DESIGN INstitute for HEALTH

Nursing Home System Study

Broadened Investigation (Phase 2) Synthesis

September 29, 2020

Deliverable 05
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.

Phase 2 Objective

The objective of Phase 2 was to further explore key learnings from Phase 1 from a broader perspective in terms of other types of long-term care facilities, subject matter experts, and people within the system, in order to develop holistic, strategic opportunities for how might we improve current and future outbreak responses in long-term care.

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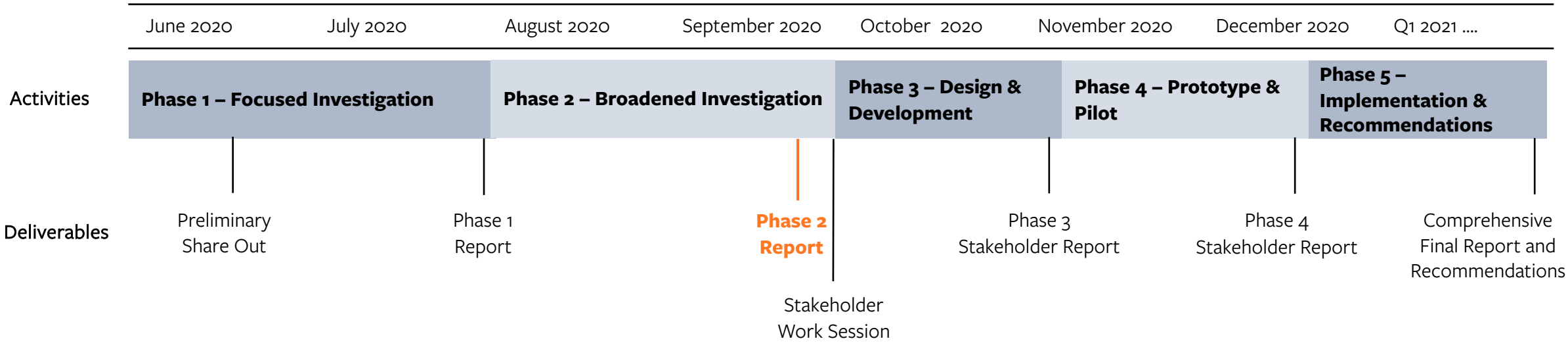
Project Timeline



**The full Statement of Work with phase descriptions can be found in the Appendix of this report.*

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

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THE UNIVERSITY OF TEXAS AT AUSTIN

SCHOOL OF NURSING

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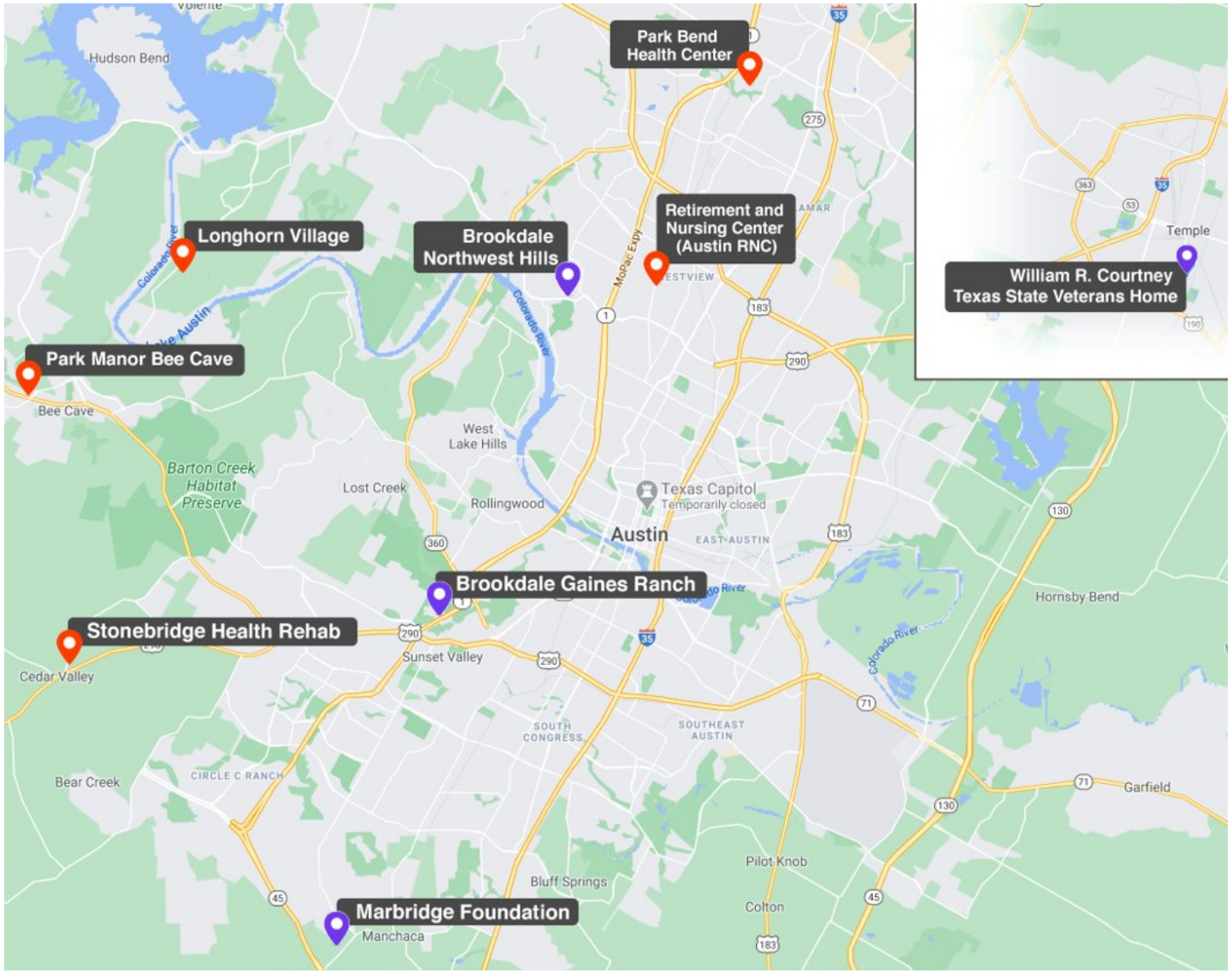
Phase 1 & 2 Facilities



