I am a physician caring for patients in the Skilled Nursing and LTC/ICF setting in the Portland Metro area.

I want to first thank you for your work, and do not envy the difficulty of making priority decisions for the Covid vaccinations, nor the work of clarifying the multiple needs of our community in providing the vaccine.

I would like to advocate for those patients who reside in LTC settings, by providing observations since the roll out of the vaccine.

1. Anecdotally, I have to confirm the observations of many in our industry and recently published observational trials of vaccine compliance in the LTC setting. Given the dynamics of the clinical work-force in these setting, we have worked for years to provide education to boost influenza vaccination compliance. I have not been surprised at the resistance to vaccination (38% LTC workers accepted vaccine out of approx. 11,000 recently studied) as a result. In discussion with staff at the facility I work, it is clear there is a profound misunderstanding of the science of this pandemic and the vaccine, as well as the vaccine's development and EUA process. Unfortunately, I think this is a consequence of our myriad information sources and misinformation directed through them. Any thought or input to educating the LTC work-force regarding this vaccine is welcome in the industry, but there will remain substantial culture bias against taking it regardless of our education efforts.
2. I am also not surprised that the same study noted 70% compliance with vaccination in the patient population in LTC settings. While resilient in their aging, our community of ill elderly is suffering like few others from the isolation of this pandemic. I suspect a majority would accept any measure to be in the presence of their loved ones and to them I would guess a vaccine seems of little risk to achieve that goal. For the lives they have lived, they deserve an opportunity to regain connection and stability in cognition and mental health. It is sadly ironic, that our community has established a care system for the ill elderly that so directly interfaces with the staff issues of vaccine resistance. Ultimately, that is a resource priority decision in the health care industry. While there are no easy answers, an intervention similar to our state run covid units, or a substitute, vaccinated work force would seem urgently necessary to provide an appropriate period of quarantine to allow our ill elderly to reconnect with those they love. Of course, their families would also need vaccine access.
3. The role out of vaccination in the hands of private entities has meant only intermittent availability. Especially in the SNF population, we are not providing predictable vaccination in a setting that should be more robust. Unless their stay overlaps with the intermittent vaccine 'clinics' that outside pharmacies are providing to our LTC facilities, these patients are transitioning from acute care situations to rehab settings to long term care or home without receiving vaccine. Any of us facing this number of exposures, especially in some of the high risk and under-vaccinated settings these transitions represent, would be hopeful they receive vaccination as soon as possible. I have had too many conversations in this setting with families who cannot understand why we don't have a system to provide patients in this most vulnerable position a vaccine. If only from a utilization standpoint, it would seem a priority to prevent secondary illness as soon as possible for the recently acutely ill.

Other than commentary about industry, none of this is meant as criticism. I wish you the best in your decisions.

This pandemic has proven to me that doing our very best is all we have. Directly witnessing the plight of our most vulnerably ill has been rewarding for the resilience they demonstrate and devastating when the challenges are too great.

Thank you
Rick Mishler, MD