

**COVID-19 ONE YEAR LATER: ADDRESSING
HEALTH CARE NEEDS FOR AT-RISK
AMERICANS**

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THURSDAY, MARCH 18, 2021

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The Committee met, pursuant to notice, at 9:32 a.m., via Webex, Hon. Robert P. Casey, Jr., Chairman of the Committee, presiding.

Present: Senators Casey, Gillibrand, Blumenthal, Warren, Rosen, Kelly, Warnock, Tim Scott, Braun, and Lee.

**OPENING STATEMENT OF SENATOR ROBERT P. CASEY, JR.,
CHAIRMAN**

The CHAIRMAN. The Senate Special Committee on Aging will come to order. Good morning to everyone. I want to welcome both new and returning members to the first hearing of this Committee for the 117th Congress. I am delighted that Senator Tim Scott of South Carolina will serve as the Committee's new Ranking Member. Senator Scott has been an active member of this Committee, and I look forward to working with him closely during this Congress.

I particularly want to welcome the new members of the Committee. We have three: Senator Mark Kelly of Arizona, Senator Raphael Warnock of Georgia, and Senator Mike Lee of Utah. I look forward to all of our contributions over the next two years. We know that the Aging Committee has historically been a committee that fosters both bipartisanship and collaboration. As Chairman, I hope to adopt that same spirit of bipartisanship and advance an agenda to build health and economic security for seniors, people with disabilities, and their families.

Today's hearing will focus on the continuing and grave threat to those Americans, and our Nation as a whole, the COVID-19 pandemic, and the effects it has had on the health of people most at risk due to the virus. We have lost more than 24,600 Pennsylvanians to this pandemic. These were our mothers, fathers, grandmothers, grandfathers, sisters, brothers, neighbors, and friends.

We all know that older adults have suffered the brunt of this pandemic, accounting for 81 percent of all deaths. A tragedy within the broader tragedy of this pandemic has taken place in our Nation's long-term care setting, where more than 178,000—more than 178,000—residents and workers combined have died from COVID-19.

Our witnesses today will help us better understand where we are one year into the pandemic. This is an important conversation, and it comes just one week after President Biden signed the American Rescue Plan into law. This historical legislation advances a bold vision to defeat the virus and begin to rebuild our economy. The American Rescue Plan, working families will have more money in their pockets, our children will return to school safely, and everyone who wants to, can be vaccinated. This bill ensures that home and community-based services are available for seniors and people with disabilities, and further will help put food on their tables. The bill strengthens our long-term care workforce, provides resources to ensure the heroes on the front lines have personal protective equipment, testing supplies, and even premium pay.

The bright light at the end of this dark tunnel are, of course, vaccines. Distribution and administration of the vaccine is one of the greatest challenges the Nation has faced in our lifetimes. Getting the vaccine into people's arms has been a huge undertaking. Local churches, senior service agencies, and many other members of our communities met this challenge head-on, helping seniors and driving people to appointments.

This bill gives states and communities the funding they need to further this important work and vaccinate those who need it the most. The plan will help us rise to the occasion and build on the progress President Biden and his administration have made in the last two months.

The actions we are taking now are only the beginning. Our work is not done. The pandemic has highlighted long-standing injustices facing many Americans.

We must enact policies to address the injustices that have plagued communities of color, people with disabilities, and older adults for far too long.

The conversation we are having today is just the beginning of a much longer and critically important dialog for this Committee. I look forward to the work of the Committee on these important issues and hearing from our witnesses today.

Just a few brief comments before I turn the microphone over to Ranking Member Scott. I wanted to remind Committee members and witnesses to please keep remarks and questions to five minutes. The countdown timer, otherwise known as a clock, can be viewed alongside the other participant windows on Webex. On mine it is in the upper right-hand corner.

Following opening remarks, Senators will ask their questions based on seniority, and I will ask that members have their cameras turned on at least five minutes prior to their questions, so that we know they will be prepared to ask a question in line.

With those final logistical notes, Ranking Member Scott, I am pleased to turn it over to you for your opening remarks.

**OPENING STATEMENT OF SENATOR TIM SCOTT,
RANKING MEMBER**

Senator TIM SCOTT. Thank you, Chairman Casey, and congratulations on your new chairmanship, and I look forward to continuing the long tradition of having the Aging Committee be the most bipartisan committee in the United States Senate and hopefully all

of Congress. It is certainly a wonderful opportunity for me, as the Ranking Member, to have an opportunity to lead our side in the conversation, the discussion around issues of the aging community.

I think back to my own life and my mother, Frances Scott, who was a nurse's assistant. Many of the folks who are on the front lines are CNAs in nursing homes, certified nursing assistants, and having been raised by a single mother who spent 16 hours a day working in hospitals, and really doing the entry-level jobs at the hospital, I thank God for someone who instilled in me the dignity of work, the hard work, focus, and going the extra mile for those who cannot do it for themselves. That is something that I hope that we, as a committee, focus on. I do want to welcome all of the new Committee members to this Committee.

Interestingly enough, by the year 2034, the seniors in America will, for the first time, outnumber the children in America. That means we are literally sitting on the type of transformation in our country that requires complete and total focus on improving the quality of the outcome of our aging population. Unlike Bob, who seems to not have aged at all, I am aware of the fact that I continue to age myself.

Nearly 18 percent of South Carolina's population, 900,000 people in South Carolina, are over the age of 65. The demographic shift highlights the importance of the Aging Committee and the work that we will have to do in the years to come.

I will certainly champion, every single day, the priorities of those folks who continue to age, including issues of financial security and health care. These are two pillars that must be our focus on the Aging Committee.

I also want to extend my gratitude to the entire health care community as they confronted COVID-19 in a way that brought tears to our eyes, a lump in our throats, as well as warmth in our hearts. We were heartened by those who were literally going into dangerous places because of this COVID-19, nurses and doctors traveling across the country to the hotspots. I once again focus on those CNAs who are working in nursing homes, where we have seen nearly 40 percent of all deaths in America come out of nursing home facilities. That means that so many folks who are on the front line trying their best to save a life, and so many of those folks, 60, 70 percent of those folks who are CNAs are African Americans, and about 80 percent of those folks are women.

We cannot say it often enough. I certainly cannot say it often enough, thank you. Thank you for your willingness to be the difference for so many people, who were trapped without their loved ones, isolated and scared. You were the loved ones. You were the extended family. For that, our Nation will always be grateful.

When this Committee held its first hearing on COVID last May, the idea that we would find a way to a vaccine quickly was, according to NBC News, impossible. It would take a miracle, they said, and thank God for miracles.

Operation Warp Speed was that miracle, and in historic fashion, President Trump's administration, partnering with the private sector, found a way to bring a vaccine to the market so that in December, less than nine months or so after it started, about nine months after the virus started, in earnest, thinking back on our first vote

in March—obviously it started before March—but nine months after we started focusing our attention on the virus we had a vaccine being shot into arms. He also purchased 300 million doses from three different companies, which allowed us to see the type of revolutionary start that we have seen.

I am also thankful and welcome President Biden's declaration that by the middle of May, every single American adult will have an opportunity to be vaccinated if they want to. Now this is a very important point, because as we watch the rollout today, the numbers in the African American community and the Hispanic community are lower than we would want them to be. We are going to have to shore up vaccine confidence and availability.

Our rural communities suffer the same fate in so many ways. They, too, need easier access to the vaccine, and we need to do a better job of making sure that our seniors and all of our Americans in our rural landscape understand the importance of getting the vaccine and participating in this process. South Carolina has certainly been a model of transparency throughout the pandemic. I look at the fact that 40 percent of the deaths nationwide come out of nursing homes, and our State of South Carolina it has been around 20 percent. I think what we want to see nationwide is a real focus on helping us improve the outcomes in nursing homes throughout this Nation, and specifically for our senior population throughout this Nation. To me, this is common sense.

I am not exactly sure where the timer is, Chairman Casey, but I hope I have a few minutes, one more minute to finish up. Sounds good. Thank you, sir.

Increasing funding for the production of the distribution of the COVID-19 vaccine is incredibly important. For us to focus our attention on the logistics right now is necessary.

The one thing I will say about the COVID relief package that was disappointing is that only one percent of the resources went for more vaccinations, went toward vaccination production, and only nine percent focused specifically on health care issues around the vaccine. This is one of the reasons why many of us on the right had troubles with this package, because too few dollars actually focused on the COVID-19 challenge that we have before us, and too many dollars focused on a progressive policy position that is not supported by the right.

We loved the day in 2020, when we were all voting. Ninety-plus Senators voted for five different packages. I certainly hope we find ourselves back letting the Aging Committee lead the rest of the Senators in a bipartisan fashion, presenting solutions to the American people that we can all be proud of.

Thank you all to the witnesses for being here with us today, and I look forward to the meaningful dialog that we will have about the way forward. Thank you, Chairman Casey.

The CHAIRMAN. Ranking Member Scott, thank you very much. As someone who has served, as I did, as the Ranking Member, I always want to give the Ranking Member any additional time he might need.

Senator TIM SCOTT. Thank you, sir.

The CHAIRMAN. Let me just turn now to our witness introduction, and just for the witnesses' benefit, what we will do is introduce

each witness one after another, and then after all witnesses are introduced that is when we will turn to the testimony, just so folks know the order of things.

Let me start with our first witness. I am pleased to introduce Dr. Anand Iyer. Dr. Iyer is from Birmingham, Alabama. Dr. Iyer is a pulmonologist working in the intensive care unit at the University of Alabama at Birmingham. He also runs the local pulmonary clinic for underserved residents of Jefferson County, Alabama. Over the last year, Dr. Iyer has been on the front lines of the pandemic, caring for the critically ill in the ICU.

He will share his experiences caring for a primarily rural African American patient population in Alabama. He will also discuss barriers to access, the access to care experienced by his patients, and the work he and his colleagues are doing to decrease vaccine hesitancy.

Dr. Iyer, thank you for being with us today and for sharing your work with the Committee.

Second, I want to introduce another doctor, Dr. Amy Houtrow. Dr. Houtrow is from my home State of Pennsylvania. In fact, she is from Pittsburgh, Pennsylvania, in the southwestern corner of our state. She is a physical and medical director of the Rehabilitation Institute at Children's Hospital of Pittsburgh. She is also a PhD public health researcher, examining models of health care delivery, and as a person with a disability she has multiple perspectives on disability, health care, and the pandemic we have been experiencing this past year.

I want to thank Dr. Houtrow for being with us today and for sharing your expertise with the Committee.

Third, Sandra Harris. I am pleased to introduce her. She is a Massachusetts resident. I know Senator Warren is pleased to have her with us today. Senator Warren will be joining us later in the hearing for questions.

Ms. Harris is the Volunteer State President of AARP Massachusetts and serves as the chairwoman of the AARP Massachusetts Executive Council. She has a long history as an advocate for older Americans. She will speak to the health care needs of older adults during the pandemic, with a focus on long-term care residents as well as seniors living in the community. She will also discuss the importance of vaccinations and access to nutrition and supportive services.

Ms. Harris, thank you for being with us today and for sharing your work with the Committee.

I will now turn to Ranking Member Scott to introduce our witness from South Carolina.

Senator TIM SCOTT. Thank you, Chairman Casey. I am pleased to introduce my good friend from the Palmetto State, Anthony Jackson. Anthony is a leader in the competitive hospital industry in South Carolina. Anthony's testimony today is based on his extensive work in South Carolina's private and nonprofit health care systems, and I know that this is a personal passion for him, as it is for me.

Anthony was named the Senior Vice President and Chief Operating Officer of Roper Saint Francis Hospitals in the spring of 2019. His historic hiring happened about 50 years after Roper Hos-

pital was first required to admit Black patients, and Anthony became Roper's first African American CEO. He has come a long way, starting out his careers as a radiology tech at Roper Hospital, and now, after more than 20 years of executive experience, he is one of the top leaders in the health care industry.

Thank you, Mr. Jackson, for being with us here today, and I look forward to hearing your testimony.

The CHAIRMAN. Thank you, Ranking Member Scott. Now we will turn to our witnesses for their statements. We will begin with Dr. Iyer.

Dr. Iyer, you may begin.

STATEMENT OF ANAND IYER, MD, MSPH, ASSISTANT PROFESSOR, DIVISION OF PULMONARY, ALLERGY AND CRITICAL CARE MEDICINE, UNIVERSITY OF ALABAMA AT BIRMINGHAM, BIRMINGHAM, ALABAMA

Dr. IYER. Good morning. My name is Anand Iyer. I am a pulmonologist and geriatric and palliative care researcher at the University of Alabama Birmingham School of Medicine. I serve in the ICU and founded a pulmonary clinic down the street from our medical center that provides care for hundreds of underserved citizens. In my clinic, 80 percent of patients are black, 20 percent are over 65, and most are uninsured. These are the people at highest risk for poor outcomes due to COVID-19 and are now the ones having the most difficulty accessing vaccines.

One of my patients is a woman in her 70's with COPD, who lives alone in public housing. She requires oxygen and has no Internet and no transportation. Every trip outside her home is a huge ordeal. It is against this backdrop of caring for people like her that I entered the pandemic. A year ago, we admitted the first people with COVID-19 to our ICU. Since then, over 10,363 of my fellow Alabamians have died. We stared directly down their vocal cords to place them on ventilators while their families anxiously waited at home. All along, we were terrified of bringing this virus home to our own families. Though the physical scars of wearing N-95 masks for our entire shifts fade, the emotional scars will not. While caring for people in the ICU at UAB I was keenly aware of the struggles my colleagues faced at smaller rural facilities across Alabama. Telehealth improved outcomes and offered an innovative way to safely reach out to people isolated in their homes during the pandemic. However, barriers to equitable broadband access created a hurdle for many. The Telehealth Modernization Act continues many of the emergency provisions enacted during the pandemic that must carry forward, and support for the Accessible Affordable Internet for All Act improves critical broadband access to close the digital divide.

The long year finally gave rise to hope in December when the vaccines appeared. I have spent every clinic visit since then encouraging my patients to get vaccinated. I describe my own vaccine experience and respond to their questions about side effects. The problem for most of my patients is not vaccine hesitancy. Many want one when it is their turn. Rather, the biggest issue for most is vaccine access. Attributing the low vaccination rates among minority populations only to vaccine hesitancy fails to acknowledge

real racial and socioeconomic disparities in vaccine access that require urgent solutions.

COVID-19 also exposed significant geographic disparities in access, especially in the rural South. When I was young, I joined my father, a family physician, on house calls to farms in northeast Alabama. He listened to his patients' lungs and I brought home baskets of tomatoes. I witnessed early on their isolation and the struggles they faced accessing care in rural Alabama.

Rural Americans have a 13 percent higher risk of death due to COVID-19. More and more are dying from chronic health conditions like COPD, and 17 rural hospitals have closed in my state in the past decade. Expansion of Medicaid could improve access to comprehensive care for rural Americans and stem the tide of rural hospital closures so people can seek help when they need it.

Our country has made great strides vaccinating older Americans. However, millions are at risk for missing their shot. This gap will widen as eligibility expands and the most vulnerable are unable to compete for spots. One in five seniors could be at risk for missing their vaccine due to age-related barriers like limited mobility, lack of transportation, no caregiver support, functional and cognitive impairments, and digital and social isolation.

The American Rescue Plan makes essential investments to improve vaccine outreach to these populations. Here are three ideas that could help these efforts succeed and dismantle access barriers for vulnerable populations.

First, create a centralized system that identifies those most at risk for missing the vaccine and partner with area Agencies on Aging and others to fill the data gap.

Second, simplify the process. Use telephone registration and expand proactive outreach through programs like Senior Buddies and Vaccine Community Connectors, who are going door to door to schedule vaccinations and arrange transportation.

Third, get the vaccine out to where people live. Expand mobile vaccination programs, get COVID vaccines to people in their homes, set up vaccination sites in the hardest hit communities, and build relationships with trusted community partners.

Leaders at UAB prioritized vaccine equity from the beginning and partnered with the city to set up vaccination sites in underserved areas around Birmingham. These efforts helped vaccinate minority communities locally at four times the state and national averages.

The COVID pandemic exposed significant disparities and divides in our health care system, especially among older and at-risk Americans. Accessible vaccines will urgently save their lives, and what we learn from the process will have long-lasting, positive impacts on our health care system.

I am honored to be here today to reflect on the past year and to bring a voice to the challenge that my patients face. The most vulnerable will not be able to raise their hand and tell us they need help. We must reach out to them.

Thank you.

The CHAIRMAN. Dr. Iyer, thank you very much. Dr. Houtrow.

STATEMENT OF AMY HOUTROW, MD, Ph.D., PROFESSOR AND VICE CHAIR, DEPARTMENT OF PHYSICAL MEDICINE AND REHABILITATION FOR PEDIATRIC REHABILITATION MEDICINE, UNIVERSITY OF PITTSBURGH SCHOOL OF MEDICINE, PITTSBURGH, PENNSYLVANIA

Dr. HOUTROW. Chairman Casey, Ranking Member Scott, and honorable Committee members, thank you for inviting me to speak today. My name is Amy Houtrow. I am the chief of rehabilitation medicine at UPMC Children's Hospital of Pittsburgh and professor and endowed chair at the University of Pittsburgh.

I am approaching my testimony from the perspective of a person with disabilities, a physician who cares for people with disabilities, as an advocate for health equity, and as an academic with training and research expertise in health services and policy. As they say, we are all weathering the storm together, but we are not all in the same boat.

My boat is small and scarred. I was born with an exceptionally rare genetic condition that shaped my body in dysmorphic atypical ways and has shaped me into the person I am today. I know of limitations; I live with them. I also know of perseverance and circumstance. In late February 2020, before most of Americans knew what was happening, I was preparing to isolate myself. My spine is twisted, my lungs cramped, the lower lobe of my right lung always vulnerable to infection because of the deformities of my chest. I take immunosuppressive medications. I knew right away that COVID-19 could easily kill me. I am an at-risk American.

My work here on this planet is not done, so I set about protecting myself and all of my patients. I am lucky that I could move the entirety of my work to the virtual space, all of my meetings, all of the planning we were doing for our pandemic response, all of my research, and yes, all of my patient care went virtual. Thankfully, with emergency waivers, we have been able to successfully deliver telehealth care, and recent telehealth innovations and expansions have benefited many patients with disabilities during the pandemic and will beyond if they are promoted and supported.

