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STATES MOVE TO SHIELD LTC FACILITIES FROM CIVIL LIABILITY

EXAMINING SYSTEMIC FLAWS AND TRAGIC OUTCOMES

DEFUND NURSING HOMES NOW

REIMAGINING ELDER CARE: A CONVERSATION WITH THE GREEN HOUSE PROJECT

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SPECIAL REPORT

IS THIS A 9/11 MOMENT FOR LONG-TERM CARE?
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The novel coronavirus has swept through U.S. nursing homes like a three-alarm blaze, causing mass fatalities as officials struggled to contain it. To date, more than 50,000 residents of long-term care facilities have died from COVID-19 since January 2020.1 In 42 states, as many as 45 percent of all COVID-19 deaths were in long-term care facilities. In six states -- Delaware, Massachusetts, Oregon, Pennsylvania, Colorado, and Utah -- deaths in long-term care facilities accounted for over 50 percent of all COVID-19 fatalities.2

At the Life Care Center nursing home in Kirkland, Washington, at least 35 residents died from COVID-19 in March after the facility held a Mardi Gras party, despite that many residents exhibited severe respiratory illness symptoms and temperatures that registered off the charts. In Richmond, Virginia, a facility with a history of twice as many health deficiencies as other homes in the state reported 35 deaths by April 8, 2020. These fatalities continued to climb for months in facilities all around the country. Despite these horrific deaths, states are increasingly moving to allow long-term care facilities to escape accountability from civil and, in a few states, criminal liability for negligent acts resulting in the death or harm to a resident. The effort to escape liability, spearheaded by the long-term care industry, took hold even before it became clear that residents of long-term care facilities would suffer most from the COVID-19 outbreak.

To date, over 26 states have granted some degree of immunity from civil liability to long-term care facilities and health care providers.3 Three states have granted facilities and providers immunity from criminal and civil liability.4 Initially, the majority of states that granted immunity did so through executive orders signed by governors, but increasingly, state legislatures have passed such laws.

Although many of the executive orders and laws contain similar language, the breadth and length of immunity varies from state to state. Most of the orders and laws with immunity provisions bar actions alleging ordinary negligence. Those immunity provisions require that the resident or family prove that the facility acted recklessly, wilfully or wantonly, or was grossly negligent, sometimes used interchangeably.

For the most part, the executive orders and laws contain language that limits the immunity to the period in which the governor for the state declared a public health emergency due to the coronavirus. However, this period of time could prove to be years, and would only end when a state’s governor declared the emergency to be over. Further, there are concerns that the industry will use the pandemic as cover to push for future immunity from liability for negligent care.

Pandemic as cover

For years, the industry sought to limit or remove liability for substandard care. Now it is clear that the industry has seized on this public health crisis to pursue that objective. Advocates for nursing home residents say they are greatly concerned that the industry will seek to make permanent temporary immunity provisions to escape accountability for negligent care that occurs after the COVID-19 crisis ends. For instance, in Ohio, the legislature is considering a bill providing blanket immunity to long-term care facilities for all periods of times when the governor declared an emergency, not just COVID-19.

Congress seems poised to take up the issue. A sweeping bill introduced in May by Tennessee Rep. Phil Roe, M.D., would grant long-term care facilities broad blanket immunity from both state and federal claims of negligence. Senate Majority Leader Mitch McConnell has signaled that any future COVID-19-related relief bill must contain broad immunity provisions for businesses, including long-term care facilities. Potential federal legislation raises the prospect of precluding federal and state tort actions and also raises concerns that Congress may bar residents and families from bringing lawsuits regarding discrimination based on a resident’s race or disability. These suits, which generally seek injunctive or declaratory relief, often lead to systemic changes that cannot

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3. These states are: AK, AL, AR, AZ, CT, GA, HI, IL, KS, KY, MA, MD, MI, MS, MT, NC, NJ, NV, NY, OK, PA, RI, UT, VA, VT, and WI.
4. These states are: NC, NJ, and NY.
be addressed in individual tort claims. Although the House bill does not mention these types of claims, many advocates for residents of America’s long-term care facilities are gravely concerned about this issue. In its push for immunity, the long-term care industry has sought to portray COVID-19 as an unforeseeable catastrophe that excuses them from their basic standards of care. However, early data show a strong correlation between facilities with a history of poor quality of care and infection control procedures and COVID-19 outbreaks, according to the Centers for Medicare and Medicaid Services (CMS). For decades, residents and advocates have seen a steady decline in quality of care as more homes are bought up by for-profit corporations, which, through cost-cutting measures, seek to maximize profits from long-term care facilities. An analysis of federal and state data by The New York Times found that for-profit homes trail non-profit homes in many quality of care measures. The report also said that for-profit facilities were cited for violations at a higher rate than their nonprofit counterparts. Another study directly ties the purchase of nursing homes by investment organizations to decreases in staff hours and staff quality. In May, a U.S. Government Accountability Office report showed that prior to COVID-19 as many as 82 percent of nursing homes in the United States were cited for deficiencies, with half of those homes having persistent problems.

### Profits versus care

Older adults and their families are now seeing the direct result of what happens when profits are put in front of patients’ and residents’ care and wellbeing. The coronavirus has illuminated the devastation of these practices on our nation’s most vulnerable elders. Nevertheless, the industry is now seeking to be excused from its years of cost-cutting and inadequate care by urging states and the federal government to shield them from accountability while residents die alone by the tens of thousands. Allowing long-term care facilities to escape accountability for their negligent actions means that residents and families will have no recourse for egregious harm that happens during the COVID-19 emergency. Consider the impact of these laws and requests in the following two scenarios:

**Scenario 1:** A resident with dementia, diabetes, incontinence and limited mobility does not receive the care she needs. She is at risk of pressure ulcers. The facility fails to assist her with eating and drinking, does not keep her clean and dry, and does not reposition her regularly. She becomes malnourished, dehydrated and develops severe pressure ulcers, which become infected, resulting in sepsis. She is hospitalized and dies from the infection.

Even though this resident’s death is not coronavirus-related, in most states the facility may be able to avoid liability because the death occurred during the COVID-19 emergency. For instance, the New York law makes a superficial attempt to tie immunity to providers responding to the COVID-19 emergency. To avoid liability, the facility could tie its negligent act to its COVID-19 response, however robust or lacking that response was.

