live at least 200 miles away. That enticed local hospital staffers to quit their jobs – and return to the same job as contract workers making substantially more money, with more flexibility in hours, Julie Pinkham, executive director of the MNA told the Globe. Pinkham

	said as many as 30% of nurses at some Boston hospitals were fixed contract or traditional traveling nurses during the height of the pandemic. In addition to sapping hospitals of much-needed permanent nurses, the reliance on travel nurses has cost the industry $1.5 billion, according to a survey by the Massachusetts Health and Hospital Association, while harming care quality. In the 2023 "The State of Nursing in Massachusetts," 53% of respondents said hospitals that rely on travel nurses have worse patient care. **Survey Executive Summary:** www.massnurses.org/StateofNursingSummary. **Survey Charts:** www.massnurses.org/StateofNursingCharts. MNA Survey
Medical Care	**20. *Washington Post** May 3, 2023 (updated) *First vaccine* targeting ng *RSV wins FDA approval. More are coming.* U.S. regulators on Wednesday approved the first vaccine to prevent the respiratory ailment RSV, a decision that marks a turning point in the six-decade-long quest to protect vulnerable people against the virus. A shot developed by pharmaceutical giant GSK to protect older adults against the respiratory syncytial virus is the first to get a greenlight from the Food and Drug Administration. A Pfizer vaccine is following close behind and is under consideration for older adults. . . The virus is responsible for 6,000 to 10,000 deaths among adults 65 and older, according to the FDA. RSV Wins FDA Approval **21. *New York Times** May 3, 2023 *Why Americans Feel More Pain* By Nicholas Kristof And while chronic pain is a global problem, it is particularly puzzling in America. In other wealthy countries, it's the elderly who report the most chronic pain, which makes some sense. But in the United States it's the middle-aged — especially the jobless and people like Wert, who did not graduate from high school — who suffer the most. It is a plague on the less educated. All this raises the question: Is this physical suffering a canary in the coal mine warning us of larger dysfunction in our society? Here's what we do know: Tens of millions of Americans are suffering pain. But chronic pain is not just a result of car accidents and workplace injuries but is also linked to troubled childhoods, loneliness, job insecurity and a hundred other pressures on working families. . . Americans die from deaths of despair — drugs, alcohol, and suicide — at a rate of more than a quarter-million a year, and the number of walking wounded is far greater. . . Acute pain typically has a specific anatomical source — such as the shock you feel when you touch a hot stove — while chronic pain sometimes, not always, originates in the brain rather than the body. An extreme example is phantom limb pain, in which an amputee feels intense pain in a limb that no longer exists. Researchers find that some people with substantial knee pain have normal X-rays, while many whose X-rays suggest significant arthritis feel no pain at all. . . Fortunately, some new treatments are emerging for chronic pain, but they are imperfect and often not covered by insurance. For starters, we're learning that pain sometimes responds better to approaches that target the brain and psyche,

