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AMERICAN BAR ASSOCIATION

COMMISSION ON LAW AND AGING
SECTION ON CIVIL RIGHTS AND SOCIAL JUSTICE
SENIOR LAWYERS DIVISION

REPORT TO THE HOUSE OF DELEGATES

Adopted by the House of Delegates August 10, 2021

RESOLUTION

RESOLVED, That the American Bar Association urges the U.S. Congress and the Department of Health and Human Services to institute a review of the advisability and feasibility of phasing in size and design standards for nursing homes that would require small, household model facilities with single rooms and private baths, given their safety and infection control advantages in public health emergencies such as the Covid-19 pandemic;

FURTHER RESOLVED, That the American Bar Association urges Congress and the executive branch to provide financial incentives for the development and operation of nursing homes meeting size and design standards developed pursuant to this review through means such as, but not limited to, restructuring the Section 202 Supportive Housing for the Elderly Program of the Department of Housing and Urban Development (HUD), tax incentives under the Internal Revenue Service, or actions by other executive branch agencies to provide or encourage low cost financing for the redesign, remodeling, building and rebuilding of nursing homes meeting these standards; and

FURTHER RESOLVED, That the American Bar Association urges the Centers for Medicare and Medicaid Services to change Medicare and Medicaid regulations and payment policies to pay for single private rooms and bathrooms for all residents, with reasonable reimbursement rates for such rooms.

REPORT

I. Introduction

During 2020 and into the start of 2021, the COVID-19 pandemic swept through U.S. nursing homes and other long-term care facilities with relentless devastation, inflicting illness and death on throngs of frail older people and people with disabilities, as well as on their caregivers.[1] According to the Kaiser Family Foundation Covid-19 Coronavirus Tracker, as of March 15, 2021, there have been over 1.4 million cases of Covid-19 in long-term care facilities, including both skilled nursing homes, assisted living and other congregate care facilities, accounting for 5% of all cases in the U.S.[2] More astounding is the death rate which resulted in nearly 180,000 deaths in long-term care facilities, accounting for 34% of total pandemic fatalities in the U.S.

This resolution is all about the need to downsize the size and density of nursing facilities. Deaths in long-term care facilities have concentrated heavily in skilled nursing homes. According to March 2021 CMS data, nursing home resident and staff Covid-19 cases combined have totaled 1,196,418, and deaths 131,921.[3] This means that 74% of all the deaths in long-term care facilities occurred in nursing homes. These statistics are all the more stark given the fact that skilled nursing home residents are less than one half of one percent of the total US population.[4]

At the state level, nursing home resident deaths as a percentage of total deaths varied widely, exceeding 50% in 11 states (the highest being New Hampshire at 70%). In 10 states the resident percentage constituted less than 25% of all deaths; and in the other 29 states, between 25% and 49% of all deaths.[5] Overall, 5 percent of the country's cases have occurred in long-term care facilities, yet deaths related to Covid-19 in these facilities account for about 38 percent of the country's pandemic fatalities.[6]

Black, Hispanic, American Indian, and Alaska Native populations are disproportionately affected by COVID-19 infections. Nationwide data show that the majority of nursing homes with a substantial black or Latino population (25 percent or

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[1] The Commission on Law and Aging acknowledges the singular assistance of Dr. Charlene Harrington, RN, PhD, FAAN, of the University of California San Francisco in the drafting of this report.

[2] The Kaiser Family Foundation (KFF) COVID-19 Coronavirus Tracker, https://www.kff.org/coronavirus-covid-19/issue-brief/state-covid-19-data-and-policy-actions/#longtermcare, updated as of March 18, 2021. The definition of long term-care facility differs by state, but the KFF data reflect a combination of nursing homes, assisted living facilities, adult care centers, intermediate care facilities, and/or other long-term care facilities.

[3] Centers for Medicare & Medicaid Services, COVID-19 Nursing Home Data, as of Week Ending: 03/07/2021. The data was broken down by resident cases (641,608) and deaths (130,296) and staff cases (554,810) and deaths (1,625).

[4] Centers for Disease Control and Prevention. US Total Cases. https://covid.cdc.gov/covid-data-tracker/#cases_casesinlast7days Cases and deaths among health care personnel. https://covid.cdc.gov/covid-data-tracker/#health-care-personnel Total US Population. (328 million). https://www.google.com/search?q=US+population&oq=US+population&aqs=chrome..69i57j69i59.4151j0j4&sourceid=chrome&ie=UTF-8

[5] See KFF *supra* note 2.