PHASE 1

Park Bend Health Center
Skilled Nursing (SNF)
Size: 39,635 SQFT, 1 story, built in 2000, Total beds: 124; Occupied beds: 95

Stonebridge Health Rehab
Skilled Nursing (SNF)
Size: 39,650 SQFT, 1 story, built in 1997, Total beds: 116; Occupied beds: 63

Retirement and Nursing Center (Austin RNC)
Skilled Nursing (SNF)
Size: 47,834 SQFT, 2 buildings, built in 1971, Total beds: 150; Occupied beds: 73

Park Manor Bee Cave
Skilled Nursing (SNF)
Size: 53,724 SQFT, 1 story, built in 2013, Total beds: 140; Occupied beds: 82

Longhorn Village
Continuing Care Retirement Community (CCRC)
Size: 68,000 SQFT, 2 story, built in 2009, Total beds: 60; Occupied beds: 34

PHASE 2

Brookdale Northwest Hills
Assisted Living (AL)
Size: 98,077 SQFT, 3 Stories, Built in 1999, Service Type: Type B, Total Beds: 240

Brookdale Gaines Ranch
Assisted Living (AL), Independent Living (IL) Size: 220,789 SQFT, 5 Stories, Built in 1999, Service Type: Type A, Total Beds: 58

William R. Courtney TSVH
Skilled Nursing (SNF)
Texas State Veterans Homes provide affordable, long-term care for Texas Veterans, their spouses, and Gold Star Parents. Total Beds: 160, Occupied Beds: 151

Marbridge Foundation
VILLAGE AT MARBRIDGE
Assisted Living (AL)
Type A Assisted Living serving IDD citizens. Total Beds 90

MARBRIDGE RANCH
Assisted Living (AL)
Type A Assisted Living serving IDD citizens. Total Beds: 99

MARBRIDGE VILLA
Skilled Nursing (SNF)
Serving IDD citizens. Total Beds: 92

Context for Phase 1: Skilled Nursing Facilities

Why do nursing homes exist?

- 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.
- Most residents are in nursing homes because their loved ones were unable to meet the complexity of their needs at home.

Who resides within nursing homes?

- 55% of residents in Texas nursing homes have been medically diagnosed with dementia.
- In 30 years, the population in Texas over the age of 65 will triple. Those over 85 will quadruple by 2050.

Who regulates nursing homes?

- Nursing homes are highly regulated by Health and Human Services Commission in each state.

How are nursing homes funded?

- 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.

What staffing challenges do nursing homes experience?

- Staff workload (physically and mentally) is disproportionate to hourly wage. Certified Nurse Aide's average wage in Austin is $13/hr.
- Staff retention is a constant challenge for facilities and administrators.
- Competition for staff is fierce when the same skillsets are in demand elsewhere.