**Scenario 2:** A resident is living in a facility that has failed to properly train staff in infection control techniques. As a result, staff do not follow appropriate hand hygiene protocols and improperly don and doff personal protective equipment. In addition, the facility does not adequately screen staff for the virus. The resident contracts COVID-19 and dies.

Even though infection control practices, training and screening are completely in the facility’s control, the facility may avoid liability once again if it is able to make a connection to its response to COVID-19 and demonstrate that it was acting in good faith. These elements — requiring negligent actions to be tied to a facility’s COVID-19 response and good faith — are common in many state immunity laws and executive orders.

State immunity provisions create yet another significant barrier to pursuing legal action: For residents or families to prevail in court, it is likely that they would have to show that the facility’s actions or inactions were grossly negligent or reckless misconduct. This heightened standard of proof allows facilities to escape accountability for acting carelessly and may have the terrible effect of deterring some residents and families from seeking to hold them accountable. All 26 states that have granted immunity to facilities from liability have included this heightened requirement of proof.

### Civil liability as a tool

Discovery and fact-finding will be necessary to determine whether a facility’s actions or omissions, resulting in the death or harm of a resident, stemmed from its response to COVID-19. Further, determinations of good faith, recklessness or gross negligence will have to be made as part of any trial. All of this must be done in addition to the normal work that goes into prosecuting these incredibly difficult and time-consuming cases. These additional elements may have a chilling effect on the

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decision of residents, their families, and attorneys to take legal action.

Since the outset of the pandemic, hospitals, nursing homes, and other health facilities have complained of shortages of personal protective equipment (PPE) and sanitation supplies. The long-term care industry says facilities should not be held accountable for their negligence due in part due to PPE shortages. However, long-term care facilities are already afforded civil or criminal liability protections where shortages or other events outside of their control prevent them from obtaining necessary equipment. Facilities that made good faith efforts to comply with standard practices and to obtain necessary equipment, but were unable to do so due to shortages, will already be protected from liability in court. Instead, the industry is asking that all facilities -- whether or not they made good faith efforts to follow accepted practices and obtain equipment -- be excused from the harm their acts or omissions resulted in.

Immunity would impact residents in other extremely serious ways. Liability for inadequate care is not just about money. Civil liability has always functioned as a tool to incentivize long-term care facilities to comply with laws and regulations. For years, federal and state oversight of long-term care facilities has decreased. Often, facilities will choose to pay a federal or state fine in lieu of compliance because it costs them less. However, facilities have long known that care that departs from the accepted standards and results in the harm or death of a resident may result in civil liability, and this knowledge as served as a tool for residents to try and obtain better quality care. To deprive residents of this during this deadly crisis will inevitably lead to facilities’ failed compliance.

Additionally, the need for civil liability is heightened by the pandemic. In pre-coronavirus times, residents were visited by loved ones who paid close attention to the resident’s condition and spoke up when they had concerns. Entities such as the long-term care ombudsman program were able to meet with residents, observe conditions, and advocate on their behalf. And importantly, state survey agencies conducted inspections of homes on a regular basis and responded to complaints. Now, due to the pandemic, CMS has barred families and ombudsmen from entering facilities, and state survey agencies are rarely onsite. Consequently, there is little to no oversight in nursing homes.

The sad reality for many people who have lost loved ones in long-term care facilities during the pandemic is that by not being able to hold facilities accountable for their negligence, they will likely never know how their loved one died. Litigation is a vehicle to discover exactly what happened to residents in long-term care facilities. As a country, we have an interest in this information coming to light in part to be better prepared for a future pandemic.

Workers at risk

Allowing facilities to escape accountability for their negligence also places nursing home workers at risk, and as a result, the communities in which they live. In its efforts to convince states to grant long-term care facilities immunity from liability for their negligent acts, the industry has disingenuously tried to make immunity about protecting health care workers from such suits. However, these workers are rarely sued for negligence. It is the facility that most plaintiffs seek to hold accountable, not underpaid and over-burdened workers. Granting immunity for long-term care facilities makes workers unsafe because facility owners see fewer reasons to comply with regulations to curb infection risk.

It has also become clear that COVID-19 is having a disproportionate impact on communities of color. A study from Yale found that black people were 3.5 times more likely to die than white people. 9 A recent New York Times article found that the disproportionate impact of COVID-19 on non-whites is true for nursing homes as well. It said that homes with a significant portion of minority residents were twice as likely to be hit by the coronavirus than homes made up mostly of white residents. 10 Experts have attributed these stark numbers, in part, to racial inequalities in access to healthcare. Consequently, people of color are being harmed more than others in long-term care facilities, and it likely will be people of color who are most impacted by executive orders and laws that prevent nursing home residents from holding facilities accountable for their negligent actions. The result: immunity laws and executive orders perpetuate racial disparities in health care.

A call to action

Many lawmakers apparently fail to understand that granting immunity to long-term care facilities eliminates rights and protections of residents who have been seriously injured or killed. To-date, industry lobbyists have dominated the conversation. Lawmakers need to hear directly from long-term care facility residents, their family members and advocates about the critical

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Catch This Timely ABA Webinar: Piercing the Corporate Veil in Nursing Facility Litigation

Nursing facilities are increasingly structured as vast networks of related entities, designed to avoid liability and obscure profits. Understanding these labyrinths is critical when litigating against nursing facilities. This session will focus on how to pierce the corporate veil in nursing facility cases, using Single v. Pioneer Church Homes II as a case study.

It’s happening on August 20 at 1 pm EDT.

Learn more about the credit details and status of CLE application: Go to https://www.americanbar.org/events-cle/mtg/web/401069021/

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SPECIAL REPORT

It’s Time to Defund Nursing Homes

By Charles Sabatino*

Just as the Defund Police movement underscores the institutional racism that cries out for fundamental change, the COVID-19 pandemic ravaging nursing home residents underscores a deep-seated ageism inherent in our institutional model of nursing home care. It is time to defund the institutional model and replace it with a radically different model.