[6] *Id.*

more) had reported at least one COVID-19 case by May, 2020.[7] Nursing homes with a higher proportion of racial and ethnic minority residents in Connecticut had 15-16 percent more confirmed COVID-19 cases, than similar facilities with less diverse populations.[8] Nationally, nursing homes that had disproportionately more racial/ethnic minority residents had more confirmed cases and/or deaths.[9]

The COVID-19 infections and deaths and the excess deaths in nursing homes are not inevitable. More robust federal and state policy directives and nursing home actions can reduce nursing home infections and deaths. Research has identified several aspects of nursing home care where policy changes and regulatory oversight can improve US nursing home care, including:

- Nurse staffing and workforce (staffing adequacy, standards, training, wages and benefits)
- PPE, testing, and emergency support
- Regulation and enforcement
- Design and environmental standards
- Transparency and accountability of nursing home ownership and management
- Government payment, financial transparency, and accountability issues

This policy resolution focuses on one major risk factor that is structural in nature, concretely measurable in implementation, and which has been shown to be highly correlated to the rate of infection and death experienced in nursing homes -- nursing home design and environmental standards, related to size and occupancy arrangements.

II. Historical Background

To understand this resolution, it is important to have a basic understanding of the role nursing homes play in the U.S. A turning point in nursing home care came in 1965 when Medicare and Medicaid began providing stable funding to nursing homes that met federal standards. The nation's nursing home industry grew primarily from small privately-owned homes to larger facilities thereafter. In 2016, there were 1.4 million people living in approximately 15,600 nursing homes in the United States.[10]

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[7] Robert Gebeloff *et al*., "Striking Racial Divide: How COVID-19 Has Hit Nursing Homes," *The New York Times* May 22, 2020, at A1. https://www.nytimes.com/article/coronavirus-nursing-homes-racial-disparity.html?action=click&module=Well&pgtype=Homepage&section=US%20News .

[8] Yue Li *et al*., "COVID-19 Infections and Deaths among Connecticut Nursing Home Residents: Facility Correlates," 68(9) *JAGS* 1899 (June 18, 2020), https://onlinelibrary.wiley.com/doi/abs/10.1111/jgs.16689.

[9] Yue Li *et al*., "Racial and Ethnic Disparities in COVID-19 Infections and Deaths Across U.S. Nursing Homes." 68(11) *JAGS* 2454 *(Nov.* 2020).

[10] Centers for Medicare and Medicaid Services (CMS). *Nursing Home Data Compendium 2015 Edition* (2016). http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareMedicaidStatSupp/index.html.

The majority of nursing homes today (69%) are operated by for-profit corporations; 58 percent are operated by corporate chains.[11] Twenty-four percent are not-for-profit facilities; seven percent are government owned. Over time, there has been a decline in public and non-profit nursing homes and beds with an increase in growth by investor-owned regional and national chains. The increasingly complex nursing home organizations with multiple corporate owners have trended toward focusing primarily on profitability for investors.[12]

The vast majority of nursing home residents, 85 percent, are older than 65 years; 45 percent of residents are 85 and older. The majority of residents have chronic illnesses and need assistance with daily living activities and/or have cognitive impairments (61 percent). Overall, nursing home residents are a highly vulnerable population.[13]

III. Size Matters

Nursing Homes are Too Large. In 2018, the overall average facility size was over 100 beds. States, however, vary in their average facility size, nonprofit and rural facilities having smaller size than for-profit and urban.[14] Research on nursing homes has found that size is a strong predictor of nursing home COVID-19 infection rates.[15] Nursing homes that are larger in size have more employees and more residents and therefore, the residents have a greater likelihood of exposure to infected staff and larger outbreaks.

One of the most cited earlier studies of trends during the pandemic found that larger facility size, urban location, and greater percentage of African American residents were significantly related to the increased probability of having COVID-19 cases.[16] Not significantly related were the overall star-rating of the facility, prior infection violations, and dependency on Medicaid payments.[17]

A study published in JAMA by Figueroa *et al*. examined the CMS star ratings of 4,254 nursing homes across 8 states and found that high star ratings specifically for "nurse staffing" were related to fewer COVID-19 cases than low-rated NHs. In contrast,

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[11] Charlene Harrington *et a*l., "*Nursing Facilities, Staffing, Residents and Facility Deficiencies, 2009 Through 2016*," KFF report, Apr. 3, 2018. https://www.kff.org/medicaid/report/nursing-facilities-staffing-residents-and-facility-deficiencies-2009-through-2016/ .

