VII. Impact of Recent Ownership Transitions

There is no single conclusion that says a sale of a county home is likely to result in a good or bad outcome for the county; the results are mixed. The process by which decisions are made becomes critical to the ultimate outcomes.

CGR conducted case studies of the experience in counties that have sold or closed their nursing homes, in order to provide local and state decision-makers with the benefit of their experience. These accounts include analysis of quantitative and qualitative data, historical information about the factors leading to the decisions to sell or close, comparisons to similarly-situated counties that have not yet sold or closed their homes, and our best estimates of the overall impact of these transitions—on residents, families, staff members, the larger long-term-care network and the broader community. In short, we talked to as many knowledgeable people as possible, and looked at as much relevant data as we could find, to tell as complete a story as possible about the experience in these counties and to share potential lessons from these experiences. *We find a very mixed picture, with both qualified successes and cautionary tales, suggesting that counties should pay very close attention to how they make these decisions and carefully consider who they wish to have in control of their nursing homes in the future.*

We begin this chapter with analyses of county nursing facilities that were sold, followed by a section on those that were closed.

County Homes that Were Sold

Oswego, Delaware, Montgomery and Fulton counties sold their homes between 2005 and 2012. Several others are in the process of selling, but for this analysis we focus on counties that had completed the transaction between 2005 and 2012, in order to provide some insight into the impact of sales.

Interviews with former and current nursing home administrators, county officials, nursing home ombudsmen coordinators and others, as well as available data, show that the outcomes of some sales were better than others. The most discouraging outcome was in Delaware County, where the state closed the home in 2012 because of poor performance six years after it had been sold to a for-profit start-up company. The owners have subsequently signed a contract to sell the home to a new operator, and the deal is under review by the state.

Sales in Montgomery and Oswego counties have had more encouraging outcomes. In Montgomery, resident care and the finances of the home have clearly improved, though there are some concerns that hard-to-place residents have less access to the home now than they did when it was county-owned. In Oswego, quality-of-care rankings have improved from

previously low levels. The impact in Fulton County is still unfolding—a New York City-based for-profit company just took over in 2012. But there have been concerns about increased admissions of younger residents with behavior problems, staff turnover and declines in the quality of care—all things the new owners say they are working to improve.

Factors Leading to Sales

Table 4

Counties that Sold Homes, at a Glance					
County	Year of Transition	Subsidy in Prior Year	Beds	Sale Price	Price per Bed
Oswego	2005	$.4 M	89	$.8 M	$9,000
Delaware	2006	$3.3 M	199	$2.5 M	$12,600
Montgomery	2007	$2.7 M	120	$.86 M	$7,200
Fulton	2012	$2-3 M	176	$3.5 M	$19,900

As shown in Table 4, the number of beds in nursing homes that sold homes between 2005 and 2012 ranged from 89 beds in Oswego to 199 beds in Delaware. Counties were making annual subsidy contributions to help make the homes whole financially, ranging from less than $500,000 in Oswego to $3.2 million in Delaware. Officials in Oswego decided to act before the financial picture worsened and thus became the first county in this century to sell its nursing home. The sale prices ranged from $800,000 to $3.5 million; on a per-bed basis, the homes were sold for between $7,200 and $19,900 a bed. *Sale prices—all less than $20,000 per bed and two less than $10,000—suggest that these counties derived the primary benefits of the sale from the future savings resulting from elimination of future nursing home deficits and from relinquishing themselves from the continuing operational burdens of ownership—more so than from the relatively small prices received from the actual sales of their homes.*

The four county homes all sold for less than $20,000 per bed, suggesting that the benefits to the counties resulted from reduced operating deficits in the future, rather than from significant financial "windfalls" from the sale per se.

Several factors contributed to financial problems at the homes, which have already been discussed in detail earlier in this report. In these four cases, they include relatively low case mix index (CMI) figures prior to sale, ranging from 0.87 to 0.93, reflecting in part a dearth of short-term rehabilitation admissions. In at least two homes, administrators acknowledge that billing procedures weren't sophisticated enough to capture all the reimbursement revenue the homes were due. Other inefficient practices were cited, including the use of expensive local vendors favored by county legislators. All of the county homes also had been paying relatively high wages and benefits, compared to non-profit or for-profit homes.

With one exception, the homes were not in serious trouble in terms of deficiencies at the time of sale, based on the available data. Data were not readily available for Oswego County, but the number of deficiencies in Delaware and Montgomery (3 and 5, respectively) in the year before sale, was not excessive compared to homes generally. The fourth county, Fulton, had more deficiencies, 10, in the year prior to its sale.

All four homes used a Request for Proposals process to solicit purchase offers for the homes. They each received between two and five proposals with, in most cases, a mix of non-profit and for-profit bidders. Generally, the counties used committees to review and evaluate proposals and narrow to a preferred buyer. One county (Oswego) sold to a non-profit current nursing home operator, and the other three sold to for-profit operators.

New Owners and Transitions

In Oswego, county officials rejected higher offers for the home in favor of a local non-profit nursing home operator with a good track record of providing care. Delaware County received only two bids for its home, and one of the bidders also wanted to buy the county's home health agency, which the county didn't want to sell. So Delaware sold to the remaining bidder, a start-up for-profit composed of three Herkimer County men with nursing home experience, including a CEO. Montgomery County sold its home to a small, new for-profit corporation, which moved quickly to improve its physical environment and staff culture. Fulton County sold its home in 2012 to a for-profit Bronx-based company that operates nursing homes throughout the state, selecting it over a local non-profit provider and two other for-profit bidders.

The transitions were difficult in each county for several reasons, including the length of time needed for the state to approve the sale, which ranged from about 12 to 18 months. During this time, home administrators had to manage the anxieties of staff and residents facing an uncertain future, which in some cases led to staff turnover and declines in the quality of care. (This was likely a factor in the 10 deficiencies cited in Fulton in 2011.) These challenges were mitigated somewhat in Oswego by allowing the new owner to come in to manage the home during the transition.

Detailed Case Studies

In the following section, we present detailed accounts of what transpired in each county that sold its nursing home, including the factors leading to the decision to sell, a brief outline of the process used to sell the home, the transition process and any challenges it presented, and the impact of the sale on nursing home residents and employees, as well as the broader community. We have compiled as much data and perspectives from as many reliable sources as we could locate to tell these stories as completely

and fairly as possible. Our efforts included interviews with county officials, nursing home administrators, union leaders, nursing home ombudsmen, administrators in neighboring nursing homes and hospital discharge planners. We also analyzed various datasets, including state data compiled by LeadingAge New York on nursing home finances and staffing, data on deficiencies from the NYS Health Department website, and quality of care data from HealthInsight, a non-profit community-based organization that works to improve health and health care.

These accounts of each county's experience are followed by an analysis of common themes and trends, and comparisons to similarly-situated counties which have not sold their nursing homes.

Andrew Michaud Nursing Home, Oswego County

Factors Leading to Sale

Oswego was the first county in New York in this new century to sell its nursing home, in 2005.[32] The Andrew Michaud nursing home, which retained its name after it was sold, was not running large deficits by today's standards – annual losses covered by the county were less than $500,000 (just 1% of its total tax levy of $38.2 million). Yet county officials predicted that financial conditions would deteriorate and decided to solicit proposals for purchasing the home.

In the view of the home's administrator at that time, many aspects of its operation were "behind the times." It was not financially savvy and didn't capture all the reimbursement revenue to which it was entitled. Although it was attached to a hospital, almost all admissions were for long-term care rather than short-term rehabilitation. Union contracts contained wage scales that drove up compensation based on longevity without regard to job function. Housekeepers who had been at the home for years were making almost as much as RNs.

In addition, political concerns interfered with efficient operations. County legislators wanted to support local vendors even when they cost more, including local pharmacy providers. The administrator worked for years to get the county to solicit proposals for providing pharmacy services. Eventually, she was able to change providers and save about $40,000. County officials, both elected and appointed, weren't familiar enough with the nursing home industry to be effective operators, she concluded.

[32] Dutchess had previously sold its county-owned nursing home in 1998.

Sale Process

In 2004, the county issued an RFP inviting bids on the home. The RFP spelled out that the county sought to sell to a buyer committed to operating the facility as a skilled nursing home and accepting indigent and uninsured residents. It also said county officials would give favorable consideration to buyers that "positively address the continued employment of the facility's current staff." Although the county was interested in selling the home, officials wanted to make sure as much as possible that the quality of care would be maintained and that staff would retain jobs.

The county received five bids for the home, with purchase prices ranging from $500,000 to $2.5 million. The bidders were a non-profit hospital, a non-profit nursing home owner/operator, and three for-profit ventures, including two nursing home owners. They proposed a range of options for financing the purchase, including one in which the county would have retained ownership of the home and leased it to the buyer. Another bidder would have required the county to make it whole if the home suffered operational losses in the first two years.

A county committee reviewed the proposals and ultimately selected St. Luke Health Services, a non-profit that operates the St. Luke Health Services nursing home in Oswego, about 10 miles north of Michaud's location in Fulton. St. Luke paid about $800,000 for the 89-bed home. Although one bidder had offered much more for the home, county officials were concerned about its track record of providing care.

Transition

The county had St. Luke come in to manage the facility as the transfer of ownership was making its way through the state Health Department approval process. This provided some continuity for residents and staff and allowed St. Luke to begin learning the facility before it formally took control.

All existing employees could apply to work for St. Luke, and about 50-60% were retained. Most of the others had not applied for jobs. Staff who were hired kept their longevity, though compensation was generally lower, especially retirement benefits. Most of the front-line workers became members of Service Employees International Union 1199, the union representing workers at the St. Luke nursing home in Oswego.

St. Luke management in the first year addressed some "low hanging fruit" changes of bidding out laundry, pharmacy and therapy services to save money. They improved health information systems, introducing their own systems, and improved the documentation of care, allowing them to draw down more reimbursement revenue.