**Reference Phase 1 Report for sources*

Context for Phase 2: Independent and Assisted Living Facilities

How are Assisted and Independent Living facilities regulated?

- Assisted Living facilities are regulated and licensed by Health and Human Services (HHS). There are two types: Type A and Type B. For a Type A facility, residents need to be able to evacuate under their own cognitive and physical ability in 13 minutes with minimal assistance. Type B Facility residents require assistance in an emergency. [1]
- Independent Living facilities are not regulated by HHS.

How do residents pay for Assisted and Independent Living?

- Assisted Living facilities are generally paid for privately. Some will accept long-term care insurance, veterans benefits and rarely Medicaid (Medicaid STAR+PLUS waivers are very limited, hard to qualify for and generally have a waiting list).[2]
- Independent Living facilities are paid for privately as well. Some will accept long-term care insurance.

Is medical care included?

- Assisted Living facilities have some clinical providers onsite (for limited hours) and on call but most are **not** staffed 24/7 with clinical providers as is the case in Skilled Nursing facilities. [3]
- Independent Living facilities do not provide medical care. They are focused on providing social connections and activities with residents who are 55+ and lowering the burden of maintenance that would be needed to reside in a stand-alone single-family home. If medical care is needed while living in these facilities, a third-party contractor would be hired.

Note: Independent Living and Assisted Living facilities may be unattainable for those on limited incomes, as they are generally paid for via private funds. As such, Medicare and Medicaid may cover the costs of home health workers or personal care assistants who visit residents in their existing apartment/condo/home during a set schedule each week. These in-home services, while helpful, do not have the same level or oversight/accountability that an in-facility care team would have.

1. https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/assisted-living-facilities-alf
2. https://www.elderoptionsoftexas.com/paying-for-texas-assisted-living.htm
3. https://www.seniorliving.org/compare/assisted-living-vs-skilled-nursing/

Austin Area Skilled Nursing Facilities & Assisted Living Facilities (currently)

32

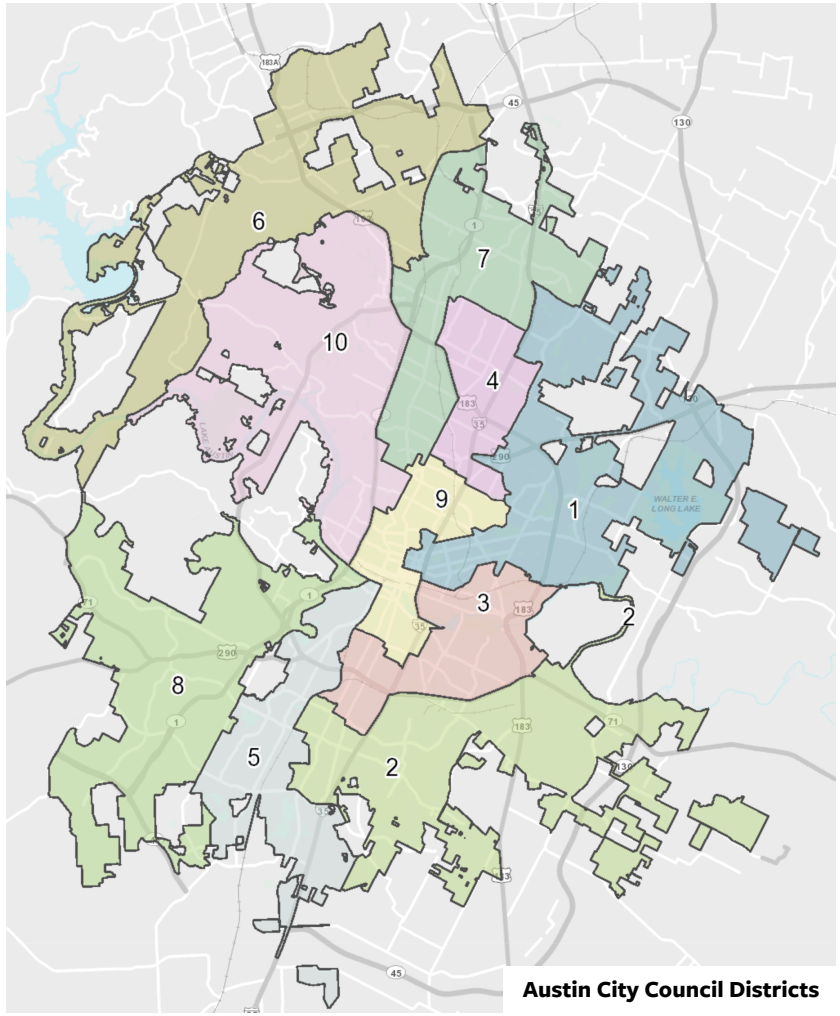
Skilled Nursing Facilities in Travis County