For the past year, we all watched, in horror and with sadness, as COVID-19 ravaged congregate care facilities. For every dark cloud, we must find the silver lining. As we plan for the future we must assure the health and the safety of people living in congregate care settings, but we also should develop and promote strategies to keep older adults and people with disabilities living in their homes with the supports and services they need. To do this we need to strengthen the home and community-based services and develop a robust home care workforce. It behooves us to do so, because most people desire staying in their homes, and according to CMS, home care is less costly than residential care. The \$12.7 billion fought for by Senator Casey in the American Rescue Plan for expansion of Medicaid home and community-based services is an excellent step forward to realizing the promise of Olmstead.

Perhaps the biggest triumph of this pandemic has been the speed at which vaccines were developed. Unfortunately, equitable distribution of the vaccines has proven challenging. As a starting point, vaccine registration systems and administration sites must meet the standards of the ADA and Section 504 of the Rehabilita-

tion Act. Moneys in the American Rescue Plan are much needed to address this urgent problem.

Active outreach in communities is also necessary to help reduce existing disparities in vaccine access that exist right now, today. Strategies to reach those in need such as mobile vaccination units that can administer vaccines inside people's homes should be expanded to vaccinate semi- or completely homebound individuals and people for whom home administration would be safer and easier than administration at vaccination sites. We should empower trusted community leaders to help reach people, whether through churches or in barber shops, to improve the vaccine distribution to those hardest hit by disparities. We need this now, and we need to have plans put in place for the next pandemic.

This pandemic is an inflection point for the United States. Do not let it go to waste. We need to address the structural problems that make certain members of our communities more vulnerable to COVID-19 and other diseases. We need to make changes to our public health infrastructure and health care systems so that we are better prepared for the next crisis. We need to make it possible for all of us to thrive—today, tomorrow, and beyond.

Thank you for the opportunity to present to the Committee and I would be pleased to answer your questions. As I close my oral testimony, I offer you this quote from Maya Angelou: "Do the best you can until you know better. Then, when you know better, do better."

The CHAIRMAN. Dr. Houtrow, thank you very much. I want to turn the microphone over to Mr. Jackson for his remarks.

STATEMENT OF ANTHONY JACKSON, MBA, SENIOR VICE PRESIDENT AND CHIEF OPERATING OFFICER, ROPER SAINT FRANCIS HEALTHCARE, CHARLESTON, SOUTH CAROLINA

Mr. JACKSON. Chairman Casey, Ranking Member Scott, and members of the Committee, thank you for inviting me to testify today. My name is Anthony Jackson and I am the Senior Vice President and Chief Operating Officer of Roper St. Francis Healthcare here in Charleston, South Carolina. Roper St. Francis is the only private, not-for-profit, faith-based health care system in Charleston. We have four hospitals with 657 beds across five counties. We are the region's largest private employer, with more than 6,000 employees, and we have more than 1,000 doctors on our medical staff.

The impact of COVID-19 on Roper St. Francis Healthcare has been dramatic. Since the start of 2020, there have been 455,495 confirmed cases of COVID in South Carolina. This pandemic has disproportionately affected older Americans, and that was especially true at Roper St. Francis Healthcare. Over this past year we experienced many difficult moments as our doctors and nurses bravely and tirelessly worked to treat COVID patients. This includes patients such as Lethia Moore, a 78-year-old great-great-grandmother who was admitted to Roper St. Francis Healthcare on April 3rd, and sadly passed away on April 12th, comforted by a nurse who refused to leave her side.

As COVID continued to spread, our hospital system adapted. While we already had a platform in place for telehealth, the COVID pandemic required us to scale up quickly. Telehealth has

proven so valuable that we intend to continue it in the long-run. We have set a goal of maintaining 20 percent of all visits via telehealth, which opens doors for many vulnerable older Americans, particularly those who are homebound, those living with disabilities, and those who live in rural areas.

We are hopeful that this pandemic will be brought to an end this year with the advent of the COVID-19 vaccine. Roper St. Francis Healthcare is working closely with the State of South Carolina to administer COVID vaccinations. We received our first batch of vaccine in December and began administering them to our health care workers on December 15. In January, we opened a COVID vaccination drive-thru for patients in the parking lot of the North Charleston Coliseum, a site that is used to accommodating crowds of more than 13,000 for events. We have the capacity to vaccinate up to 1,500 residents per day.

Additionally, this week, we launched a pop-up drive thru location in Berkeley County for residents 55 and older. This is important because about three-quarters of Berkeley County's 65-and-older population has yet to be vaccinated. Vaccine drive-thru centers can play an integral role in expanding our vaccination campaign beyond urban areas to reach a population that is often left behind. Communities and states must be proactive and creative to reach residents who cannot get vaccinated through more traditional visits to hospitals and doctors' offices. Our drive-thru vaccination sites would be a great model for others to follow.

The pandemic and vaccine rollout also have shown the importance of treating seniors across all facets of the health care continuum. Whether it is hospitals, community health centers, or nursing homes, we all have a role to play. Why is that? We know that when we consider social environmental factors such as social mobility, work, retirement, education, income, and wealth, caring for our seniors becomes even more complex.

Health care for seniors is dynamic and multidimensional, and to address them adequately, the pandemic has taught us that in the community we have to be collaborative, innovative, intentional, and equitable. Roper St. Francis is proud of the thousands of hours of community care that we provide in Charleston and the surrounding communities alongside our community partners and volunteers.

As a former licensed nursing home provider, I understand the value of senior-care communities. Our patients have turned to us for guidance over this past year, and we cannot and will not lose their trust. We need to continue to have transparency and accountability, and I am proud of the work that all the staff at Roper St. Francis has done and will continue to do as the pandemic is not over.

Ensuring healthcare providers have a sufficient and dependable supply of COVID-19 vaccine is central to our ability to successfully plan and operate vaccination events, so thank you for your continued efforts around this issue. I am thankful to every member of the Committee for their work to ensure that our hospitals have the resources they needed to fight the pandemic, and I am looking forward to continuing to serve our patients in the Lowcountry. Thank you.

The CHAIRMAN. Mr. Jackson, thanks for your remarks.

We will turn finally now to Ms. Harris.

STATEMENT OF SANDRA HARRIS, VOLUNTEER STATE PRESIDENT, AARP MASSACHUSETTS, BOSTON, MASSACHUSETTS

Ms. HARRIS. Chairman Casey, Ranking Member Scott, and members of the Committee, thank you for inviting AARP to testify today. My name is Sandra Harris and I am the volunteer State President for AARP Massachusetts. On behalf of our 38 million members, including 776,506 in Massachusetts, and all older Americans nationwide, AARP appreciates the opportunity to provide testimony at today's hearing.

COVID-19 has been particularly hard on Americans over the age of 50 and people of color. Since the start of the pandemic, nearly 95 percent of the deaths have been among people age 50 and older. Additionally, millions of Americans, older adults, have been alone and spending precious time away from loved one. I have not seen my five and eight year-old grandsons in almost 16 months. Can you imagine how much I have missed in their lives?

We have heard from so many other grandmothers and grandfathers. We are all eager to see our grandchildren and visit our parents and loved ones in their nursing homes.

Since the beginning of this pandemic, over 178,000 long-term care facilities residents and staff have died, including over 8,600 in Massachusetts, representing about 35 percent of deaths nationwide and over 50 percent of deaths in Massachusetts, despite the fact that nursing home residents comprise less than one percent of the U.S. population.

While there may be a sense of relief with the vaccine rollout and the cases and deaths in nursing homes are finally declining, the situation in our Nation's nursing homes and other long-term care facilities remain dire. In my written testimony, I have highlighted AARP's five-point plans, which include ensuring access to PPE, increasing transparency, allowing for safe in-person visitation, adequate staffing, and rejecting immunity for long-term care facilities.

We are encouraged by the progress being made in distributing the vaccines to Americans. However, with low or no connectivity, lack of access or devices, I just do not know how far too many older Americans are struggling to access an online, biased appointment system. For those who do gain access, long waits and appointment queues, Web site crashes, and finding that "no appointment available message," these are all frustrating.

I have personally stayed online for over two hours before getting that much dreaded "no appointment available" message. We urge the Federal Government to work with states to develop 1-800 numbers for scheduling appointments.

Another concern to AARP, and of grave personal concern to me, is the wide disparities in accessing the vaccine. According to the CDC, of people who are fully vaccinated, almost 69 percent are white, only seven percent are Hispanic, and almost seven percent are Black. AARP is committed to reducing this gap and has recently partnered with five of the Nation's largest nonprofit organizations to launch the COVID Vaccine Equity and Education Initiative. We have heard from many individuals who are homebound, who cannot leave their homes due to medical or other reasons. We

are pleased to see the CDC addressing these issues and funding from FEMA to work with states in developing mobile clinics and getting vaccines to those homebound individuals.

In addition to improving the health and safety of nursing home residents, Congress must take a look, longer term, to give older adults and people with disabilities more options to receive care at home, and to provide support for family caregivers. I wish I had the time to share with you the emotional and financial burdens my siblings and I are experiencing caring for our 92-year-old mother who is living at home with dementia.

Finally, it is heartbreaking to see people waiting in long lines for basic necessities like food. More than 20 percent of people age 50 to 59, and 14 percent of Americans age 60 and older are struggling to just put food on the table, with Black and Hispanic older adults reporting even higher rates of food insecurity. We are so thankful for SNAP, which has been a much-needed lifeline for so many.

Americans over the age of 50 continue to struggle with the impacts of this pandemic, and we will do so for some time. We are thankful that some relief has arrived, but we must do more to protect the health and safety of America's most vulnerable, our seniors. We can, and we must do better.

The CHAIRMAN. Ms. Harris, thanks very much for your statement. I want to thank all of our witnesses for their statements. Now we will move to a round of questions. I will start with one of our doctors, Dr. Houtrow, to ask you one basic question about some of the fundamentals that we are facing.

As I said in my opening statement, as you pointed out, older adults and people with disabilities have been disproportionately impacted by the pandemic. People with disabilities are three—three times more likely to die from COVID-19 as the general population. Over a third of the COVID-19 deaths that have occurred today have been in congregate settings, as I mentioned earlier, either residents or workers.

There are over four million people in the United States with disabilities, or older adults, who now receive, right now, home and community-based services through Medicaid. These services make it possible to reduce the risk of contracting the virus by keeping people in their homes and supporting them in their own communities. The American Rescue Plan provides, as you mentioned earlier in your testimony, \$12.7 billion in new funding—new funding—for home and community-based services for next year, including in my home State of Pennsylvania an estimated \$730 million for those services.

Doctor, your unique set of experiences include clinical care, public health knowledge, health care systems approaches, and, yourself, have a disability. Speaking from those multiple perspectives, can you look ahead and talk about the importance of establishing and maintaining a strong home and community-based services network and workforce into the future?

Dr. HOUTROW. Thank you, Chairman Casey. Your question is particularly insightful because you asked about establishing and maintaining a strong network and workforce. We do not have a strong workforce now, we did not before the pandemic, but I appreciate all of your efforts to help us create one.

In Allegheny County, Pennsylvania, where I live, the hourly wage for a direct service worker is \$12.41 an hour. This is far from a living wage, which is nearly \$34 an hour for a single mom in Pittsburgh who is raising two children. If you cannot support your family, you look for other employment. Direct service workers should be paid a living wage.

To do this, we need Medicaid restructure reform. This will help bring down our turnover, a chronic problem with the direct service workforce. We need to provide this workforce with good benefits, including access to accurate PPE and sick leave. Transportation to work is often a barrier, so assuring that the workforce has transportation is essential. We have a huge, informal, which is code for “unpaid” caregiving workforce that should be paid as direct service workers.

The CHAIRMAN. Well, I want to thank you for that response because as I made reference to, and Ranking Member Scott did as well, most of the people doing this work all across America, the high percentage are women and women in communities of color. If we are going to continue to have a system where they are not paid and have the appropriate benefits, we are not going to have the quality care that we all claim that we want to create in those settings. I appreciate you speaking directly to the need for home and community-based services and the support for the workforce.

My last question, and I have a little over a minute to go, but I will direct my attention to Ms. Harris for this question. The crisis in nursing homes by the COVID-19 pandemic required a response equal to that of the crisis at hand. The Rescue Plan included \$500 million in dedicated money for strike teams, \$200 million for technical assistance to nursing homes, and that is to promote infection control protocols and help with the vaccination process.

I have done a good bit of work on this with a number of my colleagues, including, most recently, partnering with Senator Toomey, my colleague from Pennsylvania, on a bipartisan Nursing Home Reform Modernization bill.

Ms. Harris, beyond the COVID-19 pandemic, what steps can we take to improve nursing home quality?

Ms. HARRIS. Thank you for the question, Senator, and also thank you for your leadership and the new bill, the modernization bill. AARP certainly supports it and we look forward to working with you in any way that we can.

One of the things that has truly happened is that this pandemic has highlighted the real issues, systemic issues in our long-term care nursing. I think one of the most critical things is that we need to have nursing home care reform. I think that we need to begin to look long-term as really where the issues are, because this is going on for much too long. I think in terms of that we need to make sure that we have adequate staffing and have programs for recruiting, retaining, training, and career ladders, with enough funds and benefits. I think it is really critical that we really need to address infection control, staffing, and making sure that our residents and frail elderly in these nursing homes are safe.

The CHAIRMAN. Thank you very much. Ranking Member Scott.

Senator TIM SCOTT. Thank you, Mr. Chairman, and thank you, Ms. Harris, for your last answer to the question about nursing

home safety. It is really an issue that we should all take very seriously. It is one issue that I tried to address during the COVID markup, offering a couple of amendments around the issue of nursing home safety, and frankly, getting accurate information from states. It was very hard to watch when New York was not forthcoming with all the information, and I think that we have to make sure that we have all the information in order to assess the challenges in nursing homes.

Mr. Jackson, as a health care expert I know that you have spent 30 years or so in the industry. Do you think we need to redirect or direct more resources into nursing homes, as Ms. Harris and Chairman Casey have both alluded to and specifically stated? Many of the workers in the nursing home communities are African American females—80 percent are females, 60 to 70 percent African Americans.

We see that we have a real challenge nationwide in our nursing home facilities. The real question is not based on race or income but based on the necessity of resourcing the most vulnerable population, where the vast majority of the deaths have come from, age-wise, and then 40 percent of the deaths specifically from nursing homes.

Do we need more resources there or am I missing something there, Mr. Jackson?

Mr. JACKSON. No, I would agree that we do. I think the answer, while complex, really is twofold. I think one speaks to regulatory requirements for nursing homes, especially in South Carolina, coupled with the pressures of reimbursement for staffing. When you only have as a requirement one RN per shift, and the physician is not required to see patients each day, when you look at the viability of a nursing home, they start to move away from the responsibility for which they exist, which is to take care of patients from a long-term perspective where they have moved more to taking care of short-term types of disease, which provides for quicker turnover and a better reimbursement. Certainly when you look at the way nursing homes are staff, there is no way they could ever be prepared to handle what took place with respect to this pandemic.

Senator TIM SCOTT. Thank you, sir. Now another question for you, Mr. Jackson. At home in South Carolina, as you are well aware—frankly, let me just say thank you for your continued efforts around making sure that the vaccination is something that is available—I should say the vaccine is something that is available, in rural South Carolina, the inner cities, urban South Carolina, bedroom communities. You have been a force to reckon with as relates to getting the vaccine everywhere you possibly can and in as many arms as you possibly can.

The good news is that Governor McMaster has unveiled a plan that puts our state in a position where, frankly, everybody 55 and up can get access to the vaccine. Phase 1b has started in South Carolina, and, frankly, by May 2nd my understanding is his plan is to have everyone 16 years and older who wants the vaccine getting the shot.

Given your experience in the health care industry, can you talk about the enormous progress being made in South Carolina in the

last recent months and perhaps speak about the factors specifically that has led to that type of progress?

Mr. JACKSON. I think one of the things that we recognized early on, obviously this pandemic took us all by surprise. We recognized very quickly for the need for collaboration and to work together, and this became less about competition and more about community. We worked very hard with our other market hospitals and providers, not just acute cares but skilled facilities, assisted living facilities, working with DHC, you know, in and around, finding and garnering the resources and support to be able to address those issues as it related to the health and well-being of our community.

I think the work with the South Carolina Hospital Association, the clarity and attempt at transparency in terms of gaps, mistakes, equipment, supplies, when you create an environment of culture where you can have those conversations, where everyone is truly focused on what is best for the community, you tend to have the success that we have seen in South Carolina. Not only did we get support from our state and local leaders, you know, having access to be able to reach out to your office and have them respond the way that they did, in terms of connecting us directly with manufacturers, to have conversations about the need in South Carolina, and being able to partner and knowing that we were all on the same page, with the same goal of making sure we take care of those who are most vulnerable.

Senator TIM SCOTT. Thank you, Mr. Jackson. I know my time is about up so I will just say this in my parting comment. I think Dr. Iyer hit the nail on the head as it relates to the importance of telemedicine being a permanent feature or characteristic in our health care system going forward. If I had more time I would spend more time on the issue of telemedicine with you, Mr. Jackson, and Dr. Iyer. I may ask questions for the record and look for your wisdom and expertise on how we continue unfolding telemedicine throughout this Nation, especially in rural America.

Mr. JACKSON. Absolutely. Thank you.

The CHAIRMAN. I think we are trying to get our lineup here. We have got some Senators in the queue.

I wanted to just take a moment, as an interlude here, to ask a question of Dr. Iyer. Dr. Iyer, we know the importance of getting the vaccine into all throughout the Nation, especially vulnerable populations. We also know that people across the country face barriers to the vaccine. One of the barriers, not only with regard to the vaccine but generally, is the lack of broadband access or familiarity with technology. That means that people cannot use online vaccination registration systems.

Some systems may not have their registration information in plain, easily accessible language. If you do not have family or friends to advocate for you, these barriers often can become insurmountable.

For those who are able to get the vaccine appointment, lack of transportation to a vaccine site or inability to stand in line and wait can be difficult and put them at risk. The Rescue Plan included funding to support vaccine outreach and education, including organizations like Area Agencies on Aging.

Dr. Iyer, the question I have is in your experience, how can support from trusted community partners help both seniors and people with disabilities, and especially those in minority communities, help to get vaccinated?

Dr. IYER. Thank you for that question, Senator Casey. Trusted community partners can make all the difference in this process. As I mentioned, UAB has spent decades building relationships with communities around Birmingham, and this kind of trust and partnering with city leaders, the neighborhoods, the vaccination sites in underserved areas help us to deliver vaccine to minority communities at four times the state and national average. That has also happened in places like Chicago and elsewhere around the country, that are focusing those efforts to hardest hit areas.

