

September 3, 2020

Committee on Equitable Allocation of Vaccine for the Novel Coronavirus
National Academies of Sciences, Engineering and Medicine

Re: *Discussion Draft of the Preliminary Framework for Equitable Allocation of COVID-19 Vaccine*

Dear Co-Chairs Gayle and Foege,

The American Seniors Housing Association (ASHA) and Argentum appreciate the opportunity to provide comments to the committee's *Discussion Draft of the Preliminary Framework for Equitable Allocation of COVID-19 Vaccine*. ASHA and Argentum are the leading national associations representing the professionally managed senior living communities and the older adults, staff, and families they serve. Our member companies offer the entire spectrum of seniors housing – independent living, assisted living, memory care, and Continuing Care Retirement Communities (CCRCs). Since February, our member operators and their senior living staff have been serving on the front lines of this pandemic, working tirelessly and compassionately to keep safe and engaged the almost 1.9 million residents who call “senior living” home and the close to 1 million employees who serve them. We anxiously await the development of a safe and effective vaccine to keep both residents and the senior living workforce safe.

As we continue to navigate these uncertain, unprecedented times, we appreciate the committee's work to develop guiding principles, risk-based allocation criteria and recommended phases for vaccine allocation. We appreciate the complexity associated in developing this overall strategy to address what will be a serious supply/demand decision making process and applaud the expertise and comprehensive approach you have brought to this effort.

Overall, we are very encouraged by the Preliminary Draft Report that assigns health care workers and high-risk seniors as recommended population groups for inclusion in Phase 1 in a four-phased approach to COVID-19 vaccine allocation. **ASHA and Argentum support this recommendation but request that more inclusive terminology be used in the setting descriptions. The report includes and references terms such as congregate care, residential care facilities, assisted living, long term care, nursing homes and skilled nursing homes but it is critical that when finalizing the report relative to the Phase 1 population groups, “senior living community residents and employees” are expressly included in these groupings.**

Senior living communities across the country are serving seniors and employing an essential health care workforce alongside the well-recognized and critically important nursing and skilled nursing home settings. However, nursing home settings are often generally referenced by policymakers and the media to convey long term care in its entirety. For example, the draft report currently calls for the first phase to include “older adults living in congregate settings” and cites nursing homes and skilled nursing facilities as examples. Senior living communities such

as assisted living, independent living and CCRCs are also examples and should be included in this description. Otherwise, 2 million seniors and 1 million workers could be overlooked for vaccine prioritization.

While there are differences in the two settings, the senior living industry is very much serving on the front lines during this COVID-19 crisis, along with the rest of the health care system, including nursing homes, placing our residents and team members at much risk for COVID-19. Senior living houses a high-risk population (average age is 85) living in close proximity to each other. The model of senior living is to build a “community” where residents can interact with one another through group activities and dining, and family members are encouraged to visit. Senior living communities involve far more group activities, onsite and offsite, than nursing homes which increases the need for a vaccine to prevent disease transmission. In senior living, residents tend to be more independent, more likely to congregate in the building’s common areas, and more likely to leave the building, where they can be more exposed to the virus. As the country “reopens” after months of sheltering in place, senior living residents’ potential risk for exposure to COVID-19 may therefore be greater than for many skilled nursing home residents.

And so, unless the senior living settings (both residents and employees) are expressly defined and included in the recommendations for prioritized vaccine allocation, they will be at risk of being inadvertently excluded.

The Senior Living Resident: This senior population is at higher risk than other older adults for COVID-19 infection, death, and other poor outcomes related to isolation and quarantine. As the NASEM noted in its release of the draft, as of August 1, nearly 80 percent of all COVID-19 deaths in the U.S. have occurred in people over the age of 65, which makes them among the most vulnerable groups when determining a vaccine distribution plan. Senior living residents have a significant need for assistance with daily living tasks putting them in contact with direct care workers, which increases their risk of transmitting infection. Their higher- than- average age and presence of chronic conditions puts them at higher risk of death. And preventative measures, such as lockdowns and isolation, are accelerating functional and cognitive decline among this population, leading to poor health outcomes. Protecting older adults, including those in senior living communities and the seniors living workforce, must remain among the highest priorities in the vaccine distribution plan.

