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CARING FOR SENIORS AMID THE COVID–19 CRISIS

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C O N T E N T S

CARING FOR SENIORS AMID THE COVID–19 CRISIS

THURSDAY, MAY 21, 2020

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

The Committee met, pursuant to notice, at 9:33 a.m., via Cisco WebEx and in Room 301, Russell Senate Office Building, Hon. Susan Collins, Chairman of the Committee, presiding.

Present: Senators Collins, Tim Scott, McSally, Braun, Rick Scott, Casey, Gillibrand, Blumenthal, Warren, Jones, and Rosen.

OPENING STATEMENT OF SENATOR SUSAN M. COLLINS, CHAIRMAN

The CHAIRMAN. The hearing of the Senate Special Committee on Aging will come to order.

Good morning. Welcome to today's hearing on Caring for Seniors amid the COVID–19 crisis.

COVID–19 has brought tremendous hardship and tragedy, placing a heavy burden on the frontline workers, straining our healthcare and distribution systems, and imposing a deadly toll on seniors in particular. It has hit close to home for many on this Committee, and I am sure that all of our members want to join me in expressing our condolences to Senator Elizabeth Warren, who lost her 86-year-old brother to the coronavirus.

Elizabeth, we are very sorry for your loss.

Restrictions on visitors to nursing homes have affected even those families whose relatives do not have the virus. I know two brothers from Bangor, Maine, whose father is in a nursing home and has dementia. They have not been able to see him for some time now, and his health is failing. They are worried that he may not still be alive by the time they are allowed to visit him, something that used to happen regularly.

This virus has already claimed the lives of more than 90,000 Americans, the vast majority of whom were older adults. Adults age 65 years and older are more likely to suffer severe complications from COVID–19 and to have more difficult recoveries. They represent two out of every five hospitalizations and eight out of every ten deaths from the virus. Those in nursing homes and other congregate care centers are especially at risk. Nationwide, nursing home residents represent one-third of all coronavirus deaths.

In Maine, the toll on nursing home residents is even higher. Maine is the oldest State in the Nation by median age, and the Centers for Disease Control and Prevention reports 1,819 cases in

our State, and the virus has claimed 73 lives. More than half of those deaths have been residents of long-term care facilities, so you can see that Maine has an even higher death toll in nursing homes and other long-term care facilities than the national average.

Earlier this month, Senator Sinema and I wrote to the Administrator for the Centers on Medicare and Medicaid outlining a series of recommendations to better protect older adults in nursing homes. Among the issues that we urged be considered is how long-term care facilities and in-home care settings can access adequate testing as well as personal protective equipment and how the higher health risks of older adults living in nursing homes can be taken into account in the distribution plans for any future COVID–19 treatments and vaccines.

New diagnostic tests, therapeutics, and vaccines are moving forward at remarkable speeds. I look forward to learning more about this research today as well as promising treatments and strategies that can speed recovery for the most vulnerable populations. Through this and subsequent hearings, I hope that we can gain insight into additional actions that may be needed to better protect our seniors.

Congress has already taken a number of actions in response to the pandemic. We have passed four legislative packages totaling nearly $3 trillion to provide public health support to States and economic relief to small businesses and families. Phase 1, provided appropriations to supplement the Strategic National Stockpile; to develop and purchase diagnostics, therapeutics, and vaccines; to support community health centers; and to help hospitals and health systems respond. Phase 2, provided free coronavirus testing and increased Federal funds for Medicaid and other critical safety net programs. Phase 3, known as the CARES Act, provided additional funding to purchase critical protective equipment and testing for the stockpile; new resources for medical professionals on the front lines, to whom we owe a great debt of gratitude; direct aid to States; and economic support for small businesses and their employees through the Paycheck Protection Program.

The CARES Act also included the Home Health Care Planning Improvement Act. This is a bill that I have championed for 13 years to allow nurse practitioners and physician assistants to certify home health services.

Cutting down on time-consuming, unnecessary paperwork requirements that not only fail to improve patient care, but also delays access to that care, could not have come at a better time.

In addition, the CARES Act makes a number of improvements in the delivery of telehealth. More progress is still needed, and I plan to introduce a bill soon to create a framework to reimburse for telehealth services provided by home health agencies. Finally, Phase 4 provided an additional funding for the Paycheck Protection Program, $75 billion for our hospitals, and $25 billion for additional testing.

Much of the funding provided through these bills has yet to be released by the Department of Health and Human Services; therefore, I urge the Department to act with urgency so that this funding can flow to areas where it is desperately needed.

Today we will hear from a panel of experts who are leading the charge in supporting seniors across a variety of settings of care, including in hospitals, in nursing homes, and in the community.

We will be joined by Dr. Mark Mulligan, a physician who serves as the director of the Langone Vaccine Center at New York University; Dr. Tamara Konetzka, a professor of Health Services Research at the University of Chicago whose research focuses on quality of care in long-term care settings; and Dr. Steven Landers, a geriatrician who serves as the president and chief executive officer of the nonprofit Visiting Nurse Association Health Group.

I am grateful to each of them for the work that they are doing and for taking the time to join us today. Their expertise will help us advance public policies, to slow the spread of this devastating pandemic, and to lessen its impact on our Nation's vulnerable seniors.

Senator Casey, I know you are joining us remotely, and I would now call on you for your opening statement.

I also want to acknowledge that Senator Braun has joined us in person at the hearing this morning, and as I said, there are many that are online joining us and we expect others to be here physically as well.

Senator Casey?

OPENING STATEMENT OF SENATOR ROBERT P. CASEY, JR., RANKING MEMBER

Senator CASEY. Chairman Collins, you can hear me, I hope.

[No response.]

Senator CASEY. I will assume that you are hearing me.

Chairman Collins, thank you for convening this hearing. Our Nation at this point in our history is facing the greatest public health crisis in a century. This terrible virus is causing death and destruction at lightning speed.

For seniors, the only thing that is moving faster than the virus itself is fear: the fear of being alone; the fear of contracting the virus; and of course, the fear that comes from isolation and that has every single member of the family worried, worried for our seniors.

Thousands of seniors in hospital ICUs and nursing homes are dying scared and alone, with no family and no friends to comfort them in their final moments. Millions of seniors more are at home, isolated from their loved ones and scared to death often to leave the house even to get a bag of groceries.

This unprecedented challenge calls for equally unprecedented action. The administration has to do more. Congress has to do more to help our seniors and our families at every turn.

It is now May the 21st, and we still have no national testing strategy from the administration.

The lack of personal protective equipment continues to put our health care providers and other frontline workers at risk. In turn, this puts every single person they come into contact with, and it also puts at risk the entire community.

Nursing home residents make up 0.05 percent of the population, and yet deaths associated with nursing homes and other long-term care settings account for over one-third of all deaths from COVID–

19, as Senator Collins just outlined, 0.05 percent of the population yet one-third of the deaths are nursing homes and long-term care settings.

Still to this day, we are trying to help those residents and workers in nursing homes with one hand tied behind our backs because the administration is not—is not releasing data on outbreaks in these facilities. This is unconscionable, and the administration needs to act.

We have heard promises that by the end of May, they will. We need to see specific evidence that they are changing policy to give families, residents, and workers in nursing homes and other long-term care settings more information.

Now, Congress has taken a number of steps, as Chairman Collins outlined. We have added unprecedented amounts of funding to purchase personal protective equipment to keep workers from contracting and transmitting the virus. We have funded efforts to help health care workers and health providers help patients in those settings. We have provided dollars to ensure that seniors have access to proper nutrition at home but not nearly enough.

The policies and funding in these four bills that we have passed into law only begin to scratch the surface. Congress has to do more.

Just last week, the House of Representatives passed the HEROES Act, and that legislation, among many things it does, calls for policies that I have been calling for since the beginning of this crisis, especially as it relates to seniors. It would require, the bill would, nursing homes to collect data on the impact of the virus on residents in nursing homes and other long-term care facilities so that we know how to distribute resources. The bill would also provide those nursing homes the dollars they need to contain the spread of the virus. The bill would also invest in home-and community-based services for seniors and people with disabilities, especially the 800,000 seniors and people with disabilities on waiting lists for care so that they can receive the services and the supports that they need to keep them out of congregate settings. This bill would also pay our essential frontline workers for leaving the safety of their home to care for our aging loved ones.

For the generation that has fought our wars and worked in our factories and taught our children and build the middle class, built the Nation that we have, and gave each of us life and love, we have to do more for our seniors. We cannot stop working. We cannot stop legislating. We cannot stop appropriating dollars to help our seniors. We owe it to them to do everything we can. There is no such thing here as doing too much for our seniors in the grip of this pandemic.

Chairman Collins, I want to thank you for convening this critically important hearing, the first hearing in Congress on the impact of COVID–19 on seniors, and I look forward to the testimony from our witnesses as well as the questions.

Thank you.

The CHAIRMAN. Thank you very much, Senator Casey.

For those of you who are watching us on C-SPAN, I want to explain that this room is specially configured in line with the social distancing recommendations of the CDC, which is why you see so many blank spaces, and again, we have several members who have

already joined us remotely. I see Senator Josh Hawley. I see Senator Rick Scott, and there are others as well, some more who will be coming physically as well. There are also many other members whose pictures I cannot see but who have joined us at the hearing. I wanted to explain that this is one of only three hearing rooms that is configured to allow us to hold hearings. I see Senator Blumenthal has also arrived, and I want to acknowledge him as well.

We are now going to move to our witnesses. Our first witness, Dr. Mark Mulligan, is joining us from New York University. Dr. Mulligan is the director of the Division of Infectious Diseases at the NYU Grossman School of Medicine, and director, as I have mentioned previously, of the university's Vaccine Center. He is a professor of medicine and a professor of microbiology at NYU. As the chief infectious disease specialist for NYU, he oversees the treatment of COVID–19 patients at the university's health system hospitals in Brooklyn, Long Island, Manhattan, Bellevue, and the VA.

Next, we will hear from Dr. Tamara Konetzka. Dr. Konetzka is a professor of health services research at the Department of Health Sciences at the University of Chicago. Her research focuses on the relationship between economic incentives and the quality of care in long-term care facilities. She is leading work to untangle factors associated with the disproportionate impact of COVID–19 on nursing home residents and staff.

Finally, we will hear from Dr. Steven Landers, the president and CEO of the Visiting Nurse Association Health Group. VNA is the Nation's second largest not-for-profit home health care organization in the country. Dr. Landers is a family doctor and a geriatrician with a special interest in home care, hospice, and palliative care. He focuses on home visits to low-mobility older adults and has played a critical role in caring for seniors during this pandemic.

Dr. Mulligan, we will begin with you. Thank you all for being here.

STATEMENT OF MARK J. MULLIGAN, MD, DIRECTOR, DIVISION OF INFECTIOUS DISEASES AND IMMUNOLOGY, LANGONE VACCINE CENTER, DIRECTOR, THOMAS S. MURPHY, SR., PROFESSOR, DEPARTMENT OF MEDICINE, NEW YORK UNIVERSITY GROSSMAN SCHOOL OF MEDICINE, NEW YORK, NEW YORK

Dr. MULLIGAN. Well, good morning, Chairman Collins, Ranking Member Casey, members of the Special Committee on Aging, and fellow witnesses.

I also wanted to mention I am an NIH-funded investigator working with the New York University Vaccine and Treatment Evaluation Unit, part of a new NIAID-funded network, focusing on infectious diseases, clinical research, and including work on seniors. This is a very important part of the work that I do as the clinical investigator.

This novel coronavirus emerged 5 months ago in China and rapidly led to the global pandemic that we now find ourselves combating. The human population, unfortunately, is highly susceptible; that is, we are non-immune to this virus. Most of us have been exposed to four distant cousins, seasonal co-viruses that are also

coronaviruses, but unfortunately, they do not provide cross-protective immunity against the current virus.

For physicians, scientists, and leaders, the virus has continued to humble us. There is so much we do not know yet about diagnosis prevention and treatment, about medical countermeasures that will keep us all safe, but that is an important part of what I will be discussing today.

Seniors are at increased risk due to the inexorable waning of the immune system, something called "immunosenescence." It is not only their age, however, that renders seniors less able to mount protective immunity against microbial threats, including this coronavirus. It is also the chronic health conditions that are present more frequently in seniors such as cancer; immunosuppression; chronic heart, lung, and kidney diseases; and diabetes. The highest risk for critical disease due to this coronavirus is seen in the frail elderly, those that reside in nursing homes and long-term care facilities.

The nurses, the doctors that I have worked with in the hospitals since late February taking care of patients are incredibly dedicated and caring. It is very moving to see how much they put into their jobs to help their patients, and yet, it has been a struggle. They have not had the medical countermeasures they have needed, particularly to help seniors fight this virus.

Certain work for residential settings with less effective social distancing, the long-term care facilities we have talked about, factories, have had the worst outbreaks of COVID–19, and we have heard that while just 11 percent of COVID–19 infections in the U.S. have been in nursing homes, one-third of the deaths or perhaps more once we get good data have occurred in nursing homes or nursing home residents.

Our main weapons to fight the virus continue to be non-pharmaceutical interventions, all of the social distancing. We know that these work, and they are effective, and they have provided a strong benefit to society and individuals by reducing spread of the virus. However, they come as a cost to the economy, to society, and to the human existence. Therefore, a very important additional category are the Medical Countermeasures, which I will now talk about.

A vaccine holds out the promise of immune-protection; that is, producing an immunity within our bodies that will protect us against the virus upon some future exposure with the virus. Safe vaccines have always been our most important weapons to battle infectious diseases with public health importance.

Just 2 days ago, the first early report of a COVID–19 vaccine appears, and thank goodness, it was promising. There is a long road ahead for development of safe, effective COVID–19 vaccines, but it was great to have a very positive early signal. Seniors will be included in the all-important efficacy trials that are planned to be supported by the U.S. Government.

However, the elderly do not respond as well to vaccines as younger adults do, so the approach of providing a monoclonal antibody as a pre-formed drug for treatment or prevention in seniors is one that is attractive. One U.S. Government and industry partnership that is under way is to move as quickly as possible with a randomized controlled trial of a monoclonal antibody that would be deliv-

ered to nursing home residents and nursing home workers in order to try to get control of outbreaks.

The highest-quality medical research comes from randomized controlled trials. They provide the answer: Does the treatment work? For one antiviral drug, remdesivir, preliminary information from a randomized controlled trial of remdesivir versus placebo in hospitalized COVID–19 patients, including seniors, revealed a modest benefit, a 31 percent reduction in time to recovery. This is modest but significant and a much needed first signal that we have an effective approach to begin to start to battle this virus.

Testing must be continued and increased. It provides a benefit. It allows us to identify those with infection. Until they recover, it can be isolated and thereby reduce further spread of the virus. The more we test, the more we can fight the virus.

I will close by saying that the non-pharmaceutical interventions we have deployed against the virus have been highly beneficial, and this remains doubly important for protecting our very vulnerable seniors as we await further development of medical countermeasures, including vaccines and treatments and broader testing. Medical countermeasures may need to be tailored specifically for seniors, given their differences in their biologies.

I thank the Committee for the excellent work they are doing.

The CHAIRMAN. Thank you very much, Doctor.

Dr. Konetzka?

STATEMENT OF R. TAMARA KONETZKA, Ph.D, PROFESSOR OF HEALTH SERVICES RESEARCH, DEPARTMENT OF HEALTH SCIENCES, UNIVERSITY OF CHICAGO, CHICAGO, ILLINOIS

Dr. KONETZKA. Chairman Collins, Ranking Member Casey, and distinguished members of the Committee, thank you for the opportunity to testify today.

My name is Tamara Konetzka. I am a professor of health economics and health services research at the University of Chicago, and I have been researching long-term and post-acute care for 25 years, often focusing on nursing home quality.

The central role of nursing homes in the COVID–19 pandemic has become increasingly clear. Just a month ago, nursing homes staff and residents were estimated to account for one-fifth of all deaths. The estimate is now at least one-third nationally and, as Senator Collins noted, more than half in many States.

In some ways, these high rates are not surprising. Nursing homes provide hours of hands-on care daily to large numbers of people with underlying health conditions living in close quarters. Facilities are often understaffed, a situation that has been exacerbated by the pandemic. Nursing homes compete with hospitals for both testing and PPE, which are still in short supply in many areas, but is the spread of COVID–19 in nursing homes inevitable, or have some types of nursing homes managed better than others to manage outbreaks? We set out to answer that question using data on nursing homes from 12 geographically diverse States.

We merged State lists of reported COVID–19 cases and deaths with data on nursing home characteristics, including data from nursing home house car, a five-star rating system published by CMS. We calculated the percentage of nursing homes with at least

one case or death by star readings, profit status, and several resident characteristics.

Our analysis revealed three key results. First, we found a strong and consistent relationship between race and the probability of COVID–19 cases and deaths. Nursing homes with the lowest percent white residents were more than twice as likely to have cases or deaths as those with the highest percent white residents.

Second, we found no meaningful relationship between the nursing home five-star ratings and the probability of at least one case or death. In fact, even the direction of the relationship was inconsistent from State to State.

Third, we found no difference between for-profit and nonprofit facilities and only a weak relationship with percent of residents on Medicaid.

We concluded from this analysis that while some nursing homes undoubtedly had better infection control practices than others, the enormity of this pandemic coupled with the inherent vulnerability of the nursing home setting left even the highest-quality nursing homes largely unprepared, and yet the pattern is not random. Nursing homes are often a reflection of the neighborhoods in which they are located.

Consistent with the pandemic generally, nursing homes with traditionally underserved, non-white populations are bearing the worst outcomes.

Turning to solutions, it is increasingly clear that long-term care facilities must be a top priority in fighting the pandemic, as that is where the deaths are, and we would suggest several short-term measures.

First, nursing homes need a direct influx of funding and technical assistance in order to achieve adequate numbers of staff, availability, and proper use of PPE, and regular and rapid testing of all nursing home residents and staff to enable separation.

Second, we need to enhance the ability of Medicaid beneficiaries to receive home-based services instead of institutional services. The decision between care at home or in a nursing home is difficult for families in the best of times. Now the risks and benefits have likely shifted. To best help families in this situation, resources need to be directed toward enabling them to avoid institutionalization during this high-risk time.

Third, data collection and transparency about cases and deaths are essential. Timely reporting enables resources to be directed where they are needed most, and at the same time, older adults and their families need this information in order to make their own best decisions, decisions that may be about life or death.

These short-term measures are urgent and necessary, but they do nothing to change the underlying systemic challenges to improving the quality of nursing home care and the lives of older adults who live in them. Nursing home residents are ill-equipped to monitor their own care, to advocate for themselves, or to exert political influence. This makes regulation and oversight necessary.

Some regulations have been relaxed during this pandemic, but it will be important to reinstate them once the crisis has passed, with increased attention to infection control practices, but the effectiveness of regulation is limited when the structure of nursing home

payment is fragmented, uneven, and leads to systematic underfunding of essential services.

Those of us who study long-term care are accustomed to hoping for fundamental change and not seeing it. One positive outcome of a severe financial fallout from the pandemic may be that it forces a fundamental reevaluation of how we pay for long-term care in the U.S.

Thank you for the opportunity to provide input on this very critical issue.

The CHAIRMAN. Thank you very much for your excellent testimony.

Dr. Landers?

STATEMENT OF STEVEN H. LANDERS, MD, MPH, PRESIDENT AND CEO, VISITING NURSE ASSOCIATION HEALTH GROUP, HOLMDEL, NEW JERSEY

Dr. LANDERS. Good morning. Chairman Collins, Ranking

Member Casey, members of the Senate Committee on Aging, I am Steve Landers. I am a family doctor and geriatric medicine physician. My clinical work focuses on house calls to homebound seniors, and I serve as the president and chief executive officer for Visiting Nurse Association Health Group. We are a large nonprofit home health and hospice agency headquartered in New Jersey, and we serve parts of Ohio and Florida as well.

Our team of 3,000 dedicated caregivers, they have really stepped up during this crisis to help medically fragile older adults come home from hospitals and nursing facilities and, in some cases, never have to go in the hospital in the first place.

We serve 9,000 people in our programs and services, and we have taken care of over 650 older adults in the home care setting with known COVID–19 infection. I have never seen the system so stressed and at the same time never felt more proud of the incredible people that I work with every day.

One of the reasons we have been able to keep serving has, frankly, been because of Chairman Collins and colleagues, your leadership, in the CARES Act, the provider relief fund. Some of the measures that CMS have taken have been important because our revenues have gone down because of the cancellation of elective medical procedures, and at the same time, expenses related to personal protective equipment, or PPE, testing, those expenses have gone up, so that financial support has been critical.

I want to thank you, Chairman Collins and colleagues, for your leadership, advancing the role of nurse practitioners and physician assistants in home-based elder care. Homebound older adults have had limited access to medical care. COVID–19 has made it even harder, and that extension of the team with the nurse practitioners and physician assistants is very important in preserving access, and also the other measures related to the geriatric workforce that were in the CARES Act are very important.

I have been reminded again of the incredible difference that home health and hospice can make on quality, compassion, patient safety, and we have seen the stress that hospitals in terms of bed capacity, emergency rooms, nursing facilities, the challenges that they faced and it is highlighted, the need for a strong home care option, an option to home care really when it is at its best working

in concert with hospitals, physicians, and nursing facilities to deliver coordinated care.

In order for us to provide that option, job number one, is protecting our treasured frontline caregivers. We have been able to maintain care because we have been able to maintain a supply of PPE. Now, that has been incredibly difficult to do. We are using, in my organization, 17,000 surgical masks a week, 3,500 N95s a week, thousands of isolation gowns and goggles, and we have to pay seven to ten times the normal price and use vendors really from all over the world that we could not always vet and verify, just hoping the shipments would arrive, so going forward, I would encourage us to look at policies that could make sure home health agencies have the needed PPE at a reasonable price, also important to our ability to serve during this crisis has been our spirit of innovation. We have really embraced the use of telehealth and virtual visits within our home health agency in order to help people stay safely at home during this crisis.

For the COVID–19 home-care patients, they need monitoring of vital signs, oxygen, and respiratory assessment, and so even though home health agencies are not reimbursed for telehealth, we felt that that was important.

We also had seen even before this crisis that telehealth could play an important role in home health, and we have been trying to advance that. I think going forward, to make sure we have a strong home health option for older Americans, that finding a way to reimburse telehealth services within home health agencies is really important, also preserving the ability for physicians and nurse practitioners to do the face-to-face encounter and certifies people for home health via telehealth is really important.

I really thank you for including me in the hearing this morning, and I am very sad about all the death and suffering but also optimistic that we can strengthen home care and elder care for older American, so thank you.

The CHAIRMAN. Thank you very much, Doctor.

I want to note that Senator Tim Scott and Senator Martha McSally have also joined us in person physically today.

What we are going to do, because there were many people who logged on at the very beginning, is we are just going to go in order of seniority. I cannot figure out any other way to do this, given the people who have showed up physically, but also the people who have been online at the very beginning of the hearing.

Usually, I would like to reward those who show up first, but I think since there were people online, as I said, I cannot figure out any other way to do this fairly.

Let me begin with my own questions, and then Senator Casey will question next remotely.

First of all, when we hear the statistics, which are so devastating, with half of the deaths in Maine being in long-term care facility, a third nationally, my heart just goes out not only to the patients, but to their families and to the staff of nursing homes and other assisted living facilities, congregate care settings. They are all praying that COVID–19 does not find its way into their facility.