Trust starts from those one-on-one conversations like I have with my patients every week, trying to build that trust, answer questions, get at those concerns, but also the pillars of the community and talk about neighborhood leaders, pastors, barbers, that Meals on Wheels delivery driver that is coming to bring the meals to someone's home, the leaders at the senior centers. If they get on board you can see the people, they see representation, and they see that this could be a real way to get out of the pandemic.

You know, I am from Alabama, and that is the home state of the infamous Tuskegee Syphilis Study. I even cared for a relative of a study participant during my training. When, again, it comes to mistrust and building trust, we definitely get it. We know how to build trust. It is much more nuanced. It really comes down to access as well as disparities in access. We have got to build the trust, we have got to engage those communities, and expand the access as well, and this will help for minority seniors especially.

The CHAIRMAN. I know we want to see if Senator Warnock—I think we are seeing if Senator Warnock or Senator Blumenthal might be on?

Senator BLUMENTHAL. I am ready to go, Senator Casey, if you want to—

The CHAIRMAN. Senator Blumenthal.

Senator BLUMENTHAL. Thank you, Senator Casey. First, let me thank Bob Casey of Pennsylvania for being such a steadfast champion of our seniors, of our vulnerable, and underserved population, and thank you, Senator Casey, for carrying on that work in this hearing and in so many other areas. Thank you to all who are attending today, particularly our witnesses. This topic is so central to the effort to conquer the pandemic. President Biden has led this effort with courage and strength, and the American Rescue Plan has \$20 billion for vaccination efforts, distribution, training, administration, and I am excited to see this funding at work.

In fact, I did, over just this past weekend, when I visited the Fair Haven Community Health Clinic, I actually went with members of the community out onto the streets, into homes, knocking on doors, seeking to recruit people who may not have known, may not have been able to gain access to vaccines, and overcome some of the hesitancy, reluctance, resistance that indeed can be overcome. It is on us. It is our obligation to overcome those kinds of hesitations.

These grassroots efforts, as you mentioned, Dr. Iyer, are so critical to ensuring that underserved populations are able to get vac-

minated, and the practical outreach is so important. It has been a priority of mine in Connecticut, when I visited clinics, urging them to do it, more than 20 clinics that I visited.

I like to ask you, Dr. Iyer, can you speak a little bit more about the impact of programs like Vaccinate New Haven or Vaccinate Fair Haven can have on both the individuals who have vaccine concerns and those who are ready for vaccine but simply do not know how to access them?

Dr. IYER. Thank you, Senator. Those are important points, and they come across as the practical aspects of this vaccine rollout that we need to really iron out, especially for our vulnerable seniors. You know, half do not have Internet access, or like Ms. Harris said, do not know how to log on to systems, and these complex and long forms. I know that exact situation you are describing, Ms. Harris, about feeling just upset about, man, this thing has been going on for two hours and I cannot get the vaccine. I cannot imagine seniors doing this who are isolated in their homes and do not have a caregiver for support.

Programs like you mentioned are critical, because you are going door to door, you are getting out the registration to the people where they live, and if you talk to geriatricians who are doing this around the country they are actually getting the shots in arms in the home, and these are the programs we need to replicate and learn from, because they know where their patients are. If we can build a listserv or kind of dataset about who are these people, where are the ones with limited mobility, who do not have Internet access, I think we can go a long way.

We have got to make this process simple, or simpler, and use those models like you described. That can have a real impact, especially places like rural Alabama, where you have got to drive 40 miles to the nearest vaccine site. That is not going to work. It is not going to work at all. That is already a barrier right there, with someone who might be hesitant.

You know, the tides are shifting in hesitancy rates. They are coming down in Black and minority populations. They want it but they do not know how to get it. That is what I talk to my patients about every week. "How can I get this, Doctor? Where can I get it from?" I will work with you and I will figure out some places, but we just need more help down the road.

Senator BLUMENTHAL. That is a great answer. Thank you.

Let me ask Dr. Jackson, very quickly. The community health centers, federally qualified community health centers, in my view are the unsung heroes of this effort, and I would like to ask you for your perspective on how they are positioned to provide the kind of access that Dr. Iyer was just discussing.

Mr. JACKSON. I certainly agree with you. Those facilities are key, because they are actually in communities where there is a tremendous need, and oftentimes they are the only access points for people to get access to care and those relevant treatments that are needed, from a community health perspective.

We have worked very hard, as I shared earlier, to really collaborate with each provider in each market, and we go actually to where the need is. As we set up, certainly, a centralized location for vaccinations we also set up areas where we can go and educate,

where we can communicate and understand that there are limitations in terms of broadband and things of that nature. We broke it down to the basics in terms of flyers, talking to pastors, going and having conversations and asking for a little bit of time as they are doing their virtual sermons on Sunday morning, giving us an opportunity to have those conversations.

Again, from a total community perspective, we speak broadly, utilizing every opportunity for us to engage the community in this way, to get this vaccine out.

Senator BLUMENTHAL. Thank you so much. Thanks, Mr. Chairman. Thanks, Senator Casey, for your leadership, and thanks for those excellent answers.

The CHAIRMAN. Thank you very much, Senator Blumenthal. I think the lineup we have now is Senator Lee and then Senator Warren.

Senator LEE. Great. Thanks so much, Mr. Chairman.

Mr. Jackson, the COVID-19 pandemic forced our whole country to move toward a much more virtual setting. The fact that we are able to do this really shows the resiliency of our networks, and one area that has received prominent attention during the pandemic involved the use telehealth. We have had great success with telehealth in Utah, as its advancements provide better opportunities for great success in this area, and we have seen it providing better opportunities for our Nation's seniors, to communicate with their doctors, within the privacy of their own homes, in a more risk-free environment.

There is always room for improvement, and I think there are things that we can look to from the pandemic to help us understand how best to proceed. What lessons do you think we learned from the use of telehealth during the pandemic, as we more fully incorporate telehealth into our health care system?

Mr. JACKSON. I think that we learned, our physicians learned, especially those that were concerned about not being able to assess patients in their office, to see, feel, and touch them, we learned that we were able to be effective in terms of evaluation and treatment from a telemedicine perspective.

Two years ago we began working toward this process as a part of our population health strategy, and quite frankly, there were patients that were concerned too, because they wanted to go to their physician's office, sit in their physician's office, be able to talk with them directly and see them and feel the energy of that connection. I think we learned, as a system, just how effective it can be. Certainly there are certain annual wellness checks and things of that nature that you want to have someone present for, but in terms of reviewing labs, ET cetera, and being able to help diagnose certain issues, we learned that we can do that effectively via telemedicine.

Again, we are a system that sees anywhere from 300,000 to 400,000 visits in our primary care offices, and we expect, as we go forward, to continue, at a tip of around 20 percent with budgeting, as we go forward. I think the community and our physicians are now prepared and have the confidence that is needed that this can be a vehicle that will allow us to continue to treat the communities we serve.

Senator LEE. Are there rules and regulatory changes that the Federal Government did well at adopting in the telehealth space that we should now look to make permanent?

Mr. JACKSON. I think if you look around the spectrum, I think the concern around reimbursement, because of overhead that hospitals face, and physicians, and the pressures in and around profitability, because it takes that to be able to provide care in the community. Some of the initiatives put into place, we hope that will continue. I think that will further provide the impetus or motivation that will allow us to even tag into this rural communities where there are certain subspecialists that is not available. We have been able to carry that to those communities now because there is that confidence.

I think being able to support these initiatives financially is right now the biggest opportunity for us, is to continue that, even post-COVID.

Senator LEE. That is well said. Thank you. The Joint Economic Committee recently published a report regarding the emotional and social health of seniors during the pandemic, and according to the report, quote, "Most seniors seem to be managing well emotionally last year. Despite concern of the pandemic, only six percent said that they had often felt emotionally overwhelmed since the pandemic began, and only nine percent said that they have often felt stressed," close quote.

It is more important, I think, than ever for seniors to feel connected with their loved ones and with other members of their community. Are you seeing seniors spending more time caring for their grandchildren during the pandemic due to day care and school closures, and also as a result of more parents needing to work from home?

Mr. JACKSON. Absolutely, we are seeing that. To your point earlier, what we have seen in Charleston, we do employ psychologists on our staff. We have seen a tremendous ramp-up in calls for consultation. In having conversations, as we have been able to round a bit more in our hospitals, since we are beginning to see the numbers begin to decrease, the conversations with the elderly in the hospitals and in the community, as those who are coming for vaccination, you know, they speak about the social isolation and the issue with, you know, they did not want us to feel like because someone can come to a door and wave, or a window and wave, that would suffice and make up for true interaction and human contact.

Dr. Iyer mentioned earlier, or someone mentioned about, you know, Meals on Wheels coming by, the mailman. Quite frankly, I have got aunts and uncles who look forward, because they live in rural areas and sometimes those are the only people they will see, due to their limitations from a transportation perspective. It is their only time to really engage.

We are preparing for community initiative where we are taking our positions out into the community again. We are using telehealth to make sure we have offerings, and we are letting the community know via TV, newspapers, and flyers, and again, leveraging the relationships with churches as well, to make sure there is an understanding that there is this offering.

Senator LEE. While these data are encouraging, it is obviously still important for seniors who have felt isolated and experience greater emotional struggles to receive help while staying at home. I know I am out of time, but I would be curious if we have more time later to hear, drawing on your experience previously as a nursing home provider, what some of the ways are that community members and nursing home facilities could step in to offer more resources, and help those seniors feel better connected.

Mr. JACKSON. Absolutely.

The CHAIRMAN. Senator Lee, thank you very much. Senator Warren.

Senator WARREN. Thank you, Mr. Chairman, and thank you for holding this hearing.

Seniors who choose to live in nursing homes deserve the highest quality care, and the administration must strengthen nursing home standards in the wake of this pandemic. The coronavirus has also highlighted the critical importance of providing care safely in homes and communities, particularly through Medicaid's home and community-based service programs.

HCBS programs have a simple premise: provide long-term care at individual's homes or in their communities instead of institutional settings like nursing homes. HCBS services include things like supported employment, medical equipment, home health aides. These services are cheaper to provide, and they provide a lifeline for millions of Americans, especially people with disabilities and the elderly.

Here is the problem. Millions of Americans cannot access long-term care services at home. Ms. Harris, HCBS is provided through Medicaid, and every state in this country participates in Medicaid. Now I am looking at it this way. We do not have waiting lists for kids on Medicaid to get their flu shot or for a mom on Medicaid to get a Pap smear. Why is it so hard for seniors and people with disabilities to access at-home care in their communities, or at-home or care in their communities?

Ms. HARRIS. Thank you, Senator. It is so good to see you.

Senator WARREN. Good to see you.

Ms. HARRIS. The problem is Medicaid is administered by states, who set the regulations and the eligibility. The only thing that Medicaid is mandatory to cover is nursing home care, and home health is an option, so it is not required. If you are fortunate enough to live in a state where they do offer home health then you are lucky. In those states where it is not offered as an option, then there is actually no help for you.

Senator WARREN. Well, that is a really important point, that HCBS looks different depending on where you live, and the access is limited. This means hundreds of thousands of Americans are on HCBS waiting lists right now. They need help and cannot get it.

Let's move on to Medicare and private insurance. Ms. Harris, do those typically cover long-term home and community-based care, like adult day care centers or helping with dressing and bathing?

Ms. HARRIS. No. Medicare covers limited home health care, for example, part-time school nursing and therapy—physical therapy, occupational therapy, whatever. That is the limit. It does not pro-

vide services that address the activities of daily living, like eating or bathing or dressing, and that is the problem.

Senator WARREN. Yes. If you are not well off and able to pay out of your own pocket for everything you need to live at home, or if you do not have a family member who can drop everything to help, you are pretty much on your own here.

Dr. Houtrow, let me just ask, what happens when people with disabilities and seniors cannot access HCBS services, both in normal times and during the pandemic?

Dr. HOUTROW. Thank you, Senator Warren, for that question. You are highlighting an all too common problem.

When services cannot be accessed people with disabilities and seniors become more limited in their activities. They are more likely to be depressed. Their risk of hospitalizations goes up. Their families feel the physical strain of doing more hands-on care, the emotional strain of trying to juggle the household's needs, and the financial strain of having to cut back or stop working. Anxiety and exhaustion are common, as is guilt. The weight of not getting services can result in the breaking point that we never want to happen—placement in a facility.

Here, during the pandemic, you asked how it has changed. I have a single word to add: fear.

Senator WARREN. Wow. Thank you very much. It is so important what you are covering here and the work you are doing. HCBS services have been a matter of life and death during this pandemic. President Biden has made a commitment to investing in our caregiving economy. The American Rescue package made important investments in home and community-based care. Congress must do more. It must do much more. We must make HCBS a mandatory benefit in Medicaid and expand Medicare to cover more at-home, long-term care services. We should force private insurers to commit some of their billions of dollars in profits to covering long-term care. Health care including access to long-term care provided to people in their homes and communities should be a right, not a privilege.

Thank you very much, and thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Warren. I wanted to give folks a state of play. I think the Ranking Member wanted to ask a question, I am told, and then after the Ranking Member we would have, in this order, Senator Rosen, and then we will see who comes after that.

Ranking Member Scott, did you have a question?

Senator TIM SCOTT. Well, thank you, Chairman, and it has been covered a couple of times already since I made the requisition. I will say this. Dr. Iyer, Mr. Jackson, I think Ms. Harris has made a very good point on the importance of coupling or fusing together our conversation around telemedicine, broadband access, two very critical pieces of creating access to specialists in rural America.

If you all have any additional comments on the topic, I would love to hear really just short comments on the importance of Congress addressing the issue of broadband in order to have a springboard to a real telemedicine national conversation that leads to effectiveness in the delivery system, not just making it available but making it available in the homes that do not have broadband.

Dr. IYER. Thank you, Senator Scott. I mean, telehealth can improve outcomes and outreach, as long as that digital divide is closed, so legislation like the Accessible, Affordable Internet for All Act could help improve broadband access across the country. That is step one. The Telehealth Modernization Act is the big next legislation that could be supported to improve and continue those emergency provisions, like the geographic access, rural and urban areas, audio and video visits, and those in-home visits.

I mean, as a pulmonary person I was able to deliver telehealth pulmonary and palliative care to a woman in her 80's from Tuskegee, Alabama, and with help from a caregiver we were able to set up those video visits and kept her safe and kept her quality of life up in the home. We even did that with our ICU services. I mean, imagine getting somebody off the ventilator 100 miles away, in Selma, Alabama. We were able to do that, and he was able to give me a thumbs-up virtually.

It is credible as long as digital divide is closed, because you are going to leave a lot of people behind if you do not have adequate broadband access first.

Senator TIM SCOTT. Thank you. Mr. Jackson, I will get your answer later.

Chairman, I know we have people waiting and I do not want to have a second turn before folks have had their first, so I am happy to suspend my question on telemedicine and the broadband connection if it is okay with you. We could go to the next person or I could continue, but I do not want to get in the way of other members.

The CHAIRMAN. Well, I want to thank the Ranking Member. If it is okay with him, maybe we will move to this order.

Senator TIM SCOTT. Yes, sir.

The CHAIRMAN. Far we have Senator Rosen, then Senator Braun, then Senator Kelly.

Senator ROSEN. Thank you, Mr. Chair, and thank you Ranking Member Scott. I appreciate that. Thank you for having this hearing, and everyone for your work in this area.

You know, I took care of my parents and in-laws as they aged so I know all too well the challenges that families face, the choices and challenges that they face every day when they are going through some of these things.

I really want to talk about seniors and social isolation, because now we are well over a year into COVID-19 and we know that seniors have been disproportionately affected by the virus. They are at the highest risk for severe illness and death, and the isolation that is required to stave off the infection has been devastating. In Nevada, over 25 percent of seniors live alone.

Thankfully, the University of Nevada's Sanford Center of the Aging, they really stepped up in a big way. In addition to general outreach to check on general well-being, public health information, they have helped facilitate more than 13,000 telehealth appointments since last March, and in Nevada Ensure Support Together, or NEST collective, has facilitated over 3,000 hours of virtual services and programming for Nevada seniors during the same time.

Ms. Harris, I want to ask a multi-part question. What program service and models have worked well in your experience, and I can tell you that at the Sanford Center they are using the creative re-

verse telehealth model for seniors who may not be able to use technology. Instead, they come to a senior center and see their provider virtually from there, with help from someone at the senior center, and that has been great. How can we integrate these kinds of models into our broader senior support systems now and going forward?

Ms. HARRIS. Thank you, Senator. I guess the first thing I would like to say is long before the pandemic we had a loneliness and social isolation epidemic, and the convergence of the epidemic with this pandemic has certainly just worsened the situation. Now that there is heightened awareness of what it feels like to be alone, we must address this issue.

One of the things that we have done in Massachusetts is we have created the Massachusetts Task Force to End Loneliness and Build Community. Our goal is to go out and make sure, ensure that all older adults have connections to the community and feel a sense of social well-being. We are partnered with the University of Massachusetts Boston as well as organizations, probably about 15 or 16 at this point. We have started a campaign, Reach Out MA, where we are encouraging all Bay Staters to really renew their social contracts, to remember what it means to be a good neighbor, and to stop and wave to your neighbor, send a card, pick up a telephone. That is one of the things that we are doing.

We have had community conversations. We did have to pivot and do them virtually. We went to the communities and talked to them about what are the issues that you are finding; to the community leaders, first responders, postmen, what are you finding? What are the challenges? What are the things that you are doing that are working for you? We were able to develop an online resource and share with the entire state, what are the resources that communities are using that are making a difference in addressing this issue.

We have created a Subcommittee on Technology, looking at the digital divide. It is a serious thing it addresses, and it makes all the difference in the world. Telehealth, as has been said earlier, if you do not have the connectivity it is a problem. It does really help.

We have created a public awareness campaign, just letting people know that it is okay to say that you are lonely. There is a stigma associated with being lonely. We have created an intergenerational committee where we are adding intergenerational lens to all of the work that we are doing, and inviting young people, because when you look at the research, millennials, young people are reporting as being just as depressed and isolated.

We think that we have an opportunity to work with these two individuals and let them help each other. It needs to be a reciprocal thing where the younger people help the older adults, but as well, the older adults, with all of the wisdom and everything that they have, are helping the younger people as well.

Those are the things that we are seeing working for us.