The Senior Living Workforce: Our heroic staff have been serving on the front lines of this pandemic, caring for our seniors, risking their own health for the welfare of the seniors they serve. These caregivers, nurses, housekeepers, dining staff and others interact with the residents daily, placing themselves in danger of either contracting the disease themselves and further risk infecting their families and loved ones at home. Due to lack of rapid testing capability, the asymptomatic individual can carry and transfer the virus to the resident populations and possibly create an outbreak in the community. The consequences for each of these scenarios is dangerous and can be mitigated once a vaccine is developed and distributed.

There are still a lot of unknowns about this virus but what we do know is that the people working on the front lines in senior living communities are the reason the residents have a fighting chance against COVID-19. They do their jobs against the backdrop of supply and testing shortages and worker disruptions due to childcare needs, illnesses and even fear. They must be protected.

An operators' ability to prevent and mitigate transmission of COVID-19 in their communities is affected by the rate of infection in the surrounding geographies, as well as access to personal protective equipment (PPE) and testing for current infection. These are circumstances largely out of our control despite our best efforts, thus supporting the call for prioritization in vaccine distribution.

The following details the characteristics of the senior living continuum, the workforce, and our experiences responding to the COVID-19 emergency thus far.

Senior Living Continuum of Care

Senior living refers to a range of service-enriched housing aimed at older adults who want or need specific service amenities or help with activities of daily living. Private pay senior living evolved to offer a residential alternative to nursing homes—to provide a safe version of home that prioritizes hospitality, comfort, and independence versus the institutional setting of skilled nursing facilities.

Senior living encompasses a wide continuum of senior living options.¹ Services offered in independent living and assisted living communities vary, but typically include prepared meals, transportation, housekeeping, social activities, and medication management assistance. Residents in independent living may need help with instrumental activities of daily living (IADL) like transportation or shopping; residents of assisted living require help with more basic self-care, or activities of daily living (ADLs), like bathing or walking.

Equally important to the physical assistance services provided through senior living are the human interactions and connections available to residents in these communities. Social isolation, or the lack of social connection, can lead to loneliness, which is often linked to increased health risks.² In a recent report from the National Academies of Sciences, Engineering and Medicine, researchers found that social isolation was associated with a 50 percent increased risk of dementia. Seniors living helps combat loneliness through the community it provides; opportunities for seniors to interact with others through communal dining; and onsite programming to engage residents in socially and emotionally meaningful activities.

Older adults who live in independent living and assisted living communities tend to be among those with the highest levels of chronic illness, functional impairment, and healthcare utilization. Many senior living operators support residents with their complex health needs (e.g., medication management, care coordination), and some forward-thinking operators have arranged healthcare onsite to strengthen access to primary care and offer an integrated experience for residents and families. The combination of housing and supportive services—including

¹ Continuum of senior living options include senior apartments, cohousing, active adult communities, independent living, assisted living communities or assisted living facilities, continuing care retirement communities, subsidized/affordable senior housing, and respite care. For more information on each of these communities: <https://www.bettercareplaybook.org/blog/2019/16/senior-living-101-primer-senior-living>.

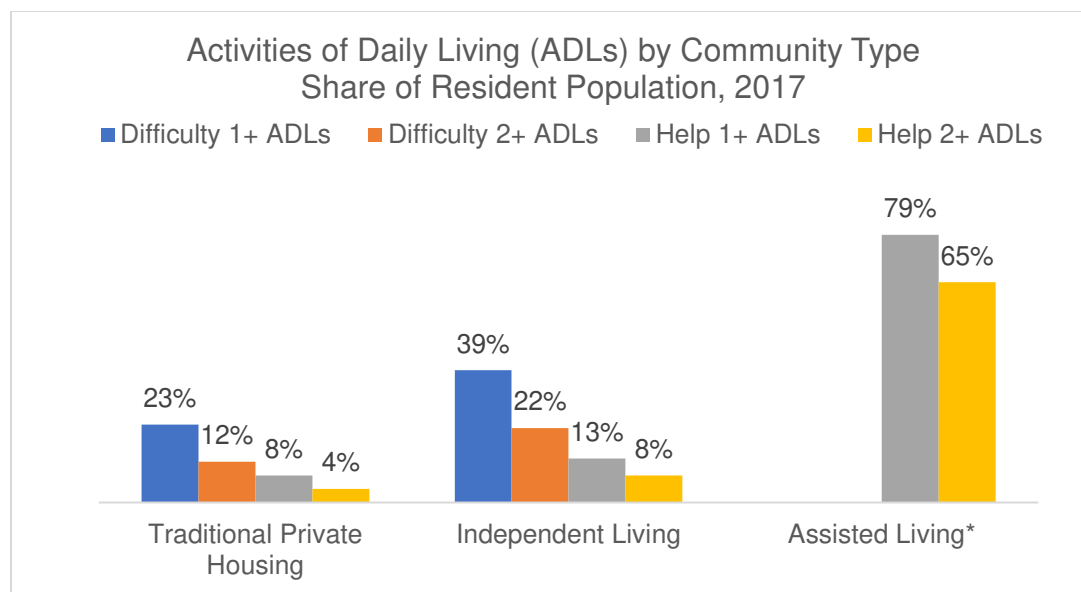
² National Academies of Sciences, Engineering, and Medicine. 2020. *Social Isolation and Loneliness in Older Adults: Opportunities for the Health Care System*. Washington, DC: The National Academies Press. <https://doi.org/10.17226/25663>.

