DESIGN INstitute for HEALTH

Nursing Home System Study

Focused Investigation (Phase 1) Synthesis

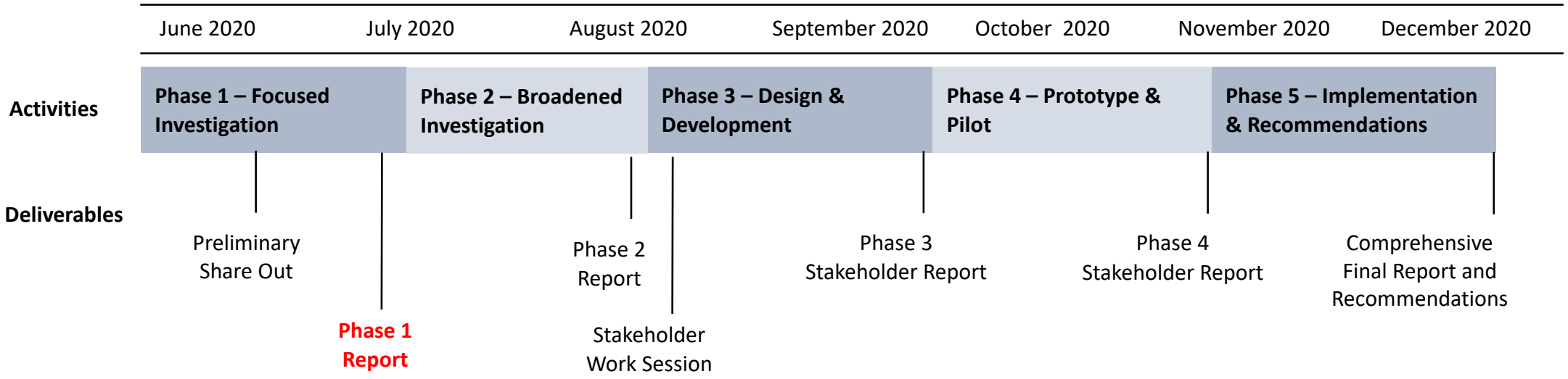
July 28, 2020

Deliverable 04
Agreement No. MA 4700 20052800052

Study Objective

The Design Institute for Health will build on the immediate emergency COVID-19 response efforts of the City of Austin by analyzing, evaluating, and identifying approaches for broader-scale system improvements to protect residents and reduce the risks of the spread of COVID-19 in nursing homes, assisted living centers, and other long-term care facilities.

Project Timeline



Steering Committee

This is a collaborative partnership of numerous entities.

AUSTIN PUBLIC HEALTH, CITY OF AUSTIN

Anjum Hanafi, Long Term Care Incident Command Team

TEXAS HEALTH AND HUMAN SERVICES COMMISSION

Michelle Dionne-Vahalik, Associate Commissioner, Long Term Care Regulation

Michael Gayle, Deputy Associate Commissioner, Policy, Rules, and Training in Long Term Care Regulatory

THE UNIVERSITY OF TEXAS AT AUSTIN

SCHOOL OF NURSING

Tracie Harrison, Director, Center for Excellence in Aging Services and Long Term Care

STEVE HICKS SCHOOL OF SOCIAL WORK

Sarah Swords, Clinical Associate Professor, Assistant Dean for Master's Programs

DELL MEDICAL SCHOOL

Stacey Chang, Executive Director, Design Institute for Health

Liam Fry, M.D., CMD, Chief of Division of Geriatrics and Palliative Care, Department of Internal Medicine

Research Progress

100+

Secondary research articles and resources reviewed and synthesized into a baseline understanding

