American Geriatrics Society (AGS) Policy Brief: COVID-19 and Assisted Living Facilities

American Geriatrics Society

This policy brief sets forth the American Geriatrics Society's (AGS's) recommendations to guide federal, state, and local governments when making decisions about care for older adults in assisted living facilities (ALFs) during the coronavirus disease 2019 (COVID-19) pandemic. It focuses on the need for personal protective equipment, access to testing, public health support for infection control, and workforce training. The AGS continues to review guidance set forth in peer-reviewed articles, as well as ongoing and updated guidance from the US Department of Health and Human Services, the Centers for Medicare and Medicaid Services, the Centers for Disease Control and Prevention, and other key agencies. This brief is based on the situation and any federal guidance or actions as of April 15, 2020. Joining a separate AGS policy brief on COVID-19 in nursing homes (DOI: 10.1111/jgs.16477), this brief is focused on ALFs, given that varied structure and staffing can impact their response to COVID-19. **J Am Geriatr Soc 68:1131-1135, 2020.**

Keywords: assisted living facility; COVID-19; geriatrics; long-term care

This policy brief sets forth the American Geriatrics Society's (AGS's) recommendations to guide federal, state, and local governments when making decisions about how best to care for all older adults residing in assisted living facilities (ALFs) during the coronavirus disease 2019 (COVID-19) pandemic. It focuses on the need for personal protective equipment (PPE), access to testing, public health support for infection control, and workforce training. The AGS continues to review guidance set forth in peer-reviewed articles, as well as updated guidance from the US Department of Health and Human Services, the Centers for Medicare and Medicaid Services (CMS), the Centers for Disease Control and Prevention (CDC), and other key agencies to inform AGS policies and recommendations. This brief is based on the situation and any federal guidance or actions as of April 15, 2020.

From the *American Geriatrics Society, New York, New York.

Address correspondence to American Geriatrics Society, 40 Fulton St, Floor 18, New York, NY 10038. E-mail: info.amger@americangeriatrics.org; Twitter handle: @AmerGeriatrics.

DOI: 10.1111/jgs.16510

Assisted Living Facilities

ALFs do not provide round-the-clock skilled nursing care and are neither considered nor licensed as medical facilities. They are residential settings that generally provide or coordinate personal and healthcare services to residents who live independently in their own homes in the building or complex. Most ALFs are apartment-type buildings where each resident leases an apartment or room and the rental package includes a limited number of services (eg, meals, cleaning). Residents typically pay for additional services to be provided in their home (eg, assistance with bathing, dressing) as their needs dictate. ALFs have emerged as an attractive option for older adults and their families because they typically offer group dining, transportation, and recreational activities (eg, weekly social hours, day trips, and clubs), in addition to a menu of supportive services that help older adults to remain at home and independent.

ALFs vary widely in the structure of available services; these may include 24-hour on-call assistance with activities of daily living and on-call nursing assistance. Residents may also hire personal care assistants externally, and some ALFs coordinate care with external home health agencies (eg, visiting nurse), depending on a resident's needs. This structure is not as conducive as nursing homes (NHs) to cohort residents. While residents could be restricted to their rooms, it would require significant staff to provide needed care, and residents would need to agree to adhere to such restrictions, which makes it difficult to enforce such universal precautions. Some ALFs specialize in the care of people with various forms of cognitive impairment and dementia, which might make isolating and cohorting even more challenging. "Memory care" units or facilities have the added challenges that residents are often unable to follow physical distancing

0002-8614/20/$15.00

instructions, or are unable to adhere to interventions such as the wearing of masks or gloves.

The vast majority of ALFs are private pay, although increasing numbers of stays are being paid through Medicaid waiver programs. ALFs vary in cost and size, and there are no federal regulations that are specific and state regulations vary. Unlike NHs, there are no requirements for a medical director, an admitting physician, or regular visits by a physician, advance practice clinician (eg, a nurse practitioner), or other health professional staff. Some ALFs have primary care clinicians come to visit residents, but this is the exception rather than the rule. The availability of nurses in ALFs varies considerably. There are also no standard requirements for infection control or an infection control practitioner, as there are in NHs. ALFs also differ widely in the amount of health information they collect from residents and the types of personal care, therapeutic, and health services they offer as part of their service menus.

Given how the vast majority of ALFs are structured and staffed, ALFs are not as well resourced to respond to the COVID-19 outbreak as other care settings. Though CMS official guidance for NHs contains elements that ALFs could adopt, ALFs may have difficulty implementing much of this guidance.

