Advisory Memorandum

To: U.S. Commission on Civil Rights
From: Connecticut State Advisory Committee
Date: September 10, 2020
Subject: Advisory Memorandum on Nursing Homes

In keeping with its responsibilities to the U.S. Commission on Civil Rights,[1] the Connecticut Advisory Committee (Committee) held two virtual briefings in July 2020, to examine how the COVID-19 pandemic has impacted the senior populations in Connecticut assisted care facilities/nursing homes.[2]

While the Committee looked at the impact of COVID-19 on the senior population in Connecticut, it is worth noting that nationwide the coronavirus has taken a heavy toll on both the senior population and communities of color.[3] Most data shows that COVID-19 is disproportionately killing the senior population.[4] Adults 65 and older account for 16 percent of the United States population but 80 percent of COVID-19 deaths.[5] In Connecticut, estimates are that 89 percent of COVID-19 deaths are people over 65 years old.[6]

Public health officials, advocates, and experts "are particularly concerned about majority-Black nursing homes, where a confluence of factors — an elderly population living in close quarters, often with shortages of staff and protective gear — have left African Americans already at increased risk of infection even more vulnerable."[7] Because the federal government does not track demographic data, it is difficult to know whether rates of infection and death are higher among Black nursing home residents; however, a recent analysis of data from more than two dozen states[8] "found that the death rate was more than 20 percent higher in majority-Black

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[1] Per its statutory mandate, the U.S. Commission on Civil Rights establishes advisory committees and charges them with collecting and providing information, findings, and recommendations about civil rights matters in their states to the Commission.

[2] This memorandum was adopted unanimously by the Connecticut Advisory Committee on September 10, 2020.

[3] *See e.g.,* Tiffany Ford, Sarah Reber, and Richard V. Reeves, "Race gaps in COVID-19 deaths are even bigger than they appear." https://www.brookings.edu/blog/up-front/2020/06/16/race-gaps-in-covid-19-deaths-are-even-bigger-than-they-appear/; Meredith Freed, et. al., "What Share of People Who Have Died of COVID-19 Are 65 and Older – and How Does It Vary By State? https://www.kff.org/coronavirus-covid-19/issue-brief/what-share-of-people-who-have-died-of-covid-19-are-65-and-older-and-how-does-it-vary-by-state/. In Frederick County, Maryland, 92 percent of all COVID-19 deaths were people over the age of 69 and 79 percent were people living in assisted care facilities.

[4] Meredith Freed, et. al., "What Share of People Who Have Died of COVID-19 Are 65 and Older – and How Does It Vary By State? https://www.kff.org/coronavirus-covid-19/issue-brief/what-share-of-people-who-have-died-of-covid-19-are-65-and-older-and-how-does-it-vary-by-state/.

[5] Ibid.

[6] Ibid.

[7] Sidnee King and Joel Jacobs, "Near birthplace of Martin Luther King Jr., a predominantly Black nursing home tries to heal after outbreak," Washington Post, Sept. 9, 2020. https://www.washingtonpost.com/business/2020/09/09/black-nursing-homes-coronavirus/.

[8] There is no official state level data for COVID-19 regarding hospitalization or death rates for Black nursing home residents in Connecticut. State level data on COVID-19 hospitalization and death rates by age is also limited.

facilities compared with majority-White facilities." The analysis, which used demographic data compiled by Brown University and included about 11,000 nursing homes — nearly three-quarters of all facilities in the United States — also found that death rates increased as the proportion of Black residents increased.[9]

The Committee's work on the topic of COVID-19 and nursing homes was prompted by its April 2020 Statement of Concern regarding COVID-19's impact on Connecticut's correctional facilities and inmate populations of color.[10] This Statement was a continuation of the Committee's examination of racial disparities in solitary confinement and prosecutorial practices. In its Statement, the Committee expressed its concern about the potential impact of COVID-19 on incarcerated men and women and encouraged immediate action be taken to prevent the spread of this deadly disease among inmate populations and correctional staff.

The Committee was also concerned about the early and alarming indications that there were racial and age disparities in COVID-19 infection and death rates among the general population. This concern led the Committee to investigate nursing homes and long-term care facilities, whose residents and staff members have been hit particularly hard by COVID-19, to gather testimony and other evidence that might assist the Commission in identifying civil rights issues affecting residents in these facilities.

National Background

Throughout the nation, the COVID-19 pandemic has had a particularly devastating impact on our senior population residing in nursing homes. Data submitted by nursing homes to the Centers for Medicare & Medicaid Services (CMS) indicate 207,315 confirmed resident infections, 124,549 suspected resident infections and 51,700 resident deaths as of August 23.[11] The deaths of nursing home residents account for nearly 30 percent of the total COVID-19 deaths reported by the Centers for Disease Control and Prevention (CDC).[12] One state-by-state investigation of 12 geographically diverse states, including Connecticut, illuminated an additional troubling correlation between resident race and the probability of COVID-19 infection and death. According to the study, nursing homes with the smallest percentage of white residents were

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Moreover, the recent executive order purportedly granting nursing homes qualified immunity may lead to inaccuracies or limitations in data collection.

[9] *Supra*, note 7.

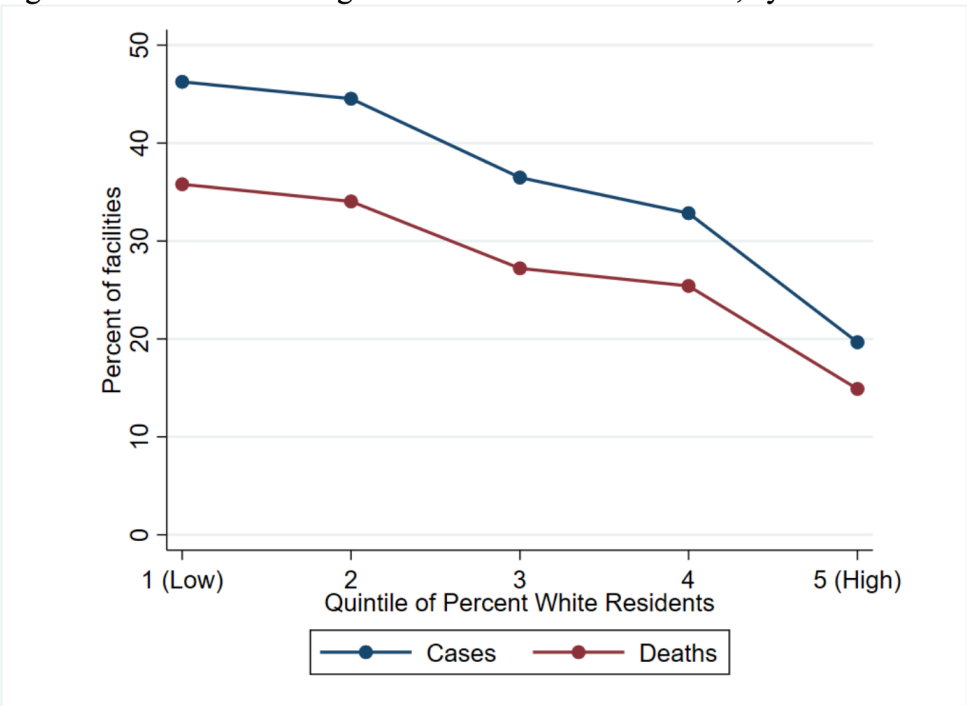
[10] Statement of the Connecticut Advisory Committee Concerned by COVID-19 in State Correctional Facilities, April 16, 2020, https://www.usccr.gov/pubs/2020/04-29-CT-SAC-Statement-of-Concern-on-Incarcerated%20People-and-COVID-19.pdf

[11] Centers for Medicare and Medicaid Services, COVID-19 Nursing Home Data, https://data.cms.gov/stories/s/COVID-19-Nursing-Home-Data/bkwz-xpvg/ (includes "data reported by nursing homes to the Centers for Disease Control's National Healthcare Safety Network system COVID-19 Long Term Care Facility Module). For more information on the Centers for Medicare and Medicaid Services' requirements for reporting COVID-19 information, *see* https://www.cms.gov/files/document/qso-20-29-nh.pdf.