Senator ROSEN. I appreciate that. I take my next question off the record, but Dr. Iyer, I am Chair of the Comprehensive Care Caucus, which focuses on palliative care. I am really glad you brought that up for seniors, and so we will submit that for the record about how telehealth and what we are doing can really increase access

to palliative care, how important it is, not just for seniors but across the board, and I look forward to speaking with you about that offline.

Thank you all again for the work you do. I yield back.

The CHAIRMAN. Senator Rosen, thank you very much. We will next turn now to Senator Braun.

Senator BRAUN. Thank you, Chairman Casey. This whole saga of trying to navigate through the COVID crisis was so disturbing, to see how disproportionately nursing homes were hit, I think maybe due to the three major predispositions, which would be age, diabetes, and maybe weight issues.

I would like to ask Ms. Harris a couple of questions. What have you found—I know that you are in Massachusetts, volunteer State President with the AARP. I communicate with them back in Indiana at least once or twice a year, and one of the times would be through kind of a live Q&A. I have not been able to do that other than early on, when we did not know a lot about COVID.

Being so heavily predisposed to COVID with devastating consequences, where are we in kind of the best practices, with the vaccinations that have been administered? I just read the other day where some of the experts are saying that we might have somewhere between four and five times as many cases of COVID that have not been tested. How are we converging on, especially related to nursing homes, when we can say that we have got some idea when that can get back to a more normal framework? I know that is a lot there to digest, but I want to give you the remaining time I have, which is probably three minutes or so, so weigh in.

Ms. HARRIS. Okay. Thank you, Senator. We know that one of the problems in nursing homes, and it has been a problem for some time, has been that of infection control and adequate staffing. We feel that there are a number of things that need to happen, and certainly the lack of PPEs.

In terms of trying to really address this problem and to begin to alleviate the problem we need to make sure that we have the PPE on hand and enough to cover not only the faculty staff but visitors and others who come to the facility.

It is critical that we have regular and ongoing testing. It is critical that we have adequate staffing—that is very, very, very important. We also have to have transparency. We have to have transparency and the data, the demographical data of what is happening on the infection rates, broken down by age, ethnicity, and things like that.

We need to make sure that we have transparency in how millions of federal dollars that are going to these nursing homes are being spent and making sure that they are being spent for the welfare of the residents versus going to the bottom line.

We need to hold nursing homes and long-term cares accountable. When there is harm done because of substandard care, dangerous care, then they need to be held responsible for that.

Senator BRAUN. That makes sense, transparency, making sure you are fully enabled to do the job right. I want you to zero in on this, because a lot of that still will need to be in place, but you can rest a little more easily when we reach herd immunity, through vaccinations and through acquiring, you know, the disease itself

and getting through it. How close do you think we are, in the most vulnerable category, nursing homes, which has been given the attention of transparency, PPE.

I think we all know that until we get to true herd immunity—and to me it looks like that is a confluence of getting anybody in a nursing home or working for it, vaccinated, along with the cases where you have had survival—where are you at, in your own mind, to where we are going to get there? I know you need to do all the other stuff, but what you gauging is that point in time? If it is not soon, we need to put more resources there.

Ms. HARRIS. Well, sir, we think one of the most important things is making sure that we have the transparency. We need to see what is happening, and I think CDC is getting the information out on a weekly basis. It needs to be more than that. We need to see this data almost daily, if possible. It will allow us to see what is happening, and to be able to focus in the specific area, identify what is it that is causing these, what are the problems, is there a certain thing about age, is this about activities? By having the data in hand, we can very quickly address the problems.

I think a large portion of it, in my mind, is just knowing what is going on and having the information as quickly and as frequently as possible. That is going to be key.

Additionally, the testing. It is very, very critical, we have to have them tested on an ongoing basis.

Senator BRAUN. Thank you. I think my time is up and I agree with all that, but at some point, not only for nursing homes but for the rest of America, we are going to need some idea of when the true remedy for everything you are talking about is the fact that we do not need as much of that anymore because we have conquered the disease through vaccination, acquiring herd immunity. It sounds like that point in time remains to be seen.

Thank you so much. I appreciate it.

The CHAIRMAN. Thank you, Senator Braun. Senator Kelly.

Senator KELLY. Thank you, Mr. Chairman.

Ms. Harris, so this year many people in our country became caregivers for the very first time, and existing caregivers are spending more time providing care, an average, from what I understand, about 7.5 more hours each week since the pandemic began. Some of these are family members. Some are friends, or neighbors, and some are paid service providers. It is hard to hire caregivers, and it is hard to retain them. There is also not enough support for folks who care for their family members.

In Arizona, there are 870,000 family caregivers who provide \$10.6 billion worth of unpaid care every year. The Continued Funding for Senior Services During COVID-19 Act passed through the American Rescue Plan, which included \$145 million for caregiver support services.

Ms. Harris, this question is for you. What are the needs that you see these funds being able to address, and how can we better support those who are supporting others?

Ms. HARRIS. Thank you, Senator, for that question. We think it is important that, number one, there is support for the caregivers, support, including respite care, counseling, being able to provide opportunities for just generally—I will share with you my own per-

sonal situation, as we are caring for our mom. We have made a decision that we are going to keep our mom at home. One of the things that we are doing is, one of my sisters had to give up her work, give up her job. She is no longer working. She has sacrificed her profession to be at home. We do have some level of home health care, but it is not enough. It does not provide enough care coverage. She is there 24 hours a day.

Being able to make sure that she has respite, being able to provide some levels of, for example, assistance with food preparation, assistance with counseling, and even online training, where she can begin to understand and go to sites to understand better how to deal with the issues that we are finding.

There are a number of things that we can do and can be doing, and even modifying, coming up with innovative ways of making sure that the caregivers get the respite, the breaks, that have the information, understand the best practices for dealing with whatever the medical diagnosis is. Those are the kinds of things that I think that additional funding will help to take care of.

Senator KELLY. Well, that would be a really positive outcome, as some of these funds can be used to provide that respite you talk about for caregivers, because they are incredibly stressed right now.

I think I have a couple of minutes. I actually do not see the timer on the Cisco Webex window. This next question is for Dr. Iyer.

I know you are based in Alabama, but you mentioned the tremendous impact that COVID-19 has had on communities of color, and that is something we are seeing in Arizona as well. Native Americans are 70 percent more likely, and Latinos 30 percent more likely to contract COVID-19. Arizona is the home of 22 tribes and is about 30 percent Latinos.

You know, many of us now are heeding the guidance to shop using, you know, curbside, to limit trips to the store, to stay in touch via Zoom, but in some tribal communities, you know, nearby stores do not offer curbside pickup, a lack of a street address means you cannot get packages delivered or groceries, multiple generations live in one household, and there is not adequate broadband infrastructure. Or sometimes you cannot even get cell reception. I have experienced that. This is true in many rural, non-tribal communities as well.

Dr. Iyer, could you speak to how these disparities affect access to health care in rural communities and how we can address them here in Congress?

Dr. IYER. Thank you, Senator Kelly. Time is very short so I will try to make a brief statement, and can take some more on the record later, if we can.

Senator KELLY. Thank you.

Dr. IYER. I appreciate you bringing up the issues that Latino and tribal communities are facing and what rural communities are facing. It really is infrastructure and disparities and practical applications of this. I think expanding broadband, supporting legislation for that is going to be key, expanding telehealth and the Modernization Act, so we can continue those emergency pandemic provisions. Medicaid expansion in the states that have not done it, so if Senate could support those states, and then getting the care out

to the rural communities is going to be key through like federally qualified health centers, recruiting and retaining rural health workers who want to leave and need to stay in those rural communities, getting out these vaccines and getting out help, in general, to the rural communities is going to be key.

Senator KELLY. Thank you, Dr. Iyer. I appreciate that.

The CHAIRMAN. Thank you, Senator Kelly. We will turn next to Senator Warnock.

Senator WARNOCK. Thank you so very much, Mr. Chairman. It is wonderful to be here at my first Aging Committee hearing, and I really look forward to working with you and also the Ranking Member as we try to support aging Americans in Georgia, and for that matter, all across the country.

The American Rescue Plan included funds to expand Medicaid. We were pushing hard for this. Senator Ossoff and I hail from the State of Georgia, a state that has yet to expand Medicaid. Dr. Iyer, I know you work in Alabama in the health field, and Alabama, unfortunately, is a state like Georgia that has yet to expand Medicaid. We have got nearly 500,000 people in the Medicaid gap in Georgia. In the American Rescue Plan, there are \$2 billion that we have made available just for Georgia, to finally expand Medicaid.

Can you talk about what it would mean for underserved and rural communities in states like Georgia and Alabama, to finally expand Medicaid?

Dr. IYER. Thank you, Senator Warnock. I mean, this is an important question for both our states, you know, us being neighbors. It would mean a lot for my patients and my clinic, my pulmonary clinic for the underserved. Like Georgia, Alabama would see a tremendous decrease in the number of uninsured. That is about 300,000 estimated in Alabama—close to what your numbers are.

I mean, we come from states that are overwhelming rural, and access is just plain tough here. You know this very well. I mean, getting to the clinic, getting to hospitals, I mean, in Alabama, 17 rural hospitals have closed in the past decade, and a dozen more are on the docket. As an ICU physician, that is incredibly frightening, for people not to have a place to go when they get sick. It happened during the pandemic, and I do not want to see that kind of stuff happen again.

The American Rescue Plan provides that rare opportunity to get this done so we can stem those rural hospital closures and provide people the access to mental health care, prescription drugs, and you name it, so we can care for them better.

Senator WARNOCK. Did you say 17 hospitals have closed in Alabama?

Dr. IYER. In the past, rural hospitals have closed in the past decade.

Senator WARNOCK. Yes, we have seen this impact is disproportionately impacting the rural communities. I think we have seen about a dozen hospitals in Georgia close over the last 10 years.

Would you say, in your opinion as a medical professional, that to expand Medicaid in states like Georgia and Alabama, is it an over statement to say that it would literally save lives and that we are losing lives because we refuse to expand Medicaid? Is that an over statement?

Dr. IYER. No, it is not an over statement. I think it could save lives.

Senator WARNOCK. Thank you so much.

Dr. IYER. Thank you.

The CHAIRMAN. Senator Warnock, thank you very much. Senator Gillibrand.

Senator GILLIBRAND. Thank you, Mr. Chairman. In my state we have seen challenges where the number of people who have passed in nursing homes was substantially underreported. In fact, we have seen that according to the recent working paper published by the National Bureau of Economic Research from private equity firms that acquired nursing homes, patients start to die more often, and taxpayers start paying more too. Total private equity in nursing homes has exploded in the last 20 years, going from \$5 billion in 2000 to more than \$100 billion in 2018.

To Ms. Harris, what do you think about private equity and the aggressive acquisition of nursing homes, and how is this impacting the longer-term care industry at large?

Ms. HARRIS. Thank you, Senator. Generally we have found, or I have personally seen that not-for-profits do a much better job in caring and providing the quality of care and safety required for our elderly, where their interest and the focus emphasis not necessarily on the bottom line. That is just the limit of my experience of the situation. I am sure that we can have our staff take a look at this and get back to you with some information.

Senator GILLIBRAND. Okay. Dr. Iyer, let me ask you a similar question. We saw patient outcomes suffer and affordability become more difficult with the surprise billing situation that many experts claim was fueled and exacerbated by private equity's acquisition of hospitals and urgent care facilities. Could we expect similar outcomes with private equity and nursing homes, and what does that acquisition on so many nursing homes mean for patients?

Dr. IYER. Thank you, Senator Gillibrand. This may be out of my scope of expertise, so I would love the opportunity to get back with you afterwards, after I do my research on this and get a better answer for you. Is that okay?

Senator GILLIBRAND. Okay. Yep. Then Dr. Harris, or Ms. Harris, so in New York State, as of the last reporting, more than 170,000 Americans, including residents and workers, have died from COVID-19 in nursing homes and other long-term care facilities, and we know that on top of the Trump administration's failures to adequately respond to the pandemic his administration also let our nursing homes and long-term care facilities down.

Ms. Harris, you are familiar with the under-reporting of the number of COVID deaths in nursing homes during the pandemic, and in New York State specifically the Attorney General confirmed an additional 3,800 nursing home residents died in hospitals than originally reported.

I co-sponsored legislation by Senator Casey, the COVID-19 Nursing Home Protection Act, that would require nursing homes to submit this data so that it could be commonly available on Nursing Home Compare Web sites. Should Congress prioritize this policy to address this underreporting issue, and are there other ways to fix it?

Ms. HARRIS. Thank you, Senator. I think you said that the 175,000 deaths were in Massachusetts?

Senator GILLIBRAND. No. That was 178,000 Americans overall, in the whole country.

Ms. HARRIS. Okay. I am sorry. I thought you said in Massachusetts. We have enough and we do not need more.

Well, first of all, we certainly do, AARP certainly does support the bill, the Casey and Toomey bill, which is looking at expressly those nursing homes that have a history of violations and bringing that to attention. That is very, very important. It goes back to the whole thought and conversation, talking points that I have about making sure that we have the transparency necessary in these nursing homes.

I do not know that without making sure that we have the transparency, the reports, and holding them accountable, and I think that the Modernization Act, bill, if enacted, will provide a lot of information that we need to make sure that we are holding these facilities accountable.

Senator GILLIBRAND. The last question. The COVID-19 Nursing Home Protection Act also included \$500 million for states to operate nursing home strike teams to manage COVID-19 outbreaks, and another \$200 million for technical assistance on infection control and vaccinations. This funding was eventually included in the ARP and is making a difference. Can you talk about the impact this would have at large?

Ms. HARRIS. A tremendous impact, because we know that the biggest issues are in infection control and staffing. What this funding will do is allow strike teams—and I call them SWAT teams—to go in when they are really, really needed, when they are much more needed, to not only help with staffing but also to help with infection control. It is funding that will bring help when it is needed the most, when there are outbreaks.

Senator GILLIBRAND. Thank you. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Gillibrand. Before we move to closing, I want to make sure the Ranking Member does not have an additional question. Otherwise, we will move to close.

Senator TIM SCOTT. Closing is great, sir. Thank you.

The CHAIRMAN. Thanks very much. Well, I want to thank everyone for today's hearing. I want to start with the Ranking Member for his work in helping us with this hearing and for all of us to have this opportunity to get together to talk about these important issues. Obviously, one hearing will not be enough, but we have covered a lot of ground today.

I want to thank our witnesses, Dr. Houtrow, Dr. Iyer, Mr. Jackson, and Ms. Harris, for taking the time to lend us your expertise, your experience, and your passion to help so many vulnerable Americans, especially at this time.

We know that there is no state in our Nation, no county, no city, no community, no town that has been spared from the terrible devastation of this virus and the pandemic that resulted. That devastation has been borne especially by seniors, people with disabilities, and most of all, by communities of color.

We are a great Nation, and a great Nation must take care of its people. The American Rescue Plan will help us begin to provide

more of the care that is needed. It will help us begin to heal our country by defeating the virus and helping our economy recovery. To do this kind of healing, pandemic protections, in my judgment, have to include supports that affect health outcomes, and that also includes funding for transportation, for housing, for food.

To address the disproportionate adverse impact of this virus, we need to address the needs of families, and we cannot ignore those living in poverty or those living in rural communities. The Rescue Plan addresses these basic needs and makes it possible for families to protect themselves against the virus.

On top of all that, we have got to continue to do our part individually. We have got to continue to wear masks, we have got to continue to social distance, and we also must keep encouraging people to get the COVID-19 vaccine when it is their opportunity.

We have much more to do, and I look forward to working with this Committee on these and other challenges.

Now I will turn to Ranking Member Scott for his closing remarks.

Senator TIM SCOTT. Thank you, Chairman Casey, and good job on your first hearing. This has been a very strong, I think, informative hearing. Your job has been well done. Thank you to your staff and your team for their hard work in preparing all of us to have an effective hearing.

I also want to, once again, reinforce my appreciation and our gratitude as a Nation to the health care workers who have been on the front line, and particularly to the CNAs, the certified nursing assistants, and all those in the nursing homes, that so often we hear so much negativity heaped upon the nursing home community, as if they are to blame for the deaths. What we are looking for are solutions and not blame, and I thank each and every person who have provided care to our seniors across this country.

To the witnesses, thank you very much. I must concede that I leave this hearing excited and energized about the synergy from the witness testimonies, the answers to so many of the questions, that reinforces the importance of the American tradition of looking for ways to help the most vulnerable in our society.

I will say, however, to some of the comments that we have heard, especially toward the end of the hearing, that there is a real concern. I think we should all be very interested and concerned about the number of hospitals that have closed in rural parts of the country, and specifically in the South. There is no question that if you look back on the last 10 years, the one thing that has changed in the last 10 years is the ACA is front and center.

Study after study shows that the price of being in business has gone up, not down, and that has caused consolidation in the hospital space, which has raised prices and left so many Americans without care. Thank God for the qualified health centers throughout the country that are trying to fill that gap. That bridge, of course, is heavy, and we need to provide more resources to those folks in the rural communities. That is why telemedicine is critically important.

Let me finally say to the Nation, and specifically to our seniors who have gone through so much for so long, isolated, depressed, good news is coming, and Chairman Casey has been providing that

good news in this hearing. I am thankful that we have heard a lot of good news about the vaccine delivery, about the numbers who have been vaccinated, about the importance of telemedicine. This is the kind of hearing that all Americans can be proud of.

Thank you, Chairman, and I look forward to our next hearing together.

The CHAIRMAN. Same here. I want to thank the Ranking Member for his good work and for working with us today on this, our first hearing. I will return the compliment—he did a really good job today as Ranking Member, and I am grateful for his work on these issues.

I also again want to thank our witnesses for contributing their time and their expertise. Just for Senators to know, if any Senator has additional questions for the record for witnesses, or statements to be added, the hearing record will be kept open for seven days, until next Thursday, March 25th.

Thank you all for participating in today's hearing.

This concludes the hearing.

[Whereupon, at 11:18 a.m., the Committee was adjourned.]

APPENDIX

Prepared Witness Statements

**Prepared Statement of Anand S. Iyer, MD, MSPH, Assistant Professor,
Division of Pulmonary, Allergy and Critical Care Medicine,
University of Alabama at Birmingham, Birmingham, Alabama**

**Recipient, Paul B. Beeson Emerging Leaders Career Development Award in
Aging, National Institute on Aging, National Institutes of Health**

Chairman Casey, Ranking Member Scott, and Distinguished Members of the Committee, thank you for the opportunity to speak with you today.