WHY IT MATTERS

Nationwide, over 800,000 Americans live in ALFs. Of ALF residents, 52% are 85 years and older and 30% are between the ages of 75 and 84 years.[1] This age group has increased susceptibility to the complications of COVID-19, including respiratory failure and death.[2] These older adults live in more than 28,000 ALFs that employ over 450,000 individuals.[3] Direct care workers provide most of the paid hands-on care and support to ALF residents.[4]

Direct care workers are essential to care for older adults and ensure overall well-being, especially during public health crises. Jobs in aging services, in addition to being physically and emotionally demanding, are complex and best performed by persons trained or experienced in the care of older adults. These workforce needs are not recognized in pay scales or reimbursement rates, nor are these needs recognized in state regulations for ALFs. States vary widely in whether they have regulations and requirements that address overnight staffing levels, number of licensed nursing staff, and workforce training.[5]

The emergence of this new and deadly coronavirus significantly exacerbated existing gaps in expertise and systemic weaknesses in healthcare service delivery for older Americans, particularly for the direct care workforce. Staff recruitment and retention in this sector was difficult before the pandemic and will remain a challenge without increases in wages, provision of benefits, and development of career ladders. The increase in positive cases also impacts staff capacity, as staff may need time off to address childcare, tend to sick family members, or become sick themselves.

As of April 8, 2020, at least 29 states reported COVID-19 cases in ALFs. One Texas-based ALF group with ownership or operations in over 120 older adult communities reported three outbreaks in its facilities.[6] In Colorado, there are 69 older adult facilities with known COVID-19 outbreaks as of April 11, 2020. One of the ALFs is under investigation for its prevention efforts due to the substantial positive COVID-19 test results among residents and staff (33 of 46 residents and 16 of 25 staff members). COVID-19 has been confirmed as the cause of death for five of the cases.[7]

As we have learned with NHs, outbreaks in ALFs and other congregate living settings are a foreseeable consequence of COVID-19, even when adhering to set guidelines. While some of this inevitability may be due to circumstances we can work to control—including the lack of available PPE and testing—other challenges will likely remain beyond our control. Nonetheless, as the priority for PPE and funding is given to frontline medical staff caring for COVID-19 patients, support for direct care workers outside the hospital has been insufficient.[8] ALFs do not have the capacity or resources to implement full CDC guidance issued for medical facilities when there is a recognized pandemic. Given asymptomatic shedding, PPE ideally must be available to all staff when caring for all residents in a facility with a known case of COVID-19. PPE not only protects the care staff but also the residents. Furthermore, staff may pass mandatory symptom and temperature screening procedures and still be infected, shedding enough virus to infect residents and other staff. Without the needed tools, many other unnecessary outbreaks, such as the one in Colorado and others that have been reported, will likely occur—possibly with high mortality rates.

County departments of health can provide guidance, whether it be for testing, staffing, PPE, training, or funding, to help ALFs in this crisis.

RECOMMENDATIONS

Issue 1: Defense Production Act and Supply Chain

Defense Production Act

We appreciate that the President has invoked the Defense Production Act to increase the supply of ventilators and, more recently, PPE. However, there are current and potential shortages of equipment and supplies across settings. ALFs, other congregate living settings (eg, NHs, residential care facilities for older adults, continuing care retirement communities), and home healthcare agencies (eg, Visiting Nurse Association) must be included as priorities when estimating what is needed for the US coordinated response to COVID-19.

As states begin to develop plans to lift shelter-in-place restrictions, the need for an adequate supply of PPE and testing supplies is critically important to protecting the health of the public given the critical need for widespread screening. The existing and future shortfalls will only be addressed if the President fully exercises his authorities under the Defense Production Act so that we can move quickly to increase production and distribution of:

- ***PPE***: This includes the masks, face shields, gowns, and gloves that all frontline healthcare professionals and direct care workers need to protect themselves against becoming infected and from spreading coronavirus within the resident population. PPE protects health workers' own safety, which is key to ensuring

we have access to the healthcare workforce we need during this pandemic.