[12] David G. Stevenson, Jeffrey S. Bramson, & David C. Grabowski, "Nursing Home Ownership Trends and their Impacts on Quality of Care: A Study Using Detailed Ownership Data from Texas," 25(1) *J. of Aging & Social Policy* 30 (2013).

[13] Centers for Medicare and Medicaid Services *supra* note 10.

[14] Medicare Payment Advisory Commission. *Report to the Congress: Medicare Payment Policy.* Chapter 8. Washington, D.C. March 2020, p.219-244.

[15] *See* Charlene Harrington, et al., "Nursing Staffing and Coronavirus Infections in California Nursing Homes, 21(2) *Policy, Politics, & Nursing Practice* 174 (2020); Nathan M. Stall et al., "For-Profit Long-Term Care Homes and the Risk of COVID-19 Outbreaks and Resident Deaths," 192 (33) *Canadian Med Ass'n J.* E946 (Aug. 17, 2020); Jose F. Figueroa, et al., "Association of Nursing Home Ratings on Health Inspections, Quality of Care, and Nurse Staffing with COVID-19 Cases," 324(11) *JAMA* 1103 (2020); Hanna R. Abrams, et al., "Characteristics of US Nursing Homes with COVID-19 Cases," 68 (8) *JAGS* 1653 (2020).

[16] Hann R. Abrams, *supra* note 15.

[17] *Id.*

there was no significant difference in the burden of COVID-19 cases between high- vs low-performing NHs for health "inspection results" or "quality measure" ratings. These findings suggest that poorly resourced NHs with nurse staffing shortages may be more susceptible to the spread of COVID-19.[18]

An enlightening study published September 30, 2020, by Mathematica focused on one state, Connecticut with 216 nursing homes, and reported results consistent with the above studies.[19] Key findings included:

- Larger nursing homes had more Covid-19 deaths per licensed bed.
- For-profit nursing homes had about 60 percent more deaths per licensed bed than nonprofit nursing homes.
- Nursing homes that were part of a chain had about 40 percent more deaths than independently owned nursing homes.
- Nursing homes with higher star ratings for staffing had fewer Covid-19 deaths.
- Overall star ratings and star ratings for Quality were not related to rates of Covid-19 deaths.[20]

A recent study of Ontario, Canada, nursing homes also found that size matters. The odds of a COVID-19 outbreak were associated with the number of residents living in nursing homes and with older design standards (including multiple residents per room), controlling for other factors. The lack of privacy for nursing home residents also results in unpleasant and undesirable living conditions.[21]

One of the most exceptional studies, not only for its findings but for its methodology, was undertaken by the National Bureau of Economic Research. It consisted of a national analysis of nursing home connections via shared staff and contractors, using geolocation data from 50 million smartphones over an 11-week period. The researchers were able to construct network measures of connectedness which showed that, on average, nursing homes shared connections (i., persons moving between facilities) with 7 other facilities.[22] Thus, it is not surprising to see how the traffic of staff in and out of multiple facilities impacts the spread of infection. Larger facilities invariably have larger staffs and more interfacility traffic.

Nursing Home Residents Do Not Have Private Rooms. Most nursing home residents are living in rooms with two to four beds and share toileting facilities which can

[18] Jose F. Figueroa supra note 15.
[19] Mathematica, A Study of the COVID-19 Outbreak and Response in Connecticut Long-Term Care Facilities: Final Report (September 30, 2020), file:///C:/Users/sabatinc/Downloads/CT_LTC_Facilities_Final_Report.pdf .
[20] *Id*., at Exhibit B.9.
[21] Nathan M. Stall *supra* not 15.
[22] M. Keith Chen, Judith A. Chevalier, & Elisa F. Long, Nursing Home Staff Networks and Covid-19, National Bureau of Economic Research, Working Paper 27608 (July 2020), http://www.nber.org/papers/w27608.

be a risk for spreading infections. Moreover, Medicare and Medicaid only pay for shared rooms so private rooms are subject to private pay rates which are much higher.[23]

The extent of room sharing is a measure of crowding or density in facilities. A recent Canadian study of more than 78,000 residents in 618 nursing homes in Ontario, Canada, found COVID-19 incidence and mortality in homes with low crowding (one per room) was less than half than that of homes with high crowding (2 or more residents per room)[24].