Today’s typical nursing home has never come close to meeting the public’s desire for humane and dignified long-term care. Warehousing large numbers of frail elders in hospital-like buildings with residents in double or triple rooms, and staff turnover as high as 100 percent, unavoidably creates a high risk for resident safety and compromises quality of care. Even before the pandemic, 82 percent of all nursing homes had infection prevention and control deficiencies cited in one or more years from 2013-2017, according to the U.S. Government Accountability Office. Forty-eight percent had such a deficiency cited in multiple years.

Despite the $90 million paid annually by Medicare and Medicaid to nursing homes, and exacting regulatory requirements addressing quality of care and quality of life for the nation’s 1.3 million nursing home residents, we as a society have failed to keep frail elders safe – let alone in an environment that any older adult looks forward to. Data from the Centers for Medicare and Medicaid Services indicate that, as of the end of May, over 32,000 nursing home residents had died in the 88 percent of nursing homes that reported data.

Other analyses have reported nursing home resident and staff deaths represent 40 percent of the nation’s COVID-19 deaths, and in some local areas, as high as 75 percent. As a result, multiple recommendations for change have gained attention, such as ensuring adequate personal protective equipment; disaster plans that facilitate quarantining; more and better trained staff; and heightened monitoring and oversight of care. Let’s be clear: These measures do little more than rearrange the deck chairs in a failing system. The COVID-19 pandemic is a 9/11 moment for nursing home care and a test of our ability to reimagine nursing home care that puts the “home” into nursing homes.

As the largest payor for nursing home care, Medicare and Medicaid hold the key. Now is the time to change facility requirements to gradually limit participation in the program only to facilities that provide the following:

- Small home-like facilities
- Single rooms and bathrooms
- A flattened, more flexible staff hierarchy with cross-trained staff
- A culture focused on residents’ goals, interests and preferences first

Fortunately, there is already a model for this kind of facility: the Green House Project, represented by 300 facilities nationally, each with 10 or 12 residents who have single rooms and private baths. The facilities are designed around a living room with fireplace and an open kitchen where meals are prepared and shared. The cross-trained staff, backed by nurses and doctors, engage personally with residents, serving as nurse aides, cooks, cleaners, and participants in meals and social activities. Not surprisingly, staff turnover is far below that of traditional nursing homes.

Of most importance to policy makers, Green House Project homes have a strong evidence-base showing high resident, family, and worker satisfaction; better quality of care and quality of life; costs comparable to traditional nursing homes; and in the midst of the current pandemic, a much greater ability to prevent and contain illness.

Data collected in ongoing research has revealed only 32 confirmed resident cases and one resident death as of June 30 in a sample of 2,384 residents in 229 Green House homes providing skilled nursing.

As long as the nursing home industry can rely on the flow of federal money for the current model of care, it has no financial incentive to change, not even after the coronavirus catastrophe. Change that flow, and a major cultural change in long-term care will follow.

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The coronavirus pandemic illuminated the systemic deficiencies in long-term care facilities in the United States, resulting in the deaths of tens of thousands of residents. Advocates, civic leaders and others are debating whether the catastrophic events created by COVID-19 will drive reforms, and alternatives, to LTC facilities. We’ve seen how these settings increase the spread of infection. Will shared bedrooms and bathrooms, large wards, common dining facilities and large buildings ultimately be relegated to the past?

In the early 2000s, Bill Thomas, M.D., a geriatrician, sought to transform elder care with an alternative to the sterile, hospital-like nursing home settings in which thousands resided. He founded the Green House model, and the resulting nonprofit Green House Project, which was responsible for replicating that model across the country. The project began as a collection of one-story homes with gardens and porches, situated in campus-like communities around the nation. Each house accommodates up to 10-12 residents with private bedrooms and bathrooms.

Residents in Green House properties apparently fared much better during the pandemic than those in traditional long-term care facilities. An analysis in USA Today suggested that up to 40 percent of deaths from COVID-19 took place in nursing homes or long-term care facilities, totaling about 40,600 residents and workers. The analysis, published on June 2, examined the death toll over the prior three months. By contrast, data collected from 256 of 268 Green House properties showed 47 cases and four deaths from COVID-19 between Feb. 1 to May 31. (This included skilled nursing and assisted living facilities.) Green House officials said they were working to collect data from the remaining properties.

BIFOCAL talked with Susan Ryan, senior director of the Green House Project, in June about the future of long-term care in the wake of the coronavirus, and the growing prospect that Americans reaching older ages will demand sound alternatives.

BIFOCAL: The coronavirus outbreak was catastrophic for residents and workers in long-term care settings around the nation. The spread of the virus underscored the infection prevention and control deficiencies that have plagued many facilities for years. Do you believe the heartbreak from the pandemic will lead to positive change in the industry?

SR: My hope would be that this is a profound wake-up call and an opportunity for policy makers, regulators and society at large to take a look and see that we’ve been warehousing [the elderly] for a long time. This pandemic has shone a light that we never had before. We need to establish a coalition of stakeholders – policy makers, regulators, providers -- and tap into their expertise for what could work. We need to ensure we are looking at this systemically and that we don’t endeavor to apply quick fixes to make it better. We need to think about how did we get here and why did we think warehousing was OK?

The Centers for Medicare & Medicaid Services this week said they’re going to impose more fines to nursing homes for violations of infection control. It’s the blame game. You’re not going to punish your way to change and improvement from a quality perspective. We need to look at what worked in the pandemic, what have we learned, to drill down and take those lessons learned and have a broader application to policy and regulation and the like.

BIFOCAL: What will it take to reimagine elder care?

SR: We are getting ready to launch a podcast and we’re interviewing people about what their vision is and a call to action to elevate elder care. I like the idea of a task force. I’d caution we avoid quick-fix things. Self-awareness as individuals, and for those of us who are Boomers, we see ourselves as change agents and are willing to take a stand. If there’s hope for a generation to bring meaningful change to an industry, I think Boomers are well suited to do it. We’ve got to have a reformation in long-term care. We can’t go back to normal because you’re only as good until the next pandemic or whatever else comes along.

BIFOCAL: If the Green House Project is a model for the future of long-term care, or one example of how elder care can be reimagined, why hasn’t your model caught on more? Is affordability for residents a factor? What about incentives for developers and providers?