healthcare—creates value for residents and families, as well as healthcare providers and insurers.

Senior Living Residents Request Assistance from Others for Daily Tasks

Residents in the various settings along the senior living continuum (e.g., independent living, assisted living, memory care and CCRCs) need long-term services and support – that is, help from another person with ADLs, such as bathing, eating and dressing, at higher rates than older adults in traditional private housing. Assisted living residents experience much higher need for help with both 1+ and 2+ ADLs compared to those living in private housing (Figure 1).³ A higher prevalence of independent living residents have difficulty and need help with multiple ADLs.⁴

Figure 1



*Note: NO comparable data on having difficulty with ADLs in Assisted Living.

Source: ATI Advisory analysis of 2017 Medicare Current Beneficiary Survey, presented in the [2020 Seniors Housing Data Book](#)

Senior Living Residents Are Vulnerable to Serious Illness

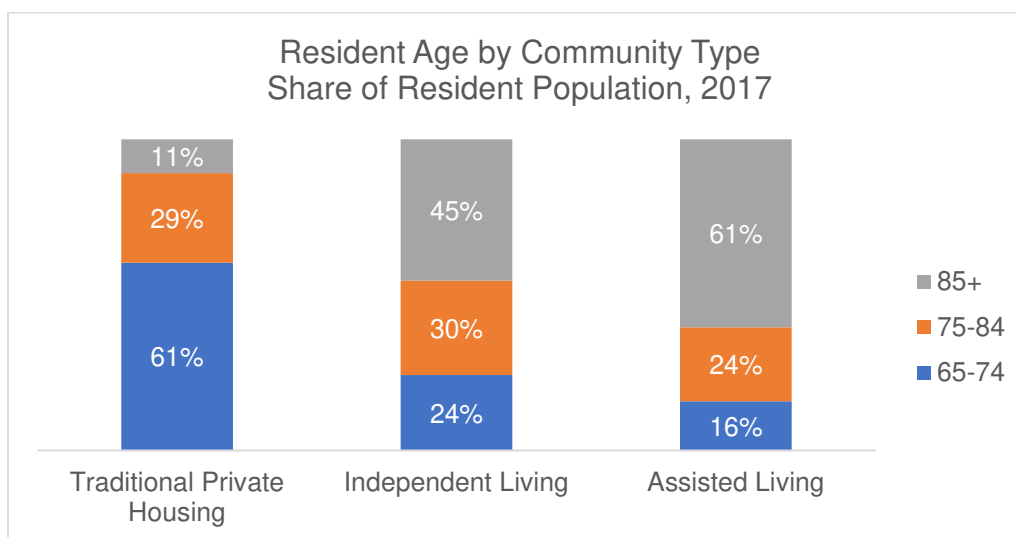
Compared to older adults living in private housing in the community, residents of independent living and assisted living are older and have higher rates of cognitive and functional impairment. Given these and other health risk factors, residents are at increased risk of serious illness and death, if infected with COVID-19.

Senior living residents are, on average, older than those who live in private housing in the community (Figure 2). The average age is 82 for independent living residents and 85 for assisted living residents, yet only 74 for those living in private housing.

³ Needing help with 1 or 2 of the following 6 ADLs: bathing, dressing, eating, transferring, walking, and using the toilet.

⁴ For more information on seniors housing, including nursing home resident profiles, see ATI Advisory's Seniors Housing Data Book, <https://atiadvisory.com/2020-seniors-housing-data-book/>.