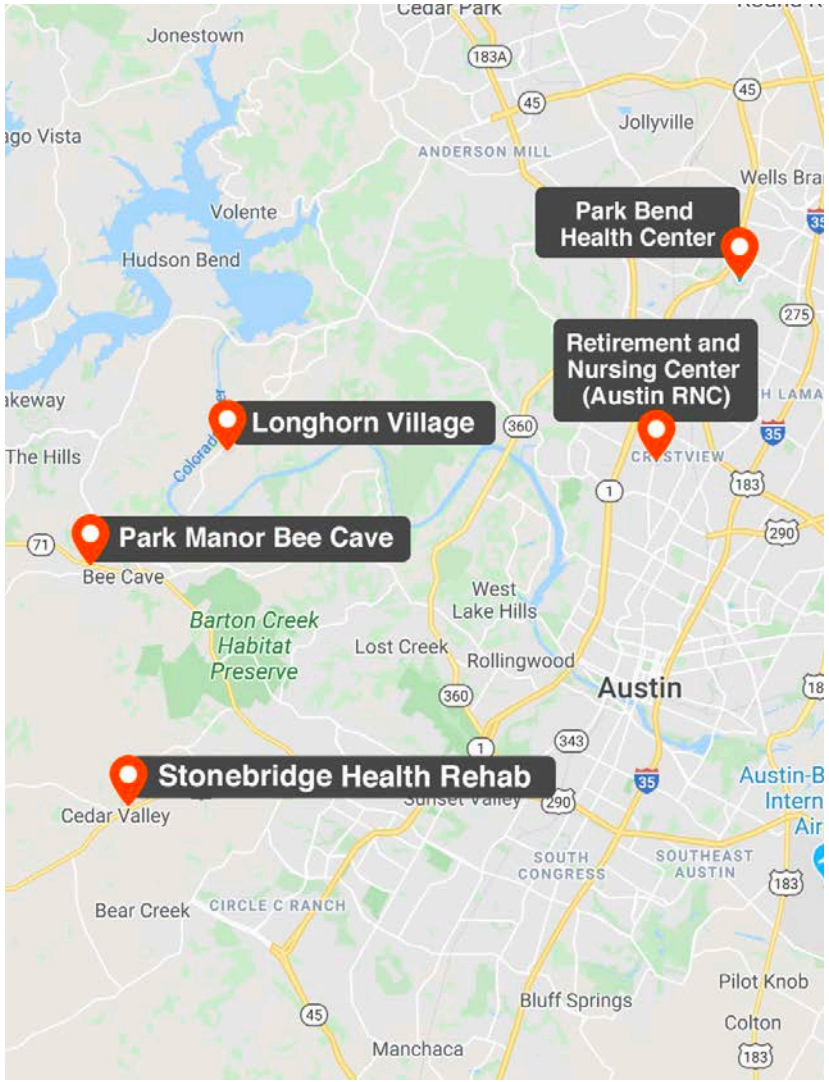
49

Interviews and workflow observations including administrators, nursing directors, infection control nurses, food services managers, certified nursing assistants, MDS nurses, social workers, and activity coordinators as well as deep dive interviews with subject matter experts