Yesterday the Government Accountability Office released a report that found that nearly half of the more than 13,000 nursing

facilities surveyed had infection control deficiency citations in consecutive years, which the report called an indicator of persistent problems, yet as Dr. Konetzka said in her testimony, even the highest-quality nursing homes have been largely unprepared. What we have usually looked at, the ratings by CMS, the number of stars, has not proven to be a reliable indicator of which nursing homes are safest in this environment, and indeed, one of the worst outbreaks in Maine was at a nursing home that had five stars.

I think what we are learning is that health care providers are rethinking some of their initial assumptions, and that we need to think more about hospital discharge planning.

Dr. Konetzka, I want to have you expand a little bit more on what we can do. I believe that you recommended universal testing for every nursing home resident and staff, which I think is a good idea and have been recommending. How often, however, would you have to do that, and would that allow family members who have been tested to finally be able to visit their loved ones?

[No response.]

The CHAIRMAN. I hope we can unmute Dr. Konetzka because I can see that she is responding, but we cannot hear her.

Doctor, go ahead.

Dr. KONETZKA. Can you hear me?

The CHAIRMAN. Yes. Thank you.

Dr. KONETZKA. Okay, great.

Yes. Thank you for that question. I think that we are learning a lot as we go about how best to fight this virus in nursing homes, and so we do not have, unfortunately, great data yet on exactly what testing strategies have been used and how successful they have been. A lot of what we are going on is anecdotal evidence, but what I can say is that there have been a few key lessons learned.

One is that it is very important to test all residents and not wait until residents are asymptomatic—I mean until residents are symptomatic because by then it is too late. There is asymptomatic spread, and given the close proximity and the fact that staff go from resident to resident every day, the virus, until people get symptomatic, can spread throughout the facility, so we have learned that lesson, that all residents really should be tested, and not only tested but tested regularly.

What I have heard from geriatricians is, generally, weekly would be good, at least biweekly, so that residents can then be separated, and the transmission can be stopped.

I think it might be very hard especially as we relax some of the restrictions on visitors, which is essential, as you mentioned, essential to prevent the sense of social isolation among our seniors. As we lax those restrictions, it is going to be very hard to prevent all cases in the nursing home. The key then is sort of a rapid response to prevent transmission to the rest of residents and staff.

The CHAIRMAN. Thank you.

Dr. Landers, I appreciate you talking to us about the importance of home care, and that can help people be safer. I have always been a strong supporter of home care.

One issue that we have is that people who are older are being increasingly isolated, and that too can have a very detrimental im-

pact on their underlying health and, thus, make them more vulnerable to the coronavirus.

Could you comment on how home health visits can help keep a senior more connected and less isolated?

Dr. LANDERS. Chairman Collins, absolutely, home health is a way to show people that they are known and worth something, that they are valued. It is an act of humility, really, and in this crisis, it has been even more important. Sometimes our nurses are the only people that are even checking in on a frail elder, and I have heard them tell stories of having to kind of go out and make sure that the person had a food supply or undergarments or other things that are essential, so the isolation is critical.

I think your focus on telehealth also adds, although it is not perfect, making sure that those people that are homebound and need home health also have access in between the visits to some interaction via telehealth but also improve the amount of attention that our older patients are getting. It is a really crisis in sort of loneliness and isolation, so we are trying to do all we can.

The CHAIRMAN. Thank you.

Senator Casey?

Senator CASEY. Chairman Collins, thanks very much.

I wanted to start my questions with Dr. Konetzka. I have a particular question for Dr. Konetzka regarding nursing homes.

We know that nursing homes have become, unfortunately, Ground Zero in this pandemic, and yet there is still no national strategy. I believe and I think the testimony today indicated in part that there is still an insufficient supply of personal protective equipment for nursing home staff. These are among the heroes in our society, literally soldiers on a battlefield in a war against the virus, and they are putting themselves at risk for the disease, contracting the virus. They are also putting themselves at risk for death itself, and that includes their families. The word "hero" definitely applies to these health care workers.

They need, I believe, simply more leadership out of the administration and Congress, more help. They do not need pats on the back only and expressions of gratitude and acclamation. That is nice. What they need is direct support and more than that.

I will start with the support for what they do on the job. The most important thing, one of the most important things we can do is to help them implementing what the public health experts tell us are proven practices.

I have been asking the administration, first and foremost, for data. The Centers on Medicare and Medicaid Services and CDC, of course, are the ones that would have to transmit this data to the American people. We are talking about basic information on case counts, basic information on deaths, so that we can direct and target the resources to the nursing homes that need it the most.

Now, they have said, as I indicated earlier, that it is coming by the end of May, but we have been hearing that for a long time.

I have introduced legislation that would focus specifically on nursing homes and other long-term care settings. This particular bill, the Nursing Home COVID–19 Protection and Prevention Act, that I introduced with Senator Whitehouse and a number of our

colleagues has as its focus $20 billion in emergency funding to invest in what works.

We know that in nursing homes, if you have cohorting, you separate the residents with COVID–19 from those who do not have the virus. That is a good practice, but that costs money. We have got to help them with that.

Other uses for the dollars could be charging of medical expertise into a nursing home.

Dr. Konetzka, I would ask you, I guess, two basic questions. Why is it so important that we have basic data on COVID–19 in nursing homes? That is question number one, data and question number two is, What are some of the policies that we can use to help nursing homes put in place information, this information in the ample resources?

Dr. KONETZKA. Thank you, Senator Casey, for that question.

As I touched on in my responsibility, I think data and transparency are critically important in this crisis. I think often during a crisis, we are tempted to downplay the need for a collection of data and prioritize other actions, but it is essential in this case for three main reasons.

One, we do need to know where resources need to be directed. We know where there are outbreaks in nursing homes. We can direct resources to them, but we can also identify the communities in which the virus is probably spreading.

Second, as we look back on this crisis, we need data in order to do the hard research to figure out what works and what did not work so that we can make better policies in the future, and, third, consumers and their families really need to have this information. Anybody looking for a nursing home placement right now or worried about their loved one in a nursing home right now really needs to be able to know what is going on in a very timely way so that they can make their best decisions.

In terms of the exact resources, I think a lot of it is about staffing, and we have had a problem with chronic understaffing in nursing homes, and the kind of resources that could help most on an emergency basis for a facility that has an outbreak is to strategize to ensure enough staff. This means providing paid sick leave. This means providing adequate PPE, basically putting nursing home staff on a par with what we naturally want to provide for hospital staff. It is the same situation.

Senator CASEY. Well, thanks very much.

I know I am almost out of time, and Chairman Collins has been generous with our time.

I will just ask Dr. Landers a quick question about our frontline heroes. A number of us in the Senate—and I know this is true in the House as well—have made it a focus to create a Heroes Fund, some manifestation of our gratitude for those who have put themselves at risk on the front lines.

I know that in the case of Dr. Landers, I am told that you have, in fact, kind of stood up and taken a lead on this, that approximately 50 of your employees have volunteered to help care for patients who have tested positive for COVID–19, and I understand in recognition of their work, you are providing these individuals with additional compensation, so we commend you for that.

I guess the basic question is simple. It is a yes or no answer. If the Federal Government provided you with the option to receive funding to provide what we can pandemic premium pay for essential workers and the work they have done in this pandemic, would you apply for the funding?

Dr. LANDERS. Senator Casey, thank you.

Yes, we are trying to do all we can to support our frontline heroes, and if there is something we were eligible for and the criteria were appropriate, we would certainly do so.

Senator CASEY. Thank you.

The CHAIRMAN. Thank you.

Senator Tim Scott?

Senator TIM SCOTT. Thank you, Chairman Collins, Chairwoman Collins. I will say this. Your leadership, Chairwoman, has been spectacular.

The CHAIRMAN. Thank you.

Senator TIM SCOTT. From the aging community to the Paycheck Protection Program and to this hearing, you consistently show up for the seniors in Maine and the seniors in America, for the small businesses. How you accomplish all that you do, I am not sure, but you are one of the hardest-working, most dedicated public servants I have met. Thank you for this hearing and the opportunity to discuss this incredibly vital issue of protecting our aging communities, which I am closer and closer being a part of, so thank you very much.

The CHAIRMAN. Thank you so much for your kind words.

Senator TIM SCOTT. To the panel, I will just say this, that without any question, if you are in South Carolina or most of our States, what you will realize very quickly is that those diagnosed with COVID–19 on average is just over 50 years old who are hospitalized, and those who die from the disease in South Carolina is just over 50—over 75 years old.

In fact, nearly 90 percent of fatalities in my State, South Carolina, have been from those over the age of 60. It is one of the reasons why I highlighted Senator Collins' dedication to this issue because one-third of all COVID–19 deaths in South Carolina happen in a nursing home or another senior care facility. This is an incredibly important issue and an incredibly timely hearing.

In other States, the numbers are even worse than in South Carolina. That said, there have been some encouraging numbers recently, and our Governor in South Carolina and, frankly, Governors around the Nation—I would like to highlight the Governor in Florida as well, DeSantis, who decided to focus the attention on the nursing homes. It is exactly where we should start this challenge, of how we should face this challenge, by focusing on the most vulnerable populations.

I have often thought about how important it is for us to recognize that nursing homes are the epicenter of activity. The folks who take care of the patients are disproportionately minorities, African Americans, who have perhaps the second most vulnerable population in our Nation.

If you think about States like Louisiana, where 70 percent of the deaths are African Americans, only 33 percent of the population; in my home State, 53 percent of the deaths, African Americans, only

27 percent of the population, so you have one vulnerable community being served by another vulnerable community, and that only highlights the importance of testing, testing, testing in our nursing home facilities.

I am thankful that in South Carolina that the 40,000 nursing home residents will be tested between now and the end of June. I am thankful that in South Carolina, we will have over 220,000 tests completed in May and in June of residents of South Carolina, 60,000 already tested so far this month.

These are encouraging numbers, and it is one of the reasons why I have introduced legislation to make this the model for the Nation, that our Nation should take serious, testing first in our nursing homes and providing more resources for the vulnerable populations in this country.

Along those lines, I have encouraged HHS to set aside a robust share of the Provider Relief Fund that we appropriated through the CARES Act along with $25 billion that we dedicated to testing specifically for nursing homes and community residential care facilities. They need the resources, the supplies, and tests as soon as possible.

My question to the full panel, beyond funding, what steps should we be taking at every level of government to help these providers and communities develop the tools and strategies necessary to detect, isolate, and address cases where they occur without straining existing resources by increasing administrative burdens?

Dr. KONETZKA. If I may answer one part of that, I think in addition to funding, technical assistance to nursing homes is essential because I think sometimes just providing the funding for it does not mean that nursing homes will necessarily know what we are learning about the best practices in terms of actually stemming an outbreak.

I think to the extent that local public health departments, State organizations can provide technical assistance and as well as the funding and the resources like surge teams to stem an outbreak, that would be helpful.

Dr. MULLIGAN. Senator Scott, I was just going to add that the importance of clinical research in seniors in nursing homes, educating families, because they are often legally authorized representatives, about clinical research, everything in our medicine cabinet is there because we have conducted clinical research, and we absolutely need to include seniors in our vaccine trials, which we will be launching in large numbers in July, as well as in special senior-focused studies, such as the monoclonal antibodies, to go into nursing homes and provide this option to participate in research.

The CHAIRMAN. Thank you, Senator.

Senator Gillibrand is joining us remotely, and she is next.

Senator GILLIBRAND. Madam Chairman, can you skip me? I am having a technical problem. I just need 5 more minutes, so do the next person.

The CHAIRMAN. Absolutely. Let me just check on your side of the aisle, and it is Senator Blumenthal, who is right here.

Senator BLUMENTHAL. Thank you, Madam Chair. Thank you, Senator Collins and Senator Casey, for bringing us together on this supremely important topic.

I was listening to my colleagues, I could not help but remember last Monday when I accompanied Senior Pastor Patrick Collins in a ritual that he has done literally every morning. He places white flags on the lawn in front of the First Congregational Church in Greenwich, Connecticut, and I accompanied him last Monday as we together placed 69 new flags for each COVID–19 death in the State of Connecticut.

On Tuesday, the day afterwards, Pastor Collins placed 41 more flags, yesterday 23. Right now, literally as we hold this hearing, exactly to the moment, Pastor Collins is almost certainly placing another 57 new white flags, adding to this sea of markers in front of the First Congregational Church in Greenwich.

Every one of those flags represents a life and the thousands of lives lost around the country. Seventy percent of them are seniors, seven in ten, and many are in nursing homes, so the obligation that we have to these vulnerable individuals is brought home very dramatically and graphically by that picture worth a thousand words, literally.

That is why I have supported the hazardous duty pay, the Heroes Fund for our nursing home workers, who all too often are risking their lives and making financial sacrifices, and it is more than just rewarding or recognizing them. It is also to retain them and to recruit new nursing home workers.

Let me ask, first of all, Dr. Konetzka a question. Is not it a fact that all too often, the employees of these nursing homes are underpaid for the risky and back-breaking work that they do?

Dr. KONETZKA. That is exactly right. Nursing home workers, especially nursing aides, are generally paid minimum wage, often have no paid sick leave, and often have no health insurance. It is natural that in normal circumstances, nursing homes have a hard time staffing adequately, but under these circumstances where staff are also afraid to get sick, afraid to bring the virus home to their families, or on the other hand may show up to work because they do not have paid sick leave, even though they are feeling ill, I think that all contributes to the issues we are seeing in nursing homes and the understaffing problem in particular.

Senator BLUMENTHAL. One of our nursing homes run by a friend of mine, Tyson Belanger, provides living facilities for the nursing home employees on the premises, so they are protected. They have to live away from their families, but they are sealed away from possible infection. The result has been to greatly reduce the incidence of infection.

Is that kind of innovation, Dr. Konetzka, a possible promising route that others should follow?

Dr. KONETZKA. Yes, certainly. I think that nursing home workers should have the option of having a different place to stay, whether that is provided by the nursing home or, like many cities have done for hospital workers, perhaps providing them with unused hotel rooms, so that they have the choice of not risking infecting their families.

Senator BLUMENTHAL. Tyson Belanger, by the way, happens to be a veteran, having served multiple tours in the Afghanistan and Iraq Wars.

I have introduced legislation with Senator Booker. It is called the Quality Care for Nursing Home Residents and Workers During COVID–19 Act. It would immediately address some of these same problems, not just more testing. In fact, it would require weekly testing of every resident and testing before every shift for health care workers. It would mandate that all health care workers have sufficient PPE and comprehensive safety training for dealing with COVID–19, and that each facility have a full-time infection control preventionist on staff to keep residents and workers safe. It would guarantee that sufficient staff is available to facilitate weekly virtual visits between residents and their families.

Those are just examples of the kinds of measures that I hope that may reduce the number of flags, those white markers that Pastor Collins places every morning in front of the First Congregational Church of Greenwich. We owe it to our seniors. We owe it to all of our families and all of their loved ones that we do better in our nursing homes.

Thank you, Madam Chair.

The CHAIRMAN. Thank you, Senator.

Senator McSally?

Senator MCSALLY. Thank you, Chairman Collins. I want to echo Senator Scott's comments about your leadership and your passion for seniors, for small businesses under your leadership in this unprecedented challenge, so thank you, and thank you for this important hearing and to our witnesses for their testimony.

In Arizona as of last night, there have been 747 deaths related to coronavirus, from the coronavirus, and 593 are over the age of 65, so that is about 79 percent.

As I think about this, this is a cruel virus, as we all know, and it is the cruelest to our most vulnerable, and this is the greatest generation we are talking about. this is our opportunity as we learn more about the virus. We did not know a lot about it, but as we are learning more about it, for us to do everything we can to protect the greatest generation. This is our generation's opportunity to give back to them and there has been an important focus on nursing homes for the vulnerable who are in these congregate settings, but we also need to think about those in memory care, those in assisted living, those who are older but in independent living.

My mom is 85. She is in good health for her age. She is in independent living, but she also has been isolated for now 2 months because she is just as vulnerable as others from this cruel disease.

I have neighbors and constituents who are sharing their stories of their loved ones who are in these settings, and we need to make sure that we protect them.

As I think about going forward—and it is not a choice of are we going to continue to protect lives or allow people to safely return to work. As we move forward, we can do both, but for seniors in congregate settings, we need to put a moat around them. We need to ensure that we have high levels of situational awareness, that anybody who goes to work there, supports there, or at some point visits there, that we know that they are not inadvertently bringing the virus in with them.

We now know, unlike several months ago, that people can asymptomatically be carrying the virus, so checking temperatures is not enough.

I thank you for the testimony today, but I want to look more broadly for all congregate settings. One of the challenges we have is where there is oversight of our nursing homes in Arizona, oversight from HHS, oversight at the State and county level, the independent living, the assisted living, they are usually private entities, and so they are trying to get PPE, trying to get testing. It is not an easy top-down thing to do with the supply chains.

We have had many innovations in Arizona. One company I visited, AmSafe, used to make seatbelts and airbags for airplanes. They just started making masks and gowns to support our nursing homes in Arizona. It is just an incredible story. More of that needs to happen. We need to bring the PPE manufacturing home.

I want to ask Dr. Konetzka, can you share broadly, if we are looking at all seniors in these congregate settings, what does it look like for us to keep that moat around them? I think it is our testing needs to be focused on staff and ideally visitors and others who are going to go in there and high levels of situational awareness, plus the controls that we have learned to isolate and be able to treat quickly but what does that look like, not just for nursing homes, but for everyone who is in this vulnerable category in a congregate setting?

Dr. KONETZKA. First, thank you very much for that question because I think there is a tendency to focus only on nursing homes, and in many States, assisted living facilities look very much like nursing homes in terms of the level of care needed and provided and the vulnerability of the residents, and yet because assisted living facilities are licensed by States and do not receive generally a lot of Medicaid or Medicare funding, we sort of tend to ignore them in these situations and yet they are completely just as vulnerable.

I think your question about the social isolation in these settings, not just assisted living, but also independent living, is a huge challenge. I think the at the riskiest time when we have to prohibit visitors, some things can be done in the meantime like making sure that these facilities have appropriate technology so that residents can at least communicate through Facetime or other video chats with their families on a regular basis.

In the longer run, I think it is essential for all the reasons that you and others have mentioned that we do worry about the social isolation and start allowing visitors, and that is one of those things that I think we will learn as we go in terms of how much is too much, but that balance has to be struck. We have to limit that social isolation even as we try to stem the virus.

Senator MCSALLY. Thank you.

I know I am over my time, but I also want to say this. Isolation, I have heard cruel story after cruel story—the virus is cruel—of people fighting for their lives alone and the amazing nurses who are with them, but not with their loved ones and family members, people taking their last breath alone without their loved ones and family members, not being able to even be there for their funeral. We have got to be able to focus on allowing people when we can

as quickly as possible to be with their loved ones safely during these times so that they can be there.

It is impactful not just for the senior, but also for the other family members who feel helpless, so working together, we have got to address this issue to allow people to safely be able to visit at the right time.

Thank you. Thank you, Madam Chair. Thank you for your grace.

The CHAIRMAN. Thank you, Senator.

Senator Gillibrand has fixed her technical problem, and she is next.

Senator GILLIBRAND. Thank you, Madam Chairwoman. I appreciate this hearing very much.

In my State of New York, the most terrible horror stories are coming out of our nursing homes, and a lot of the people who have lost their lives have lost them in nursing homes.

One of the concerns I have is for the workers who work there, and if we had had national paid leave in place at the beginning of this, then any worker who had to take care of a family member or was sick themselves or had a child home would have been able to keep their job, keep their health care, and take up to 3 months leave, so that the length of the schools being closed or the length of an illness or sickness within their family, and without that, we have no safety net that would structurally be there for our workers when they have this kind of emergency, and this pandemic is a perfect example of how it could have been used more effectively.

I want to ask Dr. Konetzka, do you agree that if workers, especially nursing home and home health workers, were allowed to consider their health or the health of their families by having access to a comprehensive paid leave program that that could better protect their patients and clients to slow the spread of the virus?

Dr. KONETZKA. I think a national paid leave program could help in a number of ways. I think in a broader sense, providing paid leave for health care workers and long-term care workers would allow them that flexibility, as you just mentioned. It would also allow perhaps other people the choice of taking care of their appearance or another family member instead of putting them in a nursing home, so I think it would affect all kinds of decisions at the margin.

Under this particular crisis, I think we would still have a staffing shortage because people leaving and having the paid leave to take care of family members as they need does not help with staffing in nursing homes, so I think there are two sides to that.

Senator GILLIBRAND. Yes.

The other concern I have is that our nursing homes are still struggling to get access to testing and PPE, and we know that nursing home workers and people they serve are among the most vulnerable around the country.

Both Dr. Landers' and Dr. Konetzka's testimony reinforce the need for an essential workers bill of rights to protect our essential workers, including nursing home and direct-care professionals during this public health emergency.

Every essential worker in our country should have access to safety and health protections. They should have access to frequent testing and PPE. They should have more robust compensation. They

should have paid leave. They should have universal sick days. They should have the kind of support that they deserve because they really are our frontline workers in this pandemic.

Dr. Landers, do you believe that the health outcomes for patients are improved? Do we have high-quality, well-paid, and well-protected direct-care professional workforces? and do you agree that we need Federal investment in direct-care workforce?

Dr. LANDERS. Senator, thank you.

The aging care, home care, nursing home care, it is all about people caring for people. That is really what matters. People need that tender loving care, and to the extent that we have a strong, well-trained, well-supported workforce, the outcomes are going to be better for patients and families. I do believe that, and I am concerned about the shortages, shortages of nurses in particular, because I hear our nursing schools are turning away half of the qualified applicants, even though we have 80 million aging older adults, so I am thankful that you and your colleagues are thinking about the workers.

Senator GILLIBRAND. I have one idea that I would like anyone to comment on. For the shortage of health care worker and home health workers and workers in nursing homes, one of the things I think we should be doing is having a health force, where we train a million workers in the next 2 months to do the contact tracing, to do the testing, and to do eventually vaccinations.

For any on the panel, do you think training up this health force in the next 2 months would be able to help us have health care workers for the future so you would not have shortages for people who work in health care for our older adults, whether it is in direct care or whether it is in an assisted living facility? You can each give an opinion on that.

Dr. MULLIGAN. Thank you, Senator Gillibrand.

I do think that having resources in place in advance of future crises is absolutely what we need. What we find is if we are not ready ahead of time, when we chase our tails, so we do have to invest in advance in order to be ready when the crises come in the future, so having a group of young people who might then get very inspired by the work that they are doing and go on to become full-time, lifelong medical professionals, health care professionals, I think that is a very inspiring thought and something we should aspire to.

Dr. LANDERS. Senator, I think, absolutely, getting new people into the workforce in these caring fields is really important, particularly home health aides and personal care workforce. There is definitely a need for more people to enter that field.

Things like nursing, I mean, the nurses really are the keys to a lot of these teams, and we need really smart bachelor-prepared nurses, and that is something that is going to require more long-term policymaking, so that going forward that we are in a better position because those cannot be created overnight, same with primary care physicians and geriatricians, but in terms of the front-line personal care, funding could help with that.

Senator GILLIBRAND. Thank you.

Dr. Konetzka?

Dr. KONETZKA. I will just add that I think it is a really good idea for both the short term and the long term. It seems like something where it could help with the urgency of this situation to increase staffing in nursing homes and in home health, and it could help with the pipeline problem in that we just do not have enough people coming out of training programs wanting to work in long-term care and getting people interested early on. Even as we try to improve the working conditions so that they want to stay in it is a good idea.