[12] Centers for Disease Control and Prevention, Daily Updates of Totals by Week and State, "Table 1. Deaths involving coronavirus disease 2019 (COVID-19), pneumonia, and influenza reported to NCHS by week ending date, United States. Week ending 2/1/2020 to 8/22/2020." https://www.cdc.gov/nchs/nvss/vsrr/covid19/index.htm (last visited Sep. 5, 2020).

twice as likely to have COVID-19 cases as homes with the highest percentage of white residents.[13] See Figure 1. The finding of racial disparities among COVID-19 infections and deaths is consistent with national infection and mortality data published by The COVID Tracking Project which has found that Black and Brown citizens are disproportionately impacted by COVID-19. According to the data collected by The COVID Tracking Project, Black Americans have died at 2.4 times the rate of White Americans during the pandemic. [14]

Figure 1: Percent of Nursing Homes with COVID-19 Cases, by Race



Note: The percent of nursing homes with at least one case based on CA, CO, CT, GA, IA, IL, MA, NJ, NV, OH, TN, and OK; the percent of nursing homes with at least one death based on CA, CO, CT, GA, IL, NJ, NV, and TN

Connecticut Background

Connecticut nursing homes have suffered significantly and have some of the worst infections and death rates in the country, ranking as the third highest in both average number of cases and average deaths per 1,000 residents.[15] Connecticut's senior population experienced exceptional losses in all long-term living facilities, accounting for over 74 percent of the total COVID

[13] Testimony of R. Tamara Konetzka, U.S. Senate Special Committee on Aging, 3 (May 21, 2020), https://www.aging.senate.gov/imo/media/doc/SCA_Konetzka_05_21_20.pdf.

[14] The Atlantic, The COVID Tracking Project, "COVID-19 is affecting Black, Indigenous, Latinx, and other people of color the most." https://covidtracking.com/race (last visited Sep. 5, 2020).

[15] CMS, COVID-19 Nursing Home Data, "Resident Cases and Deaths per 1,000 Residents." https://data.cms.gov/stories/s/COVID-19-Nursing-Home-Data/bkwz-xpvg/ (last visited Sep. 4, 2020).

fatalities in the state through the end of July.[16] On June 8, Governor Lamont issued an order for an independent analysis of the high COVID mortality rate seen in nursing homes and assisted living facilities.[17] The report, prepared by Mathematica and published on August 18, identified a number of deficits that faced nursing homes at the beginning of the pandemic including limited access to PPE, testing, and a general lack of scientific knowledge regarding asymptomatic spread.[18] The report also found that, "prevalence of COVID-19 in the surrounding community was a major predictor of its effect on nursing homes." [19] The report did not investigate nor make any findings regarding nursing home infections and fatalities based on race, though it did mention that a disparity has been seen within the state population as a whole.[20] According to data reported by the state as of September 3rd, the total death toll of Black residents per capita in Connecticut is 25 percent higher than White residents.[21]

Unfortunately, policymakers have not yet determined the causes of these troubling racial disparities—either in nursing homes or in the population as a whole. And without a comprehensive understanding of the factors that cause the disparity, it will be very challenging for policymakers to mitigate them. However, the evidence before the Committee indicates that appropriate preventative measures can reduce COVID-19 infections and deaths among all races, and the Committee hopes that the widespread adoption and implementation of COVID-19 best practices at all Connecticut nursing homes and assisted living facilities will both reduce the overall death rate among residents in these facilities and reduce racial disparities in COVID-19 fatalities.

There is reason for cautious optimism. Evidence of increased testing and PPE usage in Connecticut nursing homes and assisted living facilities has been coupled with a decrease in new nursing home infections and deaths. But the evidence available to date is not sufficient to establish conclusively that the steps Connecticut nursing homes and assisted living facilities have taken are sufficient for sustained containment of COVID-19 among their residents, and continued surveillance and protection enforcement must be implemented to promote this downward trend. The Mathematica interim report expressed recommendations to improve nursing home conditions including a continued focus on individual resident care, surveillance of local outbreaks, ongoing testing of residents and staff and improved infection control practices at

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[16] Jacqueline Rabe Thomas, "Report offers clues to what went wrong in lethal COVID outbreak in nursing homes," CT Mirror (Aug. 18, 2020) https://ctmirror.org/2020/08/18/report-offers-clues-to-what-went-wrong-in-lethal-covid-outbreak-in-nursing-homes/.

[17] Press release, "Governor Lamont Orders Independent Analysis of COVID-19 in Connecticut's Nursing Homes and Assisted Living Facilities" June 8, 2020 https://portal.ct.gov/Office-of-the-Governor/News/Press-Releases/2020/06-2020/Governor-Lamont-Orders-Independent-Analysis-of-COVID19-in-Nursing-Homes (last visited Jun. 22, 2020).

[18] *Supra*, note 16.

[19] Patricia Rowan et. al., "A Study of the COVID-19 Outbreak and Response in Connecticut Long-Term Care Facilities," Mathematica 28 (Aug. 14, 2020).

[20] Ibid., 20.

[21] CT Data, "COVID-19 Cases and Deaths by Race/Ethnicity" Updated Sep. 4, 2020, https://data.ct.gov/Health-and-Human-Services/COVID-19-Cases-and-Deaths-by-Race-Ethnicity/7rne-efic (last visited Sep. 5, 2020).

facilities.[22] In light of the extensive impact that COVID-19 has had on Connecticut senior and Black residents of nursing homes, the Committee initiated an investigation to evaluate further available data and best practices to protect these vulnerable populations. The Committee held two public briefings with local and national experts to investigate the impact that COVID-19 has had on nursing home residents.

Briefings

A virtual briefing was held on July 13 with guest speakers Mairead Painter, Connecticut State Long-term Care Ombudsman and Steven Hernández, the executive director for the Commission on Women, Children, Seniors, Equity & Opportunity of the Connecticut General Assembly.[23] The speakers described the hardships that Connecticut seniors in nursing homes are currently facing during the pandemic including solitude, limited engagement in family networks, diminished personal care and wellbeing, and adverse health side effects attributed to the restrictions placed on residents.

The Committee held a second virtual briefing on July 20th with guest speaker Dr. Tamara Konetzka, professor of Health Services Research for the Department of Public Health Services at the University of Chicago.[24] Dr. Konetzka testified to her research and findings of the devastating impact that the pandemic has had on senior populations in nursing homes.[25] Dr. Konetzka's research identified race as the most reliable predictor of nursing home infections and deaths. The collected national data showed a correlation between the quantity of non-white residents and the rate of infection and deaths among residents. See Figure 1. Further investigation of this correlation revealed the true causation to be linked to the prevalence of COVID-19 cases and spread within the community where the nursing home is located. Dr. Konetzka summarized these findings as follows:

> Consistent with racial and socioeconomic disparities in long-term care historically and in pandemic-related deaths currently, nursing homes with traditionally underserved populations are bearing the worst outcomes. Our results suggest that nursing homes serving nonwhite residents are most vulnerable to this pandemic. Because people who need nursing home care usually want to stay close to home, nursing homes are often a reflection of the neighborhoods in which they are located. Nursing homes serving predominantly non-white residents are more likely to be located in predominantly non-white neighborhoods and to draw staff from those

[22] *Supra*, note 19 at 8-16.