All current residents stayed at the home, and St. Luke managers met with them to try to address concerns and answer questions. Admissions to the home changed as St. Luke began taking more admissions from hospitals and providing more short-term rehabilitation, increasing that line of business by about 10%. This increased the case mix index and improved the finances of the home. The overall CMI increased from 0.88 in 2001 to 1.01 in 2006 and 1.07 in 2010, and the percentage of resident days covered by Medicare increased from 7% in 2004 to 16% in 2005 and 15% in 2006, before declining back to 10% 2010. While these changes raise the possibility that some lower income or hard-to-place residents were less likely to be admitted to Michaud following the transfer of ownership, CGR did not find any evidence in data or interviews proving that occurred.

St. Luke made over $2 million in capital investments in the Michaud home to modify dining areas, improve security and purchase new mattresses and therapy equipment. The initial plan was to use non-recourse loans, but St. Luke in the end had to borrow against its assets. This was somewhat risky and shows the difficulty new owners may encounter in raising funds not only to sustain operations but also to make needed capital improvements. In some cases, this may be tougher for non-profit owners, who may have less access to capital.

Impact

The home's former administrator believes the quality of care has improved under St. Luke. When she visited a few years ago, she was impressed both with the physical changes at the home and improvements in two residents that she had known. She believes St. Luke was able to recruit better medical professionals and provide more continuing education.

Michaud has worked to address issues including pressure sores and ensuring that residents get proper medication. According to HealthInsight,[33] it ranked in the 45th percentile of homes nationally in 2012, down from 81st in 2011 but up from 9th in 2009.[34] Michaud in recent

[33] HealthInsight is a nonprofit organization working to improve health care and transparency that annually produces national nursing home rankings based on publicly reported data from the Centers for Medicare & Medicaid Services. The rankings are based on 13 quality measures for long-stay residents: % with pressure ulcers, % who lose control of their bowels or bladder, % given the pneumococcal vaccine, % given the seasonal influenza vaccine, % experiencing one or more falls with major injury, % with depressive symptoms, % who have/had a catheter inserted and left in their bladder, % who lose too much weight, % who received an antipsychotic medication, % who self-report moderate to severe pain, % who were physically restrained, % whose need for help with daily activities has increased and % with a urinary tract infection.

[34] HealthInsight rankings were not available before 2006.

years has had fewer deficiencies than average for nursing homes and none of the most serious types of deficiencies. Deficiencies had also fluctuated, overall falling from 13 in 2007 to 2 in 2011.

However, the home does have fewer nursing employees than it did when it was county-owned. In 2004, nursing FTEs (including RNs, LPNs and CNAs) numbered nearly 65, compared to 56 in 2010. During those years, the quality of care as measured by the national rankings fluctuated, so it is not clear what impact those declines had.

The overall impact on taxpayers was small: the total property tax levy increased from $39.7 million in 2005 to $40.7 million in 2006 before dropping slightly to $39.2 million in 2007. But costs to the county would almost certainly have increased in succeeding years as pension and other expenses rose, had the county continued to own the nursing home.

Conclusions

Oswego County increased the community's comfort around selling its nursing home by choosing a local non-profit buyer, opting for avoidance of future annual subsidies rather than a high sale price. This appears to have been a relatively successful sale, with few negative consequences of significance.

The decision to sell the Michaud nursing home in 2005 saved Oswego County and its taxpayers from the escalating costs facing counties across the state. It occurred before the financial burden on the county was significant, and so was accomplished with less controversy and turmoil than has been the case in other places. By choosing a local, known non-profit as a buyer, the county eased some community fears about what would happen, though the transition was still difficult. As measured by quality indicators, deficiencies and interviews, the sale does not appear to have had a dramatic effect, positive or negative, on the home. Michaud remains in business and has been a stable community asset.

Countryside Care Center, Delaware County

Factors Leading to Sale

In Delaware County, financial pressures convinced county officials to consider marketing the Countryside nursing home, which kept the same name after being sold. The reported subsidy had grown from $800,000 in 2001 to $3.3 million in 2005, the last full year of county operation of the home, according to data compiled by LeadingAge New York. That was 15% of the total tax levy of $22.2 million in 2005. The administrator at the time proposed replacing the existing building at an estimated cost of about $20 million in order to gain higher reimbursements for care and to provide a more home-like environment for residents. But the county was facing a mandate to build a new jail and public safety building and constructing a new composting facility, and county officials were leery of taking on additional debt.

Sale Process

In 2004, the county issued a Request for Proposals to potential bidders for the home. The county received two bids for the home; one bidder wanted to purchase the county's home health agency as well, which the county was not interested in selling. So, in March 2005, the decision was made to sell the home to Leatherstocking Healthcare LLC, a new for-profit corporation formed by three individuals with previous experience in nursing home operations, including experience in human resources, maintenance and top leadership. The purchase price was $2.5 million to buy the 199-bed home.

It took more than 18 months for the sale to be finalized; Leatherstocking did not take over the home until December 2006. The process was longer than expected both because of the time needed to obtain state Health Department approval and efforts to put together financing for the sale.

Transition

Staff had thought the transition might happen as early as January 2006, so the additional 12 months that elapsed presented a challenge for all parties, including existing management and the buyers. The buyers wanted to retain staff members but weren't able to guarantee them their jobs. Existing management needed to keep employees, but they faced an uncertain future. To try to retain staff, the county and union agreed that employees who stayed on would be paid out for accrued personal and vacation time at the time of the sale—a deal that cost the county about $250,000.

After the state approved the sale, the buyers hired the existing administrator to continue in his job. He had about two weeks to interview existing staff and rehire employees whom he and the buyers wanted to retain—about 90%. Most of those who weren't hired back either retired or were rejected due to poor performance.

Initially, staff members were "held harmless" with regard to salary and benefits—they were maintained at the same level. This aided in the transition, and the staff began the new chapter under private ownership with good energy and a desire to prove themselves to the new owners and to the community.

However, within the year, financial pressures began to exact a toll. Starting salaries for new employees were reduced, pay for existing employees was frozen, and all employees began having to pay some of the costs of their health insurance. Although the employee union (CSEA) had lost a fight to continue representing employees at the time of the sale, employee discontent fueled two subsequent efforts to unionize, although

both ultimately failed. Following the last effort, the new owners granted retroactive pay increases.

Decisions at the state level made the financial picture even more difficult: a re-basing of Medicaid rates resulted in lower reimbursement rates for Countryside and required the home to repay about $500,000. This scuttled the new owners' plans to add an adult day care program with 35 slots. The owners also spent money to fight the unionization efforts, another drain on resources. In addition, residents' Medicaid applications to the county were often not approved in a timely manner, according to one of the owners.

Although many nursing homes try to improve their financial picture by attracting more private-pay or Medicare-funded patients (including those needing short-term rehabilitation services), data on patient revenue sources show Countryside did not have increases in these areas. The percentage of patient days paid for by Medicaid increased from 70% in 2006 to 77% in 2010. The CMI was effectively unchanged: 0.84 in 2006 and 0.86 in 2010. Countryside did reduce annual financial losses from $2.5 million in 2005 to $22,000 in 2010.

In 2010, Countryside's administrator was fired, and one of the owners temporarily took over operation of the home. The owners hired an administrator new to the field who then had some difficulty passing his licensing exam, though he eventually did pass. It was difficult to retain top staff, such as medical and nursing directors, and turnover in those positions was high. The financial strain was becoming obvious to employees—vendors that hadn't been paid began to refuse to provide supplies or services.

According to one of the owners, a key problem was their physical distance from the home. None lived in the community, and they saw the commute as too long for them to be on site every day.

Overall staffing at the home, measured by full-time equivalent employees, declined from 191 in 2005 to 179 in 2007, jumped back up to 204 in 2008 and then fell to 172 in 2010. The number of nursing FTEs followed a similar pattern but fell by a bigger percentage, declining 26% from 2008 to 2010, from 113 to 83. Hours of RN nursing care provided to residents fell from 0.2 hours per resident per day in 2005 to 0.17 in 2010, a decline of 16%.

Impact

As a result of all the turmoil, the care provided to residents began to decline, and Countryside started to rack up deficiencies in state surveys. Total deficiencies increased from three in 2006 to 10 in 2009 and 19 in 2011, according to figures from the state. In 2009, the home had four of

the most serious deficiencies (immediate jeopardy), and it had three in 2011. Countryside also fell in the national nursing home rankings developed by HealthInsight, from the 79th percentile in 2008 to the 35th in 2011.

Concerns about care had the nursing home ombudsmen at the home two to three times a week in 2011-12 responding to problems including medication errors, call bells not being promptly answered (including long waits for help to the bathroom), dietary problems (not following special diets), and incorrect documentation. During this time, rumors that the home would sell or be closed were prevalent among staff and residents.

Because of the issues with care, the state put Countryside on a special focus status, and in October 2012, the state forced Countryside to close, though the owners were in the process of trying to sell to a new owner. About 120 residents had to be moved to other facilities; because Delaware is a rural county with only two other nursing homes, many had to be moved to other counties, including Broome, Albany and Oneida.

The nursing home ombudsmen worked to notify other counties about the closure and transfers so that homes receiving Countryside residents could be on the lookout for "transfer trauma," a potential side effect of being moved. Residents suffering from transfer trauma withdraw, stop socializing or, in extreme cases, eating, and their conditions deteriorate. Some of the former Countryside residents did show signs. And other residents were just angry and distressed about being moved. "A lot of them felt like they were being thrown away," said one official who worked with residents.

In the flurry of activity closing the home, a few families had difficulty finding their loved ones, though eventually they were located. But there remain families who cannot visit their relatives because they were moved too far away, and some former Countryside residents are still trying to find a spot closer to their families.

The owners are still trying to sell Countryside, and in fact have signed a sale contract with a buyer which they did not want to identify. The potential sale is under review by the state.

The Delaware County Board chairman maintains that selling Countryside was the right thing to do for taxpayers. The property tax levy decreased from $23.2 million in 2006 to $22.5 million in 2007 and $22.2 million in 2008, which the chairman attributed to the nursing home sale. The levy then began to rise again, reaching $24.7 million in 2011, according to data from the Office of the State Comptroller.