I am honored to share my personal reflections on the past year of the COVID-19 pandemic as a pulmonologist and geriatrics-palliative care researcher in the Deep South. I want to bear witness to the challenges my patients face and discuss ways to improve vaccine access for them. The views today are my own.

My name is Anand Iyer. I am a pulmonologist and junior faculty in the University of Alabama at Birmingham School of Medicine. I care for people in the intensive care unit (ICU) and founded a pulmonary clinic at Cooper Green Mercy Health Services Authority, an ambulatory facility down the street from our academic medical center that provides care for hundreds of underserved Jefferson County citizens. There I care for people living with debilitating lung diseases like chronic obstructive pulmonary disease (COPD), the third leading cause of death among older Americans. I also research ways to integrate geriatrics and palliative care for this population supported by the National Institute on Aging of the National Institutes of Health.

People in my clinic are at highest risk for poor outcomes due to COVID-19 and are now facing immense barriers to COVID vaccine access. Eighty percent are Black, twenty percent are older than 65, and most are uninsured. One of my patients is a woman in her 70's with COPD. She lives alone in public housing, requires supplemental oxygen, has very limited mobility, and has no Internet, no family caregivers, and no transportation. Every trip outside her home is a huge ordeal.

It is against this backdrop of caring for people like her in Alabama that I entered the COVID-19 pandemic. A year ago, we saw the first people admitted to our ICU due to severe COVID-19. Since then, over 10,000 Alabamians have died, and countless family members are grieving the loss of their loved ones.

As each surge arrived last year, we worked as teams of physicians, nurse practitioners, physician assistants, nurses, and respiratory therapists to save lives. Covered head-to-toe in personal protective equipment, we placed hundreds of Alabamians on ventilators while their families anxiously waited at home.

Though the physical scars of wearing N95 masks for entire shifts fade, the emotional scars do not.

I witnessed the devastating impact of COVID-19 on older Americans firsthand. Older adults have the highest risk for dying from COVID-19, especially those who are frail and have cognitive and physical impairments.¹ The pandemic highlighted how so many of them desperately needed better access to proactive palliative care. The "Palliative Care and Hospice Education and Training Act (H.R. 647 & S. 2080)" could improve its access for a growing number of older Americans living with serious illnesses who require proactive advance care planning and much more family caregiver support.

While caring for people in the ICU at UAB, I was keenly aware of the struggles faced by colleagues at small, rural facilities. Our telehealth ICU services improved outcomes at these hospitals, and telehealth ambulatory care improved outreach across the state. Early on in the pandemic, I brought telehealth pulmonary and palliative care from UAB to a woman in her 80's who lived miles away from Birmingham and was isolated due to debilitating COPD. The "Telehealth Modernization Act (S. 368)" continues many of the emergency provisions enacted during the pandemic to support in-home visits, reimburse audio and video visits, and cover people from both rural and urban areas. The pandemic accelerated the need for innovative ways to safely improve healthcare outreach, and telehealth offered a solution. Still, barriers to equitable broadband access created a hurdle for many.

The long year finally gave rise to hope in December when the COVID vaccines appeared. The anxiety we felt as healthcare workers fighting a disease with few treatment options shifted to relief that we could serve on the frontlines with better armor. Many of us shed tears of joy when we scheduled our vaccination appointments.

¹Panagiotou OA, Kosar CM, White EM, ET al. Risk Factors Associated with All-Cause 30-Day Mortality in Nursing Home Residents with COVID-19. JAMA Intern Med. Published online January 4, 2021. doi:10.1001/jamainternmed.2020.7968.

Since then, I have spent every clinic visit encouraging my patients to get vaccinated. I describe my own vaccine experience and directly respond to their concerns about side effects. They have legitimate questions, yet most want a vaccine when it's their turn. The problem for most of my patients is not vaccine hesitancy. It's vaccine access.

Alabama is the home state of the infamous Tuskegee Syphilis study. I have even cared for a relative of a study participant during my training, so the concept of hesitancy is very real here. However, stating that the low COVID vaccination rates among minority populations are only due to vaccine hesitancy fails to acknowledge real racial and socioeconomic disparities in care and barriers to vaccine access that require urgent solutions.

COVID-19 also exposed significant geographic disparities in access to healthcare, especially in the rural South. When I was young I joined my father, a family physician, on house calls to farms in northeast Alabama. He listened to his patients' lungs, and I brought home baskets of tomatoes that his patients gave to us. I witnessed early on the isolation they experienced, the struggles they faced accessing care in rural Alabama, and the ways that our visits lifted their spirits.

Rural Americans have a 13% higher risk of death due to COVID-19 than people in urban areas,² and my research demonstrates that more and more rural Americans are dying due to chronic diseases like COPD.³ Broadband is scarce, many rural counties lack a retail pharmacy to deliver the COVID vaccine, people live miles away from a potential community vaccination site, and rural hospitals are closing at alarming rates—as many as 17 in Alabama in the past decade.^{4 5} Support for the “Accessible, Affordable Internet for All Act (S. 4131)” could improve critical broadband access to close the digital divide in these areas, while expansion of Medicaid could improve essential healthcare and medication access and stem the tide of rural hospital closures.

Our country has made great strides vaccinating older Americans. However, millions are at risk for missing a shot. Gaps will widen as eligibility expands, and the most vulnerable are unable to compete for vaccination spots. I estimate that one in five community dwelling older adults could be at risk for missing a COVID vaccine due to aging-related barriers like limited mobility, lack of transportation, no caregiver support, digital and social isolation, and functional and cognitive impairments. These are the same issues that make it difficult for them to access care in the first place. The numbers quickly add up: at least two million adults 65 years and older are homebound or semi-homebound; a quarter live alone; approximately half are digitally isolated due to lack of Internet access; and, millions are socially isolated due to debilitating medical conditions.^{6 7}

The American Rescue Plan makes many essential investments to improve vaccine outreach to these populations, including \$20 billion toward vaccine administration and distribution. A few pragmatic recommendations could make these efforts more successful and dismantle access barriers for vulnerable populations.

First, create a centralized data system that partners with Area Agencies on Aging, churches, and home-based care programs to identify those most at risk for missing a vaccine.

Second, simplify vaccine registration and administration processes and make them much more age- and disability-friendly. Many registration systems are inter-

²Ullrich F and Mueller K. Confirmed COVID-19 Cases, Metropolitan and Nonmetropolitan Counties. 2021. RUPRI Center for Rural Health Policy Analysis Rural Data Brief. Published January 2021. Accessed online on March 12, 2021 from <https://rupri.publichealth.uiowa.edu/publications/policybriefs/2020/COVID%20History/COVID%20Data%20Brief%2001272021.pdf>.

³Iyer AS, Cross SH, Dransfield MT, and Warraich HJ. Urban-Rural Disparities in Deaths from Chronic Lower Respiratory Disease in the United States. *Am J Respir Crit Care Med.* 2020; 203(6):769–772. PMID: 33211972.

⁴Berenrok LA, Tang S, Coley KC, ET al. Access to Potential COVID-19 Vaccine Administration Facilities: A Geographic Information Systems Analysis. A Report by the University of Pittsburgh School of Pharmacy and the Westhealth Policy Center. Published February 2, 2021. Accessed online on March 15, 2021 from <https://s8637.pcdn.co/wp-content/uploads/2021/02/Access-to-Potential-COVID-19-Vaccine-Administration-Facilities-2-2-21.pdf>.

⁵Finley B. Open Spaces, No Pharmacies: Rural US Confronts Vaccine Void. Associated Press. March 6, 2021. Accessed Online on March 11, 2021 from <https://apnews.com/article/health-coronavirus-pandemic-virginia-19884014220f3697889560f0027c200f>.

⁶Ornstein KA, Lee B, Covinsky KE, ET al. Epidemiology of the Homebound Population in the United States. *JAMA Intern Med.* 2015; 175(7):1180–1186. doi:10.1001/jamainternmed.2015.1849.

⁷Ausubel J. Older People are More Likely to Live Alone in the U.S. than Elsewhere in the World. Pew Research Center. Published March 10, 2020. Accessed online on March 10, 2021 from <https://www.pewresearch.org/fact-tank/2020/03/10/older-people-are-more-likely-to-live-alone-in-the-u-s-than-elsewhere-in-the-world>.

net-based and have used lengthy and complicated online forms that are impractical for older Americans who have no internet access, no e-mail accounts, and low digital literacy. Instead, use telephone-based registration and proactively reach out to people through programs like the “Senior Buddies” in Washington, DC, and the pilot “Vaccine Community Connectors” going door-to-door to schedule vaccinations and arrange transportation.

Third, continue to increase the supply of vaccines to states and centralize vaccine distribution efforts. We are grateful for the increasing number of vaccine doses going out to states each week. However, some clinics in my state that care for underserved populations still haven’t received their first doses of the vaccine, and patchwork distribution complicates vaccine delivery.

Finally, get the vaccine out to where people live. Federally supported mass vaccination sites will help to increase overall vaccination numbers. However, equity must be ensured by setting up vaccination sites directly in the hardest hit communities. Leaders at UAB prioritized vaccine equity from the beginning of the planning process and partnered with the city to set up a vaccination site in an underserved area of Birmingham. These efforts helped deliver vaccines to local minority communities at four times the state and national averages.⁸ Getting the vaccine out also involves more mobile vaccination programs and vaccinating people in their homes. Geriatricians are doing this across the country for those who are homebound. We should learn how they are succeeding and replicate their efforts.

The COVID-19 pandemic exposed significant disparities and divides in our healthcare system, especially among older and at-risk Americans. We must ensure that vaccines are easily accessible to them and that the distribution process is equitable, not only to urgently save lives but also to have a long-lasting positive impact on our healthcare system going forward.

I thank the Chairman and the members of this committee for holding this hearing to focus on issues that directly impact the people for whom I care.

Many of the most vulnerable will not be able to raise their hands and tell us they need help.

We must reach out and support them.

Thank you.

⁸Greer T. UAB Stats Show Early, Effective COVID Vaccine Reach into Underrepresented Communities. Published February 17, 2021. Accessed online on March 12, 2021 from <https://www.uab.edu/news/research/item/11859-uab-stats-show-early-effective-covid-vaccine-reach-into-underrepresented-communities>.



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Written Testimony

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The charge of the Special Committee on Aging is to study matters pertaining to problems and opportunities of older people including maintaining health, assuring adequate income, finding employment, engaging in productive and rewarding activity, securing proper housing and obtaining care or assistance. We should note that older Americans are not living their lives in a vacuum, although this past year, many have been living in isolation. Experiences over one's life affect the ability to address challenges as one ages. The life course health development model demonstrates how early events and circumstances shape our futures. The health that an older American experiences today is the result of their health trajectory- the product of cumulative risk and protective factors, the multiple determinants that interact over time throughout their life.¹ Further, many of the issues faced by seniors in the pandemic are also experienced by people with disabilities and the solutions are often similar or at least complementary. It is fitting then, that the Special Committee take up the issue of addressing the health care needs for at-risk Americans; those who are older and those with disabilities.

Life-Course Health Equity

My written testimony is framed with a life-course health equity lens. The poor health status of the US population compared to other high-income countries, the existence of avoidable health inequalities, and the policy-driven changes in social conditions underscore the importance of enacting policies addressing social and political determinants of health.² We know that socioeconomic conditions underlie many health inequities, therefore we should be compelled to find policy solutions to improve health across the life span. A good example is the child tax credit that was part of the recent American Rescue Plan (see below). Lifting hundreds of thousands of children out of poverty will have long-term benefits, including better physical and

emotional health throughout their lives. It is a game changer when it comes to the well-being of children and will be a game changer when they are seniors.

The pandemic has accelerated inequities already pervasive in health care.³ Older adults and people with disabilities have been hardest hit by the pandemic. People with disabilities who are poor and/or minorities have been even harder hit by COVID-19,⁴ as have minorities in general (especially Blacks).⁵ Early in the pandemic, it was clear that individuals with intellectual and developmental disabilities (IDD) living in residential group homes were more likely to die if they were infected than the general population (15% case fatality rate for New Yorkers with IDD versus 7.9% for the general New York population).⁶ Using a large private health insurance claims database which included 467,773 individuals with COVID-19 between April 1, 2020 and August 31, 2020, researchers found that across all age groups, patients with [developmental disorders had the highest odds of dying from COVID-19](#). Similarly, older Americans aged 70+ were at high risk accounted for 42.4% of deaths in the cohort.

These terrible statistics come as no surprise to those of us familiar with the impacts of racism, classism and ableism on health outcomes.

The Health Resources and Services Administration (HRSA) [defines health equity](#) as “the absence of disparities or avoidable differences among socioeconomic and demographic groups or geographical areas in health status and health outcomes such as disease, disability, or mortality.” In this definition, health equity is an outcome that will be achieved when disparities based on membership of a disadvantaged group or under-resourced group are eliminated. The process to achieve health equity requires the removal of obstacles and barriers to health which includes transforming the structures, policies and beliefs that systematically benefit certain groups of people over others. The [basic tenet of health equity](#) is that all people, regardless of their circumstances, have a fair and just opportunity to be as healthy as possible. The life course health equity frame places emphasis on how systems, policies, programs, services and practices enable people to be healthy throughout their lives. The opposite side of that coin is how these systems, policies, program, services and practices do not enable or restrict individuals’ ability to be as healthy as possible and how health disparities are created and perpetuated.

“Structural inequities encompass policy, law, governance, and culture and refer to race, ethnicity, gender or gender identity, class, sexual orientation, and other domains. These inequities produce systematic disadvantages, which lead to inequitable experiences of the social determinants of health... and ultimately shape health outcomes.”⁷ To dismantle these structural inequities, we must first acknowledge that they exist. For example, people with disabilities face systemic long-standing barriers to equitable health care.⁸ A [third](#) of working-age adults with disabilities do not have a usual health care provider and a [third](#) have unmet health care needs. It should go without saying, the lives of people with disabilities are equally valuable to people without disabilities and people with disabilities are equally deserving of health care. Yet unequitable treatment is pervasive and worsened in times of crises (see below).⁹

According to the CDC, [26% of adults have a disability](#) of some type. The experience of disability is more common among blacks and native adults, furthermore, disability is highly correlated with age as well as socioeconomic disadvantages.¹⁰ Disability is a part of the human experience, but disability is disproportionately experienced by individuals living in or near poverty, minorities, those with lower educational attainment and individuals living in rural areas.^{11,12} Children with disabilities are also more likely to be minorities and live in poverty.¹³ Disability is both a [cause and result](#) of poverty. As such, people with disabilities frequently have intersecting identities of categorical disadvantage.^{14,15}

The United States has been plagued by widening income inequality for decades, fueled by tax cuts for the wealthy and the false belief that [trickle-down economics](#) meaningfully impact employment or economic growth. After visiting the United States in 2017, Phillip Alston provided numerous recommendations in his [Report of the Special Rapporteur on extreme poverty and human rights on his mission to the United States of America](#). Specifically, he recommended the decriminalization of being poor, acknowledging the damaging consequences of extreme inequality, recognize a right to health care, and to ‘get real about taxes.’ The changes to the Child Tax Credit and the Earned Income Tax Credit in the American Rescue Plan Act which will [cut child poverty by an estimated 40%](#) are an important step in addressing equity for all Americans. This change in policy will provide much needed support for millions of low-income Americans. There are additional opportunities to reduce child poverty as detailed in [A Roadmap to Reducing Child Poverty](#) including making the tax credits permanent. Recognizing the long-term health benefit of poverty reduction for children, Congress should consider these options. Additionally, revamping Medicaid to cover all children and fully funding it federally (as Medicare is) are options for Congress to consider.¹⁶ Efforts to advance health equity in childhood have long-lasting societal benefits.¹⁷

Racial and other forms of discrimination are major drivers of health inequities.⁷ Groups traditionally discriminated against face [major barriers to accessing the upstream resources](#) that positively influence health and well-being such as good jobs with fair pay, stable, safe and affordable housing and quality education.¹⁸ Discrimination in policing and the criminal justice system further limit future opportunities racial minorities. [Racial discrimination](#) is both a direct and indirect (such as through [wealth](#) and resource inequality) cause of poor health outcomes.¹⁹ Therefore, Congress should work to dismantle the legalization of racial discrimination to support the health and well-being of those affected by racism.

A Year of the Pandemic

On March 11, 2020 the World Health Organization officially identified the COVID-19 outbreak as a [global pandemic](#). On that same day, the National Basketball Association’s commissioner, Adam Silver, [suspended the season](#). I distinctly remember hearing that announcement. I was in my kitchen and took a moment to be grateful that the leader of an association that would lose millions of dollars by canceling games recognized that saving lives was more important than profits. His announcement was followed by many others: [Broadway](#), the [National Hockey League](#) and [Major League Baseball](#). These announcements, followed by stay-at-home orders,

alerted Americans to the seriousness of the pandemic. Exactly one year later the [US reported 542,191 deaths and 29,862,124 cases](#) of COVID-19; more than any other country. This translates to approximately [160 individuals dying of COVID-19 per 100,000](#) people in the US.

In the spring of 2020, I, like most Americans, watched in horror as the virus spread and people died. I spoke with friends and colleagues about the case doubling rate and how easily the virus seemed to spread undetected. We saw what was happening in Italy as the virus swept through and overwhelmed their medical system. We knew the same problem would soon reach our shores. We got on planning calls, shared information, hoped for the best and prepared for it not to be the case. We saw our own hospitals and health systems stressed and strained, some beyond the breaking point. Hospitals counted the amount of PPE they had on hand in hours and minutes. There wasn't enough, in some places there still isn't. We saw the deceased, our loved ones, our friends, our colleagues, our community members, stored in refrigerated trucks because the morgues were full. States were outbidding neighboring states for supplies. We tracked the availability of ventilators. Medical care providers, my friends and colleagues, pushed past fear and fatigue to provide care and innovate to save lives. I worked with other leaders in my organization to quickly change how we delivered health care. Health systems, state and local governments, territories, public health authorities and communities scrambled to figure out what to do. We were building the plane as it was flying and it felt like we didn't have the right tools. We needed a coordinated organized response based on science, guided by public health goals. We needed the Federal Government to lead instead of impede.