4 of 5

Full-day facility onsite visits (interviews and observations) completed

Phase 1 Facilities



5 Facilities of Phase 1: all institutional model nursing homes

Size: 39,635 SQFT, 1 story, built in 2000
Total beds: 124; Occupied beds: 95

Size: 47,834 SQFT, 2 buildings, built in 1971
Total beds: 150; Occupied beds: 73

Size: 68,000 SQFT, 2 story, built in 2009
Total beds: 60; Occupied beds: 34

Size: 39,650 SQFT, 1 story, built in 1997
Total beds: 116; Occupied beds: 63

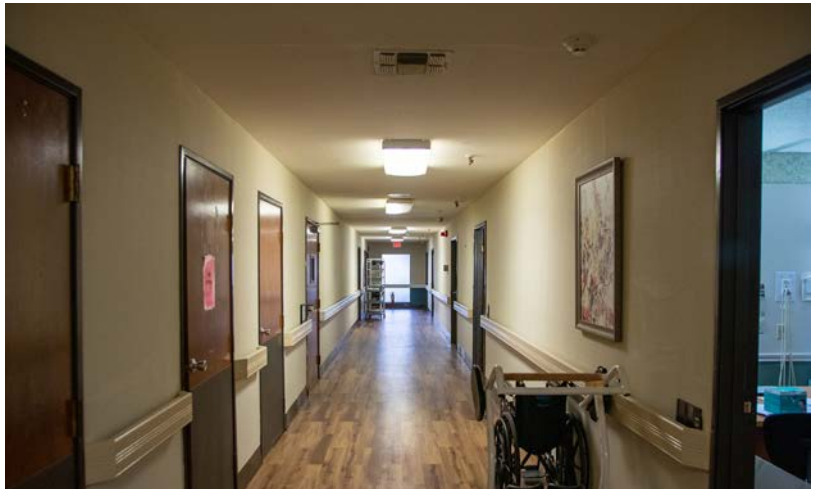
Size: 53,724 SQFT, 1 story, built in 2013
Total beds: 140; Occupied beds: 82

Glimpses inside Nursing Homes in the COVID-19 era

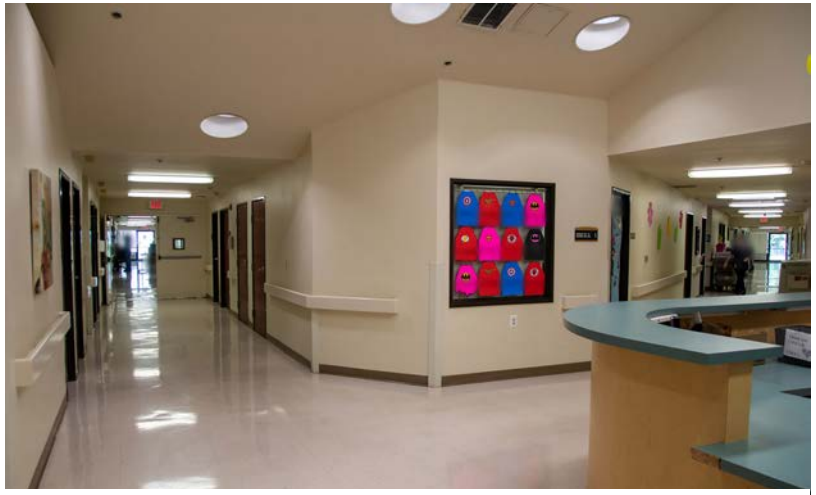
Laundry room protocols have had to evolve in response to COVID-19

Staff personal protective equipment placed in bags at entry

Carts are being used to deliver meals directly to rooms



Resident hallways, subject to social distancing protocols



The same hallways, viewed from the nurse's station

Resident room, in preparation for isolation protocols

Glimpses inside Nursing Homes in the COVID-19 era

Nurse's station in hallway, still a place for staff overlap

Dining room being used as a gym for physical therapy

Face shields hung up in a room with staff names labeled

Kitchen / dining menu placed outside dining hall

PPE and disposal bins in resident room

Kitchen prep has had to make adjustments to protocols

Establishing Context

Types of Long-term Care Services
Spectrum of need and level of care

Continuing Care Retirement Community (CCRC)
A long-term care option for older adults who want to stay in the same place through different phases of the aging process.[8]

Independent Living
Congregate living for older adults or people with disabilities. Residents are independent, but have access to assistance when desired.

Assisted Living
Includes assistance with activities of daily living (ADLs) and medication management when necessary.[4]

FOCUS OF PHASE 1 RESEARCH

Skilled Nursing Facility (SNF)
- Short-term rehab
- Long-term care
(*commonly known as a* Nursing Home)
Nursing homes are the highest level of care someone will receive outside of a hospital[3], other than at-home care. Includes assistance with activities of daily living (ADLs) and a high level of medical care.[4]

