



JAMDA

journal homepage: www.jamda.com

COVID-19 Editorial

The Need to Include Assisted Living in Responding to the COVID-19 Pandemic



Sheryl Zimmerman PhD^{a,*}, Philip D. Sloane MD, MPH^b, Paul R. Katz MD^c,
Margo Kunze RN, CALA^d, Kevin O'Neil MD, FACP, CMD^e, Barbara Resnick PhD, CRNP^f

^a Cecil G. Sheps Center for Health Services Research and Schools of Social Work and Public Health, University of North Carolina at Chapel Hill, NC

^b Cecil G. Sheps Center for Health Services Research and Department of Family Medicine, School of Medicine, University of North Carolina at Chapel Hill, NC

^c Florida State University College of Medicine, Tallahassee, FL

^d American Assisted Living Nursing Association, Belmar, NJ

^e Affinity Living Group, Hickory, NC

^f University of Maryland School of Nursing, Baltimore, MD

The risk of complications and death from COVID-19 is markedly skewed toward older adults. The US Centers for Disease Control and Prevention (CDC) recently wrote, "Given their congregate nature and residents served (eg, older adults often with underlying chronic medical conditions), nursing home populations are at the highest risk of being affected by COVID-19. If infected with SARS-CoV-2, the virus that causes COVID-19, residents are at increased risk of serious illness."¹

However, in the United States and many other countries, nursing homes are not the only congregate setting that serves older adults with underlying chronic medical conditions. More so, they have been a shrinking component of the residential long-term care system, with some of the largest growth having been in assisted living (AL). AL communities provide supportive care, at least 2 meals a day, and 24-hour supervision to individuals who need daily supportive care, but not daily nursing care.^{2,3}

Recent estimates are that there are 30,200 licensed AL communities across the United States, providing care to more than 835,000 residents⁴—which constitutes almost 40% of persons who receive residential long-term care in this country. More than half of the AL residents are "old-old" or "oldest-old": 53% are aged 85 or older, compared with 42% in nursing homes and 47% receiving hospice.⁴ More so, many have the chronic underlying conditions implicated in COVID-19: 34% have heart disease, 17% have diabetes, and 15% have lung disease (chronic obstructive pulmonary disease and allied conditions), and more than a quarter have between 4 and 10 chronic health conditions.⁵ Thus, the AL population is at high risk for being affected by COVID-19 and suffering serious outcomes.

Importantly, AL communities are not the same as nursing homes. In fact, there are several distinct components of AL that make this a unique setting and one not to be ignored in relation to COVID-19

planning and response. This editorial summarizes key differences and their related implications for care.

Distinct Components of Assisted Living in Relation to COVID-19

There are 7 key areas in which AL differs from nursing homes, each of which has implications for prevention and treatment of infectious epidemics such as COVID-19. They include the philosophy and residential nature of AL, dementia prevalence and specialized care, the content and variability of regulations, the diversity of AL, medical and nursing presence and care, direct care staffing and training, and the role of family in monitoring and surveillance. Each is discussed below.

The Philosophy and Residential Nature of AL, and the Importance of Social Engagement

More than 20 years ago, the Assisted Living Quality Coalition established that the overriding philosophy of care in AL is social, as opposed to medical—for example, to promote individuality, ensure choice, and provide opportunities for social engagement.⁶ AL also promotes aging-in-place,⁷ and some settings are integrated within continuing care retirement communities (CCRCs) with the intention of allowing easy access across the entire campus. Furthermore, as compared with nursing homes, AL settings have higher proportions of residents who are engaged in outside activities, such as trips with family members,⁸ and some own and drive cars for independent outings to maintain contacts in the community.⁹

Implications

In response to COVID-19, many AL communities are limiting visitors; some are restricting access to all but those providing critical assistance, and not allowing the older adults themselves to leave.¹⁰ Because people live in AL for years at a time (the average length of stay is roughly 2 years),⁵ it's especially important to ensure that AL residents are involved in discussions related to COVID-19, and that social distancing doesn't translate to social disengagement.

The authors declare no conflicts of interest.

* Address correspondence to Sheryl Zimmerman, PhD, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill, 725 Martin Luther King Jr. Boulevard, Campus Box 7590, Chapel Hill, NC 27599-7590.

E-mail address: JAMDA.Editors@paltc.org (S. Zimmerman).

<https://doi.org/10.1016/j.jamda.2020.03.024>

1525-8610/© 2020 AMDA — The Society for Post-Acute and Long-Term Care Medicine.