The Countryside/Delaware County experience can be viewed as a cautionary tale for potential sellers of nursing homes: what can happen without a careful selection process and resulting comfort with the new owner. Inexperienced ownership led to poor quality care and ultimately closing of the facility and disruption to residents.

Conclusions

Countryside can be viewed as a cautionary tale. The county sold to its only viable bidder: a start-up with no institutional experience in taking over, or owning and operating, a nursing home. The result was years of turmoil, union/management struggles, top-level firings, staff turnover and declining care for residents, culminating with the state's closure of the home. While the county saved money (it could stop paying a $3 million subsidy and the property tax levy declined for a few years), it seems likely that a more thoughtful, intentional approach toward marketing and selling the home might have produced more and higher quality bidders.

Montgomery Meadows/River Ridge, Montgomery County

Factors Leading to Sale

The deficits were also growing at Montgomery Meadows. In 2006, the year before the home was sold, Montgomery County provided a subsidy of $2.7 million, more than 12% of its $21 million tax levy. One county official speculated the county would have had to put $4-5 million into the home by 2013 if the home hadn't been sold.

Sale Process

In 2005-06, the county issued an RFP and received several responses, narrowing the options to a handful and then to one. The new owners, who operate the home as a for-profit company, paid $860,000 for the 120-bed home, including 25 acres of land. This represents the lowest price per bed of the four case study sales.

Transition

The new owners took over the home in January 2007 and renamed it River Ridge Living Center. To staff the home, they held a job fair at a local hotel. They had 150 positions, and the job fair attracted more than 300 applicants, including existing employees of the home. They hired about 40-50% of their staff from the pool of existing employees, but rejected the rest because they didn't meet their standards.

The new owners moved aggressively to improve the home's physical environment and culture/climate. They put in new floors, lighting, wallpaper, two fireplaces, a new roof, sprinkler system and renovated the dining room. Their website displays some before and after pictures highlighting the changes. They worked to instill a sense of professionalism and service among staff members, setting an example by helping keep the home tidy themselves. "We had to change the culture. Our people are very

professional. They're very friendly. The executives pick up garbage, so staff does too," one of the new owners said.

A new owner said they treat staff members well because "we want our residents treated well." That includes providing free lunches and paying 100% of the cost of health insurance (though that will be changing as federal health care reform provisions take hold).

The new owners also attracted more patients needing short-term rehabilitation, which can help to stabilize finances because the Medicare reimbursements for such care generally cover more of the cost than does Medicaid. Data show that River Ridge is serving more short-stay residents (21% in 2010, up from 14% in 2006) and that the Case Mix Index has improved (1.14 in 2010, compared with 0.87 in 2006).

Impact

Data show the quality of care and the finances of the home have improved. A thornier question is whether hard-to-place residents still have a place at the home.

The new owners said the only patients they do not accept are those with severe behavioral issues or who have to take very expensive medications. But the county's nursing home ombudsman said it has become more difficult to place residents with even mild behavior problems. As she explained, it is not uncommon for a patient with dementia or memory problems to become agitated and act out by swearing, resisting care or even hitting—even though such a person may not have persistent behavior issues. But even one incident is recorded in a resident's file and can require expensive, 1-on-1 supervision. River Ridge will sometimes admit such patients, but other times, depending on circumstances, will not, whereas its predecessor, Montgomery Meadows, like other county homes, consistently admitted such hard-to-place residents, according to the ombudsman. As a result, some residents with behavior challenges are now going to homes further away, such as places in Massachusetts that specialize in caring for these kinds of residents and are hungry for New York's level of Medicaid reimbursement.

The overall quality of care has improved—the national nursing home rankings placed River Ridge at the 22nd percentile in 2007 and the 84th percentile in 2012 (down slightly from 92nd in 2011). New York State surveys cited no more than 6 deficiencies at River Ridge in any year from 2007 to 2011, below state averages, though the home had 2 immediate jeopardy deficiencies in 2011. The new owner said these were related to a circuit box where a dead circuit was not plugged in, which she did not believe posed an actual danger to residents.

Financially, the home is in better shape, with annual losses of $105,000 in 2007 and $129,000 in 2010, much less than the millions the home was losing before the sale, according to data compiled by LeadingAge New York. River Ridge is attracting more private-pay and Medicare dollars: the share of overall patient days paid for by private-pay sources increased to 17% in 2010 from 10% in 2006; *the share paid by Medicare increased to 14% from 3%; and Medicaid-paid days fell to 66% from 83%. Data suggest that other nursing homes in the area may have had to pick up the slack; from 2006-10, they experienced an average 8% increase in the share of their resident days paid for by Medicaid.*

Staffing at the home has changed, returning to earlier levels after ballooning in 2005. The home had 160 full-time equivalent staff in 2001, including 77 nursing FTEs. By 2005, those numbers had increased to 219 and 135. In 2010, there were 137 FTEs overall and 72 nursing FTEs. Nursing hours have followed a similar pattern, with RNs providing 0.17 hours of care per day to each resident in 2001, a figure that rose to 0.49 in 2005 and fell back to 0.22 in 2010. Despite this decrease, the quality of care has remained high.

The impact on the county budget has been millions of dollars in savings, according to the county chairman at the time of the sale. In addition to avoiding annual subsidies, if the county had kept the home, it would have had to make physical improvements to the aging facility (as the new owners did). He speculated that the county would have exceeded its constitutional tax limit and had to raise property taxes above the state-imposed 2% cap had it not sold the home. Because of the sale, it was possible to stabilize the county budget.

The county's property tax levy declined in the years following the sale, going from $27.4 million in 2007 to $25.6 million in 2008, $25 million in 2009 and $23.5 million in 2010—savings perceived to be attributable at least in part to the sale of the home. In 2011, it went back up, to $25.9 million.

This low-price-per-bed sale appears to have been successful against most measures, including quality services; an attractive facility; high quality ratings despite reductions in staff; and significant costs avoided by taxpayers. But the share of Medicaid residents has declined, with at least some picked up by other homes.

Conclusions

Montgomery County achieved savings to taxpayers and an increase in the quality of care provided to residents by selling its nursing home at a low per-bed price. The home is physically more attractive and the staff is praised for professionalism. However, the home is not as accessible as it once was to residents with behavior problems and Medicaid residents, and compensation to staff members is lower than it was when it was county-owned.

Fulton County Residential Health Care Facility

Factors Leading to Sale

In Fulton County, the subsidy required to keep the 176-bed home afloat had grown to more than $2 million in the years before it was sold – about 7% of its total tax levy of $27.3 million. Fulton County not only sold its nursing home but also divested itself of a mental health clinic and alcohol/addiction services, and sought to sell its community home health agency. But the county home was the largest of these – the biggest county department in terms of employees with about 300 workers.

Sale Process

The county used a traditional RFP process to solicit proposals for the home in 2010, and CGR was engaged by the county to help write and distribute the RFP, as well as to help evaluate responses. The county received five responses, four for the nursing home and one just for the Certified Home Health Agency. Of the four for the nursing home, one was from a local, non-profit nursing home operator and three were from out-of-town, for-profit operators.

A review committee of county officials evaluated each response, and narrowed the list to two. In 2011, the county selected Bronx-based Centers for Specialty Care (Centers) to purchase the home at a cost of $3.5 million.

According to some accounts, the process of selling the home was made more difficult by a lack of transparency on the part of some county officials. Nursing home employees believed all options for the home's future were being considered, when in reality an RFP for the home's sale was being drafted. The home's administrator at the time floated other options, such as engaging with health care partners to have a broader discussion about the continuum of care needed to serve aging people in the county. But that was rejected as coming too late in the process.

Transition

The sale was approved by the state, and Centers took over the home in April 2012. Current employees were interviewed; about 80% were hired back and their wages were kept intact. Centers voluntarily granted recognition to the union in place, the Civil Service Employees Association, and a non-governmental CSEA unit took over representation of workers.

Shortly into the transition, however, staff began to feel that promises weren't being kept. The lower overall number of staff meant that everyone had to do more work, a change Centers maintains was justified. The former county home administrator acknowledged that as a county home, Fulton probably had more nurses than needed, but the changes were difficult for staff to adjust to. Also, benefit cuts took hold as employees had to pay more for their health insurance and new retirement plans were introduced with less generous provisions than government pensions.

At the same time, Centers began admitting different types of residents to keep the home full. Under county management, the home was often not full, with as many as 30 beds empty at times. Centers began targeting not only short-term rehabilitation patients but also bringing in residents from out of the area, some of whom had more severe behavioral or mental health issues than staff was used to seeing. These changes can be seen in the CMI, which increased from 0.83 in January 2011 to 1.21 in January 2013.

Centers said they have had to retrain staff in how to deliver proper care and how to document care so that the home can access full reimbursement. The former administrator acknowledged that documentation was an issue, saying the county hadn't wanted to invest in hiring a coding expert to ensure that the home was maximizing reimbursements.

A continuing challenge at Fulton has been staff turnover. Several sources said the home struggles to retain employees because of the working environment, which is more challenging and bottom-line driven. The new owners say they continue to lose workers who want to maintain public-sector wages and benefits to positions in the county as they become open.

Centers is making changes to address issues. They are not taking as many residents with behavior challenges, and they are working on an agreement with the union to increase wages. The home's current administrator is also suggesting adding a dialysis unit so that residents don't have to be transported for treatment.

The new owners are planning capital improvements to the home, including new furniture, floors and lighting, and they promise a full facelift sometime in the next six months. They are currently working to put cable TV and phones in all resident rooms.

Impact

The changes in the resident population, drawing more from outside the area, including the New York City area, has changed the climate of the home for the worse, according to some sources. Previously, it felt more

like a real home, and many staff members and residents were from the area and knew each other.

In a focus group, most residents said they were satisfied with their care. A few complained about the food at the home, more the lack of variety than overall quality. The residents weren't opposed to counties selling homes to private owners, and most said they understood that financial pressures were driving counties out of the business.