Pandemic simulations take into account a number of factors such as how easily the virus spreads, how quickly governments respond and the resources available in the short, medium and long-term to manage the pandemic. In 2019, the United States was rated at the top of the [Global Health Security Index with a score of 83.5](#). Despite our strengths, the US was noted to have weaknesses, such as systemic deficiencies in the public health infrastructure, indicating a clear need for improvements. The basic tenets of public health strategies to control virus spread failed us early. Severe shortages in the supply of PPE were worsened by the lack of action by the federal government to maintain and distribute supplies.²⁰ Contact tracing was inadequate.²¹ Reliable and accurate testing was in short supply.²² Mask wearing, which has been demonstrated to substantially reduce SARS-CoV-2 transmission by limiting both exhaled virus reaching others and by limiting virus inhalation,²³ has been met with substantial societal resistance. Mandating masking in public was shown to be associated with declines in COVID-19 infection growth rates.²⁴ Modeling on data from earlier in the pandemic, researchers estimated that between September 22, 2020 and February 28, 2021 129,574 lives could have been saved if the US had achieved 95% mask use in public.²⁵ Unfortunately, those lives were not saved. Engaging science and reputable research is to our advantage in future pandemics.

But from our failures, we see more clearly our opportunities. States should be incentivized to coalesce around proven public health strategies, funding should be appropriated to build our public health infrastructure at the state, tribal and local levels with an adequate workforce to test, trace and vaccinate.³ We have the opportunity to rethink our health care delivery and

payment systems to better align with the goals of health equity. As described above, we have opportunity to address structural barriers to equity.

Disability from “Long” COVID-19

Post-infection syndromes occur with a number of viruses, SARS-CoV-2 among them. The symptoms can include fatigue, ongoing shortness of breath, brain fog, sleep difficulties, fevers, abdominal symptoms, depression, anxiety, decreased endurance, weakness, muscle aches, and pain. These symptoms can persist for weeks to at least months and may last much longer.²⁶ For some people the symptoms are quite debilitating. Some people with post-acute sequelae of COVID-19 (PASC) have new disabilities, some with a history of limitations are now even more limited. “Long-haulers” can be any age and the severity of the original COVID-19 disease doesn’t necessarily predict if the person will have long-term symptoms. The NIH has a large initiative to study “long COVID” and clinicians and hospitals are trying to figure out how to provide the best care for individuals with PASC. The constellation of symptoms and our current lack of understanding how to treat PASC have been a source of frustration for patients and physicians alike. A potential bright spot are the new multidisciplinary clinics that bring together physicians from multiple specialties as well as psychologists, physical therapists and others. While these types of clinics are relatively common in pediatrics (such as for sickle cell disease, spina bifida and cerebral palsy), they are rare in adult settings. Psychiatrists, physicians who are trained in the interdisciplinary leadership and management of disability, are helping spearhead the efforts to organize long-hauler clinics mostly at major academic medical centers. We are finding that some of these ‘long-haulers’ may end up qualifying for SSDI and need supports and services that they didn’t require before. This means that federal agencies need to be prepared for this portion of the population of ‘long-haulers.’ As a society, we need to be prepared for the workforce to be partially depleted. In general, we should expect a rise in disability from COVID-19.

Ableism and Crisis Standards of Care

Throughout the pandemic, those of us in the disability community have been concerned about discrimination against people with disabilities. Our concerns were warranted as news organizations reported how ableist quality of life assessments were influencing care decisions.²⁷ Biases and inappropriate assumptions about the quality of life of people with disabilities are pervasive and can result in the devaluation and disparate assessments and subsequent treatment of people with disabilities.^{28,29} Health care providers are not exempt from deficit-based perspectives about people with disabilities,²⁹ and when health care providers make critical care decisions, the results can be a deadly form of discrimination.²⁸ Although implicit biases are underrecognized they are well documented. Many physicians misperceive quality of life for people with disabilities and medical judgments can be biased accordingly.²⁸⁻³¹ Value judgments are routinely being made about what it means to have quality of life, which in emergency pandemic situations can translate into -a life worth saving.³² Consequently, necessary care can be withheld or withdrawn inappropriately from people with disabilities.²⁸

Numerous organizations have filed complaints with states and the US Department of Health and Human Services over the crisis triage protocols in several states that discriminated against

people with disabilities.³³ A real concern was that biases against people with disabilities will lead to [under treatment of people with disabilities](#) during this crisis. Several states created policies that would do just that, according to the [Disability Rights Education & Defense Fund](#). In response to widespread concerns, the Health and Human Services Office for Civil Rights in Action released [a bulletin](#) which stated, in part, “In this time of emergency, the laudable goal of providing care quickly and efficiently must be guided by the fundamental principles of fairness, equality, and compassion that animate our civil rights laws. This is particularly true with respect to the treatment of persons with disabilities during medical emergencies as they possess the same dignity and worth as everyone else.” Yet resource allocation protocols that several states utilized during the early months of the pandemic have explicit disability-based distinctions which have been identified as in violation of the law.³² The three major federal statutes that prohibit disability discrimination in medical treatment are the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, and Section 1557 of the Affordable Care Act.³² Using the presence of a disability to assign a person with a disability a lower relative priority score in accessing scarce resources constitutes a clear violation of disability nondiscrimination law.³⁴

When public health officials and hospitals develop crisis standards of care or triage protocols for the allocation of scarce resources (such as ventilators), the risk of ableist discrimination is high.⁸ Biases easily permeate triage processes especially when not implemented well.⁸ Even when purportedly ‘objective’ criteria are used to allocate health care resources, subjective notions and ideas about the desirability of life with disabilities can play an influential role.³⁵ The challenge is to create protocols that minimize instead of magnify the structural discrimination and the impacts of implicit biases that already in operation.⁸ Having disability community engagement in the creation of these policies is an important step in helping to address structural biases.²⁷

In 2009, the Institute of Medicine published [a report](#) with a framework for establishing crisis standards of care that ensure that the response results in the best care possible given the resources at hand, that decisions are both fair and transparent, that there is consistency within and across states for policies and protocols and that citizens and stakeholders are included and heard.³⁶ To ensure best possible care, the crisis standards should adhere to fairness; have equitable processes of transparency, consistency, proportionality and accountability; engage communities and be legally sound.³⁶

Resource allocations should be based on need, prognosis and effectiveness and not based on prejudicial criteria.³⁷ “Any recommendations for training of triage staff should include the principles of disability nondiscrimination, the need for accessibility, reasonable accommodations, and policy modifications.”³⁸ Consistent with the public health norms of using the least restrictive policy possible to achieve a fundamental goal and [avoiding discrimination against persons with disabilities](#), optimal critical care resource allocation should be achieved without using categorical exclusions.²⁷ Having a human rights-based strategy in place before catastrophic events happen is key for a disability inclusive response.³⁹ The core principles of dignity, nondiscrimination, equality of opportunity, and accessibility should be central during resource allocation protocol development.³⁵ To create successful disability inclusive

community-based responses, administrators and public health planners need to ensure that people with disabilities have roles and responsibilities in the design and implementation of the responses.³⁹ While required in the [2019 PAHPA legislation](#), the National Advisory Committee on Individuals with Disabilities and Disasters has not yet been formed. It is my recommendation that that committee includes members with disabilities and experts in health equity and consider the [evaluation framework](#) developed by disability experts.

The Caregiving Workforce

In 2008, when the Americans with Disabilities Act was amended, [Congress wrote](#), “historically society has tended to isolate and segregate individuals with disabilities and despite some improvements such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem.” The issue of *isolating and segregating* people with disabilities should be front and center in our minds as we think how we can prepare for the next crisis and how we can better care for older adults and people with disabilities in general. We have the opportunity to fund services that help people stay in their homes as they desire, an opportunity to realize the full promise of the [1999 Olmstead](#) decision.

During the pandemic, families have been forced to [scramble and scrape together supports](#) for their loved ones with disabilities. I share the words of one of my colleagues, a mother of a child with severe disabilities who describes how they navigated the early days of the pandemic. Written in June by [Debbi Harris in the Journal of Pediatric Rehabilitation Medicine](#): “We have two full-time licensed nurses who work in our home – one four days per week and one four nights per week. In our area, this is remarkable staffing, given the nursing shortage. Immediate and extended family members fill in all other shifts, as our son requires 24-hour awake, hands-on care. We had just trained in a third nurse who was to start a mixture of day and night shifts on March 29, 2020. However, the full-time nurses expressed concern because the new part-time nurse also worked at a major hospital (with a newly established COVID unit), as well as at a long-term care facility. At the last moment, I asked him to hold off on his start date and assuaged the situation by paying him a bonus and promising to hold his hours until after the apocalypse... We have already asked all but immediate family to stop coming to the home, so my husband is doing about two night shifts a week, and I have about two 12- to 14-hour day shifts. We typically have no nursing on the weekends, so those are like marathons. We have been told by our DME [durable medical equipment company] that we may receive only 3 boxes of gloves per month for 24/7 care – trach, peri care, gastrostomy – everything. The respiratory therapist’s monthly visit has been replaced by a modem that sends information about vent settings to the company. Vent circuitry, tubing, connectors, humidification chambers, and temp probes are being rationed. We were told that home care is not a priority. Our home care agency has sent us nothing at all in the way of protocols or practical support. There has been no information about safety of staff, PPE, or safety for families and instead we have written our own COVID support plan.”⁴⁰

Having to scramble to meet the needs of a loved one living at home with disabilities is not a new phenomenon. Many older individuals and people with disabilities rely on direct services in their homes to maintain their health. Prior to the pandemic, there was a critical shortage of

direct service workers [due to low wages, limited benefits and high turnover](#). Limited access to PPE, risk of exposure to SARS-CoV-2, lack of accessible childcare, long work hours, and limited availability of safe transportation have all been [identified as reasons](#) why the workforce crisis has worsened during the pandemic. Most of the funding for direct services is provided by the CMS (Medicare Home Health and Medicaid Home and Community-Based Services) and the HHS Administration for Community Living, some funding is provided through private insurance, and some is out-of-pocket. There are [4.5 million home health clients](#) and a direct and home health workforce of [nearly 6 million](#). Over [20% of Americans are caregivers](#) and mostly this work is unpaid. Some of the consequences of providing unpaid caregiving include work loss and economic instability which contribute to a cycle of poverty for many families.^{41,42} Opportunities to improve the lives of families caring for people with disabilities in their homes include paying family caregivers, strengthening the Family Medical Leave Act and creating an adequate direct service workforce that is better paid with benefits. The RAISE Family Caregiving Act's Advisory Council will be developing a [national strategy](#) that will hopefully address many of the issues family caregivers currently face.

To address the workforce deficits for direct service providers, it is important to understand the lived experience of direct service workers. These individuals provide a vital service to older Americans and people with disabilities of all ages. The work they do is hard but rewarding. Financially though, they are undercompensated and struggle to make ends meet. Such is the tale of [Joyce Bumbray-Graves](#) highlighted in a recent NPR story.

According to the US Bureau of Labor Statistics, in 2019, home health and personal care aides earned a [median wages of \\$12.15/hour](#). This is far from a living wage. In my home county, Alleghany, Pennsylvania, a [living wage for a single mom of two children is \\$33.83/hour](#), nearly 3 times as high as Pennsylvania's [average wage of \\$12.41/hour](#) for a home care worker.

It is no wonder that there is [high turnover \(26.5% in 2020\)](#) for home care aides. If we want to realize the goal of having people with disabilities living in their homes, the supports and services needed must be available -this means paying a living wage and making systemic changes to problems that lead to burnout and turnover. Further, entry into programs to serve people with disabilities should be simplified, across sector collaborations should be supported and promoted, waiting lists eliminated, and emphasis placed on autonomy and self-direction.

Vaccine Access

As mentioned in my oral testimony, there have been substantial problems administering vaccines to eligible individuals. While the CDC appropriately prioritized appropriately older people living in long-term care facilities for vaccination, older adults and people with disabilities who are homebound did not receive the attention they needed to ensure their rapid vaccination. Additionally, while direct service providers are considered health care providers in some states and essential workers in others, many direct service workers have struggled to secure vaccinations. [Millions of homebound older adults await vaccinations](#) because there is no reasonable way for them to access the vaccines. While the CDC has provided [guidance](#) for vaccinating homebound individuals, our public health infrastructure and our health care delivery systems are ill-equipped to administer vaccines in people's homes. Coordination,

training and resources are needed to quickly implement home vaccinations at scale. Rapid determination of how FEMA and other governmental agencies can assist in the identification of people needing home vaccination and how to operationalize the delivery of home vaccines could reduce virus transmission to this vulnerable population and save lives.

Mass vaccination sites offer a logical solution to address the challenges of vaccinating the majority of the population quickly and efficiently.⁴³ As with any effective public health strategy, community acceptance, accessibility and equity should be addressed from the outset.⁴³ Unfortunately, older adults and people with disabilities have found accessibility of vaccination sites problematic. Our piecemeal, confusing and malfunctioning distribution strategy is the result of inadequate coordination between stakeholders. We must create a comprehensive vaccine infrastructure that is truly equitable -we should work to improve our current infrastructure and create a strategy for the future based on a framework of equitable distribution.⁴⁴ This requires human capital, data systems, supply chains and public health messaging from trusted reliable sources.³ Publicity campaigns with trust brokers may help overcome vaccine hesitancy in higher risk communities.⁴³ Overcoming [vaccine hesitancy](#) is especially important in the long-term care workforce among whom early vaccine acceptance was below 40%.⁴⁵

While the CDC has provided [prioritization guidance](#) for offering COVID-19 vaccines, [states](#) are [taking different approaches](#) and have had [varying success](#) immunizing the population quickly. Disability advocates from around the country have helped inform prioritization by highlighting data that demonstrate the risk of death from COVID-19 among people with disabilities. People with disabilities face an [uphill battle](#) qualifying for, signing up for and actually getting a COVID-19 vaccine. While using existing platforms or building new websites for vaccine sign-up allowed for their quick roll-out, seniors and people with disabilities are often frustrated because the websites are confusing and inaccessible. Digital literacy varies between individuals, but is influenced by age and other sociodemographic factors (older Americans and those with a high school degree or less were the most likely to report that they [didn't find the internet essential](#) during the pandemic).⁴⁶ Contributors to the 'digital divide' include lack of access to broadband internet, overall literacy and digital literacy, lack of access to devices such as computers or smart phones, cultural expectations regarding digital use and the physical and cognitive capabilities required to navigate the digital space.⁴⁷

The [challenge of getting vaccinated](#) is heartbreakingly articulated by Emily Ackermann in a blog post for the [Disability Visibility Project](#) last week. Ms. Ackermann, a young adult with disabilities, states: "While the state of Pennsylvania recognizes my need for early vaccination on paper, the effort largely ends there. With no uniformity or accountability, county clinics have tiered phase 1A itself, refusing to vaccinate anyone under 65 regardless of high-risk status and devaluing the lives of those living with co-morbidities. Appointments at pharmacies are difficult to come by, occur at one day's notice (the disabled nightmare: "No time to plan?!") and demand constant monitoring combined with a quick draw at entering your information in a race against the local contingency of the estimated 3.5-4 million Pennsylvanians eligible for phase 1A." Unfortunately, her story is not unique. Seniors and people with disabilities struggle

to sign up for a vaccine and once scheduled often experience [accessibility barriers](#) at vaccine administration sites. These barriers are even more substantial for poor and minorities with disabilities.

Telehealth

Maintaining and expanding telehealth has great promise to improve access to services especially for those who struggle with transportation, have difficulty leaving their homes or have limited time away from other responsibilities such as work and maintaining the household. While many physicians and other health care providers note the limitation of not being able to physically examine a patient by the laying on of hands, we should recognize that telehealth has great benefits. Certainly, an examination solely conducted by observation is different, but in some ways it is better. This is especially true for people with disabilities of all ages. I wrote an editorial recently published in [Archives of Physical Medicine and Rehabilitation](#) regarding my telehealth experiences that I will quote from here: “All of the children I care for have disabilities, so it is incredibly valuable for me to be able to see them perform activities in their own environments.⁴⁸ I can actually see the barriers that might be present or how a simple adaptation to their kitchen table set up might make things easier for the child...I am honored that families trust me enough to having me come into their homes on video, especially the ones who don’t have a lot of resources. Occasionally I see the chaos of a large number of people living in a small space. Sometimes it becomes apparent to me that the family is food insecure and that I could help by connecting them with resources or prescribing nutritional supplementation for their child with a history of dysphagia from their Chiari malformation. Seeing children in their homes provides me a window into their lives.⁴⁹ The children tend to be more comfortable than at the clinic so are more participatory, especially the little ones. The exam I do fully by observation is not the same as the one I would do if we were conducting the visit in person,⁵⁰ but in some ways it is better, providing me with different information. As a physician who focuses on functioning, being able to evaluate functioning in a child’s home, even if only by video, is amazing.”⁵¹

The [Telehealth Modernization Act of 2020 \(S. 4375\)](#), supported by the [American Medical Association](#), would remove many regulatory restrictions on telehealth and expand provider eligibility. But, telehealth also has the potential to worsen disparities.⁵² This is especially true for seniors because [approximately 40%](#) of them do not have home broadband access. The Department of Veterans Affairs has been addressing digital access by providing veterans with cellular Wi-Fi enabled iPads. This program served over [50,000 veterans](#) prior to the pandemic and has been expanded. Moving forward, innovations in delivering telehealth care, assuring equitable access and maintaining reimbursement will be necessary to reap the full benefits of this technology.

Conclusion

As we envision a more equitable future for seniors and people with disabilities where everyone has the opportunity to live their lives to the fullest, I remind us of where we’ve been and opportunities before us. I quote our most recent inaugural poet, [Amanda Gorman](#), “There will always be light, if only we’re brave enough to see it, if only we’re brave enough to be it.”

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**Prepared Statement of Anthony Jackson, Senior Vice President and Chief
Operating Officer, Roper Saint Francis Healthcare,
Charleston, South Carolina**

Chairman Casey, Ranking Member Scott, and members of the committee, thank you for inviting me to testify today. My name is Anthony Jackson and I am the Senior Vice President and Chief Operating Officer of Roper St. Francis Healthcare in Charleston, South Carolina. Roper St. Francis is the only private, not-for-profit, faith-based health care system in Charleston. We have four hospitals with 657 beds across five counties. We are the region's largest private employer 6,000 employees, and we have more than 1,000 doctors on our medical staff.

The impact of COVID-19 on Roper St. Francis Healthcare has been dramatic. Since the start of 2020, there have been 455,495 confirmed cases of COVID in South Carolina. This pandemic has disproportionately affected older Americans, and that was especially true at Roper St. Francis Healthcare. Over the past year, we experienced many difficult moments as our doctors and nurses worked bravely and tirelessly to treat COVID patients. This includes patients such as Lethia Moore, a 78-year-old great-great-grandmother who was admitted to Roper St. Francis Healthcare on April 3, and sadly passed away on April 12, comforted by a nurse who refused to leave her side.