[23] Briefing Before the Connecticut State Advisory Committee to U.S. Commission on Civil Rights, Hartford, CT, Jul. 13, 2020, (hereinafter cited as *Hartford Briefing 1*).

[24] Briefing Before the Connecticut State Advisory Committee to U.S. Commission on Civil Rights, Hartford, CT, Jul. 20, 2020, (hereinafter cited as *Hartford Briefing 2*).

[25] Dr. Tamara Konetzka's brief to the Committee, titled "Summary of remarks to: US Commission on Civil Rights," is attached to this memorandum as an appendix.

> neighborhoods. As these are the neighborhoods and the people being most affected by the pandemic, nursing homes in these areas are also most at risk.[26]

Dr. Konetzka further testified to the Committee that there was not an observable correlation between the nursing home's quality rating and the prevalence of infections or deaths.[27] The data does, however, imply that homes with adequate staffing, PPE and resources are able to better manage and control infection rates than homes that have limited or diminished resources. Dr. Konetzka's national data is made applicable to Connecticut through the testimony of Ombudsman Painter and Mr. Hernández, who voiced their concerns regarding specific deficiencies of Connecticut nursing homes and how these deficiencies have impacted residents.

Dr. Kontezka's data, along with the testimony of Ombudsman Painter and Mr. Hernández, have lead the Committee to compile findings and recommendations to protect vulnerable populations in nursing homes. These suggestions are intended to protect the liberty and civil rights interests of seniors in nursing homes.

Assertions and Themes

The Committee is deeply grateful to the speakers who provided critical testimony illuminating the challenges that residents in nursing homes and assisted living facilities in Connecticut—and elsewhere—are confronting because of the COVID-19 pandemic. Based on their testimony and other evidence before the Committee, the Committee has identified the following assertions and themes that it wishes to bring to the Commission's attention for the Commission's consideration, discussion and further investigation as appropriate:

1. Racial Disparities in COVID-19 Infection and Death Rates Remain an Issue of Great Concern.

Although no witness could pin-point the reasons for racial disparities in COVID-19 infection and death rates, all witnesses agreed on two key points. First, any racial disparity has deeply troubling civil rights implications. Second, it is incumbent on policymakers to investigate these racial disparities further to identify and address their root causes—not only to mitigate the losses from COVID-19 but also to improve health policy to avoid racial disparities in health outcomes in future outbreaks.

2. Appropriate Nursing Home Staffing Levels Are Essential to Protecting Civil Rights.

The evidence before the Committee also highlights the critical role that staff in nursing homes and assisted living facilities play in protecting residents' civil rights. Staffing levels strongly correlate to improved health outcomes. For example, a study of Connecticut nursing homes published in June showed that increased nurse staffing time resulted in a decrease in COVID-19 infection rates for facilities with at least one infection. Similarly, homes with increased nurse

[26] *Supra,* note 13 at 5.

[27] R. Tamara Konetzka, *Hartford Briefing 2*, transcript p. 6.

staffing time showed fewer COVID-19 deaths in facilities with at least one confirmed COVID-19 death.[28] This Connecticut-specific data corresponds to Dr. Konetzka's testimony that increased staffing was shown to prevent further spread of infections in homes elsewhere in the country. Additionally, the Committee heard testimony about the importance of having multi-lingual staff members and providing translations of key written information for non-English-speaking residents.

3. Isolation Measures Designed to Limit the Spread of COVID-19 Can Have Unintended Consequences that Disproportionately Burden Vulnerable Senior Populations.

COVID-19 infection is not the only health risk that residents in nursing homes and assisted living facilities face during this pandemic. Witnesses testified in detail about the unintended side-effects of forced isolation and distancing measures on vulnerable senior populations in nursing homes and assisted living facilities. These include loneliness, lack of mental stimulation, loss of recreation and loss of appetite.[29]

Moreover, visiting restrictions limit opportunities for family members to observe and report health issues to providers, advocate for residents receiving substandard care, and provide supplemental care for their loved ones. Under normal circumstances, many interested non-residents—including family, friends and Ombudsman staff—regularly visit Connecticut nursing homes and assisted living facilities.[30] These individuals are able to observe directly and report any concerning issues. But to reduce the risk of COVID-19 transmission, all visitation in long-term care settings is severely restricted; in many cases, visits are limited to conversations over video, separated by window or in outdoor recreation areas. For months, family and friends have not been able to enter long-term care facilities to observe their current conditions.[31] Witnesses testified that family members have reported seeing significant declines in their loved ones during this time. These declines include reports of weight loss, cognitive loss, failure to thrive, overall physical decline and injury.

In-person visits by the Long-Term Care Ombudsman and her staff have also been restricted. The Ombudsman testified that her office is making every effort to observe current conditions in Connecticut nursing homes and assisted living facilities and to advocate on behalf of residents

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[28] COVID-19 Infections and Deaths among Connecticut Nursing Home Residents: Facility Correlates, Yue Li et al., Journal of the American Geriatrics Society, June 18, 2020, https://onlinelibrary.wiley.com/doi/full/10.1111/jgs.16689.

[29] The Committee previously examined the harmful impacts of long-term isolation on prison inmates. In the course of this work, the Committee learned that there is a growing consensus that even the most dangerous offenders need and deserve a basic level of human interaction and outdoor recreation for the sake of their mental and physical health. The evidence before the Committee demonstrates that senior populations in nursing homes and assisted living facilities have the same basic needs. Just as Connecticut has found ways to provide for those needs safely among its inmate population, it can do so for residents in nursing homes and assisted living facilities.

[30] Mairead Painter, *Hartford Briefing 1*, transcript p. 3.

[31] At the end of August, Connecticut nursing homes, which were off limits to family and friends during the coronavirus pandemic, expanded visits depending on the facilities. https://www.ctpost.com/news/coronavirus/article/Lamont-announces-expanded-visiting-hours-at-CT-15520576.php.

and their families. She is urging the state to allow family members to have video camera access to resident rooms.[32] She is also pressuring for her office to have expanded physical access to nursing homes and assisted living facilities to ensure that the civil rights and health care needs of residents are being respected. Witnesses agreed that this type of oversight is particularly important for the vulnerable senior populations in long-term care facilities, who often have no other means of expressing their needs and concerns during the extended periods of extreme isolation that have resulted from COVID-19 safety protocols.

The challenge of providing quality care in nursing homes and assisted living facilities also underscores the importance of clear lines of communication between family members and facilities about resident needs and expectations. Witnesses who testified before the Committee were consistent in their view that senior populations in Connecticut deserve standards of care that rise to meet their needs during these extraordinary emergency times. One proposal discussed was the implementation of a Care Plan for each resident. These plans could identify residents' individualized needs, name the family members who should be consulted about key issues, include benchmarks for important hygiene issues (like tooth brushing, hearing aids, and showers), plan for recreation, address visits by family, friends and clergy members, and facilitate medical appointments. Residents in hospice care could also address end-of-life issues like religious last rites ceremonies, do-not-resuscitate preferences, and funeral services. Having plans like these would provide greater clarity of expectations for facilities and family members while setting out clear goals and objectives against which each resident's quality of care could be judged.

