Moving Needles
A CDC FUNDED INITIATIVE

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POST-ACUTE AND LONG-TERM CARE MEDICAL ASSOCIATION

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# Infrastructure, Access, and Cost:

## A Review of Systems Barriers to Immunizing Residents and Staff in Long-Term Care Settings

# Contents



# Acknowledgements


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# Executive Summary

Adults residing in post-acute and long-term care (PALTC) settings such as skilled nursing facilities (SNFs) and assisted living are at high risk of vaccine-preventable illness and complications. Staff working within PALTC settings are also at increased risk for infection because they work in close contact with residents. The percent of PALTC residents who are up-to-date on recommended immunizations (known as immunization coverage) is low and decreasing, and immunization coverage among PALTC staff is even lower.

This paper reviews systems-level barriers such as regulations, policies, and market forces that make it difficult to implement immunization recommendations within PALTC settings, specifically, SNFs (also known as nursing homes) and residential care communities such as assisted living. It focuses on immunizations recommended for PALTC residents based on the established evidence base for vaccine-preventable illness and mitigation. For residents these recommended vaccines are influenza (annual), COVID-19 (seasonal), Tdap (once per decade); and respiratory syncytial virus (RSV), pneumococcal, and shingles. For PALTC staff recommended vaccines are influenza (annual), COVID-19 (seasonal), and hepatitis B. The paper draws on learnings from Moving Needles, a CDC-funded large quality improvement project focused on increasing resident and staff immunization within SNFs and assisted living facilities, as well as insights from a group of immunization and long-term care experts and stakeholders.

## Systems Barriers to Immunizing Skilled Nursing Facility Residents

Key Context: SNFs are highly regulated and must balance many compliance issues across resident care, clinical standards, and staffing. These regulations include offering residents influenza, COVID-19, and pneumococcal vaccines but do not extend to other immunizations recommended for older adults.

**Gaps in information technology (IT) infrastructure create fragmented immunization records and inefficient processes –** Technology gaps create inefficiencies in assessing individual residents' immunization needs, planning facility-level immunization efforts, and billing for vaccination. As a result, obtaining a complete immunization history for residents requires significant time and resources as staff seek information from multiple sources, aggregating records to pinpoint quality improvement opportunities is challenging, and billing pathways may work for one vaccine type or workflow but not others.

**Reimbursement pathways complicate vaccine administration –** Reimbursement for immunizing SNF residents is extraordinarily complex, with regulations requiring different entities (i.e., SNFs or long-term care pharmacies) to purchase, administer, and/or bill for different vaccines under different scenarios. Vaccine product and administration are typically billed separately, and reimbursement requirements differ by resident healthcare coverage, type of SNF stay, and vaccine. As a result, workflows for who administers a vaccine are tied to billing and reimbursement mechanisms. Facilities are at financial risk when reimbursement is delayed or denied due to discrepancies in administration and billing requirements. PALTC EHRs struggle to support these complex billing pathways, adding further inefficiency to the billing process.

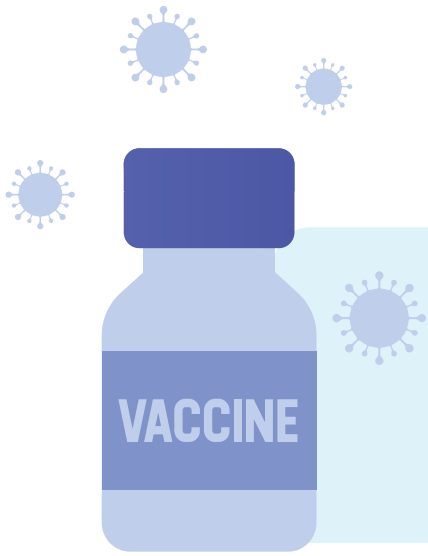
# Systems Barriers to Immunizing SNF Staff

Key Context: SNFs rely on a wide variety of full-time, part-time, and contracted staff with different skillsets, licensures (when required), and education and training requirements. The long-term care industry faces significant staffing shortages and high turnover, particularly among nurses and certified nursing assistants (CNAs), and these shortages are likely to grow as the U.S. population ages.

**Increasing resistance to vaccine requirements –** Resentment about the federal COVID-19 vaccine requirement for long-term care workers during the pandemic, as well as subsequent resistance to other vaccine recommendations, make requirements a less effective tool for increasing immunization among SNF staff. This is true even for influenza and hepatitis B vaccines that were less controversial prior to the pandemic.

**Access and cost barriers complicate staff COVID–19 immunization efforts –** Evidence shows that referring staff to offsite locations to receive vaccines is far less effective than offering vaccines to staff for free at work. Removing the dual barriers of access and cost can significantly raise staff immunization rates. Inability to bill commercial insurance, a nonexistent safety net for uninsured or underinsured staff, as well as the high cost of some vaccines (such as COVID-19) require PALTC facilities to make trade-offs around vaccine offerings to staff.

**SNFs lack infrastructure to efficiently monitor staff immunization –** High staff turnover and gaps in data infrastructure make it burdensome for SNFs to collect, track, and aggregate staff immunization data.




Making vaccines free and convenient can raise staff immunization coverage. High costs of some vaccines (such as COVID-19) require PALTC facilities to make trade-offs around vaccine offerings to staff.

## Systems Barriers to Immunizing Residential Care Community Residents and Staff

Key Context: Residential care communities focus on providing personal care assistance primarily to older adults through a variety of models, including independent or senior living, assisted living (which may include memory care), and continuing care retirement communities. While some residential care communities, especially assisted living, may maintain nursing staff onsite and may offer medication management or other limited healthcare services, residents primarily receive medical care from their own clinicians, usually through a clinician's office. Residential care communities are regulated at both federal and state levels, with each state differing in its definitions of residential care and related requirements.

**Limited attention to immunization in residential care –** Although the risks of infectious disease to residents and frontline staff are similar in SNFs and residential care communities, immunization has received much less attention in residential care settings. Few states address immunization in residential care regulations, and the extent to which a particular residential care community focuses on immunization for residents or frontline staff often depends on corporate and facility leadership priorities and resources.

**Few systems for maintaining immunization records in residential care –** Many residential care communities lack systematic ways of assessing residents' immunization history, instead relying on asking residents or their family members, who may not recall dates or other important immunization details. For those residential care communities without direct access to residents' immunization records, it is difficult to assess and mitigate the level of risk for vaccine-preventable disease among their residents.

**Lack of infrastructure to provide immunization onsite –** Residential care communities generally do not have their own licensed clinical staff to vaccinate residents or staff, and even those that do typically are not able to bill insurance directly for the cost of vaccine product and administration. Instead, residential care communities interested in offering immunizations onsite to residents or staff must contract with a third-party healthcare provider to administer vaccines and process insurance claims. It is unclear how many residential care communities make the effort to do so.

### Conclusion

Public health has long recommended immunizing PALTC residents and staff to decrease the spread of infectious diseases within facilities where highly vulnerable older adults live in close quarters. Yet systems barriers have made it difficult for both the public health and PALTC sectors to act on these priorities. Addressing these barriers and increasing PALTC resident and staff immunization will require collaborative solutions bridging the public and private sectors to make it easier and more affordable to immunize residents and staff within SNFs and residential care communities, and more efficient to monitor immunization efforts over time.

# 01 Introduction

## Background

Adults residing and working in post-acute and long-term care (PALTC) settings such as skilled nursing facilities and assisted living are at high risk of vaccine-preventable illness and complications. The PALTC resident population is uniquely at risk for infection due to their age (>85 years of age on average), medical complexity, and often functional impairment, cognitive decline, or frailty. In particular, natural deterioration of the immune system with age makes older adults especially vulnerable to infectious disease. Staff working within PALTC settings are also at increased risk for infection because they work in close contact with residents. In addition to being at increased risk for infection themselves, staff represent a primary means of viral transmission into PALTC settings. Immunization of residents and staff reduces the risk of infectious disease outbreaks in PALTC facilities, while also reducing hospitalizations and deaths among residents related to vaccine-preventable illness.