SR: There’s a misperception that the model is not cost-effective. Providers say, I can’t spend capital for 10 to 12 people in this model; there is no cost efficiency. And I can tell you that you can. You actually can gain efficiency by having greater occupancy. The occupancy rates are far higher than in traditional homes. And this is where you want your loved one to be in a COVID-19 environment. Three- to four-person rooms should never be an option. They should be forbidden. Private rooms with your own bathroom give you dignity and the infection control gives you a leg up.

It’s important to me we don’t create a model for those who have the wherewithal to pay privately. We want it to be affordable and fit in Medicaid structure – 42 percent of elders living in Green House homes were supported by Medicaid. In some states Medicaid reimbursement is higher. What can we do to incentivize this? The ability to attract private pay in your payer mix – Medicaid, Medicare, private pay; getting the mix right is important to viability. Creating special financing opportunities to incentivize providers to do this affordably is important.
BIFOCAL: You talk about person-centered care in long-term care settings. Tell us more.

SR: You gain so much efficiency when you see people as individuals and you understand what they need. It sounds over-simplified but person-centered care in the Green House model is about creating deep, knowing relationships that see each person as an individual with unique needs -- and that translates into better quality of life experiences and good outcomes clinically and financially. The Green House has two consistent caregivers working with the same 10-12 people every day. When I get to know what Mary likes, and what she wants to eat, her care and living is optimized. If she’s not looking as well today, I can ask a nurse to take a look at her. We can intervene and address something earlier than when it’s so full blown that she has to go to a hospital.

Can an App Make a Difference Between Life and Death? Yes, it Can

It was the phone call Sandra was hoping never to get. Her father, who lived 900 miles away, was in a hospital’s Intensive Care Unit. His condition was dire. Hospital officials wanted to know whether he had an advance care directive. They asked her about the medications he’d been taking. Who was his cardiologist? Did Sandra have her father’s health insurance information? Was she his health care proxy? Did she have a signed copy of his wishes?

Sandra, trembling, tried to answer the rapid-fire questions but couldn’t remember all of her father’s prescriptions, nor could she recall his cardiologist’s name, let alone his contact information. She had a copy of the advance directive, but she was in Virginia and her father was in Florida. Now what?

Medical emergencies like these play out in hospitals and in living rooms across America routinely. As families are spread far and wide, a pandemic barreling through communities has made situations in which medical information is needed suddenly and immediately even worse.

Now there’s an app that can help.

Mind Your Loved Ones, or MYLO, is a mobile app that enables people to store and manage their own and their loved one’s critical medical information and advance care planning documents on their phone or tablet. Having quick access to one’s medical information -- in the event an emergency situation arises, or even during a routine medical appointment – can feel reassuring. The app was recently released in cooperation with the American Bar Association Commission on Law and Aging.

The medical information stored on one’s device can be viewed, printed, faxed, or emailed directly from the app. Naturally, its greatest value is in the sharing of information with loved ones who could be caregivers or health decision-makers. Other highlights include:

- Key information such as medications, physician contacts, insurance information, medical notes, health care advance directives and more can be stored on the app.
- There is no limit to the number of profiles that can be stored on a device. You decide with whom to share the information and can do so either through email or a simple process that uses Dropbox to transfer your profile to another’s phone or tablet.

The app is available as an annual subscription. The retail price of the app in the Apple Store or Google Play is $9.99 per year, but anyone can purchase the app for a discounted price of $7.99 through the ABA at the following link: https://www.americanbar.org/membership/aba_advantage_discounts/mylo/.
Examining Systemic Deficiencies, Tragic Outcomes in LTC Facilities

By Marianne Udow-Phillips and Robyn Rontal

The challenges of coping with a deadly coronavirus outbreak in nursing homes drive home the need for systemic change. The COVID-19 pandemic has disproportionately affected nursing home residents and staff, and illness and fatalities will likely continue to mount until effective treatments and vaccines are available. As of June 18, 2020, long-term care facilities in the U.S. reported more than 240,000 cases and 50,000 deaths from COVID-19. That means less than 1 percent of the population resides in long-term care facilities yet residents and workers account for about 40 percent of all COVID-19 deaths in the U.S. Now is the time to examine systemic issues that have plagued nursing homes and led to tragic outcomes, and consider deep reforms that would improve the quality of care and life for residents.

Concerns about the quality of care in nursing homes are not new or specific to COVID-19. Various studies and regulatory oversight have identified long-standing issues with infection control and staff shortages in nursing homes. In 2017, approximately 40 percent of Medicare/Medicaid-certified nursing facilities surveyed by state regulators had at least one infection control program deficiency, the most common deficiency reported to the Centers for Medicare and Medicaid Services (CMS). In six states -- California, Michigan, Illinois, Missouri, Mississippi, and Delaware -- infection control deficiencies were reported in more than half of all facilities.

COVID-19 has also highlighted deficiencies in the current quality oversight and regulatory processes. For example, CMS has rated nursing homes on quality since 2008 using a star ratings system intended to help consumers choose a facility based on a defined set of quality measures. The coronavirus outbreak underscored the limits of the star rating system. In early CMS data, nursing homes with high star ratings failed to demonstrate significantly lower rates of COVID-19 cases compared with facilities with low star ratings.

COVID-19 has also brought into sharp focus the lack of data captured at the state and federal level about nursing homes. Consumers have had difficulty learning the number of COVID-19 cases and deaths in particular facilities. Data collected by officials is often confusing, inconsistent, and incomplete. Without comprehensive and accurate data, interventions to improve outcomes and quality are limited. Also, consumers have difficulty discerning how risky a particular facility might be.