As COVID continued to spread, our hospital system adapted. While we already had a platform in place for telehealth, the COVID pandemic required us to scale up quickly. Telehealth has proven so valuable that we intend to continue it in the long run. We have set a goal of maintaining 20 percent of all visits via telehealth, which opens doors for many vulnerable older Americans, particularly those who are homebound, those living with disabilities, and those who live in rural areas.

We're hopeful that this pandemic will be brought to an end this year with the advent of the COVID-19 vaccine. Roper St. Francis Healthcare is working closely with the State of South Carolina to administer COVID vaccinations. We received our first batch of vaccine in December and began administering them to our health care workers on December 15. In January, we opened a COVID vaccination drive-thru for patients in the parking lot of the North Charleston Coliseum, a site that is used to accommodating crowds of more than 13,000 for events. We have the capacity to vaccinate up to 1,500 residents per day.

Additionally, this week, we launched a pop-up drive thru location in Berkeley County for residents 55 and older. This is important because about three-quarters of Berkeley County's 65 and older population has yet to be vaccinated. Vaccine drive-thru centers can play an integral role in expanding our vaccination campaign beyond urban areas to reach a population that is often left behind. Communities and states must be proactive and creative to reach residents who cannot get vaccinated through more traditional visits to hospitals and doctors' offices, and our drive-thru vaccination site would be a great model for others to follow.

The pandemic and vaccine rollout also have shown the importance of treating seniors across all facets of the health care system. Whether its hospitals, community health centers, or nursing homes, we all have a role to play. Why? We know that when we consider social environmental factors such as social mobility, work, retirement, education, income, and wealth, caring for our seniors becomes even more complex. Healthcare for seniors is dynamic and multidimensional; and to address them adequately, the pandemic has taught us that care in the community has to be collaborative, innovative, intentional and equitable. Roper St. Francis is proud of the thousands of hours of community care that we provide in Charleston and the surrounding counties alongside our community partners and volunteers.

As a former licensed nursing home provider, I understand the value of senior-care communities. Our patients have turned to us for guidance over the past year, and we cannot lose this trust. We need to continue to have transparency and accountability, and I am proud of the work that all the staff at Roper St. Francis has done and will continue to do as the pandemic is not over. Ensuring healthcare providers have a sufficient and dependable supply of COVID-19 vaccine is central to our ability to successfully plan and operate vaccination events, so thank you for your continued efforts on this issue. I am thankful to every member of the committee for their work to ensure that our hospitals had the resources they needed to fight the pandemic, and I'm looking forward to continuing to serve our patients in the Lowcountry.

**Prepared Statement of Sandra Harris, Volunteer State President, AARP
Massachusetts, Boston, Massachusetts**

Chairman Casey, Ranking Member Scott, and members of the committee, thank you for inviting AARP to testify today. My name is Sandra Harris and I am the volunteer State President for AARP Massachusetts. On behalf of our 38 million members, including 776,506 in Massachusetts, and all older Americans nationwide, AARP appreciates the opportunity to provide testimony at today's hearing.

COVID-19 has been particularly hard on Americans over the age of 50 and people of color. Since the start of the pandemic, nearly 95 percent of the deaths from COVID-19 have been among people age 50 and older. The situation in America's nursing homes is particularly dire. Over 175,000 long-term care facility residents and staff have died—including over 8,600 in Massachusetts due to COVID-19, representing about 35 percent of the deaths nationwide and over 50 percent of deaths in Massachusetts, despite the fact that nursing home residents comprise less than one percent of the U.S. population. Further, nursing homes with more residents of color have reported triple the number of COVID-19 deaths. Moreover, millions of older Americans have been socially isolated, spending holidays and birthdays away from loved ones, for a year now. AARP members are eager to see their grandchildren again, or visit their parents in a nursing home for the first time in a long time. I am one such person—I have not seen my grandchildren in over a year and I am very much looking forward to reuniting with them.

Thankfully, safe and effective vaccines to combat COVID-19 have provided new hope to Americans over the age of 50. We cannot stress enough how eager many are to receive a vaccine, which offers so much promise for a return to normalcy. We have heard many questions from AARP members about when and how they can expect to be vaccinated, who will notify them, what information they will need to provide, and where they can sign up. We are encouraged by the progress being made, with over twenty-one million Americans over the age of 50 fully vaccinated. We are also very pleased with the progress that has been made in providing vaccines to residents and staff of long-term care facilities (LTCFs), including the Long-Term Care Partnership that has fully vaccinated 2.7 million LTCF residents and staff. In Massachusetts, approximately 84 percent of all nursing home residents and 71 percent of staff have received both doses.

However, we continue to hear from Americans over the age of 50 who are having difficulty accessing COVID-19 vaccines, and in many states, demand continues to outstrip supply. In addition, there has been wide disparities in access to these vaccines, with the Centers for Disease Control and Prevention reporting that of those who have received both vaccine doses, 67 percent are White. AARP is committed to reducing this gap and ensuring all those who want a COVID-19 vaccine can access it. AARP recently joined with five of the Nation's largest nongovernmental, non-profit membership organizations—which combined, reach more than 60 million Americans—to launch a COVID vaccine equity and education initiative. The effort includes the American Diabetes Association, the American Psychological Association, the International City/County Management Association, the National League of Cities, and the YMCA. It aims to ensure that accurate and transparent information about the COVID-19 vaccine is available to Black Americans to help them make informed personal decisions about vaccination.

Accessing the vaccine continues to be a challenge for many older adults who are struggling to make appointments, including those who do not have access to the Internet or do not regularly use the Internet. The appointment process varies state to state, or even county by county. Many Americans over the age of 50 are unsure how to make or confirm their appointment and are deeply frustrated and increasingly desperate. Furthermore, many do not have access to the Internet or do not have experience using online appointment systems. I consider myself a fairly technology-savvy individual, and yet I had significant difficulties in getting an appointment through Massachusetts's vaccine appointment Web site. In addition, some states require individuals to visit multiple Web sites just to monitor vaccine appointment availability. States like Massachusetts have moved to a pre-registration system for vaccine appointments at the state's seven mass vaccination sites, which we hope will help ease the stress of competing for vaccine appointments. We also urge the Federal Government to work with states to develop 1-800 numbers for scheduling vaccine appointments that are centralized, well-staffed, and offer culturally competent customer service in several languages. States and counties should also set aside a specific number of vaccine appointments for these call centers so these individuals are not competing with those going online to schedule appointments.

We are pleased that the CDC has launched an online tool that will allow them to use their ZIP code to search for where they can get a vaccine. We encourage the CDC to build on this tool and work with states to allow consumers to easily book a vaccine appointment after finding available vaccines in their area. AARP has also been particularly focused on ensuring vaccines are reaching homebound individuals. Many older Americans do not have access to transportation or cannot leave their home due to medical reasons. Others are unable to stand for long periods of time, as is required at many vaccination sites. It is critical that states and counties utilize mobile clinics and other solutions to administer COVID-19 vaccines to this population. The CDC released helpful guidance on vaccinating homebound individuals, and the Federal Emergency Management Agency has made funding available to states for the creation of mobile clinics. In addition, new funding provided by the American Rescue Plan Act to the CDC allows them to provide technical assistance to states as they set up mobile clinics.

While there may be a sense of relief with vaccines rolling out, and cases and deaths in long-term care facilities finally declining, policymakers and facilities are not relieved of their responsibility to protect nursing home residents. AARP has heard from thousands of people all across the country whose loved ones lost their lives in nursing homes, and throughout the pandemic, we remain steadfast in advocating for the health, safety, and well-being of residents and staff.

We recognize that that nursing home problems are not new. Even before the pandemic, many long-term care facilities struggled with basic infection control and adequate staffing. It is not a could act or should act situation, it is a must act situation. AARP has urged action on a five-point plan to slow the spread and save lives:

1. Ensure facilities have adequate personal protective equipment (PPE) for residents, staff, visitors, and others as needed, and prioritize regular and ongoing testing.

Even with vaccines, we know that PPE and regular testing are still needed to stop the spread of coronavirus and other pathogens. AARP supports the funding in the American Rescue Plan Act for infection control and vaccine uptake support provided by quality improvement organizations to skilled nursing facilities.

2. Improve transparency on COVID-19 and demographic data, vaccination rates of residents and staff by facility, and accountability for taxpayer dollars going to facilities.

AARP has called for increased transparency of COVID-19 cases, deaths, and vaccination rates in long-term care facilities, including demographic data. Better data is important for families and will help us effectively understand and respond to the crisis in a timely and focused way so that we can minimize the spread of the virus, disrupt disparities, and improve health outcomes now and into the future.

We also believe there needs to be greater transparency around how the billions of dollars in taxpayer money that has gone to facilities was spent from the Provider Relief Fund. We have urged that any federal funding should be used for the health, safety, and well-being of residents and staff.

3. Ensure access to in-person visitation following federal and state guidelines for safety, and require continued access to facilitated virtual visitation for all residents.

We were pleased that CMS issued updated nursing home visitation guidance on March 10, providing welcome news for families and nursing home residents who want and need to visit with their loved ones, while also continuing to emphasize that nursing homes, visitors, and others follow infection prevention and control practices. The guidance will enable more residents and their loved ones to visit more easily and safely in-person. For many Americans living in nursing homes and other facilities, their friends and family serve as a source of comfort and an important safety check.

4. Ensure quality care for residents through adequate staffing, oversight, and in-person access to long-term care ombudsman.

We are deeply concerned about staffing shortages at residential care facilities. AARP's Nursing Home Dashboard has consistently found over 25 percent of nursing homes nationally reporting a shortage of direct care workers since June 2020, and in fact, many facilities had inadequate staffing prior to the pandemic. This is an ongoing concern, as higher staffing levels are associated with fewer deaths and COVID-19 cases in nursing homes. AARP supports funding in the American Rescue Plan Act for state strike teams in nursing homes with COVID-19 cases. AARP further urges Congress to take action to ensure that staffing levels in long-term care facilities are adequate, such as through pay and other compensation, paid leave, recruitment, training, and retention. It also remains important for residents to have

in-person access to long-term care ombudsmen, who play an important role in advocating for residents and their families.

5. Reject immunity and hold long-term care facilities accountable when they fail to provide adequate care to residents.

The pandemic has put residents' lives at unprecedented risk, as reflected by the horrific death tolls. We know that staff in many long-term care facilities are doing heroic work, putting their own health on the line to care for people in nursing homes. Sadly, AARP has heard from thousands of families whose loved ones were not treated with the compassion or dignity that every American deserves. AARP strongly urges Congress to protect the safety of residents, including by maintaining the rights of residents and their families to seek legal redress to hold facilities accountable when residents are harmed, neglected, or abused.

In addition to reforming our Nation's long-term care facilities, we need to support the ability of people to remain in their homes and communities. Not only will this help people to live where they want to be, but also help to alleviate some of the challenges we are facing in our Nation's nursing homes. Enabling people to live in their own homes helps save lives in nursing homes. Furthermore, on average, for every one person residing in a nursing home, Medicaid can fund three individuals receiving community-based long-term care. AARP supports the 10 percent enhanced FMAP for Medicaid HCBS included in the American Rescue Plan Act to help enable more people to live in their homes and communities.

Congress must also look longer-term to give older adults and people with disabilities more options to live in their homes and communities, including more options to receive care at home, and more support for family caregivers who help make it possible. My family has worked to ensure my mother, who has dementia, has the care she needs to stay at home through a combination of home care services and family caregiving, but it has not been easy. A family caregiver tax credit, as in the bipartisan, bicameral Credit for Caring Act, would help provide some financial relief to eligible family caregivers.

Finally, we are seeing large numbers of older adults facing hunger as a result of the pandemic. More than 20 percent of people age 50 to 59 and 14 percent of Americans age 60 and older are struggling to put food on the table, with Black and Hispanic older adults reporting even higher rates of food insecurity. In 2020, grocery store food prices outpaced the historical average by 75 percent. For people living on a tight budget, including many older adults on fixed incomes, this can make it much harder to buy enough food. We have learned about the real struggle many older adults are experiencing during the pandemic—how they are having to rely on their kids and grandkids, and how they are having to make difficult decisions between paying for rent, food, or essential medicine.

For older people scrambling to make ends meet, the Supplemental Nutrition Assistance Program (SNAP) is a much-needed lifeline. Through improved nutrition and decreased financial strain, SNAP participation is associated with better health and decreased hospitalization. Further, these benefits can be an important stimulus to support local businesses. AARP supports the 15 percent SNAP benefit increase through September. We also support the additional resources for state SNAP administration to continue support for people in need and additional funding to support improvements to help people buy groceries online using their SNAP benefits.

With Older Americans Act (OAA) nutrition services providing more meals to more people, AARP supports the emergency funding to help the aging network meet the needs of seniors, so they can continue to stay safe and healthy at home. People in Massachusetts and across the country are also continuing to turn to food banks as a vital lifeline, and in many cases, those people are visiting food banks for the first time.

The uncertain nature of the pandemic introduces challenges to forecasting future needs making it essential that we closely monitor food insecurity, especially as critical benefits expire and as supplemental funding is spent down. We also believe it will be important to continue the temporary SNAP boost for the duration of the COVID-19 crisis, adjusting the length and amount of the relief based on health and economic conditions.

Americans over the age of 50 continue to struggle with the impacts of this pandemic and will continue to for some time. We are thankful that some relief has arrived, but more needs to be done to protect the health and safety of older Americans.

Questions for the Record

Questions for the Record To Anand Iyer

From Senator Rosen

Palliative Care and Telehealth

As Chair of the bipartisan Comprehensive Care Caucus, which I launched to raise public awareness and promote the availability and benefits of palliative care, I'm so pleased to hear about your background and work in this field.

Question:

Dr. Iyer, can you tell me more about the work you have been doing throughout the pandemic to increase access to palliative care, and how are you delivering this care now via telehealth? What more can Congress do to support you and others in these efforts?

Response:

Dear Senator Rosen,

Thank you for your question on palliative care and telehealth. I am grateful for your leadership on the Comprehensive Care Caucus and for your continued advocacy for palliative care. As a pulmonary-critical care physician, I see firsthand the value of palliative care to improve quality of life for people living with serious illness in our intensive care unit and at my pulmonary clinic for undeserved citizens in Jefferson County, AL. I advocate for palliative care integration into my field of pulmonary medicine through multiple national organizations and research innovative ways to improve its delivery to people with chronic lung disease. My research, supported by a 2020 Paul B. Beeson Emerging Leaders Career Development Award (K76) from the National Institute on Aging, focuses on implementing geriatrics and palliative care in chronic obstructive pulmonary disease (COPD), the third leading causes of death among older Americans. We are developing the first geriatrics and palliative care framework for clinicians who care for patients with COPD and are testing an innovative telephone-based geriatrics and palliative care intervention for older adults with COPD and their families.

Regarding telehealth, leadership at UAB Medicine had the foresight to implement telehealth before the pandemic and were primed to scale it last year and meet an incredible demand. I was excited to be a part of that revolution in healthcare delivery. Our division harnessed telehealth to bring subspecialty pulmonary care to Alabamians across the state in areas without routine access to pulmonologists. Given my devotion to palliative care, I used every opportunity during each telehealth visit to connect patients with my colleagues at the UAB Center for Palliative and Supportive Care, where my mentors and their teams have been working hard to develop and research innovative telehealth strategies long before the pandemic. I recall caring for a woman in her 80's who lives far from Birmingham and was isolated in her home due to COPD. I connected her with telehealth palliative care, and as a team we were able to improve her quality of life while keeping her safe at home and removing a significant barrier to in-person clinic visits: transportation. This outreach also extended to patients at my county pulmonary clinic, where I helped a gentleman who was suffering with severe breathlessness due to end-stage COPD find relief with the help of telehealth palliative care. Finally, our telehealth ICU teams safely cared for hundreds of critically ill patients last year at rural facilities across Alabama. It was thrilling to help an ICU team 100 miles away get a man off the ventilator who had respiratory failure due to COVID-19 and watch him give me a thumbs up over the video. Telehealth has immense potential but only if we can first expand broadband access to rural and underserved areas and improve digital literacy among older adults.

In the next decade, millions of Americans with serious illnesses will grow older, and this will further strain our healthcare system. Without a parallel increase in the number of specialist palliative care clinicians and geriatricians, there will be a deficit of over 1000 clinicians needed who are uniquely trained to care for them. The current turnover of trainees in palliative care and geriatrics is insufficient to meet that demand, especially when physician training spots across the country are going unfilled. This is already creating a huge gap in care that requires urgent solutions. One of the most immediate opportunities is to pass the bipartisan "Palliative Care and Hospice Education and Training Act" (PCHETA; S. 2080/H.R. 647) that promotes palliative care education, research, and workforce development. Its fate has hung in the balance for years, and I hope that 2021 can be the year that it passes. There is also the "Provider Training in Palliative Care Act" (S. 1921) proposed by you and Senator Murkowski to expand palliative care through the National Health Services Corp. Both would expand the palliative care workforce and provide someone like me the training in palliative care to deliver it on the frontline for my pa-

tients and their families. This would go beyond training in communication and planning about the end of life and extend to broad symptom management and caregiver support. Opportunities to expand my training in palliative care are very limited. A primary palliative care model, i.e. training frontline clinicians from diverse disciplines and specialties in palliative care, seems to me to be the most practical and actionable solution to grow the palliative care workforce and close the widening gap.

The pandemic spotlighted the importance of palliative care. As a discipline, it is underappreciated and underutilized and we have a lot of work to do to increase awareness and acceptance. I would be honored to continue to work with you in the future to expand palliative care, to educate the public and my fellow healthcare workers, and to develop innovative solutions that bring palliative care to more Americans and their families and make it a standard of care for serious illness.

Sincerely,

Dr. Anand S. Iyer

Additional Statements for the Record

Meals on Wheels America

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Dear Chairman Casey, Ranking Member Scott, and Members of the Committee: On behalf of Meals on Wheels America, the national network of community-based senior nutrition programs, and the individuals they serve, thank you for holding the important hearing, “COVID–19 One Year Later: Addressing Health Care Needs for At-Risk Americans.” We are grateful for your leadership and commitment to addressing the needs of our Nation’s older adults, especially as we pass the difficult one-year anniversary of the COVID–19 pandemic, which has disproportionately claimed the lives of thousands of older Americans and has harmed the health and well-being of millions of others.