	not the body. For example, phantom limb pain is helped with mirror therapy, in which the sufferer repeatedly looks in the mirror at a remaining limb, to trick the brain into thinking that the body is doing just fine. There is no single pain center in the brain, but chronic pain often reverberates in parts of the brain that can also be involved in emotions and traumatic memories, and that resonates with Bobbie Wert. She looks back at her odyssey through unexplained pain and addiction and has a simple explanation: "It was trauma." As the title of a best-selling book by Bessel van der Kolk on how psychological trauma can manifest as physical pain puts it, "The Body Keeps the Score." Why Americans Feel More Pain
Health Care Policy	**22. *New York Times** May 2, 2023 (updated) *Made to Care For Those Left Behind, This Hospital Leads the Way* In "The People's Hospital," Ricardo Nuila, a practicing physician and associate professor at Baylor College of Medicine, focuses on Ben Taub, the hospital that succeeded Jefferson Davis as Houston's publicly funded flagship. But rather than dwelling on the horrors of a facility, Nuila deconstructs the deplorable inequality that creates the need for this, the largest safety-net hospital in what has become one of America's largest and most diverse cities, in the state with the nation's biggest population of uninsured. At the core of "The People's Hospital," Nuila, a Houston native who has spent more than a decade as a medical student, resident and now attending physician at Ben Taub, asks a simple but profound question: "Why do some people benefit from health care in America, while others are excluded?" His answer is equally simple: Because the principal goal of the American health care system is to make money, period. Other things, like preventing illness and empowering people, can — and do — happen, but only after the first goal is met. He also offers what seems like an audacious idea: that Ben Taub should serve as a model for change. Throughout "The People's Hospital," Nuila hammers home this central thesis. He unbraids the interlocked strands of hospitals, health insurance companies, Big Pharma and profit-minded physicians — what he calls "Medicine, Inc." — all unified in the purpose of solving sickness through the mechanism of business. Made to Care **23. New York Times (free access)** March 9, 2023 *American Health Care Is Dying. This Hospital Could Cure It.* By Dr. Ricardo Nuila Health insurance was supposed to improve his medical experience, but my patient couldn't find an oncologist or hospital — even in the public system — that accepted his particular type. After months of searching, he grew discouraged; eventually he gave up. "A lot of this is on me," he told me, ruefully. This is the level of confusion and complexity we've come to accept as normal in our healthcare system. I work as an internal medicine doctor at Houston's Ben Taub Hospital, which is part of a public health system that treats Harris County's most vulnerable patients, many of whom don't have insurance. I often see the back end of our insurance fiasco: I've cared for dozens of patients who were sent to our E.R. hours after receiving inadequate treatment elsewhere. I've felt the injustice of a patient dying after he was dropped by his insurance. I've also seen patients hit

with unexpected medical bills showing arbitrary prices after visiting the emergency room of a private hospital.

Visiting a hospital or clinic today feels like facing a firing squad, with rounds and rounds of bills coming from every direction. Fewer than half of Americans rate the quality of U.S. health care as excellent or good. We all have our stories. Whether through Twitter rants or opinion pieces or surveys quantifying how many of us grade the system as a failure — 56 percent at last count — we are fed up.

Patients are burned out. Nurses are leaving the profession. Doctors are demoralized. In the meantime, the people not sick or tending to sickness — the corporate middlemen in charge of insurance companies, private hospitals, doctor practices and pharmaceutical companies — are feasting. As Donald Berwick, a former administrator for the Centers for Medicare and Medicaid Services, noted, the "glorification of profit, salve lucrum, is harming both care and health."

After listening to partisan rants on both sides that aim only to tweak rather than remake our system, I suggest we hold a national referendum on health care. Americans should vote yea or nay on a system that provides basic health care for all.

A federal ballot measure like this has never been held in our country. A referendum would ask Americans to focus on the proposal rather than on a candidate or political party. There's reason to believe that a direct vote could help us solve our health care quagmire. In a recent survey, about two out of three Americans said it was the government's responsibility to provide universal health coverage. Another study conducted in my home state showed the same, with seven out of 10 Texans declaring universal health coverage important.

It won't be easy. Scholars have indicated that it may take multiple election cycles, along with volunteers collecting millions of signatures across the country, to achieve such a monumental feat. Americans are already split about how private insurance would figure into the equation. If history is any indication, those who benefit from our bloated system — the large corporations that keep American consumers in a stranglehold — would brew confusion about the plans in an effort to resist any change.

If the referendum resulted in a majority of "yes" votes, it would send a clear message to Congress and the president: Build us a universal health care system. The hard work of constructing that system and a way of paying for it would start there. Medicare for All, as proposed by Senator Bernie Sanders, would eliminate private insurance that duplicated what was offered in the single-payer system. This standard insurance would eliminate patients' out-of-pocket expenses and make it harder for hospitals and doctors to cherry-pick those with more lucrative insurance. Multiple iterations of single-payer plans have sprung from Medicare for All, including some that would preserve private insurance. An altogether different plan, a public option, would preserve Americans' choice to buy private insurance. The drawback would be that without a mandate, health care gaps would most likely still exist.