3 Chidambaram, Data Note: How might Coronavirus Affect Residents in Nursing Facilities?
A recent study from Harvard University noted that larger facility size, greater percentage of African American residents, urban location, and non-chain status were significantly related to increased probability of COVID-19 cases, whereas CMS five-star rating, prior infection violation, Medicaid dependency, and ownership were not.8

Opportunities for improvement

Long-standing research, along with what we’ve learned from the COVID-19 outbreak, provide a strong road map for improvement opportunities in nursing homes.8 Among the reforms:

- Regulatory changes are needed to provide better oversight of the quality and procedures within nursing homes. CMS has already begun to make some regulatory changes.9, 10
- Enhanced data reporting and information systems are essential for states and local officials to know where to target resources in crisis situations and for staff, families, and individuals to have more transparency about the risks within particular nursing homes. CMS and states are beginning to require and publish this data.11
- Resources, including more personal protective equipment, more guidance on best practices, and assessment tools for compliance with infection control need to be directed at nursing homes to help keep residents and staff safe from infection.12, 13

The physical structures of nursing homes need to change. Smaller environments with fewer residents have been shown to curb spread of infection.14

Moreover, the financing of nursing homes in America needs to be reimagined. Unlike many other countries, the U.S. has no comprehensive approach to long-term care. Nursing homes in the U.S. perform multiple roles, from short-term rehabilitation of an acute injury or illness to long-term custodial care. These services are paid for through multiple funding streams with different

8 Institute of Medicine (US) Committee on Improving Quality in Long-Term Care, summary to Improving the Quality of Long-Term Care, eds. GS Wunderlich and PO Kohler (Washington, DC: National Academies Press, 2001), https://www.ncbi.nlm.nih.gov/books/NBK224506/.
10 On June 1, 2020, CMS announced that (i) funding to States based on the Coronavirus Aid, Relief and Economic Security (CARES) Act will be tied to performance on nursing home infection control surveys and (ii) the penalties for nursing home infection control deficiencies will be increased to between $5,000 - $20,000 per instance. “COVID-19 Survey Activities, CARES Act Funding, Enhanced Enforcement for Infection Control deficiencies, and Quality Improvement Activities in Nursing Homes,” CDC, accessed on June 24, 2020, https://www.cms.gov/files/document/qso-20-33-all.pdf.
14 On May 22, 2020, HHS announced the distribution of $4.9 Billion in relief funds directly to SNFs. Nationally, all facilities with six or more certified beds will receive a baseline payment of $50,000, plus an additional $2,500 per bed. These funds can be used to address needs such as staffing, workforce training, testing, reporting, acquiring personal protective equipment, and other expenses directly related to the pandemic. HHS, “HHS Announces Nearly $4.9 Billion Distribution to Nursing Facilities Impacted by COVID-19,” News release, (May 22, 2020), https://www.hhs.gov/about/news/2020/05/22/hhs-announces-nearly-4-9-billion-distribution-to-nursing-facilities-impacted-by-covid19.html.
rules, payment levels, and criteria for coverage. Because funding comes from a variety of payers, all with different rules around eligibility, quality measures and reimbursement incentives, nursing homes have designed structures that may not be in the best interest of public health. For example, many nursing home patients have both Medicare and Medicaid coverage. Because Medicare and Medicaid cover different services with different rules, there is no one entity that is responsible for the oversight, quality of care or cost of the entire care for these patients within a nursing home.

Today, Medicare and most private health insurance plans cover only a skilled level of post-acute care at nursing homes. Medicare covers acute skilled nursing and rehabilitative care for a maximum of 100 days per illness, within 30 days of a hospital stay that lasted at least three days (the three-day requirement is currently being debated but the requirement for nursing home care being limited to post-acute inpatient care is not).

Medicaid is the only public funder of long-term care that does not require nursing home care to be connected to a hospital stay. But while Medicaid’s coverage is broad, its payment is low. Private insurance also exists for long-term care, but very few seniors have such coverage and benefits are often limited. About 13 percent of people aged 65 and older are estimated to have private long-term care insurance. Private-pay residents pay approximately 25 percent more per day for nursing home care than Medicaid pays; Medicare pays almost double the Medicaid rate for nursing home residents receiving rehabilitation services. Therefore, long-term care facilities must make sure that there are enough Medicare and private pay residents in their facilities, with higher margins than Medicaid, for financial solvency. Facilities that are more reliant on Medicaid residents are more likely to close, have lower-paid staff, and face more staff shortages and turnover.

Nursing homes have employed a variety of strategies to attempt to stay solvent, including selling their facilities to private equity and leasing them back. These strategies may work in the short term to provide liquidity but mean that nursing homes have less ability to restructure their physical plants than they would if they maintained ownership of their facilities.

A better model of care would segment nursing home facilities and care to target specific types of need. In this model, there would be nursing homes designed to work with residents in need of shorter-term, acute care with a focus on enabling a return to independence at home or in the community. There would also be separate facilities designed to provide subacute care services with a different physical design for residents who need long-term support for activities of daily living. Facilities oriented to subacute care can have more physical separation and smaller patient units since clinical oversight is less critical.

Such a structure could be better integrated with hospital systems to take a population health approach. In this approach, new models of care that have developed through the COVID-19 experience to date, like telehealth and hospitals at home (i.e. hospital level of care provided in a patient’s home) could be better deployed through an integrated system with nursing facilities.

17CBO, Rising Demand for Long-Term Services and Supports for Elderly People.

21Kacik, “COVID-19 Pandemic Proves to be a Pivotal Moment for Senior Care.”
Such a rethinking of nursing home structures would also require a rethinking of Medicaid reimbursement, Medicare coverage, and private health insurance. Better coordination between Medicare and Medicaid is needed, with an emphasis on the population that is eligible for both Medicare and Medicaid (the “duals”) so that innovative approaches can be taken and care and coverage can be seamless and coordinated. Also, new models of private coverage will be needed to ensure that our aging population does not become destitute when long-term care services are needed.

Moving forward

New and promising models are developing along these lines:

- Medicare Advantage Special Needs Plans (SNPS) are a model to build upon
- Expansion of eligibility in proven, effective programs like Programs of All-Inclusive Care for the Elderly (PACE), which provide care in the community as an alternative to nursing homes
- New approaches to Accountable Care Organizations can be used to encourage better integration of hospital and nursing home care
- States are experimenting with conflict-free “options centers” to provide consumers with more transparent information to better navigate the long-term care services and programs in which they are eligible
- CMS has allowed states to apply for innovation waivers for Medicaid long-term care as part of the response to COVID-19. These new waiver models, such as Michigan’s MI Health Link program, provide more integration of acute and long-term care with strong care management and can be built upon to provide a stronger long-term care system for the future

Seniors want to remain at home and be as independent as possible for as long as possible. COVID-19 has vividly exposed the cracks in our current system. What we’ve learned can be used to point the way to a future of integrated design changes and a comprehensive public policy framework for long-term care.