However, the percent of PALTC residents up-to-date on recommended immunizations (known as immunization coverage) is low and decreasing. In mid-2025, only a little over half (59%) of SNF residents were up-to-date on influenza immunization, just one third (35%) were up-to-date on COVID-19 immunization, and only 1 in 5 (22%) had received a respiratory syncytial virus (RSV) vaccine. Between 2016 and 2020 (the most recent years with data available), the rate of pneumococcal immunization among SNF residents declined from 70% to 63%. Immunization coverage among PALTC staff is even lower. Fewer than half (45%) of SNF staff received the 2023 – 2024 influenza vaccine and just 8% were up-to-date on COVID-19 immunization as of mid-2025.

In addition to the health and safety benefits, there also may be cost benefits to high immunization coverage among residents and staff. Vaccine-preventable illness outbreaks within PALTC facilities are costly. During outbreaks residents' care needs increase at the same time that staff may have unplanned absences or need to take sick leave. During severe outbreaks, facilities may need to stop admitting new residents, decreasing revenue when bed space cannot be filled. High immunization coverage mitigates these economic costs while keeping residents and staff healthier.

Despite the many benefits of immunizing residents and staff, many PALTC facilities struggle to improve – or even monitor – immunization coverage. This paper reviews systems-level barriers to immunizing residents and staff in PALTC settings, specifically, skilled nursing facilities (also known as nursing homes) and residential care communities such as assisted living.

In mid-2025

**59%**
of SNF residents were up-to-date on influenza immunization

**35%**
of SNF residents were up-to-date on COVID-19 immunization

**22%**
of SNF residents had received a respiratory syncytial virus vaccine

## Scope and Key Definitions

This paper focuses on immunization in residential PALTC facilities. These include facilities providing intensive medical care, such as skilled nursing, as well as assisted living and other residential care communities that provide primarily personal care assistance with less focus on onsite clinical care. Personal care assistance includes support with activities of daily living, such as eating and bathing, as well as instrumental activities of daily living, such as preparing meals.

**Residential facilities providing intensive medical care** include skilled nursing facilities (SNF), inpatient rehabilitation facilities (IRF), and long-term care hospitals (LTCH). These facilities provide personal care assistance as well as direct medical care. They maintain clinical staff onsite at all times and are regulated as healthcare providers. SNFs provide care to many more individuals (daily average of nearly 1.3M people in 2020) compared to IRFs (approximately 342,000 people daily) and LTCH (81,000 people daily). In this article, we focus on SNFs in discussing considerations for immunizing residents within this category of residential PALTC.

**Residential care communities** focus on providing personal care assistance primarily to older adults through a variety of models, including independent or senior living, assisted living (which may include memory care), and continuing care retirement communities. These various types of facilities differ in the level of resident independence and available support services (see glossary for descriptions), but generally do not provide round-the-clock medical care, although some may include clinical staff onsite during some shifts. Residential care communities are regulated at both federal and state levels, with each state differing in its definitions of residential care and related requirements. In this article, we focus especially on assisted living facilities.

The PALTC workforce includes a wide variety of staff, including frontline and administrative roles. In this article, we focus on **frontline staff:** workers who are likely to interact directly with residents.

**Frontline staff** include physicians, nurses with a variety of licensures (e.g., registered nurses, licensed practical nurses, nurse practitioners), rehabilitation professionals (e.g., occupational, physical, or respiratory therapy; speech pathology), pharmacists, social workers or case managers, certified nursing assistants (CNA), and personal care aids. Depending on the facility, additional frontline staff roles may include activities coordinators, food service, janitorial, and front office staff, among others

We focus on immunizations recommended for PALTC residents and staff based on the established evidence base for vaccine-preventable illness and mitigation of that risk via vaccination.

[1]Continuing care retirement communities (CCRCs) typically include a mix of residential support, ranging from independent living through skilled nursing. For the purposes of this article, we discuss separately immunization considerations for residential care and SNF segments of CCRCs.

### Immunizations recommended* for PALTC residents

- Influenza (annual)
- COVID-19 (seasonal)
- RSV
- Pneumococcal
- Shingles
- Tdap (once per decade)

### Immunizations recommended* for PALTC staff

- Influenza (annual)
- COVID-19 (seasonal)
- Hepatitis B (if not yet completed)

*Recommendations from the Centers for Disease Control & Prevention as of January 2025

# About this White Paper

This paper draws on learning from Moving Needles,[2] a large CDC-funded quality improvement project focused on increasing resident and staff immunization within SNFs and assisted living facilities, as well as insights from a group of immunization and long-term care experts and stakeholders. It focuses on systems barriers such as regulations, policies, and market forces that make it difficult to implement immunization recommendations within PALTC settings.

Specifically, this paper discusses systems barriers to immunizing:

- Skilled nursing facilities residents and staff
- Residential care community residents and staff

Each section begins with a snapshot highlighting the current **landscape**, **key players**, and **challenges**, followed by a detailed discussion. Public health professionals, policymakers, and long-term care advocates can use these insights to develop solutions and strategies that increase immunization within SNFs and residential care settings, ultimately protecting older adults and the workers who care for them.

[2]Support for Moving Needles, and this paper, provided by the Centers for Disease Control and Prevention (CDC) cooperative agreement NH23IP922655

# 02 Systems Barriers to Immunizing Skilled Nursing Facility Residents

## SNAPSHOT

### The Landscape

**Skilled nursing facilities** (SNF) are highly regulated and must balance many compliance issues across resident care, clinical standards, and staffing. These regulations include offering residents influenza, COVID-19, and pneumococcal vaccines but do not extend to other immunizations recommended for older adults such as respiratory syncytial virus (RSV) or shingles. Focus on compliance can incentivize reactionary measures (e.g., managing an outbreak of infectious disease) rather than proactive prevention (e.g., prioritizing immunizing residents ahead of respiratory virus season).

**SNF residents** may be covered by traditional Medicare Part A for a rehabilitation stay up to 100 days per benefit period; by Medicaid for as long as individuals meet income and care need requirements; or by private pay. Increasing numbers of SNF residents are enrolled in Medicare Advantage plans, which introduce further variation in covered services and reimbursement mechanisms. A resident's type of stay (short-stay vs long-term) and healthcare coverage (e.g., traditional Medicare, Medicare Advantage, Medicaid, commercial insurance) determine the reimbursement pathways for different immunizations.

### Key Players

**A physician** or other licensed provider must order an immunization before it is administered to a resident. Usually, the facility's medical director or an attending physician places the order, either on an individual basis or through standing orders for routine immunizations for all residents. Medical directors are typically contracted roles, while attending physicians bill directly for their services through Medicare Part B or Medicare Advantage. Both medical directors and attending physicians often work across multiple facilities.

**Resident immunization efforts** generally fall under the responsibility of directors and assistant directors of nursing (DON, ADON) and infection preventionists (IP) who are employed by a facility. These are most often full-time employees with responsibilities that span nurse recruitment, onboarding, and education; clinical supervision; prevention and management of infectious disease outbreaks; and development of procedures to maintain standards of care. Regarding immunization, these clinical leaders must establish procedures for assessing residents' immunization status, recommending needed vaccines, facilitating vaccine orders, administering or coordinating the administration of vaccines onsite, and documenting administration. Nurses, licensed practical nurses, or pharmacists often carry out key tasks in immunization workflows under the supervision of clinical leaders.