Controlling health care costs is a problem that has long confounded Americans. For this reason, I favor something different, a public health care system modeled after the one I've worked in for the past 12 years. The system provides health care directly — without the middleman of insurance — to nearly half its patients. When it bills a patient's insurance, the system does so at a reasonable

	rate, on par with what Medicare pays. As a resident, I rotated through private hospitals and saw how easy it is to default toward more expensive treatment. In a public system, doctors like me work on salary without financial incentives to overutilize tests or procedures, which further keeps costs in check and patient outcomes top of mind. The lack of a profit motive allows the system I work in to focus on providing quality care while cutting costs. In fact, in 2022, Ben Taub Hospital and the public system saved more than $1.8 billion in health care costs. This amounts to $2.30 in health care cost savings to Harris County taxpayers for every $1 in county taxes collected. The public health care system in Harris County came into existence thanks to a local referendum in November 1965. The charity hospital that preceded it, Jefferson Davis Hospital, was notoriously under resourced and underfunded. When news spread of its deplorable conditions, citizens decided that the city's standards had to be addressed. Health care had become a moral issue. I'm not a specialist; I'm the hospital's jack-of-all-trades, the doctor tasked with keeping care effective and efficient. As a hospitalist, I don't have to spend time figuring out if an insurance company will authorize a patient's treatment. Not worrying about reimbursements means I can focus on medicine. Ours are not easy jobs — our patients often arrive with undiagnosed diseases resulting in one or more organs failing — but at least we can provide good care to everyone. More than 50 years later, it remains as such. I take solace in knowing that I work for a system that tries to help all patients. After the news sank in of his cancer's return, my patient asked that I sit down with him. He had things on his mind, questions. He confided to me that his family didn't know about his illness, and I told him how much I wished he had stayed at Ben Taub and that things had been different. I began to tell him what kind of treatments he might still expect. He stopped me. "I appreciate this hospital so much," he said. "Y'all are here when no one else is." American Health Care Is Dying
International	**24. New York Times (free access)** May 8, 2023 *Deaths of Seniors in Hospital Fire Point to China's Elder Care Shortfall* The country's supply of nursing home beds has not kept pace with its rapidly aging population, leading some families to seek unlicensed alternatives. The hospital in southern Beijing advertised itself as specializing in vascular tumors, especially benign birthmarks that often appear in infants. But when a fire broke out there last month, killing at least 29 people, many of the victims had been there for another reason: They were older people with disabilities receiving nursing care, some of them staying at the private hospital for months or even years, even though it was not licensed as a provider of long-term elder care. The tragedy at Changfeng Hospital — the deadliest fire in China's capital in more than two decades — has renewed scrutiny of a long-running problem. China's population is rapidly aging, with 400 million people, nearly 30 percent of the population, expected to be over 60 by 2040. But medical resources have not kept up; there were only about eight million nursing home or elder care beds at the end of 2020, according to official statistics. . . Social stigmas against retirement or nursing facilities are still widespread in a culture that emphasizes children's caretaking duties toward their parents. Even

	for people who are willing to embrace care institutions, public facilities often have long waiting lists, and private ones — which are not covered by public medical insurance — can be prohibitively expensive. . . But China, like many countries, has a dire shortage of staff trained to care specifically for older patients. And the government departments that oversee medical care and nursing care are separate, further slowing the approval process, said Professor Luk, in Singapore. . . [T]he need is only going to grow. The number of older Chinese with disabilities is expected to more than double this decade, reaching 100 million by 2030, according to official statistics. China's Elder Care Shortfall
	*May require registration before accessing article.
Dignity Alliance Massachusetts Legislative Endorsements	Information about the legislative bills which have been endorsed by Dignity Alliance Massachusetts, including the text of the bills, can be viewed at: https://tinyurl.com/DignityLegislativeEndorsements Questions or comments can be directed to Legislative Work Group Chair Richard (Dick) Moore at rmoore8473@charter.net.
Websites	
Previously recommended websites	The comprehensive list of recommended websites has migrated to the Dignity Alliance MA website: https://dignityalliancema.org/resources/. Only new recommendations will be listed in *The Dignity Digest.*
Previously posted funding opportunities	For open funding opportunities previously posted in *The Tuesday Digest* please see https://dignityalliancema.org/funding-opportunities/.
Websites of Dignity Alliance Massachusetts Members	See: https://dignityalliancema.org/about/organizations/
Nursing homes with admission freezes	**Massachusetts Department of Public Health** *Temporary admissions freeze* On November 6, 2021 the state announced that it would require certain high risk nursing homes and rest homes to temporarily stop all new admissions to protect the health and safety of residents and prevent further COVID-19 transmission. Stopping admissions enables homes to focus resources such as staff and PPE on the health and safety of its current residents and enables the home to stabilize before taking on new residents. Homes that meet certain criteria will be required to stop any new admissions until the Department of Public Health has determined that conditions have improved, and the facility is ready to safely care for new residents. The Commonwealth will work closely with homes during this time and provide supports as needed to ensure resident health and safety. • There are a number of reasons why a facility may be required to stop admissions, and the situation in each facility is different. Some of the factors the state uses to make this decision include: • Number of new COVID-19 cases within the facility • Staffing levels • Failure to report a lack of adequate PPE, supplies, or staff • Infection control survey results • Surveillance testing non-compliance Facilities are required to notify residents' designated family members and/or representatives when the facility is subject to an admissions freeze. In addition, a