Recognizing that 72% to 85% of AL residents have contact with families at least twice a month,¹¹ telephone calls remain important, as do mobile and Internet-based options (eg, texting, FaceTime, Skype) for capable residents and communities. In those instances, AL staff may need to be more involved than usual to facilitate social contact, and to actually assume responsibility for doing so, especially for residents with cognitive or physical impairment. In addition, staff may need to help families and others connect through other means, such as sending letters and photographs, and perhaps dropping off special meals at the AL door. There have been anecdotal reports of families connecting with their relative from outside the community, such as a husband who celebrated his 67th wedding anniversary with his wife from outside her window¹²; encouraging such engagement may be especially meaningful for family members as well.

The Prevalence of Dementia and Specialized Dementia Care

More than 70% of AL residents have some cognitive impairment, with 42% having moderate or severe dementia.² Furthermore, memory care units in AL have grown steadily over the last decade.¹³ Simply stated, AL has become the primary provider of residential care for older adults with dementia.

Implications

Persons with dementia are not only less able to adhere to social distancing recommendations than persons without dementia, but isolating them may in fact be problematic; for example, forcing people with confusion to remain in their room or to don a face mask to limit exposure is likely to induce agitation and other undesirable behaviors. In addition, persons with dementia have higher hospitalization rates than persons without dementia, even when comparing those who have underlying health conditions including diabetes, chronic kidney disease, and chronic obstructive pulmonary disease.¹⁴ Because persons with dementia are at greater risk and typically unable to communicate their medical symptoms, it's important to remain especially vigilant to medical signs of possible COVID-19 in persons with dementia.

Lack of National Regulations, and State Variability, Especially Related to Infection Control

AL communities are regulated by the states, which leads to wide variability across the country. Variability in regulation extends to staffing,¹⁵ nursing services,¹⁶ and most importantly for COVID-19, infection control practices. Furthermore, recent federal enhancements in infection control practices targeted at nursing homes have not affected AL.¹⁷ Across the country, although 31 states have some type of infection control policies for AL (such as requiring the development of such policies or compliance with public health requirements), only 13 (26%) have an actual infection control program.¹⁸

Implications

A lack of focus on infection control practices suggests that the majority of AL communities have limited, if any, stockpiles of personal protective equipment. Overall, there is cause to be circumspect about AL infection control practices, and to be proactive in instilling such practices in light of COVID-19. Outside organizations with infection expertise, such as state health departments, may need to step up quickly to enhance the infection control capacity and practices in these settings.

Wide Variation in AL Types, Populations, and Care Resources

Recommending any one strategy for AL staff to embrace is challenging given the highly variable nature of AL. Some AL communities

cater more to residents with dementia, or to those who have psychiatric illnesses, or to those with functional impairment.¹⁹ Communities range in size from 4 to 499 beds (the average is 33 beds),⁴ and not surprisingly, smaller communities lack the technological resources of larger ones. They also lack sufficient space to allow for social distancing among the residents themselves and offer fewer services and activities.³

Implications

It's necessary to consider the capacity of each AL community to promote social engagement and provide infection control, especially in relation to the next 2 topics—medical and nursing presence and care, and direct care staffing and training. Furthermore, for resident, staff, and visitor screening and surveillance to be consistent within and across settings, outside technical assistance at the state or local level may be needed.

Limited Medical and Nursing Provider Presence and Care, in Comparison With Nursing Homes

Although many AL residents have underlying chronic conditions (eg, in addition to the statistics above, 57% have high blood pressure, 25% to 28% depression, 27% arthritis, 21% osteoporosis, 11% cancer, and 11% stroke), almost half (46%) of AL communities do not have a registered or licensed nurse on staff.^{2,5,20} There have been calls for more nursing presence in AL,²¹ and also for physician presence on-site,²² but such models are the exception rather than the rule, and in contrast to nursing homes, the medical director role has not been formally defined and is not mandated.²³ Furthermore, medical care providers themselves have noted concern about the ability of AL staff to assess and monitor medical problems.²⁴

Implications

Given the absence of a medical director who in nursing homes is responsible for the development of policies and procedures related to the delivery of medical care, consistent practice is often lacking in AL. Thus, while one medical provider may be comfortable treating a semi-urgent issue on-site, another may prefer to send the patient to the emergency room—which raises the possibility of exposure in the hospital and subsequently to the AL community when the patient returns. In the wake of COVID-19, it's especially important that medical care providers be kept informed not only about the status of their patients but also about the capacity of the given AL community to provide care—and to make available telehealth alternatives, if possible.