Senator GILLIBRAND. Thank you, Madam Chairwoman.

The CHAIRMAN. Thank you.

Senator Braun?

Senator BRAUN. Thank you, Madam Chair.

I want to echo what Senator Scott said. I am on several committees here in the Senate, and I think the best hearings have been in this Committee because you generally pick a topic that needs to be talked about at that moment in time, so thank you.

The CHAIRMAN. Thank you.

Senator BRAUN. I have got several questions teed up. As a business guy and entrepreneur, when I look at trying to apply the skills that work there, generally, you need to be agile. You need to think out of the box. You need to do things differently if you are going to be successful in a market.

I am interested because we have made the case that disproportionately nursing homes have been impacted. What has been the rate of improvement in these few months that we have been grappling with it? Have we seen the rate of infections and deaths come down, or are we still at a level that I know is bad, but have we seen any improvement? and then the corollary with that would be, what best practices, what things have we seen in the successful nursing homes that would be maybe of key importance, one, two, and three? so has the rate improved, and then what best practices have surfaced in this time we have been tackling it?

Any on the panel, feel free to jump in.

Dr. KONETZKA. I will be happy to start with that.

I think the answer to your first question is we do not quite know because we do not have great data yet. Even for our study, we had to sort of pull State lists off the Internet and do a lot of data cleaning to make sure that we were analyzing something valid, and without the data to really know exactly where the infections and cases and deaths are, we will not be able to really answer that question.

I suspect we are still learning as we are going and that many areas will still see outbreaks in nursing homes.

For your second question in terms of best practices, I do think there are a few things we have learned, as I mentioned earlier. Testing everybody in a nursing home on a regular basis, to prevent asymptomatic spread, and then separating residents as possible into COVID-and non-COVID-positive parts of a facility, I think has been successful in many places.

Dr. LANDERS. Senator, I think that——

Dr. MULLIGAN. Senator Braun—go ahead.

Dr. LANDERS. I just want to say to the Senator that we are seeing in the home health setting over time that it seems like the

rates of infection of our treasured workforce, it does seem to becoming less common week by week. These are people working in the hardest-hit areas of northern New Jersey where we have seen some of the highest levels of infection in the country.

I do think week by week, the social distancing measures, the PPE, the expanded testing which still needs to expand further, but we are certainly in a better spot than we were in, in early March, where there was nothing, so we have a long ways to go, but the screening and education of the workforce, making sure they know when and how to ask for help and when to get them out of the workforce, and then also the testing programs for the workers is increasingly important.

Dr. MULLIGAN. I think, Senator, the only thing I would like to add—and this gets at the innovation piece—is the research, the clinical trials.

I agree with what my fellow panelist said about what we should be doing immediately in terms of implementing what appear to be best practices.

In addition, we have to invest in research as a Nation supporting the NIH and doing the clinical trials that will help us get out of this thing as a whole, but in doing that, we will support the seniors.

For example, one of the Senators talked about—Senator McSally—making a moat around our seniors. It made me think about herd immunity. If we can vaccinate the population broadly, even if seniors do not respond as well to vaccines, get the population immune. Then the workers who often bring the virus into nursing homes, this will not happen because they will have been protected and would not have become infected, so investment in clinical research.

Senator BRAUN. Thank you.

This one will be for Dr. Landers because I think as we debrief this over time, finding out what works, these best practices, but we have noticed that in Florida where arguably you might have the most vulnerable populations, is there something there that we can glean? I think the laboratory of States gives us a much better way to learn than maybe that one-size-fits-all site.

The CDC, when we first looked at testing, cost us 30, 40, 50 days because of that focus on just one way.

Is there something there in Florida that anybody can weigh in on? Dr. Landers, do you think that this will speed the move from nursing homes to home care over time? It seems like you are probably more safe in your home than you would be in a place that has got a lot of folks in the same building.

Dr. LANDERS. Thank you, Senator.

There is no question that there is increasing interest in home health care, and I have been in several living rooms, quite frankly, in the last couple weeks with families who have brought family members home from facilities to continue their recovery at home. They have been relieved and happy to get the home health and visiting nurse support, which is really critical for them being able to come home.

In terms of the differences in different locations, absolutely, there are—we have seen geographic variations, and we should try and

learn from those. Living in New Jersey, a lot of the people we serve actually travel between Florida and New Jersey. It is a fairly common consideration for snowbirds and such, and a lot of the questioning we have gotten has been around can people come back for their—you know, those people that are fortunate enough to be able to travel as such and is it safe.

We are all interconnected, but at the same time, there are differences. We will have to learn from this going forward.

Senator BRAUN. Thank you.

The CHAIRMAN. Thank you.

Senator Warren, I do not know whether you heard my opening remarks, but I do want you to know that I know I speak for every member of this Committee in expressing our condolences to you. You have been touched very personally by this virus, so welcome.

Senator WARREN. Thank you so much. I appreciate it, Madam Chair. You reached out to me personally right after my brother died, and he died in a comforted setting facility, in a rehab, so thank you. I appreciate it, and I very much appreciate that you are holding this hearing today.

In fact, what I want to talk about is I want to talk more about how seniors are bearing the brunt of COVID–19. Nursing homes have become the epicenter of the crisis, and it is important that we do everything we can, that there is testing and that there is contact tracing, and that we get a vaccine, and that we develop treatments.

One of the things we need to do is collect more data. I want to start by asking Dr. Konetzka, Why is it so important that nursing homes collect and report, in a timely manner and transparently, data about COVID–19 infections?

Dr. KONETZKA. I think it is critical for several reasons. One is just that we need to know where to direct resources. Nursing homes need help when they are having an outbreak, and so we need to know that right away. It also gives us a signal about what is happening in the communities in which nursing homes are located. Second, it will enable us to do research that will help us later figure out what worked and what did not work so that we can perhaps do better the next time. Finally, it is really critical for consumers. We have been encouraging consumers since 2009 to get on Nursing Home Compare and look at information for their nursing homes good care, but right now, they cannot easily find which ones have COVID outbreaks. We would like to give them that information so they can make good decisions.

Senator WARREN. Thank you. I think that is really important.

It is such a serious issue. In Massachusetts, for example, more than half of the COVID–19 deaths are directly linked to long-term care facilities.

Now, the Center for Medicare and Medicaid Services, the Federal entity that regulates nursing homes, is taking some important steps to ensure better data, and just last month, as you may know, CMS started requiring nursing homes to report new COVID–19 infections, outbreaks, hospitalizations, and deaths directly related and they have to report it to the CDC. Nursing homes also must notify residents and families of these infections.

Nursing homes are not the only facilities, long-term care facilities that have been hit hard by this pandemic. Roughly 800,000

Americans live in assisted living facilities. In Massachusetts, about two-thirds of assisted living facilities have reported COVID–19 infections.

Now, residents in assisted living facilities that serve older Americans require less frequent medical care than those in nursing homes and less help with activities for daily living, but populations in both places are similar, older people who need some help from caregivers in order to conduct daily tasks.

Dr. Mulligan, you have been serving on the front lines of the coronavirus pandemic. When it comes to the patients that you have seen, does coronavirus affect nursing home residents any differently from how it affects assisted living residents, or are people living in both settings vulnerable to the crisis?

Dr. MULLIGAN. There is no question that they are both very vulnerable.

I think the assisted living facility and even the community dwelling seniors are at equal risk. If you think about a third of deaths are nursing home residents, but 80 percent of deaths are in seniors, that means there is an equal number to the nursing home deaths that are outside the nursing home.

Senator WARREN. That is right.

Dr. MULLIGAN. Absolutely, Senator, you are correct.

Senator WARREN. Okay. That is really important.

The reality is this virus does not care whether seniors are living in assisted living facilities or living in nursing homes. It can affect them, regardless.

Let me go back to you, Dr. Konetzka. Are assisted living facilities required to report the same coronavirus information as nursing homes like report on infections or hospitalizations or deaths or outbreaks to the Federal Government and to the families and to the people who live there?

Dr. KONETZKA. No, they are not. Just like data collection and long-term care, generally, we do not collect much data from assisted living because they are not as dependent on Federal funding.

Under the CMS guidance, as I understand it, we are also not collecting information from assisted living facilities, which for all the reasons you mentioned is unfortunate.

Senator WARREN. Yes. Assisted living facilities have similar populations as nursing homes. They face similar infection risks, but they are not subject to the same regulations when it comes to the coronavirus, and that is why I have launched an investigation with Senator Markey and with Congresswoman Maloney into how assisted living facilities are tracking coronavirus infections and preventive measures at these facilities and whether they have enough preventive measures in place.

Assisted living facility residents and their families deserve to know whether or not their facilities are experiencing a coronavirus outbreak just like nursing home residents are entitled to know that, so I believe we owe it to our seniors to get this done.

Thank you all for being here today, and thank you again, Madam Chairman.

The CHAIRMAN. Thank you.

Senator Rick Scott had to leave and go preside. He had joined us remotely. Now we still turn to Senator Doug Jones.

Senator JONES. Thank you, Madam Chairman. Thank you very much for holding this hearing. I appreciate it, and thanks to all of our panelists for this very, very important hearing.

I kind of want to followup a little bit about not just the assisted living but nursing homes in particular. My mom is in an assisted living, so it has been a challenge for all of us and especially her over the last few weeks. We lost dad in December. The isolation has been a struggle. We lost dad to Alzheimer's, and I think it has been particularly tough on Alzheimer's patients and caregivers. Those forms of dementia create special problems, regardless, it has been said.

To listen to my mom, she has been talking every week. She will mentioned that as much as she misses my dad who she was married to for 70 years, she is also somewhat thankful that he passed before all of this pandemic hit. In part, I think that is because of the problems that she would have faced. She used to go down and visit him every day, and that is especially troubling.

My friend, John Archibald, who writes for al.com, wrote an article this week called "Coronavirus Creates a Special Hell for Dementia Caregivers," and he talked about trying to imagine what it is like for an Alzheimer's patient or caregivers. Imagine what it is like to try to explain social distancing to a person who does not share the reality, and he quotes Pam Leonard, who is a program director in Birmingham of the CJFS CARES program. She talks about caregivers and said that it is kind of like being on an airplane. You got to take care of yourself. You got to put on your own oxygen mask before you are able to help those around you.

I would like to get to anyone on the panel. Given the special and unique needs and challenges that we are seeing, what can we do to more support individuals with dementia, both in these facilities and out, and their families and caregivers, and are there special trainings that might be needed for any of these long-term care and dementia facilities in a situation like we are in now which we have not seen before, but we could see again?

I will open it to anybody.

Dr. MULLIGAN. Senator Jones, I really think that you have touched on something so important. I think as a society, we will always be judged by how we take care of the most vulnerable, and certainly, our dementia seniors at this point are among the most vulnerable. They are not able to express, for example. If they are becoming ill, they would not necessarily be able to express that they do not feel well, that they feel hot, that they are short of breath, et cetera. They have medical as well as the sort of psychological, emotional vulnerabilities at this time of this pandemic that are unique to them, I think.

I do not know that I have any specific answer for you, but I would encourage any effort to bring together a think tank to brainstorm about this. I think it is absolutely needed, and thank you for raising it.

Dr. LANDERS. Senator Jones, thank you for raising this critical issue, and I share your deep concern for the well-being of people living with dementia.

Actually, one of the sad parts about all this has just been hearing my staff explain what is going on when they are doing nursing vis-

its with older adults with severe dementia. In cases when they have had to do a test, those nasopharyngeal swab tests, for example, that has in some cases been fairly traumatic and upsetting even to do the test because the person just does not understand.

One thing in assisted living and independent living, because that has been a big topic in this hearing, we should point out home health agencies are able to come into those settings, as are hospice agencies in certain instances, to buttress the care in those facilities, so to the extent that we continue to have a strong home health option and focus on the things that Senator Collins is focused on around telehealth, I think that is going to strengthen dementia are and assisting living and also encouraging people to focus on goals of care and family caregiving plans also can help, but really tough issues we are facing.

Senator JONES. Great. Well, thank you. Thank you very much, both of you, for that.

Dr. Konetzka, real quick, as my time runs out, your research has indicated that racial and ethnic minorities and low-income individuals have been disproportionately affected with nursing homes that have larger minority populations, more likely to have coronavirus cases and deaths. I think there is an article about that also in the New York Times.

Could you briefly share more about what factors might contribute to those disparities?

Dr. KONETZKA. Yes. Thank you for that question.

Disparities in nursing home outcomes from COVID are not unlike disparities we see across the health care system, and it is the result of many years of differences by race in health infrastructure and resources and risk factors of populations.

What we found in our research was not necessarily that nonwhite residents were more—were having worse outcomes within a facility. It was about the percent white in a facility. To me, it is really about the neighborhoods in which nursing homes are located and staff going back and forth between those facilities and the neighborhoods.

I think it is a lot about where the virus is circulating and who is in those facilities and who is going back and forth.

Senator JONES. All right. Well, thank you, and thank you, Madam Chairman, for holding this hearing. It is very, very important. Thank you.

The CHAIRMAN. Thank you, Senator.

Senator Rosen.

Senator ROSEN. Thank you, Senator Collins, for holding this very important hearing. It is incredibly sad to see what is happening in our nursing homes and our assisted livings, what is going on with our caregivers across our country.

I was a caregiver for my parents and in-laws. I understand this from a firsthand perspective, and it is overwhelming, frightening, and frustrating particularly at this time.

One thing that I think we really need to focus on is research, research to fully understand how this virus works and how to best treat and prevent it. It is so critical.

I recently introduced legislation with Senator Rubio, the Ensuring Understanding of COVID–19 to Protect Public Health Act. It is

going to require a longitudinal study of COVID–19, including individuals of all ages along with diversity in race, ethnicity, gender, geography, underlying health conditions. We need to understand why the virus impacts some people like our seniors differently than others. We need to understand what the presence of antibodies really needs, if seniors or others who get sick gain an immune response or not.

That is the theory that they gain an immune response, but reports of groups of patients becoming ill a second time is really concerning, and there has been recent reports, of course, across that group of sailors on the USS Theodore Roosevelt getting reinfected.

Dr. Mulligan, I have a two-part question. Do you know what the latest research is, or can you talk about it, the latest research that is following patients who are diagnosed a second time with coronavirus, including seniors? this could have a further impact on our senior living centers. Do we know if this is a brand-new infection or if this is the original infection making them sick again, and what do you think this information might have? What impact might it have on vaccine development?

Dr. MULLIGAN. Thank you, Senator Rosen, for this question.

I do think that the jury is out in terms of formal proof that having recovered successfully, one is immune. Certainly, most people that recover make antibodies. We have seen that in our own studies, and many others have reported that.

With most viral infections, it is true that once you have had it, you are protected at least for a period of time. I personally expected that should be true here as well. The formal proof of that will be done in studies such as you described, and I think that is a fantastic study.

We are entering a time point where we have more and more convalescent patients, and now we can study how they do over time.

I think the jury is out on these reports of possible reinfections that may well represent an intermittent negative test than a positive test that occurred as a result of their original infection. We know that can occur. The test is not perfect, and so that would not surprise me if that was the cause of some of those, but the jury is out, and for vaccine development, it is the same. I am a scientist. I want to know what the evidence says. If we do our studies correctly, if we are well supported, we will get the truth. We will get the answer, and that is what science will do for us.

Senator ROSEN. I want you to also—in your testimony, you said that medical countermeasures may need to be tailored to seniors in order to optimally protect them. Would you expand on that a little bit in a minute or so that I have left, please? Give us some good examples.

Dr. MULLIGAN. Sure, I am very happy to do that.

Maybe the most prominent example is that we have a couple of special vaccines for flu for seniors. We have a high-dose vaccine. We have a vaccine with adjuvant. We know, as I said, seniors' immune systems are weaker, and they do not respond as well to vaccines. Having a stronger vaccine, one with an adjuvant, one with a higher dose, may be necessary for COVID–19 in seniors as well. We need to do those kinds of special studies.

We also want to be sure that treatments are tolerated well and are safe in seniors. Their system is different, and so we need to be sure to include seniors in our treatment studies as well as our vaccine studies.

Then another great example is the monoclonal antibody approach. If a senior cannot make a nice antibody themselves, perhaps we can infuse the antibody, this monoclonal antibody drug, and that is something that is going to be explored in the nursing home setting, and I think is very important.

Senator ROSEN. Well, I thank you and all the other witnesses for your work, your passion, your commitment. We really need you. We thank you all. We are very thankful you are doing what you are doing, and please stay well and safe. Thank you.

The CHAIRMAN. Thank you, Senator.

Dr. Mulligan, I want to followup on the questions you were just asked by Senator Rosen about your work on vaccines, and you have made the very important point that older adults sometimes do not respond as well as younger adults to vaccines, but that vaccines can convert this herd immunity that can help protect seniors.

You have also distinguished about different kinds of vaccines. Could you describe to us the two vaccine trials that I understand you are currently involved with and whether or not you have seniors enrolled in those trials?

Dr. MULLIGAN. Sure. Thank you, Senator Collins, for the question.

We are currently conducting a Phase 1 trial in healthy younger adults, age 18 to 55, with one candidate vaccine. As soon as we see in this trial that the vaccine is tolerated and safe in these younger adults, we will go to a second group, including seniors. It is not unusual in medical research to make sure in the first in human studies that the new treatment or vaccine is safe and well tolerated in healthier younger adults before you go to a more vulnerable population, which might be seniors or children or pregnant women. We will quickly move to seniors in the trial we are currently conducting at our university.

The second trial is a very large efficacy trial that will be launched in July supported by the U.S. Government, NIH, in collaboration with the vaccine that had the very promising early report, earlier this week with that company. That trial will be for adults aged 18 and older. From the very beginning, that efficacy trial will include seniors and will do so at a significant proportion. At least a quarter or more will be seniors as it is currently planned.

The CHAIRMAN. That is very encouraging to hear.

Could you also talk a little bit more and explain to us the fact that you could have the monoclonal antibodies approach? It is my understanding that when you give a vaccine, it is usually with a live virus, and then your body produces the antibodies that would allow you to fight off exposure to the virus later on, but if you use the—are you suggesting that an alternative approach is rather than injecting the virus, you would inject antibodies? Is that correct? Did I understand that correctly?

Dr. MULLIGAN. Yes, Senator, you did.

The standard approach is known as "active immunization." We deliver a vaccine, which might be a weakened virus. It might just be a protein, a piece of the virus. It could be RNA, as was reported this week, and we ask the body to produce a bit of the vaccine protein and make an immune response, make the antibody.

Seniors are not as good at doing that, and so an alternate is what is called "passive" rather than "active immunization." In that case, you actually infuse the antibody, and the antibody has a half life of a month. There are ways to tweak it where it could even last for a couple of months. It is an interim approach, perhaps, to get us through the worst of this where we could protect our very vulnerable seniors, and it has to be tested in a randomized control trial.

The CHAIRMAN. That is fascinating.

Where are those antibodies produced? Are they taken from individuals who have already had the coronavirus, or are they manufactured, if you will, in a lab? How are they produced?

Dr. MULLIGAN. Yes. Thank you. It really is fascinating.

I will give you one example. Actually, the first human in the United States to come down with coronavirus, his antibodies were cloned by a company and created—converted in a laboratory to a drug. You can mass produce the antibody molecules and then have that available for infusion into research participates in the future, so you take—and you pick an antibody, I should have said. You pick the antibody that is very potent at neutralizing the virus, so you pick basically the champion virus and then champion antibody, and then that becomes your monoclonal antibody drug for testing.

The CHAIRMAN. Very interesting. Thank you.

Senator Casey?

Senator CASEY. Madam Chair, thank you very much for the hearing and also for the brief second round of questions.

I just have two. I want to start with Dr. Konetzka. I had mentioned earlier the wait lists, the 800,000 individuals who are on waiting lists for both services and supports in their homes and their communities. I get that number from Kaiser Family Foundation. It is an awfully big number.

That number did not arise since the crisis began. That has been a number that predated the crisis, but I want to emphasize these are people on waiting lists that qualify for services but there is insufficient funding to provide those services.

We have some States, I know, that are increasing pay for direct-service providers, and that is one of the steps we should consider.

I have a bill that would encourage every State to do what some States are doing, which has served as a foundation for the enhanced matching dollars the Federal Government provides for Medicaid in their recent legislation.

Dr. Konetzka, can you explain the importance of addressing these wait lists for what is known as home-and community-based services in the context of the current pandemic?

Dr. KONETZKA. Thank you. I would be happy to talk to that.

First, I should note, though, that interpreting these wait lists is a little bit difficult. These are wait lists for home-and community-based care waiver programs under the Medicaid program, and each State does it a little bit differently, so 800,000 sounds like a lot,

but in some States, they just do not use wait lists. We may be underestimating the people who actually need services there.

In other States, they do not assess people for eligibility before putting on the wait lists, so the wait lists are huge in those States.

That aside, I think we can certainly agree that there are probably many more people who could benefit from these services that are getting them, and during this crisis, I think it is absolutely essential that we do what we can to try to enable more people to get those home-based services because the risks of entering a nursing home right now have just grown astronomically, so enabling more home-and community-based care right now may really save lives.

Senator CASEY. Thank you very much, Doctor.

The last question I have is for Dr. Landers. I just want to go back because I was jotting down numbers before, and I think I missed one of the numbers in your testimony. It is regarding the personal protective equipment, PPE.

You had indicated, I thought, that you needed for just a week, 17,000, and I was not sure what that was. If you could repeat those numbers, because one of the real failures—and this is a colossal failure—of the PPE is not simply that we have all kinds of instances where there is not enough in care settings, not to mention first responders and other circumstances, but what is going to happen in the months ahead? It is not just a question of what we need for this month or next month, and I think we do not have a sense yet of the numbers, the scale of the problem.

I guess I just wanted to give and provide an emphasis on one provider or one care setting and what you need.

Dr. LANDERS. Senator Casey, thank you.

Yes. Our current kind of "burn rate" is kind of the term that is being used in terms of how fast we are going through PPEs as a company is that just over 17,000 of the surgical masks and then over 3,500 of the N95 masks every week. When I look to our chief operating officer and chief financial officer who are responsible for procuring this stuff, that is kind of what they are trying to find on the market with various vendors. It still remains a challenge for them to track down enough vendors.

I am thankful that you are considering that going forward because it is an ongoing issue, and that is who we are able to continue to serve is by having that protective equipment.

I actually did a home visit. It was a little bit warm last week. I was in an apartment building that was not very well ventilated, and I was sweating, and I was realizing, oh, I need to change my mask because the mask is getting soaked, so we do have to remember that sometimes these get soiled. There is a lot of need there, and so thank you for looking out for that issue.

Senator CASEY. Thank you.

Thank you, Chairman Collins.

The CHAIRMAN. Thank you very much, Senator Casey, and I would second your concern about the availability of PPE for our home health agencies. That has been a problem in the State of Maine as well that I have been working on personally to deliver some PPE to our home health agencies. It is something that is very difficult for them to do their jobs without it.

I want to thank our terrific witnesses for being with us today and for their work and their research. It really makes a difference. I want to thank the staff for figuring out how we can safely hold this hearing and observe social distancing, which we did throughout.

I would note that virtually every member of the Committee joined the hearing either in person here in the hearing room or remotely, and I am very pleased with that. I think it shows how much people care about this issue.

I also want to give a special shout-out to the technical experts who made this possible. When you have that many Senators who are joining us remotely, Senators who are joining us here, and witnesses in three different places in the country, it is amazing to me that our technical experts were able to make everything go so smoothly, and I thank them.