Low need/ Low level of care

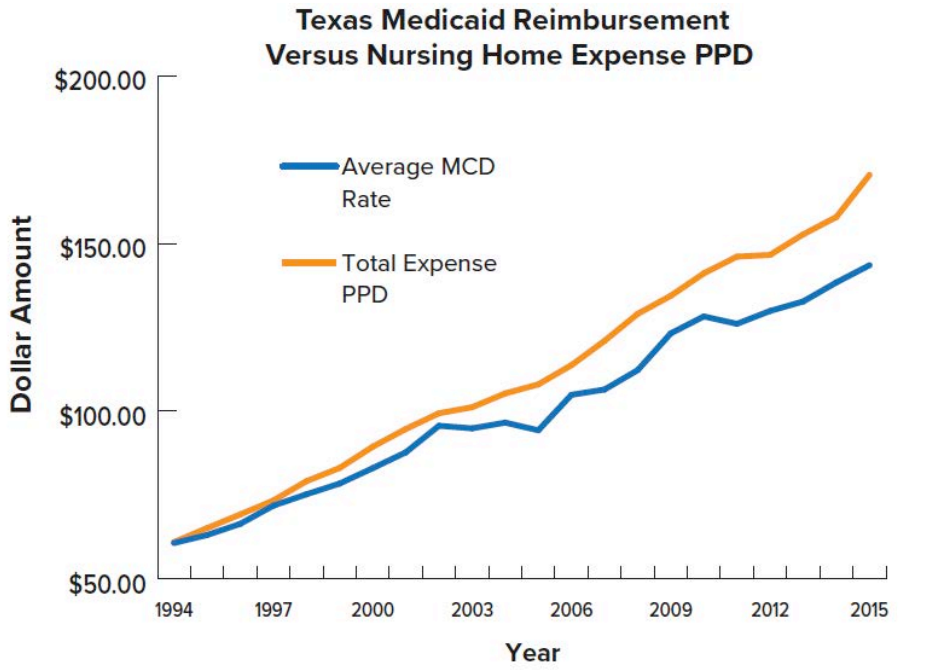
High need / High level of care

Patient acuity in nursing homes today is similar to what you would find in hospital recovery a decade ago. Nursing homes are medical facilities, not retirement homes.

An inability to perform the activities of daily living (ADLs) is the most common reason for residence in a nursing home.

80-85% of Texas nursing home residents depend on Medicare or Medicaid funding for their care.

86% of Texas nursing homes reported allowable costs that exceeded Medicaid reimbursement.[1]



Source: THCA Crisis Report April 2018[6]

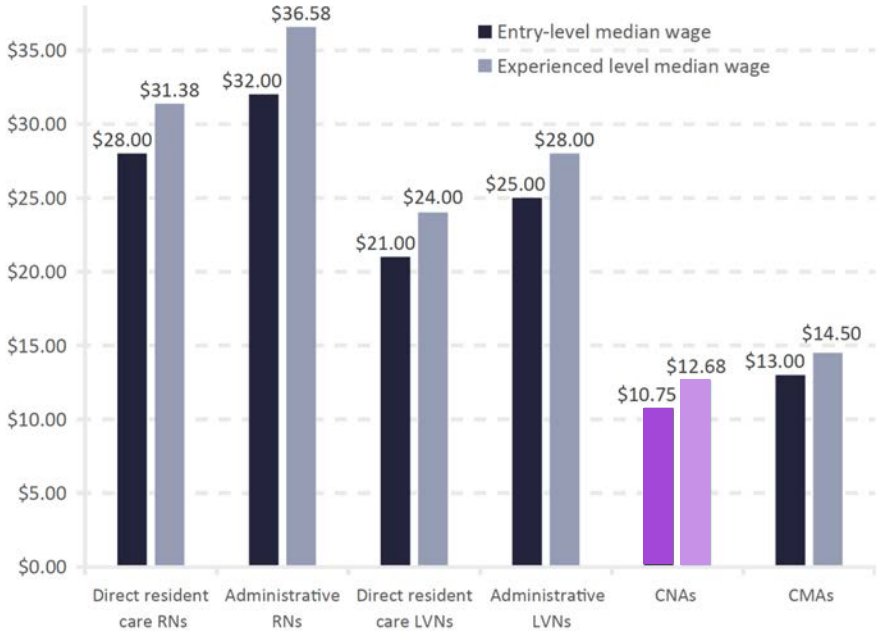
In 30 years, the population in Texas over the age of 65 will triple. Those over 85 will quadruple by 2050.