Limited Direct Care Staffing With Minimal Training

Personal care assistants provide the majority of supportive care in AL; their position is similar to nursing assistants in nursing homes, in that they have limited training and provide almost all hands-on care.²⁵ However, their numbers are fewer than in nursing homes. In AL, fewer than 40% of states specify minimum staffing ratios, and only 25% of states require that direct care staff have at least 11 hours or more of training (compared to a mandated 75 hours in NHs).²⁶

Implications

It's a fair question to ask within any given AL community whether the direct care workforce has the knowledge and skills to provide the care necessary in times of a crisis such as COVID-19, and if not, to mandate and/or provide the needed assistance to ensure that infection control and surveillance is adequate.

Key Role of Family in Monitoring and Surveillance

Because AL communities are not medical settings—as reflected in their basic philosophies, regulations, medical and nursing presence and care, and direct care staffing and training—families not only provide social contact but also assume the role of monitoring their relative's health, well-being, and finances.²⁷ Restrictions on visitors and on movement within communities because of COVID-19 may make it difficult for families to carry out these roles, cause them understandable concern, and place residents at increased risk for having health status changes go undetected.

Implications

Some family may be inclined to temporarily move their relative to their own home to prevent infection, but on balance, it's arguably likely that infection control procedures are more rigorous in AL communities than in a private home. Therefore, it's critical that AL staff engage in continuous communication with family members, clearly and honestly conveying the practices they have in place to prevent and combat COVID-19—and also helping them to remain meaningfully involved, such as through eliciting their understanding of resident preferences and promoting social engagement.

Summary: Assisted Living Should Not Be Ignored in COVID-19 Response Planning

AL communities are not intended to be medical settings, and in the wake of COVID-19, they should not be faulted for not being medical settings. However, they provide care for individuals among the highest risk for COVID-19 and serious outcomes, making it especially important to not ignore COVID-19 in AL. This editorial suggests special attention toward 7 areas toward that end. Key recommendations for health care and health policy planning around COVID-19 should therefore include these action steps:

- Ensure that AL residents are involved in discussion related to COVID-19, and that social distancing does not translate to social disengagement
- For residents with dementia, be mindful of the effects of social distancing and remain especially vigilant to medical signs of possible COVID-19
- Be proactive in instilling infection control practices in AL
- Consider the capacity of each AL community to promote social engagement and provide infection control, and their need for outside assistance
- Keep medical care providers informed about the status of their patients, and also of the capacity of the given AL community to provide care; make telehealth available, if possible
- Be mindful of whether the direct care workforce has the knowledge and skills to provide the care necessary in times of crisis; provide resources to enhance those skills if necessary
- Engage in continuous communication with family members, conveying the practices in place to prevent and combat COVID-19, and helping them remain meaningfully involved in resident oversight and well-being

These recommendations are best situated alongside practical guidelines for long-term care in general as presented in a recent *JAMDA* editorial: reduce morbidity and mortality among those infected; minimize transmission; ensure protection of health care workers; maintain health care system functioning; and, as especially relevant for AL, maintain communication with residents and family members.²⁸ The CDC recognizes AL communities as a component of the long-term care system,²⁹ and along with nursing homes, they are a critical provider of residential long-term care to our nation's older

adults. There has never been a better time for AL communities to develop infection control programs as recommended in CDC guidelines.