4. Weekly COVID-19 Testing is a Critical Tool in Fighting COVID-19 in Nursing Homes and Assisted Living Facilities.

The U.S. Centers for Disease Control and Prevention ("CDC") recommends weekly testing for all staff in nursing homes and assisted living facilities unless and until there is minimal-to-no community transmission.[33] This sensible guidance appropriately accounts for asymptomatic carriers who may be traveling in and out of communities at risk of COVID-19 transmission. The CDC's protocol aligns with Dr. Konetzka's data, which shows that nursing home populations are more likely to be exposed to a COVID-19 infection if the surrounding community is experiencing a spread of the virus.

In June, Governor Lamont issued an executive order requiring weekly testing for Connecticut nursing home staff unless the facility has been COVID-19-free for two weeks.[34] This protocol

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[32] See Letters in Support of Virtual Visitation and Cameras, AARP Connecticut, April 29, 2020. See also Mairead Painter, *Hartford Briefing 1*, transcript p 5.

[33] Centers for Disease Control and Prevention, Testing Guidelines for Nursing Homes, https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-testing.html (last updated July 21, 2020); *see also* Patrick Skahill, *Testing Nursing Home Staff is Costly and Uncertain. Here's Why*., July 10, 2020, https://ctmirror.org/2020/07/10/testing-nursing-home-staff-costly-uncertain-coronavirus/

[34] Governor Ned Lamont, Executive Order No. 7UU (Jun. 1, 2020), https://portal.ct.gov/-/media/Office-of-the-Governor/Executive-Orders/Lamont-Executive-Orders/Executive-Order-No-7UU.pdf?la=en.

falls short of the CDC guidance, but even this more limited testing has proven beneficial. Between June 17 and July 28, 2020, 223 Connecticut nursing home workers tested positive for COVID-19 and were directed to quarantine.[35] The identification and removal of infected staff members has limited the spread of the virus through already greatly impacted nursing homes and assisted living facilities.

The evidence before the Committee indicates, however, that benefits of these testing protocols can be undone if staff are not continuously monitored for infections. Despite a decline of infections in a nursing home, staff may still carry the virus in from outside the facility. The State of Connecticut is scheduled to continue funding weekly testing for nursing homes through October.[36] Starting in November, Connecticut nursing homes and assisted living facilities will be expected to rely on individual testing protocols and prevention plans to continue to reduce infection risks.

A consistent theme throughout the Committee's briefing was that continued testing in accordance with CDC guidance is one of the most important measures policymakers can take to limit the spread of COVID-19 to nursing home residents and staff members. The evidence before the Committee strongly supports the CDC's conclusion that weekly testing of all staff should remain a priority. And witnesses advocated for Connecticut to continue funding this testing in order to protect residents and staff in nursing homes with limited financial resources.

5. Continued Access to Adequate PPE Will Limit the Spread of COVID-19 in Long-Term Care Settings.

The evidence before the Committee confirms that personal protective equipment has been, and will remain, an essential resource to nursing homes and assisted living facilities in limiting the spread of COVID-19. During the early stages of the pandemic, acquiring PPE was a challenge for most facilities. The state committed to provide PPE to nursing homes through August. This was an important step to stem the tide of infection among long-term care populations. But residents and staff members remain at risk, and PPE remains in high demand.[37] Witnesses testified that it is essential for the state to continue to acquire and provide adequate PPE in order to promote to the continued containment of COVID-19 in Connecticut nursing homes and assisted living facilities. Moreover, if the state cannot guarantee PPE supplies, the Committee fears that facilities at greatest risk of running short on PPE will be those disproportionately serving populations of color. The state's continued provision of PPE may therefore be a critical

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[35] Jenna Carlesso, *State Extends Funding for Nursing Home Staff Testing Through October*, (Aug. 13, 2020), https://ctmirror.org/2020/08/13/state-extends-funding-for-nursing-home-staff-testing-through-october/.

[36] Ibid.

[37] Christine Stuart, *Medical Grade PPE Still in High Demand for Nursing Homes and Assisted Living Facilities*, (July 8, 2020), https://www.ctnewsjunkie.com/archives/entry/20200708_state_backstop_for_ppe_will_end_in_august /.

factor in avoiding even greater racial disparities in COVID-19 infection and death in Connecticut nursing homes and assisted living facilities.

Conclusion

The information summarized in this Advisory Memorandum is concerning. Seniors in Connecticut and throughout the nation face alarming infection and mortality rates from COVID-19. Nursing homes and assisted living facilities in Connecticut have been hit particularly hard by this pandemic. And there is disturbing evidence that COVID-19 is having a disparate impact on nursing home populations of color. Moreover, in addition to the tragedy of illness and death, nursing home residents and their families are facing personal hardships and struggles as unintended consequences from efforts to prevent the spread of COVID-19 within nursing facilities.

The evidence before the Committee is clear that COVID-19 presents a tremendous challenge to nursing facilities and to policymakers responsible for protecting elderly populations and populations of color. COVID-19 is devastating nursing homes in Connecticut and throughout the country. Given the magnitude of the civil rights concerns the Committee's briefings have raised, the Committee urges the Commission to address this issue promptly. Unless preventative action is taken and existing policies enforced, the virus will continue to devastate nursing homes in Connecticut and nationwide with a particularly damaging effect on elderly residents of color.

The Committee thanks the Commission for its close attention to these issues and for its hard work and leadership in safeguarding civil rights in Connecticut and throughout the country.

R. Tamara Konetzka, PhD
Professor, Departments of Public Health Sciences and Medicine
Biological Sciences Division
University of Chicago

Summary of remarks to: US Commission on Civil Rights
July 20, 2020

On May 21, 2020, I provided testimony to the US Senate Special Committee on Aging on nursing homes and the COVID-19 pandemic. Below, I include some of that testimony and then update it with our subsequent research findings.

The Prominence of Nursing Homes in the COVID-19 Pandemic

The high rates of COVID-19 cases and deaths in nursing homes have attracted much media attention and public alarm. A *New York Times* article in mid-April referred to nursing homes as "death pits"[1] due to the seemingly uncontrollable spread of the virus through these facilities. At that time, nursing home staff and residents were estimated to account for one-fifth of all COVID-19-related deaths. Long-term care facilities are now estimated to account for one-third of deaths nationally and as much as one-half in many states.[2]

In some ways, the high rates of COVID-19 cases and deaths in nursing homes are not surprising: Nursing homes house, in close quarters, large numbers of people with multiple comorbidities who need hours of hands-on care on a daily basis. These realities of long-term care make social isolation impossible. Facilities are often understaffed and depend on Medicaid reimbursement for the majority of their residents. Existing staff gaps are exacerbated by pandemic-related absences for illness or child care. Thus, working staff members must often care for both COVID-positive and COVID-negative residents, increasing the probability of transmission.

Given asymptomatic spread and inadequate testing, staff often do not know which residents are infected. Nursing homes compete with hospitals for both testing supplies and personal protective equipment, still in short supply in many areas. With policymakers and the public initially focused on the spread of infection within hospital settings, nursing homes often lost that competition, putting both staff and residents at risk. These circumstances lend an aura of inevitability to the spread of COVID-19 in nursing home settings. Indeed, the first death reported was from a nursing home in Washington State that had a 5-star rating.

The challenges of avoiding the spread of the virus to nursing homes are exacerbated by the dual roles played by most of these facilities. They are providers of post-acute, rehabilitative care, and they are providers of long-term care. Although these two care activities may seem quite

similar to the general public, the economics and the COVID-related risks are actually rather different.