55% of residents in Texas nursing homes have been medically diagnosed with dementia.

Nursing homes are highly regulated.

Staff workload (physically and mentally) is disproportionate to hourly wage.

Median hourly wage, experience level by staff type in Texas[3]



From the *Texas Center for Nursing Workforce Studies: Long Term Care Nurse Staffing Study 2019*[3]

*Note: Austin passed a $15 minimum wage in 2018.[5]

Competition for staff is fierce when the same skillsets are in demand elsewhere.

Staff retention is a constant challenge for facilities and administrators.

Facility turnover rate statistics for Texas[2]

Staff Role	Median Turnover Rate (2019)
Direct Resident Care RN	*75%*
Administrative RN	*55%*
Direct Resident Care LVN	*61%*
Administrative LVN	*34%*
Certified Nursing Aide (CNA)	*85%*
Certified Medication Aide (CMA)	*40%*

From the *Texas Center for Nursing Workforce Studies: Long Term Care Nurse Staffing Study 2019*

Austin Area Nursing Homes (currently)

31

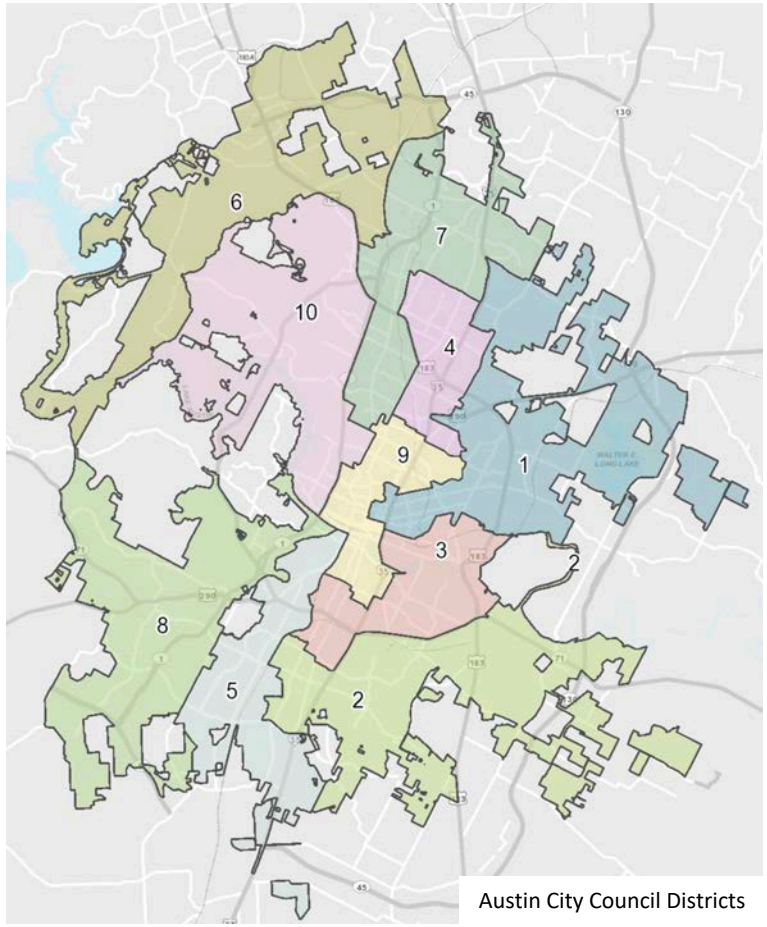
Skilled Nursing Facilities in Travis County

~4000-5000

Staff working in Skilled Nursing Facilities

~3000

Nursing Home Residents



Austin City Council Districts

DISTRICT 1
4 Nursing Homes

DISTRICT 2
None

DISTRICT 3
1 Nursing Home

DISTRICT 4
1 Nursing Home

DISTRICT 5
5 Nursing Homes

DISTRICT 6
2 Nursing Homes

DISTRICT 7
4 Nursing Homes

DISTRICT 8
2 Nursing Homes

DISTRICT 9
1 Nursing Home

DISTRICT 10
1 Nursing Home

Insights

This is a complex system of people.