There are also concerns about the quality of care. In 2007, Fulton was in the 51st percentile in the national HealthInsight rankings. This fell to the 40th percentile by 2011 and dropped to the 2nd percentile in 2012. Deficiencies cited by the state have increased from 8 in 2010 to 10 in 2011 to 24 in 2012. (Note that the new owners took over in April 2012, so some of 2012's poor track record is attributable to the county.) The ombudsman's office has received more calls and complaints about the home in the last 12 months than it got in the prior 10 years about issues such as from pressure sores, toileting problems and resident privacy. The home's reputation has declined, and people don't want to go there, several sources report. However, the ombudsman did note that conditions seem to be improving, with staff becoming more responsive and gelling as a team.

The financial impact on the county has been positive, according to the county administrator, though he says it's too early to precisely quantify the savings. The tax levy did not decline after the sale, largely because sales tax revenues continue to decline. The county has saved money in indirect costs supporting the nursing home—e.g., the county did not have to replace a staff person in its personnel department, mostly due to nursing home sale.

Conclusions

The outcome of the Fulton County nursing home sale is a work in progress, with mixed results to date and problems being addressed about 15 months into the new ownership.

The Fulton County home has experienced significant tumult since being sold—with major changes to both the resident population and staff. Some 15 months after the sale, staff turnover continues to be a problem, and several outside observers say the home's reputation has declined. On the positive side, the county has been relieved of a $2 million annual commitment to the home, and the home's new owners and administrator say they are committed to improving its operations.

Trends and Implications of County Home Sales

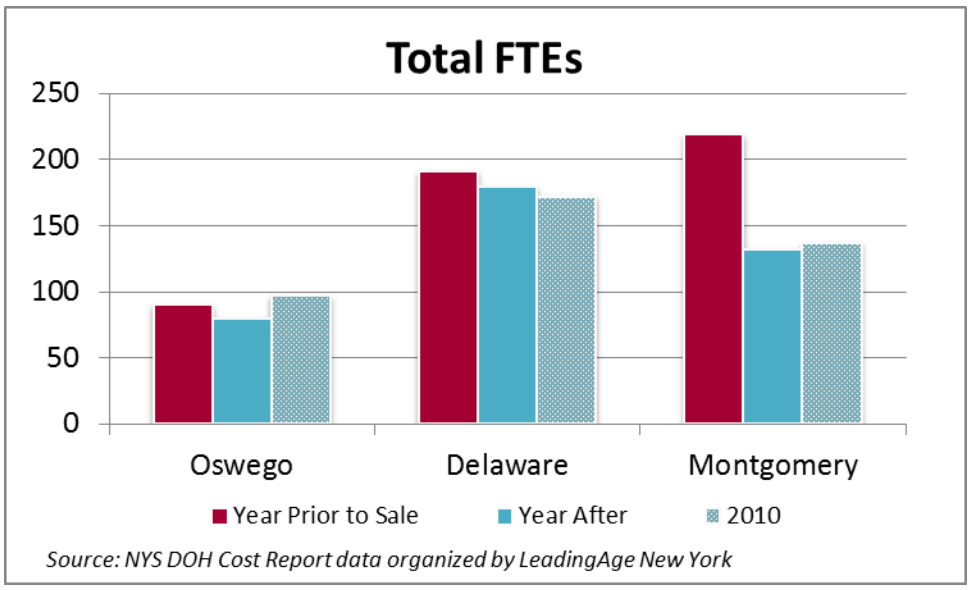
Having looked in some detail at a case study of each county that sold its nursing home, we now turn to a summary of overall issues across the four counties to discern common themes and trends, compare the experience in counties that sold their homes to similar homes in other counties that have

not sold, and seek lessons for counties contemplating the sale of their homes in the future.

Staffing

New owners retained roughly half or more of current staff, but at the two homes that have experienced more problems (Delaware and Fulton), staff turnover was or has been a recurring issue. As shown in Figure 39, overall staffing levels declined in two of the three counties, decreasing sharply in Montgomery[35], declining more gradually in Delaware and remaining fairly consistent in Oswego. (Note that meaningful data for Fulton was not available for the following several measures, since it was so recently sold.)

Figure 39



A similar pattern characterizes changes for nursing FTEs (see Figure 40). Hours of RN care, shown in Figure 41, provided per resident per day, fell sharply in Montgomery, dipped slightly in Delaware and also fell in Oswego, though this was due to a change in reporting rather than a true shift in staffing.

[35] 2005 data were used for Montgomery for the year prior to sale because 2006 data were not available. On several of the following measures, the data for Montgomery was especially high in 2005 relative to earlier years. The reasons are unclear, but the basic trends and conclusions remain the same, even if earlier years are used as comparisons.

Figure 40

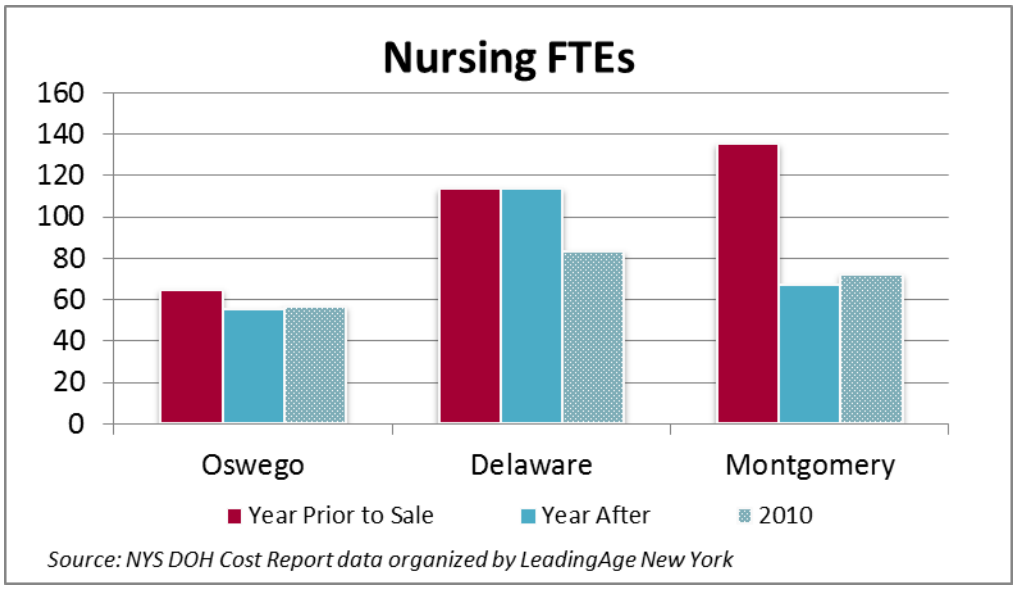
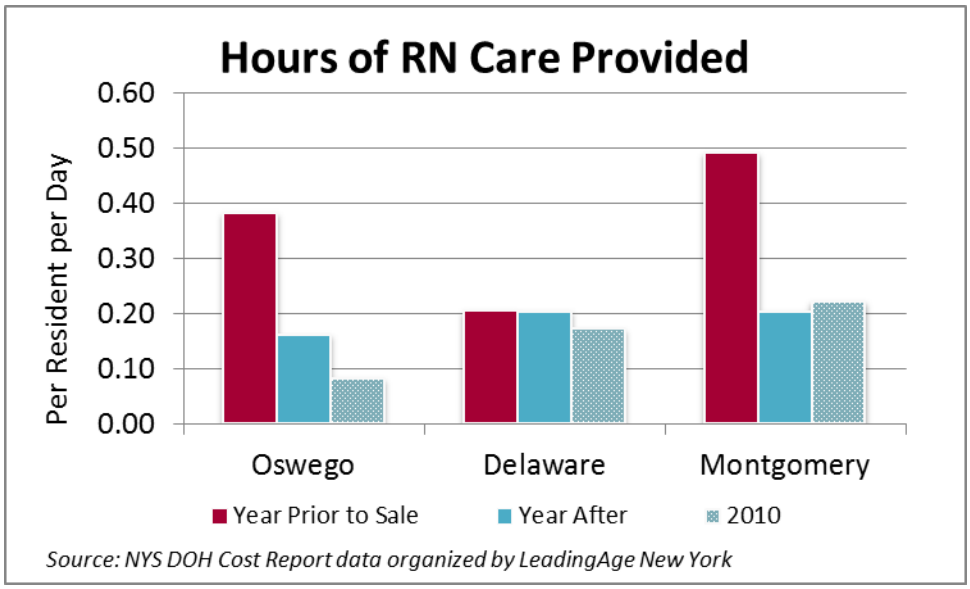


Figure 41

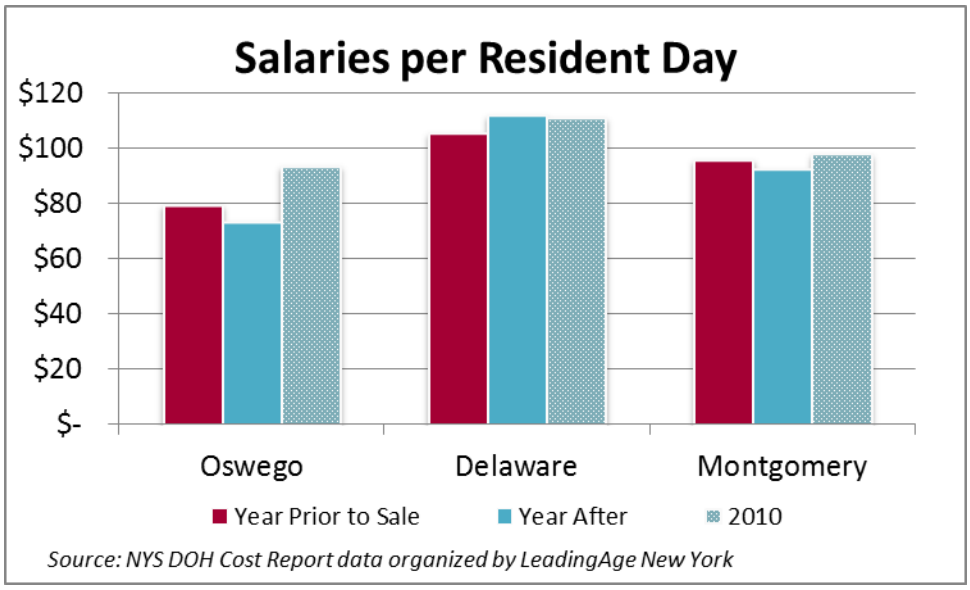


Based on these data and on interviews, it seems clear that some of the homes were overstaffed under county ownership. In Montgomery County, for example, staffing reductions did not have the effect of reducing the quality of care—in fact, the quality of care appears to have improved substantially in the last several years. However, staff reductions in Delaware County, along with financial strain and overall turmoil, likely contributed to declines in the quality of care.