list of facilities that are currently required to stop new admissions and the reason for this admissions freeze will be updated on Friday afternoons, and as needed when the Department of Public of Health determines a facility can be removed from the list.

Updated on May 2, 2023. Red font – newly added

Name of Facility	City/Town	Date of Freeze	Qualifying Factor	Star Rating
Hillside Rest Home	Amesbury	5/2/2023	Cases	N/A
Sancta Maria Nursing Facility	Cambridge	3/29/2023	Cases	3

Massachusetts Department of Public Health Determination of Need Projects

Massachusetts Department of Public Health

Determination of Need Projects: Long Term Care

2023

Navigator Homes of Martha's Vineyard, Inc. – Long Term Care Substantial Capital Expenditure

Royal Wayland Nursing Home, LLC – Conservation Long Term Care Project

2022

Ascentria Care Alliance – Laurel Ridge

Ascentria Care Alliance – Lutheran Housing

Ascentria Care Alliance – Quaboag

Berkshire Healthcare Systems, Inc. – Windsor Long Term Care Conservation

Fairlawn Rehabilitation Hospital-Hospital/Clinic Substantial Capital Expenditure

Long Term Centers of Lexington – Pine Knoll – Long Term Care Conservation

Long Term Centers of Wrentham – Serenity Hill – Long Term Care Conservation

Next Step Healthcare LLC-Conservation Long Term Care Project

Royal Falmouth – Conservation Long Term Care

Royal Norwell – Long Term Care Conservation

Wellman Healthcare Group, Inc

2020

Advocate Healthcare, LLC Amendment

Campion Health & Wellness, Inc. – LTC - Substantial Change in Service

Heywood Healthcare, Inc. – Hospital/Clinic Substantial Capital Expenditure Notre Dame Health Care Center, Inc. – LTC Conservation

2020

Advocate Healthcare of East Boston, LLC.

Belmont Manor Nursing Home, Inc.

List of Special Focus Facilities

Centers for Medicare and Medicaid Services

List of Special Focus Facilities and Candidates

https://tinyurl.com/SpeciialFocusFacilityProgram

Updated March 29, 2023

CMS has published a new list of Special Focus Facilities (SFF). SFFs are nursing homes with serious quality issues based on a calculation of deficiencies cited during inspections and the scope and severity level of those citations. CMS publicly discloses the names of the facilities chosen to participate in this program and candidate nursing homes.

To be considered for the SFF program, a facility must have a history (at least 3 years) of serious quality issues. These nursing facilities generally have more deficiencies than the average facility, and more serious problems such as harm or injury to residents. Special Focus Facilities have more frequent surveys and are subject to progressive enforcement until it either graduates from the program or

is terminated from Medicare and/or Medicaid.
This is important information for consumers – particularly as they consider a nursing home.

What can advocates do with this information?

- Include the list of facilities in your area/state when providing information to consumers who are looking for a nursing home. Include an explanation of the SFF program and the candidate list.
- Post the list on your program's/organization's website (along with the explanation noted above).
- Encourage current residents and families to check the list to see if their facility is included.
- Urge residents and families in a candidate facility to ask the administrator what is being done to improve care.
- Suggest that resident and family councils invite the administrator to a council meeting to talk about what the facility is doing to improve care, ask for ongoing updates, and share any council concerns.
- For long-term care ombudsmen representatives: Meet with the administrator to discuss what the facility is doing to address problems and share any resources that might be helpful.