It includes people who need care,
and people who provide care.

Each of them has stories of…

Heroes
Caregivers
Relationships

"We're here for the same reason, just as any other nurse, any nurse practitioner, any doctor. I can't stress that enough, because it's not... Like I said, we're just overlooked as aides. I want people to know that we're here, and we're doing our best, just like they are, to make sure we're keeping ourselves together and we're keeping the lives that are in our hands together, because I feel like we go very unappreciated."

- Certified Nursing Aide

INSIGHT 1

Theory vs. Reality in Nursing Homes

Many COVID-19 infection control protocols are fundamentally misaligned with the realities of both living and working inside a nursing home. This results in significant effort to comply with recommendations that are logistically and operationally challenging, clinically misaligned, and at times behaviorally infeasible.

INSIGHT 1

Theory vs. Reality in Nursing Homes

Isolation units – Life safety code, Displacing residents, Staff separation

Social distancing – Patient care, Resident interaction, Resident appetite

Quarantine – Visitation, Field trips

PPE – Appearance, Mask adherence, Hearing impairment

Technology – Telehealth

Financial Impacts – Hot zones, Elective surgeries, New admissions

"Some residents are unquarantinable. It's their right to leave their room."

- Director of Nursing

Entrance to isolation unit that currently has no COVID-19 positive cases

INSIGHT 2

Evolving Guidance and Recommendations

Nursing homes receive conflicting or hard-to-interpret guidance for COVID-19 infection control – recommendations are communicated frequently, often from different sources, and lack clear, actionable directives for implementation, resulting in Directors of Nursing (DONs) and Facility Administrators absorbing the responsibility of clinically interpreting and operationally translating these evolving guidelines into action. Given the complexity and possible enforcement, DONs and Administrators are forced to deprioritize their other critical duties, as this sensemaking process necessitates tremendous time, collaboration, and decision-making.

INSIGHT 2

Evolving Guidance and Recommendations

Unclear Infection Control Guidance

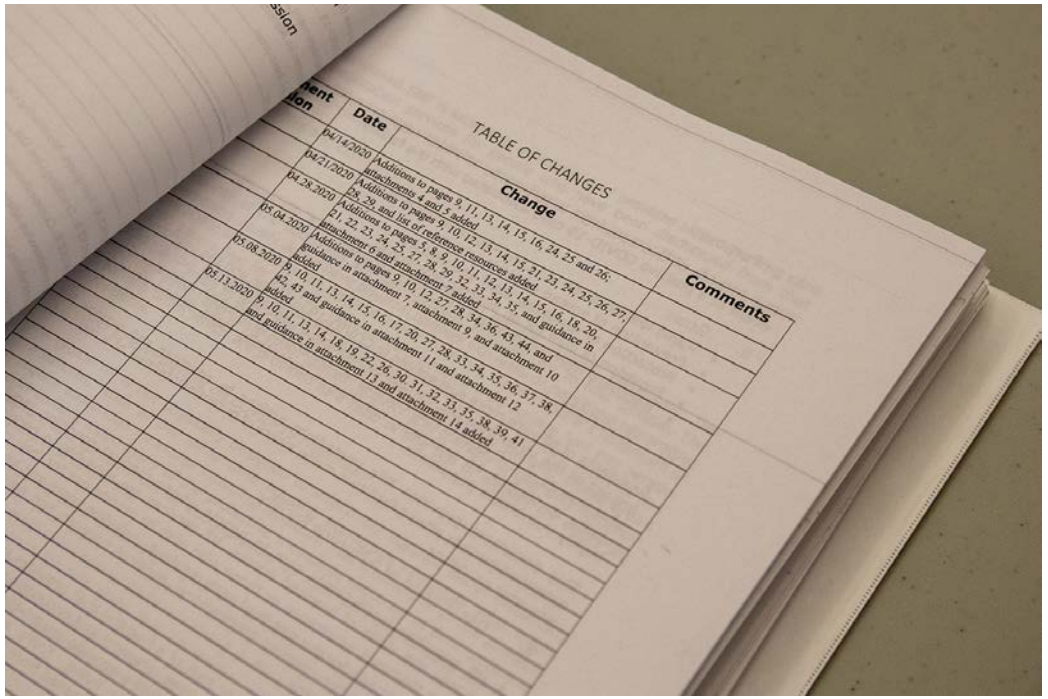
Penalties and Incentives

Impact on Facility Operators

Lack of Support for Staff

"There are lots of mixed messages with COVID information…we don't know if what we are doing is right."