This week, the overall death toll in the United States from the COVID–19 virus surpassed 90,000 people, 80 percent of whom were older adults. This means that we have lost more than 72,000 older adults to this pandemic.

At the beginning of this hearing, I remarked on the enormous challenges and tragedy that COVID–19 has brought to our country. It has also brought countless examples of great courage and selflessness from those on the front lines of this pandemic, including our medical personnel and our direct-care workforce, but they are not the only ones. We see it at the grocery stores. We see it with those who are stocking the shelves and running our gas stations and other essential businesses. We see it as those as I have seen in the State of Maine who are making the swabs in rural Maine that are essential for our testing. We see it all over our country as people step forward and businesses step up to convert their lines and do their part. I appreciate all of that sacrifice, that compassion, that effort.

I also want to pay special tribute to our witnesses today. I thought they were absolutely excellent and really increased our understanding.

Dr. Mulligan's leadership on vaccine development helps advance tangible medical countermeasures for those most in need, and I appreciated his giving us a great education today.

Dr. Konetzka's research helps us better inform our efforts to protect the residents not only of nursing homes but of assisted housing that our seniors have and other congregate care facilities.

Dr. Landers focused on home health care, which has always been a special passion of mine, and technologies such as telehealth which helps us to improve care of older adults in their own homes, and after all, that is where most older adults want to be. They want to be in the privacy, security, comfort of their own homes if they can be.

This Committee will continue to explore potential solutions to the challenges discussed in this hearing as well as other impediments to the health and safety of our Nation's senior.

This week, members of the Aging Committee introduced a resolution to designate this month as Older Americans Month. As we work to improve care for older adults amid this pandemic, we also should take the time to recognize our seniors as valued members

of our society, our culture, and our lives. The health and well-being of seniors strengthen our Nation as a whole and is the very mission of this Committee.

Senator Casey, I would like to call upon you for any closing comments.

Senator CASEY. Chairman Collins, thank you for convening this hearing on such an important topic, and I am grateful for the opportunity that we have had. I am certainly grateful for the testimony of our witnesses who bring to bear a degree of expertise and experience with these issues that are so important to families when it comes to caring for our seniors in all settings, and we are grateful that the witnesses are with us today, and I know there will be even more followup.

I do want to thank and reiterate what Chairman Collins said about the staff. This is a technical challenge, and they helped all of us through this. We are grateful for their good work, as we always should commend the staff in the Senate who do such good work and especially under these circumstances.

We also want to thank, of course, as we all have in one way or another, all of the health care and home health workers throughout the country, service providers as well, caregivers for caring for our aging loved ones all the time but especially during this terrible virus, which has caused such devastating across the country.

We owe all of those workers a debt of gratitude. I think we should do more than just say thanks. We talked about pandemic premium pay and other ways to reward their work because they are not just frontline workers. In many cases, they are at the front of the front line, exposing themselves and putting themselves at risk, and our Nation should reward them as we did returning soldiers from other battlefields in our history.

Congress has done a number of things to help seniors in the four pieces if legislation that have been passed, but I would argue not nearly enough, not nearly what we must do for our seniors. That is why we have to keep acting legislatively.

I am frustrated, as I know a number of Senators are, that we spent virtually the whole month of May on nominations and not voting on COVID–19 policy or appropriations, and unfortunately, we are going into June with that same setting or that same circumstance in the Senate. I think we should be voting—if we are going to be here and voting every week, we should be voting on COVID–19. That should be the top priority and, of course, the economic consequences that flow in the wake of this terrible virus, so we have more to do. We certainly need to do more on testing nationally. I think the administration should outline a strategy at long last.

We mentioned personal protective equipment for our frontline workers. We cannot talk about or work on this issue enough. There is just no way to comprehend that in a Nation as powerful as ours, a Nation that was able to produce the armaments and other production capacity to win World War I and all the wars in between, including World War II, the idea that that same Nation cannot produce enough masks—masks or gloves or personal protective equipment for everyone that needs it is really an appalling—it is an appalling failure and we have to worry about the next couple

of months. I know that as of eight o'clock this morning in the State of Pennsylvania, 64,412 cases, the death number in Pennsylvania is now 4,767. That is only for March, April, and May. I do not want to be sitting here in December because we did not do enough on testing and personal protective equipment and find out that another 4,700 or 5,000 Pennsylvanians have died.

We need the productive capacity, and we are not doing enough as a Nation. The Federal Government has to demand that we set forth the production capacity on PPE. If we could do it in the past to win wars, we can do it now to win this war, and the administration has to do a lot more to make sure we can produce what we need, so we have a long way to go, lots more work to do, lots more legislating and appropriating, but we are grateful, Chairman Collins, for this hearing and thank you for giving us this opportunity.

The CHAIRMAN. Thank you.

Committee members will have until Friday May 29th to submit additional questions for the record. If we do receive some, we will pass them on to our witnesses.

Again, I want to thank everyone for participating, and this hearing is now adjourned.

[Whereupon, at 11:35 a.m., the Committee was adjourned.]

APPENDIX

Prepared Witness Statements

COVID-19 and Aging

Mark J. Mulligan, MD
Director, NYU Langone Vaccine Center
Director, Division of Infectious Diseases
NYU Langone Health and NYU Grossman School of Medicine

May 21, 2020

A novel coronavirus

A novel coronavirus emerged 5 months ago in China, it rapidly led to a global pandemic. The human population is highly susceptible (non-immune) to this virus. Most of us have been exposed to the four seasonal coronaviruses that cause common colds – but these past infections are not producing immunity against this novel virus.

The new virus, called SARS-CoV-2, has shown dangerous potential to produce a serious illness, known as COVID-19. Globally, there have now been 4.8M infections and 318,000 deaths (6.6%). In the US, there have been 1.5M infections and 90,000 deaths (6%).

For physicians, scientists, leaders - this virus has continued to humble us – there is much we don't know about this new virus.

Aging population

Seniors are at increased risk, due to the Inexorable waning of the immune system – something call immunosenescence. It is not only their age that renders seniors less able to mount protective responses to microbial threats. It is also the chronic health

conditions that are present more frequently in aging persons: for example, cancer, immunosuppression, chronic heart, lung, and kidney diseases, and diabetes.
The highest risk for critical disease in seen in the frail elderly, e.g., those residing in long-term care facilities.
According to the CDC, 8 out of 10 deaths reported in the US have been in adults 65 years of age and older. The nurses and doctors I have worked with are incredibly dedicated and caring, but they have not had to medical countermeasures needed to effectively help many vulnerable seniors who have died of this disease.

Nursing homes

It has been observed that certain work or residential settings with less effective social distancing, e.g., long-term care facilities, prisons, factories, have had the worst outbreaks of COVID-19. It has been reported that while just 11% of COVID-19 infections in the US have occurred in nursing homes, one-third of COVID-19 deaths in the US have occurred in nursing homes.

Medical Countermeasures

Non-pharmaceutical interventions continue to be our main weapons to fight the virus. Social distancing, closures, hand washing, quarantine, isolation. These are effective and provide a benefit to society and individuals by reducing spread of the virus. However, they come with a cost to the economy. There is another category of interventions that are emerging: the Medical Countermeasures.

Vaccines

A vaccine holds out the promise of immune-protection: that is, producing within our bodies an immunity that will protect us against the virus in some future exposure. Vaccines have always been our most effective means to combat infectious diseases that threaten human health. Just two days ago the first early report of a COVID-19 vaccine appeared, and it was promising. Seniors will be included in upcoming large scale efficacy trials.

Monoclonal antibodies

However, the elderly do not respond as well as younger adults to vaccines, so the approach of providing a monoclonal antibody as a pre-formed drug for treatment or prevention in the elderly is one that is attractive. One effort is underway to move as quickly as possible with a randomized controlled trial of a monoclonal antibody for nursing home residents and staff.

Treatments – remdesivir

The highest quality of medical research evidence comes from such randomized controlled trials. They provide the answer: does the candidate treatment work? For one antiviral drug, remdesivir, preliminary information from a randomized controlled trial of remdesivir versus placebo in hospitalized COVID-19 patients revealed a modest benefit, a 31% reduction in time to recovery.

Testing

Continued and increased testing provides benefit: it allows us to identify and isolate those with infection until they recover and thereby reduces further spread of the virus. The more we test, the more we can fight the virus.

The future

The non-pharmaceutical interventions we have deployed against the virus, have been highly beneficial. And this remains doubly important for our vulnerable seniors, as we await further development of medical countermeasures. Medical countermeasures may need to be tailored to seniors in order to optimally protect them.

Testimony of R. Tamara Konetzka, PhD
Professor, Departments of Public Health Sciences and Medicine
Biological Sciences Division
University of Chicago

Submitted for the record at a hearing on:
Caring for Seniors amid the COVID-19 Crisis

Before the
United States Senate Special Committee on Aging
May 21, 2020

Chairman Collins, Ranking Member Casey, and distinguished members of the Committee, thank you for the opportunity to testify today on the topic of caring for seniors with long-term care needs during the COVID-19 crisis.

My name is Tamara Konetzka. I am a professor of health economics and health services research at the University of Chicago. I have been researching long-term and post-acute care for 25 years. I have been the principal investigator on numerous federal grants and published studies that explore the quality of nursing home care and how public policy might improve it, how Medicare and Medicaid policy influence care access and quality, and the health consequences of increased provision of services in home- and community-based settings. I also serve on the technical expert panel that advises the Centers for Medicare and Medicaid Services on the Nursing Home Compare 5-star rating system that publicly reports nursing home quality.

The Prominence of Nursing Homes in the COVID-19 Pandemic

The high rates of COVID-19 cases and deaths in nursing homes have attracted much media attention and public alarm. A *New York Times* article in mid-April referred to nursing homes as "death pits"[1] due to the seemingly uncontrollable spread of the virus through these facilities. At that time, nursing home staff and residents were estimated to account for one-fifth of all COVID-19-related deaths. Long-term care facilities are now estimated to account for one-third of deaths nationally and as much as one-half in many states.[2]

In some ways, the high rates of COVID-19 cases and deaths in nursing homes are not surprising: Nursing homes house, in close quarters, large numbers of people with multiple comorbidities who need hours of hands-on care on a daily basis. These realities of long-term care make social isolation impossible. Facilities are often understaffed and depend on Medicaid reimbursement for the majority of their residents. Existing staff gaps are exacerbated by pandemic-related absences for illness or child care. Thus, working staff members must often care for both COVID-positive and COVID-negative residents, increasing the probability of transmission.

Given asymptomatic spread and inadequate testing, staff often do not know which residents are infected. Nursing homes compete with hospitals for both testing supplies and personal protective equipment, still in short supply in many areas. With policymakers and the public initially focused on the spread of infection within hospital settings, nursing homes often lost that competition, putting both staff and residents at risk. These circumstances lend an aura of inevitability to the spread of COVID-19 in nursing home settings. Indeed, the first death reported was from a nursing home in Washington State that had a 5-star rating.

The challenges of avoiding the spread of the virus to nursing homes are exacerbated by the dual roles played by most of these facilities. They are providers of post-acute, rehabilitative care, and they are providers of long-term care. Although these two care activities may seem quite similar to the general public, the economics and the COVID-related risks are actually rather different.

Medicare pays relatively generously for post-acute care. The reality is that many nursing homes depend on these revenues to subsidize care of long-term care residents who are predominantly funded by Medicaid. The provision of post-acute care, however, involves shorter stays and more frequent interactions with hospitals, potentially increasing the risk of spreading the virus even if the post-acute care is not COVID-related. Directly accepting post-acute patients with COVID may help to sustain key relationships with hospitals but may simultaneously endanger vulnerable long-term care residents.

But is the spread of COVID-19 in nursing homes inevitable, or have some types of nursing homes managed better than others to avoid new infections from occurring? An early National Public Radio analysis[3] of selected nursing homes in New York suggested that facilities which serve a higher proportion of nonwhite patients were more likely to experience COVID deaths. Perhaps surprisingly, that study did not find the expected negative relationship between the probability of such deaths and nursing home quality, as measured by the Nursing Home Compare 5-star ratings. Because the analysis sample was small, incomplete, and limited to New York, it is unclear how such results may generalize to other states and populations.

Analysis of the Relationship between Nursing Home Quality and Covid-19[1]

In the past month, we set out to assess on a broader scale whether the pattern of COVID-19 cases and deaths in nursing homes appears to be random or connected to nursing home quality.

We used a sample of nursing homes from 12 geographically diverse states. We merged data from the Nursing Home Compare archives (for 2020 star ratings and some nursing home characteristics) and LTCFocus[4] (for racial distribution and percent of residents on Medicaid as of 2017[2]) with states' publicly available lists of long-term care facilities with reported COVID-19

[1] This analysis was done in collaboration with Rebecca Gorges, a doctoral student at the Harris School of Public Policy, University of Chicago, whom I thank for spending countless hours extracting state case and death lists and painstakingly merging them with the Nursing Home Compare data, in addition to providing substantive input.
[2] Although the LTCFocus data are several years old, the payer mix and racial distributions of nursing homes do not change substantially over this amount of time.

cases or deaths. We relied upon data released as of May 13, 2020, in twelve states that had released case counts and, of those, eight states that had released death counts.[3] For the case analysis, we analyzed a total of 5,527 nursing homes, of which 36% had at least one case. For the death analysis, we analyzed 3,461 nursing homes, of which 29% had at least one death. We calculated the percent of nursing homes with at least one case or death[4] by Nursing Home Compare star ratings, profit status, and several resident characteristics.

Our analyses revealed three key results:

1. **We found a strong and consistent relationship between race and the probability of COVID-19 cases and deaths** (Figure 1). Nursing homes with the lowest percent white residents were more than twice as likely to have COVID-19 cases or deaths as those with the highest percent white residents.

2. **We found no meaningful relationship between nursing home quality and the probability of at least one COVID-19 case or death**. We measure quality using the Nursing Home Compare overall star rating. On average we see only a marginally lower probability of cases for nursing homes with higher quality ratings (Figure 2).

   That overall finding masks considerable heterogeneity (Figure 3). In some states, such as Illinois, nursing homes with higher quality ratings (4 or 5 stars) were marginally *less* likely to have a case of COVID-19, but in other states, such as New Jersey, higher quality homes were marginally *more* likely to experience a case. Both the direction and strength of the relationship between star ratings and COVID-19 cases across and within states can best be characterized as inconsistent.

   The Nursing Home Compare overall star rating is derived from scores across three domains of quality: inspections, staffing, and clinical quality measures. The *inspections* domain is based on the results from roughly annual visits of state surveyors to each facility to monitor compliance with requirements for participation in the Medicare and Medicaid programs. This domain is weighted most heavily in the overall ratings and is often considered the most objective. While the inspections-domain rating is more predictive than the overall star rating, the magnitude of the difference is not practically meaningful. The staffing domain and the clinical quality measures domain are not predictive.

3. **We found no meaningful differences by profit status and only a weak relationship with Medicaid**. We found no significant differences in the probability of COVID-19 cases by profit status, with for-profit nursing homes and not-for-profit nursing homes being equally likely to have cases (36%). A suggestive but weak relationship was found for the percent of residents on Medicaid, with nursing homes somewhat more likely to have cases if they were more dependent on Medicaid.

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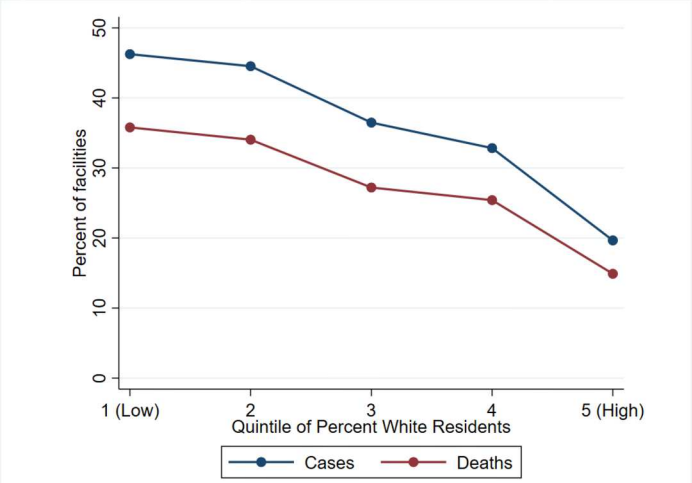
[3] Case counts drawn from CA, CO, CT, GA, IA, IL, MA, NJ, NV, OH, TN, and OK; death counts drawn from CA, CO, CT, GA, IL, NJ, NV, and TN.

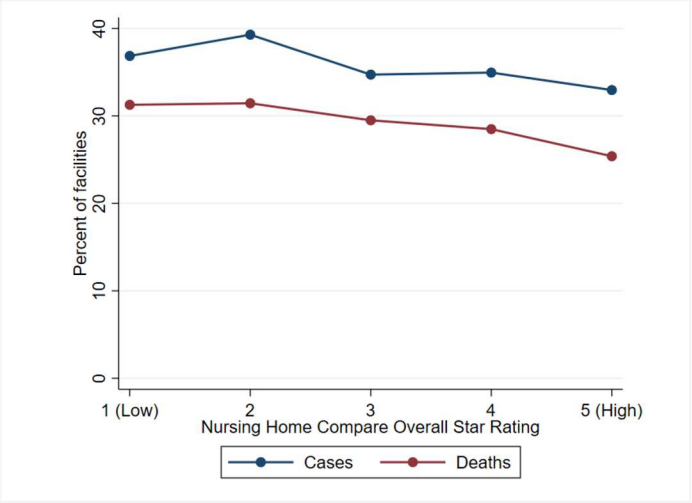
[4] We focused on the existence of at least one case or death as opposed to the number of cases or deaths because variability in testing and reporting practices makes the counts less reliable.

Figure 1: Percent of Nursing Homes with COVID-19 Cases, by Race



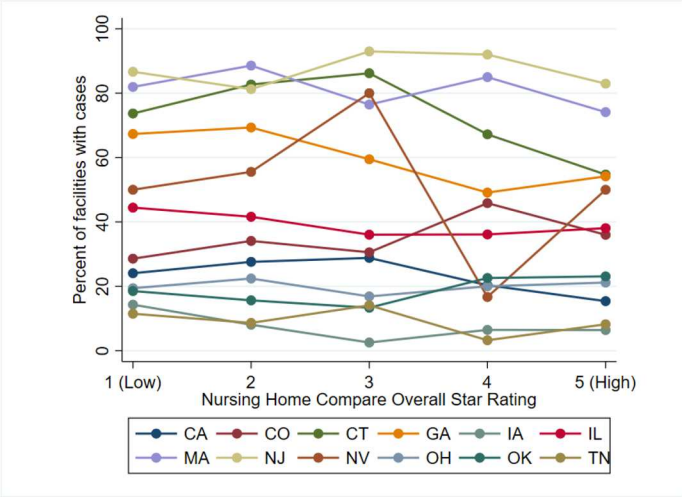
Note: The percent of nursing homes with at least one case based on CA, CO, CT, GA, IA, IL, MA, NJ, NV, OH, TN, and OK; the percent of nursing homes with at least one death based on CA, CO, CT, GA, IL, NJ, NV, and TN

Figure 2: Relationship between Nursing Home Quality and COVID-19 Cases and Deaths



Note: The percent of nursing homes with at least one case based on CA, CO, CT, GA, IA, IL, MA, NJ, NV, OH, TN, and OK; the percent of nursing homes with at least one death based on CA, CO, CT, GA, IL, NJ, NV, and TN

Figure 3: Relationship between Nursing Home Quality and COVID-19 Cases, by State



We conclude from this analysis that at least the standard quality measures do not distinguish which nursing homes ended up with cases and deaths. While some nursing homes undoubtedly had better infection control practices than others, the enormity of this pandemic, coupled with the inherent vulnerability of the nursing home setting, left even the highest-quality nursing homes largely unprepared.

And yet, the patterns of infections and deaths are not random. Consistent with racial and socioeconomic disparities in long-term care historically and in pandemic-related deaths currently, nursing homes with traditionally underserved populations are bearing the worst outcomes. Our results suggest that nursing homes serving nonwhite residents are most vulnerable to this pandemic. Because people who need nursing home care usually want to stay close to home, nursing homes are often a reflection of the neighborhoods in which they are located. Nursing homes serving predominantly non-white residents are more likely to be located in predominantly non-white neighborhoods and to draw staff from those neighborhoods. As these are the neighborhoods and the people being most affected by the pandemic, nursing homes in these areas are also most at risk.

Short-Term Measures to Reduce the Effects of the Pandemic on Nursing Homes

Given high rates of COVID-19 infection and death among long-term care facility residents and staff, reducing risk in long-term care facilities must be a top priority. I would place the most promising interventions into three categories: 1) Resources aimed directly at long-term care facilities; 2) Resources to enable prospective or current residents funded by Medicaid to receive services at home rather than in institutional settings; and 3) Requirements for data collection and transparency. I describe each of these in more detail below.

Funding and technical assistance resources aimed directly at long-term care facilities:

- *Regular and rapid testing of all nursing home residents and staff, symptomatic or asymptomatic*. Facilities must effectively separate COVID-infected and uninfected residents in order to prevent new infections. In the nursing home setting, test results that are delayed beyond (at maximum) a few days are not particularly useful, nor can facilities wait to test until symptoms appear. Separating residents into distinct wings or floors is ideal if possible. Transferring residents to separate facilities (established or temporary) should be considered, given urgent need to limit transmission, although there are known risks to transfer for frail older adults that must be weighed against the risks of transmission.

- *Adequate numbers of staff*. Adequate staffing is essential to achieving any reduction in infection risks in nursing home settings. Ideally, staff would be assigned to COVID-positive or COVID-negative residents and not go back and forth between them, which may require more staff than usual. Of course, understaffing in nursing homes was a problem long before the pandemic. Nurse aides, who provide the majority of direct care to nursing home residents, are generally paid minimum wage and often have no paid sick leave or health insurance. Registered nurses, who provide essential oversight and diagnostic functions as well as skilled care, would often rather work in hospitals which often offer higher wages and better working conditions.

  Even prior to the current emergency, nursing homes rarely possessed the staff capacity to address much milder challenges than those posed by the COVID-19 pandemic. Nurses and nurse aides in these settings also share many of the same vulnerabilities experienced by in the communities where COVID-19 is most prevalent. These staff members are predominantly non-white, low-income, and dependent on public transportation. Many live in families and communities with other essential workers who are unable to work at home and practice social isolation. These staff members are more likely to be sick, to have caregiving responsibilities for children or other family members, and to be facing financial hardship. Some fear showing up to work and risking contracting the virus. Other may come to work despite feeling symptomatic due to a lack of paid sick leave, fear of job loss, or a sense of dedication when staff are desperately needed.

  Under these circumstances, additional resources are critical. These should include paid sick leave, guaranteed coverage of health care costs, and hazard pay for nursing home staff. These may also include the use of hotel rooms for nursing home staff who do not want to risk infecting family members, similar to those provided for hospital staff in many areas.

It is also important to acknowledge the limitations of these measures. While improved pay, benefits, and lodging resources may help retain current staff, they may not suffice to recruit enough staff in time to handle a COVID-19 crisis. Thus, technical assistance in the form of temporary "surge teams" may also be needed to assist with measures to stem transmission and care for residents who are critically ill with COVID-19 may be necessary in many nursing homes.