## Key Players *(continued)*

**Long-term care pharmacies** provide specialized services to SNFs and other PALTC facilities, managing the often complex mix of medications prescribed to older adults. These pharmacies, which can include specialized or community pharmacies, typically contract with SNFs and coordinate with facilities regarding medication billing and administration. Long-term care pharmacies provide many vaccines to SNFs and often handle a portion or all of the billing, depending on their contract, the vaccine type, and a resident's healthcare coverage. In some cases, long-term care pharmacy personnel may administer vaccines.

## The Challenges

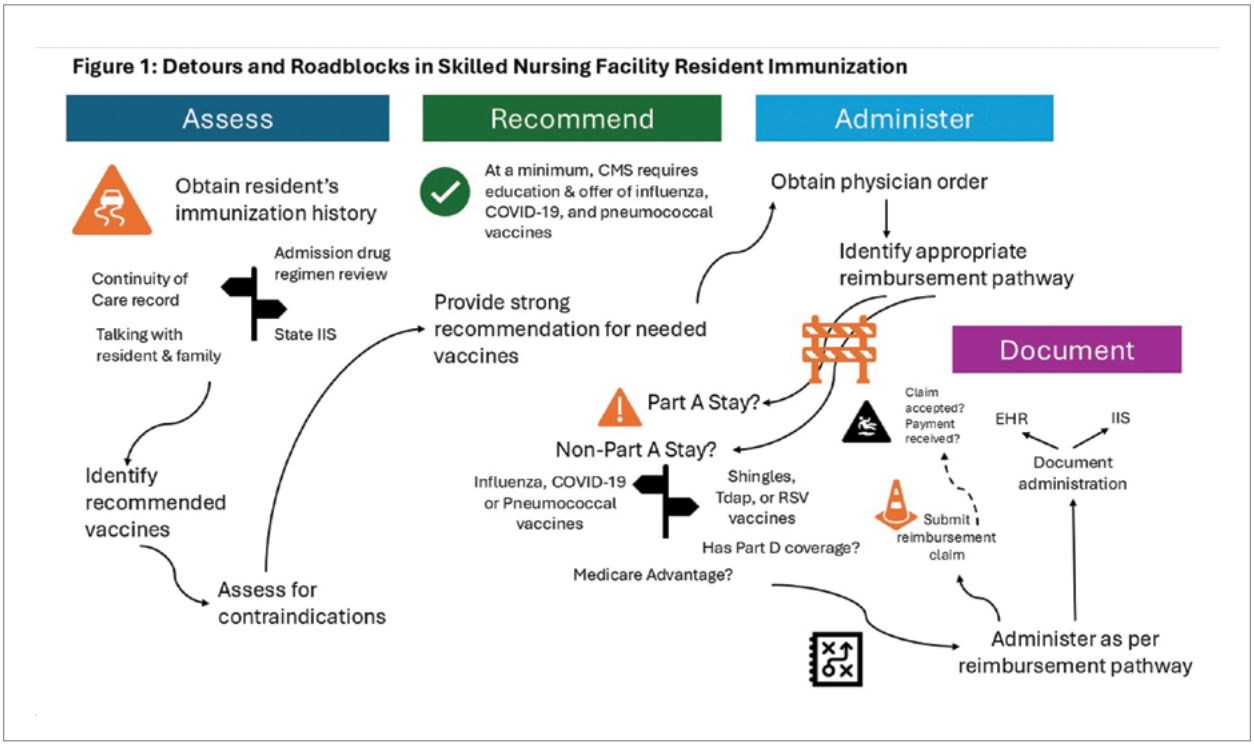
**Gaps in information technology (IT) infrastructure create fragmented immunization records and inefficient processes** – Obtaining a complete immunization history for residents requires significant time and resources as staff seek information from multiple sources. State Immunization Information Systems (IIS) – confidential, population-based databases of immunization doses administered within a state – can be helpful to fill gaps in immunization history, but many SNFs struggle to access and contribute data to these systems due to gaps in PALTC health information technology (IT) infrastructure. Access to IIS and electronic health record (EHR) interoperability in PALTC facilities lags other healthcare settings in large part because these facilities and their EHR systems were excluded from the 2009 EHR incentive program known as Meaningful Use. As a result, SNFs generally cannot yet use their EHRs to exchange information with hospitals, outpatient practices, or state IIS databases. Furthermore, EHR systems in use within SNFs generally lack functionality to aggregate immunization records across residents, making it difficult for SNFs to monitor and proactively manage gaps in coverage. These technology gaps create inefficiencies in assessing individual residents' immunization needs, planning facility-level immunization efforts, and billing for vaccination.

**Reimbursement pathways complicate vaccine administration** - Reimbursement for immunizing SNF residents is extraordinarily complex, with regulations requiring different entities (i.e., SNFs or long-term care pharmacies) to administer and bill for different vaccines under different scenarios. Vaccine product and administration are typically billed separately, and reimbursement requirements differ by resident healthcare coverage, type of SNF stay, and vaccine. This means that workflows for who administers a vaccine are tied to billing and reimbursement mechanisms. Adding further complexity, guidance on reimbursement policies is spread among multiple regulations, with no single source of information to guide all scenarios. This complexity means that each time a resident is due for a vaccine, SNF staff must first determine who is permitted to administer and bill for the vaccine, requiring SNFs to simultaneously implement several different workflows for immunizing residents. This complexity has increased in recent years alongside growing enrollment in Medicare Advantage plans, which each have their own billing requirements. Furthermore, facilities are at financial risk when reimbursement is delayed or denied due to discrepancies in administration and billing requirements. PALTC EHRs struggle to support these complex billing pathways, adding further inefficiency to the billing process.

# DETAILED DISCUSSION

Ideally, long-term care resident immunization efforts follow the National Vaccine Advisory Committee (NVAC) Standards for Adult Immunization Practice encompassing the principles to Assess, Recommend, Administer, and Document vaccinations. However, several structural challenges create detours and roadblocks making it difficult for SNFs to follow these standards as they work to protect residents from vaccine-preventable illnesses (Figure 1).

## Figure 1: Detours and Roadblocks in Skilled Nursing Facility Resident Immunization




## Gaps in IT Infrastructure Create Fragmented Immunization Records and Inefficient Processes

As with any immunization process, the first step is to assess residents' immunization history and determine which, if any, vaccines they need. At a minimum, CMS regulations require that PALTC facilities establish policies and procedures to ensure that each resident is offered pneumococcal and COVID-19 immunization, and offered influenza immunization annually between October 1 and March 31, unless the resident has already been immunized or has a vaccine contraindication. This means that facilities must assess residents' immunization status for these three vaccines. Though not mandated, ideally SNF staff assess residents' complete immunization history as part of an admission drug regimen

review or other in-take process and reassess residents periodically to determine whether they are due for additional recommended immunizations, such as RSV, shingles, or Tdap.

Each SNF establishes its own procedures for assessment, but one common challenge across facilities is fragmented immunization records. Whether admitted from the hospital, community, or other setting, SNF residents rarely arrive with a complete immunization history. Assessing and documenting this history within the SNF EHR requires time- and resource-intensive efforts by staff to manually gather information from across multiple sources, such as:

- Asking about immunization history during admission. Residents and their legally authorized representatives may lack information about immunization history or lack sufficient detail to determine whether the resident is fully up-to-date on all recommended vaccines.
- A Continuity of Care Document or other medical history accompanying a resident at admission may provide some immunization history, but would likely include only recent immunizations administered, such as any received during a recent hospital stay.
- Requesting information from residents' primary care or other community-based provider may offer a more complete immunization history, although obtaining this information often requires manual processes because outpatient and PALTC EHRs generally are not able to directly exchange electronic data. In addition, these providers may not have records of immunizations administered at community pharmacies.
- Searching the state IIS may help fill some gaps in residents' immunization history, but as discussed further below, long-term care EHRs generally lack interoperability with IIS. SNFs vary widely in their use of these systems and when doing so, most often rely on manual processes. Often only one staff person has credentials to access each facility's IIS account and frequent staff turnover can disrupt access. In addition, many hospitals and adult medical providers do not report immunizations to an IIS and some states record adult immunization history only when individuals opt into the IIS. In cases where residents recently moved from out-of-state, information within the SNF's state IIS will be incomplete, and state IIS systems generally do not exchange information. Nationally, adult participation in state IIS databases is high, but lags behind in some states.
- For residents enrolled in traditional Medicare, PALTC pharmacies may query a resident's Medicare claims to determine if a particular vaccine has previously billed for that resident. However, these claims are not available for residents with healthcare coverage under Medicare Advantage, Medicaid, or commercial insurance, and this method requires coordination between the PALTC pharmacy partner and SNF staff conducting an immunization assessment.

