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Spotlight

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United States' Nursing Home Finances: Spending, Profitability, and Capital Structure

By Charlene Harrington, Richard Mollot, and Dunc Williams, Jr.

Sage Journals

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Abstract

Little is known about nursing home (NH) financial status in the United States even though most NH care is publicly funded. To address this gap, this descriptive study used 2019 Medicare cost reports to examine NH revenues, expenditures, net income, related-party expenses, expense categories, and capital structure. After a cleaning process for all free-standing NHs, a study population of 11,752 NHs was examined. NHs had total net revenues of US$126 billion and a profit of US$730 million (0.58%) in 2019. When US$6.4 billion in disallowed costs and US$3.9 billion in non-cash depreciation expenses were excluded, the profit margin was 8.84 percent. About 77 percent of NHs reported US$11 billion in payments to related-party organizations (9.54% of net revenues). Overall spending for direct care was 66 percent of net revenues, including 27 percent on nursing, in contrast to 34 percent spent on administration, capital, other, and profits. Finally, NHs had long-term debts that outweighed their total available financing. The study shows the value of analyzing cost reports. It indicates the need to ensure greater accuracy and completeness of cost reports, financial transparency, and accountability for government funding, with implications for policy changes to improve rate setting and spending limits.

Studies over many years have documented poor quality care and inadequate staffing in nursing homes (NHs) in the United States.[1–4] While the public focus is generally on care and conditions of long-term residents, who are typically among the oldest and most frail individuals, even short-stay Medicare NH residents have a high rate of adverse events and deaths,[5] and high rates of hospital readmissions for common and preventable problems.[6] In light of these longstanding and widespread problems, the National Academics of Science, Engineering and Medicine recently issued a report calling for immediate action to initiate fundamental changes to improve the quality and lives of nursing home residents.[7]

Poor NH quality has been associated with low nurse staffing levels, particularly low registered nurse (RN) staffing.[7,8] In 2017–2018, about 75 percent of NHs almost never met the Centers for Medicare & Medicaid Services (CMS) expected RN staffing levels based on resident acuity.[9] Other studies show that most NHs failed to meet the CMS 2001 recommended minimum staffing levels in 2019 (4.1 total nurse staffing hours per resident day, including 0.75 RN hours per resident day[10]) and staffing levels recommended by experts based on acuity in 2017.[11,12] In addition to putting residents at risk, heavy workloads, low wages and benefits, and poor working conditions have been associated with persistent staff dissatisfaction, shortages, and high staff turnover levels.[7,13,14]

NHs are primarily funded by the government (59%[15]), including Medicare, which pays for short-term, rehabilitation care, and Medicaid (funded jointly by the state and federal governments) which pays for long-term care.[16] Medicare's prospective payment system is adjusted for the estimated staffing needs to meet facility-reported resident acuity, while giving NHs wide discretion in spending.[17,18] State Medicaid reimbursement methodologies and rates vary widely; some states conduct audits and have imposed requirements for financial accountability.[19]

In 2019, the Medicare Payment Advisory Commission (MedPAC) reported that the Medicare fee-for-service programs spent about $27.8 billion (all dollar amounts in U.S. dollars) on free-standing NH services for about 1.5 million Medicare beneficiaries in 15,000 NHs.[16] In addition, Medicaid spending was about $39 billion.[16] While MedPAC reported that the total NH profit margin for all payers including Medicaid was 0.6 percent,[16] the 2019 profit margin on Medicare spending was 11.3 percent and has remained over 10 percent for the past 20 years. Medicare rates for post-acute care are higher than Medicare managed care rates and Medicaid rates for long-stay residents. MedPAC has long reported that Medicare is overpaying for NH services.[16]

The American Health Care Association, the country's largest association of NH providers, has long claimed that Medicaid reimbursements cover only 70–80 percent of NH costs and that more than half of NHs operate at a loss.[20] The Medicaid and CHIP Payment and Access Commission, however, reported that median 2019 state Medicaid facility-allowed base rates were 86 percent of reported facility costs, with some states providing supplemental rates.[21] Medicaid residents tend to be long-stay residents with less intensive needs than Medicare post-acute residents.[7] NHs with very high Medicaid resident days generally have lower staffing levels.[22] A recent study found that California NHs had increased profits between 2019 and 2020 and that the percentage of Medicaid resident days were not

associated with lower profits until Medicaid resident days were higher than 70 percent of total days.[23]

The American Health Care Association has also claimed that the low Medicaid reimbursement has put many NHs at financial risk of closing.[24] There are, however, many reasons for NH closures, including low occupancy rates associated with the increasing percentage of Medicaid dollars spent on home and community-based services, which is now greater than institutional spending.[25] Increased enrollment in Medicare and Medicaid managed care organizations (that have financial incentives to reduce nursing home use) have also played a role in the decreasing numbers of U.S. NHs.[26] To a far lesser extent, actions taken by government regulators against individual facilities for poor quality have also resulted in NH closures.[27] The fragmented payment system and payment policies have been the subject of debate in terms of how to improve NH care and financial transparency. . .[7]

Key Findings

- Nursing homes had total net revenues of $126 billion and a profit of $730 million (0.58%) in 2019.
- However, when excluding $6.4 billion in disallowed costs and $3.9 billion in non-cash depreciation expenses, the average nursing home profit margin was 8.84 percent.
- Overall spending for direct care was 66 percent of net revenues, including 27 percent on nursing, in contrast to 34 percent spent on administration, capital, other, and profits. . .

Discussion

This study found that U.S. NHs had net inpatient revenues of $117.70 billion and total net revenues of $126.25 billion (average of $10.75 million per NH) in 2019. NHs reported a loss on inpatient operations of $7.37 billion but a net profit of $730 million on their operations. The NH net profit margin for all payers including Medicaid was 0.58 percent in 2019, which was the same amount reported by MedPAC for 2019.[16]

When disallowed costs (including related-party disallowances) were excluded from expenditures, the total margin was 5.66 percent. Further, when the disallowances and depreciation expenses were excluded, the 2019 total margin was 8.84 percent. This total margin showed a wide range of profits (up to 83% profit) and losses (up to 161%), after the winsorization process adjusted for outliers.

The disallowed costs of $6.42 billion, including related-party disallowances, were 5.08 percent of total net revenues. As noted, the Medicare disallowed expenses were for expenses not related to patient care. This would include association dues, legal fees, and related-party disallowances that exceed the fair market value of comparable goods and services in the marketplace. It should be noted, however, that not all disallowed expenses are profits. For

example, 44 states had mandatory state provider taxes for nursing facilities in 2022 (to increase their federal Medicaid matching funds), but the amount of these state provider taxes was not reported.[30]

The Medicare prospective payment system neither requires NHs to return disallowed costs nor CMS to make facility-specific rate adjustments for the coming year that take into account prior year disallowed costs.[31] Because disallowed expenses are not required to be paid back to Medicare and the NH has discretion over these expenditures, they should be excluded to more accurately reflect NH income margins. Because CMS does not require facilities to return disallowances, overall Medicare reimbursement rates are inflated. This policy appears to result in compounding the inflation of rates on an annual basis. It is worth noting that, in respect to Medicaid, some states may adjust for disallowances. For example, the California Medicaid program conducts audits and makes adjustments for disallowances in its facility-specific rates for the coming year but does not require disallowed expenses to be returned to Medicaid.[23,32]

NHs can legally do business with related-party organizations. Approximately 77 percent of NHs in this study reported $11 billion (9.54% of revenues) in related-party payments in 2019. NHs reported $1.95 billion in disallowed related-party expenses because payments exceeded the fair market value of comparable goods and services in the marketplace. The Medicare cost reports do not require NHs to submit detailed reports on related-party service expenses, profits and losses, or administrative costs that can be used to verify the disallowed costs. Therefore, some profits and administrative costs may not be identified, and some related-party organizations may not be identified.[33] The accuracy of the self-reported related-party disallowances cannot be determined without an audit.

In 2023, the National Academics of Science, Engineering and Medicine Committee concluded that NHs may be using related-party and unrelated party entities to hide profits. They identified the underlying problems of inadequate financial transparency and inaccurate and incomplete cost reporting and urged policy changes to improve transparency and accountability.[7] One study of California NHs found that NHs with related-party transactions were more likely to report lower profit margins,[23] suggesting that the use of related-party organizations may be a successful way to hide profits.

Related-party transactions are facing increased scrutiny by state and federal regulators to determine if federal regulations are followed and if funds are diverted away from resident care.[34–36] For example, the New York State Attorney General recently filed a lawsuit against four NHs alleging for multiple fraudulent schemes to divert government funds through related-party real estate arrangements, unnecessary and exorbitant loans with inflated interest rates, phony fees paid to companies they and their family members own, and paying

themselves inflated salaries for work that was not performed. The lawsuit alleges that the diversion of funds led to shortages of staffing and significant resident neglect, harm, and humiliation.[37] The findings from our study suggest the need for more transparency of related-party transactions.

This study examined how NHs spend their revenues. NH net expenses, without disallowed costs and depreciation, were 27 percent on inpatient services and nursing, 10 percent on ancillary services, 21 percent on support services, and seven percent on employee benefits in 2019. Of total net revenues, about 66 percent was spent on direct care services.

Administrative expenses were 14 percent, capital expenses were approximately 10 percent, and other expenses one percent for a total of 25 percent of total net revenues, and the total margin was reported to be about nine percent profit, after excluding disallowances and depreciation.

Expenditures were about 66 percent on direct services compared to 34 percent for administration, capital, and profits. This finding suggests that NHs may be able to shift some spending from administration, capital, and profits toward staffing, wages and benefits, and resident services. Medical loss ratio legislation, adopted in the Patient Protection and Affordable Care Act, requires health insurance companies to spend a certain proportion of premiums on medical claims and activities rather than on administration and other profits.[38] If the government required a certain percentage of total NH revenues to be spent on direct care, this could improve both financial accountability and quality of care.