70

Assisted Living Facilities in Travis County

~90%

Of Austin's long-term care facilities are located west of I-35



Austin City Council Districts

Within Austin City Districts:

DISTRICT 1
4 Nursing Homes
3 Assisted Living

DISTRICT 2
None

DISTRICT 3
1 Nursing Home

DISTRICT 4
1 Nursing Home
3 Assisted Living

DISTRICT 5
4 Nursing Homes
8 Assisted Living

DISTRICT 6
3 Nursing Homes
6 Assisted Living

DISTRICT 7
4 Nursing Homes
9 Assisted Living

DISTRICT 8
2 Nursing Homes
8 Assisted Living

DISTRICT 9
1 Nursing Home
1 Assisted Living

DISTRICT 10
2 Nursing Home
7 Assisted Living

DISTRICTLESS
5 Nursing Home
14 Assisted Living

**This list does not include Independent Living facilities as they are not regulated by HHSC.*

Phase 1 Insights – Skilled Nursing Facilities

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 #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 #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 #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.

Phase 2 Expanded Insights – Independent and Assisted Living Facilities

INTRODUCTION

A majority of the key observations, findings, and insights we gleaned from our Phase 1 work were also present in the additional facilities we observed and interviewed during Phase 2. However, additional insights, specifically pertaining to variances noted in Assisted Living and Independent Living facilities did emerge, which are as follows:

Insight #5: **Aging-in-Place vs. Resident Safety**

Independent Living is primarily a lifestyle choice made by residents. Many seniors are drawn to the concept of living in a community with planned social activities and programming. In joint Assisted Living / Independent Living facilities and Continuing Care Retirement Communities (CCRC), residents appreciate the ability, when the times comes, to move into an Assisted Living or Skilled Nursing facility without losing the connection to their home and social network.

Generally speaking, Assisted Living and Skilled Nursing are both regulated by HHSC, while Independent Living is not regulated by any state/government agency. However, in crisis situations such as COVID-19, some operators/facilities of communities with varied facility types and resident acuity adopted and implemented more conservative guidance in the interest of protecting their more vulnerable residents. In some instances, this required Assisted Living and Independent Living residents (living in close proximity to higher acuity residents) to abide by more restrictions and to experience more significant constraints placed on their freedom and independence.

Insight #6: **The Price of Wellness**

Because Assisted Living and Independent Living facilities are primarily private pay, with some accepting long-term care insurance, select owners and operators of these facilities have less limitations with how they use their funds. In some instances, this translates to an ability to take a more holistic approach to care for residents that, for example, considers the six dimensions of wellbeing – physical, social, emotional, spiritual, intellectual, and occupational. In other instances, it means they have the gift of additional resources and space to respond to crises such as COVID-19 with more flexibility, adapting extra conference rooms for PPE storage. By contrast, Medicaid-funded Skilled Nursing facilities do not enjoy the same and tend to operate within tight financial and spatial constraints. While providing residents with this quality of care before and during a pandemic increases the potential for residents to live this chapter of their lives with fulfillment and purpose, the necessity for private pay prevents all aging populations from being able to equally access these living situations.

Phase 2 Expanded Insights – Independent and Assisted Living Facilities - *continued*

Insight #7: **Impact of Trust on Facility Culture & Staff Retention**

The correlation between communication, transparency, and trust in organizational cultures is widely understood. The presence and impact of these cultural elements was also felt in the Skilled Nursing, Assisted Living, and Independent Living facilities we observed. Facility leadership that was proactive and transparent about the nature of their COVID-19 planning, preparation and outbreak response were touted by staff as a key factor in their decision to continue working at those facilities.

Family Survey Overview

The families and caregivers of residents in long-term care facilities play a crucial role in the health and wellbeing of the residents. From our facility interviews, we learned that family, friends, and loved ones help fill gaps for resident care and quality of life (e.g., necessary social and emotional support, extra support at meal times, checking on missing laundry, etc.). Given the important role they play, we created a short, accessible five-question survey for family members and caregivers to share their stories, perspectives, and reaction to the COVID-19 response. We shared this with all the facilities we visited and asked them to distribute the survey through their family communication channels.

As guidance is ever-evolving, the family responses (and our initial questions) don't necessarily match current visitation policies. The changing nature of guidance will persist, so we will continue to incorporate family input throughout the subsequent phases.