Medicare pays relatively generously for post-acute care. The reality is that many nursing homes depend on these revenues to subsidize care of long-term care residents who are predominantly funded by Medicaid. The provision of post-acute care, however, involves shorter stays and more frequent interactions with hospitals, potentially increasing the risk of spreading the virus even if the post-acute care is not COVID-related. Directly accepting post-acute patients with COVID may help to sustain key relationships with hospitals but may simultaneously endanger vulnerable long-term care residents.

But is the spread of COVID-19 in nursing homes inevitable, or have some types of nursing homes managed better than others to avoid new infections from occurring? An early National Public Radio analysis[3] of selected nursing homes in New York suggested that facilities which serve a higher proportion of nonwhite patients were more likely to experience COVID deaths. Perhaps surprisingly, that study did not find the expected negative relationship between the probability of such deaths and nursing home quality, as measured by the Nursing Home Compare 5-star ratings. Because the analysis sample was small, incomplete, and limited to New York, it is unclear how such results may generalize to other states and populations.

Analysis of the Relationship between Nursing Home Quality and Covid-19[1]

In the past month, we set out to assess on a broader scale whether the pattern of COVID-19 cases and deaths in nursing homes appears to be random or connected to nursing home quality.

We used a sample of nursing homes from 12 geographically diverse states. We merged data from the Nursing Home Compare archives (for 2020 star ratings and some nursing home characteristics) and LTCFocus[4] (for racial distribution and percent of residents on Medicaid as of 2017[2]) with states' publicly available lists of long-term care facilities with reported COVID-19 cases or deaths. We relied upon data released as of May 13, 2020, in twelve states that had released case counts and, of those, eight states that had released death counts.[3] For the case analysis, we analyzed a total of 5,527 nursing homes, of which 36% had at least one case. For the death analysis, we analyzed 3,461 nursing homes, of which 29% had at least one death. We calculated the percent of nursing homes with at least one case or death[4] by Nursing Home Compare star ratings, profit status, and several resident characteristics.

Our analyses revealed three key results:

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[1] This analysis was done in collaboration with Rebecca Gorges, a doctoral student at the Harris School of Public Policy, University of Chicago, whom I thank for spending countless hours extracting state case and death lists and painstakingly merging them with the Nursing Home Compare data, in addition to providing substantive input.

[2] Although the LTCFocus data are several years old, the payer mix and racial distributions of nursing homes do not change substantially over this amount of time.

[3] Case counts drawn from CA, CO, CT, GA, IA, IL, MA, NJ, NV, OH, TN, and OK; death counts drawn from CA, CO, CT, GA, IL, NJ, NV, and TN.

[4] We focused on the existence of at least one case or death as opposed to the number of cases or deaths because variability in testing and reporting practices makes the counts less reliable.

1. **We found a strong and consistent relationship between race and the probability of COVID-19 cases and deaths** (Figure 1). Nursing homes with the lowest percent white residents were more than twice as likely to have COVID-19 cases or deaths as those with the highest percent white residents.

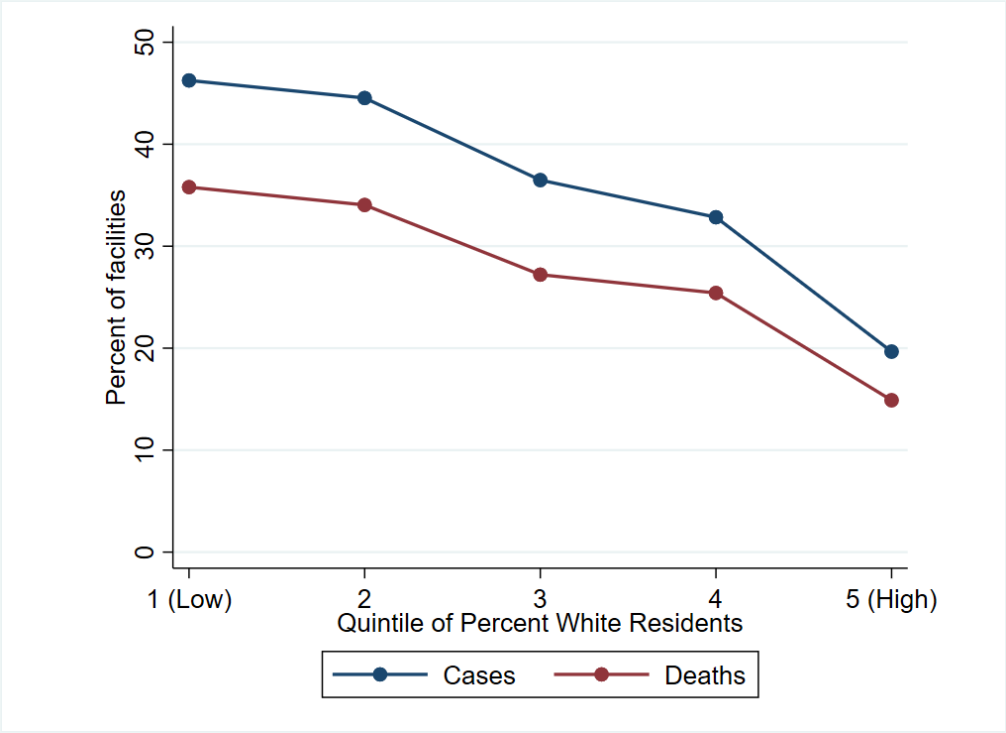
2. **We found no meaningful relationship between nursing home quality and the probability of at least one COVID-19 case or death**. We measure quality using the Nursing Home Compare overall star rating. On average we see only a marginally lower probability of cases for nursing homes with higher quality ratings (Figure 2).

   That overall finding masks considerable heterogeneity (Figure 3). In some states, such as Illinois, nursing homes with higher quality ratings (4 or 5 stars) were marginally *less* likely to have a case of COVID-19, but in other states, such as New Jersey, higher quality homes were marginally *more* likely to experience a case. Both the direction and strength of the relationship between star ratings and COVID-19 cases across and within states can best be characterized as inconsistent.

   The Nursing Home Compare overall star rating is derived from scores across three domains of quality: inspections, staffing, and clinical quality measures. The *inspections* domain is based on the results from roughly annual visits of state surveyors to each facility to monitor compliance with requirements for participation in the Medicare and Medicaid programs. This domain is weighted most heavily in the overall ratings and is often considered the most objective. While the inspections-domain rating is more predictive than the overall star rating, the magnitude of the difference is not practically meaningful. The staffing domain and the clinical quality measures domain are not predictive.