Four states (New Jersey, New York, Massachusetts, and Pennsylvania) have passed legislation requiring a percentage of NH revenues to be spent on direct care services, with limitations on administrative costs, property costs, and profits.[39] For example, New York's legislation requires at least 70 percent of total operating expenses for direct care, including 40 percent for resident-facing staffing, and limited profits to no more than 5 percent of expenses. These states require NHs to return funds that exceed the state limits.[39]

In terms of the NH capital structure, the study found that the average debt-to-capital ratio was 3.20 percent. Ratios of >1 show that debt exceeds equity. NHs also reported a debt-to-equity ratio (52.45%). There are many reasons for NHs to take on debt such as to finance expansion and improvement, deduct debt from taxable income to reduce tax burden, maintain control over an organization rather than bringing in other owners or investors, or earn more on investments than the cost of the debt. Too much debt, however, is associated with a higher risk of insolvency.

Private equity (PE)-owned NHs have been criticized for loading companies with excessive debt, selling off assets and real estate of

acquired companies, taking advantage of tax loopholes, and charging high management fees.[40,41] Such financial schemes may have consequences for NH quality and costs. A recent national cohort study found that long-stay residents of PE firm–owned nursing homes were more likely to have an ambulatory care-sensitive emergency department visit and hospitalization after acquisition compared with residents of non-PE firm–owned, for-profit nursing homes. The PE firm-owned nursing homes also had higher total Medicare costs.[42]

A few NHs reported small or no assets or debts. One possible reason might be the segregation of assets and liabilities, where the operational aspect of a NH (i.e., care provision, staffing, etc.) is kept separate from the real estate and property aspect, which may be owned by a related-party or a different entity altogether. This arrangement can serve to protect the property assets from operational liabilities and lawsuits.[28]

Studies have reported that many NHs have placed their land and buildings in separate property companies that are related-party or un-related organizations.[28,43,44] Other NHs have sold or placed property into real estate investment trusts (REITs), which may or may not be related parties. One recent study reported that REITs owned 12 percent of NHs and had $116.8 billion in NH assets in 2019.[45]

Additionally, some NHs might have paid off any initial startup or acquisition loans a long time ago, and they may currently operate without needing to incur additional debts. However, the lack of reported debts can also be indicative of financial strategies to optimize balance sheets for various reasons, such as attracting investors or for tax benefits. It is also plausible that certain reporting nuances or accounting practices allow for the deferment or restructuring of debt, making it appear as low in certain reports.

While the cost reports do not provide a direct linkage between NHs reporting few debts and their affiliations with separate property entities or REITs, it is important to consider how such structures might serve protective, operational, or financial optimization purposes.

In terms of limitations, we used Medicare NH cost reports, which have been shown to have inaccuracies.[46] Medicare cost reports, however, are the only publicly available source of information about NH financial revenues and spending nationally.[47] Although this study implemented extensive cleaning procedures to improve accuracy, there may be missing and inaccurate data. Another potential limitation is that, due to NH-specific fiscal year reporting periods, some cost reports covered March through June of 2020 at the beginning of the COVID-19 pandemic, which could have impacted revenues and expenditures during that period.

A U.S. General Accountability Office (GAO) study of NH cost report data from 2011–2014 found that CMS does little to ensure the accuracy and completeness of the data.[47] The GAO recommended

	that CMS should make data accessible to the public and ensure data reliability because of the importance of this data source. Despite these recommendations in 2016, CMS NH cost reports do not have computerized accuracy checks for simple math errors, and cost reports are not required to be audited or validated by an accounting professional before they are submitted to CMS. In addition, the cost report data only show the amount of cash at the end of the year and not the total cash removed by NH owners throughout the year. As noted above, the cost reports do not require sufficient information to verify disallowances, especially on the profits and administrative costs on related-party transactions. Because CMS claims to use NH cost report data for determining its Medicare rates annually, there is a clear need to improve the accuracy and completeness of the reports.[48] Medicare may conduct financial audits in situations where fraud may be suspected or to confirm provider charges for bad debts resulting from Medicare deductible and coinsurance amounts which are uncollectible from Medicare beneficiaries. As a general rule, however, CMS does not conduct Medicare financial audits on NHs. CMS has no requirements for consolidated cost reports that provide information on corporate chains or entire companies that own NHs. Moreover, CMS has no penalties for false reporting, even though this could improve the accuracy and transparency of cost reports.[41] In conclusion, this study provided an in-depth report on U.S. NH financial status for 2019. When disallowances and depreciation were excluded, total income margins increased from less than one percent to approximately nine percent. Most NHs (77%) reported related-party transactions that accounted for about 10 percent of net revenues, suggesting these transactions require further study as to whether they are accurately reported and whether funds are diverted away from needed resident care. Disallowances, including those from related parties, are not required to be returned to Medicare, thereby increasing NH income margins. Finally, approximately 66 percent of net expenses were for direct care compared to 34 percent for administration, capital, and profits. Policy changes may improve the proportional spending on direct care and patient quality. Overall, the study findings illustrate the value of analyzing NH financial performance using cost reports. They also suggest that there are potential policy options that could be implemented to improve rate setting, reimbursement methods, the accuracy, and the transparency of cost reports, including related-party transactions, and the accountability for spending government funds.
Quotes	*"Too many seniors and families accept substandard care and inhumane conditions because their nursing home tells them that they cannot afford to hire more staff. This study*

[United States' Nursing Home Finances: Spending, Profitability, and Capital Structure] provides important evidence showing that nursing homes get plenty of money, they are just not being held accountable for using it appropriately."

Richard Mollot, executive director of the Long Term Care Community Coalition and a co-author of the study, ***United States' Nursing Home Finances: Spending, Profitability, and Capital Structure***, **Sage Journals,** December 19, 2023

Health care is "the only business that doesn't reward for quality care. All we reward for is volume. Do more, and you're going to get more money."

Dr. Michael Imburgia, a Louisville cardiologist, *America's epidemic of chronic illness is killing us too soon*, **Washington Post** (free access), October 3, 2023

In 1900, life expectancy at birth in the United States was 47 years. . .Then came a century that saw life expectancy soar beyond the biblical standard of "threescore years and ten". . . The rise of life expectancy became the ultimate proof of societal progress in 20th century America. Decade by decade, the number kept climbing, and by 2010, the country appeared to be marching inexorably toward the milestone of 80. It never got there.

America's epidemic of chronic illness is killing us too soon, **Washington Post** (free access), October 3, 2023

Immunizing people to reduce the spread of disease is perhaps one of the easiest and most beneficial of these measures. Polio, measles, diphtheria, smallpox, and yes, COVID. These are some of the immunizations that not only benefit individuals, but also benefit society.

Many of the COVID hospitalizations and deaths are avoidable through immunization. All of society pays a cost for these avoidable hospitalizations. Healthcare workers are needlessly put at risk. Insurance and Medicare expenses

are unnecessarily high. The human toll on families and friends is high, and often avoidable. . .
This is a social contract issue. People's ignorance and superstition should not trump the public good.

Theodore S. Widlanski, *What government can do about dismal nursing home vaccination rates* **(Washington Post** (free access), December 27, 2023)

When I get together with old friends, our first ritual is an "organ recital" — how's your back? knee? heart? hip? shoulder? eyesight? hearing? prostate? hemorrhoids? digestion? The recital can run — and ruin — an entire lunch.

Robert Reich, ***A holiday question: How old is too old?***, **Substack,** December 25, 2023

"Just try, dear. So many people are old at 60. They just want to sit all day. You won't make it to 90 like that. You have to try.". . . "Age is just another bother attempting to convince you of the impossible in a world absolutely blooming with possibilities."

New York Times writer Richard Morgan's 93-year-old grandmother, *At 93, Teaching Me About Possibility*, **New York Times (free access),** December 22, 2023

Hospitals and health insurers once made money in order to provide health care. Now, hospitals and health insurers provide health care in order to make money.

Robert Reich, *How private equity is destroying the labors of love*, **Substack,** August 11, 2023

"I'm trying to keep my patients alive. What does it mean for the role of the physician, as healer, as bringer of hope, to be offering death? And what does it mean in practice?"