85 Responses

5 Facilities took part in the survey

SURVEY QUESTIONS:

1. Tell us the story of how your resident came to live in this facility (e.g. location, resident preference, other options considered, physical/mental state, etc.)
2. Since March 2020 when changes due to COVID-19 started (i.e., restricted visiting), have you been in touch with your loved one?
3. How? (i.e., Facetime, Zoom calls, phone calls, window visits)
4. What has worked well for you? What hasn't worked? Why?
5. Overall, what have been your greatest concerns regarding your resident and/or the facility during COVID-19?
6. Anything else you would like to share? (Optional)

Survey Synthesis

Families provided important insight into their visitation experiences and their concerns with loved ones in facilities during COVID-19. The survey results were an important component in developing the strategic opportunities. **Select key takeaways are captured below.**

1) Family members are worried that their loved ones are declining due to the isolation.

Family members consistently shared their concern over the psychosocial impacts of isolation for their resident.

"I respect that protecting the health of all residents and staff takes precedence, but having my mom locked away behind closed doors dying alone sucks.."

- Family Member

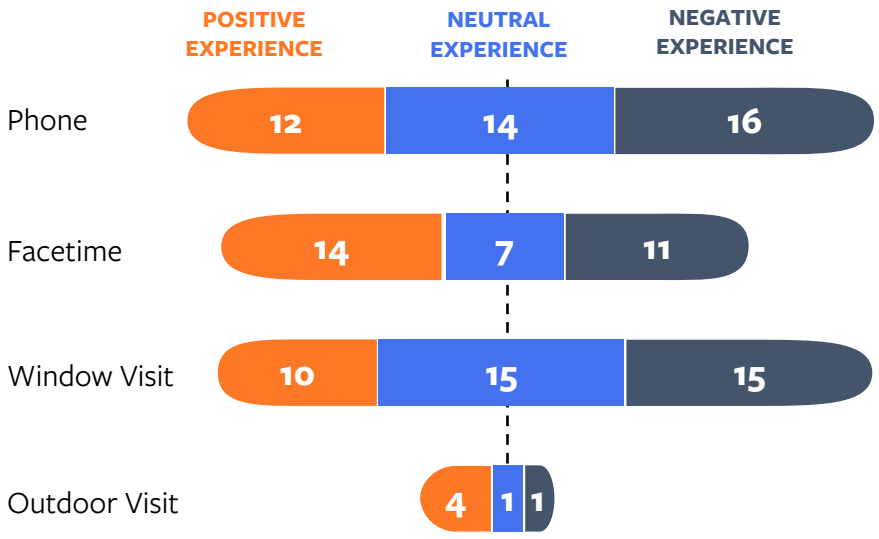
"Daddy getting sick and me not being there in person to hold his hand , talk to him and to hug him. He is getting depressed (understandable). Was told he wouldn't eat breakfast this morning. Which isn't like him."

- Family Member

2) There isn't a one-size fits all for visitation.

The survey responses showed varying experiences across the 4 types of communication/visitation between family and resident.

Visitation Experience For Families via Type of Communication



**Note that some families used multiple types of communication, so the numbers above do not match the number of respondents. Survey conducted from August 6, 2020 to September 16, 2020.*

Part 6

Strategic Opportunities

What Strategic Opportunities did we identify?

In this body of work, the specific Strategic Opportunities our team identified are as follows:

1. Infection Control – COVID-19 and Beyond
2. Staff Wellbeing
3. Expansion & Evolution of Staff Roles
4. Staff Retention and Incentives
5. Resident Wellbeing

Overview of Strategic Opportunities

Evolving guidance for COVID-19 protocols will continue to impact our strategic opportunity areas

Strategic Opportunity matrix	1. Infection Control – COVID-19 and Beyond	2. Staff Wellbeing	3. Expansion & Evolution of Staff Roles	4. Staff Retention and Incentives	5. Resident Wellbeing
 NOW	• Accommodating Different Learning Models • Building Depth in Knowledge • Cultural Self-Accountability • Reducing Physical and Cognitive Load • Accommodating Staff Basic Needs	• Preventing Staff Burnout	• Qualifying Non-Essential Staff	• Building Staff Morale	• Prioritizing Resident Dignity • Resident Engagement with Peers • Improving Communication Capabilities • Sustainable and Adaptable Visitation
 NEAR	• Interpreting Infection Control Guidance • Differentiated Infection Control Guidance • Optimizing Existing Space • Improving Staff Experience in PPE	• Prioritizing Staff Mental Health	• Expanding Staff Capability	• Improving Remuneration • Building Staff Camaraderie • Developing Cultural Leadership	• Re-establishing Visitation • Leveraging Community Assistance • Communication Technology Solutions • Coordinated Outbreak Isolation
 FAR	• Contained Networks Across the System • Flexible Space Considerations • Equitable Access to Resources • Proactive Future Planning	• Supportive Staff Spaces • Community Partnership to Support Staff	• Addressing Staffing Gaps • Advancing Staff Training	• Redefining Career Value	• Improving Family Placement Knowledge

1. Infection Control – COVID-19 and Beyond

NOW

Training **Building Depth in Knowledge**

How might we foster a deeper understanding of "the why" behind infection control protocols such that staff are empowered through knowledge to take proper, safe, effective action?