- ***Testing kits and related laboratory supplies***: Supplies for reliable diagnostic and serologic testing are integral to protecting the health and safety of residents and workers during this pandemic.
- ***Supplies for symptom management and end-of-life care***: Many residents of ALFs may have multimorbidity or complex advanced illness. Some of these residents may be enrolled in hospice or need access to hospice-level services during the COVID-19 crisis. It is critical to prevent a gap in the supply of the medicines and equipment critical to symptom management, especially at the end of life. COVID-19, particularly for people who develop the distressful and uncomfortable symptoms of respiratory failure, has resulted in an increase in demand for medications (eg, opioids) and equipment commonly used in symptom management and at the end of life. In light of this, the federal government should proactively monitor the available supply of medications and, if shortages are imminent, the President should fully exercise his authorities under the Defense Production Act to ensure that there is an adequate supply.

Supply Chain

The Department of Defense (DoD) has significant expertise and the requisite equipment to coordinate the supply chain with state and federal governments. The President should authorize the DoD to work with the federal and state governments to: (1) coordinate the sharing of scarce resources within and across states; (2) deliver new resources to states and communities; and (3) help to prioritize ALFs and other congregate living settings and home healthcare agencies (eg, Visiting Nurse Association) for the tools and resources they need.

Issue 2: COVID-19 Testing and Contact Tracing

The federal and state governments are beginning to plan for reopening the economy, and there is a critical need for widespread COVID-19 testing and contact tracing. Making the United States safe means slowing the rate of infection with coronavirus to a level that our health systems can address. We must dramatically scale up the availability of diagnostics that offer accurate, rapid results. This represents our best chance for identifying asymptomatic COVID-19 carriers as well as confirming disease in those with COVID-19 symptoms, reducing the number of people who need to be isolated, and protecting all Americans. Expert estimates of the US need for testing range from 750,000 tests per week to more than 22 million per day, with widespread and repeated testing of the population.[9-11] Contact tracing to target COVID-19 and track disease spread also will be vital as we start to loosen restrictions safely. For older adults residing in ALFs and other congregate living settings, screening for COVID-19 will be particularly important for protecting the health and safety of their communities.

Issue 3: Safe Transitions of COVID-19 Patients

For individuals who test positive for COVID-19 or are strongly suspected of having contracted the disease, several important factors will impact decisions on transitions between care settings.

Decisions to Send COVID-19–Positive ALF Residents to the Emergency Room

As recommended by the CDC, the first and best option is for COVID-19–positive individuals to remain at home and quarantined unless their symptoms are so serious that they need care that is only provided in a hospital setting. For ALFs, decisions to transfer a symptomatic or known COVID-19–positive resident should consider resident goals of care and be guided by a clinician (eg, registered nurse, nurse practitioner, physician assistant, or physician who is affiliated with the facility), who can work with the individual's primary care provider to manage conditions in place, if possible, without transferring the person. To the extent allowed by the state, the inclusion of a licensed home health service can provide a bridge for clinical support for the individual and the facility. At a minimum, the ability to care safely for and isolate the positive individual must be taken into account.

ALF Residents Ready for Discharge From Other Settings Who Have Tested Positive for COVID-19

Residents discharged from other settings (eg, hospitals, skilled nursing facilities) who test positive for COVID-19 should not be discharged back to an ALF unless the ALF can safely and effectively isolate the patient from other residents and has adequate infection control protocols and PPE for staff and residents. This includes the ability to isolate or cohort the resident(s) separately from the rest of the community and provide dedicated staff to meet increased care needs for people with COVID-19. Such transfers should be in accordance with current CDC guidance.

Issue 4: Infection Control

State, county, and local health departments should immediately engage with ALFs in their communities to offer assistance with taking steps to limit the spread of COVID-19 in ALFs. Such support should include:

1. Technical assistance with implementing policies and procedures for screening staff, visitors, and private-pay care assistants aligned with guidance from the CDC and updated regularly to account for situational change. Infection among staff may be a major source of exposure for ALF residents. Isolation rules must be carefully considered so as not to quarantine staff unnecessarily or for too long a period, which could decimate the ALF workforce.
2. Obtaining testing for residents and staff who are symptomatic or with known exposure, including arranging for on-site testing to be available.
3. Providing guidance on implementing advanced hygiene practices, including:
   a. Increasing signage about the effectiveness of handwashing for at least 20 seconds with soap and hot water; physical distancing (also referred to as social distancing); and face covering.