Salaries and Benefits

Overall salaries paid to staff (Figure 42) did not change dramatically, though these figures have not been adjusted for inflation, so any declines or small increases may actually represent stagnation or reduced purchasing power. *In general, new owners tried to maintain salaries for existing employees who were hired back but reduced wages for new hires.*

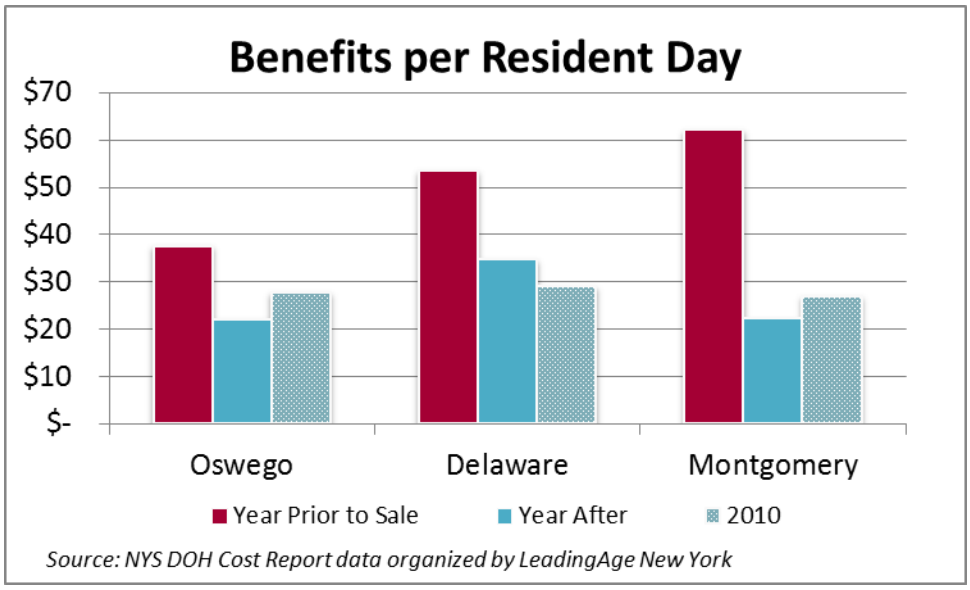
Figure 42



In contrast, as shown in Figure 43, *benefit levels declined in all three counties.* This reflects changes to both health insurance—usually requiring workers to pay more of their premiums—and retirement, where less generous plans replaced government pensions.

Two of the four homes retained union representation of workers. In Oswego, employees became part of the Service Employees International Union 1199 that already represented workers at the new owner's other facility. In Fulton, the new owners voluntarily granted recognition to a non-government unit of the existing union, the Civil Service Employees Association. In Delaware and Montgomery, workers were no longer represented by unions, though in Delaware, there were efforts to unionize workers, which ultimately failed.

Figure 43



Salaries have remained relatively comparable to pre-sale levels in most new-owner homes, at least for original county employees, with lower levels for new hires. Benefit levels have declined significantly in each sold facility.

The data show that reduced compensation (salaries plus benefits) for staff is a near-certain outcome of a county sale—no surprise given the financial condition of county homes. The biggest changes were seen in benefits, rather than wages. It is not clear what impact reduced compensation will have on a home's overall operation or quality, as we have examples of homes that have improved and homes that have declined.

Resident Population

There were clear changes in resident population as a result of the new owners taking over county-owned homes—but some changes were dramatic and others were more subtle. In three of the four counties where homes were sold, the new owners changed admission practices to try to attract more short-term rehabilitation patients in order to improve the home's financial stability and performance. However, this seems to have had a large and lasting effect in only one county, Montgomery. The share of resident days paid for by Medicaid declined and the overall CMI increased in Montgomery, as reflected in Figures 44 and 45. In Oswego, while the CMI has increased, the share of days paid by Medicaid dipped and then rose to previous levels. In Delaware, there were small changes in CMI and a down-and-up pattern in Medicaid days.

Figure 44

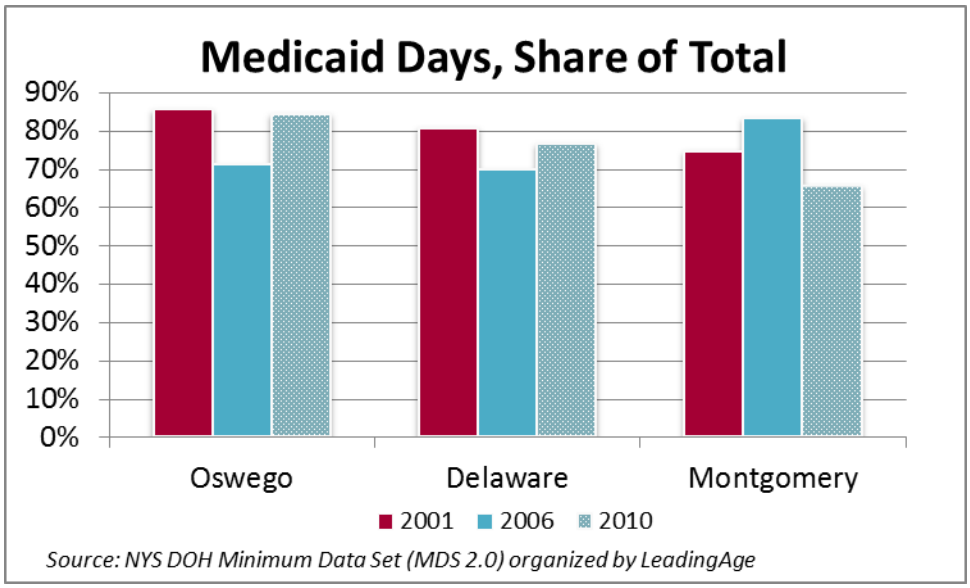
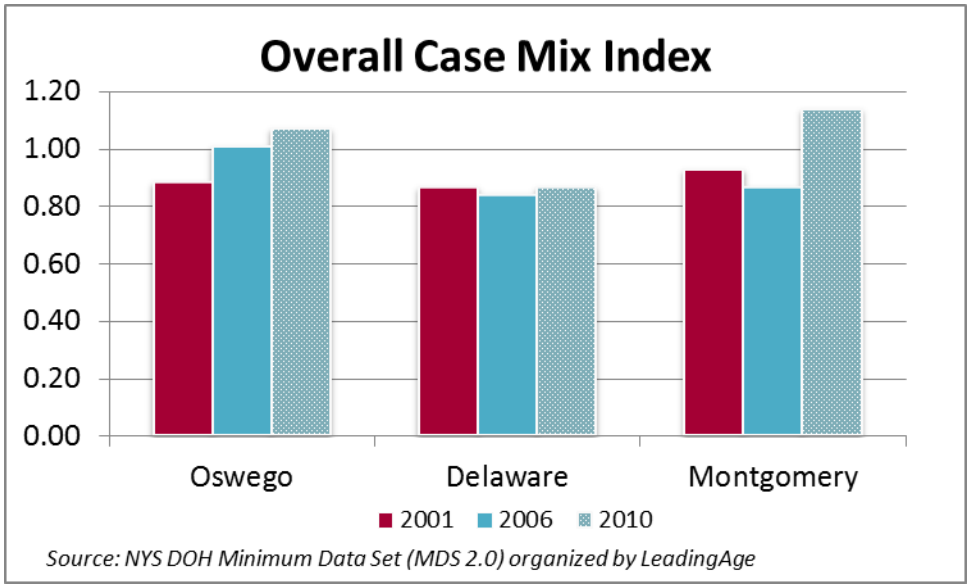


Figure 45



While we do not yet have post-sale data for Fulton, we know from interviews that new owners have tried to improve the home's financial condition through increasing the occupancy rate in part by accepting more difficult-to-place residents.

We can conclude that new owners may share the same goal—financial stability, if not profitability—but they may take different approaches to meeting that goal. While some may seek to be more selective in

admissions, others may be more flexible in order to keep the home full. And each approach may have its own up and down sides—a more selective admissions practice might help to improve overall quality as staff face fewer difficult challenges with residents, but hard-to-place residents could lose out. On the other hand, a more liberal approach to admissions might make the home more challenging for staff to manage, but access to care is preserved. Overall, to date, *the impact on access to care appears mixed across counties, with some of the new-ownership homes appearing to be relatively open to "hard to place" residents, while at least one appears to have been more resistant.*

There appears to be no overall evidence that low-income and other "hard to place" persons are not being served by new owners, with one possible exception— where other competitors may help pick up any slack.

Quality of Care

Available data and perspectives present a mixed picture on the quality of care in homes that were sold. Caution should be observed in using the quality data, but the two indicators used suggest generally consistent trends within each facility in the case study. Resident care clearly improved in Montgomery County, as evidenced by a higher national percentile ranking and a low number of deficiencies (see Figures 46 and 47). In Delaware County, the quality ranking declined as deficiencies soared, and in Oswego, both measures have been somewhat up and down since the home was sold in 2005—overall, quality appears to have improved in terms of fewer deficiencies, but with fluctuations in national rankings ranging from improvement from very low levels in 2007 and 2008, but at the 45th percentile nationally in 2012, Oswego's home is currently ranked below the national median. Fulton had a low ranking and high number of deficiencies in 2012, but that is only partly attributable to the new owners, who took over in April of that year.