- Infection Control Nurse



Director of Nursing COVID-19 Protocol binder: Page indicating regulation changes from previous versions

INSIGHT 3

Staff Behaviors, Sacrifices, and Risks

The novelty and unknown characteristics of this virus have presented a new challenge to nursing homes as significant risks for COVID-19 transmission do not solely exist within the facility but can be introduced through those who traverse external facility boundaries as well. While it is understood that staff choices in their personal lives, such as social distancing, are a key component of a facility's ability to control infection, facilities likewise acknowledge that they can neither monitor nor control staff behaviors off the clock.

INSIGHT 3

Staff Behaviors, Sacrifices, and Risks

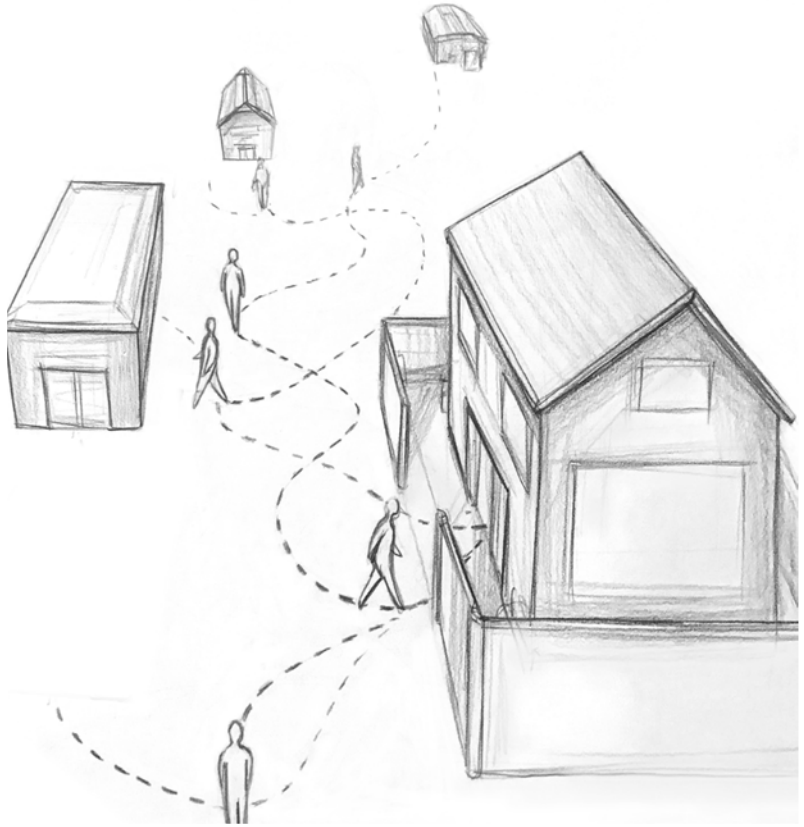
Staff Fear and Guilt

Concerns for the Future

Staff Risk

"I don't go anywhere. I tell my family because of the fact that I want to stay COVID free …I always tell them I don't want to be the one that brings it to work…I try not to go out very often [to the grocery store] if I don't have to. No one's allowed at my house. It's just affected me personally just completely. I completely social distance myself from people."