Dr. John Maher, a psychiatrist in Barrie, Ontario, *Death by Doctor May Soon Be Available for the Mentally Ill in Canada,* ***New York Times,** December 27, 2023

The concept of vulnerability is intricately tied to health justice. Vulnerability is heightened when social and structural determinants of health interact to create power imbalances that inhibit people's ability to exert agency over

	their own health, protect themselves, and influence decision makers. [*The Health Justice Policy Tracker: COVID-19 Policies to Advance Health Justice for Vulnerable Populations*](), **Health Affairs,** December 2023
Observations Robert Reich was Secretary of Labor during the Bill Clinton Administration. has been the Chancellor's Professor of Public Policy at the [Goldman School of Public Policy]() at [UC Berkeley]() since January 2006.	[***A holiday question: How old is too old?***]() *My guide to when to get out* **Substack** By Robert Reich December 25, 2023 Friends, Happy holidays. In the spirit of Christmas past and future, and in light of the age of our likely two major candidates for president in 2024, I thought it a good day to ask: How old is too old? (Forgive me if I've asked this before. I'm old and occasionally repeat myself.) I have a personal stake in the answer. I'm now a spritely 77. I feel fit, I swing dance and salsa, and I can do 20 pushups in a row. Yet I confess to a certain loss of, shall we say, *fizz.* Joe Biden could easily make it until 86, when he'd conclude his second term. After all, it's now thought a bit disappointing if a person dies before 85. "After 80, it's gravy," my father used to say. Joe will be on the cusp of the gravy train. In 1900, gerontologists considered "old" to be 47. Today, you're considered "youngest-old" at 65, "middle-old" at 75, and at 85, you are a member of the "oldest-old." Three score and 10 is the number of years of life set out in the Bible. Modern technology and Big Pharma should add at least a decade and a half. Beyond this is an extra helping. Where will it end? There's only one possibility, and that reality occurs to me with increasing frequency. My mother passed at 86, my father two weeks before his 102nd birthday, so I'm hoping for the best, genetically speaking. Yet I find myself reading the obituary pages with ever greater interest, curious about how long they lasted and what brought them down. I remember a *New Yorker* cartoon in which an older reader of the obituaries sees headlines that read only "Older Than Me" or "Younger Than Me." Most of the time I forget my age. The other day, after lunch with some of my graduate students, I caught our reflection in a store window and, for an instant, wondered about the identity of the short old man in our midst. It's not death that's the worrying thing about a second Biden term. It's the dwindling capacities that go with aging. "Bodily decrepitude," said Yeats, "is wisdom." I have accumulated somewhat more of the former than the latter, but Biden seems fairly spry (why do I feel I have to add "for someone his age?"). I still have my teeth, in contrast to my grandfather, who I vividly recall storing his choppers in a glass next to his bed and has so far steered clear of heart attack or stroke (I pray I'm not tempting fate by my stating this fact). But I've lived through several kidney stones and a few unexplained fits of epilepsy in my late 30s. I've had both hips replaced.

And my hearing is crap. Even with hearing aids, I have a hard time understanding someone talking to me in a noisy restaurant. You'd think that the sheer market power of 60 million boomers losing their hearing would be enough to generate at least one chain of quiet restaurants.

When I get together with old friends, our first ritual is an "organ recital" — how's your back? knee? heart? hip? shoulder? eyesight? hearing? prostate? hemorrhoids? digestion? The recital can run — and ruin — an entire lunch.

The question my friends and I jokingly (and brutishly) asked one other in college — "getting much?" — now refers not to sex, but to sleep.

I don't know anyone over 75 who sleeps through the night. When he was president, Bill Clinton prided himself on getting only about four hours. But he was in his 40s then. (I also recall Cabinet meetings where he dozed off.) How does Biden manage?

My memory for names is horrible. I once asked Ted Kennedy how he recalled names, and he advised that if a man is over 50, just ask, "How's the back?" and he'll think you know him.

I often can't remember where I put my wallet and keys or why I've entered a room. And certain proper nouns have disappeared altogether. Even when rediscovered, they have a diabolical way of disappearing again. Biden's Secret Service detail can worry about his wallet, and he's got a teleprompter for wayward nouns, but I'm sure he's experiencing some diminution in the memory department.

I have lost much of my enthusiasm for travel and feel, as did Philip Larkin, that I would like to visit China, but only on the condition that I could return home that night. Air Force One makes this possible under most circumstances. If not, it has a first-class bedroom and personal bathroom, so I don't expect Biden's trips are overly taxing.

I'm told that after the age of 60, one loses half an inch of height every five years. This doesn't appear to be a problem for Biden, but it presents a challenge for me, considering that at my zenith, I didn't quite make it to five feet. If I live as long as my father did, I may vanish.

Another diminution I've noticed is tact. Several months ago, I gave the finger to a driver who passed me recklessly. Giving the finger to a stranger is itself a reckless act.

I'm also noticing I have less patience, perhaps because of an unconscious "use by" timer that's now clicking away. Increasingly, I wonder why I'm wasting time with this or that buffoon. I'm less tolerant of long waiting lines, automated phone menus, and Republicans.

Cicero claimed "older people who are reasonable, good-tempered, and gracious bear aging well. Those who are mean-spirited and irritable will be unhappy at every stage of their lives." Easy for Cicero to say. He was forced into exile and murdered at the age of 63, his decapitated head and right hand hung up in the Forum by order of the notoriously mean-spirited and irritable Marcus Antonius.

How the hell does Biden maintain tact or patience when he has to deal with Michael Johnson, Mitch McConnell, and the White House press corps?

The style sections of the papers tell us that the 70s are the new 50s. Septuagenarians are supposed to be fit and alert, exercise like mad, have rip-roaring sex, and party until dawn. Rubbish. Inevitably, things begin falling apart. My aunt, who lived far into her 90s, told me "getting old isn't for

	sissies." Toward the end, she repeated that phrase every two to three minutes. Philosopher George Santayana claimed to prefer old age to all others. "Old age is, or may be as in my case, far happier than youth," he wrote. "I was never more entertained or less troubled than I am now." True for me, too, in a way. Despite Trump, notwithstanding the seditiousness of the Republican Party, regardless of the ravages of climate change, near record inequality, a potential nuclear war, and another strain of COVID making the rounds, I remain upbeat — largely because I still spend most days with people in their 20s who buoy my spirits. Maybe Biden does, too. But I'm feeling more and more out of it. I'm doing videos on TikTok and Snapchat, but when my students talk about Ariana Grande or Selena Gomez or Jared Leto, I don't have a clue whom they're talking about (and frankly, don't care). And I find myself using words — "hence," "utmost," "therefore," "tony," "brilliant" — that my younger colleagues find charmingly old-fashioned. If I refer to "Rose Marie Woods" or "Jackie Robinson" or "Ed Sullivan" or "Mary Jo Kopechne," they're bewildered. The culture has flipped in so many ways. When I was 17, I could go into a drugstore and confidently ask for a package of Luckies and nervously whisper a request for condoms. Now it's precisely the reverse. (I stopped smoking long ago.) Santayana said the reason that old people have nothing but foreboding about the future is that they cannot imagine a world that's good without themselves in it. I don't share that view. I'm not going to tell Joe Biden, Donald Trump, or any other "middle-olds" and "oldest-olds" what to do. But as for myself, I recently made a hard decision. I taught my last class at the end of April, after more than 40 years of teaching. Why? I wanted to leave on a high note when I felt I could still do the job well. I didn't want to wait until I could no longer give students what they need and deserve. And I hated the thought of students or colleagues whispering about the old guy who shouldn't be teaching anymore. Getting too old to do a job isn't a matter of chronological age. It's a matter of being lucid enough to know when you should exit the stage *before* you no longer have what it takes to do the job well. It saddens me that I won't be heading back into the classroom this spring. But it was time for me to go.
Guide to news items in this week's *Dignity Digest*	**Private Equity** *How private equity is destroying the labors of love* (**Substack,** August 11, 2023) *How private equity investment in health care could be driving up costs* (YouTube) (**Yahoo! Finance,** October 11, 2021) **Medicare** *UnitedHealth used secret rules to restrict rehab care for seriously ill Medicare Advantage patients* (***STAT+,** December 28, 2023) **Covid / Long Covid** *What government can do about dismal nursing home vaccination rates* **(Washington Post** (free access), December 27, 2023)

	The Health Justice Policy Tracker: COVID-19 Policies to Advance Health Justice for Vulnerable Populations **(Health Affairs,** December 2023) *Global COVID-19 Tracker* **(KFF,** December 14, 2023) **Health Care Topics** *America's epidemic of chronic illness is killing us too soon* **(Washington Post (free access),** October 3, 2023) **Ageism** *At 93, Teaching Me About Possibility* **(New York Times (free access),** December 22, 2023) **From Other Countries** *Death by Doctor May Soon Be Available for the Mentally Ill in Canada* **(*New York Times,** December 27, 2023)
DignityMA Study Sessions	***A conversation with Dr. Lisa Iezzoni, Board Member, Massachusetts Department of Transportation Board of Directors, representing the disability community*** **Wednesday, January 10, 2024 from 2:00 to 3:00 p.m.** **Presenter: Dr. Lisa Iezzoni**, Board Member, Massachusetts Department of Transportation Board of Directors, representing the disability community. She is a professor at Harvard Medical School as well as the director of the Mongan Institute for Health Policy at Massachusetts General Hospital. She is a Dignity Alliance Massachusetts participant. Questions which may require specific responses can be submitted in advance via this link: https://forms.gle/QGQWDunjS1SY1QkLA Join Zoom Meeting https://us02web.zoom.us/j/87529064921?pwd=QlcvQlRRTjhRdXNLbndISFF5ZnJvQT09 Meeting ID: 875 2906 4921 Passcode: 741150 One tap mobile: +13052241968,,87529064921#,,,,*741150# Telephone: 305 224 1968
Webinars and Other Online Sessions	**1. U. S. Access Board** Thursday, January 4 from 2:30 to 4:00 p.m. *Sporting: The Spectator's Experience* For thousands of years, people have been gathering at stadiums to watch sports. The Americans with Disabilities Act (ADA) and Architectural Barriers Act (ABA) Standards specify accessibility requirements to ensure inclusion for all spectators and enabling everyone to experience one of civilization's oldest pastimes. The presenters of this webinar will cover the spectator's experience at sporting events from a youth soccer game to the World Cup. Seating, assistive listening systems, ticketing/concessions, and access to areas of sport activity will all be addressed. Video remote interpreting and real-time captioning will be provided in this webinar. Questions can be submitted in advance of the session or may be posed during the live webinar. Speakers: Debra Martins , Accessibility Specialist, **U.S. Access Board** Travis Saner, Accessibility Specialist, **U.S. Access Board**
Previously posted webinars and online sessions	Previously posted webinars and online sessions can be viewed at: https://dignityalliancema.org/webinars-and-online-sessions/