Figure 46

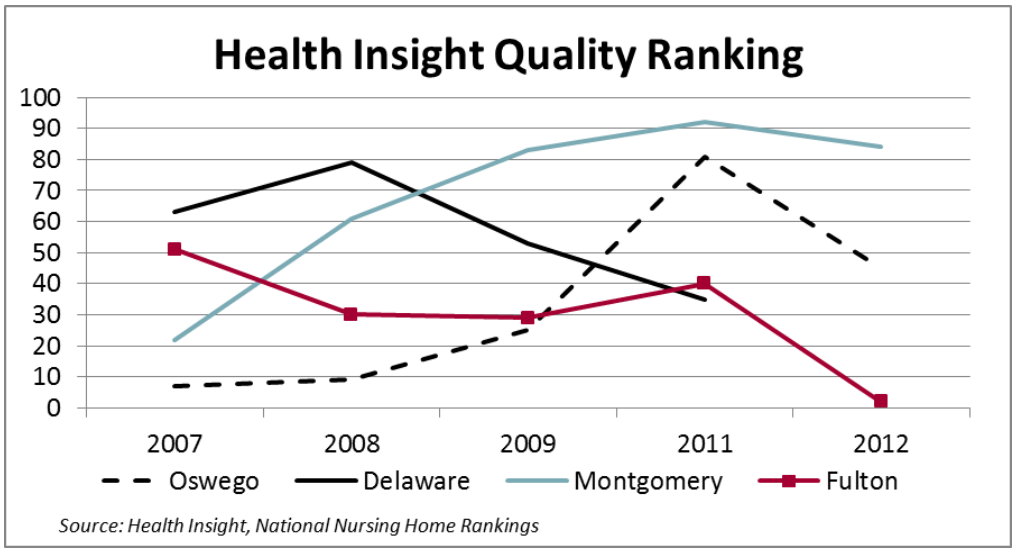
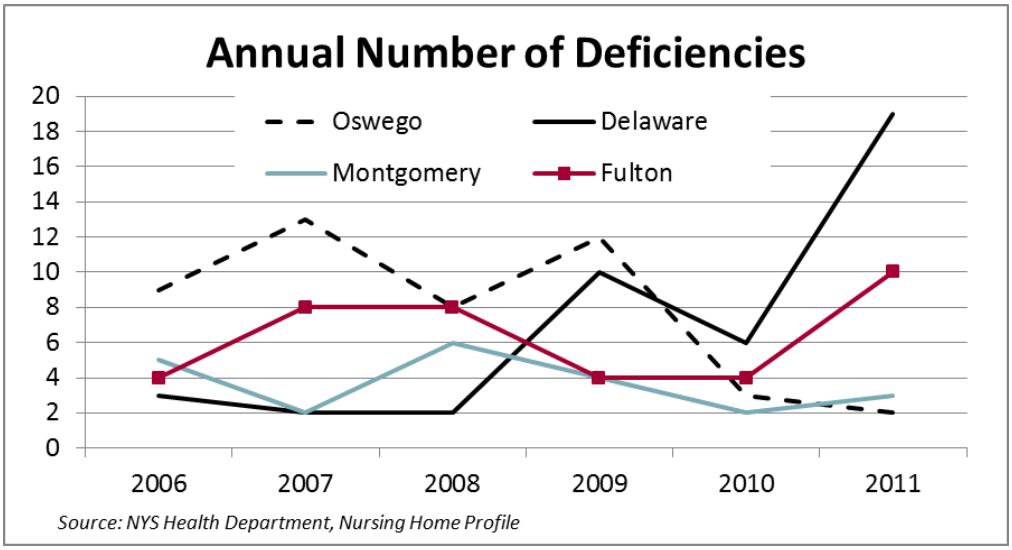


Figure 47



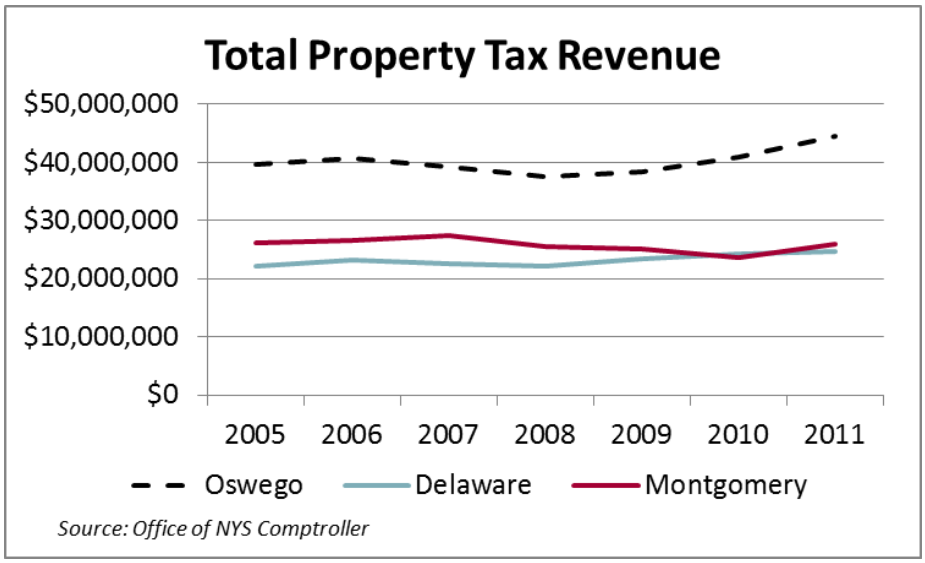
Tax Impact

All four counties achieved some savings by selling their homes, as they no longer had to provide operational subsidies ranging from $500,000 to more than $3 million. In some cases, these subsidies represented a significant slice of the property tax levy, at 12% in Montgomery and 15% in Delaware. In addition, counties that sold their homes saved the future costs associated with any mandated increases to staff wages or benefits and any capital investments needed in the homes. Overall property tax levies did not decline dramatically as a result of nursing home sales, as shown in Figure 48.

Sale of nursing homes appears to have had its primary financial impact on avoidance of future subsidy costs and taxes and/or freed-up resources for other government purposes.

While there were often decreases for a few years, as detailed in the case studies, other factors bearing on county budgets began to drive overall property tax collections back up after two or three years of declines. On the other hand, given the relatively small impact nursing homes in most counties have on the overall county budget and tax levies, one would not expect large overall impacts on the levies as a result of the sales. The real impact of the sales of the homes, from a future perspective, is in terms of subsidy costs avoided, thereby helping to avoid additional taxes, and/or freeing up additional resources for other purposes of county government.

Figure 48



Impact on the Long-Term Care Landscape

CGR conducted interviews with hospital discharge planners and nursing home administrators in the areas surrounding the homes that were sold, as well as analyzing available data, to gauge the impact of the sales on the overall network of long-term care. We did not find significant, measurable impacts, with two exceptions. Obviously, the closure of the former Delaware County home caused residents to be moved to other homes in Delaware and surrounding counties, but there was capacity to absorb them. Also, the efforts at the former Montgomery County home to recruit short-term rehabilitation patients, and to perhaps be more selective in admissions, seem to have affected other facilities. The overall CMI at Montgomery Meadows/River Ridge increased 0.27 from 2006-10, while nearby homes experienced an average decline of 0.05.

Comparative Analysis: How Similar County Homes Fared

While it is not possible to determine definitively what might have happened in these four counties if they hadn't sold their homes, it is feasible to compare homes in the sale counties with comparable homes in other counties.

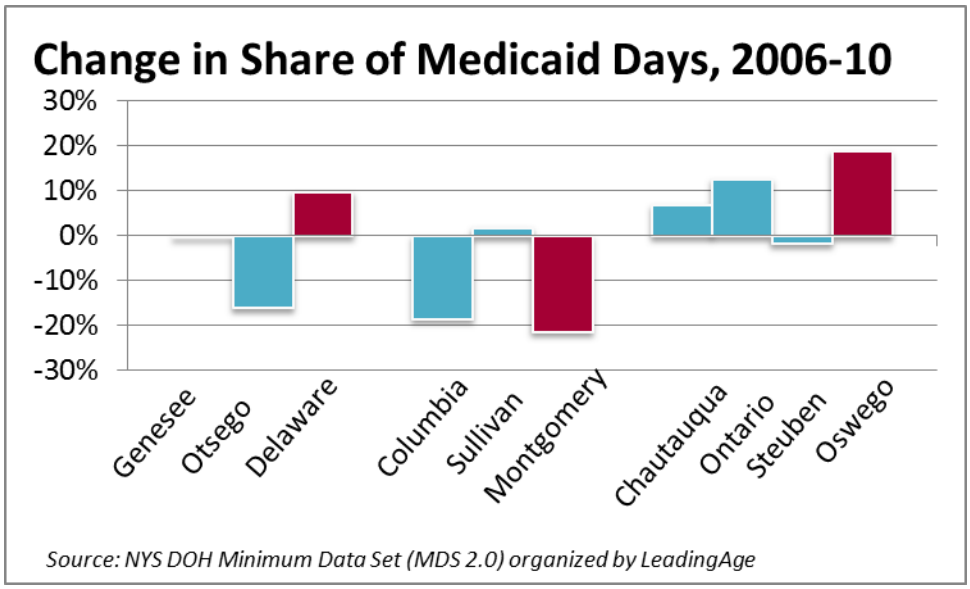
For this analysis, CGR matched homes that were sold with two to three similar county homes (matching on the basis of total beds, total population in the county, financial condition and share of resident days paid by Medicaid) and analyzed data for a few key variables. The matches were: Genesee and Otsego Counties for Delaware; Columbia, Washington and Sullivan for Montgomery; and Chautauqua, Ontario and Steuben for

Oswego. Once again, it was not possible to include Fulton in this analysis because of how recently the sale occurred.