1. Consider creating training materials in languages other than English to facilitate staff comprehension and comfort with the subject matter.

2. Consider on-demand options for training materials such that staff can educate and re-educate themselves on an as needed basis, on their own time, and/or when they have the capacity for retention.

3. Consider methods such as video recording in select facility spaces as a means to observe, review, and discuss opportunities for improvement through concrete, personal examples in familiar context.

4. Consider ways to get collective staff buy-in around training initiatives by ensuring their discipline/department is represented in the planning and development (e.g. create a training and education committee).

> *"I would have really liked for them to do a whole webinar in Spanish or something that we can save so they can hear it and visually see it than just to hand them 35 pages of a handout all in Spanish."*
>
> ***- Director of Nursing***

A Director of Nursing facilitates impromptu PPE training with staff around a nurse's station.

1. Infection Control – COVID-19 and Beyond

NEAR

Training

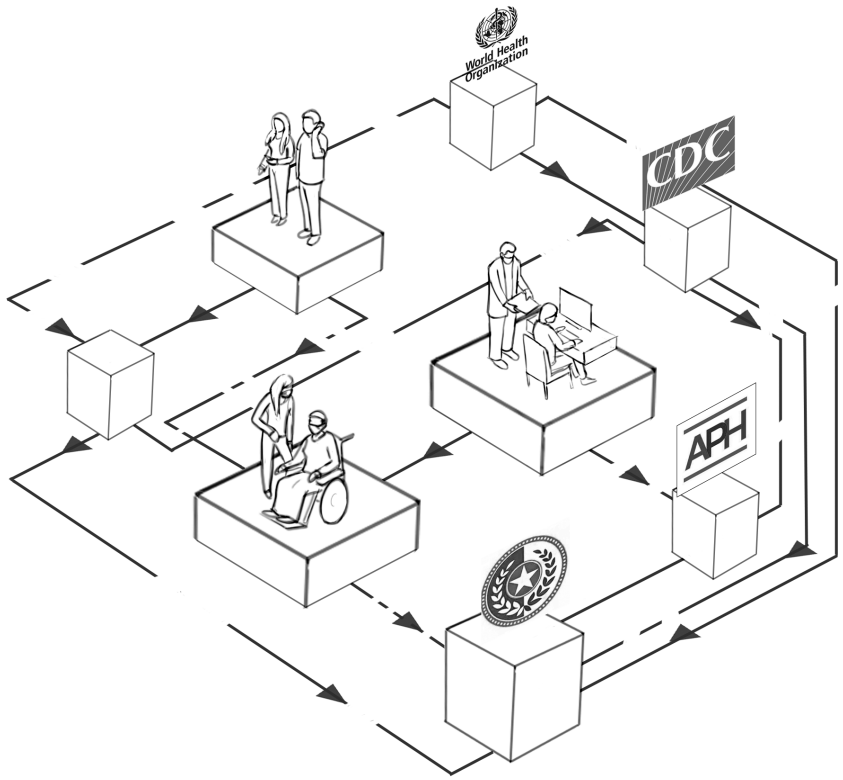
Interpreting Infection Control Guidance

How might we alleviate facilities' burden of accessing and interpreting infection control guidance to focus their attention and energy in a more beneficial way?

1. Consider publishing infection control guidance and updates as flow charts or decision trees (static or interactive) to reduce the cognitive burden of frequently needing to understand, interpret, and make decisions.

2. Consider creating a single platform (e.g. website, Google doc) per facility where updates, training materials, and other pertinent communications are archived, paired with easy, direct links to a point of contact who can answer questions in their specific domain(s).

3. Consider a centralized cloud-based system (an existing solution or a customized development) for guidance, two-way communication, and data collection for local and state-level needs.



1. Infection Control – COVID-19 and Beyond

FAR

Human Needs in PPE **Equitable Access to Resources**

How might we ensure timely, adequate access to resources critical for infection control (e.g. PPE) during times of crisis?