   b. Ensuring soap dispensers are full; providing easy access to alcohol-based hand sanitizer; and implementing routine surface cleaning protocols to high-touch surfaces where contamination risks are high, such as communal areas and areas around sinks and toilets.[12]
4. Communicating about, and supporting adherence to, the need for physical distancing, face covering, and enhanced hygiene practices, such as washing hands for 20 seconds. When providing care for those with cognitive impairments, staff will need to provide direct supervision, as much as possible, to improve adherence.
5. Training all staff on infection control, the proper use of PPE, and recognition of COVID-19 symptoms.
6. Developing plans for caring for residents who are symptomatic, including criteria to guide collaborative decision making around transfer vs manage-in-place. For those residents who are managed in the ALF, plans must address ensuring access to PPE, clinical staff, and telehealth for coordination with the resident's primary care clinician and family.
7. Facilitating local collaborations among ALFs, hospitals, and NHs with consideration for dedicated COVID-19 facilities that have the expertise, PPE, and supplies to care safely for these patients. As recommended by the CDC, the first and best option is to discharge to home in isolation with any needed home care. Because ALFs are the individual's home, this will involve ensuring that enough home healthcare resources are available to patients who have remaining health needs. It will also involve the use of telemedicine for clinicians to monitor patients discharged to home. Departments of public health should work with ALFs to ensure they have access to clinical advisors who can assist with managing COVID-19–positive residents safely, including assisting with planning to isolate them from other residents and conducting contact tracing within the ALF. At the same time, the federal government and states should build capacity to care for patients with COVID-19 post-hospital discharge if they cannot return home. This will include working with the network of providers (hospitals, NHs, ALFs, home health, long-term services, and support providers) to identify safe locations for those with wandering behaviors and highly complex care needs, and identifying housing for patients who are not stable enough for discharge to home but who still need support and close monitoring.
8. Ensuring adequate and safe staffing ratios for all disciplines providing care to ALF residents by working with state and local governments to ensure that ALFs are included in emergency personnel deployment planning.
9. Providing access to training and resources to promote advance care planning discussions by coordinating with primary care clinicians and other clinical staff. This entails eliciting goals of care and completing Physician Orders for Life-Sustaining Treatment forms or other portable physician orders.

Issue 5: Workforce

Paid Leave

We recognize that Congress has taken steps to address access to paid family leave for all Americans. However, more must be done to ensure that all health professionals and direct care workers on the frontlines of addressing this crisis have access to paid family, medical, and sick leave, including paid time when isolating due to exposures. Ensuring access to paid leave is important for ALF staff, including certified nursing assistants, personal care assistants, dietary staff, direct care workers, and environmental support staff, as well as home care workers who are paid hourly, often lack paid sick leave, and commonly have marginal financial resources at baseline.

Tax Relief

Congress should ensure that tax relief is provided to those ALFs that provide paid family leave to support nurses, therapists, and direct care workers caring for older adults and people with disabilities. While the recently passed Families First Coronavirus Response Act takes some important steps to support paid leave, it does not provide a way for most healthcare organizations to offset the costs of providing medical and family leave to employees. In addition to ALFs, home care agencies, hospitals, NHs, and clinician practices should have immediate access to federal grants, interest-free loans, or tax relief to help offset these costs.

Supporting the Direct Care Workforce

As we continue to learn and grow from this emergency, we urge Congress to provide educational and grant opportunities for direct care workers. The following actions would enhance the profession and strengthen the pipeline of individuals to work in aging service: (1) implement immediate recruitment campaigns, particularly targeting displaced workers; (2) provide funding for online training relevant to the ALF population (including entry-level and COVID-19 content) and competency evaluations; (3) increase funding to direct care training providers to enhance the training infrastructure; and (4) provide funding for in-person training following the public health emergency to increase and maintain direct care workforce capacity.

ACKNOWLEDGMENTS

The following individuals comprised the writing group responsible for this policy brief: William Hung, MD, MPH; Annette (Annie) M. Medina-Walpole, MD, AGSF (AGS President Elect); Joseph G. Ouslander, MD, AGSF; Cheryl Phillips, MD, AGSF; Barbara Resnick, PhD, CRNP, AGSF; Debra Saliba, MD, MPH, AGSF; and Kathleen Unroe, MD, MHA. AGS staff Nancy Lundebjerg, MPA Alanna Goldstein, MPH and Ahreum Anna Kim, MSW, also provided writing, editing, and review for this piece. The AGS Executive Committee (G. Michael Harper, MD, AGSF; Peter Hollmann, MD, AGSF; Laurie Jacobs, MD, AGSF; Sunny Linnebur, PharmD, BCPS, BCGP; Annie Medina-Walpole, MD, AGSF; and Mark Supiano, MD, AGSF) reviewed and approved this policy brief on behalf of the AGS Board.