- Assistant Director of Nursing



Staff movement in and out of facilities carries unseen consequences

INSIGHT 4

Psychosocial Consequences of COVID-19

Resident isolation from family, friends, and other residents has resulted in a cascade of resident psychosocial consequences, such as depression and loneliness. With families currently unable to provide support to residents, staff choose to absorb this emotional burden themselves – a response that is not sustainable long-term. However, with no end in sight to visitation restrictions, the potential for resident decline and staff burnout in the near-term seems inevitable.

INSIGHT 4

Psychosocial Consequences of COVID-19

Increased Family Requests

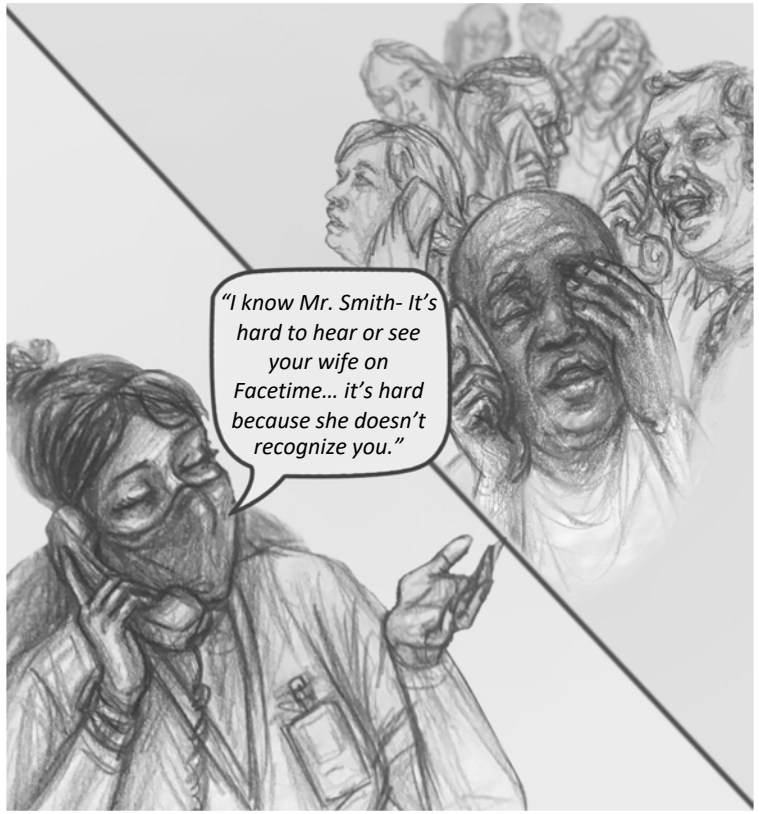
Staff Processing Needs

Staff Retention

Impact of Staff Burnout

"How long can we sustain this before we see residents start to die from the depression and isolation? There has to be a middle ground between rules and regulations and what people need. It's awful watching them decline."

- Social Worker



Increased family requests place additional burden on staff and communications

Emerging Insights

The four insights are not exhaustive list. There are several emerging insights, including a few below, that merit further exploration in subsequent phases.

1. The successful utilization of technology for social support is heavily dependent on a resident's ability.

2. Texas only enforces federal minimum standards for staffing, which leads to staffing taking on additional responsibilities to meet resident needs.

3. Routines are now constantly disrupted by infection control protocols, and this stability is essential to resident mental and emotional wellbeing.

4. There is an implementation gap between guidance provided to facilities and how those facilities operationalize the guidance. Some organizations are better equipped to address that gap than others.

5. Modern (or legacy) facility design has a significant influence on adaptability to COVID-19 protocols.

6. What is regulated are those things that can be measured, but those things than can be measured don't always have the most direct effect on the quality of care.

Next Steps – Phase 2 and beyond

Next Steps

- Study additional nursing homes (i.e., other areas of Austin) where perspective would be informative
- Expand study to assisted living facilities and other models (i.e., aging in place)
- Interviews with residents and family, and staff that have departed the field
- Investigate role and utilization of technology
- Evaluate policies in place or being considered that may impact nursing homes and staffing
- Review value and cost from leveraging temporary staffing agencies
- Development of frameworks to understand landscape of challenges, and opportunities to respond

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Thank you.