Many Nursing Home Buildings Are Old and Outdated. A major portion of nursing home buildings are old, outdated, poorly configured, and out of scale for consumer tastes.[25] Unfortunately, no national inventory of the age and condition of the nation's nursing homes exists. The COVID-19 pandemic has exposed serious problems with design and layout that facilitated the rapid and unchecked spread of the virus. The nation's facilities are subject to a variety of natural disasters including but not limited to earthquakes, fires, storms, power shortages, and floods. Although CMS has regulatory standards for fire and life safety and gives deficiencies for failure to meet the standards, nursing homes have been found to violate these standards frequently.[26] Existing guidelines on design have largely overlooked infection control.

IV. The Need for Structural Reform

There is general agreement that alternative models are needed to ensure quality of life and improve infection control and pandemic preparedness.[27] For quality of life, several factors have been proposed: proximity to a person's home community, integration and health and social care and emergency services, neighborhood and public services, improved care models and building configurations, expanded resident spaces with private rooms and bathrooms, air circulation and ventilation to reduce infection exposure, transitional spaces, outdoor areas and spaces to exercise, staff spaces, and other modern features.[28] This resolution prioritizes a structural reform as a first step, focusing on size and density.

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[23] American Council on Aging. Nursing Home Costs by State and Region – 2019. October 24, 2019. https://www.medicaidplanningassistance.org/nursing-home-costs/.

[24] Keven A. Brown *et al.,* "Association Between Nursing Home Crowding and COVID-19 Infection and Mortality in Ontario, Canada," *JAMA Internal Medicine* (published online November 9, 2020), https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2772335 .

[25] *See* Justin Davidson, "The American Nursing Home Is a Design Failure," *New York Magazine, Cityscape*, June 25, 2020. https://nymag.com/intelligencer/2020/06/the-american-nursing-home-is-a-design-failure.html; Dave Altimari, "Connecticut Nursing Homes Are Old and Ill-Equipped to Contain Viral Spread" *Hartford Courant* (Dec 20, 2020), https://www.courant.com/coronavirus/hc-news-coronavirus-old-nursing-homes-deaths-20201220-4vonyep6bffcnosfn7qhx6axsq-story.html.

[26] Office of the Inspector General (OIG). California Should Improve Its Oversight of Selected Nursing Homes' Compliance with Federal Requirements for Life Safety and Emergency Preparedness. A-09-18-02009. Washington, DC: OIG, November 2019.

[27] Dana C. Anderson et al., "Nursing Home Design and COVID-19: Balancing Infection Control, Quality of Life, and Resilience," 21 (11) *JAMDA* 1519 (2020).

[28] *Id*. at 1520.

Norway, Denmark, and other nations have pioneered the design and operation of small modern nursing home clusters. These have residential, home-like environments, private rooms and bathrooms, therapeutic outdoor spaces, and other environmental and safety features that ensure the protection of residents. [29]

Clustered neighborhood design has become a model for nursing homes around the world where the clusters have 8-12 people, each with their own room. This helps limit virus transmission while allowing for more targeted and intimate care. Within each cluster of rooms, there is a living room, dining room, kitchen and adequate space for residents, families, and nursing staff. Research shows such architectural factors have a strong influence on improvements of quality of life and quality of care for nursing home residents.[30]

The Green House Project

In the United States, a variety of small homes representing the "household model" have been successful, but they currently represent a small proportion of nursing home beds. There is no official definition of what constitutes "small," but 20 or fewer residents has been a common cut-off.[31] The most visible and well established is The Green House® Project, originally funded by the Robert Wood Johnson Foundation. There are 300 Green House homes nationally, normally built-in clusters of five or six homes, each with 10 or 12 residents who have single rooms and private baths. Urban variations also exist with a multi-floor building comprised of the separate homes on each floor.