Because the sales all occurred from 2005-07, we looked at percentage changes since 2006 to 2010 in share of resident days paid by Medicaid and overall case mix index, as well as changes in national quality rankings from 2007 to 2012 (the span of years available).

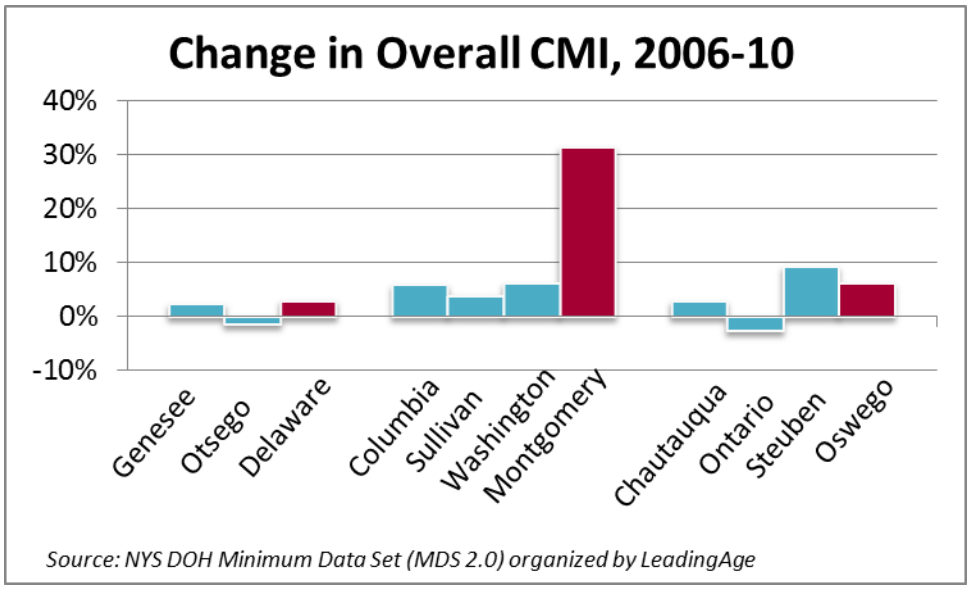
As indicated in Figure 49, compared to similar homes, the formerly county-owned homes in both Delaware and Oswego had larger increases in the share of resident days paid by Medicaid between 2006 and 2010, while the former county home in Montgomery had a larger decline than its comparison homes.

Figure 49



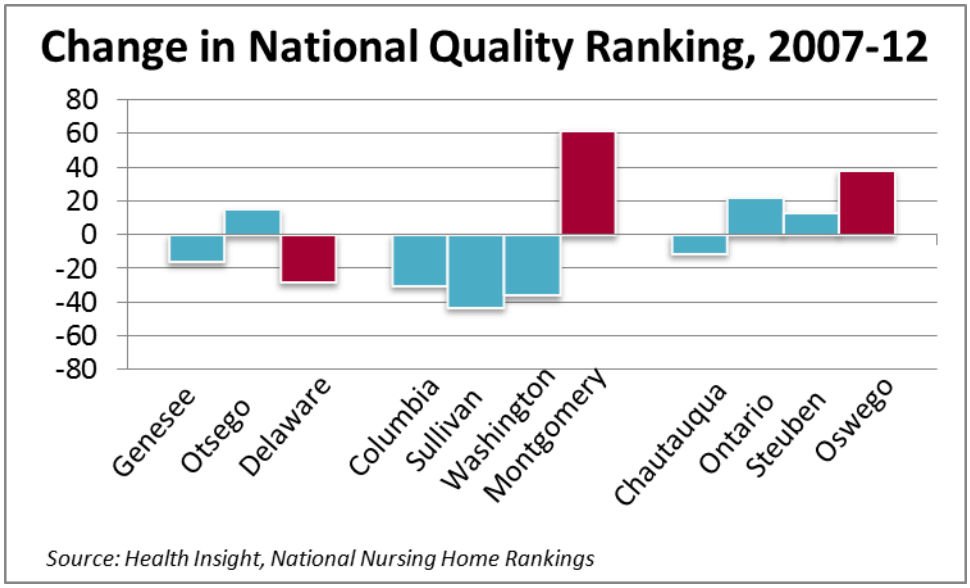
As shown in Figure 50, most of the homes in the analysis saw only small increases in their overall CMI, but the former county home in Montgomery had a large increase, far outpacing its comparison homes.

Figure 50



Compared to similar homes, the former Montgomery County home had a much larger increase in its national quality ranking (62 percentile points) between 2007 and 2012. Oswego also had a larger increase, 38 points, than its comparison homes, while Delaware before it closed in 2012 had experienced a greater decline, falling 28 points by 2011.

Figure 51



Summarizing the impact of what happens when a county nursing home is sold, the most realistic statement may be "it depends," as there is evidence suggesting either success or problems can occur. Much depends on the due diligence process used to determine what is important to each county pre-sale, and carefully selecting a buyer able to meet those expectations.

These comparisons do not yield a neat, consistent story about what is likely to happen when a county home is sold. More than similar homes in other counties, Montgomery County's home increased its CMI and quality ranking while decreasing reliance on Medicaid as a payer source. But homes in Oswego and Delaware counties had more subtle and inconsistent changes and did not depart as much from their comparison homes. *Like much of the other information gathered for this analysis, and as summarized in Table 5, these comparisons suggest that the outcome of a sale is very much dependent on who takes over the home and how they approach the challenge of making the home financially stable while maintaining or improving care to residents.*

Table 5

Summary of Impact of Sales of County Homes

County	Oswego	Delaware	Montgomery	Fulton
Year of Transition	2005	2006	2007	2012
2012 Quality Ranking	45	35	84	2
2011 Total Deficiencies	2	19	3	10
Admission Practices	Attracted more short-term rehab patients.	No major changes.	Attracted more short-term rehab patients; more selective about behaviorally challenged residents.	Tried to increase occupancy by garnering more out-of-area residents, some with behavior challenges. Also attracted more short-term rehab patients.
Hard to Place Residents	No evidence they are not admitted.	No evidence they were not admitted.	Some evidence to suggest they are not as frequently admitted.	No evidence they are not admitted.
Change in FTEs	-11%	-6%	-40%	NA
Change in Salaries	-8%	6%	-4%	
Change in Benefits	-41%	-35%	-64%	
Staff Union	SEIU 1199	None	None	CSEA non-govt unit
Tax Implications of Sale	Tax levy declined 4% and 5% for 2 years, then began to rise.	Tax levy declined 3% and 1%, then began to rise.	Tax levy declined 7%, 2% and 6%, then began to rise.	Tax levy has not yet declined, in part because sales tax revenues are down.

Notes: Delaware quality ranking change is for 2011, as home was closed in 2012. Ranking is on 100-point percentile scale. Changes in FTEs, salaries and benefits presented for one year post-sale. Salaries and benefits represent total per resident day.

Potential Lessons from Sale Counties

The varying outcomes of sales in the four counties don't point directly to selling or retaining a county-owned home as the best option. Instead, they suggest that the outcome of a sale hinges largely upon who buys the home,

Careful due diligence in terms of whether to sell or continue to own its nursing home, and a careful selection process IF the decision is to sell, are critical to successful decisions about the future of a county's home.

and that therefore how the buyer is selected, if the decision is made to sell, is critically important.

Based on the two more successful sales in Oswego and Montgomery, the failed experience of Delaware and the mixed initial outcomes in Fulton, we suggest counties considering selling their homes pay close attention to the following recommendations, IF the decision is to sell.

Thoroughly research potential buyers, finding out not only about the track records of any current nursing home operators but also about their financial backgrounds and available resources. Selling to an organization with thin financial resources, or a poor track record of providing quality care, is likely to lead to serious problems in the long run.

Consider more than just the sale price in choosing a buyer. A big dollar figure is surely appealing to a financially strapped county looking to divest itself of a nursing home. But that should be balanced with the needs of residents and their families to see the best possible new operators take over the home. In addition, county officials should decide what pre-conditions they might want to attach to the sale, such as providing preference in admissions to county residents; continuing to admit low-income, uninsured or behaviorally difficult residents; or giving preference to existing staff members in filling positions. This can be done by spelling out requirements in a Request for Proposals and/or through follow-up interviews and conversations with bidders.

Put time and thought into the process, involving stakeholders as much as possible, and being honest with them about what is happening. In counties where employees felt officials weren't forthright about their intentions to sell, new owners had more trouble establishing good working relationships. Dealing as much as possible with objections in an upfront way can set the tone for open, productive relationships among staff, residents and new owners.

Consider ways to provide as much continuity as possible through the transition. These might include entering into a management contract with the buyer before a sale is finalized, as was done in Oswego, or requiring the buyer to retain a certain percentage of existing staff members to help residents adjust to the change.

Consider whether county officials can or would like to be involved in an oversight role following the sale. In one of the sale counties, a committee of county officials and the home's buyers and administrator was set up to meet periodically and discuss the home's operations. While this structure wasn't well implemented in this county, it could potentially help maintain a county's interest in seeing the home succeed under new ownership.

County Homes that Were Closed

The experiences of two county homes that were closed is likely to have limited relevance to most counties that are or may be considering selling their nursing homes, as the circumstances of those two homes and counties were significantly different from most counties currently contemplating sales.

Two counties, Niagara and Westchester, have closed nursing home facilities in the last several years. These counties are distinct from those that sold their homes in that they are in larger, more metropolitan areas than most, and they were determined by state officials to have an excess of nursing home beds when the state conducted an in-depth analysis of health care facilities in 2006, as described in more detail below. For these reasons, the following accounts of these closures may not have as much relevance to the counties currently considering the future of their nursing homes, which for the most part appear to have little or no interest in closing their homes.