1. Consider a regional stockpile to expedite the distribution of PPE as opposed to relying on federal supply chains, as well as mitigate storage challenges many facilities face.

"So once those cases happened there [in Houston], I said, "Oh my gosh, it's going to be here and we need to start ordering PPE." The next week COVID-19 was in Austin and I checked our supplier and they said, "It's on back order". So I got on Amazon and I ordered so much with my personal money. I ordered so many masks and PPE from Amazon because I knew that was going to happen. And sure enough, that's how we survived from my Amazon mask order because it came. "

*- **Director of Nursing***

2. Staff Wellbeing

NOW

Preventing Staff Burnout

How might we address staff burnout by implementing support systems both within facilities and across the field in order to prioritize staff wellbeing, especially during and after crises like COVID-19?

1. Consider long-term care staff support groups and/or process groups led by a social worker or professional facilitator. Explore low-investment and low-fidelity options, such as email, phone/computer application, or virtual meet-ups.
2. Consider ways to support staff in their personal lives (i.e., childcare options, short-term loans, food pantry staples at discounted rate, meal delivery).
3. Consider coordinating and facilitating in-services focused on self-care and mental health first aid.
4. Consider collaborative partnerships with nearby hotels, restaurants, etc. where staff could be housed temporarily and get local meals delivered.
5. Consider avenues and forums to foster collaboration across facilities and reduce staff burden in order to facilitate idea generation and/or resource sharing for different roles (i.e., Facebook groups for Activity Coordinators to share ideas for activities while abiding by COVID-19 infection control protocols).

> *"I've had friends who don't work in the industry who ask about my work, and I say, "You wouldn't get it. I can't talk to you about it. You wouldn't get it."...Why is it I can talk to people who have been through it, and I won't talk to people who aren't in it?"*
>
> ***– Facility Social Worker***

A support group for long-term care staff led by a professional facilitator, such as a licensed social worker.

3. Expansion & Evolution of Staff Roles

NOW

Qualifying Non-Essential Staff

How might we redefine and expedite the qualification of non-essential staff as essential staff in order to create a labor pool capable of supporting resident wellbeing needs?

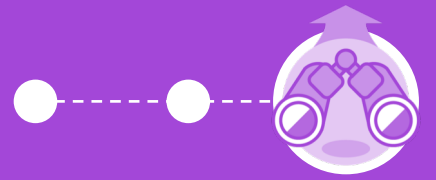
1. Consider qualifying volunteers as essential staff in order to create a minimal to no cost staffing solution who are willing and capable of supporting residents with their psychosocial needs.
2. Consider generating and regularly updating facility-specific crisis response onboarding materials (i.e. "Fast Facts") that includes key information such as points of contact, notable resident needs, floorplan, facility culture, etc. To expedite immersive training of new staff and other supporting personnel.

"Do you know how many people are at home right now that just want to get out and want to volunteer?...we've gotten letters like galore from pen pals. Well, most of my residents can't write and my staff, unfortunately, don't have the time to sit there and help them write a letter back, but a volunteer would do that. Can you imagine if I had a volunteer, that's all they did all day?"

- Facility Executive Director

A volunteer from the community helps a resident write a letter to a pen pal.

3. Expansion & Evolution of Staff Roles



Addressing Staffing Gaps

How might we proactively prepare for potential staffing gaps for future pandemics and/or outbreaks?

1. Consider ways to identify and proactively train analogous work forces (e.g. search and rescue volunteers, health professional retirees, medical/ nursing students, volunteer firefighters, etc.) to create an additional local labor pool ready for crisis response.
2. Consider increasing various staff to resident ratios to proactively balance and prioritize sustainable workloads for staff to allow for more flexibility during a crisis.
3. Consider developing and sharing a staffing model for crisis management for any future pandemics as a way to prepare for extreme situations (i.e. less than 12-hour notice that twenty staff members are unable to work).

"One thing they never tell you about COVID buildings... After someone has COVID we [social worker and three other staff members] had to go in there, pack all their belongings, wearing full PPE. Everything went to an offsite storage unit. And then you come back, and you have to deep clean all the rooms. So guess who was deep cleaning rooms? Guess who was packing up rooms? Guess who was coordinating with family members to come pick up belongings of people who had passed away from COVID?"

– Facility Social Worker

4. Staff Retention and Incentives

NEAR

Developing Cultural Leadership

How might we better understand best practices in successful, high-retention workplace cultures, including leadership characteristics, in order to create shareable learnings for other facilities?