In the Green House model, homes are designed around a living room with a fireplace and an open kitchen where meals are prepared and shared. The cross-trained staff teams, backed by nurses and doctors, engage with residents, serving as nurse aides, cooks, cleaners and participants in meals and social activities. Green House staff turnover appears to be well below that of traditional nursing homes.[32] Residents are exposed to fewer staff, because Green House care staff are cross-trained to handle multiple aspects of daily life from resident care to cooking, cleaning, and recreation. Of importance to both the public and policymakers, Green House Project homes have been proven to have high resident, family and worker satisfaction; better quality of care and quality of life than traditional nursing homes; care costs comparable to traditional nursing homes and, most importantly in the midst of the pandemic, a much greater ability to prevent and contain illness.[33]

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[29] Victor A. Regnier, *Housing Design for an Increasingly Older Population: Redefining Assisted Living for the Mentally and Physically Frail*. (2018).
[30] AnneMarie Eijkelenboom et al., "Architectural Factors Influencing the Sense of Home in Nursing Homes: An Operationalization for Practice" 6 *Frontiers of Architectural Research*, 111 (2017).
[31] *See* Action Pact, a long-term care culture change company that promotes the Household Model, https://www.actionpact.com/household/household_model .
[32] Sheryl L. Zimmerman *et al*., "New Evidence on the Green House Model of Nursing Home Care: Synthesis of Findings and Implications for Policy," *Health Services Research, Special Issue*, 51:1, Part II (February 2016); Nicholas G. Castle, "Measuring Staff Turnover in Nursing Homes," *Gerontologist*, 2006 Apr;46(2):210-9.
[33] *Id.*

A survey of 229 Green House nursing homes that participate in Medicare or Medicaid compared Covid-19 infection rates and death rates to those in traditional nursing homes geographically near them. The traditional nursing homes were grouped into smaller traditional homes (those with <50 beds) and larger traditional homes (those with ≥50 beds). Regardless of size, traditional homes generally had multiple residents per room and greater division of labor among multiple staff roles. Green House homes were compared to both the larger and smaller traditional homes during a study tracking period that ran from January 20, 2020 to July 31, 2020.[34]

The results are astounding. The median death rate per 100 residents for nursing homes with 50 or more beds was 12.5%, and 10% in homes with 49 or fewer beds; but in Green House homes the rate was statistically 0.[35] The zero rate in Green House homes does not mean there were absolutely no deaths at all; but rather, the number was so low that the median is mathematically zero.

The results for infection rates were equally dramatic. Infection rates were defined as new positive Covid-19 cases and persons admitted or readmitted who were previously hospitalized for Covid-19. Rates were expressed in terms of numbers per 1000 residents. Because those ratios are quite low on that scale, the researchers found it useful to compare the 75th percentile of Covid-19 cases in each of the three groups. On that metric, traditional nursing homes <50 beds and ≥50 beds had twice and 9 times the 75th percentile rates of Covid-19 cases, respectively, as Green House homes.

The authors acknowledge that the advantage of Green House homes comes from more than mere size. They have the advantage of private bedrooms and bathrooms, limited ancillary staff, and fewer admissions. Together these factors point to the need to fundamentally change the physical plant structure of nursing homes as an essential starting point in preventing a long-term care pandemic debacle from ever happening again.

V. Options Government Needs to Consider

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, especially after the coronavirus catastrophe has passed. To move the industry toward the small house model, government will need to consider both legislative and regulatory change. The Centers for Medicare and Medicaid Services (CMS) has established fire life safety codes for certified Medicare and Medicaid nursing homes. These standards need to be revisited to ensure private rooms and bathrooms and safe living environments that can protect in the era of pandemics. CMS does not pay for single rooms, except under limited circumstances.[36] The pandemic experience and the research showing that density

[34] Sheryl Zimmerman *et al*., "Nontraditional Small House Nursing Homes Have Fewer COVID-19 Cases and Deaths," 22 *J. Am. Med. Directors Ass'n,* 489 (Published online: January 25, 2021).

[35] Id. At 490

[36] 42 C.F.R. §483.10(f) & §483.10(h).

increases disease spread demonstrates the needs to change this, so that single rooms may become the norm.

There is also a Facility Guidelines Institute (FGI) that provides direction on programming and sets minimum safeguards for nursing homes and assisted living.[37] Building inspectors use the International Building Code, which is updated every three years by the International Code Council. The NFPA 101, Life Safety Code, updated by the National Fire Protection Association every three years, guides fire officials.[38] These standards set comprehensive, coordinated building safety and fire prevention codes to protect public safety. These standards need review with the objective of better accommodating small home-like models of skilled care.

