Voices From the Field: COVID-19 Discussions with Senior Housing and Care Operators Highlight Agility and Dedication

By Ryan Brooks, Senior Principal, Research & Analytics, NIC

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"I don't think our infectious disease protocol will ever go back to the way it was before, quite frankly. COVID has changed all of us and how we look at infectious disease."

In March and April of 2021, researchers from the National Investment Center for Seniors Housing and Care (NIC) and NORC at the University of Chicago (NORC) spoke with a dozen senior housing and care operators about their experiences, challenges, and successes throughout the COVID-19 public health emergency during 2020. Discussion topics included workflow changes implemented in response to various state and federal requirements, testing strategies employed, PPE access, challenges with dementia care residents, interventions to address loneliness and social isolation, and efforts to vaccinate residents and staff.

These qualitative interviews came from senior housing and care operators located in a variety of states, including Colorado, Connecticut, Florida, Georgia, and Pennsylvania. Operators ranged in size from just a few properties to several hundred and included both for-profit and not-for profit status, freestanding and mixed-use properties, and CCRCs (Continuing Care Retirement Community, aka Life Plan Community). These interviews supported the quantitative analysis on COVID-19 mortality rates by care setting and allowed the research teams to better understand the context of the COVID-19 death data as well as the challenges they faced throughout the various stages of the COVID-19 pandemic and associated public health emergency.

"The collaboration and creativity between departments and team members was probably the silver lining of all of this. It knocked down a lot of silos."

Key findings from the quantitative study show that 51% of senior housing properties studied experienced no COVID-19 deaths in 2020, made up by 67% of independent living, 64% of assisted living, 61% of memory care, and 39% of skilled nursing properties experiencing no COVID-19 deaths in 2020. COVID-19 mortality rates across senior housing increased as the health and caregiving complexity of residents increased, with independent living properties' COVID-19 mortality rate being comparable to that of their respective counties. This suggests that residents who live in independent living properties were not at higher risk by virtue of their congregate care setting.

A second phase of the study is being planned to build upon these findings by comparing death rates across levels of care while risk-adjusting for age and health status, as well as understanding the impact of COVID-19 on all-cause mortality by care setting. To view the study's complete findings and conclusions for Phase 1, please visit NIC's COVID-19 study landing page.

A predominant theme from the interviews is that senior housing and care operators were incredibly agile and dedicated through the pandemic and worked 24/7 to keep residents safe while continuing to compassionately care for residents. NIC is publishing a selection of stories and quotes from our series of interviews to highlight the efforts that operators have successfully made to protect, safeguard, and maintain engagement with their residents and staff. This may be helpful as a guide moving forward.

Staffing and Workflow Changes

The COVID-19 public health emergency necessitated fundamental shifts in processes, workflows, and operational thinking to protect patients, residents, and staff. Throughout the pandemic, operators remained nimble, adapting to keep their properties appropriately staffed to meet the social and medical needs of residents. These process changes ensured safety as new tasks, like donning and doffing personal protective equipment (PPE), were introduced.

Throughout the pandemic, many operators faced devastating staffing shortages. For some operators, providing employee recognition, appreciation from executive leadership, and increased communication were enough to maintain a stable workforce. For others, incentive pay, bonuses, and additional paid time off were needed.

"We had to create new positions – like the screening folks, in-room dining attendants – because everything went to room service. There was a lot of pivoting of people doing jobs. The drivers weren't driving buses, they were converted to cleaners or greeters."

Staff at many properties also had to learn several new processes that previously hadn't been needed. These included setting up plastic walls, setting up clean rooms for donning PPE, setting up dirty rooms on the exit side for staff doffing PPE, how to appropriately wear PPE, how to care for residents who were COVID-19 positive, and how to go home and come back to work safely. Many of these incredibly important new tasks had to be learned for the first time.

"One of the biggest things we realized is that [the pandemic] really created a labor shortage. As time went on, it wasn't just cohorting within your campus. It was cohorting for those who had more than one job. And in healthcare, for the direct caregivers, often they are carrying two jobs, in two different environments."

Establishing a Central Command Center

In the early days of the pandemic – January, February, and March 2020 for most operators – establishing emergency command centers or task forces that focused solely on the pandemic occurred often. These groups were responsible for establishing different levels or stages, based on statewide and community COVID-19 penetration data. Staffing ratios and changes to what residents could or could not do were determined by the corresponding stages.

"We had an emergency command center set up that could immediately go into action. This very quickly became a full-time project."

Emergency command centers aren't a novel concept in long-term care or other healthcare institutions. Command centers are made up of a collection of various departments that come together to help communities and residents through a crisis. One executive vice president of operations of a multi-state operator explained that they were already experienced at setting up command centers to handle emergencies, including hurricanes, floods, wildfires, and tropical storms. A few things differentiated the COVID-19 command center from others, however.

First, there was no existing manual with COVID-19 protocols to open, as there would have been with an impending storm or potential flooding. There is also often advance notice when a hurricane is

coming. A command center is set up three days in advance, everyone knows the protocols and their respective roles, there's an emergency manual with procedures to be followed. When the critical event ends, the command center closes within a few days, and remains closed until the command center is needed for the next critical event. In the case of the COVID-19 public health emergency, many command centers have remained open throughout its entirety.

"There were these moments of time where we thought "Yes! Testing sounds like a great idea – let's build a protocol around it. And then you went into the reality that, you couldn't get testing, and when you could, you were passing the quarantine time before you got the test results. Testing was the thing that kept breaking our hearts because we wanted it to work in a way that we felt it should."

The FDA first gave emergency use authorization to a COVID-19 vaccine on December 11, 2020. Prior to this point, a robust testing strategy remained the most effective strategy for protecting residents and staff from widespread infection. Testing strategies differed based on a variety of factors, including various state-level requirements, community infection rates, and possibly most importantly, actual availability of tests.