- *Availability and proper use of personal protective equipment (PPE)* among nursing home staff, as well as related practices such as hand-washing. As is obvious from experience in the hospital setting, adequate PPE is critical to protect nursing home staff. As supply challenges begin to ease, nursing home settings must be a priority for these materials. Policymakers should not assume that hospital staff are in greater need than nursing home staff, as the level and duration of direct contact with COVID-positive patients may be greater for many nursing home staff. And having appropriate equipment is not always sufficient. Prior to the pandemic, inadequate infection control practices such as inadequate hand-washing and treatment of linens were the most commonly cited deficiencies by nursing home inspectors. Almost 40% of nursing homes were cited with inadequate infection control in 2017.[5] Thus, technical assistance may be necessary to ensure training in best practices in infection control.

Based on our analysis of nursing home cases and deaths, I would argue that all nursing homes and other long-term care facilities are in urgent need of this assistance. Such assistance should not be delayed by debates about which facilities could have been better prepared. There is too much at stake in terms of the lives and well-being of our most vulnerable older adults. If scarce resources must be prioritized, the most immediate assistance should be provided to nursing homes that serve primarily non-white residents where the risk of cases and death are the greatest.

Resources to enable prospective or current residents funded by Medicaid to receive home-based services in place of institutional services.

Older adults in need of long-term care and their families often face the difficult decision between receiving services in a nursing home setting or receiving services at home. Families must weigh the level of need against the availability of caregivers in the home, their level of comfort with the type of care needed, the potential effects on employment, physical stress, and emotional stress of caregivers, the costs of care, the ease or difficulty of finding in-home help, and the preferences of both the care recipient and other family members. In the best of times, this is a difficult decision.

Over the past few decades, Medicaid coverage has markedly shifted toward increased home- and community-based services (HCBS) rather than services in the nursing home setting. This shift has removed some previous constraints around this decision for Medicaid recipients. Whereas low-income people who depend on Medicaid for their long-term care used to have little choice but to move to a nursing home if they needed extensive assistance, now more than half of all Medicaid long-term care funding goes to HCBS, with substantial variation by state and county. Much of this shift has been achieved through Section 1915(c) waivers, which allow

states to provide long-term care services through HCBS as long as costs do not exceed those under nursing home care. However, the number of waiver slots is generally capped to control expenditures, such that the number of beneficiaries who want HCBS might exceed availability.

COVID-19 has changed the costs and benefits of this difficult decision for families. On one hand, the risks of entering a nursing home have increased substantially. On the other hand, care at home has also become more complicated. It may be more difficult to find home care workers who are willing to enter people's homes and risk infecting themselves and their families. Families of the care recipient may be reluctant to have regular interaction with home care workers who are likely caring for multiple patients. Care recipients in the home setting may also face higher risks of hospitalization. Thus, even as the risks associated with institutionalization are at their highest, the probability of institutionalization may be growing.

To best help families in this situation, resources should be directed toward enabling them to avoid institutionalization during this high-risk time. For Medicaid recipients, the clearest policy lever to achieve this is to expand HCBS waiver programs, to make home-based care feasible for as many families as possible.

Requirements for data collection and transparency.

At times of crisis, issues of documentation and data collection often seem secondary or trivial relative to the urgent priority of saving lives. Accordingly, recent temporary waivers by the Centers for Medicare and Medicaid Services of some documentation requirements in nursing homes seem reasonable. Yet at times of crisis, some data collection and transparency issues become paramount. It remains critical that states require timely reporting of COVID-19 cases and deaths and, in turn, that states make that data available to the public. This is essential for three key reasons.

- Timely reporting enables resources to be directed where they are needed most. Outbreaks of COVID-19 in nursing homes are often a signal of the communities into which the virus is spreading. This may be a starting point for contact tracing, and enables states to identify which nursing homes might need the most immediate assistance.
- Over time, such reporting will enable researchers to study the spread of the virus, connect it to the policy response, and establish rigorously what worked and what didn't work. This information will be crucial to learn from COVID-19 and to improve our reaction to the next pandemic.
- Consumers must know the status of nursing homes they might be considering for care or in which a loved one already resides. As noted above, older adults in need of long-term care face particularly difficult decisions during the pandemic, weighing the need for care against the risk of infection in each potential care setting. Ideally, data on cases and infections would be released in a more consumer-friendly form than now available. Many states that release data simply list the name of a nursing home or sometimes the name and the county. For our study described above, we could harness the skills and time of academic researchers to connect the state-released case and death data to Nursing Home Compare. This is not feasible or straightforward for the typical consumer who may want a fuller picture of quality and staffing in the home they are considering. A full facility name and address/ZIP code should be minimally required so that consumers can connect the case lists to Nursing Home Compare information.

I classified the above measures as short-term measures because they are truly urgent and necessary. They do nothing, however, to change the underlying, systemic challenges to improving the quality of nursing home care and the lives of older adults who live in them. Long-term policy changes are also required.

Long-Term Measures to Improve Nursing Home Quality and Reduce Future Risk

The quality of nursing home care in the United States has been a longstanding challenge. Although many high-quality nursing homes exist and meaningful gains have been made, low quality and understaffing remain endemic. Why are solutions to low-quality nursing home care so elusive? First, given their health status, nursing home residents are ill-equipped to monitor their own care, to advocate for themselves, or to exert political influence. Family members are not always available to advocate on behalf of residents.

Second, the structure of nursing home payment is fragmented, uneven, and leads to systematic underfunding of essential care. About two-thirds of nursing home residents are dependent on Medicaid to pay for their care, at payment rates that often are lower than the costs of care. To the extent that adequate staffing and meaningful quality improvement require resources, high-quality care may be out of reach for some nursing homes. This is particularly true of nursing homes located in poor neighborhoods, where the limited resources of the nursing home are matched with the limited resources of families.

Given these challenges, how can nursing home quality be improved, and the consequences of future health crises, such as another pandemic, be minimized? I briefly discuss two of the most common approaches below.

Is More Regulation and Oversight the Answer?

Given that nursing home residents are often unable to advocate for themselves, regulation and oversight are necessary. Some regulations and monitoring have been temporarily relaxed during the pandemic, but it will be important to reinstate them once the crisis has passed. Regulation and oversight play the critical role of attempting to set a quality floor, avoiding the worst instances of abuse and neglect.

At the same time, regulation and oversight are limited in their effectiveness. Despite vast resources poured into regulation and oversight of nursing homes and some successes, poor quality of nursing home care is still common. Raising the quality of the lowest-quality facilities has proved to be exceedingly difficult; in study after study, quality improvement efforts have led to average improvements without changes in the bottom tier.[6-8] Regulators are often reluctant to terminate the lowest-quality facilities if no alternatives exist in a neighborhood, prioritizing access over quality. For these reasons, I argue that *regulation and oversight are necessary but not sufficient* to improve the quality of nursing home care.

Prior to the pandemic, 40% of nursing homes were cited with deficiencies in their infection control practices.[5] Enforcement of these regulations did little to prepare nursing homes for the pandemic. New regulations to increase focus on infection control are clearly warranted, but in resource-constrained nursing homes, it may be a zero-sum game; better infection control may come at the cost of focus on other critical aspects of care.

Is More HCBS the Answer?

One potential solution to low-quality nursing home care is to have fewer people in nursing homes. The increased availability of HCBS as an alternative to nursing home care is undoubtedly a good thing. All things equal, most people would prefer to age in place and not move to a nursing home. But rarely are all things equal. Even with preferences to stay at home, as an individual's needs for help become greater and greater, families sometimes make appropriate decisions to place an older adult in a nursing home, decisions that should be construed neither as a failure of the family nor of the system.

Well-intentioned stakeholders often see HCBS and nursing homes as simply competitors for funding and advocate for a higher and higher proportion of funding to be allocated toward HCBS. However, the need for nursing homes remains. For individuals who might otherwise be in nursing homes, home-based care can also be risky, entailing more frequent hospitalizations.[9-11] We should wish for seniors that they be able to receive the care that they need in the right place at the right time, and sometimes that place may be a nursing home. We should fund HCBS, but we also need to fund nursing homes such that seniors can receive the care that they need if a nursing home admission becomes necessary.

Conclusions

Most potential solutions, including increased regulation and further expansion of HCBS, are inherently limited in the extent to which they can produce meaningful change in nursing home quality and preparedness for the rest of this pandemic or the next one. To solve the challenge on a more fundamental level, the structure and level of nursing home funding, or long-term care funding more generally, has to change. At least, Medicaid rates need to be substantially higher to address our chronic under-funding of this critical health care sector. At best, the fragmented system of state-specific payment rates and cross-subsidization from Medicare would be eliminated altogether, consolidating long-term care payment into one consistent program.

Those of us who study long-term care are accustomed to hoping for fundamental change and not seeing it. In this case, however, there may be a separate impetus to revisit the funding structure of long-term care. Much of the nursing home industry relies on private-pay revenues and Medicare reimbursement to stay afloat in the presence of large Medicaid populations. During the pandemic, at least in the short run, these revenue sources have diminished or disappeared. Elective surgeries in hospitals, a major source of lucrative post-acute referrals for nursing homes, have been put on hold in most hospitals. New private-pay residents, who can presumably afford alternatives, are more likely to avoid nursing home placement during the pandemic. If nursing homes cannot survive these negative revenue shocks, a fundamental restructuring of how we pay for nursing home care may be unavoidable.

Absent this more fundamental change, I expect there will be more regulatory focus on infection control, which may help marginally to institute better practices. Those nursing homes that are cited with deficiencies in infection control could benefit from working with Quality Improvement Organizations for technical assistance. The pandemic has made these issues suddenly less hypothetical, and approaches to this issue are likely to improve somewhat. The underlying challenges to improving nursing home quality will remain. But, hopefully, an emergency influx of resources will have addressed the immediate challenges of securing

adequate testing, staffing, and protective equipment to minimize further transmission of the virus and related deaths in nursing homes.

Thank you for this opportunity to share my thoughts and expertise on the critical question of caring for older adults with long-term care needs during the COVID-19 pandemic and beyond.

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Testimony of Steven H. Landers, MD, MPH
President and CEO, VNA Health Group
Submitted for the record at a hearing on:
Caring for Seniors amid the COVID-19 Crisis
Before the United States Senate Special Committee on Aging
May 21, 2020

Good morning! Chairman Collins, Ranking Member Casey, and Senators of the Committee on Aging, my name is Steve Landers[1], I am a family medicine / geriatric medicine physician and my clinical practice focuses on home visits to low mobility older adults. I also serve as President and Chief Executive Officer of Visiting Nurse Association Health Group[2], a large non-profit home health and hospice care agency that's headquartered in New Jersey, we also serve parts of Ohio and Florida. Our team of 3,000 dedicated caregivers has stepped up during the COVID-19 crisis[3], in spite of all the challenges and risks, to help medically fragile older adults get home from hospitals and nursing homes and in some cases we've intervened to help people never have to leave their homes in the 1st place. On any given day, our team has over 9,000 people under our care and we've served over 650 older adults with known COVID-19 infection. I have never seen the system so strained, but I also have never felt more proud of the skilled, compassionate, and courageous people I work with.

Chairman Collins and committee members thank you for your efforts that have made it possible for our agency to continue to serve through this crisis. The provider relief funding in the CARES Act has been critical to helping my organization stay financially stable, also important, have been several steps taken by the Centers for Medicare and Medicaid Services. These measures are important, as we have seen significant lost revenues due to the cancellation of elective medical care. While revenues have gone down, our expenses have gone up due to the dramatic escalation in expenses related to personal protective equipment (PPE), employee health resources such as testing and counseling, and expanded telehealth resources within the home health agency.

I also must thank you, Chairman Collins and colleagues, for the important measure within CARES Act that expanded the role of nurse practitioners and physician assistants in elder home health care—there is a shortage of geriatric medicine physicians and homebound older adults have poor access to primary medical care[4][5], the COVID-19 crisis has worsened this situation. The new authorization for nurse practitioners and physician assistants to order Medicare home health care is an important step in preserving access.

During the COVID-19 crisis I have been again reminded of the powerful difference that home health and hospice teams can make on the overall Medicare delivery system in terms of quality, compassion, patient safety and efficiency of care –the impact has been greatest when working in concert with physicians, hospitals and nursing facilities to provide comprehensive and coordinated care.. As we all know, the crisis has uncovered limitations to hospital and emergency room bed capacity, and has also uncovered the potential challenges of nursing facility-based care --highlighting the importance of a strong home care option.

For our organization to provide this home care option, job number one has been protecting our front-line caregivers, and we have been able to continue to serve because we have been able to maintain a supply of PPE. However, maintaining this supply has been incredibly challenging and expensive. We are using over 17,000 surgical masks and over 3,500 N95 masks each week and we are also using thousands of isolation gowns, gloves, goggles and face shields. We have had to pay 7-10 times the usual prices and reach out to vendors all over the world, vendors who we couldn't fully vet and verify, sometimes just hoping that shipments would arrive. For the future, I urge you to find ways to prioritize home health and hospice agencies getting needed PPE.

We have been also able to step up and make a difference during this crisis because of a spirit of innovation. The expansion of telehealth and virtual visits has been an important part of our services during this pandemic. Although home health agencies have no direct reimbursement for telehealth, we have found these tools to be an essential part of providing great care. The remote monitoring and virtual assessments of the vital signs, oxygen levels and other symptoms of COVID-19 home health patients has been critical to them safely remaining at home. We were already finding that telehealth could improve the quality of home care before the crisis, and COVID-19 has reinforced these benefits. I urge you to explore ways to expand telehealth within home health agencies to prepare for the next phase of the COVID-19 pandemic and to better address the home health needs of an aging population. I specifically recommend addressing the lack of reimbursement for home health agency telehealth services, and extending indefinitely the emergency measure that allows physicians and other providers to perform the home health face-to-face encounter via telehealth.

Thank you for this opportunity to be with you today and for the chance to share some of my thoughts and experiences about elder home care during the COVID-19 crisis. While I am saddened by the death and suffering, I am optimistic we can learn from these challenges and take steps to strengthen and improve home care for a growing population of older Americans.

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[1] Steven Landers biography
[2] About VNA Health Group
[3] COVID-19 visiting nurses home care: 'Extremely rewarding ... and extremely scary' Michael L. Diamond, Asbury Park Press https://www.app.com/story/news/health/2020/04/14/vna-covid-home-care-nurses-coronavirus-patients/2960746001/
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Questions for the Record

U.S. Senate Special Committee on Aging
"Caring for Seniors Amid the COVID-19 Crisis"
May 21, 2020
Questions for the Record
Dr. Mark J. Mulligan

Senator Robert P. Casey, Ranking Member

Question for Dr. Mulligan:

A significant health threat facing Americans today is the rise of antimicrobial resistance. This threat has been amplified by the recent crisis. In fact, a recent study indicates that "Based on limited data from case series, it is reasonable to anticipate that an appreciable minority of patients with severe COVID-19 will develop superinfections..." New antibiotics are needed to combat growing resistance, but there has been a significant decline in the number of companies investing in antibiotic R&D.

What should be done to encourage more industry investment and stabilize long-term development of novel antibiotics? Furthermore, does the current reimbursement system disincentivize appropriate use of novel antimicrobials?

U.S. Senate Special Committee on Aging
"Caring for Seniors Amid the COVID-19 Crisis"
May 21, 2020
Questions for the Record
Dr. Tamara Konetzka

Senator Doug Jones

Question for Dr. Konetzka:

Racial Disparities

Dr. Konetzka, as your testimony and analyses indicate, nursing homes with larger minority populations have a higher case and fatality rate of COVID-19 in their facilities as compared to those with a larger white population. Can you provide additional information on what contributes to these disparities?

At this time, responses are not available for printing. Please contact the U.S. Special Committee on Aging for further updates and to perhaps obtain a hard copy, if available.

Additional Statements for the Record

Statement for the Record

TO:

Special Committee on Aging

United States Senate

On:

Hearing: CARING FOR SENIORS AMID THE COVID-19 CRISIS

Thursday, May 21, 2020

SUBMITTED BY:

The American Seniors Housing Association (ASHA)

and

Argentum

On behalf of the American Seniors Housing Association (ASHA) and Argentum, we commend Chairman Collins and Ranking Member Casey for holding this hearing, Caring for Seniors Amid the COVID-19 Crisis. It is only appropriate the committee give this issue focused attention. The owners and operators of senior living have held a front row seat to this pandemic along with their employees who diligently, responsibly and compassionately serve on the front lines of this battle to care for our nations seniors, many of them veterans and their spouses. There is much to learn from this health crisis particularly as it impacts seniors. We feel it is important that attention not only focus on the challenges of COVID-19 but also recognize the very good work and outcomes occurring in communities all across this country every day to keep residents and staff safe. There are lessons to be learned from this work and our members are already developing best practices.

ASHA and Argentum are the leading national associations exclusively dedicated to supporting companies operating professionally managed, resident-centered senior living communities and the older adults and families they serve. Our member communities offer assisted living, independent living, memory care, continuing care retirement communities representing approximately 75 percent of the professionally managed senior living industry. We therefore are pleased to share with the Committee the perspectives of the senior living industry relative to their challenges and successes as they continue their efforts to combat this terrible disease and health crisis.

Seniors Are Most at Risk for COVID-19

A Centers for Disease Control and Prevention (CDC) report released on March 26, 2020 found that "[o]overall, 31% of cases, 45% of hospitalizations, 53% of ICU admissions, and 80% of deaths associated with COVID-19 were among adults aged ≥65 years with the highest percentage of severe outcomes among persons aged ≥85 years. The average resident living in a senior living community is a woman in her 80s, she needs assistance with three or more ADLs and/or suffers from Alzheimer's disease or related dementia. This profile combined with the fact that this virus is invisible, highly contagious, symptoms may not appear for 2-14 days after exposure, supplies and testing has been largely unavailable, and there is currently no vaccine or treatment available has created significant challenges for everyone operating, living and working in a residential senior setting. Regardless we strongly believe that senior living communities represent a critical defense in the fight against COVID-19. They are in the business of taking care of seniors, they have planned, they are responding and in time they will recover smarter and better from this experience. We are confident there is no better place for a senior who currently resides in one of our communities to be at this time.

COVID-19 Planning and Response in Senior Living

At the earliest signs of COVID-19, the senior living industry triggered their emergency planning programs to address what was soon to become an unprecedented health crisis. They began by educating themselves on the virus and the most critical steps to take to protect their communities. They continue this education process today by actively monitoring communications from the World Health Organization (WHO), the CDC, the state community licensing entities, local

health departments, infectious disease experts and each other. As with any infectious disease, prevention in a senior living community is its first and best defense.

Education and training of staff, residents, visitors, and volunteers on the essential infection control practices from the beginning of this crisis included what has now become standard minimum requirements:

- Hand hygiene (frequent washing, use of gloves, and use of hand sanitizers).
- Respiratory hygiene / cough and sneeze etiquette (use of disposable tissues, or elbow when tissues unavailable, use of facemasks).
- Environmental cleaning (wiping down surfaces with antibacterial / virucide cleansers. Clean frequently touched areas, such as doorknobs. Provide disposable wipes for commonly used surfaces).
- Observing waste disposal best practices (e.g. touchless, lined wastebaskets).
- Reminder trainings of staff and volunteers on sources of exposure, prevention, recognition of symptoms, response when an outbreak has been identified, and communication protocols.
- Education of residents and visitors about prevention practices, response, and precautions implemented at the community.
- Post educational materials about the coronavirus that explain why infection control precautions are necessary.
- Posting signs notifying residents, staff, and visitors to report any experienced respiratory systems to management.
- Assess status of the community's preparedness (stockpiling supplies such as sanitizer, masks, gloves, gowns, EPA certified cleaning products, water, food, and linens).

As more became known about the virus, additional and more stringent protocols were adopted to protect resident and staff. Some of the more common include:

Community Access

- Limiting access to the community: No visitors including family with exceptions for essential medical providers and immediate family members during end of life. Prohibition on outside vendors, planning for alternative mail delivery and cleaning surfaces of all delivered packages
- Social Distancing: Communal dining, activities and social events have all been eliminated.

Resident/Staff Monitoring:

- Increased symptom monitoring of residents: Check temperature twice per day with non-contact thermometers and document. Symptomatic residents are quarantined and monitored. Residents who test positive are isolated and monitored for symptom progression and if necessary, transferred to the hospital.

- Increased symptom surveillance of staff: Daily temperature check prior to shift. If fever greater than 100 or symptomatic, employee sent home. As test kits become more available communities are testing staff more frequently.

Communication:

- Keep families and staff updated on community protocols and changes. Communicate exposure and outbreaks to families and make required reporting to health and state licensing agencies regarding infections and deaths according to federal and/or state mandates.

Supplies/PPE:

- Establish protocol for PPE use such as surgical and N95 masks including proper removal techniques to reduce risk of contamination. Train staff on use of gowns, to be worn once and replaced between different room visits and never worn in the hallway. Maintain inventory of supplies for each community.

Environmental Disinfecting:

- Increased housekeeping and special laundry processes that include wearing PPE, washing resident clothes separately, cleaning hampers with disinfecting cleanser (EPA-certified to kill COVID-19) after dirty laundry removed.

The above is just a representative sample of the kinds of practices currently in place at senior living communities to prevent and mitigate the spread of COVID-19. It is not an exhaustive list and does not reflect any one community protocol.

COVID-19 and Senior Living: Supplies, Testing and Staffing Challenges

The COVID-19 pandemic has created a challenging environment for seniors and those who care for them. While ensuring the health and well-being of residents and employees is always the highest priority for senior living providers, this unprecedented public health crisis has tested the industry. Accustomed to preparing for seasonal flu, COVID-19 presented a more challenging scenario for providers. But the industry has risen to the challenge. For example, while the rest of the country shut down, the people that operate and work in senior living never stopped. They continue to do what they do best; they go to work every day, compassionately caring for seniors who rely on them to not only show up but to be present and engaged, on good days and not so good days.

Supply Shortages and Expenses: Supplies and testing capabilities continue to be scarce or non-existent. While the health care industry and essential workers were prioritized for PPE, our industry was largely overlooked. Our members were left to source what they could on their own from vendors who had limited supplies and/or placed orders with businesses in foreign countries hoping the supplies ordered would one day appear and at costs that far exceeds traditional pricing for such products such as gowns and gloves that typically cost pennies and now are marked up 400% or more. Recognizing the overall shortage across the country for these supplies,

we reached out to Congress, the Administration and State Governors offices asking that they prioritize the senior living industry in their dissemination process as supplies come online. Fortunately, most providers have finally identified private sources for PPE and other supplies, but inventory levels remain a concern, especially if a resurgence of the virus occurs in the Fall as predicted. At least 30% of member companies report they are still challenged in securing adequate PPE.

Testing: To fully protect our seniors, reliable and rapid result testing must be readily available for staff and residents. Most providers are relying on the services of private labs but these are limited, require long wait times and not fully reliable. The ability to test residents and staff and receive rapid results will be the single most important gain we can make in this effort to beat this virus in senior communities of all types. This must be the goal and policymakers must not only advance a national effort but also create a funding stream to subsidize or reimburse the costs of the tests.

Staffing: Implementing new and additional policies and protocols requires additional staffing. Direct care staff serving on the front lines were suddenly confronted with the choice between work and childcare as schools began to close across the country. Other staff stayed home to take care of an ill loved one or became ill themselves. And some employees were understandably uncomfortable with the risk of working with vulnerable seniors who may be at risk for the virus. Bonuses, overtime, "hero pay", agency pay, new hires, sick leave and training have become common and necessary business expenses to ensure adequate staffing levels are in place to care for residents and keep them safe. These adjustments in staffing, training, wages and benefits are necessary to the fight against COVID-19 but come at a significant expense to each community.