Obtaining a complete immunization history for new residents often requires significant time from SNF staff who must gather information from these many sources. Yet having a complete history is important to make the most appropriate recommendations for immunizations that will protect residents. To ensure individuals are protected, CDC recommends vaccinating in cases where immunization history is unavailable; however, for SNFs this may result in unpaid reimbursement claims if CMS has previously been billed for that vaccine for a beneficiary. This creates a disincentive to offering vaccines in cases where immunization history is unknown. Overall, fragmented records

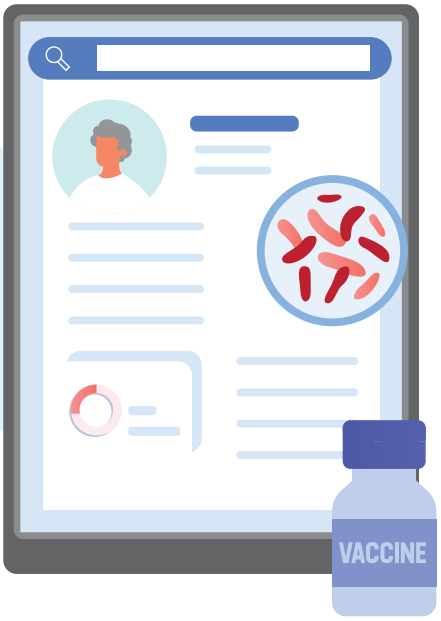
## DETAILED DISCUSSION *(continued)*

and time-consuming assessment processes create barriers to keeping residents up-to-date on recommended vaccines, especially in facilities facing staffing shortages, as is frequently the case in long-term care.

EHR functionality in SNFs lags other healthcare settings in large part because these facilities were excluded from the 2009 EHR incentive program. This program, also known as Meaningful Use, provided incentives for hospitals and outpatient providers to adopt EHRs and develop interoperability – the ability to exchange health information with other providers and public health systems. PALTC facilities and providers were not included in the program. Without financial incentives to support technology implementation, EHR adoption proceeded more slowly in SNFs and other PALTC settings, as have efforts to make PALTC systems interoperable with other healthcare and public health information systems. As a result, SNFs generally cannot use their EHRs to exchange information with hospitals and outpatient providers about residents' health history, risks, or needs, creating inefficiencies in assessing residents' immunization history. Similarly, EHRs used in SNFs generally cannot exchange information with state IIS databases, requiring manual processes both for obtaining immunization history and updating residents' records after receiving an immunization at their facility. Training SNF staff on IIS log in, query, and reporting procedures takes time, and as a result, often only one staff member has credentials to access each facility's IIS account. Access may be delayed or disrupted during staff transitions.

Further complicating immunization efforts, EHRs vary widely in where and how they record information on immunizations, often requiring extra time for staff to document and monitor residents' immunization history. This can complicate efforts to identify when existing residents are due for additional vaccines or doses and creates extra burden when billing for vaccination (discussed further below).

Obtaining a complete immunization history for new residents often requires significant time from SNF staff who must gather information from many sources.



# Reimbursement Pathways Complicate Vaccine Administration

After completing an assessment and recommending needed vaccines to residents or their legally authorized representative, the next step is administration for those residents who agree to be vaccinated. Key steps in the vaccine administration pathway are spread out among physicians, nursing staff, and long-term care pharmacy partners, requiring close coordination among these roles. Further complicating vaccine administration, reimbursement pathways often restrict which entities and providers can bill for immunization and under what circumstances.

A physician must order immunization for individual residents or through standing orders, but typically they do not administer vaccines. Although there are ample licensed clinical staff available who can administer vaccines to SNF residents, because administration is tied to complex reimbursement pathways, facilities cannot rely on any one administration approach for all resident vaccination efforts. Furthermore, SNFs typically offer residents annual vaccines like influenza and COVID-19 through seasonal clinics, whereas other recommended vaccines such as pneumonia, shingles, and Tdap may be offered to individual residents on a case-by-case basis.

Following the appropriate administration and billing mechanism is essential for SNFs to be reimbursed for their vaccination efforts, an important consideration in an often resource-constrained environment.[3] Concerns about rejected or unpaid immunization claims creates a disincentive for SNFs to offer vaccines beyond those required by CMS regulations (influenza, COVID-19, and pneumococcal). Vaccine reimbursement is split into two components: the vaccine product itself, and its administration. Reimbursement further depends on residents' healthcare coverage (i.e., traditional Medicare, Medicare Advantage, Medicaid, dual eligible, commercial or long-term care insurance), the type of vaccine (i.e., influenza, pneumococcal, RSV), and for residents enrolled in traditional Medicare, the type of SNF stay (i.e., Part A vs non-Part A long-term stay), as further discussed below.

Code of Federal Regulations 42 CFR § 483.30 allow SNFs to establish standing orders for residents for influenza and pneumococcal vaccines. Other vaccines, such as COVID-19, RSV, shingles, and Tdap, require patient-specific orders.


[3]Previously, some SNFs provided influenza vaccine to residents without reimbursement, but increasing financial pressures within the PALTC sector today make this strategy unsustainable for most facilities.

## Insurance Coverage

One of the most important factors in determining reimbursement pathways for vaccinating SNF residents is insurance coverage.

- **Traditional Medicare (Fee-for-Service)** – As of 2024, 46% of Medicare beneficiaries were enrolled in traditional Medicare. For these residents, rules governing vaccine billing differ by stay and vaccine type, as outlined below. This can mean following a different reimbursement pathway for two vaccines given to the same resident at the same time (see Sidebar on next page).
- **Medicare Advantage** – As of 2025, 54% of Medicare beneficiaries were enrolled in a Medicare Advantage Plan. Each plan differs in how it covers immunization, sometimes reimbursing both vaccine product and administration under the pharmacy benefit (part D), sometimes reimbursing both under the medical benefit (Part B), and sometimes reimbursing the vaccine product under Part D but the administration under Part B. Reimbursement requirements also may differ by vaccine. These differences in reimbursement pathways require different workflows for ordering, administering, and billing for immunization for residents covered under each Medicare Advantage plan. With many different Medicare Advantage plans available, mapping out and training staff to follow these complex reimbursement pathways becomes cost prohibitive.
- **Medicaid and Dual Eligible** – In 2020, approximately 62% of SNF residents had Medicaid coverage. Many SNF residents have both Medicare and Medicaid coverage, known as dual eligibility. This is especially true for long-stay residents, for whom Medicaid typically covers the SNF stay. For residents who are dually eligible, Medicare provides coverage for vaccines, and reimbursement for these residents follows the pathways outlined above for traditional Medicare or Medicare Advantage, depending on the resident's specific coverage. Rules governing vaccine reimbursement for SNF residents with Medicaid-only coverage (i.e., not dually eligible) varies by state and may also depend upon whether a resident is enrolled in traditional (FFS) Medicaid, or a Medicaid Managed Care plan. This adds yet another source of complexity for SNFs when determining the appropriate administration and reimbursement pathway for residents.
- **Commercial Insurance** – Although making up only a small minority of the SNF population, some residents have commercial insurance. Facilities must contact these residents' health plans to understand vaccine benefit coverage, reimbursement, and administration requirements.