Legislatively, Congress should consider the option of changing the conditions of participation in Medicare and Medicaid to mandate a phase in of small household models and phase out larger facilities. Financial incentives are equally essential to move the field forward. The Department of Housing and Urban Development (HUD) could, by regulation, or with the help of Congressional action, stimulate the development of small nursing homes by restructuring the HUD program to allow the program to finance the redesign, remodeling, building, and rebuilding of new nursing homes using mortgage loan programs, direct loans, bonds, and other mechanisms, provided through the HUD program. At the same time, CMS may need to override or waive state certificate of need requirements to allow redevelopment and replacement of traditional facilities to proceed.

VI. What this Resolution Does

The resolution focuses on the need to reconsider the building design of nursing homes as a necessary first step to ensure the safety of nursing home residents. By itself, design does not ensure safety, quality of life, or quality of care, but the evidence overwhelmingly suggests it is a major factor.

The first resolved clause calls on both Congress and the Department of Health and Human Services to review whether it is advisable and feasible to phase in size and design standards for nursing homes that would require small, household model facilities with single rooms and private baths, given their safety and infection control advantages in public health emergencies such as the Covid-19 pandemic. Nursing homes already meet a variety of federal, state, and local requirements for design and safety. A key lesson of the pandemic is that those standards need to be reviewed and reconsidered. Home-like, residential household designs of 20 or fewer beds each, arranged in single rooms with private baths already exist and participate in Medicare and Medicaid, the most established being Green House Project homes with a capacity of no more than 12 beds, typically in clusters of units to enable certain administrative efficiencies and professional

[37] Facility Guidelines Institute (FGI) *Guidelines for the Design and Construction of Residential Health, Care, and Support Facilities*, 2018. https://fgiguidelines.org/.

[38] Liao, A., "Getting Better with Age: Design for Senior and Assisted Living Facilities," *Architect.* June 29, 2018. https://www.architectmagazine.com/practice/getting-better-with-age-design-for-senior-and-assisted-living-facilities_o .

support. Therefore, the examination called for by the first resolved clause has concrete models to compare and assess.

The second resolved clause urges Congress to provide incentives for the development and operation of nursing homes meeting size and design standards developed by the above review. To accomplish this, it recommends means such as creating or restructuring programs of the Department of Housing and Urban Development (HUD), the Internal Revenue Service, and other executive branch agencies to provide special financing or subsidies for the redesign, remodeling, building, and rebuilding of new nursing homes. Programs such as the HUD Section 202 Supportive Housing for the Elderly Program would be a logical vehicle, because the program already provides interest-free capital advances to private, nonprofit sponsors to finance the development of supportive housing for the elderly. Other mechanisms such as targeted low-cost mortgage loan programs, direct loans, bonds, tax incentives, or other incentives may also be appropriate.

The third resolved clause addresses a federal regulatory barrier that needs to be changed to allow for single rooms under Medicare and Medicaid – the lack of reimbursement for private rooms unless for a medically necessary reason such as infection control.[39] Private rooms not only reduce infection spread but also conform to most adults' accustomed living preference. This is an action that can be done now, regardless of the outcome of the review of design standards.

VII. Need for ABA Action

The Covid-19 pandemic has highlighted not only the infection control shortcomings of today's nursing home industry but also fundamental human rights shortcomings. The most senior of human rights instruments, the Universal Declaration of Human Rights, states plainly, "Everyone has the right to life, liberty and security of person." Nursing home residents saw these rights slip away with frightening prevalence, especially for persons of color. The Convention on the Rights of Persons with Disabilities further calls on governments to:

- take all necessary measures to ensure its effective enjoyment by persons with disabilities on an equal basis with others. (Article 10)
- take all necessary measures to ensure the protection and safety of persons with disabilities in situations of risk, including situations of armed conflict, humanitarian emergencies and the occurrence of natural disasters. (Article 11); and
- To recognize a right to respect for his or her physical and mental integrity on an equal basis with others (Article 17)

The ABA has traditionally fulfilled a leadership role in problem-solving discussions about human rights, access to justice, equity, and protection of vulnerable groups. This is a subject that calls for ABA action in the problem-solving discussion about how to

[39] 42 C.F.R. §483.10(f) & §483.10(h).

reimagine nursing homes to better meet the needs of the vulnerable populations they serve. There are at present no bills or proposal before Congress or the States to mandate the small, household model of nursing homes. Yet the evidence of their need as a result of the past year's experience is clear and concrete.

Downsizing nursing homes will not in itself ensure more humane and safe care, but it is the structural base that makes all other improvements more readily attainable. The policy resolution focuses on the need to consider a remedy that is straightforward in objective, concretely measurable in implementation, and which has been shown to be highly correlated to the rate of infection and death experienced in nursing homes.