Each change in policy has a multiplier effect in terms of the staffing needs. For example, staff must be trained and retrained on new infection control protocols, social distancing, recognizing signs of respiratory illness, practice good personal hygiene, understand the proper use and disposal of PPE among other things. While enforcing a "no visitors" policy is critical to the safety of residents and staff, this also creates new and added employee responsibilities to ensure residents are engaged socially and physically. Quarantines and social distancing have limited the style of most residents who enjoy the company of their neighbors, family and friends. Without this connectivity, seniors are prone to loneliness and even depression. We often hear of instances of community staff creatively assembling entertainment baskets filled with puzzles, games and books for resident delivery. Some may organize a car parade for a special occasion or host a game of Hallway Bingo which is apparently a community favorite. As in- room dining service has replaced communal dining, additional staff time is needed to deliver the meal, put on appropriate PPE, offer assistance with eating if necessary, engage in conversation with the resident and upon exiting the room removal and disposal of all PPE.

The additional staffing, supply and testing costs coupled with the impacts of limited move-ins during this pandemic are creating financial pressures that are not sustainable. Just as the overall health care industry is receiving federal grants and forgivable loans to assist their businesses during these unprecedented times, the senior living industry should have similar access to financial relief. Policymakers should recognize this and take steps to facilitate such assistance.

Conclusion

The senior living industry has not escaped the tragedy that is COVID-19 but they have certainly risen to the challenge. They have prepared, they continue to respond and are optimistic that better days are ahead. Compassionate and creative staff work to ensure residents are not only safe from the virus but feel secure in this uncertain time. We learn each day that examples of ingenuity and resourcefulness are not in short supply in this industry.

There are still a lot of unknowns about this virus but what we do know is that the people working on the front lines in senior living communities are the reason the residents remain safe from COVID-19. They do their jobs against the backdrop of supply and testing shortages and worker disruptions due to childcare needs, illnesses and even fear. Employees should not be concerned about supply and testing shortages. Employers should not be concerned about the additional staffing costs required to keep the residents safe in these unprecedented times. Policymakers should take action to address these shortages and when a vaccine is available, they should prioritize seniors in all care settings for access

We thank you for your support and passage of the CARES Act. We ask that you urge HHS to include senior living in funding available under the provider relief fund. Every senior living resident that remains virus free and out of the hospital represents a savings to the federal government through reduced Medicare spending. The costs associated with COVID-19 response cannot be overstated and the industry should be adequately recognized and allocated the necessary federal financial relief from the HHS Provider Fund. This battle is far from over underscoring the necessity to arm this industry with the resources they need to continue the work.

Thank you for holding this hearing and focusing on this most important topic.

May 29, 2020

Written Testimony:
Caring for Seniors Amid the COVID-19 Crisis
United States Senate Special Committee on Aging

Lori Delagrammatikas, Executive Director & William Benson, National Policy Advisor
National Adult Protective Services Association

Chairman Collins, Ranking Member Casey, and Senators of the Committee,

Thank you for convening the *Caring for Seniors Amid the COVID-19 Crisis* hearing to begin addressing the impact of the COVID-19 crisis on older adults and its impact that goes well beyond the illness itself. We hope this will be only the start of Committee discussions to focus on the many challenges related to older adults and the pandemic. With the majority of older Americans living in the community there are many more major issues to highlight and examine, including elder abuse, neglect, and exploitation, and the very few resources available to address this particularly devastating issue.

The National Adult Protective Services Association (NAPSA) represents Adult Protective Services (APS) programs and workers across the country. APS programs are the only mandated system in all states, DC, and the territories to respond to and conduct civil investigations of reports of physical, sexual, and emotional abuse, neglect, self-neglect, and exploitation of vulnerable older adults and people with disabilities. For years, APS programs have been increasingly overwhelmed with skyrocketing reports and cases, while operating with increasingly inadequate funding. The COVID-19 crisis has only exacerbated that need.

Research has shown that isolation is a major risk factor for abuse and the lack of regular interaction with outside family, friends, neighbors, and service providers exacerbates the risk and limits response. Moreover, states' mandatory reporting laws are far less effective during a shut-down. Reporters, such as physicians and other health care providers, social services workers, and banking and other financial services industry personnel, along with neighbors and family members, are the front-line for identifying potential abuse and reporting it to APS and law enforcement. These individuals have little to no contact with potential victims during a shut-down. Once the pandemic subsides and people are able to emerge from their homes, APS administrators across the country expect a surge in the number of reports and cases as has occurred in natural disasters.

Awareness and support are essential to react quickly now and in the future. While we applaud funding and focus on the aging network and other services for older adults and people with disabilities in the Families First Coronavirus Response Act and in the CARES Act, there has been no corresponding response to support APS programs' capacity to address abuse, neglect, and exploitation of older adults and younger adults with disabilities. APS services are more

critical than ever before. With the Committee's ongoing commitment to addressing elder abuse, particularly fraud and financial exploitation, NAPSA encourages the Committee to bring awareness to the impact of COVID-19 on elder abuse, neglect and exploitation, and systems such as APS.

One ongoing APS need is for personal protective equipment (PPE). While many states have directed APS workers not to have face-to-face meetings with victims, alleged perpetrators, and potential witnesses in the absence of PPE, unless there is an imminent risk of harm; in other states, workers may still be required to have direct contact with clients. As states begin to increase face-to-face operations PPE will be in ever greater need to protect both workers and clients. However, even basic items such as masks and hand sanitizer can be difficult to obtain.

As a county APS administrator noted (in April), "My 10 N95 masks is the exception to the rule. And that's 10 masks I did not have for a month of asking, till Monday, yes yesterday…and I'm told I'll get no more, and (we) typically do 90+ investigations monthly…PPE a huge need…(and my CPS colleagues seem to have more PPE, perhaps b/c of better stocking ahead of time; and they simply have more resources in general)." The same person noted, "That with 10 masks that is more than other counties [in our state]. Most APS programs have NO masks." This challenge continues to be true today in many APS programs across the country.

Technology for APS to respond to and investigate reports remotely whether in the community or in long-term care facilities is also an urgent need. Given the nature of APS work this includes the need for secure and confidential means of doing video conferences or other tools for home visits and investigations.

Support for APS is fundamental to protecting vulnerable older adults and people with disabilities during this crisis and in subsequent easing of restrictions. We encourage the Committee to continue their strong record of addressing elder abuse and not overlook the detrimental impact of the COVID-19 epidemic on older victims and the programs that serve them.

We look forward to the Committee's further efforts to consider the impact on older adults of the COVID-19 pandemic and thank you for your enduring commitment to the nation's older adults.

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CLPC
Community Living Policy Center

May 2020

Short-Term Money Follows the Person Extensions Resulted in a Significant Drop in State Efforts to Transition People Out of Institutions

H. Stephen Kaye and Joe Caldwell

What is the Money Follows the Person Demonstration?

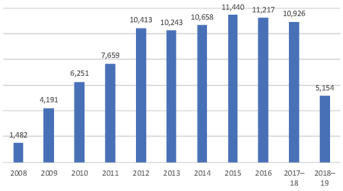
The Money Follows the Person (MFP) Demonstration is a long-standing Medicaid program that helps states with:

1. transitioning people who want to move back home from nursing facilities and other institutions; and
2. enhancing overall access to home and community-based services so people with disabilities and older adults have greater choice of where they live and receive services.

MFP was first authorized through the Deficit Reduction Act of 2005 with strong bipartisan support. The program was extended in the Affordable Care Act through September 2016, with flexibility to use funding through 2018. Since then, there have been five short-term extensions to keep the program afloat.[1]

However, funding lapses, coupled with short-term extensions to MFP funding, have resulted in a dramatic drop in state efforts to transition people out of institutions. Recent data on the number of transitions in each state, obtained from the Centers for Medicare and Medicaid Services (CMS)[2], show that the number of annual transitions dropped by more than half (53.6 percent) across all state programs, from an average annual level of 11,100 transitions per year in 2014–16 to 5,154 in the 12-month period between July 2018 and June 2019 (Figure 1). Before that, the annual number of transitions had been above 10,000 in every year since 2012.

Figure 1: Annual Money Follows the Person transitions, 2008–2019



1. Medicaid Extenders Act of 2019, Pub. L. No. 116-3 (1/24/19) – provided $112 million; Medicaid Services Investment and Accountability Act of 2019, Pub. L. No. 116-16 (4/1819) – provided $20 million; Sustaining Excellence in Medicaid Act of 2019, Pub. L. No. 116-39 (8/6/19) –provided $122.5 million; Further Consolidated Appropriations Act, 2020, Pub. L. No. 116-94 (12/20/19) –provided $176 million; Coronavirus Aid, Relief, and Economic Security Act, Pub L. No. 116-127 provided $337.5 million through Nov. 30, 2020.
2. Note: Data provided by CMS is self-reported by states.

Few states have been able to maintain their prior level of effort on their MFP programs, and many have shut them down or appear to be in the process of doing so. As shown in Figure 2, of the 44 states with MFP programs in 2016, only 14 states[3] maintained roughly the same the level of transitions in 2018–19 as they had in prior years. These states transitioned a similar level of people as they had in 2014–16, with a decline of no more than 10 percent, or reported a greater number of transitions than in previous years. These 14 states represent less than a third of the 44 states with MFP programs through 2016.

Eight states[4] reduced their MFP efforts substantially but still transitioned at least half the number as in previous years. An additional 12 states[5] continued operating MFP programs for at least part of the year, but transitioned a greatly reduced number of institutional residents—fewer than half of the 2014–16 average. Ten states[6] reported no transitions between July 2018 and June 2019; these appear to have ended their MFP programs prior to mid-2018. The remaining seven states[7] didn't have MFP programs.

Figure 3 shows the annual number of transitions across all state programs, separately for people with and without intellectual and developmental disabilities (I/DD).

Figure 2. Status of state Money Follows the Person programs, 2018–19

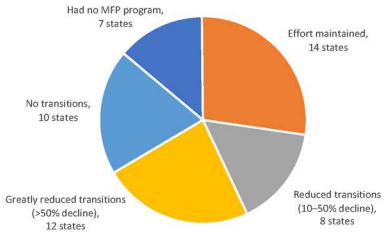
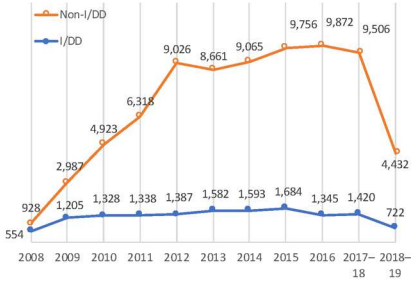


Figure 3. MFP transitions, by population, 2008–2019



Note: Figure for 2017–18 is annualized based on 18 months of reported data.

3. Alabama, Colorado, Connecticut, Georgia, Idaho, Iowa, Louisiana, Maryland, Minnesota, Missouri, New Jersey, New York, North Carolina, and South Carolina.
4. Hawaii, Maine, Nebraska, North Dakota, Pennsylvania, Rhode Island, West Virginia, and Wisconsin.
5. California, District of Columbia, Kentucky, Mississippi, Montana, Nevada, Oklahoma, South Dakota, Texas, Vermont, Virginia, and Washington.
6. Arkansas, Delaware, Illinois, Indiana, Kansas, Massachusetts, Michigan, New Hampshire, Ohio, and Tennessee.
7. Alaska, Arizona, Florida, New Mexico, Oregon, Utah, and Wyoming. Oregon dropped out of MFP and completed its last transitions in 2011.

The pattern is similar for the two populations, except that the decline in I/DD transitions appears to begin as early as 2016. The number of transitions in 2018–19 represents a decline of 53.1 percent from the 2014–16 average for the I/DD population and 53.7 percent for the non-I/DD population.

Conclusion

The MFP program has been incredibly successful. The program has assisted over 91,540 individuals with disabilities and older adults in transitioning from institutions to home and community-based settings. Evaluations of the program have demonstrated enhanced quality of life outcomes and cost savings for states. However, recent short-term extensions of the program have significantly curtailed progress.

It took many years for states to build up infrastructure to operate successful MFP programs. Lapses in funding and short-term extensions for several months at a time have contributed to state staff being let go or reassigned, programs stopping new transitions, and eroding of the infrastructure to support successful transitions. Advocates believe the program need to be made permanent to provide certainty for states and continue the great progress made over the past decade and half.

How to Cite

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Senate Special Committee on Aging
Caring for Seniors Amid the COVID-19 Crisis
May 21, 2020
Statement for the Record

LeadingAge and its partners, the Visiting Nurse Associations of America (VNAA) and ElevatingHOME (EH), representing almost 6000 nonprofit aging services providers, including nursing homes, home health care, assisted living, continuing care retirement communities, hospice, home and community-based service, adult day services, PACE, and affordable housing, appreciates the opportunity to provide this statement for the record.

We thank the Committee for its commitment to older Americans and for holding a Congressional hearing on, "Caring for Seniors Amid the COVID-19 Crisis" to highlight the devastating impact of the novel coronavirus on older Americans. The COVID-19 pandemic is the worse public health crisis our Nation has endured during this century. Tragically, the virus has claimed the lives of nearly 100,000 Americans. Moreover adults age 65 or older are more likely to suffer severe complications from COVID-19 and have more difficult recoveries.

As the Committee takes into account additional actions in response to the COVID-19 pandemic, we urge the Committee to treat older Americans and the settings where they live as a high priority, and allocate funds specifically to aging services providers to ensure that these needs are met:

1. We strongly support utilizing all levers of the federal government to manufacture and distribute essential personal protective equipment (PPE), in nursing homes, and also assisted living, retirement communities, and HUD-assisted housing, all of which serve vulnerable elders. We also cannot forget home care providers, direct care workers, and Service Coordinators in HUD-assisted housing whose need for PPE is equally critical to serve their clients in the community.
2. We urge the Committee to ensure that accurate and swift testing is available to all residents and staff in our settings and communities, to allow for the safe care and treatment of residents and determine which staff and residents are asymptomatic. We appreciate the efforts in the CARES Acts to provide funding for healthcare providers and for HUD-assisted senior housing but as you are aware, and as the testimony at this hearing confirmed and emphasized, these efforts are not enough.
3. As we face a steep climb ahead to not only "reopen" (most aging services providers never closed), but to recover as well, we must also plan for a fundamentally and permanently changed aging services system. We must reimagine the way we care for the people we serve, the way we provide shelter

and supportive services, and the way we pay for these services and housing. We recommend creating a Bipartisan Congressional Commission on the Future of Aging Services to conduct a comprehensive review of the gaps in the aging/long term care infrastructure, identify what we learned from the COVId-19 pandemic's impact on older people, their family members and aging services, and address how we can better serve older people in the future as well as prevent the kind of fallout from the current crisis.

The witnesses, and the remarks by members of the Committee, showed the critical importance of addressing issues affecting seniors, and while much of the testimony focused on nursing homes, the lessons presented by the witnesses affect all seniors and emphasize the need to address aging services as a system.

Dr. Mark Mulligan's testimony spoke to the novel nature of this virus, saying "for physicians, scientists, leaders – this virus has continued to humble us – there is much we don't know about this new virus." His testimony underscored the significant challenges to care for older persons with compromised immune systems in places where social distancing is extraordinarily difficult and counter to the norm – no eating together, no activities, no family visits - coupled with the risks for healthcare workers both within the congregate setting and in the community, as carriers, especially asymptomatic carriers.

Professor Tamara Konetzka's testimony underlined the unique nature of the disease and its impact on nursing homes specifically. Her research showed that our normal expectations of quality do not apply – early research showed that: (1) there is no relationship between a nursing home's Five-Star quality rating and the presence of COVID cases or deaths; (2) there is no difference between for profit and nonprofit homes; and (3) there is a strong relationship between the racial composition of residents and the presence of COVID cases and deaths. Other research supports the demographic relationship underlying the likelihood of COVID cases in a nursing home. Professor Vince Mor of Brown University also has studied the impact of COVID on nursing homes. As with Professor Konetzka's study, he did not find a statistically significant relationship between quality rankings or staffing in determining whether a community had COVID. Rather, the Mor study found that the only statistically significant factors affecting COVID outbreaks were: (1) the size of the community, (i.e., large community) and (2) widespread community spread (i.e., hotspot). He concluded that this was because of the likelihood that staff and contractors were bringing the disease in. In other words, large nursing homes in urban settings were more likely to be affected than nursing homes in non-COVID hotspots. These findings should help guide our understanding of the disease and how to respond most effectively.

Professor Kontezka's conclusions mirror LeadingAge's: We have known about the risks but have not prioritized aging services providers in the distribution of funds appropriated in the CARES Act; we have not had a national strategy to prioritize access to PPE for aging services

settings; and we have not prioritized availability of fast, accurate tests in nursing homes or other congregate settings, both to ensure that staff are not carrying the disease though asymptomatic, and to ensure that residents are appropriately separated.

However, as also noted by Professor Konetzka, this is not only a nursing home issue. She points to the challenges associated with substituting home and community- based services programs for nursing home care and concludes that both the lack of funding for Medicaid (which also implicates nursing home care) and the significant physical and mental frailty of nursing home residents make care in the community challenging, especially without more resources.

And, as LeadingAge member Dr. Steven Landers, President and CEO of Visiting Nurse Association Health Group testified, home-based care including home health and hospice are playing a critical role during the pandemic. He discussed how his agencies are utilizing telehealth effectively to continue to provide care. His testimony underscored that it is critical that home health agencies (HHAs) be able to count telehealth visits as part of a unit of service especially since they anticipate serving patients released from the hospital or sheltering at home with COVID-19. Most of the members of the home health team – physicians, advance practice nurses, physician assistants, and therapists – can now bill Medicare Part B for telehealth services at the equivalent rate as an in-person visit but the agencies cannot. CMS has recently indicated that this request can only be addressed through a change in law. We ask that Congress amend section 1895(e) either directly or through directing CMS to issue a waiver via section 1135 of the Social Security Act to allow telehealth visits to count as part of the payment system so long as telehealth visits are included in the plan of care for the duration of the public health emergency.

Additionally, professionals who can order home health must sign written orders and certify in writing that patients are eligible for home care in order for home health agencies to bill for services. In the current environment, physicians, advanced nurse practitioners, and physician assistants are increasingly unavailable to sign home care documents, making even electronic signatures extremely difficult to obtain. Having the flexibility to rely on documented verbal orders and eligibility certifications would expedite safe discharges and referrals to home care – and enable the critical services that Dr. Landers' described to be billable.

As we examine the impact of COVID on older Americans, we also greatly appreciate the support of the Committee for HUD's affordable housing programs. More than 1.6 million older adults receive housing assistance from HUD. While understood that COVID-19 disproportionately impacts older adults, there has been no focus to address the significant COVID-19-related issues HUD-assisted senior housing, and minimal resources provided for this population.

LeadingAge supports a $1.2 billion package of relief for HUD-assisted multifamily housing, including $845 million to cover the cleaning, disinfecting, PPE, meals, services, and staff costs incurred by affordable senior housing providers; $300 million for Service Coordinators to ensure that more HUD-assisted senior communities have a Service Coordinator and to cover COVID-19 related costs of existing Service Coordinators; $50 million for the installation and fees for wireless internet in HUD-assisted senior housing common areas and apartments to provide connection to telehealth, services that combat social isolation, and community programs; and, $7 million for a one-year extension of HUD's Integrated Wellness in Supportive Housing demonstration, which is set to sunset September 30, 2020. Inclusion of these affordable senior housing priorities in the next COVID-19 relief package is critical to the health of HUD-assisted seniors.

Not only are older adults served by HUD's housing programs, these programs also disproportionately provide stable, affordable, service enriched housing to racial minorities, compared to non-subsidized housing. In addition to serving older adults, HUD-assisted housing renters are more likely to be African American than their non-HUD assisted peers. Of all renters, 21.4% are African American; of residents of privately-owned HUD-assisted housing (such in the largest of HUD's such programs, Section 8 Project-Based Rental Assistance and the Section 202 Housing for the Elderly), 38.2% are African American. Any successful effort to address the racial inequities of the impact of COVID-19 must include HUD-assisted housing.

We cannot strongly enough urge Congress to pass additional legislation that addresses the needs of all seniors. We will share the extensive recommendations we submitted to Leader McConnell and Leader Schumer on May 5, but for purposes of this statement, in addition to the recommendations above regarding HUD-housing and telehealth, we emphasize the following essential actions to address the needs of the entire aging services ecosystem and the older people we serve:

ESSENTIAL ACTIONS FOR CONGRESS

1. Assurance that states will consider the safety and protection of older Americans as they consider reopening.
    a. As we re-integrate aging services into the society as a whole, we urge creation of the Bipartisan Congressional Commission on the Future of Aging Services so we can understand the lessons from this pandemic and address aging services in the future;
    b. We certainly recognize the importance of a vibrant, functioning economy, but we must also recognize the disproportionate impact of this disease on older persons and persons of color.

   c. Our efforts to re-open must not have a disproportionately adverse impact on these communities or place the blame on them for this disease and its devastating impact.

2. Immediate access to ample and appropriate PPE for all providers who serve older Americans, not just nursing homes. Policymakers must act now to get these providers on the same priority tier as hospitals.
   a. The lack of a nationally coordinated effort to manufacture, obtain and distribute PPE over 5 months after this pandemic took hold is a disgrace. Our members, their staff, and the people we serve Should not be put in a situation where they are responsible when they cannot obtain adequate and affordable PPE and medical supplies.
   b. Unfortunately, the most recent effort by the federal government to have the Federal Emergency Management Association (FEMA) distribute PPE to nursing homes has been remarkably unsuccessful, with members reporting receiving inappropriate gear (cloth masks), 10% of what they use in a week, and incomplete packages.

3. On-demand access to accurate and federally-funded rapid-results testing for older adults and their care providers and employees. Aging services providers must also be on the same priority tier as hospitals. Results are needed in minutes, not days or weeks.
   a. As the witnesses at this hearing confirmed, testing is a critical component to ensuring that both residents and staff with COVID-19 are identified so they can be treated and others protected.
   b. To be effective, testing in our communities must include reimbursement for providers over and above the cost of the test, ensuring that health insurers pay for repeated testing, testing must be fast and accurate.
   c. One of the results of identifying asymptomatic staff especially will be the need to have additional staff available to provide "surge capacity" for staff who must be quarantined, and the need for additional funding to ensure adequate staff is most critical.

4. Recognition for the heroic frontline workers serving older Americans in all of the settings where they live –in congregate, affordable and community-based housing. Ensure pandemic hazard pay, paid sick leave and health care coverage for essential workers. Aging services frontline workers have kept America safe and running just as surely as America's hospital workers.
   a. We strongly support the HEROES Fund and urge bipartisan support for increased pay for healthcare workers, including recruitment efforts.

b. Again, as noted by Professor Konetzka, we have to address the current funding inequities in aging services exemplified by low Medicaid rates, and the lack of coordinated, coherent financing across the aging services ecosystem.

5. Funding and other support for aging services providers across the continuum of care. In its next relief package, Congress must allocate $100 billion to cover COVID-19 needs specifically for aging services providers as well as other critical support such as: $1.2 billion in federal housing assistance, support to deliver telehealth, access to loans, Medicaid increases, and administrative relief.
    a. As has been noted by all the witnesses and by members of this Committee, aging services has been woefully ignored in the distribution of funds designed to address this pandemic.
    b. Funds must be separately appropriated for aging services because all the elements in this ecosystem are affected, not just nursing homes – home based services, as Dr. Landers testified; low income senior housing; retirement communities; assisted living; nursing homes. Seniors live in all these settings, as well as in the broader community. They are all at risk and their caregivers are, too.