Investment in this system will be needed. But given the mass casualties and harm stemming from COVID-19 in the current environment, an investment is one we must make now and into the future.

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Canada: Socialized medicine. Hockey. Snow. More hockey. Maple syrup. Stable. Wealthy. Caring. The polite people who live next door. When the world thinks of Canada, these might be the images that come to mind. However, these images were vastly changed when COVID-19 ravaged nursing homes in two of Canada’s most populous provinces, Ontario and Quebec, and the Canadian military was called in to provide care services to 29 LTC facilities. What the Canadian military found in those LTC homes -- residents who hadn’t been fed for days, filthy and crying out for help -- horrified even seasoned veterans, who in some cases said it was worse than what they had seen on battlefields.

COVID-19 hit Canada in mid-March and it has taken four months to significantly flatten the curve across the country. As a nation, we are looking with great worry at a second wave expected in the fall. As seniors’ advocates, we are trying to understand an oft-quoted “new normal,” which means living with COVID19, rather than trying to avoid or defeat it.

LTC is part of Canada’s socialized health care system, but not in a straightforward way. When the original governing legislation for the publicly funded health insurance, the Canada Health Act1 was passed in 1984, LTC did not substantively exist in the format we think of now.2 With the average age of death at 76 years, much of the end-of-life “nursing” care was provided at home, or if necessary in an extended-care hospitalized setting.3 Simply put, the founders of Canada’s publicly funded health insurance never imagined the additional decades of longevity, the degree of frailty of the oldest old, nor the need to include LTC as we now think of it into the Canada Health Act.

What this translates to is a very different experience for users of Canadian hospitals or medical services compared to users of Canadian LTC. In Canada, all that one is required to do to receive hospital or medical services is to show one’s provincial health card. While there may be some quite modest charges for assistive devices like crutches or costs for ambulance transfers, and some procedures may be elective and not covered by universal health care, on the whole, Canadians generally go to publicly funded hospitals or doctors’ offices, receive publicly funded health care services and return home without thinking twice about it, and none the poorer.

However, without this truly universal health care coverage for LTC, Canadians receive LTC from a mix

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1 Canada Health Act, R.S.C., 1985, c. C-6
of not-for-profit and municipal (local government) organizations or for-profit companies, including smaller family-run homes as well as large well-known companies.

While the exact funding model varies from province to province⁴, generally the resident pays a daily housing rate (often $60-90), which is based on a calculation of the age and services of the building and the type of room (four-room, two-room or single occupancy). Subsidies are available from the provincial government. No one will be denied LTC based on an ability to pay nor can a person be evicted for non-payment of fees. The government transfers a pot of funding to provide for the “nursing” part of the nursing home budget, which covers everything that is not part of the “housing” component. This is the same regardless of the ownership (non-profit, municipal or for-profit) of the home. Financial profits are supposed to be realized through additional services not covered in the socialized LTC model.

### Ontario’s LTC (LTC) situation (February 2019)⁵

- 626 homes are licensed and approved to operate in Ontario
- 58% of homes are privately owned, 24% are non-profit/charitable, 16% are municipal
- About 40% of homes have 96 or fewer beds
- About 300 homes need to be redeveloped to meet safety codes or other structural improvements (more than 30,000 beds)
- The average time to placement is 161 days

The wait list for long-stay beds, as of February 2019, was 34,834. While people are waiting for LTC home beds, they are often caught in a limbo – either waiting in acute care hospital beds, causing them to be known as “bed blockers,” or they are waiting at home with home care services, which do not adequately meet their needs.

Ontario has created a new category of people waiting for LTC home beds, known as “Alternative levels of Care” (ALC). Seniors who are ALC are often housed in otherwise unused hospital wings, sometimes in retirement homes or wherever there is space in the system.

### Outbreak in British Columbia

British Columbia’s Provincial Health Officer Dr. Bonnie Henry declared an outbreak of COVID-19 in early March in North Vancouver, British Columbia (BC), on Canada’s Pacific Coast. By late March 8, the first LTC resident died. Within 14 days, seven more residents died, and 36 residents and 18 health care workers tested positive.

In what would become a model for proactive response, the province of British Columbia under Dr. Henry’s leadership took several immediate steps:

She stopped all visits to LTC homes, enacted a requirement that staff only work at a single health care location, transferred funds to top up salaries to allow LTC facilities to turn multi-site part-time workers into single-site full time employees, created a direct telephone phone line for personal protective equipment (PPE) to get to LTC homes and prioritized PPE and testing to both LTC and acute care settings. This became the formula for a successful response in LTC and flattened the very dangerous curve. Unfortunately, this BC response model was not

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⁴ For example the model in Ontario is explained at: https://www.ontario.ca/page/get-help-paying-long-term-care

⁵ “This is LTC 2019” Ontario LTC Association: https://www.oltca.com/OLTCA/Documents/Reports/TILTC2019web.pdf
replicated across the country. As each province has its own health system and provincial health officer, as well as its own government and approach, a patchwork of responses led to a lack of coordinated response.

Raising the alarm

Advocates quickly turned to the largest provinces, Ontario and Quebec, and began raising the alarm bell to an even greater degree. Reliable, accurate information was sorely lacking in Ontario and Quebec and so were the policy responses. Outbreaks in these provinces started quickly and only got exponentially worse. Provincial responses varied⁶. Unsurprisingly, where early action was taken, the COVID19 virus was better managed.

Advocates at CanAge⁷, the Advocacy Centre for the Elderly⁸, the National Initiative for Care of the Elderly, the National Institute on Ageing⁹ and others emerged as leaders in this public health crisis and began creating downloadable tools to help people decide whether to remove a loved one from LTC¹⁰. Helpful trackers were created by the Toronto Star¹¹ and think tanks also created trackers for deaths, infection rates, locations and spread.¹²

Commissions have already been announced into LTC in the near future for Ontario and Quebec. In Ontario alone, there are four types of commissions or investigations announced. The federal government has so far stopped short of announcing a commission or inquiry but has indicated several times during daily briefings by the Prime Minister Justin Trudeau that answers would be sought. There is hope that the findings of the various commissions will lead to substantive change and a sense that Canada has reached a watershed moment in its LTC system. However, advocates and experts in the sector are consistently reminding government that the solutions to LTC in Canada are well known, and that there is no need to wait to implement changes such as staffing, funding transfers and investments in the physical structures of LTC buildings.