Private Equity	***2.*** **Substack** [*How private equity is destroying the labors of love*] By Robert Reich August 11, 2023 *Private equity is turning every business into a short-term profit center.* Hospitals and health insurers once made money in order to provide health care. Now, hospitals and health insurers provide health care in order to make money. Blue Cross and Blue Shield began as nonprofits that insured all comers. But as big profit-seeking insurers targeted younger and healthier people, the Blues were left to insure the older and less healthy, which made it impossible for them to continue. They turned to making money. Now, private equity runs hospitals, into the ground. ***3.*** **Yahoo! Finance** *How private equity investment in health care could be driving up costs* (YouTube) October 11, 2021 Interview with Loren Adler, Associate Director of the USC-Brookings Schaeffer Initiative for Health Policy
Medicare	**4.** ***STAT+** December 28, 2023 *UnitedHealth used secret rules to restrict rehab care for seriously ill Medicare Advantage patients* By Bob Herman and Casey Ross Health insurance giant UnitedHealth Group used secret rules to restrict access to rehabilitation care requested by specific groups of seriously ill patients, including those who lived in nursing homes or suffered from cognitive impairment, according to internal documents obtained by STAT. The documents, which outline parameters for the clinicians who initially review referrals for rehab care, reveal that many patients enrolled in Medicare Advantage plans were routed for a quick denial based on criteria neither they, nor their doctors, were aware of.
Covid / Long Covid / Infectious Disease	**5.** **Washington Post** (free access) December 27, 2023 *What government can do about dismal nursing home vaccination rates* By Leana S. Wen Only 33 percent of nursing home residents have received the updated coronavirus vaccine, according to data released last week by the Centers for Disease Control and Prevention. This dismal number is particularly concerning as covid-19 hospitalizations are rising around the country, putting this vulnerable group at risk for preventable tragedy. Some states, notably North and South Dakota, are doing better than others to promote nursing home vaccine uptake, and some facilities have taken matters into their own hands to achieve remarkable vaccination numbers. The low national rate, though, suggests that there are systemic challenges requiring policy changes. The federal government can take the following four steps: **Allow pharmacists to bill Medicare for all vaccine administration in nursing homes.** The end of the covid-19 public health emergency in May brought about an end to the waiver that enabled pharmacists to bill Medicare for all coronavirus vaccines administered in long-term care facilities. Now, the process is more complicated.

Elizabeth Sobczyk, a project director with the Society for Post-Acute and Long-Term Care Medicine, known as AMDA, explained to me that pharmacists can now bill for coronavirus shots delivered during some periods of a resident's nursing home stay but not others. The facilities themselves can bill for the latter periods, but "the administrative barriers to doing so are very high." Simplifying the process would make vaccines more readily accessible.

Enable single-dose vaccine orders for long-term care facilities. Now that vaccines are no longer free of charge; providers have to pay upfront and then seek reimbursement. This presents a new challenge in matching supply with demand to avoid wastage, according to David Gifford, chief medical officer at the American Health Care Association/National Center for Assisted Living.

I understand Gifford's point. Coronavirus vaccines are currently delivered in multidose vials. Once opened, they need to be used quickly or be discarded. And they are expensive: "The cost of the covid-19 vaccine is about $130 per dose, which is significantly higher than the influenza vaccine, which is about $20 per dose," Gifford said.

Many nursing homes are already operating on tight budgets. They won't want to open an entire vial to give a couple of vaccines, knowing they can't recoup the significant cost of the unused doses. That could result in a resident waiting weeks for enough other residents to sign up for the shot — an unnecessary delay that would be alleviated with single-dose vials.

Encourage vaccinations before admission. "One of the challenges we face is that many new admissions have not yet received the vaccine from either their primary-care physician or the hospital," Gifford said. "A common response nursing home staff hear when they recommend the vaccine to a new resident is that their doctor or hospital said they did not need it."

Because, according to Gifford, about 85 percent of nursing home admissions come directly from a hospital, those hospitals need to emphasize vaccination before discharge. The federal government should launch a national educational campaign that also includes directing primary-care providers whose patients are entering nursing homes to ensure that shots are up to date before arrival.

Incentivize nursing homes. A spokesperson from the Centers for Medicare and Medicaid Services, the federal agency that oversees long-term care facilities, told me that "CMS requires that nursing homes educate their residents and staff on the importance of the vaccine and to offer them covid-19 vaccines." Facilities found not to be compliant are "cited for deficient practice and required to implement a plan of correction."

I don't think this goes far enough, given the critical importance of the vaccines to this highly susceptible population. "Educating residents and staff" can range from a posted sign and a cursory mention to in-depth conversations with each resident and their family. Similarly, an "offer" of vaccines is not the same as doggedly overcoming administrative barriers to bring shots directly to residents. Facilities that prioritize vaccination should be rewarded for their commitment and persistence.

The federal government can set the expectation that nursing home vaccinations are of great importance by publishing the names of facilities that meet a certain threshold and providing them a financial reward. Notably, there is one solution I did not mention, even though it proved to be effective in the past. Federal mandates for vaccinating nursing home residents and staff helped achieve the

nearly 87 percent uptake of the primary vaccine series, and instituting the same requirement for boosters would dramatically increase rates now.
However, years of top-down requirements have taken a toll on Americans' tolerance of covid-related government intervention, and, as Sobczyk said, "the appetite for mandates and further regulation in the nursing home setting is very low." In the face of that reality, the government should consider these other practical policy measures that can boost protection as covid rates rise this winter.
or rates could face penalties.

6. **Health Affairs**
December 2023
The Health Justice Policy Tracker: COVID-19 Policies to Advance Health Justice for Vulnerable Populations
By Malvikha Manoj, Phong Phu Truong, Jeremy Shiffman, and Yusra Ribhi Shawar
Abstract
The rapid spread of COVID-19 throughout the world in early 2020 created unprecedented challenges for national governments. Policies developed during the early months of the pandemic, before the first mRNA vaccines were authorized for emergency use, provide a window into national governments' prioritization of populations that were particularly vulnerable. We developed the COVID-19 Health Justice Policy Tracker to capture and categorize these policies using a health justice lens. In this article we present the results of a preliminary analysis of the tracker data. The tracker focuses on policies for six population groups: children, the elderly, people with disabilities, migrant workers, incarcerated people, and people who were refugees or were seeking political asylum. It includes 610 policies, most targeting children and the elderly and providing financial support. National governments also prioritized measures such as policies to ensure access to mental health care and social services, digital and teleservices, continuity of children's education, and food security. The tracker provides a resource for researchers and policy makers seeking model language and tested policy approaches to advance health justice during future crises. . .
During the COVID-19 pandemic, certain population groups in countries worldwide were especially vulnerable. The elderly faced heightened risk for severe disease and death due to their age, comorbidities, and barriers in access to health care. Elderly people living in long-term care facilities also faced heightened risks of exposure to COVID-19. Protective measures such as stay-at-home orders and quarantines amplified social isolation among this group, thus worsening their mental and physical well-being.

7. **KFF**
December 14, 2023
Global COVID-19 Tracker
This tracker provides the cumulative number of confirmed COVID-19 cases and deaths, as well as the rate of daily COVID-19 cases and deaths by country, income, region, and globally. It will be updated weekly, as new data are released. As of March 7, 2023, all data on COVID-19 cases and deaths are drawn from the World Health Organization's (WHO) Coronavirus (COVID-19) Dashboard. Prior to March 7, 2023, this tracker relied on data provided by the Johns Hopkins University (JHU) Coronavirus Resource Center's COVID-19 Map,

	which ended on March 10, 2023. Please see the Methods tab for more detailed information on data sources and notes. To prevent slow load times, the tracker only contains data from the last 200 days. However, the full data set can be downloaded from our GitHub page. The tracker accounts for national policies established between March 11, 2020, and December 31, 2020, when the first mRNA vaccines were authorized for emergency use and for priority groups. The tracker categorizes these policies into four domains: health, social, financial, and "other." Manoj and coauthors specifically focus on the effects of these policies on six vulnerable population groups: children, the elderly, people with disabilities, migrant workers, incarcerated people, and people who were refugees or were seeking political asylum. They find that of the 610 policies identified by the tracker, most targeted children and the elderly, and financial policies accounted for the majority of policies. The authors conclude that policy makers and researchers could use the tracker to inform policy development aimed at advancing health justice.
Health Care Topics	**8. Washington Post** (free access) October 3, 2023 *America's epidemic of chronic illness is killing us too soon* By Joel Achenbach, Dan Keating, Laurie McGinley, Akilah Johnson, and Jahi Chikwendiu The United States is failing at a fundamental mission — keeping people alive. After decades of progress, life expectancy — long regarded as a singular benchmark of a nation's success — peaked in 2014 at 78.9 years, then drifted downward even before the coronavirus pandemic. Among wealthy nations, the United States in recent decades went from the middle of the pack to being an outlier. And it continues to fall further and further behind. A year-long Washington Post examination reveals that this erosion in life spans is deeper and broader than widely recognized, afflicting a far-reaching swath of the United States. While opioids and gun violence have rightly seized the public's attention, stealing hundreds of thousands of lives, chronic diseases are the greatest threat, killing far more people between 35 and 64 every year, The Post's analysis of mortality data found. Heart disease and cancer remained, even at the height of the pandemic, the leading causes of death for people 35 to 64. And many other conditions — private tragedies that unfold in tens of millions of U.S. households — have become more common, including diabetes and liver disease. These chronic ailments are the primary reason American life expectancy has been poor compared with other nations. Sickness and death are scarring entire communities in much of the country. The geographical footprint of early death is vast: In a quarter of the nation's counties, mostly in the South and Midwest, working-age people are dying at a higher rate than 40 years ago, The Post found. The trail of death is so prevalent that a person could go from Virginia to Louisiana, and then up to Kansas, by traveling entirely within counties where death rates are higher than they were when Jimmy Carter was president.