In conclusion, we must not allow seniors and the people who serve them to be treated with lack of dignity and respect, demonized because of their age or frailty or race or nationality. We appreciate the Committee's strong commitment to working on behalf of seniors amid the COVID-19 crisis and stand with you to act urgently to provide the support they desperately need. For further information, please contact Ruth Katz, Senior Vice President, Policy, rkatz@leadingage.org.

Sincerely,

Katie Smith Sloan

Katie Smith Sloan
President and CEO LeadingAge
Acting President and CEO, VNAA/Elevating Home

May 21, 2020

Sen. Susan Collins, Chairwoman
Sen. Bob Casey, Ranking Member
United States Senate Special Committee on Aging
G31 Dirksen Senate Office Building
Washington, D.C. 20510

Re: Hearing on Caring for Seniors Amid the COVID-19 Crisis

Dear Chairwoman Collins and Ranking Member Casey,

The Consortium for Citizens with Disabilities (CCD) is the largest coalition of national organizations working together to advocate for federal public policy that ensures the self-determination, independence, empowerment, integration and inclusion of children and adults with disabilities in all aspects of society. The undersigned co-chairs of the CCD Long Term Services and Supports Task Force write in response to today's hearing, "Caring for Seniors Amid the COVID-19 Crisis."

People with disabilities and older adults face a particularly high risk of complications and death if exposed to COVID-19, a risk that has been elevated by the severe outbreaks in institutional and congregate settings across the country. While the media and public have understandably focused on the outbreaks and deaths in nursing homes, people with disabilities and older adults face increased risks in all institutional and congregate settings, which we addressed in an April 21, 2020 letter regarding the Centers for Medicare and Medicaid Services' (CMS) "New Nursing Homes COVID-19 Transparency Effort" (attached). None of these institutional and congregate settings have been immune to the COVID-19 crisis and conversations around safety must

address all of them, not only nursing homes, if we hope to effectively mitigate the outbreaks these settings face.

Furthermore, given the danger such settings pose to people with disabilities and older adults, conversations around safety must also include diversion and transition strategies. As we noted in a May 5, 2020 letter regarding CMS' announced creation of an independent commission to address safety and quality in nursing homes, identifying resources to assist with diversion and transition from institutional settings should be a key part of any strategy to address the impact this crisis is having on such settings (attached). Diverting people from unnecessary admissions into nursing homes and other institutional settings and transitioning people who currently reside in such settings to settings in the community that are smaller and more individualized addresses COVID-19 safety concerns inherent in larger settings. Emphasizing diversion and transition also helps avoid unnecessary institutionalization, vindicating the civil rights individuals with disabilities to live in community-based settings. We were pleased to see that the Nursing Home COVID-19 Protection and Prevention Act introduced by Senators Casey and Whitehouse covers people in a range of institutional settings and includes a focus on transition to the community.

One of the most important ways to prevent unnecessary placement of people with disabilities and older adults in nursing homes and other institutions during the COVID-19 crisis is to increase funding for home and community based services (HCBS), as we addressed in a letter from April 13, 2020 supporting the Coronavirus Relief for Seniors and People with Disabilities Act (HR 6305/S. 3544) (attached). The grants proposed in that bill, or the dedicated increased funding included in the HEROES Act that just passed in the House, would help more people with disabilities and older adults receive the services they need in their homes and communities, allowing them to better protect their health during this pandemic.

The dangers posed by institutional and congregate settings did not start with the COVID-19 crisis. Instead, COVID-19 has laid bare the risks inherent in congregate facilities, where infection control and other safety concerns have always existed. We need to invest in state HCBS systems not only during this acute crisis, but beyond. This is why we also have urged Congress to permanently reauthorize the Money Follows the Person program (MFP), which provides enhanced funding to states that thus far has helped over 91,000 seniors and people with disabilities who want to move out of institutional care and back to the community make that transition (attached).

We appreciate the opportunity to provide written testimony and thank you for your consideration. If you have any questions, feel free to contact Alison Barkoff (abarkoff@cpr-us.org).

Sincerely,

Long-Term Services and Supports Co-Chairs

Alison Barkoff
Center for Public Representation

Julia Bascom
Autistic Self Advocacy Network

Dan Berland
National Association of State Directors of Developmental Disabilities Services

Nicole Jorwic
The Arc of the United States

Jennifer Lav
National Health Law Program

Sarah Meek
American Network of Community Options And Resources (ANCOR)

Attachments:

April 21, 2020 Letter from CCD LTSS Task Force to CMS re Nursing Home Transparency Initiative

May 5, 2020 Letter from CCD LTSS Task Force to CMS re Nursing Home Initiatives

April 13, 2020 Letter from CCD LTSS Task Force to Congressional Leadership re Including HCBS Funding in the Coronavirus Relief Package

December 15, 2019 Letter from CCD LTSS Task Force to Congressional leadership re Permanent Funding of Money Follows the Person

CONSORTIUM FOR CITIZENS WITH DISABILITIES

April 21, 2020

Honorable Alex Azar
Secretary, U.S. Department of Health and Human Services
200 Independence Avenue S.W.
Washington, DC 20201

Seema Verma
Administrator, Centers for Medicare & Medicaid Services
200 Independence Avenue S.W.
Washington, DC 20201

Robert Redfield, M.D.
Director, Centers for Disease Control and Prevention
1600 Clifton Road
Atlanta, GA 30329

By electronic mail

Dear Secretary Azar, Administrator Verma, and Director Redfield,

The Consortium for Citizens with Disabilities (CCD) is the largest coalition of national organizations working together to advocate for federal public policy that ensures the self-determination, independence, empowerment, integration, and inclusion of children and adults with disabilities in all aspects of society. The undersigned co-chairs of the CCD Long-term Services and Supports taskforce write in response to the Administration's "New Nursing Homes COVID-19 Transparency Effort" announcement earlier this week.

People with disabilities and older adults are, and will be, particularly at risk for COVID-19, facing a high risk of complications and death if exposed to the virus. While the media and public have understandably focused on the outbreaks and deaths in nursing homes across the country, people with disabilities and older adults face increased risks in all institutional and congregate settings. Like nursing facilities, there have been similar outbreaks and deaths in Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IIDs), including in Illinois (where the outbreak has been so significant that the National Guard has been called in), Massachusetts (where nearly half of the residents in a state-

operated ICF are infected), Utah, Texas, and New Jersey just to name a few; Institutions for Mental Disease (IMDs) and other psychiatric and substance use disorder treatment facilities, including in Washington state, District of Columbia, and New York; and in group homes across the country, including across New York, Maryland, and New Jersey.

We strongly support the steps that CMS announced earlier this week to ensure transparency and information about infections and deaths in nursing homes. These critical steps include: (1) requiring nursing homes to inform residents, their families and representatives of cases of COVID-19 in their facilities; (2) requiring nursing homes to report cases of COVID-19 directly to the Centers for Disease Control and Prevention (CDC), as well as to state and local officials; and (3) requiring nursing homes to fully cooperate with CDC surveillance efforts around COVID-19 spread. **We implore CMS to extend these same requirements to all institutional settings -- including ICF-IIDs, IMDs, substance use disorder treatment facilities, and psychiatric residential treatment facilities -- and other Medicaid-funded congregate settings where older adults and people with disabilities live, including group homes and assisted living facilities.** The need for transparency, information and data collection is equally as critical to protecting the safety and welfare of people in these settings as they are for residents of nursing homes.

We appreciate all of the important efforts the Department has taken during the COVID-19 pandemic. We urge you to act quickly to help protect the lives of ALL people with disabilities and older adults residing in congregate facilities, who are at serious risk during this crisis. If you have any questions, feel free to contact Alison Barkoff (abarkoff@cpr-us.org).

Sincerely,

Long-Term Services and Supports Co-Chairs

Alison Barkoff,
Center for Public Representation

Nicole Jorwic
The Arc of the United States

Julia Bascom,
Autistic Self Advocacy Network

Jennifer Lav,
National Health Law Program

Sarah Meek
American Network of Community
Options and Resources (ANCOR)

Cc: Calder Lynch, Deputy Administrator, CMCS
Alissa DeBoy, Director, Disabled & Elderly Health Programs Group (DEHPG)
Melissa Harris, Deputy Director, DEHPG
David Wright, Director, Center for Clinical Standards and Quality, Quality and Safety Oversight Group

May 5, 2020

Honorable Alex Azar
Secretary, U.S. Department of Health and Human Services
200 Independence Avenue S.W.
Washington, DC 20201

Seema Verma
Administrator, Centers for Medicare & Medicaid Services
200 Independence Avenue S.W.
Washington, DC 20201

Lance Robertson
Administrator, Administration for Community Living
330 C St. S.W.
Washington, D.C. 20201

By electronic mail

Re: CMS Nursing Home Initiatives

Dear Secretary Azar, Administrator Verma, and Administrator Robertson:

The Consortium for Citizens with Disabilities (CCD) is the largest coalition of national organizations working together to advocate for federal public policy that ensures the self-determination, independence, empowerment, integration, and inclusion of children and adults with disabilities in all aspects of society. The undersigned co-chairs of the CCD Long-term Services and Supports taskforce write in response to the Administration's recent announcement of the creation of an independent commission to address safety and quality in nursing homes.

We appreciate the Administration's efforts to protect the health and safety of people in nursing homes, where there have been extremely high numbers of outbreaks and deaths of residents. But as we discussed in our April 21, 2020 letter to you regarding your new "Nursing Homes COVID-19 Transparency Effort," **people with disabilities and older adults face increased risks in all institutional settings, not just nursing homes.** Like nursing facilities, there have been similar outbreaks and deaths in

Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IIDs), including in Illinois Massachusetts, Utah, Texas, and New Jersey just to name a few. In Illinois, the outbreak is so significant that the National Guard has been called in, and in Massachusetts nearly half the residents (44 individuals) of a state-operated ICF have been infected. Serious outbreaks are also taking place in Institutions for Mental Disease (IMDs) and other psychiatric and substance use disorder treatment facilities, including in Washington state, District of Columbia, and New York.

The lives of people with disabilities in these settings are equally as at risk – and equally as worth protecting – as people in nursing homes. We again implore you to expand any efforts to protect the lives of people in nursing homes from COVID-19 to other Medicaid-funded institutional and congregate settings.

We know that people with disabilities and older adults are at higher risk for infection and death from COVID-19 in institutional settings. As the Administration moves forward with its safety initiatives, we encourage you to include strategies for diverting people from unnecessary admissions and transitioning people from institutions to smaller, more individualized settings in the community. This not only is critical to addressing safety concerns, but also would help vindicate the civil rights of these individuals to receive services in the community instead of in institutional settings under the Americans with Disabilities Act and the Supreme Court's decision in *Olmstead v. L.C.* We encourage CMS to work with states – and for ACL to work with its disability and aging networks – to identify resources available to assist with diversion and transition activities.

We appreciate all of the important efforts the Department has taken during the COVID-19 pandemic. We urge you to act quickly to help protect the lives of ALL people with disabilities and older adults residing in institutions, who are at serious risk during this crisis. If you are willing, we would be interested in meeting with you to discuss these strategies further. Please contact Alison Barkoff (abarkoff@cpr-us.org) to schedule a meeting.

Sincerely,

Long-Term Services and Supports Co-Chairs

Alison Barkoff,
Center for Public Representation

Nicole Jorwic
The Arc of the United States

Julia Bascom,
Autistic Self Advocacy Network

Jennifer Lav,
National Health Law Program

Sarah Meek
American Network of Community
Options and Resources (ANCOR)

Cc: Calder Lynch, Deputy Administrator, CMCS
David Wright, Director, Center for Clinical Standards and Quality, Quality and Safety Oversight Group
Alissa DeBoy, Director, Disabled & Elderly Health Programs Group (DEHPG)
Melissa Harris, Deputy Director, DEHPG
Roger Severino, Director, Office of Civil Rights

CONSORTIUM FOR CITIZENS WITH DISABILITIES

April 13, 2020

The Honorable Mitch McConnell
Majority Leader
U.S. Senate
Washington, DC 20510

The Honorable Charles Schumer
Minority Leader
U.S. Senate
Washington, DC 20510

The Honorable Nancy Pelosi
Speaker
U.S. House of Representatives
Washington, DC 20515

The Honorable Kevin McCarthy
Minority Leader
U.S. House of Representatives
Washington, DC 20515

Dear Leaders McConnell and Schumer and Speaker Pelosi and Leader McCarthy,

The Consortium for Citizens with Disabilities (CCD) is the largest coalition of national organizations working together to advocate for federal public policy that ensures the self-determination, independence, empowerment, integration and inclusion of children and adults with disabilities in all aspects of society. The undersigned co-chairs of the CCD Long-term Services and Supports taskforce write in response to the growing outbreak of COVID-19 across the United States, and the growing need for home and community-based services (HCBS) of people with disabilities in the face of the pandemic. The first three legislative packages all but ignored the critical need for HCBS and the dire need for funds to stabilize the system through this crisis and support the workforce that provides these essential services.

People with disabilities are, and will be, particularly at risk as COVID-19 continues to spread across the country, facing high risk of complications and death if exposed to the outbreak and needing to isolate themselves for protection. We urge Congress to focus on people with disabilities and their needs in the fourth COVID-19 bill. Specifically, as the fourth piece of legislation moves forward, we urge Congress to ensure that emergency HCBS grant funding is included in the next COVID-19 legislative package.

Meaningful investments in HCBS are one of the most important steps Congress can take to safeguard the disability community. The fourth package must fund HCBS grants, such as the ones found in the Corona Virus Relief for Seniors and People with Disabilities (HR 6305, S. 3544) to provide additional funds to strapped state HCBS systems and to support the Direct Support Professional (DSP) and Home Health Workforce. Without additional resources, aging adults and people with disabilities will be forced out of their homes and communities and into congregate settings, at grave risk to their health--as

demonstrated by severe and persistent outbreaks in nursing facilities, institutions and other settings that are proving a danger to the health of people with disabilities.

Additionally, Direct Support Professionals (DSPs), personal care attendants, and other direct care workers, whether paid for through Medicaid, the VA or other federal programs, or through private payment arrangements, should be designated essential personnel in order to ensure access to PPE. DSPs and other direct care workers are not currently included in the definitions of Essential Workers who are prioritized for access to personal protective equipment (PPE). DSPs are on the frontlines of the COVID-19 response, assisting people with underlying conditions and disabilities with tasks such as toileting, eating, and bathing. Often these services cannot be provided from 6 feet away and require close personal contact. We are already seeing tragic cases of people with disabilities dying after being infected by their DSPs. The work DSPs do is essential, and they must have access to the tools they need to do their job safely.

We were glad to see that the important work of direct support professionals, personal care attendants and home health aides was included in the "Heroes Fund" proposal. We support the concept of paying essential employees additional wages directly for the work that they are doing during the pandemic. We also are glad to see that there are components to assist with recruitment to this and other vital workforces. Direct care workers are a core part of the infrastructure of our nation's HCBS system, but there are many other components in jeopardy without immediate funding. This fund would be a valuable supplement to the critical and urgently needed HCBS grants, which will provide crucial resources to stabilize the critical community services provider network, support providers of HCBS services to transform service delivery to reach seniors and people with disabilities who are isolated due to the response to COVID-19, move individuals from HCBS waitlists as needed to address emergencies when other support networks fail, and continue to assure the health and welfare of the people they serve during the extraordinary disruption caused by the pandemic. The broader HCBS grants would also allow states the flexibility to pay for additional training for DSPs, purchase PPE, and pay more overtime wages.

We know that we must act now to prevent much of the worst impact of this outbreak. We urge Congress to act quickly, incorporate these urgent disability community priorities in the 4th COVID-19 legislative package, and promptly pass this crucial legislation. If you have any questions, feel free to contact Nicole Jorwic: jorwic@thearc.org

Sincerely,

Long-Term Services and Supports Co-Chairs

Alison Barkoff,
Center for Public Representation

Julia Bascom,
Autistic Self Advocacy Network

Dan Berland
National Association of State Directors

Nicole Jorwic
The Arc of the United States

Jen Lav,
National Health Law Program

Sarah Meek
American Network Community Options and Resources (ANCOR)

The Disability and Aging Collaborative &

CCD
CONSORTIUM FOR CITIZENS WITH DISABILITIES

December 15, 2019

The Honorable Mitch McConnell
Majority Leader
U.S. Senate
Washington, DC 20515

The Honorable Charles Schumer
Minority Leader
U.S. Senate
Washington, DC 20515

The Honorable Nancy Pelosi
Speaker
U.S. House of Representatives
Washington, DC 20515

The Honorable Kevin McCarthy
Minority Leader
U.S. House of Representatives
Washington, DC 20515

Dear Leaders McConnell and Schumer and Speaker Pelosi and Leader McCarthy,

The undersigned member organizations of the Consortium for Citizens with Disabilities (CCD), Disability and Aging Collaborative (DAC), and other state and national organizations write to urge you to pass the permanent extension of the Money Follows the Person Program (MFP) and Spousal Impoverishment Protections included in the bi-partisan Prescription Drug Pricing Reduction and Health and Human Services Improvement Act. While we have appreciated the short-term extensions passed this Congress, and the 4 ½ year extension that the House passed in June 2019, permanent reauthorization is necessary to ensure that states continue to participate in the MFP program. Several states have already stopped transitions under MFP or even dropped out of the program entirely while awaiting the assurance of long-term funding.

The MFP program provides enhanced funding to states to help transition individuals who want to move out of institutional care and back to the community. The enhanced funding states receive assists with the costs of transitioning people back to the community, including identifying and coordinating affordable and accessible housing and providing additional services and supports to make successful transitions. The program has helped over 91,000 people with disabilities and older adults transition back to their communities.

MFP has consistently led to positive outcomes for people with disabilities and older adults and shown cost-savings to states since it began in 2005. The Centers for Medicare & Medicaid Services (CMS) found an average cost savings of $22,080 in the first year per older adult participant, $21,396 for people with physical disabilities, and $48,156 for people with intellectual disabilities.[1]

The program works, and without it, people with disabilities and older adults would be stuck in institutions and other segregated settings. "The most recent empirical analyses suggest that after five years of operating an MFP demonstration, approximately 25 percent of older adult MFP participants and 50 percent of MFP participants with intellectual disabilities in 17 grantee states would not have transitioned if MFP had not been implemented." [2] We need a permanent reauthorization so that states know the funding is sustainable.

Medicaid's "spousal impoverishment protections" make it possible for an individual who needs a nursing home level of care to qualify for Medicaid while allowing their spouse to retain a modest amount of income and resources. Since 1988, federal Medicaid law has required states to apply these protections to spouses of individuals receiving institutional LTSS. This has helped ensure that the spouse who is not receiving LTSS can continue to pay for rent, food, and medication while the other spouse receives their needed care in a facility. Congress extended this protection to eligibility for HCBS in all states beginning in 2014, so that married couples have the same financial protections whether care is provided in a facility or in the community.

This common-sense policy ensures that couples can continue to live together in their homes and communities as they age and families can stay together when caring for loved ones with disabilities and conditions such as dementia, multiple sclerosis, or traumatic brain injury. But it is set to expire at the end of this year.

On behalf of people with disabilities and older adults, we request that Congress pass the permanent re-authorization of both Money Follows the Person and HCBS Spousal

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[1] https://www.medicaid.gov/medicaid/ltss/downloads/money-follows-the-person/mfp-rtc.pdf (Page 11)
[2] https://www.medicaid.gov/medicaid/ltss/downloads/money-follows-the-person/mfp-rtc.pdf (Page 11)

Impoverishment Protections. For additional information or questions, feel free to contact CCD LTSS and DAC co-chair Nicole Jorwic: jorwic@thearc.org.

Sincerely,

Access Living

Aging Life Care Association

American Association on Health and Disability

American Association on Intellectual and Developmental Disabilities

American Civil Liberties Union

American Network of Community Options and Resources (ANCOR)

American Therapeutic Recreation Association

APSE

Association of University Centers on Disabilities (AUCD)

The Arc of the United States

The Arc of Colorado

The Arc of Delaware

The Arc of Indiana

The Arc of Kentucky

The Arc of Massachusetts

The Arc of Minnesota

The Arc of New Jersey

The Arc of New Mexico

The Arc of North Dakota

The Arc of Oregon

The Arc of South Carolina

The Arc of Tennessee

The Arc of West Virginia

Autism Society of America

Autistic Self Advocacy Network

Arkansas Long-Term Care Ombudsman Program

Association of Programs for Rural Independent Living

Autism Speaks

Bay Path Elder Services

Bet Tzedek Legal Services

Buffalo Trace Long Term Care Ombudsman Program

California Advocates for Nursing Home Reform

California Association of Public Authorities for IHSS

California Down Syndrome Advocacy Coalition (CDAC)

California Foundation for Independent Living Centers

Caring Across Generations

Center for Elder Law and Justice

Center for Public Representation

Choice in Aging

Christopher & Dana Reeve Foundation

Coalition of Disability Health Equity

Colorado Cross-Disability Coalition

Community Catalyst

Community Residential Services Association

Delta Center for Independent Living

Disability Law Center

Disability Law Center of Alaska

Disability Law Center of Virginia

Disability Law Colorado

Disability Rights Education and Defense Fund

Disability Rights Arkansas

Disability Rights California

Disability Rights Florida

Disability Rights Iowa

Disability Rights Center-New Hampshire

Disability Rights New Jersey

Disability Rights New York

Disability Rights North Carolina

Disability Rights Ohio

Disability Rights South Dakota

Disability Tennessee

Disability Rights Texas

Disability Rights Vermont

Disability Rights Washington

Disability Rights West Virginia

Down Syndrome Alliance of the Midlands

Down Syndrome Association of Delaware

Down Syndrome Indiana, Inc.

Easter Seals

Epilepsy Foundation

Family Voices

Hawaii Disability Rights Center

Healthcare Rights Coalition

Independence Inc.

Independent Connection Inc.

Indiana Disability Rights

Individual Family Social Work Counseling

Iowa Developmental Disabilities Council

Lakeshore Foundation

Long Term Care Community Coalition

The Jewish Federations of North America

Justice in Aging

Lutheran Services in America-Disability Network

Life Path Inc.

Maine Long-Term Care Ombudsman Program

Meals on Wheels of America

Medicare Rights Center

Michigan Protection & Advocacy Service, Inc. (MPAS)

Missouri Hospice and Palliative Care Association

National Academy of Elder Law Attorneys

National Alliance for Caregiving

National Association for Home Care and Hospice

National Association of Area Agencies on Aging (n4a)

National Association of Councils on Developmental Disabilities

National Association of State Directors of Developmental Disabilities Services

National Association of State Head Injury Administrators

National Association of State Long-Term Care Ombudsman Programs (NASOP)

National Council on Aging

National Council on Independent Living

National ADAPT

ADAPT Montana

ADAPT of Texas

National Association of Social Workers (NASW)

National Consumer Voice for Quality Long-Term Care

National Disability Rights Network

National Down Syndrome Congress

National Health Law Program

Nevada Disability Advocacy & Law Center

National Respite Coalition

Nursing Home Victims Coalition Inc.

Oklahoma Disability Law Center, Inc.