Conflict of Interest: This article received no funding, and members of the writing group declare no conflicts of interest.

Author Contributions: The writing group responsible for this policy brief included William Hung, MD, MPH; Annette (Annie) M. Medina-Walpole, MD, AGSF; Joseph

G. Ouslander, MD, AGSF; Cheryl Phillips, MD, AGSF; Barbara Resnick, PhD, CRNP, FAAN, FAANP, AGSF; Debra Saliba, MD, MPH, AGSF; and Kathleen Unroe, MD, MHA. Nancy Lundebjerg, MPA; Alanna Goldstein, MPH; and Ahreum Anna Kim, MSW, provided writing, editing, and review assistance. The AGS Executive Committee (G. Michael Harper, MD, AGSF; Peter Hollmann, MD, AGSF; Laurie Jacobs, MD, AGSF; Sunny Linnebur, PharmD, FCCP, FASCP, BCPS, BCGP; Annie Medina-Walpole, MD, AGSF; and Mark Supiano, MD, AGSF) reviewed and approved this policy brief on behalf of the AGS Board.

Sponsor's Role: None.

REFERENCES

1. Centers for Disease Control and Prevention (CDC). FastStats: Residential Care Communities. March 11, 2016. https://www.cdc.gov/nchs/fastats/residential-care-communities.htm. Accessed April 13, 2020.
2. Centers for Disease Control and Prevention (CDC). People Who Are at Higher Risk for Severe Illness. April 2, 2020. https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-at-higher-risk.html. Accessed April 13, 2020.
3. Harris-Kojetin L, Sengupta M, Lendon JP, Rome V, Valverde R, Caffrey C. Long-term care providers and services users in the United States, 2015–2016: National Center for Health Statistics. Vital Health Stat. 2019;3(43):1-78.
4. Kelly C, Craft Morgan J, Kemp CL, Deichert J. A profile of the assisted living direct care workforce in the United States. J Appl Gerontol. 2020;39(1):16-27.
5. Harris-Kojetin L, Sengupta M, Lendon JP, Rome V, Valverde R, Caffrey C. Long-Term Care Providers and Services Users in the United States: Data From the National Study of Long-Term Care Providers, 2015–2016: National Center for Health Statistics. Vital Health Stat. 2019;3(43):1-80.
6. Ungar, L., Hancock, J. COVID-19 crisis threatens beleaguered assisted living industry. *Kaiser Health News*. April 9, 2020. https://khn.org/news/covid-19-crisis-threatens-beleaguered-assisted-living-industry/. Accessed April 13, 2020.
7. Goodland, M. Public health officials announce Aurora assisted living facility with 49 cases, eight deaths from COVID-19. *Colorado Politics*. April 11, 2020. https://www.coloradopolitics.com/coronavirus/public-health-officials-announce-aurora-assisted-living-facility-with-49-cases-eight-deaths-from-covid/article_e8c2f132-7c22-11ea-8df6-1326eafc59cf.html/. Accessed April 13, 2020.
8. American Geriatrics Society. American Geriatrics Society (AGS) policy brief: COVID-19 and nursing homes. J Am Geriatrics Soc. 2020. https://doi.org/10.1111/jgs.16477. [Epub ahead of print].
9. Kates J, Michaud J, Orgera K, Levitt L. What Testing Capacity Do We Need? Kaiser Family Foundation Website. April 17, 2020. https://www.kff.org/coronavirus-policy-watch/what-testing-capacity-do-we-need/. Accessed April 21, 2020.
10. American Enterprise Institute (AEI). National Coronavirus Response: A Road Map to Reopening. March 29, 2020. https://www.aei.org/research-products/report/national-coronavirus-response-a-road-map-to-reopening/. Accessed April 21, 2020.
11. Romer P. Simulating COVID-19: Part 2. Paul Romer Professional Website. March 24, 2020. https://paulromer.net/covid-sim-part2/. Accessed April 21, 2020.
12. Dietz L, Horve PF, Coil DA, Fretz M, Eisen JA, Van Den Wymelenberg K. 2019 Novel coronavirus (COVID-19) pandemic: built environment considerations to reduce transmission. mSystems. 2020;5(2):e00245-20. https://doi.org/10.1128/mSystems.00245-20