This phenomenon is exacerbated by the country's economic, political and racial divides. America is increasingly a country of haves and have-nots, measured not just by bank accounts and property values but also by vital signs and grave markers. Dying prematurely, The Post found, has become the most telling measure of the nation's growing inequality.

The mortality crisis did not flare overnight. It has developed over decades, with early deaths an extreme manifestation of an underlying deterioration of health and a failure of the health system to respond. Covid highlighted this for all the world to see: It killed far more people per capita in the United States than in any other wealthy nation.

Chronic conditions thrive in a sink-or-swim culture, with the U.S. government spending far less than peer countries on preventive medicine and social welfare generally. Breakthroughs in technology, medicine and nutrition that should be boosting average life spans have instead been overwhelmed by poverty, racism, distrust of the medical system, fracturing of social networks and unhealthy diets built around highly processed food, researchers told The Post.

The calamity of chronic disease is a "not-so-silent pandemic," said Marcella Nunez-Smith, a professor of medicine, public health, and management at Yale University. "That is fundamentally a threat to our society." But chronic diseases, she said, don't spark the sense of urgency among national leaders and the public that a novel virus did.

America's medical system is unsurpassed when it comes to treating the most desperately sick people, said William Cooke, a doctor who tends to patients in the town of Austin, Ind. "But growing healthy people to begin with, we're the worst in the world," he said. "If we came in last in the next Olympics, imagine what we would do."

The Post interviewed scores of clinicians, patients, and researchers, and analyzed county-level death records from the past five decades. The data analysis concentrated on people 35 to 64 because these ages have the greatest number of excess deaths compared with peer nations.

What emerges is a dismaying picture of a complicated, often bewildering health system that is overmatched by the nation's burden of disease:

- Chronic illnesses, which often sicken people in middle age after the protective vitality of youth has ebbed, erase more than twice as many years of life among people younger than 65 as all the overdoses, homicides, suicides, and car accidents combined, The Post found.
- The best barometer of rising inequality in America is no longer income. It is life itself. Wealth inequality in America is growing, but The Post found that the death gap — the difference in life expectancy between affluent and impoverished communities — has been widening many times faster. In the early 1980s, people in the poorest communities were 9 percent more likely to die each year, but the gap grew to 49 percent in the past decade and widened to 61 percent when covid struck.
- Life spans in the richest communities in America have kept inching upward, but lag far behind comparable areas in Canada, France and Japan, and the gap is widening. The same divergence is seen at the bottom of the socioeconomic ladder: People living in the poorest areas of America have far lower life expectancy than people in the poorest areas of the countries reviewed.

- Forty years ago, small towns and rural regions were healthier for adults in the prime of life. The reverse is now true. Urban death rates have declined sharply, while rates outside the country's largest metro areas flattened and then rose. Just before the pandemic, adults 35 to 64 in the most rural areas were 45 percent more likely to die each year than people in the largest urban centers.

"The big-ticket items are cardiovascular diseases and cancers," said Arline T. Geronimus, a University of Michigan professor who studies population health equity. "But people always instead go to homicide, opioid addiction, HIV."

Behind all the mortality statistics are the personal stories of loss, grief, hope. And anger. They are the stories of chronic illness in America and the devastating toll it exacts on millions of people — people like Bonnie Jean Holloway.

For years, Holloway rose at 3 a.m. to go to her waitress job at a small restaurant in Louisville that opened at 4 and catered to early-shift workers. Later, Holloway worked at a Bob Evans restaurant right off Interstate 65 in Clarksville, Ind. She often worked a double shift, deep into the evening. She was one of those waitresses who becomes a fixture, year after year.

Those years were not kind to Holloway's health.

She never went to the doctor, not counting the six times she delivered a baby, according to her eldest daughter, Desirae Holloway. She was covered by Medicaid, but for many years, didn't have a primary care doctor.

She developed rheumatoid arthritis, a severe autoimmune disease. "Her hands were twisted," recalled friend and fellow waitress Dolly Duvall, who has worked at Bob Evans for 41 years. "Some days, she had to call in sick because she couldn't get herself walking."

The turning point came a little more than a decade ago when Holloway dropped a tray full of water glasses. She went home and wept. She knew she was done.

Her 50s became a trial, beset with multiple ailments, consistent with what the Centers for Disease Control and Prevention has found — that people with chronic diseases often have them in bunches. She was diagnosed with emphysema and chronic obstructive pulmonary disease — known as COPD — and could not go anywhere without her canister of oxygen.

Her family found the medical system difficult to trust. Medicines didn't work or had terrible side effects. Drugs prescribed for Holloway's autoimmune disease seemed to make her vulnerable to infections. She would catch whatever bug her grandkids caught. She developed a fungal infection in her lungs.

Tobacco looms large in this sad story. One of the signal successes of public health in the past half-century has been the drop in smoking rates and associated declines in lung cancer. But roughly 1 in 7 middle-aged Americans still smokes, according to the CDC. Kentucky has a deep cultural and economic connection to tobacco. The state's smoking rates are the second-highest in the nation, trailing only West Virginia. Holloway began smoking at 12, Desirae said. And for a long time, restaurants still had a smoking section right next to the nonsmoking section.

"Her mother was a smoker, her father was a smoker," Desirae said. "I think I was the one in the family that broke that cycle. I remember what it was like to grow up in the house where the house was filled with smoke."

In June 2022, Bonnie Jean's son Dalton, known to his family as "Wolfie" — a smoker, too — went to the emergency room with what he thought was a

collapsed lung. After an X-ray, he was prescribed a muscle relaxer. The pain persisted. A second scan led to a diagnosis of lung cancer, Stage 4.
Dalton died in the hospital on Jan. 31. He was 30.
Bonnie Jean Holloway was in a wheelchair at her son's funeral. Her health deteriorated after that. When hospitalized for what turned out to be the final time, she was diagnosed with mucormycosis, a fungal infection that, according to Desirae, had eaten into her ribs. A scan showed a suspicious spot in her lungs, but she was too weak by then for a biopsy.
In her final weeks, Holloway would look into a corner of her hospital room and speak to someone who was not there. The family felt she was speaking to Wolfie.
One day, she told Desirae she couldn't hang on any longer. "Wolfie needs me," she said.
Desirae felt her mother deserved better in life. "Mom, your life was just not fair," Desirae told her.
She died in the hospital on Memorial Day. She was 61.
In 1900, life expectancy at birth in the United States was 47 years. Infectious diseases routinely claimed babies in the cradle. Diseases were essentially incurable except through the wiles of the human immune system, of which doctors had minimal understanding.
Then came a century that saw life expectancy soar beyond the biblical standard of "threescore years and ten." New tools against disease included antibiotics, insulin, vaccines and, eventually, CT scans and MRIs. Public health efforts improved sanitation and the water supply. Social Security and Medicare eased poverty and sickness in the elderly.
The rise of life expectancy became the ultimate proof of societal progress in 20th century America. Decade by decade, the number kept climbing, and by 2010, the country appeared to be marching inexorably toward the milestone of 80.
It never got there.
Partly, that is a reflection of how the United States approaches health. This is a country where "we think health and medicine are the same thing," said Elena Marks, former health and environmental policy director for the city of Houston. The nation built a "health industrial complex," she said, that costs trillions of dollars yet underachieves.
"We have undying faith in big new technology and a drug for everything, access to as many MRIs as our hearts desire," said Marks, a senior health policy fellow at Rice University's Baker Institute for Public Policy. "Eighty-plus percent of health outcomes are determined by nonmedical factors. And yet, we're on this train, and we're going to keep going."
The opioid epidemic, a uniquely American catastrophe, is one factor in the widening gap between the United States and peer nations. Others include high rates of gun violence, suicides, and car accidents.
But some chronic diseases — obesity, liver disease, hypertension, kidney disease and diabetes — were also on the rise among people 35 to 64, The Post found, and played an underappreciated role in the pre-pandemic erosion of life spans.
Then covid hit.
In 2021, according to the CDC, life expectancy cratered, reaching 76.4, the lowest since the mid-1990s.

	The pandemic amplified a racial gap in life expectancy that had been narrowing in recent decades. In 2021, life expectancy for Native Americans was 65 years; for Black Americans, 71; for White Americans, 76; for Hispanic Americans, 78; and for Asian Americans 84. Death rates decreased in 2022 because of the pandemic's easing, and when life expectancy data for 2022 is finalized this fall, it is expected to show a partial rebound, according to the CDC. But the country is still trying to dig out of a huge mortality hole. For more than a decade, academic researchers have disgorged stacks of reports on eroding life expectancy. A seminal 2013 report from the National Research Council, "Shorter Lives, Poorer Health," lamented America's decline among peer nations. "It's that feeling of the bus heading for the cliff and nobody seems to care," said Steven H. Woolf, a Virginia Commonwealth University professor and co-editor of the 2013 report. In 2015, Princeton University economists Anne Case and Angus Deaton garnered national headlines with a study on rising death rates among White Americans in midlife, which they linked to the marginalization of people without a college degree and to "deaths of despair." The grim statistics are there for all to see — and yet the political establishment has largely skirted the issue. "We describe it. We lament it. We've sort of accepted it," said Derek M. Griffith, director of Georgetown University's Center for Men's Health Equity. "Nobody is outraged about us having shorter life expectancy." It can be a confusing statistic. Life expectancy is a wide-angle snapshot of average death rates for people in different places or age groups. It is typically expressed as life expectancy at birth, but the number does not cling to a person from the cradle as if it were a prediction. And if a country has an average life expectancy at birth of 79 years, that doesn't mean a 78-year-old has only a year to live. However, confusing it may be, the life expectancy metric is a reasonably good measure of a nation's overall health. And America's is not very good. For this story, The Post concentrated its reporting on Louisville and counties across the river in southern Indiana. The Louisville area does not, by any means, have the worst health outcomes in the country. But it possesses health challenges typical in the heartland, and offers an array of urban, suburban, and rural communities, with cultural elements of the Midwest and the South. Start with Louisville, hard by the Ohio River, a city that overachieves when it comes to Americana. Behold Churchill Downs, home of the Kentucky Derby. See the many public parks designed by the legendary Frederick Law Olmsted. Downtown is where you will find the Muhammad Ali Center, and the Louisville Slugger Museum & Factory, and a dizzying number of bars on what promoters have dubbed the Urban Bourbon Trail. This summer, huge crowds gathered on the south bank of the Ohio for free concerts on Waterfront Wednesdays. Looming over the great lawn is a converted railroad bridge called the Big Four, which at any given moment is full of people walking, cycling, or jogging. But for all its vibrancy, Louisville's life expectancy is roughly two years shorter than the national average, and the gap has tripled since 1990. Death rates from