References

1. Centers for Disease Control and Prevention. Coronavirus Disease 2019 (COVID-19). Preparing for COVID-19: Long-term care facilities, nursing homes. Available at: <https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/prevent-spread-in-long-term-care-facilities.html>. Accessed March 22, 2020.
2. Zimmerman S, Sloane PD, Reed D. Dementia prevalence and care in assisted living. *Health Aff* 2014;33:658–666.
3. Zimmerman S, Gruber-Baldini AL, Sloane PD, et al. Assisted living and nursing homes: Apples and oranges? *Gerontologist* 2003;43:107–117.
4. Harris-Kojetin L, Sengupta M, Park-Lee E, et al. Long-term care providers and services users in the United States: Data from the national study of long-term care providers, 2013–2014. National center for health statistics. *Vital Health Stat* 2016;3.
5. Caffrey C, Sengupta M, Park-Lee E, et al. Residents living in residential care facilities: United States, 2010. NCHS data brief, no 91. Hyattsville, MD: National Center for Health Statistics. 2012. Available at: <http://www.cdc.gov/nchs/data/databriefs/db91.pdf>. Accessed March 22, 2020.
6. Assisted Living Quality Coalition. Assisted Living Quality Initiative: Building a Structure that Promotes Quality. Washington, DC: Public Policy Institute, American Association of Retired Persons; 1998.
7. Bernard S, Zimmerman S, Eckert JK. Aging-in-place. In: Zimmerman S, Sloane PD, Eckert JK, editors. *Assisted Living: Needs, Practices and Policies in Residential Care for the Elderly*. Baltimore, MD: Johns Hopkins University Press; 2001.
8. Zimmerman S, Cohen LW, Reed D, et al. Comparing families and staff in nursing homes and assisted living: Implications for social work practice. *J Gerontol Soc Work* 2013;56:535–553.
9. Lum HD, Ginde AA, Betz ME. Older adult drivers living in residential care facilities. *Ann Longterm Care* 2015;23:21–26.
10. Gershman A. Guide to state coronavirus lockdowns. *The Wall Street Journal*, March 21, 2020. Available at: <https://www.wsj.com/articles/a-state-by-state-guide-to-coronavirus-lockdowns-11584749351>. Accessed March 22, 2020.
11. Sengupta M, Zimmerman S, Harris-Kojetin L. Activity engagement in residential care settings: Findings from the national survey of residential care facilities. *J Hous Elderly* 2019;33:1–20.
12. Seipel B. Husband wishes wife happy anniversary from outside nursing home as COVID-19 keeps them apart. Available at: <https://thehill.com/homenews/news/487923-husband-wishes-wife-happy-anniversary-from-outside-nursing-home-as-covid-19>. Accessed March 22, 2020.
13. Adler J. Investors rethink memory care. Available at: <https://seniorshousingbusiness.com/investors-rethink-memory-care/>. Accessed March 22, 2020.
14. Alzheimer's Association. Alzheimer's disease facts and figures. 2018. Available at: <https://www.alz.org/media/documents/facts-and-figures-2018-r.pdf>. Accessed March 22, 2020.
15. Rome V, Harris-Kojetin L, Carder P. Variation in licensed nurse staffing characteristics by state requirements in residential care. *Res Gerontol Nurs* 2019;12:27–33.
16. Beeber AS, Zimmerman S, Mitchell CM, Reed D. Staffing and service availability in assisted living: The importance of nurse delegation policies. *J Am Geriatr Soc* 2018;66:2158–2166.
17. Department of Health and Human Services Centers for Medicare & Medicaid Services. Medicare and Medicaid programs; reform of requirements for long-term care facilities. *Fed Regist* 2016;81:192. Available at: <https://www.govinfo.gov/content/pkg/FR-2016-10-04/pdf/2016-23503.pdf>. Accessed March 22, 2020.
18. Bucy T, Smith L, Winfree J, et al. Variability in state regulations pertaining to infection control and pandemic response in U.S. assisted living communities. *J Am Med Dir Assoc* 2020;21:701–702.
19. Park NS, Zimmerman S, Sloane PD, et al. An empirical typology of residential care/assisted living based on a four-state study. *Gerontologist* 2006;46:238–248.
20. Gruber-Baldini AL, Zimmerman S, Boustani M, et al. Characteristics associated with depression in long-term care residents with dementia. *Gerontologist* 2005;45:50–55.
21. Resnick B, Allen J, McMahon E. The American Assisted Living Nurses Association. The role of physicians practicing in assisted living: What changes do we really need? *J Am Med Dir Assoc* 2018;19:104–105.
22. Katz PR, Kronhaus A, Fuller S. The role of physicians practicing in assisted living: Time for change. *J Am Med Dir Assoc* 2018;19:102–103.
23. Kronhaus A, Zimmerman S, Fuller S, Reed D. Implementing integrated care into assisted living—the road (finally) taken. *J Am Med Dir Assoc* 2018;19:914–915.
24. Sloane PD, Zimmerman S, Perez R, et al. Physician perspectives on medical care delivery in assisted living. *J Am Geriatr Soc* 2011;59:2326–2331.
25. Zimmerman S, Sloane PD, Williams CS, et al. Residential care/assisted living staff may detect undiagnosed dementia using the minimum data set cognition scale. *J Am Geriatr Soc* 2007;55:1349–1355.

26. Carder P, O'Keeffe J, O'Keeffe C, et al. State regulatory provisions for residential care settings: An overview of staffing requirements. RTI Press Publication No. OP-0030-1607. Research Triangle Park, NC: RTI Press; 2016.
27. Port CL, Zimmerman S, Williams CS, et al. Families filling the gap: Comparing family involvement for assisted living and nursing home residents with dementia. *Gerontologist* 2005;45:87–95.
28. Dosa D, Jump RLP, LaPlante K, Gravenstein S. Long-term care facilities and the coronavirus epidemic: Practical guidelines for a population at highest risk. *J Am Med Dir Assoc* 2020;21:569–571.
29. Centers for Disease Control and Prevention. Nursing homes and assisted living (long-term care facilities [LTCFs]). Available at: <https://www.cdc.gov/longtermcare/index.html>. Accessed March 22, 2020.