"In March and April (2020), you could barely get people tested. HHS told us to test people twice after coming from the hospital, but this wasn't possible because there were no tests."

Many organizations made strategic plans under the assumption that testing would very soon become widespread and easily available, which in retrospect, was clearly not the case. Even when testing was available, turnaround times for obtaining results could sometimes take weeks – even at times exceeding the required quarantine period. In these unfortunate situations, residents underwent the uncomfortable nasopharyngeal PCR testing process unnecessarily.

"Testing has been a challenge, and I really think if it was available more, we would have been able to curb [COVID infections] a little bit better."

Access to Personal Protective Equipment (PPE)

Personal protective equipment (PPE), including masks, gowns, and gloves are an essential component in protecting seniors housing and care residents and staff from COVID-19. Even when the pandemic is finally behind us, the continued use of PPE will be a standard practice in the sector. Unfortunately, during the first several months of the pandemic, access to PPE was a well-documented challenge.

Global supply chain issues led to an overwhelming shortage of the necessary PPE in seniors housing and care in the beginning of the public health emergency. Operators were competing against each other for the limited PPE supply at the same time as demand was being driven up by all businesses looking to acquire such stocks. Operator interviews indicate that larger, multi-state operators, who were more likely to have existing relationships with multiple suppliers, had a somewhat easier time obtaining the needed PPE. Smaller operators were more likely to find their distributor unable to meet their requests. Oftentimes it seems their stock may have been sold to a higher bidder.

> *"Procuring even the simplest things became difficult. I remember feeling so helpless that I couldn't get thermometers for my associates to take resident temperatures."*

One executive interviewed highlighted her experience procuring PPE during the pandemic, and how it differed from the routine process. This executive recounted sitting at a cargo bay waiting for their international shipment to arrive by plane. She was waiting with representatives from the Sherriff's Department and another hospital, who were all vying for the same materials. Ultimately, on this trip, she was not able to get the supplies that the company had already paid for. Stories like these became more pervasive throughout the pandemic, with governmental agencies, healthcare entities, and businesses all competing for the same limited supply of PPE.

Following this experience, this executive began using her personal garage to store all the needed supplies and equipment. She joked that she became known as the "west coast shipping center," as she had begun storing goggles, thermometers, and PPE and she would ship directly from her house to west coast properties, as it would often be faster.

> *"We vetted over 1,000 vendors, to get down to 36 that had valid, acceptable materials to use."*

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Challenges with Dementia Care

Memory care units serve a particularly vulnerable population that thrives on routine and daily structure to keep patients calm and safe. Operators reported that memory care residents often did not adapt well to infection control and operational workflow changes. Patients with cognitive impairment were unable to understand the need for social distancing, masking, or why visitation was banned. Many were extremely fearful of staff wearing PPE and were not able to or were unwilling to themselves wear PPE. While social distancing measures were critical to reducing the spread of COVID-19, operators emphasized the particular challenge with memory care as residents typically require very close contact care, such as dressing, bathing, and feeding.

"[Memory care] residents did not do well with iPads. It was hard on family members because residents did not recognize them."

Loneliness and Social Isolation

As the public health emergency unfolded in the early months of 2020, senior housing and care operators had to rethink non-essential group activities and events. Essential activities like meals were brought to resident rooms or were staggered to minimize contact with multiple staff members and other residents. Operators suddenly needed to find creative ways of ensuring that physical separation did not translate to social isolation and feeling of loneliness. Many activities, like religious services and interactive games, started to be broadcast directly to residents' rooms.

"There are a lot of stories about social isolation, and they are real. But there are lots of heroic stories about connection that are just as real."

Residents were often still able to sit in their doorways to participate in activities that were being led in the hallways, allowing for a safe distance to be kept between residents. In properties where dining halls closed, food delivery became a consistent avenue of social interaction. Nutrition workers bringing meals were making enhanced efforts to make a social connection and connect with the resident – even if only for a few minutes. This often meant that residents had at least three reliable interactions a day.

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Vaccination Efforts

Some forward-thinking operators mandated staff vaccinations as a condition of employment shortly after the emergency use authorization was given by the FDA. Others were more cautious, given the fact that the FDA's approval was only for emergency use. Operators who did mandate vaccinations as a condition of employment did so to make their environments safer for both staff and residents.

"This is fundamental. Our residents deserve to live in a vaccinated environment, and our staff deserve to work in a vaccinated environment. It is the right thing to do."

A critical component of vaccination efforts across the board was education. These education efforts came from all angles and was particularly needed to fight misinformation that could often be found on social media. Some operators had executive leadership make video messages encouraging vaccination to all employees. Others brought in outside physicians and infectious disease experts to hold town halls for staff, answering questions and dispelling myths in the process. Many found that pro-vaccination peers, working in similar roles, were the most effective messenger.

Each of these interviews provided insight into the efforts that operators made to protect, safeguard, and maintain engagement with their residents and staff throughout the COVID-19 public health emergency. As it looks increasingly likely that the coronavirus will become endemic and a permanent part of our lives in some fashion, it is imperative that the industry take stock of the lessons learned during this time. Throughout this entire period, the seniors housing and care industry proved how quickly they can respond and how agile the industry is.

As mentioned earlier, a second phase of the study is being conducted and that will compare mortality rates across levels of care and will take into account age and health status of individuals. These data findings will be critical to improving the public's understanding of the safety levels within the various seniors housing care segments. Phase 2 of the COVID-19 research study is expected to be completed by March 2022. the 2018 pace of new supply growth until 2026.

As stated at the beginning of this article, it is also important to keep in mind that these estimates are solely based on demographic demand and do not consider changing consumer preferences regarding their housing and care needs.

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