Ontario and Quebec LTC facilities did close for visitors at the beginning of the outbreak but few of the other steps modeled by BC were taken. For instance, the Ontario Chief Medical Officer of Health, David Williams, continually refused to prioritize PPE or testing in LTC homes in Ontario despite escalating pleas from advocates, families and seniors. Indeed, it was not until Ontario Premier Doug Ford announced that a new “COVID-19 Action Plan”¹³ effective April 22 that steps by BC would be implemented in Ontario LTC homes, including:

- Enhancing testing for symptomatic residents, staff and those exposed to COVID-19; expanding screening of asymptomatic contacts; and leveraging surveillance tools to enable care providers to move proactively against the disease
- Supporting LTC homes with public health and infection control expertise; providing training and support for staff working in outbreak conditions
- Redeploying staff from hospitals and home and community care to support the LTC workforce and respond to outbreaks, along with ongoing recruitment initiatives

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⁶ https://www.nia-ryerson.ca/covid-19-long-term-care-resources
⁷ www.canage.ca
⁸ www.acelaw.ca
⁹www.nia-ryerson.ca
¹⁰ https://www.canage.ca/resources On busy days, media requests to CanAge were commonly in the 15-25 interviews a day range. Media impressions for CanAge alone topped 10 million hits in under 3 months.
¹² https://www.nia-ryerson.ca/covid-19-long-term-care-resources
Within less than 48 hours, the government announced it would also immediately act to deliver the same or similar measures. The reality of this plan was starkly different from the ambitious tone and goals stated above. In fact, testing remained far less than required or promised, PPE did not get deployed efficiently, and staff recruiting measures remained subpar.

Ontario and Quebec: from bad to worse

With the spread of COVID-19 out of control in Quebec’s LTC homes, the Premier of Quebec François Legault took the unprecedented step of calling on Prime Minister Trudeau to send military troops to work in their worst-hit homes on April 22. Ontario followed suit the same day. More than 1,000 members of the Canadian Armed forces were sent into the worst-hit homes.

The military was so appalled at the conditions in those homes that they sent a whistleblower report to the federal government, first for Ontario on May 20, and then for Quebec shortly after. The Ontario report was particularly horrific, detailing cases in which residents hadn’t been fed or bathed and were crying out for help. One resident was forced-fed, choked and died. Cases of cockroach infestations, poor hygiene, people being left in their own feces for hours or days were also detailed. Prime Minister Trudeau, visibly shaken during his daily briefing, called the report deeply disturbing and said, “We need to do a better job of supporting our seniors in LTC right across the country, through this pandemic and beyond.”

Canada vs OECD countries

The Canadian Institute for Health Information (CIHI) is the key organization in Canada for reliable non-partisan health information. In a recent report it found that as of May 25, only about 18 percent of cases of COVID-19 were in LTC homes but accounted for about 81 percent of all measured fatalities. The study found that while Canada’s overall COVID-19 death rate was fairly low compared with other Organization for Economic Cooperation and Development (OECD) countries, it had the highest proportion of deaths occurring in LTC. Indeed, Canada at 81 percent was nearly twice the rate of LTC deaths to the average OECD country. Perhaps because of its very large geographic size (9.9 million square kilometres or 3.8 million square miles), the CIHI snapshot’s finding that variation amongst Canada’s provinces and territories was greater than variation among OECD countries should not be completely surprising. Indeed, as of May 25, Newfoundland and Labrador, Prince Edward Island, New Brunswick and the territories had no reported deaths in retirement homes or LTC facilities. By contrast, LTC home deaths accounted for 70 percent of all COVID-19 deaths in Quebec, Ontario and Alberta and 97 percent of all deaths in Nova Scotia.

Indeed, Canada at 81 percent was nearly twice the rate of LTC deaths to the average OECD country.

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15 For example: https://www.youtube.com/watch?v=MwryQWKF8bs
16 https://www.youtube.com/watch?v=s0nWX5F8dxk
18 Canada was compared to Australia, Austria, Belgium, France, Germany, Hungary, Ireland, Israel, Italy, the Netherlands, Norway, Portugal, Slovenia, Spain, the United Kingdom and the United States. The OECD average was 42 per cent of deaths in LTC with Hungary a low seven per cent, the U.S. at 31 per cent, Italy at 32 per cent and Spain at 66 per cent.
19 Supra, 16 at page 2.
As of June 30, most LTC homes in Canada remained substantively closed to visitors. Alberta began instituting outdoor visits earlier than most provinces, followed by Quebec. Ontario finally allowed some outdoor visits on June 18\(^{20}\). This required visitors to be subject to strict health and safety protocols, including passing screenings at each visit, confirming they’ve tested negative for COVID-19 within the previous two weeks, and complying with infection prevention and control protocols (including wearing a face covering during visits).

Additionally, LTC and retirement homes, as well as other residential care settings, must meet the following conditions before they welcome visitors:

- Homes must not be in outbreak
- Homes must have an established process for communicating visitor protocol and safety procedures
- Homes must maintain the highest infection prevention and control standards.

Indoor visits to LTC homes in Ontario were promised a week after the state of emergency was lifted. For many families who have not seen their loved one, that feels like a time with no end in sight. Some called for a more standardized “Essential Caregivers Program” for LTC in which designated family or friends could be identified as part of the resident’s essential care team, provided with training and then given an identification badge. This type of caregiver would be then allowed inside an LTC home, possibly even if the home was in outbreak. Staff would then assist with donning and doffing the PPE required and to oversee infection control.