## Stay Type and Vaccine

For residents enrolled in traditional Medicare, reimbursement pathways depend on both the type of stay and vaccine. Residents' first 100 days in a SNF are known as a Part A stay, as their care is covered during this time by the inpatient benefit, known as Part A. These residents may also be referred to as short-stay. After 100 days residents are considered in a non-Part A stay. These residents may also be referred to as long-stay. Reimbursement pathways vary for Part A and non-part A stays, depending on the vaccine type. For example, during a Part A stay, only facilities may bill for the product and administration of influenza, pneumococcal, and COVID-19 vaccines. This billing falls under Medicare Part B, and influenza, pneumococcal, and COVID-19 are sometimes referred to as Part B vaccines. Under a recent change, hepatitis B vaccines are also now covered under Part B for SNF residents. But for the same resident (traditional Medicare, in Part A stay), a pharmacy must provide and bill for Tdap, shingles, and RSV vaccines. This billing falls under Medicare Part D, and these are sometimes referred to as Part D vaccines. Either the pharmacy or facility can bill for administration of Part D vaccines. Residents lacking Part D coverage would have to pay for these vaccines out of pocket. These pathways vary still further for residents in a non-Part A stay, adding additional complexity, particularly as residents transition from Part A to non-Part A status. Stay type does not impact vaccine reimbursement for residents enrolled in Medicare Advantage or other types of plans. Figure 2 provides a snapshot of the many factors impacting reimbursement and required vaccine administration methods for SNF residents with different healthcare coverage.

EXAMPLE

## Navigating Immunization Reimbursement and Administration

Mr. Smith is enrolled in traditional Medicare and was recently admitted to the Shady Grove nursing home. On admission, the nurse determines he is due for an annual influenza vaccine and that he has not yet received the RSV vaccine. Because he is in a Part A stay, the facility must provide and administer the influenza vaccine and bill a Part B claim. However, for the RSV vaccine, only the facility's LTC pharmacy can provide and bill for the product. Either the facility or the pharmacy can bill for the RSV administration fee. In this case, Shady Grove has a contract with the pharmacy stipulating that the pharmacy will bill for both the product and administration fee for RSV, then pass on the administration fee to Shady Grove, which will actually administer it.

A year later, Mr. Smith is due for another annual influenza vaccine. He also is due for a Tdap booster, which is recommended once every 10 years. Now that Mr. Smith is under a non-Part A stay, either the facility or the pharmacy can bill for the product and administration of influenza vaccines. But only the pharmacy can bill for the Tdap product because it is a Part D Vaccine. In this case, the pharmacy administers both vaccines to Mr. Smith and bills for the product and administration fees for both vaccines.

Mrs. Jones is enrolled in a Medicare Advantage plan. She, too, is due for the annual influenza and RSV vaccines upon admission to Shady Grove. Because she has Medicare Advantage, only the facility's LTC pharmacy can bill for her vaccines, even during her Part A stay. In this case, the pharmacy administers both vaccines, and bills for both the product and administration fees.

## Figure 2. Factors Determining Vaccine Reimbursement Mechanisms within Skilled Nursing Facilities, by Resident Insurance Status

| | Traditional Medicare | Medicare Advantage | Medicaid | Commercial Insurance |
|---|---|---|---|---|
| Dependencies | **STAY TYPE**<br>**Type A** - short-term rehabilitation<br>**Non-type A** – long-term<br>**VACCINE TYPE**<br>**Part B** – Influenza, pneumococcal, COVID-19, hepatitis B<br>**Part D** – Tdap, shingles, RSV<br>**FACILITY-LEVEL FACTORS**<br>Pharmacies may bill for vaccines administered by SNF staff, then pass that fee on to the facility* | **PLAN-LEVEL GUIDANCE**<br>Each plan differs in its vaccine administration and billing requirements<br>**FACILITY-LEVEL FACTORS**<br>Pharmacies may bill for vaccines administered by SNF staff, then pass that fee on to the facility* | **DUAL ELIGIBLE^**<br>Medicare covers vaccination. See applicable Medicare reimbursement dependencies<br>**MEDICAID ONLY**<br>**Traditional:** State-specific guidance determines vaccine reimbursement<br>**Managed care:** State- and plan-level guidance determines vaccine reimbursement | **PLAN-LEVEL GUIDANCE**<br>Each plan differs in its vaccine administration and billing guidance |
| Additional Requirements | **Part A stay + Part B Vaccine** - SNF must provide and bill for both vaccine product and administration<br>**Any stay type, Part D vaccine**<br>Pharmacy must provide and bill for vaccine product | **For all vaccines**<br>Pharmacy must bill for vaccine product and administration | Varies by state and (when applicable) managed care plan | Varies by health plan |

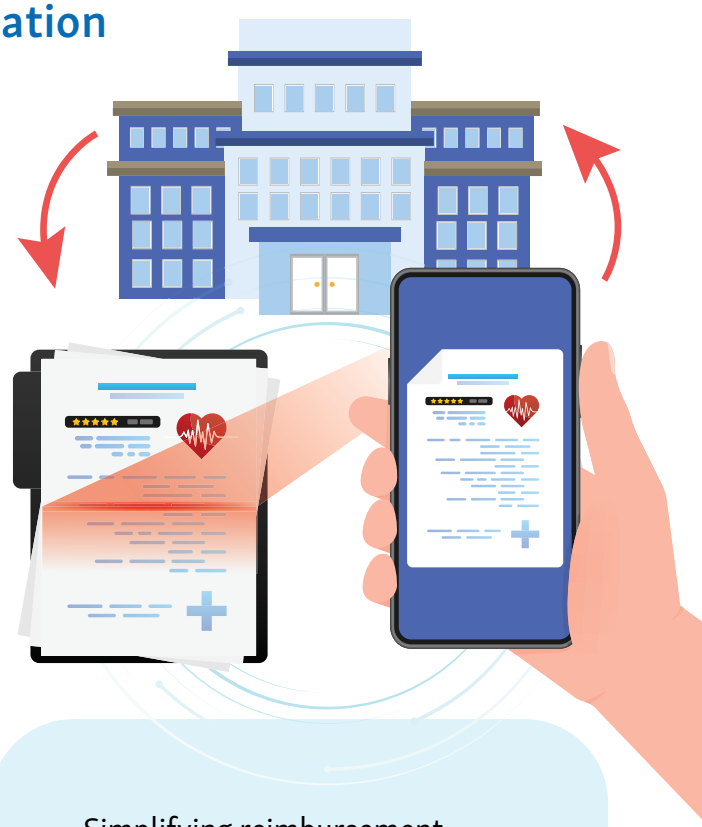
*Agreements for pharmacies to pass-through vaccine administration fees should be written into facility contracts.

^Dual eligible means individuals covered by both Medicare and Medicaid. This could include managed care plans (e.g., Medicare Advantage and/or Medicaid managed care)

As the previous examples show, in addition to assessing residents' immunization history and consulting best practice guidelines for recommended vaccines, SNF staff must also determine the appropriate billing mechanisms for each resident and each vaccine. Doing so requires following a complex series of rules, necessitating extra time and expertise. Mistakes in applying these rules put the facility at risk of absorbing the cost of vaccination without reimbursement; these mistakes frequently cannot be corrected after a vaccine is administered. Furthermore, typical methods of documenting immunization in PALTC EHRs and billing software do not readily support these complex billing processes, requiring additional time and effort to process reimbursement paperwork.