Figure 2

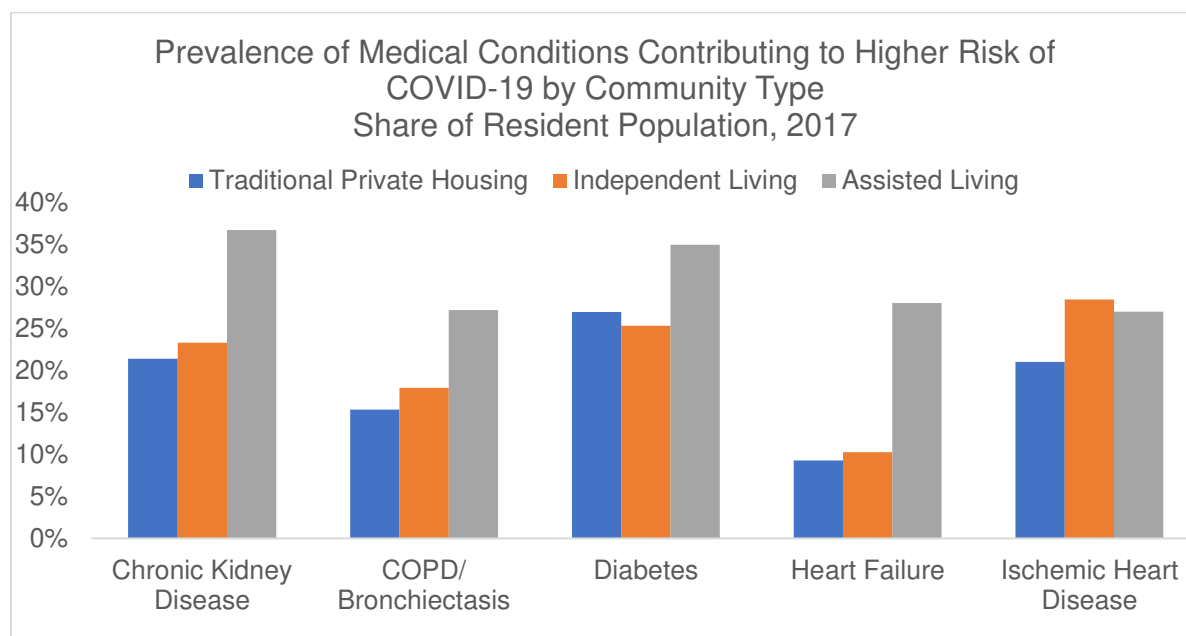


Source: ATI Advisory analysis of 2017 Medicare Current Beneficiary Survey, presented in the [2020 Seniors Housing Data Book](#)

The prevalence of certain chronic conditions among the senior living population creates a higher risk for poor outcomes from COVID-19 compared to those in private housing in the community. According to the Centers for Disease Control and Prevention (CDC)⁵, people with chronic kidney disease, chronic lung disease (such as COPD), diabetes, and serious heart conditions are at a higher risk for severe illness from COVID-19. These conditions are more prevalent among assisted living residents in particular – 49% of those living in private housing have at least one of these five conditions; but the prevalence is higher, 68%, for those living in assisted living communities. This pattern holds for each individual condition, as the prevalence of heart failure is more than triple for assisted living residents, compared to private housing residents, and the prevalence of both CKD and COPD are almost double. Independent living residents have a chronic condition profile that is more similar to private housing residents than assisted living residents, but still experience higher prevalence rates of all specified conditions except diabetes (Figure 3).

⁵ Centers for Disease Control & Prevention, "People Who Are At Higher Risk for Severe Illness," <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-at-higher-risk.html>.

Figure 3



Source: ATI Advisory analysis of 2017 Medicare Current Beneficiary Survey, presented in the [2020 Seniors Housing Data Book](#)

Preventative Strategies Take Their Toll

Operators have infection control protocols in place to reduce the spread of pneumonia, urinary tract infections, influenza, etc. However, despite clinical knowledge and preparedness for flu viruses (influenza A and influenza B), operators face an enormous task in protecting residents from SARS-CoV-2, the virus that causes COVID-19. Early research indicates its high contagiousness and rapid spread,⁶ and there are still many unknowns including routes of transmission (e.g., through air particles) and the likelihood and timing of vaccine availability.

Operators' ability to prevent and mitigate transmission of COVID-19 in their communities is affected by the rate of infection in the surrounding geographies, as well as access to personal protective equipment (PPE) and testing for current infection. Other external factors such as public health guidance, state mandates, and other public policy decisions have informed and directed operators' responses (e.g., visitor limits, testing requirements and cadence).