	liver disease and chronic lower lung disease are up. The city has endured a high homicide rate comparable with Chicago's. "We have a gun violence epidemic in Louisville that is a public health crisis," Mayor Craig Greenberg (D) told The Post. In 1990, the Louisville area, including rural counties in Southern Indiana, was typical of the nation as a whole, The Post found, with adults between 35 and 64 dying at about the same rate as comparable adults nationally. By 2019, adults in their prime were 30 percent more likely to die compared with peers nationally. Rates of heart disease, lung ailments and liver failure all were worse in the region compared with national trends. The same is true of car accidents, overdoses, homicide, and suicide. And then there's the rampant disease that's impossible to miss: obesity. Every day, the faces of this American health crisis come through the doors of Vasdev Lohano's exam rooms at the Joslin Diabetes Center in New Albany, Ind. Born and raised in Pakistan, Lohano arrived in the United States in 1994, landing in New York after medical school, where he was astonished by what Americans ate. Processed food was abundant, calories cheap, the meals supersized. Most striking was ubiquitous soda pop. When Lohano visited a fast-food outlet in Queens, he ordered a modest meal, a hamburger, and a Coke. The employee handed him an empty cup. Lohano was confused. "Where's my soda?" he asked. The employee pointed to the soft drink machine and told him to serve himself. "How much can I have?" Lohano asked. "As much as you want," he was told. "Cancel my burger, I'm just going to drink soda," he announced. Lohano, an endocrinologist whose practice sits a short drive north from Louisville, says he has "seen two worlds in my lifetime." He means not just Pakistan and the United States, but the past and the present. When he was in medical school in Pakistan, he was taught that a typical adult man weighs 70 kilograms — about 154 pounds. Today, the average man in the United States weighs about 200 pounds. Women on average weigh about 171 pounds — roughly what men weighed in the 1960s. In 1990, 11.6 percent of adults in America were obese. Now, that figure is 41.9, according to the CDC. The rate of obesity deaths for adults 35 to 64 doubled from 1979 to 2000, then doubled again from 2000 to 2019. In 2005, a special report in the New England Journal of Medicine warned that the rise of obesity would eventually halt and reverse historical trends in life expectancy. That warning generated little reaction. Obesity is one reason progress against heart disease, after accelerating between 1980 and 2000, has slowed, experts say. Obesity is poised to overtake tobacco as the No. 1 preventable cause of cancer, according to Otis Brawley, an oncologist and epidemiologist at Johns Hopkins University. Medical science could help turn things around. Diabetes patients are benefiting from new drugs, called GLP-1 agonists — sold under the brand names Ozempic and Wegovy — that provide improved blood-sugar control and can lead to a sharp reduction in weight. But insurance companies, slow to see obesity as a disease, often decline to pay for the drugs for people who do not have diabetes. Lohano has been treating David O'Neil, 67, a retired firefighter who lost his left leg to diabetes. When he first visited Lohano's clinic last year, his blood sugar

level was among the highest Lohano had ever seen — "astronomical," the doctor said.
O'Neil said diabetes runs in his family. Divorced, he lives alone with two cats. He said he mostly eats frozen dinners purchased at Walmart.
"It's easier to fix," he said.
Three years ago, he had the leg amputated.
"I got a walker, but when you got one leg, it's a hopper," he said. "I've got to get control of this diabetes or I won't have the other leg."
What happened to this country to enfeeble it so?
There is no singular explanation. It's not just the stress that is such a constant feature of daily life, weathering bodies at a microscopic level. Or the abundance of high-fructose corn syrup in that 44-ounce cup of soda.
Instead, experts studying the mortality crisis say any plan to restore American vigor will have to look not merely at the specific things that kill people, but at *the causes of the causes* of illness and death, including social factors. Poor life expectancy, in this view, is the predictable result of the society we have created and tolerated: one riddled with lethal elements, such as inadequate insurance, minimal preventive care, bad diets and a weak economic safety net.
"There is a great deal of harm in the way that we somehow stigmatize social determinants, like that's code for poor, people of color or something," said Nunez-Smith, associate dean for health equity research at Yale. And while that risk is not shared evenly, she said, "everyone is at a risk of not having these basic needs met."
Rachel L. Levine, assistant secretary for health in the Department of Health and Human Services, said in an interview that an administration priority is reducing health disparities highlighted by the pandemic: "It's foundational to everything we are doing. It is not like we do health equity on Friday afternoon."
Levine, a pediatrician, pointed to the opioid crisis and lack of universal health coverage as reasons the United States lags peer nations in life expectancy. She emphasized efforts by the Biden administration to improve health trends, including a major campaign to combat cancer and a long-term, multiagency plan to bolster health and resilience.
Public health experts point to major inflection points the past four decades — the 1990s welfare overhaul, the Great Recession, the wars in Iraq and Afghanistan, changes in the economy and family relationships — that have clouded people's health.
It is no surprise, Georgetown's Griffith said, that middle-aged people bear a particular burden. They are "the one group that there's nobody really paying attention to," he said. "You have a lot of attention to older adults. You have a lot of attention to adolescents and young adults. There's not an explicit focus or research area on middle age."
An accounting of the nation's health problems can start with the health system. The medical workforce is aging and stretched thin. The country desperately needs thousands more primary care doctors. The incentives for private companies are stacked on the treatment side rather than the prevention side. Policy proposals to change things often run into a buzz saw of special interests.
Michael Imburgia, a Louisville cardiologist, spent most of his career in private medical facilities that expected doctors to see as many patients as possible. He now volunteers at a clinic he founded, Have a Heart, a nonprofit that serves

uninsured and underinsured people and where Imburgia can spend more time with patients and understand their circumstances.

Health care is "the only business that doesn't reward for quality care. All we reward for is volume. Do more, and you're going to get more money," Imburgia said.

Elizabeth H. Bradley, president of Vassar College and co-author of "The American Health Care Paradox," said if the nation's life-expectancy crisis could be solved by the discovery of drugs, it would be a hot topic. But it's not, she said, because "you would have to look at everything — the tax code, the education system — it's too controversial. Most politicians don't want to open Pandora's box."

James "Big Ken" Manuel, 67, spent four decades as a union electrician, a proud member of the International Brotherhood of Electrical Workers. He has a booming voice, a ready laugh, a big personality.

His life story illustrates a health system built on fragmented and often inadequate insurance, and geared toward treatment rather than prevention.

And to the perils of dangerous diets and the consequences of obesity.

He was born and raised in Lake Charles, La., when Black families like his in the Deep South had to navigate the racism of the Jim Crow era. But Manuel talks of his blessings. Two loving parents who worked hard. Friends who stayed close for life. A deeply satisfying career.

These days, retired, he has a modest aspiration: "I want to enjoy my pension."

For now, it is a challenge to simply get across the room and answer his front door in Louisville's West End. He needs a walker to get around. Even then, he's huffing and puffing.

One day in late May, Manuel was at the Have a Heart clinic in downtown. That morning, he weighed 399 pounds.

He is dealing with, by his account, diabetes, gout, hypertension, congestive heart failure and COPD. And he has been obese since he entered elementary school, "twice the size of regular kids."

"Might not have had a lot of money in the bank, but we had food on the table," he recalled. "We had all kind of Cajun dishes. Gumbos. Everything with rice. Rice and gravy. Steak and rice. Potato salad. Macaroni and cheese, baked beans. Traditional red beans, black-eyed peas. All that traditional cholesterol, heart-jumping dishes."

He remembered a visit to a doctor about 20 years ago, when his weight was on a trajectory to 500: "Mr. Manuel, I've never had a patient as big as you and as healthy as you. But it's going to catch up with you."

And it did.

His insurance was spotty over the years. He wanted bariatric surgery — a proven but costly treatment for morbid obesity — but he said his Louisiana-based union insurance wouldn't cover it.

And when he was out of work, he let his insurance lapse rather than pay the expensive fees for continued coverage. Like so many Americans, he paid for medical care out of his pocket.

After he stopped working about seven years ago, he briefly qualified for Medicaid. But then he began collecting Social Security at 62, and his income exceeded the Medicaid eligibility limit.