VIII. Existing ABA Policy

ABA policy addressing long-term care facilities, summarized below, focuses on issues quite different than that addressed by this resolution. The proposed policy poses no inconsistencies with existing ABA policies.

- **2016MY100** opposes the use of binding forms of alternative dispute resolution involving residents in disputes with long-term care facilities or similar health care institutions unless the parties agree to do so voluntarily and knowingly after a dispute arises.
- **1992MY112** calls for better enforcement of existing consumer protection provisions and the adoption of additional measures that will protect the consumer in the sale, financing, and delivery of long-term care products and services.
- **2015MY100** addresses advanced illness and calls for expanded research to improve care delivery and payment practices that will benefit individuals and families facing advanced illness.
- **1983MY114** urges the retention of effective enforcement mechanisms to ensure adequate quality of care in nursing homes participating in the Medicare and Medicaid programs.

Another related area of policy relates to advocacy to reduce reliance on nursing home and to expand home and community -based services (HCBS). The ABA has had policy since 2011 (**2011AM106S**) urging Congress, and all federal, state, and territorial administrative bodies to continue efforts to expand the availability of HCBS as a viable long-term option by making HCBS a mandatory service under Medicaid available to anyone who would otherwise qualify for institutional long-term care. While HCBS have expanded in the last 10 years, they are still not mandatory, nor will they ever entirely do away with the need for nursing home facilities. The current resolution focuses on what those facilities should look like moving forward.

IX. Conclusion

This policy resolution responds to consistent findings of Covid-19 research showings that the bed size and density (i.e., multiple residents per room) of nursing home buildings represents one of the most powerful risk factors fostering high rates of Covid-

19 infection and death rates. The prevailing model of nursing home design and construction has failed to protect the lives, safety, and security of persons in need of nursing home care and needs to change if nursing homes are to provide safe and humane environments in the face of current and future public health challenges. Fortunately, this tragic design flaw is fixable. The report establishes that small household models, represented most visibly by Green House Homes, already exist. Green House and other small household model nursing homes have participated in Medicare and Medicaid and have been shown to be viable and significantly effective in preventing infection spread and death compared to traditional nursing homes.

Accordingly, this resolution calls on Congress and the Department of Health and Human Services to institute a review of the advisability and feasibility of phasing in size and design standards for nursing homes to require small, household model facilities with single rooms and private baths. Second, the resolution urges Congress and the executive branch to provide financial incentives for developing and operating facilities that meet the size and design standards developed through this review.

Finally, the resolution urges the Centers for Medicare and Medicaid Services to change Medicare and Medicaid regulations and payment policies to pay for single private rooms and bathrooms for all residents under reasonable reimbursement rates.

We ask the House of Delegates to support this resolution.

Respectfully submitted,

Hon. Louraine C. Arkfeld
Chair, Commission on Law and Aging

August 2021

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GENERAL INFORMATION FORM

Submitting Entity: Commission on Law and Aging

Submitted By: The Honorable Louraine C. Arkfeld, Chair

1. Summary of the Resolution(s).

   The Resolution urges Congress and the Department of Health and Human Services to institute a review of the advisability and feasibility of phasing in size and design standards for nursing homes that would require small, household model facilities with single rooms and private baths, given their safety and infection control advantages in public health emergencies such as the Covid-19 pandemic.

   It further urges Congress and the executive branch to provide financial incentives for the development and operation of nursing homes meeting size and design standards developed as a result of this review.

   Third, it calls on the Centers for Medicare and Medicaid Services to change Medicare and Medicaid regulations and payment policies to pay for single private rooms and bathrooms for all residents, with reasonable reimbursement rates for such rooms.

2. Indicate which of the ABA's Four goals the resolution seeks to advance (1-Serve our Members; 2-Improve our Profession; 3-Eliminate Bias and Enhance Diversity; 4-Advance the Rule of Law) and provide an explanation on how it accomplishes this.

   The resolution advances the Rule of Law by addressing the failure of prevailing building and design configurations of the nursing home industry to provide minimally adequate protection against illness and death for the population of vulnerable adults requiring care in nursing home care.

3. Approval by Submitting Entity.

   Approved by the Commission on Law and Aging on (April 16, 2021).
   Approved by the Senior Lawyers Division on May 3, 2021.