During the time of COVID-19, there have been significant calls for an end to the for-profit model. Officials are now discussing if Canada should include LTC services in its Canada Health Act, which would end all private ownership of LTC in Canada. It is a very appealing argument and currently very popular\(^{21}\). However, right now, approximately 50 percent of all LTC home spaces are provided by for-profit homes, and with a shortage of beds, it seems unclear how moving to shut the for-profit model would affect those spaces. Dr. Pat Armstrong, a leading expert in LTC in Ontario, suggested that the Canada Health Act could continue to oversee universal health care in its current state. A new parallel piece of legislation might be drafted, which would cover LTC and include it in universal health care, without triggering a constitutional amendment and possible constitutional crisis. Provinces rarely, if ever, voluntarily cede power to the federal government, which is what it would take to include LTC in federal purview. In the time of a minority government, seems an unlikely path forward in practical terms at this point. However, just the fact that the provincial and federal government are even in discussions about opening up a constitutional amendment is nearly unprecedented and speaks to the severity of the impact that COVID-19 has had.


both on the LTC population, but also the psyche of the Canadian public.

Prime Minister Trudeau pledged to work with the provinces to bring in national standards and extra funding but made clear that provincial governments are directly responsible for nursing homes. He said, “This pandemic has shown from the beginning that the job isn’t being adequately done.”

A call for standards

Calls are being considered by all levels of government to have national quality standards for LTC, which do not exist by agreement or any form of legislation. Currently, it is up to each province to implement such legislation. In thinking about whether Canada should have standards and what those standards should entail, the Australian model is being closely considered as it is a country with a similar division of governmental powers and a similar mix of public and private-funded LTC facilities. Key aspects of that model include not only national standards, but also a national oversight body with the ability to regulate, license, fine or take over management of a non-compliant home.

It is expected that any such standards would include staffing ratios; professional staffing mixes; training standards for each level of staffing; medication protocols; building standards, including mostly single rooms with private bathrooms; heating and cooling requirements; inspections; disaster response; abuse prevention and reporting; infection control; vaccine distribution and uptake; dementia training and associated resources.

Fixing LTC in Canada has become an urgent issue. While governmental commissions and inquiries and ombudsman reviews are starting up soon, it is important to remember that we do not need to wait to take needed steps. The recipe for improvement for LTC is clear.

Fix Funding. It is painfully clear that the provinces cannot, or will not, fund the perpetually cash-starved LTC sector. Dedicate and transfer appropriate federal funds to the provinces for delivery of LTC home services but have those federal funds tied to meeting national quality standards. Create a federal LTC Home Regulatory Authority and tie funding and licensing to this body; work closely with the provincial governments to ensure support.

Fix Staffing. Improve wages, benefits and create pensions. Pay the same level of staffing the same amount no matter if they work in hospital, home care or LTC. Provide full-time, single-site jobs. Create incentives to enter the field such as educational grants. Add geriatric care expertise to Canadian immigration priorities to attract newcomers with this needed skill set. Put doctors and add registered nurses back into LTC facilities. Increase the number of skilled professional staffing ratios by inverting the current trend of downshifting medical care to often inconsistently trained, poorly paid personal support workers and aides. Train all medical professionals with mandatory geriatric training and placements. Give staff paid sick days and ensure they do not come to work sick. Train and certify essential caregivers as key, albeit unpaid, part of the care team.

Fix Buildings. Make needed upgrades to facilities. In Ontario alone, we stand to lose 30,000 of about 78,000 LTC beds because they will not pass fire safety standards in five years. Create dedicated “swing space” for residents to live in while their original rooms are being upgraded. Eliminate multi-person ward rooms and shared bathing facilities. Upgrade HVAC systems and install air conditioning in all resident rooms.

Fix Infection Control. Ensure that all residents are vaccinated for flu, shingles, pneumonia, under Canadian National Advisory Committee on Immunization (NACI) recommendations.

Revamp Canada’s vaccine approval, purchase and distribution systems and test them by integrating the vaccines we already have that are proven effective, so that we can have a system in time for a much-hoped-for COVID-19 vaccine. Create effective supply chain management and integrated data systems for procurement of PPE and needed supplies, using the Alberta model.

**Fix the Institutional Model.** No one wants to be in a large institution. Move away from the medical, institutional model to an emotion-focused model, such as the Butterfly Model, the Eden Alternative, the Green House model and others. Adopting one of these transformative models of care makes residents and staff happier and safer, while also creating person-centred supports for aging.

LTC homes in Canada can get better. We know what needs to be done. We simply have to do it. And with most of Canada’s LTC homes still in isolation and a second wave of COVID-19 possibly around the corner, we had better start right away.

About the author

Laura Tamblyn Watts is the CEO of CanAge, Canada’s National Seniors’ Advocacy Organization. She teaches Law and Aging at the University of Toronto.

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Please direct all questions about the scholarship program, and submit all applications, to David.Godfrey@Americanbar.org

Scholarship applications are due July 30, 2020.

Meet COLA’s New Summer Interns

Sarah Kolick

Sarah Kolick is a rising second-year student at the George Washington University School of Law in Washington, D.C. She graduated from Smith College in 2019, where she double majored in east Asian languages and government. She studied Chinese, Japanese and Korean and completed an honors thesis in which she extensively researched Zimbabwe’s Marange diamond fields, the blood diamond trade and ethical certification schemes in the diamond industry.

Sarah’s passion for advocating for elders’ health care rights was sparked by watching her mom and aunt take care of her grandparents and great aunt near Cleveland, Ohio. Sarah is pursuing a career in the field of social justice activism and plans to examine how race, gender, sexuality and socio-economic status affect people’s experiences as they age. After graduating from law school, Sarah plans to advocate for, and empower, vulnerable individuals. In the fall, Sarah will be participating in her law school’s domestic violence clinic.

Sarah currently volunteers at Feminist Majority Foundation and the DC Center for the LGBT Community in Washington. She enjoys practicing Celtic harp, reading Chinese literature and watching old M*A*S*H television episodes in her spare time.

Megan Richelsoph

Megan Richelsoph graduated from North Carolina State University with an undergraduate degree in business. During her time there, she joined a service fraternity that worked with organizations such as the Boys & Girls Club of America and the Society for the Prevention of Cruelty to Animals. That’s when she realized her passion for helping others and began contemplating going to law school.

She interned with the legal department of Mercedes-Benz Vans, LLC, working on projects relating to contracts, real estate and immigration. She called that internship “a wonderful stepping stone into law.” She now attends the University of Maryland Francis King Carey School of Law. She is leaning toward working in civil rights or criminal law. Her ultimate goal is to land a job the Innocence Project, which works to exonerate the wrongly convicted.
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