Meals on Wheels America is the national nonprofit organization that supports the network of 5,000 community-based senior nutrition programs across the country that are dedicated to addressing senior isolation and hunger. With the support of committed volunteers and staff members, local Meals on Wheels programs deliver nutritious meals in group settings and/or the home, and provide friendly visits and social interaction, safety checks, and connections to other social and health services to older Americans in virtually every community nationwide. The individuals served through the senior nutrition network are among the most vulnerable to experiencing severe complications related to COVID–19, as well as challenges accessing nourishing food and social connections.

For nearly 50 years, community-based senior nutrition providers have been welcomed into the homes of our Nation’s seniors with every meal delivery. The person-centered services provided by this network are made possible by the federal funding and support authorized by the Older Americans Act (OAA) and are designed to specifically meet the nutritional and social needs of high-risk, underserved seniors. Senior nutrition programs have long worked on the front lines of combating the harmful effects of hunger, social isolation and loneliness in older adults, but their efforts have never been as essential as during the pandemic, as they continue to provide their communities with nutrition, social connection and most recently, support with accessing vaccinations.

The variety of topics covered at the hearing and diversity of experiences and perspectives outlined by the witnesses were informative and encouraging. Well-coordinated mass vaccine distribution plans and outreach, expansion of broadband and telehealth, improved caregiver and direct workforce support, and funding for essential wrap-around aging services are all vital to ensuring the health and well-being of older adults. We appreciate the opportunity to submit this written testimony for the hearing record and will focus our statement on the senior nutrition network’s specific experience—both the successes and challenges—around providing care and support to older adults in their homes and communities amid the pandemic.

**Addressing Senior Hunger and Isolation Before
and During COVID–19**

Senior hunger, social isolation and loneliness are recognized as major threats to public health, though the awareness of these issues has grown significantly due to the pandemic. Before the COVID–19 crisis, nearly 9.7 million seniors in the United States faced the threat of hunger; among those, 5.3 million were food insecure or very low food secure.¹ One in four older adults reported feeling lonely, and over 17 million lived alone, putting them at risk of social isolation.² ³ We know that a far more significant number of older adults are now experiencing food insecurity, and many more are lonelier than before the pandemic.

¹ Feeding America (research conducted by J. Ziliak and C. Gunderson), 2020, The State of Senior Hunger in America in 2018. Available at <https://www.feedingamerica.org/research/senior-hunger-research/senior>.

² AARP, 2018, Loneliness and Social Connections: A National Survey of Adults 45 and Older. Available at <https://www.aarp.org/research/topics/life/info-2018/loneliness-social-connections.html>.

³ U.S. Census Bureau, 2020, American Community Survey 2018. Available on the Administration for Community Living Aging, Independence, and Disability Program Data Portal (AGID): <https://agid.acl.gov/CustomTables>.

Despite the efforts of dedicated local programs working tirelessly to serve their communities with limited resources, the gap between those struggling with hunger and those receiving nutritious meals through the OAA continues to widen across the country. Even prior to the pandemic, federal funding for aging services, like Meals on Wheels, was not keeping pace with increasing demand, rising costs and inflation. Consequently, the network served over 17 million fewer OAA meals in 2019 than in 2005, and with the onset of the health and economic crises caused by COVID-19, the demand for OAA services like Meals on Wheels has soared to unprecedented levels.⁴ With 12,000 individuals turning 60 every day, and the pandemic exacerbating existing inequities in food and health access, further federal investment is unequivocally needed.

As we heard from witnesses in the hearing, local community-based programs have been critical to our Nation's pandemic response, and Meals on Wheels programs, in particular, have been highly sought out for the trusted nutrition and social connections they offer. More than a year into this public health crisis, these programs are continuing to deliver these life-saving services at sustained high rates.

Care During Covid: The Meals on Wheels Response and Outlook

Practically overnight, the Meals on Wheels network faced an unprecedented surge in demand as the number of older adults sheltering in place increased and congregate centers shifted ways of operating. Programs quickly adapted their traditionally high-touch service model to continue safely offering their senior clients critical person-centered components that go well beyond the meal itself. Most Meals on Wheels programs reported being able to not only continue their operations, but also to rapidly scale up to serve more older Americans in need because of the hope and promise that additional emergency funding would be coming their way.

The innovative approaches that Meals on Wheels programs have utilized during pandemic response include transitioning congregate services to fully home-delivered or to grab-and-go and curbside pick-up alternatives that allowed older adults get their meals from the safety of their car in senior center parking lots. To address social isolation, many programs that were temporarily unable to offer a daily touch point with in-person deliveries pivoted to offering virtual socialization alternatives and wellness checks over the phone. In light of the challenging circumstances, Meals on Wheels programs further established creative community partnerships with food banks, restaurants and other local non-profits to meet the needs of the clients they serve as well as to reach other higher-risk populations living in rural or un-served delivery areas. Local providers are also proving to be critical partners in the national effort to improve COVID-19 vaccine awareness, access and distribution to homebound older adults, including through education and referral information to isolated individuals, assisting with vaccine registration, partnering with health departments and pharmacies, coordination of vaccine deployment, and use of congregate sites for vaccine administration.

Despite the incredible response from the senior nutrition network to quickly scale services, challenges remain in addressing the full demand for services. According to a survey of Meals on Wheels America membership, nine in 10 local Meals on Wheels programs report there is unmet need for home-delivered meals in their community, and many report increased numbers of seniors forced to go on waiting lists for services. On average, Meals on Wheels programs are serving about 60 percent more home-delivered meals than before the onset of COVID-19, and the majority believe they will not be able to sustain their current levels of operations without additional emergency federal funding.⁵

The federal relief packages passed in response to the widespread health and economic effects of the pandemic have provided the aging services network with desperately needed supplemental funds to continue delivering meals to and maintaining social connections with seniors. The Families First Coronavirus Response Act (FFCRA), the Coronavirus Aid, Relief, and Economic Security (CARES) Act of 2020, the Continuing Appropriations Act of 2021, and the American Rescue Plan (ARP) Act of 2021 delivered a cumulative total of almost \$1.7 billion for OAA Congregate, Home-Delivered and Native American Nutrition Services and the flexibilities required to enable this crucial support to local nutrition programs in every state and district. However, additional congressional funding and action is necessary to ensure the safety and social connectedness of our Nation's seniors, build the capacity of

⁴ Administration for Community Living (ACL), 2021, State Program Reports 2005–2019. Available on the AGID: <https://agid.acl.gov/CustomTables>.

⁵ Meals on Wheels American (research conducted by Trailblazer Research), 2020, results from a COVID-19 impact survey of Meals on Wheels America membership.

OAA programs and services to better serve this skyrocketing population, and bridge the growing gaps and unmet need for services in communities nationwide.

Recommendations

We hope that our insights on the response and experience of the senior nutrition network in providing essential services throughout the pandemic are valuable as the Committee considers further action to support older adults, their families and caregivers. There remains a clear need for a strong community-based aging services and supports system as the country's older adult population rapidly grows. It is also essential to prepare for future emergencies and unknowns that may again disproportionately complicate and harm the lives of seniors. Fortunately, with adequate support, Congress can strengthen and leverage existing private-public programs like Meals on Wheels, which are already reaching and serving the most at-risk and vulnerable older adults—and keeping them more healthy, safe and independent at home and out of Emergency Rooms, hospitals and long-term care facilities.

Therefore, we urge Congress to continue its tradition of bipartisan support for this network and consider the following recommendations to support local nutrition providers and the older adults they serve:

- Increase federal funding for the Older Americans Act (OAA) Nutrition Program to, at a minimum, a total level of \$1,091,753,000 in FY 2022, which is \$140 million (or 15%) above current levels. This simply reflects the total amount previously authorized for the program in the Supporting Older Americans Act of 2020 reauthorization legislation.
- Implement the Supporting Older Americans Act of 2020, the law reauthorizing the OAA as the primary piece of legislation supporting nutrition and social services for individuals age 60+ and their caregivers for more than 50 years, with consideration for the evolving needs of senior nutrition programs due to pandemic response and recovery.
- Strengthen other federal anti-hunger nutrition programs, like the Supplemental Nutrition Assistance Program (SNAP) and the Commodity Supplemental Food Program (CSFP), that provide essential services to older adults and their families.

Conclusion

Thank you again for convening this important hearing and for the opportunity to share our unique perspectives and experience on this pressing issue. We would like to extend special appreciation to Chairman Casey, Ranking Member Scott and their staff for their leadership and commitment to bipartisan work that will benefit the health, safety and economic security of older adults. We hope the insights shared in this statement are helpful in the Committee's work to address and implement policies that support older Americans, in COVID-19 response and recovery and beyond. We look forward to working together to ensure that no senior is left hungry and isolated and realize our vision of an America in which all seniors live nourished lives with independence and dignity.

The Healthcare Leadership Council Mary R. Grealy, President

Dear Chairman Casey and Ranking Member Scott: Thank you for holding a hearing, "COVID-19 One Year Later: Addressing Health Care Needs for At-Risk Americans." The Healthcare Leadership Council (HLC) appreciates the opportunity to share its thoughts with you on this important issue.

HLC is a coalition of chief executives from all disciplines within American healthcare. It is the exclusive forum for the Nation's healthcare leaders to jointly develop policies, plans, and programs to achieve their vision of a 21st century healthcare system that makes affordable high-quality care accessible to all Americans. Members of HLC—hospitals, academic health centers, health plans, pharmaceutical companies, medical device manufacturers, laboratories, biotech firms, health product distributors, post-acute care providers, home care providers, and information technology companies—advocate for measures to increase the quality and efficiency of healthcare through a patient centered approach.

The COVID-19 health pandemic has been an unprecedented challenge for all Americans. Over 28 million Americans have tested positive for COVID-19 and over 500,000 have tragically lost their lives. Stay-at-home orders have resulted in millions of job losses. However, due to the outstanding cooperation between the private sector and federal, state and local officials, significant progress has been made in

confronting the pandemic. The newly enacted American Rescue Plan Act will continue to strengthen healthcare quality and access during the public health crisis. Yet, health inequities from the pandemic continue to exist in this country with regard to health outcomes. Black and Hispanic men and women are more at risk than their white counterparts due to longstanding racial health inequities and social determinants of health (SDOH) that leave them more vulnerable. The higher rates of infection and fatality in communities of color are linked to existing health inequities facing people of color, such as higher rates of diabetes and hypertension, and barriers to care. The importance of SDOH and their impact are more apparent than ever.

According to the Kaiser Family Foundation (KFF), “SDOH are the conditions in which people are born, grow, live, work, and age that shape health.” These can include income, socioeconomic status, education, geographic location, employment, access to healthcare, transportation, food and nutrition, social isolation and many more broad categories; but can also be specific social, behavioral, and functional limitations such as home-state/home safety, the ability to perform activities of daily living, and the level of in-home support available to mitigate these limitations. Addressing inclusion in the community and employment have a greater impact on prevention of exacerbated health conditions than access to healthcare alone. HLC is supportive of providers and payers screening people for social determinants to help identify those who are considered at risk and in need of support and services. Investments in social services have been shown to be a stronger predictor of health outcomes than healthcare spending, so it’s easy to see that addressing social determinants to improve population health can help slow the healthcare costs growth curve and improve overall health for at-risk Americans.

In addition, HLC urges Congress to pass S. 104, the “Improving Social Determinants of Health Act.” This legislation will provide grants to nonprofit organizations and institutions of higher education to conduct research on SDOH best practices, provide technical, training and evaluation assistance and/or disseminate those best practices. Recently, HLC developed a SDOH report, “Care, Context, and Community: Creative Ways to Address Social Determinants of Health,” using the Department of Health & Human Services’s Healthy People 2030 framework to identify potential areas of focus for progress, and includes a large number of recommendations, as well as successful examples to address social determinants. These recommendations rest on a three-part foundation we believe will help collaborations across the country move beyond pilot programs to implement robust interventions and achieve significant results. The three-part foundation comprises:

- Developing a standard set of SDOH definitions using the Healthy People 2030 framework, giving all partners a common starting point and frame of reference.
- Utilizing community-based organizations that are positioned and equipped to act as true business partners.
- Building a national clearinghouse of program information and best practices.

This national clearinghouse will leverage HLC’s established Redefining American Healthcare criteria. It will include a dashboard, a set of recommended measurements, descriptions of successful pilot programs, tools and methods for research and evaluation, and a compendium of best practices. As this national clearinghouse develops, HLC will share any forthcoming details or information with the committee as we believe this work will substantially improve the health of at-risk populations within the country.

Thank you for the Committee’s work on addressing the healthcare needs of at-risk Americans. HLC looks forward to continuing to collaborate with you on our shared priorities.

Alzheimer’s Association and Alzheimer’s Impact Movement

The Alzheimer’s Association and Alzheimer’s Impact Movement (AIM) appreciate the opportunity to submit this statement for the record for the Senate Special Committee on Aging hearing entitled “COVID–19 One Year Later: Addressing Health Care Needs for At-Risk Americans.” The Association and AIM thank the Committee for its continued leadership on issues important to the millions of people living with Alzheimer’s and other dementia and their caregivers. This statement provides an overview on the long-term care policy recommendations released by the Association and impact COVID–19 has had on persons living with dementia.

Founded in 1980, the Alzheimer’s Association is the world’s leading voluntary health organization in Alzheimer’s care, support, and research. Our mission is to eliminate Alzheimer’s and other dementia through the advancement of research; to provide and enhance care and support for all affected; and to reduce the risk of de-

mentia through the promotion of brain health. AIM is the Association's sister organization, working in strategic partnership to make Alzheimer's a national priority. Together, the Alzheimer's Association and AIM advocate for policies to fight Alzheimer's disease, including increased investment in research, improved care and support, and development of approaches to reduce the risk of developing dementia.

The COVID-19 pandemic continues to create additional challenges for people living with dementia, their families, and caregivers including compounding the negative consequences of social isolation that many older adults already experience. Social isolation is an issue within the aging community as a whole, exacerbated due to the current public health crisis, and felt particularly hard in the Alzheimer's and dementia community. We were thrilled to see important provisions on long-term care strike teams, infection control, vaccine education for older adults, and funding for home- and community-based services and elder justice programs included in the American Rescue Plan.

American Rescue Plan and Long-Term Care Provisions

An estimated 6.2 million Americans age 65 and older are living with Alzheimer's dementia in 2021. Total payments for all individuals with Alzheimer's or other dementias are estimated at \$355 billion (not including unpaid caregiving) in 2021. Medicare and Medicaid are expected to cover \$239 billion or 67 percent of the total health care and long-term care payments for people with Alzheimer's or other dementias. Total payments for health care, long-term care, and hospice care for people with Alzheimer's and other dementias are projected to increase to more than \$1.1 trillion in 2050. These mounting costs threaten to bankrupt families, businesses, and our health care system.

At age 80, approximately 75 percent of people with Alzheimer's dementia live in a nursing home compared with only 4 percent of the general population at age 80. In all, an estimated two-thirds of those who die of dementia do so in nursing homes, compared with 20 percent of people with cancer and 28 percent of people dying from all other conditions. It is critical that all residents of nursing homes, including those in skilled nursing facilities and Medicaid nursing facilities, receive consistent, high-quality care, especially as people can live for many years in these settings.

At least 163,000 residents and employees of nursing homes and other long-term care settings have died from COVID-19, representing over 30 percent of the total death toll in the United States. These communities are on the frontlines of the COVID-19 crisis, where 48 percent of nursing home residents are living with dementia, and 42 percent of residents in residential care facilities have Alzheimer's or another dementia. Residents with dementia are particularly susceptible to COVID-19 due to their typical age, their significantly increased likelihood of coexisting chronic conditions, and the community nature of long-term care settings. Across the country these communities, their staff, and their residents are experiencing a crisis due to a lack of transparency, an inability to access the necessary testing and personal protective equipment, incomplete reporting, and more.

To best support individuals living with Alzheimer's and dementia during the pandemic, the Alzheimer's Association released a comprehensive set of long-term care policy recommendations for federal and state lawmakers, *Improving the State and Federal Response to COVID-19 in Long-Term Care Settings*. These recommendations focus on four areas: (1) rapid point-of-care testing, (2) reporting, (3) surge activation, and (4) providing support.

These policies are designed to create a strong and decisive response to the COVID-19 crisis in all long-term care settings and we were heartened to see them in the American Rescue Plan Act of 2021. We thank you for including these important provisions and strongly believe these provisions are critical to our populations and represent a significant step forward in improving their care during this pandemic and beyond.

Recent Nursing Home Legislation

AIM and the Alzheimer's Association have endorsed Chairman Casey and Senators Warnock, Whitehouse, Booker and Blumenthal's COVID-19 Nursing Home Protection Act that would provide \$750 million in funding to states for the purpose of establishing and implementing strike teams to ensure a sufficient number of aides, nurses, and other providers are available to care for residents. The bill would guarantee that \$210 million is available to the Secretary of Health and Human Services (HHS) to contract with quality improvement organizations to provide essential infection control assistance to nursing homes. Last, the bill would require HHS to collect and post on the Nursing Home Compare Web site demographic data on COVID-19 cases and deaths among nursing home residents and workers, including

information on age, race, ethnicity and preferred language. These crucial provisions are consistent with the Alzheimer's Association's recently released long-term care policy recommendations.

Additionally, AIM and the Alzheimer's Association have endorsed Chairman Casey and Senator Toomey's Nursing Home Reform Modernization Act which would help ensure high-quality care by establishing an Advisory Council on Skilled Nursing Facility Rankings under Medicare and Nursing Facility Rankings under Medicaid at the Department of Health and Human Services (HHS). This new Advisory Council would provide HHS with recommendations on how to rank high rated and low-rated facilities, with information on those rankings posted publicly to the Nursing Home Compare Web site. Importantly, the Special Focus Facility Program would transition to the low-rated facility program and Quality Improvement Organizations would work with those low-rated facilities to improve their quality of care through onsite consultation and educational programming. When choosing a facility for themselves or their loved ones, families deserve to have all the information available in a clear, easily digestible way. We appreciate that this bipartisan bill also directs HHS to utilize focus groups and consumer testing to ensure these ratings are easily understood by older adults, individuals with disabilities and family caregivers.

Conclusion

The Alzheimer's Association and AIM appreciate the steadfast support of the Committee and its continued commitment to advancing policies important to the millions of families affected by Alzheimer's and other dementia. Thank you, Chairman Casey and Ranking Member Scott, for your continued commitment to supporting individuals living with Alzheimer's disease and other dementia, and their families. We look forward to working with the Committee in a bipartisan way to advance policies that would help this vulnerable population during the COVID-19 pandemic and beyond.

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