4. Has this or a similar resolution been submitted to the House or Board previously?

   No

5. What existing Association policies are relevant to this Resolution and how would they be affected by its adoption?

   None

6. If this is a late report, what urgency exists which requires action at this meeting of the House?

   N/A

7. Status of Legislation. (If applicable)

   None at present.

8. Brief explanation regarding plans for implementation of the policy, if adopted by the House of Delegates.

   ABA entities such as the Commission on Law and Aging, working through Government Affairs will collaborate with other aging groups such as AARP to seek federal legislation and regulation to implement the resolution.

9. Cost to the Association. (Both direct and indirect costs)

   None.

10. Disclosure of Interest. (If applicable)

    N/A

11. Referrals.

    The recommendation has been or is being referred to the following ABA entities:

- Standing Committee on the Delivery of Legal Services
- Standing Committee on Governmental Affairs
- Standing Committee on Legal Aid and Indigent Defendants
- Standing Committee on Pro Bono and Public Service
- Commission on Disability Rights
- Commission on Domestic and Sexual Violence
- Commission on Homelessness and Poverty
- Commission on Hispanic Legal Rights and Responsibilities
- Government and Public Sector Lawyers Division
- Section of Administrative Law and Regulatory Practice
- Section of Business Law
- Section of Civil Rights and Social Justice
- Section of Family Law
- Section of Health Law
- The Judicial Division
- Section of Labor and Employment Law
- Section of Litigation

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- Section of Real Property, Probate and Trust law
- Section of Science and Technology Law
- Senior Lawyers Division
- Section of State and Local Government Law
- Section of Taxation
- Section of Tort, Trial and Insurance Practice
- Solo, Small firm and General Practice Division
- Young Lawyers Division
- National Legal Aid & Defender Association

12. Name and Contact Information (Prior to the Meeting. Please include name, telephone number and e-mail address). Be aware that this information will be available to anyone who views the House of Delegates agenda online.)

Charlie Sabatino
Director, Commission on Law and Aging
202-390-8447
Charles.sabatio@americanbar.org

13. Name and Contact Information. (Who will present the Resolution with Report to the House?) Please include best contact information to use when on-site at the meeting. Be aware that this information will be available to anyone who views the House of Delegates agenda online.

Hon. Louraine C. Arkfeld
Chair, Commission on Law and Aging
480-250-5044
louraine.arkfeld@gmail.com

EXECUTIVE SUMMARY

1. Summary of the Resolution.

The Resolution urges Congress and the Department of Health and Human Services to institute a review of the advisability and feasibility of phasing in size and design standards for nursing homes that would require small, household model facilities with single rooms and private baths, given their safety and infection control advantages in public health emergencies such as the Covid-19 pandemic.

It further urges Congress and the executive branch to provide financial incentives for the development and operation of nursing homes meeting size and design standards developed as a result of this review.

Third, it calls on the Centers for Medicare and Medicaid Services to change Medicare and Medicaid regulations and payment policies to pay for single private rooms and bathrooms for all residents, with reasonable reimbursement rates for such rooms.

2. Summary of the issue that the resolution addresses.

This policy resolution responds to consistent findings of Covid-19 research showings that the bed size and density (i.e., multiple residents per room) of nursing home buildings represents one of the most powerful factors fostering high rates of Covid-19 infection and death rates. The prevailing model of nursing home design and construction has failed to protect the lives, safety, and security of persons in need of nursing home care and needs radical change if nursing homes are to provide safe and humane environments in the face of current and future public health challenges.

3. Please explain how the proposed policy position will address the issue.

This resolution calls on Congress and the Department of Health and Human Services to institute a review of the advisability and feasibility of phasing in size and design standards for nursing homes that would require small, household model facilities with single rooms and private baths. The report establishes that such models, represented most visibly by Green House Project homes, already exist. Green House and other small household model nursing homes have participated in Medicare and Medicaid and have been shown to be viable and significantly effective in preventing infection spread and death compared to traditional nursing homes. Therefore, the proposed policy urges a review of the feasibility and advisability of mandating smaller facility design standards and providing financial incentives for facilities to meet standards resulting from such review. In addition, the policy addresses Medicare and Medicaid reimbursement barriers against paying for single rooms by urging regulatory steps to enable payment for single rooms with private baths.

4. Summary of any minority views or opposition internal and/or external to the ABA which have been identified.

None identified at this time.