Next, he moved to an Affordable Care Act plan. Bouncing from plan to plan, he negotiated the complexities of being in-network or out-of-network. He

eventually found the Have a Heart clinic and continued to go there even after he turned 65 and enrolled in Medicare.
Manuel drove to the clinic one morning with a bag containing all his medicines. Hydralazine. Torsemide. Atorvastatin. Metformin. Carbetol. Benzonatate. Prednisone. Fistfuls of medicine for a swarm of cardiometabolic diseases.
"It's a lot of medicine. And it's expensive. Eating up my pension," Manuel said. He was desperate to get stronger, because he was engaged to be married in a few months.
"I got to be able to walk down the aisle," he said.
Mary Masden, 60, dated Manuel for years before deciding to get married.
She remembers when Manuel had more mobility. He could still dance. She is praying he will be able to dance again someday.
"I want him here for another 20, 30 years," she said. "I don't want to worry about him not waking up because he can't breathe."
On Sept. 2, Manuel and Masden were joined in marriage, and he did walk her down the aisle. He thought better of trying to jump, ceremonially, over the broom. He and his bride honeymooned at a resort in French Lick, Ind. The wedding, they agreed, was beautiful.
The geography of life and death in America has changed in recent generations, with decaying life expectancy in much of rural America. Janette Kern, 49, grew up in one of those patches of rural America, in the hamlet of Little Bend, in Meade County, Ky., west of Louisville. "The boonies," she said.
Today, Kern lives and works at an extended-stay hotel in Clarksville, Ind. Her health is pretty good when she takes her medicine. She has several chronic conditions: hypertension, a thyroid disorder, high cholesterol, and anxiety and depression.
In Kern's family, long lives are not common. Both her parents died at 64. Her father, a truck driver, had diabetes, suffered mini-strokes, and died after failing to wake up following a surgical procedure. Her mother died when a blood clot came loose, she said. An uncle died at 64, too, and an aunt at 65.
"My family is in their 60s when they're passing. It's because of heart disease, diabetes, cancer," she said.
She hopes to break with that family tradition.
"I would hope that I would at least make it to 75," she said.
Recently, she had a rude surprise: Trouble filling a prescription. She fears she has been booted off her medical insurance.
Millions of people are being purged from Medicaid rolls. Early in the pandemic, states temporarily stopped the usual yearly renewals to determine eligibility for the program, a joint responsibility with the federal government. This spring, states were allowed to begin eligibility renewals again, and Kern hadn't jumped through the bureaucratic hoops. "I've not gotten any paperwork," she said.
At the hotel, she is the friendly face at the front desk or smoking a Marlboro Light outside. Guests checking in may notice a pendant around Kern's neck featuring a photograph of a young man.
It says, "I never walk alone. Donnie walks with me."
Donnie DeJarnette was her firstborn. He was a technician at a car dealership and had become a father in November 2020. He had long suffered from headaches, his mother said. He had medical insurance but couldn't afford the co-pays and didn't see doctors. On Jan. 3, 2021, he was in Meade County when, while talking

on the phone with a friend, he collapsed. He died at a hospital hours later from what Kern said was a brain aneurysm. He was 25.

The loss devastated her. She still went to work, then would go home and just lie in bed.

"Part of me died. Until you lose a child, you'll never know," she said.

She lost a newborn, Billy, in 1999, to an infection two days after delivery.

She still has her youngest son, Matthew, who is 23.

"I tell him, 'I'm going to put you in a bubble, so nothing can happen to you,'" she said. "I've been pregnant five times, I've had two miscarriages, I delivered three, and now I'm down to one."

Across the heartland, countless communities are barely hanging on. This has long been a story described in economic terms — hollowed-out factories, bankruptcies, boarded-up downtown storefronts. But the economic challenges of these places go hand-in-hand with physical pain, suffering and the struggle to stay alive.

When economies go bad, health erodes, and people die early.

"The people in our country who are dying are the poor and the marginalized communities," said Imburgia, the cardiologist. "It's a money thing."

The geographical divide in health can be seen within Louisville and reflects America's history of racial discrimination and segregation.

"Cardiovascular disease, cancers, asthma, diabetes, it's all higher two- to threefold west of Ninth Street," said Kelly McCants, a cardiologist and head of Norton Healthcare's Institute for Health Equity in Louisville. He was referring to the unofficial boundary between the West End, whose residents are mostly African American, and the rest of the city.

A recent study estimated that residents in some areas of the wealthier East End of town live on average 12 years longer than residents in parts of the West End.

The pandemic, in tandem with the 2020 killing of Breonna Taylor in a no-knock police raid, compelled community leaders to confront disparities in life expectancy, said Greenberg, the city's mayor.

"Where you live, where you're born, unfortunately and tragically has a huge impact on your life expectancy today. We absolutely need to change that," Greenberg said.

One of McCants's recent patients was a young woman with a damaged heart — "advanced cardiomyopathy" — who had a heart pump successfully implanted. But McCants is worried about the patient's living conditions.

"I'm limited," he said, shaking his head. "I can be the best doctor ever. Her surgery went well. We got her through all of that. But now she could be readmitted to the hospital because of the housing situation."

Crystal Narcisse, a colleague of McCants's at Norton, is an internal medicine physician and pediatrician who focuses on the root causes of patients' ailments. It's not enough to focus on the hypertension. What is this patient's life like?

"There's a reason someone's blood pressure isn't under control, or someone's diabetes isn't under control," Narcisse said. "It could be because of depression, or anxiety or [post-traumatic stress disorder] or abuse."

One of her longtime patients is Regina Riley-Smith, a 48-year-old working at a General Electric factory, putting hinges on refrigerators. She rises on weekdays at 3:45 a.m. to be on the line at GE, clocked in, at 5:35 a.m.

She has transformed herself since a troubled adolescence in Lexington, Ky., where she had a baby at 15 and dropped out of school after 10th grade. The

	baby went to live with a grandmother while Riley-Smith ran with a wild crowd and became addicted to crack cocaine. Her mother died in 1996, at 64, and her father in 2001, at 65. A few months later, she moved to Louisville, at age 26, and was "re-raised," as she put it, by an aunt. She got off drugs, and life has blessed her since. She and her husband have six children and 13 grandchildren and live in a cozy home in the West End. She has struggled with multiple chronic ailments: type 2 diabetes, hypertension, asthma, and rheumatoid arthritis. She could file for disability but, for now, works extra shifts, hoping to pay off debts. "She stays on my diet," Riley-Smith said of her doctor. "I've backed off the drinks, the sodas. The main thing she's working on is stopping smoking." Riley-Smith is down to half a pack a day of Newport Menthol Golds. Narcisse, listening to her patient, smiled and said, "I want you to live long. A lot of people are counting on you." Riley-Smith wants the same thing but worries about her long-term prospects. "I feel like I'm short-lived," she said. "That's why I live life to the extreme every day. I try not to be angry with nobody. Because I don't know if I'm going to wake up the next morning." A health disaster, like misfortune generally, can strike randomly. Although risky behavior — smoking, eating too much, never exercising — can be a major factor in poor health, sickness can arise without any obvious cause, such as some unseen element in the environment. Then there's the case of Bruce DeArk of Jeffersonville, Ind., who put his health at risk simply by going to work. DeArk was the deputy fire chief of Jeffersonville. One day in early 2018, he began feeling nauseated. He thought: the flu? When he began experiencing excruciating pain in his lower abdomen, he suspected appendicitis. He got a scan. The diagnosis: Stage 4 colon cancer. "I got in my vehicle to go to hospital and I couldn't move, I just sat there thinking there is no way!" he later wrote, preparing to advocate for earlier colon cancer screening. "I was 49 years old at the time and thought of this disease as an older person disease." Since 1991, the U.S. cancer death rate has fallen 33 percent, reflecting sharp declines in smoking and new treatments, according to the American Cancer Society. But cancer is mysteriously increasing among people younger than 50, with the highest increase in breast, thyroid, and colorectal cancer. DeArk had excellent insurance and a huge support network. But early last year, after a four-year battle, and escorted by a fleet of police and fire vehicles, DeArk made his final trip home from the hospital and died four days later. He was 53. He had fought a lot of fires over the decades, enveloped in hazardous smoke. The International Agency for Research on Cancer has declared the occupation of firefighting "carcinogenic to humans," its highest-risk category. Following an extensive investigation, state officials ruled DeArk's death was in the line of duty. "The world has gotten toxic, with building materials, and then you light a match to them," said his widow, Janet DeArk. "And our food supply has gotten toxic. We just have a very toxic environment."

	She and Bruce married just four months before his cancer diagnosis. Now at 53, living with four large dogs in a house where the walls are covered with photographs of her late husband, Janet has to figure out the rest of her life. "For the first year after he died, I wanted to die. I did not take care of myself at all," she said. She still struggles to get out of bed in the morning, she said, but has no choice — she has four large dogs wanting breakfast. She is trying to heal herself. She vowed to lose some of the weight she had gained during the four traumatic years of watching her husband suffer. She started cycling at 6 a.m. along the Ohio River and doing spin classes at night. She told herself: "Start eating better. Start exercising. Get back to who you know you are. But that first year, my entire future was gone. Because Bruce was my future."
Ageism	**9. New York Times (free access)** December 22, 2023 *At 93, Teaching Me About Possibility* By Richard Morgan Awake from a nap in her favorite chair, my grandmother ran her fingers through her wavy white hair, looked out her window at the English Channel, and asked me what I would wish for if I had just one wish. She often asks this, and I always answer the same way because it will make her happy — "To have Granddad back" — which usually gets her reminiscing about him. But on that day a few months ago, she shook her head, then said with a sigh: "Richard, we had our innings. Good innings. Make a wish for yourself, dear." I wish I knew we could have been like this sooner. For decades I had the same kind of grandmother many people have: a money-filled birthday card in the mail; a phone call on Christmas; a pleasant little song and dance so polite and practiced that it became like the way people say "Bless you" after sneezes. Then, about a decade ago, she began to lose her hearing precipitously. The phone calls got harder. And I noticed that if I asked what she had for lunch, she might say, "Oh, the weather has been lovely today." So accustomed to the family's same few questions, she seemed to recycle the same handful of answers. Our time together was diminished. She was diminished. This is called "grayspeak" or "elderspeak," a shift in the way we address elders that treats them less like sages and more like toddlers or pets. We say things like, "Today was rainy. Did you see the rain?" and "Was your dinner yummy?" It's a bogus, tedious, and stupid way to interact, so I fought it. I started to show up for her more, in person, despite her living in Dover, England, and me in New York City. During my visits, I started throwing her curveballs: What did you do with your first-ever paycheck? What did you think about when you were hiding in caves during the war? What was the best invention of your lifetime? Her answers: Buying electricity for her parents' house so she wouldn't have to scrape candle wax off the stairs. Eating oranges. Running water (with microwaves a close second). More than answers, they were springboards into unexpected conversations.