## Streamlining SNF Resident Immunization

Real-world experience from the Moving Needles quality improvement project showed that implementing standard operating procedures is an effective strategy to increase immunization rates in long-term care settings. But complex reimbursement pathways mean that SNFs cannot follow any one standard workflow when administering vaccines to residents, while gaps in IT infrastructure make it harder for SNFs to obtain, access, and document the information necessary to determine residents' immunization history and appropriate administration and reimbursement pathways. This complexity adds additional challenges to an already resource-constrained, high-stakes environment. Amid many competing priorities and frequent staff turnover, immunization too often slips through the cracks or down the priority list. Simplifying reimbursement options for vaccinating SNF residents and strengthening IT systems within PALTC settings could go a long way toward streamlining workflows for assessing, recommending, administering, and documenting resident immunization. Ultimately, reducing complexity and creating opportunities for streamlining these processes will make it easier for SNFs to protect their residents from vaccine-preventable illness, avoid emergency department visits and hospitalizations related to infectious disease, and reduce morbidity and mortality within this high-risk population.



Simplifying reimbursement and strengthening IT systems within PALTC settings could go a long way toward streamlining immunization for SNF residents.

# 03 Systems Barriers to Immunizing SNF Staff

## SNAPSHOT

### The Landscape

**SNFs provide both clinical care and assistance** with activities of daily living, such as bathing and dressing. To do this, they rely on a wide variety of full-time, part-time, and contracted staff with different skillsets, licensures (when required), and education and training requirements.

**The long-term care industry** faces significant staffing shortages and high turnover, particularly among nurses and CNAs. These shortages are likely to grow as the U.S. population ages, with workforce projections estimating approximately 40% growth in demand for PALTC workers such as RNs, LPNs, and CNAs by 2037. Ongoing financial constraints within the long-term care sector make it difficult to hire and retain staff.

### Key Players

**SNFs** employ a wide range of frontline staff who interact directly with residents, including nurses with a range of licensures (e.g., registered nurses, licensed practical nurses, advanced practice nurses), CNAs, pharmacists, personal care aides, and staff working in food preparation, janitorial services, transportation, and social activities. SNFs also typically contract with clinicians to provide clinical oversight, including the role of medical director.

**Staff immunization efforts** generally fall under directors and assistant directors of nursing (DON/ADON) and infection preventionists (IP). These administrators' responsibilities include staff recruitment, onboarding, and education; prevention and management of infectious disease outbreaks; and spearheading staff immunization efforts such as onsite clinics, education, or implementation of vaccine mandates. Human resources staff may also play a role in gathering staff immunization history, particularly as part of onboarding procedures.

## The Challenges

- **Increasing resistance to vaccine requirements** – Resentment about the federal COVID-19 vaccine requirement for long-term care workers during the pandemic, as well as subsequent resistance to other vaccine recommendations, make requirements a less effective tool for increasing immunization among SNF staff. This is true even for influenza and hepatitis B vaccines that were less controversial prior to the pandemic.
- **Access and cost barriers complicate staff immunization efforts** - Evidence shows that referring staff to offsite locations to receive vaccines is far less effective than offering vaccines to staff for free at work. Removing the dual barriers of access and cost can significantly raise staff immunization rates, but lack of ability to bill commercial insurance, a nonexistent safety net for uninsured or underinsured staff, as well as the high cost of some vaccines (such as COVID-19) require PALTC facilities to make trade-offs around vaccine offerings to staff.
- **SNFs lack infrastructure to efficiently monitor staff immunization** - High staff turnover and gaps in data infrastructure make it burdensome for SNFs to collect, track, and aggregate staff immunization data.

# DETAILED DISCUSSION

Keeping long-term care staff up-to-date on adult immunizations is important to reduce the spread of infection among staff and residents. Higher rates of immunization among staff mean lower risk for vaccine-preventable illness within the facility. Influenza, COVID-19, and hepatitis B immunization are especially high priority for frontline staff, as they are at greatest risk of becoming ill from or transmitting these vaccine-preventable illnesses while working in close contact with residents. Infectious disease outbreaks among staff often result in or exacerbate staffing shortages, and outbreaks among residents increase the workload for staff in addition to causing high morbidity and mortality among residents.

## Increasing Resistance to Vaccine Requirements

Fewer than half of states require any immunization for SNF staff. SNFs instead rely on a mix of mandates and voluntary efforts to encourage staff immunization.

- **Influenza immunization** – A 2016 review (the most recent available) found that fifteen states require that SNFs and other healthcare providers ensure staff are up-to-date on influenza immunization, 20 states require SNFs to assess workers' influenza immunization status, and 19 states require that SNFs offer influenza vaccines to staff. Washington, DC requires that SNFs take all three actions (assess, offer, and ensure influenza immunization for staff).

# Increasing Resistance to Vaccine Requirements *(continued)*

- **Pneumococcal immunization** – The same 2016 review found that four states and Washington, DC require pneumococcal immunization for PALTC workers.
- **COVID-19 immunization** – During the pandemic, there was a federal requirement that all healthcare workers receive the primary series of COVID-19 vaccine, but it never applied to COVID-19 boosters and ended in June 2023. As of mid-2025, only three states have an active COVID-19 immunization requirement that applies to PALTC workers. In contrast, nine states limit the ability to implement immunization requirements that would apply to healthcare workers, particularly for COVID-19 vaccines.

Details of these statutes, their implementation, and enforcement vary widely across states and continue to evolve. Unless prohibited by local or state law, SNFs may also implement their own staff immunization mandates and related policies, such as requiring masking or additional testing for staff who are not immunized.

Even when state-level mandates do not apply, some SNFs require immunization as a condition of employment; for example, staff influenza vaccine mandates have been in place for decades at many SNFs. But faced with persistent staffing shortages, high staff turnover, and recruitment challenges, many SNF administrators are hesitant to add barriers to hiring and onboarding new frontline staff. Anecdotes from the Moving Needles quality improvement project suggested most SNFs between 2022 to 2024 relied less on mandates as an immunization strategy.

Evidence suggests addressing vaccine hesitancy among healthcare workers requires tailored approaches that respect workers, recognize their concerns, promote dialogue, and build trust.

One study from 2021 showed that within SNFs, the most effective strategies for promoting staff COVID-19 immunization were non-monetary rewards such as t-shirts or merchandise that normed immunization as part of community-building efforts, setting a facility-level immunization goal, and designating frontline staff as immunization champions.

## Access and Cost Barriers Complicate Staff Immunization Efforts

Offering vaccines to staff onsite, during work hours, and for free can increase rates of staff immunization. SNFs implemented this effective strategy for many years by providing influenza vaccines to staff each fall, typically paying for the vaccine directly and relying on clinical staff already onsite to administer through employee clinics. However, at between $120 - $130 per dose, few SNFs can cover the cost of COVID-19 vaccines for staff.

Commercial insurers and Medicaid plans generally cover the full cost of COVID-19 vaccines but typically will not pay for vaccines administered onsite at SNFs because they consider PALTC providers and long-term care pharmacies out-of-network. Since commercialization of COVID-19 vaccines in 2023, SNFs instead have typically referred staff to retail pharmacies or doctor's offices to receive COVID-19 vaccines offsite, creating additional time, transportation, and access barriers for staff. For staff lacking insurance, the cost of COVID-19 vaccines is an especially high barrier to immunization. Currently, no national safety net program exists to ensure access to immunization for uninsured adults.

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## SNFs Lack Infrastructure to Efficiently Monitor Staff Immunization

Collecting and tracking accurate data is key to immunization efforts. Yet gaps in IT infrastructure make it difficult for SNF administrators to assess, document, and aggregate information on staff immunization status, adding to the burden of monitoring immunization rates. SNFs are required to report employee immunization rates for influenza and COVID-19 vaccines to the National Healthcare Safety Network, but in practice, facility staff with infection control responsibilities may not have access to this information. Similarly, although many SNFs ask staff to self-report immunization history as part of the hiring process, this documentation often resides in human resources systems where it is difficult for the appropriate clinical staff (e.g., DON, ADON, IP) to access and aggregate. Staff themselves may have difficulty obtaining immunization records, particularly for hepatitis B, which many people in the U.S. receive as a child.