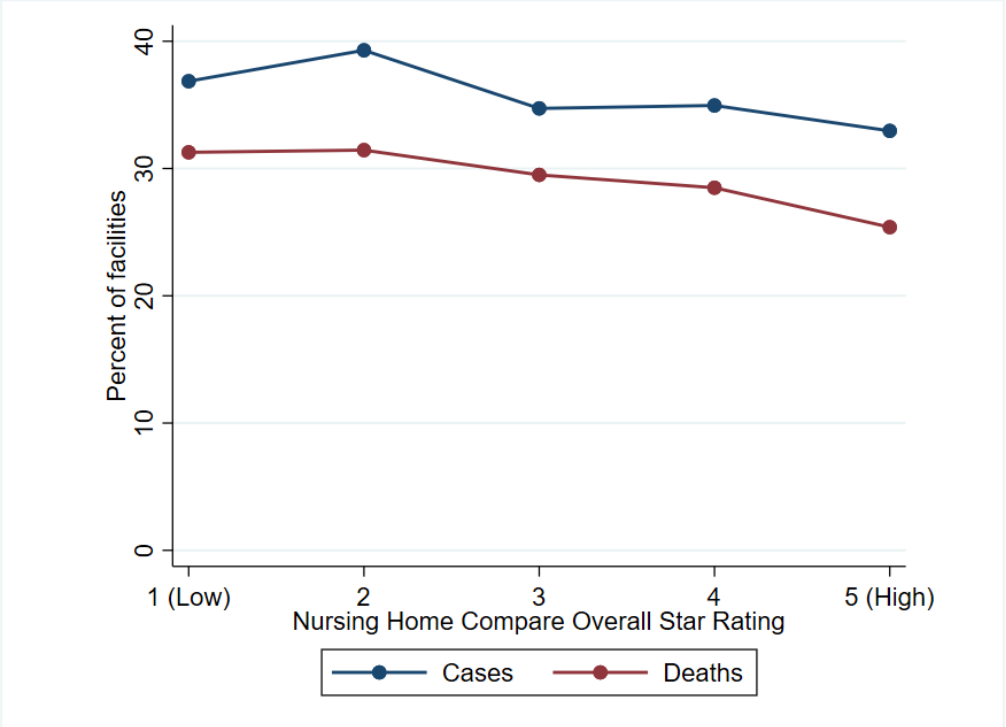
3. **We found no meaningful differences by profit status and only a weak relationship with Medicaid**. We found no significant differences in the probability of COVID-19 cases by profit status, with for-profit nursing homes and not-for-profit nursing homes being equally likely to have cases (36%). A suggestive but weak relationship was found for the percent of residents on Medicaid, with nursing homes somewhat more likely to have cases if they were more dependent on Medicaid.

Figure 1: Percent of Nursing Homes with COVID-19 Cases, by Race



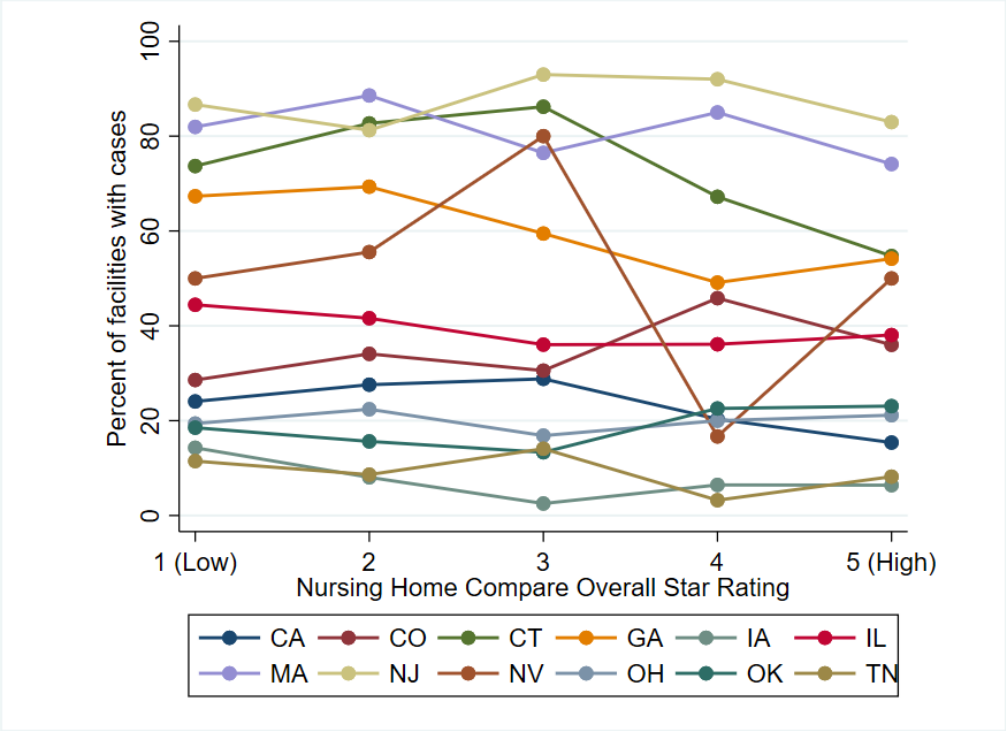
Note: The percent of nursing homes with at least one case based on CA, CO, CT, GA, IA, IL, MA, NJ, NV, OH, TN, and OK; the percent of nursing homes with at least one death based on CA, CO, CT, GA, IL, NJ, NV, and TN

Figure 2: Relationship between Nursing Home Quality and COVID-19 Cases and Deaths



Note: The percent of nursing homes with at least one case based on CA, CO, CT, GA, IA, IL, MA, NJ, NV, OH, TN, and OK; the percent of nursing homes with at least one death based on CA, CO, CT, GA, IL, NJ, NV, and TN

Figure 3: Relationship between Nursing Home Quality and COVID-19 Cases, by State



We conclude from this analysis that at least the standard quality measures do not distinguish which nursing homes ended up with cases and deaths. While some nursing homes undoubtedly had better infection control practices than others, the enormity of this pandemic, coupled with the inherent vulnerability of the nursing home setting, left even the highest-quality nursing homes largely unprepared.

And yet, the patterns of infections and deaths are not random. Consistent with racial and socioeconomic disparities in long-term care historically and in pandemic-related deaths currently, nursing homes with traditionally underserved populations are bearing the worst outcomes. Our results suggest that nursing homes serving nonwhite residents are most vulnerable to this pandemic. Because people who need nursing home care usually want to stay close to home, nursing homes are often a reflection of the neighborhoods in which they are located. Nursing homes serving predominantly non-white residents are more likely to be located in predominantly non-white neighborhoods and to draw staff from those neighborhoods. As these are the neighborhoods and the people being most affected by the pandemic, nursing homes in these areas are also most at risk.

In the two months since my testimony, analyses by several other researchers have emerged that are very consistent with these findings.[5,6] We have also updated our analysis (now under review at an academic journal) in significant ways:

1. We now use national data on nursing home infections and deaths collected and released by the CMS/CDC.

2. We have built a rigorous statistical model in order to assess the effects of race, quality, staffing, and local prevalence of the virus while controlling for potential confounders.
3. We examine not only the probability that a nursing home has at least one case, but also the number of deaths conditional on having at least one case.

We find that:

1. 71% of the 13,167 nursing homes that reported COVID-19 data as of June 14 had at least one case among residents and/or staff. Of facilities with at least one case, 27% experienced an outbreak, defined using the CMS threshold of an outbreak: more than 1 confirmed case per 10 certified beds or more than 1 total confirmed and suspected cases per 5 certified beds or more than 10 deaths.
2. By far the strongest predictor of cases and outbreaks in nursing homes are per capita cases in the county.
3. Larger facilities are more likely to have cases and deaths.
4. We still find no relationship between the Nursing Home Compare star ratings and COVID-19 cases or deaths.
5. Higher RN hours are associated with a higher probability of experiencing any cases. However, among facilities with at least one case, higher nurse aide and total nursing hours are associated with a lower probability of experiencing an outbreak and fewer deaths. (See figure below.)

Percent of Nursing Homes with Any Cases and Outbreak by Quintile of Nurse Aide Hours

We conclude that although prevalence of COVID-19 in the community remains the strongest predictor of COVID-19 in nursing homes, facilities with higher baseline RN staffing levels are more likely to experience one or more cases. Once COVID-19 enters the facility, nursing homes with higher nurse aide and total nursing hours are more able to contain the number of cases and deaths.