1. Consider further research around high-retention facilities to better understand best practices and integral leadership characteristics that can then be shared with other facilities.
2. Consider leadership cultivation programs and initiatives to develop a workforce of strong, competent leaders for long-term care facilities.
3. Consider further research around the incorporation of program evaluation processes and feedback loops into leadership training in order to improve implementation and sustainability of facility initiatives.

5. Resident Wellbeing

NOW 

Resident Engagement with Peers

How might we balance engagement between residents with appropriate infection control protocols in order to prioritize quality of life and socialization in facilities?

1. Consider coordinating Facetime dates with neighbors to help create community while residents are quarantined to rooms.

2. Consider workarounds for resident activities to maintain normalcy and routines. A few examples: 1) play the same movie in every room, so residents feel like they are all watching the same movie together, 2) divide resident activities by hallway and facilitate group activities in small pods (socially distanced with individual materials).

3. Consider fun ways to engage residents in safety protocols such as hats that have built in face shield.

"The only concern we have is the isolation of our parents from us and from each other and the effect on their mental well-being."

- Family Member

"I think my biggest concern is that the isolation causes loneliness and depression. And that he will pass before a cure can return things to some semblance of normalcy."

- Family Member

5. Resident Wellbeing

NEAR

Re-establishing Visitation

How might we design a visitation area that can be used for future pandemics or immunocompromised visitors such that the experience respects resident privacy, incorporates the element of touch, and is a sustainable, long-term resource?

1. Consider creating a permanent space that can be used for visitation for any future outbreaks/ pandemic and/or immunocompromised visitors beyond COVID-19.
2. Consider implementing readily available touchless inexpensive audio solutions to improve visitation experience for both family members and residents. Also, potentially eliminating the need for a staff member to "supervise" the visit.
3. Consider further research around visitation with touch. Reference analogous examples, such as neonatal visitation units and South Korean's phone booth testing sites.

A woman visits her grandmother in a futuristic visitation booth - allowing for embrace and physical contact.

5. Resident Wellbeing

NEAR

Leveraging Community Assistance

How might we leverage and engage community networks and organizations to provide resources and connection to residents such that a sense of normalcy is brought back to the facilities in a COVID-safe way?

1. Consider redesigning community spaces for residents to safely enjoy group activities with appropriate social distancing and smaller groups.
2. Consider utilizing outdoor spaces to bring local entertainers on site for resident events. Use the same staffing screening protocol for risk mitigation.
3. Consider coordinating with Austin Parks and Recreation to allow nursing home residents to visit local parks to get outside.

A MOMENT OF REFLECTION

We started this work with the intent to contribute to the collective goal of reducing morbidity/mortality in long-term care facilities due to COVID-19 by leveraging our design expertise to identify and ultimately pilot various tools and strategies that will support, enable, and empower facilities – their staff, residents, and resident families – to be more resilient today, and in potential future outbreaks.

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Simply put, in many ways, COVID-19 did the unthinkable – it halted U.S. society in March 2020, and has since forced us to pause, step back, and reflect on exactly where we are and how we got here. As we approach the start of the 87th Texas Legislature, the time to present big ideas, ask hard questions, and together find the best way forward is now.

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In the context of this work, this means examining the long-term care system in greater Travis County (and beyond) and asking, for example:

- **When, if ever, should we prioritize a person's quality of life over infection control, and allow them to live the last 1-2 years of their life as optimally and humanely as possible?**
- **Societally, people are living longer with more chronic conditions and less money – what practical, affordable long-term care options exist for the aging populations of today and their needs as modern medicine will work to keep them alive?**
- **What behaviors and practices are we incentivizing in the long-term care system, and do they result with the realities and needs of facilities, staff, and residents?**
- **How are all people and entities in the long-term care system communicating with one another, and are there opportunities to resolve breakdowns and augment coordination and collaboration?**
- **How do we rethink how American society treats our aging population and encourage integrated, multi-generational community approach to facilities?**

Gratitude

Our team is grateful for the City's commitment to the cross-functional collaboration on this initiative. The knowledge, perspective, guidance, and collegiality in every phase of the effort has made the work immeasurably better, not just for this study, but for the nursing homes and the residents they serve.

As one facility administrator told us, "I think one of my godsends through this whole situation has been the Austin Public Health Department, I really don't know where we would have been without them...I don't know how people do it in other counties where they don't have Austin Public Health helping them and being that involved with the facility issues...had we not had them I truly believe that we would have been in a much worse situation."

We also want to thank all of the partners that continue to make this project possible and the Steering Committee who continues to serve selflessly.

We are working to secure funding to support the subsequent phases of this work and look forward to collaborating with each of you again.