Taken together, these data gaps increase the time and resource costs for monitoring and improving staff immunization rates. High staff turnover in SNFs only adds to the burden, because immunization rates fluctuate as staff come and go. For SNF administrators facing many competing priorities, expending effort to maintain up-to-date staff immunization records may become a lower priority. Yet without up-to-date information on staff immunization, SNF administrators cannot accurately assess the level of risk for vaccine-preventable illness among residents and staff.

# 04 Systems Barriers to Immunizing Residential Care Community Residents and Staff

## SNAPSHOT

## The Landscape

**Medicare** does not cover assisted living or other types of residential care for seniors. In some states Medicaid may cover a limited number of support services provided in residential care communities, such as medication management or personal care, but does not cover room and board.

**Residential care communities** are regulated at both the federal and state levels. Each state differs in its definitions of residential care and related requirements and regulations.

**While some residential care communities**, especially assisted living, may maintain nursing staff onsite and may offer medication management or other limited healthcare services, residents primarily receive medical care from their own clinicians, usually through a clinician's office.

## Key Players

**Residential care communities** rely heavily on personal care aides as well as kitchen staff, janitors, shuttle drivers, activity coordinators and other frontline staff who provide non-medical support to residents. Especially in assisted living, personal care aides are often in close contact with residents as they provide assistance with bathing, dressing, and other activities of daily living.

**Residential care communities employ** relatively few licensed clinical staff, but especially in assisted living facilities, they may include nurses onsite during some shifts.

## The Challenges

**Limited attention to immunization in residential care** – Although the risks of infectious disease to residents and frontline staff are similar in SNFs and residential care communities, immunization has received much less attention in residential care settings.

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## The Challenges *(Continued)*

**Few systems for maintaining immunization records in residential care** - Many residential care communities lack systematic ways of assessing residents' immunization history, instead relying on asking residents or their family members, who may not recall dates or other important immunization details. For those residential care communities without direct access to residents' immunization records, it is difficult to assess and mitigate the level of risk for vaccine-preventable disease among their residents.

**Lack of infrastructure to provide immunization onsite** - Residential care communities generally do not rely on their own licensed clinical staff to vaccinate residents or staff. Those communities, such as assisted living, that do have staff onsite with licensures that include vaccination administration typically are not able to bill insurance directly for the cost of vaccine product and administration. Instead, residential care communities interested in offering immunizations onsite to residents or staff must contract with a third-party healthcare provider to administer vaccines and process insurance claims. It is unclear how many residential care communities make the effort to do so.

# DETAILED DISCUSSION

Residential care communities such as assisted living, continuing care retirement communities, and group homes, provide residential and personal care services for older adults, or younger adults with disabilities who are unable to fully care for themselves. They typically provide room, board, supervision, and assistance with activities of daily living such as eating, dressing, and bathing. Some communities also include a memory care unit that provides specialized care for residents with dementia.

Residential care communities are regulated at both the federal and state levels. Some federal regulations relate to these communities' role as employers (e.g., oversight by the Occupational Safety and Health Administration and Department of Labor), and about half (48%) of residential care communities have Medicaid certification to offer home- and community-based services (HCBS) and are thus subject to federal oversight specifically for HCBS.

At the state level, residential care community regulations vary widely, including in how residential care is defined and the extent to which these communities can offer any medical services, such as assistance with medications. In its 2024 review of state regulations, the National Center for Assisted Living (NCAL) reported that 45 states and the District of Columbia have infection control requirements in place specifically for assisted living facilities, although many of these requirements were quite broad, such as "establish written policies related to infection control procedures." At the time of that review, only three states (Massachusetts, South Dakota, and Tennessee) had regulations in place regarding immunization in residential care communities.

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- Massachusetts' requirements mandate influenza and COVID-19 immunization for all assisted living staff, including employees, contractors, and volunteers, whether paid or unpaid. The mandate requires that assisted living staff receive the seasonal influenza vaccine annually and stay up-to-date on COVID-19 vaccines as per CDC recommendations, while requiring that assisted living facilities notify staff of the vaccine mandate, educate them on the benefits and risks of influenza and COVID-19 vaccines, inform staff about how to receive the vaccines, and maintain documentation of staff immunization status.
- Tennessee requires that assisted living facilities offer influenza vaccines, at no cost to individuals, to all staff and independent practitioners. The state also requires facilities to educate staff about influenza transmission and impact, the vaccine, and other infection control measures; encourage all staff to receive the influenza vaccine annually; and maintain documentation of staff influenza immunization status.
- South Dakota's assisted living regulations focus on resident rather than staff immunization, requiring that all facilities offer residents the influenza vaccine upon admission and annually. The state also requires assisted living facilities to assess residents' pneumococcal immunization status at admission and encourage them to receive the vaccine if recommended by the resident's primary care provider. Facilities also must maintain records of resident influenza and pneumococcal immunization status.

No other states address immunization for residents or staff within assisted living regulations, although Oregon previously required COVID-19 immunization for all healthcare personnel – which the state defined as including assisted living staff – but this requirement was repealed in 2023 after expiration of the public health emergency.

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## Limited Attention to Immunization in Residential Care

With few states addressing immunization in residential care regulations, the extent to which a particular residential care community focuses on immunization for residents or frontline staff often depends on corporate and facility leadership priorities and resources. During the Moving Needles quality improvement project, one participating corporate entity found that offering immunization onsite to residents served as a positive marketing tool for several assisted living facilities. In contrast, another assisted living chain moved away from focusing on immunization because of a shift in leadership priorities, despite making substantial gains in the percentage of residents up-to-date on influenza, pneumococcal, and shingles immunizations at all three participating facilities.

This variability is itself a challenge. While the risks of vaccine-preventable illness for residents and frontline staff are common across regions and residential care communities, strategies to mitigate this risk depend on regulations in place in each state, local economic and policy context, and organizational policies and priorities within individual facilities or corporate entities.

## Few Systems for Maintaining Immunization Records in Residential Care

For those residential care communities that do focus on immunization for residents, an initial challenge is obtaining timely and accurate information on residents' immunization history, and documenting immunizations if provided onsite.

While a growing number of assisted living facilities are investing in adapting or developing their own electronic records systems, not all residential care communities have this technology in place. Facilities that have implemented electronic health records through participation in the National Institutes of Aging-funded long-term care data cooperative may be able to receive aggregated reports related to resident immunization, such as the percent of residents who are up-to-date on specific immunizations. However, records within these systems are still dependent upon information residents or their families provide when they move into a community, with wide variation in level of detail and accuracy depending on each community's admissions process. Residents may be less open to sharing immunization history or discussing recommended immunizations with residential care community staff because the facility generally is not directly involved in other aspects of their healthcare.

## Lack of Infrastructure to Provide Immunization Onsite

As discussed above, in some states, regulations may bar residential care communities from providing any medical services, including delivering immunizations. Other states may allow these communities to provide some limited medical services, which could include immunization. However, many residential care communities do not have staff onsite with appropriate licensure to administer vaccines. Those that do typically have such staff onsite only during certain shifts. These staff may not have bandwidth to incorporate immunization into other duties such as care coordination or medication administration. In addition, few residential care communities have protocols or systems in place to manage adverse reactions following an injection.

While these clinical considerations are important, the main barrier to onsite immunization efforts within residential care communities is lack of infrastructure to bill insurance for vaccine product and administration. This applies for both residents, who are primarily covered by Medicare and sometimes also Medicaid, and for staff, who typically have commercial or Medicaid insurance. With very few exceptions, residential care communities do not bill Medicare, Medicaid, or commercial health insurance. Instead, to cover the cost of vaccine product and its administration, these communities must bring onsite a third-party healthcare provider such as a retail pharmacy, local healthcare system, community health center, or public health department that can both administer vaccines and bill insurance to cover the cost of vaccination. With this approach, residential care communities play the role of facilitating, rather than providing, onsite vaccine clinics.