What about race and ethnicity?

Our original research found that the race distribution of a nursing home was the strongest predictor of whether it had COVID-19 cases. Our interpretation of this result was that race was highly correlated with where the virus was circulating in the community, as staff move daily between the nursing home and that community. Our current research directly confirms this interpretation: Once we control for the prevalence of the virus in the community, which has a sizable effect, race has no effect on the probability that a nursing home has at least one case or has an outbreak – it was simply a proxy for being in an area where the virus is prevalent. However, even after we control for the prevalence of the virus, race is a significant predictor of the number of deaths in nursing homes that have at least one case. Nursing homes with more nonwhite residents have more deaths. This may be because the underlying health conditions of residents in mostly nonwhite facilities makes them more vulnerable to adverse effects of the virus once an outbreak occurs.

The Policy Response

Unfortunately, CMS has taken the stance that low-quality nursing homes are to blame for the consequences of COVID-19, despite the fact that research shows no correlation with standard quality measures. Focusing on increased enforcement and fines when nursing homes may not have the resources to address a crisis of this magnitude is likely to lead to unnecessary cases and deaths. Priority should be placed on providing resources and technical assistance to nursing homes in virus hotspots so that they may have a chance at minimizing the probability of transmission and deaths. In the short run, this is still a crisis that nursing homes are ill-equipped to handle. In the long run, infection control procedures can be improved, and quality-related differences may emerge in which nursing homes have best adapted to the new normal. We are not there yet.

Our original recommendation was to use race as a proxy for which nursing homes were most in need of assistance. Given our new results, it might also make sense to use prevalence of the virus in the community to decide which nursing homes may be most in need of assistance. As these are correlated, the result should be similar. However, given that death rates are higher in nursing homes that have more nonwhite residents, the highest priority should be nursing homes in virus hotspots with large nonwhite populations.

Recommendations presented to Senate in May, unchanged:

Short-Term Measures to Reduce the Effects of the Pandemic on Nursing Homes

Given high rates of COVID-19 infection and death among long-term care facility residents and staff, reducing risk in long-term care facilities must be a top priority. I would place the most promising interventions into three categories: 1) Resources aimed directly at long-term care facilities; 2) Resources to enable prospective or current residents funded by Medicaid to receive services at home rather than in institutional settings; and 3) Requirements for data collection and transparency. I describe each of these in more detail below.

Funding and technical assistance resources aimed directly at long-term care facilities:

- *Regular and rapid testing of all nursing home residents and staff, symptomatic or asymptomatic*. Facilities must effectively separate COVID-infected and uninfected residents in order to prevent new infections. In the nursing home setting, test results that are delayed beyond (at maximum) a few days are not particularly useful, nor can facilities wait to test until symptoms appear. Separating residents into distinct wings or floors is ideal if possible. Transferring residents to separate facilities (established or temporary) should be considered, given urgent need to limit transmission, although there are known risks to transfer for frail older adults that must be weighed against the risks of transmission.

- *Adequate numbers of staff.* Adequate staffing is essential to achieving any reduction in infection risks in nursing home settings. Ideally, staff would be assigned to COVID-positive or COVID-negative residents and not go back and forth between them, which may require more staff than usual. Of course, understaffing in nursing homes was a problem long before the pandemic. Nurse aides, who provide the majority of direct care to nursing home residents, are generally paid minimum wage and often have no paid sick leave or health insurance. Registered nurses, who provide essential oversight and diagnostic functions as well as skilled care, would often rather work in hospitals which often offer higher wages and better working conditions.

  Even prior to the current emergency, nursing homes rarely possessed the staff capacity to address much milder challenges than those posed by the COVID-19 pandemic. Nurses and nurse aides in these settings also share many of the same vulnerabilities experienced by in the communities where COVID-19 is most prevalent. These staff members are predominantly non-white, low-income, and dependent on public transportation. Many live in families and communities with other essential workers who are unable to work at home and practice social isolation. These staff members are more likely to be sick, to have caregiving responsibilities for children or other family members, and to be facing financial hardship. Some fear showing up to work and risking contracting the virus. Other may come to work despite feeling symptomatic due to a lack of paid sick leave, fear of job loss, or a sense of dedication when staff are desperately needed.

  Under these circumstances, additional resources are critical. These should include paid sick leave, guaranteed coverage of health care costs, and hazard pay for nursing home staff. These may also include the use of hotel rooms for nursing home staff who do not

want to risk infecting family members, similar to those provided for hospital staff in many areas.

It is also important to acknowledge the limitations of these measures. While improved pay, benefits, and lodging resources may help retain current staff, they may not suffice to recruit enough staff in time to handle a COVID-19 crisis. Thus, technical assistance in the form of temporary "surge teams" may also be needed to assist with measures to stem transmission and care for residents who are critically ill with COVID-19 may be necessary in many nursing homes.

- *Availability and proper use of personal protective equipment (PPE)* among nursing home staff, as well as related practices such as hand-washing. As is obvious from experience in the hospital setting, adequate PPE is critical to protect nursing home staff. As supply challenges begin to ease, nursing home settings must be a priority for these materials. Policymakers should not assume that hospital staff are in greater need than nursing home staff, as the level and duration of direct contact with COVID-positive patients may be greater for many nursing home staff. And having appropriate equipment is not always sufficient. Prior to the pandemic, inadequate infection control practices such as inadequate hand-washing and treatment of linens were the most commonly cited deficiencies by nursing home inspectors. Almost 40% of nursing homes were cited with inadequate infection control in 2017.[7] Thus, technical assistance may be necessary to ensure training in best practices in infection control.

Based on our analysis of nursing home cases and deaths, I would argue that all nursing homes and other long-term care facilities are in urgent need of this assistance. Such assistance should not be delayed by debates about which facilities could have been better prepared. There is too much at stake in terms of the lives and well-being of our most vulnerable older adults. If scarce resources must be prioritized, the most immediate assistance should be provided to nursing homes that serve primarily non-white residents where the risk of cases and death are the greatest.

Resources to enable prospective or current residents funded by Medicaid to receive home-based services in place of institutional services.

Older adults in need of long-term care and their families often face the difficult decision between receiving services in a nursing home setting or receiving services at home. Families must weigh the level of need against the availability of caregivers in the home, their level of comfort with the type of care needed, the potential effects on employment, physical stress, and emotional stress of caregivers, the costs of care, the ease or difficulty of finding in-home help, and the preferences of both the care recipient and other family members. In the best of times, this is a difficult decision.

Over the past few decades, Medicaid coverage has markedly shifted toward increased home- and community-based services (HCBS) rather than services in the nursing home setting. This shift has removed some previous constraints around this decision for Medicaid recipients. Whereas low-income people who depend on Medicaid for their long-term care used to have little

choice but to move to a nursing home if they needed extensive assistance, now more than half of all Medicaid long-term care funding goes to HCBS, with substantial variation by state and county. Much of this shift has been achieved through Section 1915(c) waivers, which allow states to provide long-term care services through HCBS as long as costs do not exceed those under nursing home care. However, the number of waiver slots is generally capped to control expenditures, such that the number of beneficiaries who want HCBS might exceed availability.

COVID-19 has changed the costs and benefits of this difficult decision for families. On one hand, the risks of entering a nursing home have increased substantially. On the other hand, care at home has also become more complicated. It may be more difficult to find home care workers who are willing to enter people's homes and risk infecting themselves and their families. Families of the care recipient may be reluctant to have regular interaction with home care workers who are likely caring for multiple patients. Care recipients in the home setting may also face higher risks of hospitalization. Thus, even as the risks associated with institutionalization are at their highest, the probability of institutionalization may be growing.