Massachusetts facilities listed (updated March 29, 2023)

Newly added to the listing

- Somerset Ridge Center, Somerset
  https://somersetridgerehab.com/
  Nursing home inspect information:
  https://projects.propublica.org/nursing-homes/homes/h-225747
- South Dennis Healthcare
  https://www.nextstephc.com/southdennis
  Nursing home inspect information:
  https://projects.propublica.org/nursing-homes/homes/h-225320

Massachusetts facilities not improved

- None

Massachusetts facilities which showed improvement

- Marlborough Hills Rehabilitation and Health Care Center, Marlborough
  https://tinyurl.com/MarlboroughHills
  Nursing home inspect information:
  https://projects.propublica.org/nursing-homes/homes/h-225063

Massachusetts facilities which have graduated from the program

- The Oxford Rehabilitation & Health Care Center, Haverhill
  https://theoxfordrehabhealth.com/
  Nursing home inspect information:
  https://projects.propublica.org/nursing-homes/homes/h-225218
- Worcester Rehabilitation and Health Care Center, Worcester
  https://worcesterrehabcare.com/
  Nursing home inspect information:
  https://projects.propublica.org/nursing-homes/homes/h-225199

Massachusetts facilities that are candidates for listing (months on list)

- Charwell House Health and Rehabilitation, Norwood (15)
  https://tinyurl.com/Charwell
  Nursing home inspect information:
  https://projects.propublica.org/nursing-homes/homes/h-225208

	• Glen Ridge Nursing Care Center (1) https://www.genesishcc.com/glenridge Nursing home inspect information: https://projects.propublica.org/nursing-homes/homes/h-225523 • Hathaway Manor Extended Care (1) https://hathawaymanor.org/ Nursing home inspect information: https://projects.propublica.org/nursing-homes/homes/h-225366 • Medway Country Manor Skilled Nursing and Rehabilitation, Medway (1) https://www.medwaymanor.com/ Nursing home inspect information: https://projects.propublica.org/nursing-homes/homes/h-225412 • Mill Town Health and Rehabilitation, Amesbury (14) No website Nursing home inspect information: https://projects.propublica.org/nursing-homes/homes/h-225318 • Plymouth Rehabilitation and Health Care Center (10) https://plymouthrehab.com/ Nursing home inspect information: https://projects.propublica.org/nursing-homes/homes/h-225207 • Tremont Health Care Center, Wareham (10) https://thetremontrehabcare.com/ Nursing home inspect information: https://projects.propublica.org/nursing-homes/homes/h-225488 • Vantage at Wilbraham (5) No website Nursing home inspect information: https://projects.propublica.org/nursing-homes/homes/h-225295 • Vantage at South Hadley (12) No website Nursing home inspect information: https://projects.propublica.org/nursing-homes/homes/h-225757 https://tinyurl.com/SpeciialFocusFacilityProgram
Nursing Home Inspect	**ProPublica** ***Nursing Home Inspect*** Data updated November 2022 This app uses data from the U.S. Centers for Medicare and Medicaid Services. Fines are listed for the past three years if a home has made partial or full payment (fines under appeal are not included). Information on deficiencies comes from a home's last three inspection cycles, or roughly three years in total. The number of COVID-19 cases is since May 8, 2020, when homes were required to begin reporting this information to the federal government (some homes may have included data on earlier cases). Massachusetts listing: https://projects.propublica.org/nursing-homes/state/MA **Deficiencies By Severity in Massachusetts** (What do the severity ratings mean?) # reported Deficiency Tag 250 **B** 82 **C**