This model addresses many of the barriers to onsite immunization within residential care communities, though still requires facilities to identify and contract with appropriate third-party providers and coordinate details of onsite vaccine clinics. Experience from the Moving Needles quality improvement project showed that some third-party providers, especially retail pharmacies, charge a fee for onsite vaccine clinics and also require advanced commitment to administer a

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minimum number of vaccines. This puts the onus on residential care communities to build support for immunization and adds financial risk to purchase unused vaccines if a vaccine clinic falls short of the required minimum participants. Periodic vaccine clinics work best for seasonal immunizations such as influenza and COVID-19 vaccines but are less financially and logistically feasible for immunizations that only a few residents or staff need at any one time (e.g., pneumococcal or Tdap for residents, hepatitis B for staff) and for multi-dose vaccines (e.g., shingles). In the absence of reporting requirements or regulatory oversight in most states, it is unclear how many residential care communities make the effort to provide immunization onsite to residents or staff.

For some staff working in residential care communities, an additional barrier to immunization is lack of insurance.

Medical professionals working in PALTC facilities who lack health insurance (both SNFs and residential care communities)

**12%** Personal care aides **11%** LPNs **6%** RNs

*The Kaiser Family Foundation estimation in 2022*

A recent report from the LeadingAge long-term services and supports center estimated that overall, 15% of direct care workers (nursing assistants, personal care aides, and home health aides working in PALTC settings and home health) lack health insurance. Third parties providing vaccine clinics onsite at residential care communities rely on insurance payments to cover the costs of vaccine product and administration. Uninsured staff would need to pay the full cost of immunization out of pocket to participate in such vaccine clinics. In 2025, the cost of COVID-19 immunization without insurance ranged from $90 to $200 at retail pharmacies, and for influenza the range was $20 to $65. Paying out of pocket for both immunizations represents one to two days' wages for staff earning on average between $12 and $14 per hour. In contrast, staff with insurance generally would have no co-pay, as federal regulations require most insurers to cover the full cost of recommended immunizations. Offering immunization free onsite to some but not all staff exacerbates inequities among different staff roles. Currently there is no national program to provide free or low-cost vaccines to adults, even for individuals caring for older adults who are highly vulnerable to vaccine-preventable illnesses.

# 05 Conclusion

Public health has long recommended immunizing PALTC residents and staff to decrease the spread of infectious diseases within facilities where highly vulnerable older adults live in close quarters. Immunization protects residents from the added morbidity and mortality of vaccine-preventable illness while helping workers avoid the added burdens of illness, missed work, and increased workload during outbreaks. For PALTC facilities, increasing immunization makes business and economic sense as disease outbreaks, admission freezes, and staffing shortages are all costly.

Yet systems barriers have made it difficult for both the public health and PALTC sectors to act on these priorities. Fragmented records, gaps in IT infrastructure, and convoluted billing and reimbursement mechanisms mean there are many opportunities for SNF residents to slip through the cracks and miss recommended immunizations. Vaccine cost and access barriers contribute to low immunization rates among SNF staff, while high staff turnover and increasing resistance to vaccine requirements discourage SNF employers from requiring staff immunization. And in residential care communities, lack of attention toward immunization for residents or staff, combined with gaps in infrastructure to track immunization or provide vaccines onsite, means many older adults and staff in these settings are at high risk for vaccine-preventable illnesses.

At the time of this writing, federal immunization policy and processes are undergoing major changes. While adding to the challenges outlined in this paper, the current dynamic public health policy environment does not change the fundamental barriers to immunizing PALTC residents and staff outlined in this paper, nor the imperative to overcome these barriers at a time when the number of older adults living within PALTC settings is projected to increase dramatically.

Addressing these barriers and increasing PALTC resident and staff immunization will require creative and collaborative solutions that bring together stakeholders from across the public and private sectors. It will also require working at local, state, and national levels while adapting to the shifting policy landscape. In the near-term, a key step is redoubling attention on immunization within PALTC settings – especially in the rapidly-growing residential care community model – and building on learning from improvement efforts such as the Moving Needles project to develop work-arounds adapted to specific local contexts. Corporate leaders within the PALTC sector can play an especially important role in this process by emphasizing ways that immunization protects their residents, staff, and bottom lines through fewer outbreaks, admission freezes, and staffing shortages.

Long-term, systemic barriers to PALTC immunization will require systemic solutions. Such solutions must make it easier and more affordable to immunize residents and staff within SNFs and residential care communities, and more efficient to monitor immunization efforts over time. Overcoming these barriers and increasing immunization coverage among residents and staff means more financial stability for PALTC facilities, lower rates of preventable morbidity and mortality, and ultimately healthier seniors and staff.

# Glossary

**Activities of Daily Living (ADL):** Basic routine tasks that most healthy individuals can perform without assistance, including personal care tasks such as eating, dressing, bathing, toileting, managing continence, and transferring. The ability to perform activities of daily living is an essential measure of an individual's functional status (Source). **Instrumental Activities of Daily Living (IADL)**, such as cooking, cleaning, transportation, laundry, and managing finances, are activities that allow an individual to live independently in a community (Source).

**Assisted Living Facilities:** Offer a more independent living environment for seniors who need some assistance with activities of daily living (ADLs) but do not require constant medical supervision (Source).

**Certified Nursing Assistants (CNA):** Help patients with daily activities, monitor vital signs, and provide patient comfort and hygiene (Source).

**Continuing Care Retirement Communities (CCRCs):** Provide a continuum of care, including independent living, assisted living, and nursing care, allowing residents to transition between levels of care as their needs change (Source).

**Immunization Coverage:** The percentage of a population who are up-to-date on a particular vaccine as of a specific month or date (Source).

**Independent Living:** A senior living community that caters to older adults, typically older than age 55 or 60, who can care for themselves without support. Residents typically live in private apartments or rooms. These communities often offer a variety of services onsite such as housekeeping, laundry, activities, and a restaurant, but usually do not have personal care aids or nursing staff onsite around the clock. Residents may hire in-home help separately when needed. (Adapted from Source and Source).

**Licensed Practical Nurses (LPN):** Provide care under the direction of a registered nurse (RN). Together, RNs and LPNs make sure someone's plan of care is being followed and their needs are being met. LPNs typically have one year of training (Source).

**Memory Care:** Specialized facilities or units within long-term care facilities designed to meet the needs of individuals with Alzheimer's disease and other forms of dementia (Source).

**Personal Care Aides:** Personal care aides assist older adults and people with disabilities living at home with activities of daily living such as bathing, dressing and eating. Personal care aides also help with instrumental activities of daily living, such as grocery shopping, meal preparation, and managing medications (Source).

**Post-Acute and Long-Term Care:** Post-acute and long-term care (PALTC) settings include skilled nursing facilities, long-term care and assisted living communities, continuing care retirement communities, home care, hospice, Program of All-Inclusive Care for the Elderly (PACE) programs, and other settings (Source).

**Registered Nurses (RN):** In long-term care settings, RNs are responsible for the overall delivery of care and assess overall health care needs. RNs are typically required to have between two and six years of education (Source).

**Residential Care Community:** Includes facilities that provide residential and personal care services for older adults or younger adults with disabilities who are unable to fully care for themselves. These settings can include assisted living facilities, continuing care retirement communities, and group homes for adults with disabilities. The care typically includes room, board, supervision, and assistance with activities of daily living (Source).

**Skilled Nursing Facility (SNF):** Also known as a nursing homes, these facilities provide 24-hour skilled nursing care for individuals with chronic illnesses or disabilities who are unable to care for themselves independently (Source).