Our deepening relationship has been a bit of a happy accident. Many folks get to know their parents as real people later in life, but I, gay and estranged from my parents, redirected that energy toward my grandmother.

My grandmother isn't just old. She survived being kidnapped in Ireland. She was bombed into homelessness three times during the war, living on the front lines along the white cliffs of Dover. She met Queen Elizabeth II when Elizabeth was still a princess. At 20, my grandmother walked herself through the snow to birth her first children, twins, on Christmas Day. She is now blind and arthritic yet still knits blankets for the local hospital's premature babies. Even at 93, she buys books to keep up with her French.

In our newfound closeness, she also became much funnier. Peering at the pile of chocolate sprinkles at the bottom of her coffee, I said, "What's going on? I thought you didn't take sugar?"

"Chocolate isn't sugar, dear," she said. "It's flavor."

After recovering from emergency surgery earlier this year, she said, "I've never been so lazy!"

"You're not lazy," I said. "You're recovering."

"You're the expert," she said. "What's it like?"

"What's what like?"

"Laziness, dear," she said. "You have more experience than I do."

"I did fly all the way over here!"

"Did you do the flying?" she said with an impish grin.

One day after I made us coffee, I asked her: "What's the secret to being successful in your 90s?"

"Just try, dear. So many people are old at 60. They just want to sit all day. You won't make it to 90 like that. You have to try."

"Try what?"

"Try walking," she said. "Try gardening. Try cooking. Trying doesn't require a lot of trying. Just try a little. Like, with this coffee you've made us. I know you tried."

Another time we saw four coveted apple turnovers at the grocery after days of them being sold out. I got us two. She told me to get all four. When I said we should leave the other two for other people, she said "Two are for us now. And the other two are for whoever we find ourselves to be tomorrow."

Being with her is a ridiculous amount of fun. I have met her friends, and she has met my special someone ("You've gone for younger!" she said of him — he's 50 to my 44. "Isn't he handsome?" I asked. "Yes, so much more than you!" she said with a laugh.)

We waltz to Vera Lynn, build gingerbread houses, wear Korean face masks. She watches me do arduous jigsaw puzzles and then, after putting in the final piece, celebrates how "we" completed it. I got her a bird-covered blouse at a charity shop, and she got me a bear onesie.

When I was a child — maybe 5, small enough that my siblings and I slept sardine-style in the same bed — she would pop her head in during bedtime and ask if anyone needed the toilet. This was my cue to announce that I had a big poo to do. Then I would sneak downstairs with her, and we would watch "The Paul Daniels Magic Show."

Maybe she knew I was gay before I came out to her, but she wanted me to believe in wonder and magic regardless. If wisdom is knowledge plus time, she embodies wisdom's next evolution: kindness.

	"Age," she told me once, "is just another bother attempting to convince you of the impossible in a world absolutely blooming with possibilities." In her 60s, she climbed Snowdon, Wales's tallest peak. In her 70s, she survived the death of her only daughter. In her 80s, she lost her husband of 67 years, my grandfather. This year, she had emergency surgery, and the doctors asked if they could write about her in a medical journal because her condition was so rare. Even her illnesses are exceptional. Her sense of possibility has been revolutionary for me. I have found friends — great, intimate friends — in unexpected places: four-hour dinners with my former schoolteachers; a holiday window tour across Manhattan with my friend's alone-on-Thanksgiving mother; special-effects texting with my 11-year-old nephew. It may be true that the world is blooming with possibilities, but even possibility has limits. Before too long I will need to adjust to having the same kind of grandmother many other people have in a different way: She'll be gone. I will be gutted. But I won't cry for the lack of birthday cards in my future. I'll mourn the openness and fullness and wholeness. My life will feel so closed and empty and partial. Yet even in such moments, her wisdom prevails, which is to be "mizzy," because "saying 'miserable' is too miserable." The best part of refusing grayspeak and unlocking the rainbow of insights that follows is that now I know — with certainty, pride, and all my heart — that she is unlike anyone else. I hope that if I make it to her age, I might look upon a faraway hill — a surprise Napoleonic fort — and climb it (she was 85 then). Or embrace the novelty of a first-ever milkshake (at 87). In her 90s, she has developed a habit of keeping a drawer full of candy bars in the fridge. When I asked her why, she shrugged her response: "They're better cold, dear." During an argument about her stealing my outfit when we found ourselves wearing something similar, I accused her of stealing hearts, too. "Kindness wins hearts, Richard. I don't bother with stealing." After a lecture on how amazing bread is, I asked what her favorite food is, and her answer was quick: "Butter. That's why you get the bread in the first place." Not long ago, when she found a bubble-gum pink cashmere sweater for one pound in a charity shop, she said she wanted to be buried in it. When I gasped, she said, "Oh, I shouldn't have said that. I'm going to be cremated. Not buried. What a shame to burn such lovely clothing." From a relationship of polite predictability, we now have a deeply loving kinship where neither of us knows what comes next — except for what we know comes next for everyone. What comes first, though, is spending this Christmas together. No card or phone call will do. We are each other's best gift.
From Other Countries	**10. *New York Times** December 27, 2023 *Death by Doctor May Soon Be Available for the Mentally Ill in Canada* By Vjosa Isai Canada already has one of the most liberal assisted death laws in the world, offering the practice to terminally and chronically ill Canadians. But under a law scheduled to take effect in March assisted dying would also become accessible to people whose only medical condition is mental illness, making Canada one of about half a dozen countries to permit the procedure for that category of people.

	That move has divided Canadians, some of whom view it as a sign that the country's public health care system is not offering adequate psychiatric care, which is notoriously underfunded and in high demand. . . Canada's existing assisted death law applies only to people who are terminally ill or living with physical disabilities or chronic, incurable conditions. The country's Supreme Court decriminalized assisted death in 2015 and ruled that forcing Canadians to cope with intolerable suffering infringes on fundamental rights to liberty and security. About 13,200 Canadians had an assisted death last year, a 31 percent increase over 2021 according to a report by the federal health ministry. Of those, 463 people, or 3.5 percent, were not terminally ill, but had other medical conditions. Patients who are approved have the option to end their lives using lethal drugs administered by a physician or nurse, or by taking drugs prescribed to them.
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	***Global COVID-19 Tracker*** **KKF** This tracker provides the cumulative number of confirmed COVID-19 cases and deaths, as well as the rate of daily COVID-19 cases and deaths by country, income, region, and globally. It will be updated weekly, as new data are released. As of March 7, 2023, all data on COVID-19 cases and deaths are drawn from the World Health Organization's (WHO) Coronavirus (COVID-19) Dashboard.
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/
Contact information for reporting complaints and concerns	**Nursing home** Department of Public Health 1. Print and complete the Consumer/Resident/Patient Complaint Form 2. Fax completed form to (617) 753-8165 Or Mail to 67 Forest Street, Marlborough, MA 01752 Ombudsman Program
Nursing Home Closures	**Massachusetts Department of Public Health** *South Dennis Health Care* Target closure date January 30, 2024 Notice of Intent to Close (PDF) | (DOCX)
Nursing homes with admission freezes	**Massachusetts Department of Public Health** *Temporary admissions freeze* There have been no new postings on the DPH website since May 10, 2023.

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
DignityMA Call Action	• 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**
Access to Dignity Alliance social media	Email: info@DignityAllianceMA.org Facebook: https://www.facebook.com/DignityAllianceMA/ Instagram: https://www.instagram.com/dignityalliance/ LinkedIn: https://www.linkedin.com/company/dignity-alliance-massachusetts Twitter: https://twitter.com/dignity_ma?s=21

	Website: www.DignityAllianceMA.org		
Participation opportunities with Dignity Alliance Massachusetts	**Workgroup**	**Workgroup lead**	**Email**
Most workgroups meet bi-weekly via Zoom.	General Membership	Bill Henning Paul Lanzikos	bhenning@bostoncil.org paul.lanzikos@gmail.com
	Behavioral Health	Frank Baskin	baskinfrank19@gmail.com
	Communications	Lachlan Forrow	lforrow@bidmc.harvard.edu
	Facilities (Nursing homes)	Arlene Germain	agermain@manhr.org
	Home and Community Based Services	Meg Coffin	mcoffin@centerlw.org
	Legislative	Richard Moore	rmoore8743@charter.net
	Legal Issues	Jeni Kaplan	jkaplan@cpr-ma.org
	Interest Group	**Group lead**	**Email**
Interest Groups meet periodically (monthly, bi-monthly, or quarterly).	Assisted Living and Rest Homes	In formation	
	Housing	Bill Henning	bhenning@bostoncil.org
	Veteran Services	James Lomastro	jimlomastro@comcast.net
	Transportation	Frank Baskin Chris Hoeh	baskinfrank19@gmail.com cdhoeh@gmail.com
Please contact group lead for more information.	Covid / Long Covid	James Lomastro	jimlomastro@comcast.net
	Incarcerated Persons	TBD	info@DignityAllianceMA.org
The Dignity Digest	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		
Note of thanks	Thanks to the contributors to this issue of *The Dignity Digest* • Judi Fonsh • 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.*		

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.