Mount View Health Facility, Niagara County

Niagara County closed its Mount View residential health facility in December 2007. The County had operated it as a skilled nursing facility with a 25-slot adult day health care program. Closing the home was the culmination of a multi-year process in which the County had deliberated on whether to try to operate it more sustainably or privatize and get out of the business. Formal discussions about transitioning the facility off of the County's books began in earnest in 2003 coinciding with the hiring of a new county administrator and a mandate from the County Legislature to find solutions for the nursing home.

Factors Contributing to Closure

Niagara County hired a new administrator in May of 2003. For several years prior, Mount View Health had not been covering its costs and was consistently using tax revenue to subsidize its operation. The new administrator had previous experience in privatizing a nursing home, and was hired in part because of the Legislature's interest in developing a plan to fix the imbalance in revenues and expenses for the nursing home. Upon being hired, the administrator was charged by the Legislature to find solutions to make the nursing home become self-sustaining.

At the time of hire, the Legislature in the County was relatively evenly divided along partisan lines, though Democrats held a slight edge and thus narrow control of the governing body. The Democratic faction was supportive of the nursing home, though pragmatic about the need for the nursing home to be self-sustaining. Democrats were also supportive of the unions representing nursing home staff. The early charge from the Legislature was not to close the facility, but to develop solutions to the problem of sustainability.

The primary issues facing the home at the time were low occupancy rates, changing demographics with low income populations requiring increasing levels of care, and low reimbursements, largely from Medicaid, that fell short of covering costs. With authorization from the Legislature, the new

administrator began in late 2003 to negotiate with the two unions (AFSCME and CSEA) that represented the majority of the workforce for the nursing home. The goal was to obtain salary and benefit concessions that could balance the nursing home budget over a multi-year period. After significant negotiations over several months, it became apparent that the unions were not going to make any concessions. The stumbling block was not their awareness of the need, but that they were representing multiple departments within the County. AFCSME and CSEA were reluctant to make concessions for nursing home staff that would negatively impact the membership in other county departments unrelated to the nursing home.

A significant shift occurred in the politics of the County in the fall of 2003. Republicans took control of the Legislature by supporting Democrats who agreed to caucus with them. What had been a narrow majority for Democrats became a sizable majority for Republicans. With the shift in control, the goal of finding a sustainable solution for the nursing home shifted to a formal mandate to find a private buyer for the facility and get the county out of the business of running a nursing home.

Based on his previous experience in privatizing a nursing home, the administrator issued a Request for Qualifications (RFQ) to determine if parties would be interested in purchasing the home. The only offer received by the county in 2004-05 was considered too low and rejected by the administrator and the Legislature. The RFQ was reissued in 2005-06 and one buyer was identified. The bidder was determined not to be a perfect fit, but the administrator decided it was worth entering into negotiations. Around the same time, the New York State Commission on Health Care Facilities in the 21st Century (a.k.a. Berger Commission) was developing its final report for the State. There were several uncertainties regarding final recommendations and how they would impact Niagara County.

Negotiations with the potential buyer continued throughout 2006, though they were difficult and proceeding slowly—without significant progress as of the end of the year. A potential contract developed at the time included a provision that the sale of the home would become null and void if the findings of the Berger Commission included specific recommendations that impacted the Mount View facility. The Berger Commission report was released in December 2006 and contained specific recommendations regarding Mount View. Once the report was public, the potential buyer of Mount View walked away from the deal and the county began deliberating over the findings of the Berger Commission.

The formal recommendation of the Berger Commission was that the Mount View Health Facility should downsize all 172 nursing home beds (due to over-capacity in the region), rebuild a new facility on its existing

campus, and add assisted living, adult day services and possibly other non-institutional services. The Berger Commission report cited several factors that contributed to its recommendations for Mount View, including:[36]

- A very low occupancy rate of close to 75% (97% is considered ideal for viability – 95% is acceptable);
- An old/outdated building;
- An uncertain financial viability.

The facility was losing approximately $2.5 million annually, and required subsidization from Niagara County, which the taxpayers could not afford indefinitely. The administrator and Legislature reevaluated their plan for privatization. Since there were no longer buyers at the table and privatizing was not an option, they considered whether they could repurpose the existing facility according to the vision of the Berger Commission Report. Since the new facility required substantial investment, there was no guarantee of money to support the transition and officials viewed the venture as risky, the Legislature determined in early 2007 to close the facility.

Closure Process

The county filed a lawsuit with the state soon after the findings of the Berger Commission because officials realized the burden of eliminating the beds could have left them on the hook for a facility with high costs of closure and no associated revenue sources. The state offered Niagara County about a quarter of the estimated closure costs, around $8 million of the $28 million total, to help with closing the facility. The nursing home administrator at the time was subsequently offered another job, leaving the county administrator to oversee the transition. In spring 2007, the administrator hired a person to facilitate the closure process. The official decision to close occurred in early July 2007, and the facility was finally closed at the end of December 2007.

The closure plan was regulated by New York State to ensure the well-being of residents met high standards. Under the direction of the transition leader, the county developed a plan using Microsoft Project identifying the tasks required for closure, regulatory requirements, and responsibilities to families and other stakeholders. Employees were given layoff plans, though few actually lost their jobs; most were redeployed to other areas of the county workforce. The county also developed a job

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[36] Berger, S. (2006). *A Plan to Stablize and Strengthen New York's Health Care System.* New York: Commission on Health Care Facilities in the 21st Century. Retrieved from http://www.nyhealthcarecommission.org/docs/final/commissionfinalreport.pdf

retraining plan for all redeployed workers. Each resident of the home had a transition plan and was assigned a social worker. Each individual transition plan was overseen by the state with regular outreach to families from social workers and from staff of their new nursing homes.

At the time of the Berger Commission report, there were 125 residents in the 172-bed facility. However, by the time the closure process was in full swing that number had dwindled considerably. Residents began moving out on their own and finding alternative placements. The county maintained its full operation throughout the closure process to assure there was no loss of service or continuity of care. All residents found an alternative placement if they required one. Almost all found placements in Niagara County, though a few went to Orleans or Genesee counties.

The county maintained ownership of the physical facility, though it was essentially mothballed. At the time of the writing of this report, the facility had a suitor to develop a Medicaid-eligible assisted living facility.

Impact

Though few if any counties seem to be seriously considering closure of their nursing homes, the experience in Niagara County of closing Mount View seems to have been reasonable in light of its unique circumstances.

Though the decision to ultimately close the facility was driven largely by the findings of the Berger Commission, it was clear for many years that the Mount View facility was not self-sustaining and was costing taxpayers millions of dollars to operate. Those interviewed for this report believe to a person that closure was ultimately the right decision for the County. Not only did it stop the bleeding in regards to the operational losses, it also saved millions of dollars to the County that was ultimately repurposed in other areas of the budget. The transition process was not easy, particularly for the frailest individuals. Closure of any facility must be done with the utmost care and sensitivity to the people who are being served. In the case of Mount View, there seem to be few if any major complaints with the transition.

Taylor Care Center, Westchester County

Multiple attempts to contact individuals with direct or historical knowledge of the closure of this facility were unsuccessful. Information that follows is from CGR awareness and newspaper articles from the time of the closure, in addition to the findings of the Commission on Health Care Facilities in the 21st Century (Berger Commission).

The Taylor Care Center (TCC) was operated by the Westchester Public Health Corporation, which also operated (and currently still operates) the Westchester Medical Center. TCC was originally a 321-bed residential health care facility which provided baseline services, including a 27-bed ventilator-dependent care unit and a 42-bed unit providing distinctive sub-acute care for individuals with complex medical needs. This unit received referrals from Westchester Medical Center, St. John's Hospital, White Plains Hospital, Montefiore Hospital, and Columbia-Presbyterian

Hospital. Beyond those two units, TCC was licensed for an additional 252 skilled nursing beds, but staffed only 156 at the time of the Berger Commission report, which cited TCC's low occupancy level as support for downsizing. TCC had a high case mix index (1.25), and provided solid quality of care. TCC at some point housed 10 uncompensated residents, adding to the county costs of operating the facility. Very few nursing homes, even county-financed homes, have more than one or two residents on charity care at any point. Due to its high-intensity care and several uncompensated cases, TCC operated at a significant loss of $6 million per year, which was down from as much as $13 million in previous years.[37]

The Berger Commission report determined that there was a significant excess of residential health care beds in Westchester County. This led to low occupancy rates county-wide among all nursing homes. The report recommended that Taylor Care Center downsize by approximately 140 beds to approximately 181 residential health beds. That reduction was achieved in 2007. In 2008, the Westchester Medical Center received approval from the NYS Department of Health to further reduce its number of residential health beds by 90, leaving it with 91 residential health care facility beds.

In 2009, the Westchester Medical Center received the second of two drastic fiscal year cuts in Medicaid funding. Nearly $75 million was cut over the course of two fiscal years, forcing a layoff of nearly 10% of the workforce. Leadership then determined that the TCC did not fit with the core mission of the Medical Center and was costing too much money and decided to pursue closure. Closing the facility was estimated to save the Medical Center approximately $8.5 million and determined to be a benefit to all the nursing homes in the region. *Since there was substantial capacity in other facilities (394 of 6,815 available beds), there was little concern that the 96 remaining residents would have any trouble finding placement in other locations*. The other goal at the time was to find placement for as many of the 195 staff of the TCC as possible within the Westchester Medical Center. The TCC was slated to close in spring 2009. It is not known how many personnel were ultimately transitioned.

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[37] Berger, S. (2006). *A Plan to Stablize and Strengthen New York's Health Care System.* New York: Commission on Health Care Facilities in the 21st Century. Retrieved from http://www.nyhealthcarecommission.org/docs/final/commissionfinalreport.pdf

Potential Lessons from Counties with Nursing Home Closures

Closure of county homes can make sense, but primarily in special circumstances: For example, in areas with low occupancy rates and excess nursing home beds, cases in which it may not only be possible to save money for counties but also to help streamline the overall health care system, as the state's Berger Commission envisioned. Nonetheless, care should be taken to transition residents to appropriate nearby facilities, and staff members and the larger community should be involved in discussions about the home's future and kept abreast of decision-making.