To best help families in this situation, resources should be directed toward enabling them to avoid institutionalization during this high-risk time. For Medicaid recipients, the clearest policy lever to achieve this is to expand HCBS waiver programs, to make home-based care feasible for as many families as possible.

Requirements for data collection and transparency.

At times of crisis, issues of documentation and data collection often seem secondary or trivial relative to the urgent priority of saving lives. Accordingly, recent temporary waivers by the Centers for Medicare and Medicaid Services of some documentation requirements in nursing homes seem reasonable. Yet at times of crisis, some data collection and transparency issues become paramount. It remains critical that states require timely reporting of COVID-19 cases and deaths and, in turn, that states make that data available to the public. This is essential for three key reasons.

- Timely reporting enables resources to be directed where they are needed most. Outbreaks of COVID-19 in nursing homes are often a signal of the communities into which the virus is spreading. This may be a starting point for contact tracing, and enables states to identify which nursing homes might need the most immediate assistance.
- Over time, such reporting will enable researchers to study the spread of the virus, connect it to the policy response, and establish rigorously what worked and what didn't work. This information will be crucial to learn from COVID-19 and to improve our reaction to the next pandemic.
- Consumers must know the status of nursing homes they might be considering for care or in which a loved one already resides. As noted above, older adults in need of long-term care face particularly difficult decisions during the pandemic, weighing the need for care against the risk of infection in each potential care setting. Ideally, data on cases and infections would be released in a more consumer-friendly form than now available. Many states that release data simply list the name of a nursing home or sometimes the name and the county. For our study described above, we could harness the skills and time of academic researchers to connect the state-released case and death data to Nursing Home Compare. This is not feasible or straightforward for the typical consumer who may want

a fuller picture of quality and staffing in the home they are considering. A full facility name and address/ZIP code should be minimally required so that consumers can connect the case lists to Nursing Home Compare information.

I classified the above measures as short-term measures because they are truly urgent and necessary. They do nothing, however, to change the underlying, systemic challenges to improving the quality of nursing home care and the lives of older adults who live in them. Long-term policy changes are also required.

Long-Term Measures to Improve Nursing Home Quality and Reduce Future Risk

The quality of nursing home care in the United States has been a longstanding challenge. Although many high-quality nursing homes exist and meaningful gains have been made, low quality and understaffing remain endemic. Why are solutions to low-quality nursing home care so elusive? First, given their health status, nursing home residents are ill-equipped to monitor their own care, to advocate for themselves, or to exert political influence. Family members are not always available to advocate on behalf of residents.

Second, the structure of nursing home payment is fragmented, uneven, and leads to systematic underfunding of essential care. About two-thirds of nursing home residents are dependent on Medicaid to pay for their care, at payment rates that often are lower than the costs of care. To the extent that adequate staffing and meaningful quality improvement require resources, high-quality care may be out of reach for some nursing homes. This is particularly true of nursing homes located in poor neighborhoods, where the limited resources of the nursing home are matched with the limited resources of families.

Given these challenges, how can nursing home quality be improved, and the consequences of future health crises, such as another pandemic, be minimized? I briefly discuss two of the most common approaches below.

Is More Regulation and Oversight the Answer?

Given that nursing home residents are often unable to advocate for themselves, regulation and oversight are necessary. Some regulations and monitoring have been temporarily relaxed during the pandemic, but it will be important to reinstate them once the crisis has passed. Regulation and oversight play the critical role of attempting to set a quality floor, avoiding the worst instances of abuse and neglect.

At the same time, regulation and oversight are limited in their effectiveness. Despite vast resources poured into regulation and oversight of nursing homes and some successes, poor quality of nursing home care is still common. Raising the quality of the lowest-quality facilities has proved to be exceedingly difficult; in study after study, quality improvement efforts have led to average improvements without changes in the bottom tier.[8-10] Regulators are often reluctant to terminate the lowest-quality facilities if no alternatives exist in a neighborhood, prioritizing access over quality. For these reasons, I argue that *regulation and oversight are necessary but not sufficient* to improve the quality of nursing home care.

Prior to the pandemic, 40% of nursing homes were cited with deficiencies in their infection control practices.[7] Enforcement of these regulations did little to prepare nursing homes

for the pandemic. New regulations to increase focus on infection control are clearly warranted, but in resource-constrained nursing homes, it may be a zero-sum game; better infection control may come at the cost of focus on other critical aspects of care.

Is More HCBS the Answer?

One potential solution to low-quality nursing home care is to have fewer people in nursing homes. The increased availability of HCBS as an alternative to nursing home care is undoubtedly a good thing. All things equal, most people would prefer to age in place and not move to a nursing home. But rarely are all things equal. Even with preferences to stay at home, as an individual's needs for help become greater and greater, families sometimes make appropriate decisions to place an older adult in a nursing home, decisions that should be construed neither as a failure of the family nor of the system.

Well-intentioned stakeholders often see HCBS and nursing homes as simply competitors for funding and advocate for a higher and higher proportion of funding to be allocated toward HCBS. However, the need for nursing homes remains. For individuals who might otherwise be in nursing homes, home-based care can also be risky, entailing more frequent hospitalizations.[11-13] We should wish for seniors that they be able to receive the care that they need in the right place at the right time, and sometimes that place may be a nursing home. We should fund HCBS, but we also need to fund nursing homes such that seniors can receive the care that they need if a nursing home admission becomes necessary.

Conclusions

Most potential solutions, including increased regulation and further expansion of HCBS, are inherently limited in the extent to which they can produce meaningful change in nursing home quality and preparedness for the rest of this pandemic or the next one. To solve the challenge on a more fundamental level, the structure and level of nursing home funding, or long-term care funding more generally, has to change. At least, Medicaid rates need to be substantially higher to address our chronic under-funding of this critical health care sector. At best, the fragmented system of state-specific payment rates and cross-subsidization from Medicare would be eliminated altogether, consolidating long-term care payment into one consistent program.

Those of us who study long-term care are accustomed to hoping for fundamental change and not seeing it. In this case, however, there may be a separate impetus to revisit the funding structure of long-term care. Much of the nursing home industry relies on private-pay revenues and Medicare reimbursement to stay afloat in the presence of large Medicaid populations. During the pandemic, at least in the short run, these revenue sources have diminished or disappeared. Elective surgeries in hospitals, a major source of lucrative post-acute referrals for nursing homes, have been put on hold in most hospitals. New private-pay residents, who can presumably afford alternatives, are more likely to avoid nursing home placement during the pandemic. If nursing homes cannot survive these negative revenue shocks, a fundamental restructuring of how we pay for nursing home care may be unavoidable.

Absent this more fundamental change, I expect there will be more regulatory focus on infection control, which may help marginally to institute better practices. Those nursing homes that are cited with deficiencies in infection control could benefit from working with Quality Improvement Organizations for technical assistance. The pandemic has made these issues

suddenly less hypothetical, and approaches to this issue are likely to improve somewhat. The underlying challenges to improving nursing home quality will remain. But, hopefully, an emergency influx of resources will have addressed the immediate challenges of securing adequate testing, staffing, and protective equipment to minimize further transmission of the virus and related deaths in nursing homes.

Thank you for this opportunity to share my thoughts and expertise on the critical question of caring for older adults with long-term care needs during the COVID-19 pandemic and beyond.

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