	7,056 D 1,850 E 546 F 487 G 31 H 1 I 40 J 7 K 2 L
Nursing Home Compare	**Centers for Medicare and Medicaid Services (CMS)** *Nursing Home Compare Website* Beginning January 26, 2022, the Centers for Medicare and Medicaid Services (CMS) is posting new information that will help consumers have a better understanding of certain staffing information and concerns at facilities. This information will be posted for each facility and includes: • **Staff turnover:** The percentage of nursing staff as well as the number of administrators who have stopped working at a nursing home over the past 12-month period. • **Weekend staff**: The level of weekend staffing for nurses and registered nurses at a nursing home over a three-month period. Posting this information was required as part of the Affordable Care Act, which was passed in 2010. In many facilities, staffing is lower on weekends, often meaning residents have to wait longer or may not receive all the care they need. High turnover means that staff are less likely to know the residents, recognize changes in condition, or implement preferred methods of providing care. All of this contributes to the quality-of-care residents receive and their quality of life. https://tinyurl.com/NursingHomeCompareWebsite
Data on Ownership of Nursing Homes	**Centers for Medicare and Medicaid Services** *Data on Ownership of Nursing Homes* CMS has released data giving state licensing officials, state and federal law enforcement, researchers, and the public an enhanced ability to identify common owners of nursing homes across nursing home locations. This information can be linked to other data sources to identify the performance of facilities under common ownership, such as owners affiliated with multiple nursing homes with a record of poor performance. The data is available on nursing home ownership will be posted to data.cms.gov and updated monthly.
Long-Term Care Facilities Specific COVID-19 Data	**Massachusetts Department of Public Health** *Long-Term Care Facilities Specific COVID-19 Data* *Coronavirus Disease 2019 (COVID-19) reports related to long-term care facilities in Massachusetts.* **Table of Contents** • COVID-19 Daily Dashboard • COVID-19 Weekly Public Health Report • Additional COVID-19 Data • CMS COVID-19 Nursing Home Data

<table>
<tr><td>DignityMA Call Action</td><td colspan="3">

The MA Senate released a report in response to COVID-19. Download the DignityMA Response to Reimagining the Future of MA.
Advocate for state bills that advance the Dignity Alliance Massachusetts' Mission and Goals – State Legislative Endorsements.
Support relevant bills in Washington – Federal Legislative Endorsements.
Join our Work Groups.
Learn to use and leverage Social Media at our workshops: Engaging Everyone: Creating Accessible, Powerful Social Media Content

</td></tr>
<tr><td>Access to Dignity Alliance social media</td><td colspan="3">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</td></tr>
<tr><td rowspan="12">Participation opportunities with Dignity Alliance Massachusetts

Most workgroups meet bi-weekly via Zoom.

Interest Groups meet periodically (monthly, bi-monthly, or quarterly).

Please contact group lead for more information.</td><td>Workgroup</td><td>Workgroup lead</td><td>Email</td></tr>
<tr><td>General Membership</td><td>Bill Henning
Paul Lanzikos</td><td>bhenning@bostoncil.org
paul.lanzikos@gmail.com</td></tr>
<tr><td>Behavioral Health</td><td>Frank Baskin</td><td>baskinfrank19@gmail.com</td></tr>
<tr><td>Communications</td><td>Pricilla O'Reilly
Lachlan Forrow</td><td>prisoreilly@gmail.com
lforrow@bidmc.harvard.edu</td></tr>
<tr><td>Facilities (Nursing homes, rest homes, assisted living)</td><td>Arlene Germain</td><td>agermain@manhr.org</td></tr>
<tr><td>Home and Community Based Services</td><td>Meg Coffin</td><td>mcoffin@centerlw.org</td></tr>
<tr><td>Legislative</td><td>Richard Moore</td><td>rmoore8743@charter.net</td></tr>
<tr><td>Legal Issues</td><td>Jeni Kaplan</td><td>jkaplan@cpr-ma.org</td></tr>
<tr><td>Interest Group</td><td>Group lead</td><td>Email</td></tr>
<tr><td>Housing</td><td>Bill Henning</td><td>bhenning@bostoncil.org</td></tr>
<tr><td>Veteran Services</td><td>James Lomastro</td><td>jimlomastro@comcast.net</td></tr>
<tr><td>Transportation</td><td>Frank Baskin
Chris Hoeh</td><td>baskinfrank19@gmail.com
cdhoeh@gmail.com</td></tr>
<tr><td>Covid / Long Covid</td><td>James Lomastro</td><td>jimlomastro@comcast.net</td></tr>
<tr><td>Incarcerated Persons</td><td>TBD</td><td>info@DignityAllianceMA.org</td></tr>
<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
MailChimp Specialist: Sue Rorke</td></tr>
<tr><td>Note of thanks</td><td colspan="3">Thanks to the contributors to this issue of The Dignity Digest
• Dick Moore
Special thanks to 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 Digest@DignityAllianceMA.org.</td></tr>
</table>

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.