Operators recognize, however, that the responses and many of these protocols, prolonged over time, may pose a different set of risks to residents. Isolation, lack of engagement, and loneliness can contribute to functional and cognitive decline as well as depression and anxiety. As societal risks from the COVID-19 pandemic continue for the foreseeable future, and with states relaxing restrictions, senior living operators are responding with strategies to minimize both COVID-19 transmission risk and the risks of poor outcomes resulting from isolation. Social isolation, or the

⁶ Sanche S, Lin YT, Xu C, Romero-Severson E, Hengartner N, Ke R. High contagiousness and rapid spread of severe acute respiratory syndrome coronavirus 2. *Emerg Infect Dis.* 2020 Jul. <https://doi.org/10.3201/eid2607.200282>.

lack of social connection, can lead to loneliness, which is often linked to increased health risks.⁷ In a report from the National Academies of Sciences, Engineering and Medicine, researchers found that social isolation was associated with a 50 percent increased risk of dementia.

As operators begin to permit more resident engagement, allow non-essential visitors, and enable new move-ins, seniors living providers are taking a strategic public health approach to balance multiple competing priorities and risks. The industry is committed to ensuring the safety of their residents and workers during the COVID-19 emergency as well as long-term health and social-emotional issues unrelated to COVID. Access to PPE, testing for residents and staff and, eventually, access to a vaccine are key factors for consideration as they develop and implement new strategies.

Protecting the Health and Capacity of the Workforce

Infection control and prevention is critical to protect residents of independent and assisted living and those who work with the resident population. Personnel often have extensive and close contact with vulnerable populations within the senior living population. According to CDC guidance, health care providers with signs or symptoms of COVID-19 should be prioritized for SARS-CoV-2 testing. The CDC also recommends using authorized nucleic acid or antigen detection assays that have received an FDA Emergency Use Authorization to test persons with symptoms when there is a concern of potential COVID-19.⁸

While CDC has provided guidance for testing for current infection, testing in senior living is also dependent on both operator resources and state requirements. States may require widespread testing for staff and residents, but many operators struggle with access to, and resources, for testing. We are encouraged by recent attention to these challenges and note that the same issues are relevant for prioritization of vaccine distribution. In addition, prioritizing testing, and vaccine supplies for older adults in senior living communities and facilities, the prioritization must extend to workers in these communities.

The Senior Living Workforce Are Part of the Essential Healthcare Workforce

Senior living workers are an integral part of the essential healthcare workforce, and they cannot be overlooked in the federal plans for vaccine distribution. These workers are in direct contact with residents, while engaging with their broader community outside of the senior housing community. Because of the potential exposures, workers should remain a tier 1 priority in order to protect their health and safety and mitigate the potential exposure for the senior housing population.

We cannot serve our vulnerable seniors unless our staff are free from COVID-19. Screening for symptoms and testing that returns results in 5-7 days offers little help in the face of this pandemic. This industry has suffered from a workforce shortage prior to the pandemic. The additional staffing required to address COVID-19 in our communities underscores the need for a healthy workforce. It is also important to not underestimate the relationships between a caregiver and a resident. In many ways they are dependent on each other and reflect a necessary balance that we strive to protect.

⁷ National Academies of Sciences, Engineering, and Medicine. 2020. Social Isolation and Loneliness in Older Adults: Opportunities for the Health Care System. Washington, DC: The National Academies Press. <https://doi.org/10.17226/25663>.

⁸ <https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html>

Further, the senior living workforce shortage impacts day to day operations at these communities. The COVID-19 emergency exacerbates this situation for many operators. We believe, therefore, that the tier 1 priority must reflect the need to protect the capacity of the senior housing workforce.

Conclusion

We recognize that the constraints of the supply chain are likely to require difficult decisions in prioritizing initial access to a vaccine. We recommend, however, that the committee retain the tier 1 priority for adults over the age of 65 and frontline long-term care providers and workers and that it is clear this includes senior living communities. Further we urge that the committee's report specifically reference the full continuum of senior living settings in its description of the tier 1 group for older adults and frontline workers.

Thank you for your consideration and if you have any questions please feel free to reach out to Jeanne McGlynn Delgado at jeanne@seniorshousing.org or Maribeth Bersani at mbersani@argentum.org with questions.



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