Office of the State Long-Term Care Ombudsman

Ohio Region 5 Long-Term Care Ombudsman Program

On Lok PACE

Our Mother's Voice

Paralyzed Veterans of America

Partners in Care Foundation

Personal Assistance Services Council

Personal Attendant Coalition of Texas

The Program to Improve Eldercare, Altarum

Protection and Advocacy Project North Dakota

Protection and Advocacy for People with Disabilities South Carolina

Service Employees International Union (SEIU)

Starkloff Disability Institute

SKIL Resource Center

SourceAmerica

TASH

Three Rivers Inc.

Topeka Independent Living Resource Center

United Spinal Association

United Spinal Association, Iowa Chapter

United Spinal Association, Louisiana Chapter

United Spinal Association, New Mexico Chapter

United Spinal, Oregon Spinal Cord Injury Connection

United Spinal, South Carolina Spinal Cord Association

Submitted Public Comment of Christopher Laxton, Executive Director,
AMDA – The Society for Post-Acute and Long-Term Care Medicine

Senate Special Committee on Aging
Hearing on "Caring for Seniors Amid the COVID-19-19 Crisis"
May 27, 2020

Madame Chair, Ranking Member, and other Members of the Committee,

Thank you for holding this important hearing about aging Americans during the COVID-19-crisis. I am the Executive Director of AMDA – The Society for Post-Acute and Long-Term Care Medicine. We are the only medical specialty society representing the community of over 50,000 medical directors, physicians, nurse practitioners, physician assistants, and other clinical specialists working in the various post-acute and long-term care (PALTC) settings. The Society's 5,500 members work in skilled nursing facilities, long-term care and assisted living communities, CCRCs, home care, hospice, PACE programs, and other settings.

Our nation's nursing homes are on the front lines of the response to the Coronavirus Disease 2019 (COVID-19) pandemic. One in six nursing homes have publicly reported COVID-19 cases.[1] Further, there have been over 38,000 reported resident and staff deaths due to COVID-19 in post-acute and long-term care (PALTC) facilities in the 39 states that publicly report such data, representing 43 percent of all deaths due to COVID-19 in those states.[2] COVID-19 places nursing home populations at significant and disproportionate risk due to their age and multiple co-morbid conditions, which is exacerbated by personal protective equipment (PPE) and testing limitations.

My testimony focuses on a few key areas of concern for our nation's seniors and those who work in the PALTC community.

Data Limitations – Need for a Medical Director National Registry

The limitations and inconsistencies in data about the nursing home workforce during the COVID-19 pandemic is a major area for concern. First, we support the collection of uniform data on COVID-19 spread within the PALTC community for both residents and the work force. Second, we support the collection of uniform data on screening and testing within the PALTC community for both residents and the work force. Third, we support uniform data about our nation's PALTC physicians and advanced practice clinicians (APCs) who are working closely with nursing facilities

[1] Washington Post, https://www.washingtonpost.com/investigations/number-of-nursing-homes-with-publicly-report ed-cases-of-the-coronavirus-soars/2020/04/29/7375941c-898c-11ea-ac8a-fe9b8088e101_story.html
[2] Kaiser Family Foundation, https://www.kff.org/health-costs/issue-brief/state-data-and-policy-actions-to-address-coronavirus/?utm_source=web&utm_medium=trending&utm_campaign=covid-19

across the country to mitigate the virus's spread. Unlike a hospital setting, very few nursing home settings have physicians or APCs inside the buildings 24/7.

Unfortunately, public records regarding these physicians and APCs do not exist. As a result, federal, state, and local public health agencies have been unable to identify facility medical directors to aid in the preparation for, as well as the response to, the COVID-19 pandemic. A clinician list would be of enormous value for public health agencies to address preparedness for influenza, norovirus, and other seasonal outbreaks as well as other emergency uses during the COVID-19 pandemic. Under 42 CFR §483.70(h), the Centers for Medicare and Medicaid Services (CMS) requires every nursing home to designate a physician to serve as medical director who is responsible for the implementation of resident care policies and the coordination of medical care in the facility.

We believe that CMS should begin keeping a public record, by name, of medical directors and associate medical directors or other physicians being paid as administrative personnel in each nursing home. Of note, a key role of the medical director involves implementing an effective antibiotic stewardship program and maintaining and improving staff understanding of, and compliance with, infection control procedures. The public needs and deserves access to immediate and adequate data about the clinicians who perform this vital role.

Engaging PALTC expertise

Several states have either mandated or facilitated specialists in PALTC medicine and geriatrics to help state and local governments plan and implement strategies to prevent and mitigate COVID-19 in facilities. Involving those with expertise in the clinical care and management of this highly complex patient and resident population, as well as those responsible for the leadership and administration of the nursing home and assisted living communities, in formulation of policy and guidance for the PALTC community will yield the best results.

Hospitals, nursing homes, and local health authorities need to work together to develop surge capacity and options to keep all patients safe. Safe transfers from hospitals to the post-acute setting and the community is of critical importance. Nursing homes, hospitals and state/county health agencies should immediately form collaborative COVID-19 response teams to develop options for bed capacity, staffing, PPE, and testing availability.

Testing

There is a clear understanding that protecting our vulnerable post-acute and long-term care (PALTC) population is dependent on adequate access to testing. Testing must be readily accessible, completed in a timely manner by those with appropriate training, have low false negative or false positive rates, impose a low physical or emotional burden on the person being tested, provide rapid results (ideally within 24 hours), and be appropriately reimbursed.

Many states, local health departments, facilities, and consumers are calling for "universal testing" of PALTC residents and staff. The underlying premises behind these calls are that tests would be available for all, would meet the criteria set forth above, result in better care being delivered to our PALTC residents, and save lives. However, multiple considerations must be addressed before implementing universal testing. We have summarized the most important of these below.

1. **What is meant by universal testing?** To some, universal testing involves all residents and staff in a facility, whether or not any individual has symptoms. Here the goal is early

identification and assessment of baseline infection rates. In other cases, facility-wide testing is only done once a case occurs. The goal of this approach is to limit spread and assist with management.

2. **How often must universal testing be done?** Universal testing provides a point prevalence estimate. The information obtained is only meaningful for that point in time. Anyone exposed but negative at the time of the point prevalence study may turn positive over the next couple of days or weeks, contributing to spread. Repeat testing should be done, though there is no consensus on how frequently.
3. **What is the turnaround time for testing?** A basic tenet of effective testing is the rapid turnaround time necessary to take prompt action. Many areas of the country have experienced turnaround times of up to a week for polymerase chain reaction (PCR) tests. If results take more that 24-48 hours to return, the value of such testing is reduced considerably. In addition, laboratory capacity may be quickly overwhelmed when large numbers of tests are ordered, for example, through a state or federal order.
4. **Should healthcare personnel, residents, or both be tested?** While the focus of testing is to protect residents, healthcare personnel (HCP) should also be considered for testing. HCP enter and exit the building and enter the larger community each day, increasing risk of acquiring COVID-19 and asymptomatic infections are well documented for this disease. Focusing on just residents will likely miss detecting infected staff who can introduce the virus to the facility.
6. **Can facilities cover the costs of testing?** Average costs currently range from $50-110 or more per test. For residents on Part A coverage, this cost is borne entirely by the facility, many of which are already under financial stress. Directives in some states shift the entire cost of testing to facilities. Facilities simply do not have the financial ability to cover such directives.
7. **Do we have enough tests?** Many areas of the country do not have access to readily available tests as of the time of publication of this document. Universal screening of residents and staff can deplete regional testing supplies and put symptomatic individuals at risk due to shortages.
8. **Is there a plan in place to deal with the test results?** Facilities need to have a plan in place to address issues such as cohorting, ensuring adequate supplies of personal protective equipment (PPE) and staff shortages.
9. **What happens if large numbers of staff must suddenly be furloughed?** Facilities need to be prepared for the possibility of having a large percentage of their staff furloughed because of positive results and the probable need for isolation for at least 10-14 days. This negatively impacts staffing levels and the quality of care that can be provided. Staff shortages also have the potential to worsen infection control practices, such as reducing the capability to separate exposed and unexposed staff. Facilities may need to evacuate residents in the event of severe staffing shortages.
10. **What is the emotional impact of repeated testing of residents with dementia, anxiety, post-traumatic stress disorders or other psychological health conditions?** Nasopharyngeal testing is uncomfortable. Residents, especially those with impaired cognition, may suffer physical and emotional distress from testing, particularly if repeated.

Testing is only a technology and any technology used incorrectly or without a broad strategy will fail. We cannot test our way out of COVID-19. Testing must be done in conjunction with strict

attention to clinical case-finding, screening of staff for symptoms, and visitor restrictions, in addition to prevention of transmission with universal masking, appropriate use of PPE, and environmental cleaning. Testing decisions must be individualized to the facility with a clear understanding of the regional prevalence of disease, local testing accessibility and capacity, and well-defined goals of testing.

Without making sure that all complexities related to testing are addressed, in consultation with PALTC medical and clinical specialists, such mandates are likely to be counterproductive and will not produce the results they were intended to deliver.

Re-opening

As states and local communities begin to reopen their retail stores, residents and employees of post-acute and long-term care facilities, along with their families, will wonder when they too will be able to end no-visitor policies, dine together again, and enjoy group activities and routine visits to the salon.

Residents of post-acute and long-term care (PALTC) facilities remain the most vulnerable population during this ongoing COVID-19 pandemic. While some areas in the country have seen a decline in hospital admissions and deaths from COVID-19, other areas continue to see a rise in cases, hospitalizations, and deaths within PALTC. The disproportionately high number of nursing home and assisted living related COVID-19 deaths reported in the U.S. may, unfortunately, be an undercount.

Infectious disease experts warn that the country will experience a second wave of the virus this fall, and it is unclear if we will be prepared for it. PALTC reopening must consider widespread, reliable testing which is still not a reality for many PALTC communities, nor is a consistent supply of personal protective equipment for healthcare workers in long term care.

Given these factors, the decision to reopen or to relax social distancing efforts within PALTC communities must be made with great caution and on an individual basis, regardless of the status of the surrounding community. Any re-occurrence of COVID-19 in a facility must trigger a return to maximum restrictions. This critical decision rests with the people most familiar with residents, staff, and resources—the clinical leaders managing the care of the patients and residents in these facilities. Medical directors, executive directors and directors of nursing, along with their regional leadership, should work in collaboration with their local health departments and hospital systems to determine the appropriate time to reopen their nursing homes and assisted living communities to visitors, to relax social distancing policies and personal protective equipment requirements.

Finally, we urge federal, state and local governments and health authorities to stipulate that, in the chain of events leading to reopening businesses and buildings, that PALTC facilities, where older adults most at risk of serious illness or death from COVID-19 reside, be the last to open to visitors and outside contractors and vendor

Specialized COVID-19 Positive Centers

We also recommend designating specific nursing facilities as specialized “COVID-19 Positive Centers” using a data-driven approach. These facilities could prepare for the expected fall surge by declining new uninfected patients effective immediately, and, if they cannot be well-isolated, transferring uninfected longer-term residents to other facilities. Having these centers will help designate safe care options for Medicare and Medicaid patients and their families.

We further propose that states gather data from every skilled nursing facility (SNF) and construct a post-acute COVID-19 plan. Congress should provide funds through state/local authorities to prepare new COVID-19 positive post-acute units and facilities and hire new staff, including trained infection preventionists. States and localities should develop and use metrics within their plans to set up and select facilities. The number of SNFs that should be designated as COVID-19 positive centers will need to be made by local regulatory authorities using the best-available estimates of beds needed. States must also work with facilities without the threat of fines as we have seen in Kirkland, Washington. In the current environment, facilities need financial resources to help set up COVID-19 units with proper PPE. Fining facilities at this juncture simply exacerbates this problem.

In closing, I want to emphasize the need to include PALTC expertise at the policy table. Without the involvement of clinical expertise, the results will continue to be detrimental to the care and safety of our most vulnerable older adults. We are experts in the field and stand ready to provide our guidance to all stakeholders and policymakers on issues that affect our patients and residents. We hope to continue to work together to ensure a safe environment that provides quality of life for those we care for. The Society looks forward to the opportunity to work with the Committee in the future on the important and evolving issue of caring for aging Americans in the PALTC continuum facing issues involving COVID-19.

Alzheimer's Association and Alzheimer's Impact Movement Statement for the Record

United States Senate Special Committee on Aging
Hearing on "Caring for Seniors Amid the COVID-19 Crisis"

May 21, 2020

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's hearing entitled "Caring for Seniors Amid the COVID-19 Crisis." 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 of specific policies that would help people living with Alzheimer's and other dementia during the COVID-19 pandemic, including long-term care policy recommendations, the *Promoting Alzheimer's Awareness to Prevent Elder Abuse Act* (S. 3703/H.R. 6813), the *Improving HOPE for Alzheimer's Act* (S. 880/H.R. 1873), and efforts to expand capacity for health outcomes through Project ECHO.

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 dementia 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.

Long-Term Care Policy Recommendations

The COVID-19 pandemic continues to create additional challenges for people living with dementia, their families, and caregivers. These challenges are particularly being felt in long-term care settings. Nursing homes and assisted living 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 other 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 facilities, their staff, and their residents are experiencing a crisis due to a lack of transparency, an inability to access the necessary testing, inaccurate reporting, and more. According to some estimates, more than 28,000 residents and workers have died from the coronavirus at nursing homes and other long-term care communities.

The Alzheimer's Association recently released new policy recommendations, *Improving the State and Federal Response to COVID-19 in Long-Term Care Settings*, to address the immediate and long-term issues impacting care facilities during the COVID-19 pandemic. These recommendations focus on four main areas: enhancing testing in long-term care community settings; implementing necessary reporting; developing protocols to respond to a rise in cases;

and ensuring all facilities have necessary support, like personal protective equipment (PPE). Each nursing home and assisted living community must have the onsite testing capability to verify that all residents, staff, and visitors are free of COVID-19 infection, whether or not they are symptomatic. Government support is needed to ensure accelerated production and delivery of testing, with rapid turnaround testing staffed by trained personnel. Once this testing is implemented, all cases of COVID-19 at nursing homes and assisted living communities need to be reported immediately and accurately. Additionally, these reports should be updated upon remission, death, transfer, or other appropriate status update. With all appropriate privacy safeguards for individuals, this reported data should be freely and immediately accessible to everyone, down to the facility level. As "hot spots" occur, they must be dealt with urgently and effectively. Any reported cases should trigger careful, ongoing monitoring and, if conditions warrant, "strike teams" should be deployed to the facility to provide needed support until the outbreak is appropriately contained and eliminated. Finally, all nursing homes and assisted living communities must have full access to all needed PPE, testing equipment, training, and external support to keep them COVID-19 free. Importantly, this includes requiring nursing homes and assisted living communities to address social isolation and ensure people with Alzheimer's and other dementia are able to communicate with designated family and friends. As the Committee and Congress work to craft the next COVID-19 response package, we respectfully request that you include these policy solutions to help protect this vulnerable population.

Promoting Alzheimer's Awareness to Prevent Elder Abuse Act

There are also several bipartisan bills that we hope the Committee and Congress will consider for inclusion in the next response package. We thank Chairman Collins for introducing the *Promoting Alzheimer's Awareness to Prevent Elder Abuse Act* (S. 3703/H.R. 6813), which would improve interactions between justice personnel and people with Alzheimer's and other dementia. With the current COVID-19 pandemic and given the growing population of persons with dementia, police, emergency personnel, and social workers will increasingly encounter these vulnerable individuals, and working with them can be fundamentally different from working with other older victims of abuse or exploitation. For example, individuals living with dementia often have difficulty understanding or explaining situations. Common behaviors experienced by individuals living with Alzheimer's and other dementia could be viewed as uncooperative, disruptive, or combative unless professionals have training on the unique needs of someone living with dementia. This bipartisan bill is consistent with the *National Plan to Address Alzheimer's Disease* and will help ensure greater success for the Department of Justice's efforts to combat elder abuse, neglect, and financial fraud targeting seniors. This bill would require the Department of Justice to develop training materials to assist professionals supporting victims of abuse living with Alzheimer's and other dementia. Dementia-specific training materials for these professionals will improve the quality of their interactions with individuals living with Alzheimer's and other dementia, and will also help protect them from elder abuse.

Improving HOPE for Alzheimer's Act

We also ask the Committee and Congress to include the bipartisan *Improving HOPE for Alzheimer's Act* (S. 880/H.R. 1873), which would educate clinicians on Alzheimer's and dementia care planning services available through Medicare. As the COVID-19 pandemic continues to

challenge health systems worldwide, it raises many important issues including care planning in the presence of acute life-threatening illness, especially for patients with chronic diseases like Alzheimer's and other dementia. Robust care planning is the first step to learning about long-term care options and selecting the preferred, most appropriate services for persons with dementia, families, and caregivers. Analyses show dementia-specific care planning can lead to fewer hospitalizations, fewer emergency room visits, and better medication management. Alzheimer's and related dementia also complicate the management of other chronic conditions, so care planning is key to their management and better care coordination. The availability of CPT® code 99483, care planning for persons with cognitive impairment, is an important step in that direction; however we must ensure that clinicians are aware of this code. Nearly half of Congress has cosponsored this vital legislation.

Expanding Capacity for Health Outcomes (Project ECHO)

Finally, we ask that you consider crucial provisions to expand the use of technology-enabled collaborative learning and capacity-building models. These education models, often referred to as Project ECHO, can improve the capacity of providers, especially those in rural and underserved areas, on how to best meet the needs of people living with Alzheimer's. During the COVID-19 pandemic, Project ECHO is helping primary care physicians in real-time understand how to use validated assessment tools appropriate for virtual use to make early and accurate diagnoses, educate families about the diagnosis and home management strategies, and help caregivers understand the behavioral changes associated with Alzheimer's, which can be heightened during isolation. Project ECHO is also helping long-term care providers in real-time understand how to train temporary staff that may not be familiar with how to best care for people with Alzheimer's, implement important health strategies, such as hand-washing and social distancing for people with Alzheimer's, and effectively communicate with residents to help them understand the COVID-19 pandemic.

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. We also thank Ranking Member Casey for introducing the *Nursing Home COVID-19 Protection and Prevention Act*, which would provide $20 billion to help states, nursing homes, and intermediate care facilities contain the spread of COVID-19. We look forward to working with the Committee and other members of Congress in a bipartisan way to advance this and other policies that would help this vulnerable population during the COVID-19 pandemic, including long-term care policy recommendations, the *Promoting Alzheimer's Awareness to Prevent Elder Abuse Act* (S. 3703/H.R. 6813), the *Improving HOPE for Alzheimer's Act* (S. 880/H.R. 1873), and efforts to expand capacity for health outcomes through Project ECHO.

Written Testimony of Janice Monks
President and CEO, American Association of Service Coordinators
U.S. Senate Special Committee on Aging
"Caring for Seniors amid the COVID-19 Crisis"
May 21, 2020

Chairwoman Collins, Ranking Member Casey, and members of the Committee,

Thank you for the opportunity to submit written testimony. We appreciate this hearing and your attention to the impact COVID-19 has had on older adults and how best to assist them through this crisis. Supporting and educating service coordinators who are supporting vulnerable older Americans is the purpose of the American Association of Service Coordinators (AASC).

For more than 20 years AASC has represented the interests of service coordinators in every state and territory and provided them with training, policies and guidance on best practices. Our 3,500 members play a pivotal role in nationwide efforts to assist older adults to independently age in place and reduce health care costs while improving health outcomes. To achieve these goals, service coordinators identify older adults' needs and connect them to community-based organizations. They navigate their healthcare benefits and address their social determinants of health.

The needs of older Americans have increased dramatically during the COVID-19 pandemic. Service coordinators have been imperative to the lives of residents living in affordable housing. They are working tirelessly to ensure that older adults remain safe, connected to healthcare services and have access to those supports and services that allow them to independently age in place.

Currently, the majority of service coordinators work in affordable senior housing funded by the U.S. Department of Housing and Urban Development (HUD). There are an estimated 5,000 service coordinators working in HUD Section 202 properties. Of those, more than 1,700 are funded through $100 million in HUD grants, which are subject to funding availability and renewed on an annual basis. The remaining service coordinators are funded through the operations of HUD multifamily property budgets.

HUD also funds nearly 300 grants for Resident Opportunity and Self-Sufficiency (ROSS) service coordinators who work in public housing. Because elderly and disabled households make up 57% of households receiving HUD rental assistance[1], the majority of ROSS coordinators report working on properties made up mostly or entirely of older adults.

Properties that take advantage of Low-Income Housing Tax Credits employ service coordinators as well. While there is little or no financial assistance available to most LIHTC properties to hire service coordinators, a growing number of owners and property management companies have made service coordination a priority because of the impact service coordinators have on resident well-being and retention.

Providing Increased Support

In normal times, service coordinators in all types of senior housing communities are connecting residents with food, healthcare and socialization. The demand for these efforts has expanded significantly in response to the pandemic as service coordinators are uniquely skilled at solving complex

challenges and swiftly connecting residents to resources. A key role of service coordinators is to build support systems of government and community-based organizations that they can call on to address critical needs and keep residents healthy, stably housed and socially connected. Moreover, they are well-known and relied upon by the residents of affordable housing properties.

In uncertain times such as these, service coordinators become even more vital to the residents they serve. With COVID-19 came mandates tied to stay-at-home orders and changes to Medicare, the Supplemental Nutrition Assistance Program and many other benefits older adults rely on. Service coordinators have capitalized on their trusted relationships with residents to ensure they have accurate information about these COVID-19-related changes.

Service coordinators are also helping residents navigate the unfamiliar territories of stimulus checks and the technology that is needed for telehealth and connecting with family and friends. Protecting residents from fraud and scams is a common function of service coordinators but during COVID-19 this work has become a top priority for service coordinators.

The number of service coordinator interactions with residents has significantly risen each month since the virus began spreading rapidly in the U.S.[2] In April, more than 2,500 service coordinators using the AASC Online case management system reported providing residents with information about infectious disease screenings 15,913 times and infectious disease prevention 40,600 times. They also reported providing 121,673 infectious disease wellness checks last month.

Meanwhile, assisting residents with disastrous events in their lives, such as COVID-19, significantly increased from 699 instances in February before the pandemic was declared to 8,048 in April. Telephone reassurance to residents was provided 3,177 times in February, 29,047 times in March and 68,682 times in April. And service coordinators using AASC Online followed up with residents on COVID-19 related matters more than 67,000 times in April, which represents a 158% increase over February and a 66% increase over March.

In-person events led by service coordinators prior to the pandemic have been replaced with weekly check-in calls and personal notes slipped underneath residents' doors to ensure their critical needs continue to be met and that they do not suffer from the mental health challenges social isolation can create.

To determine if a resident is at higher risk of having negative outcomes linked with COVID-19, service coordinators and property managers are using a Resident Vulnerability Tool created by AASC. Service coordinators have used this assessment and the key data points, including food insecurity, age, social isolation and connection to community based resources, to identify which residents have needs that require prioritization throughout this pandemic. The de-identified data in this report can be distributed to local health and emergency professionals if COVID-19 were to become active at a property and special precautions would need to be taken.

Serving Older Adults in Congregate Settings

The two million seniors who live in congregate settings, including federally subsidized housing, are at an increased risk of suffering dire consequences of contracting the virus. The average age of residents in HUD Section 202 properties for older adults is 79[3] and 55% of older adults who are dually eligible for Medicare and Medicaid have five or more chronic conditions[4] which makes them more susceptible to

COVID-19 complications.[5] Black and Latino Americans, who have been disproportionally infected with and died from the virus[6], respectively make up 44% and 26% of public housing populations.[7]

Despite the health disparities and complications associated with these populations, 93% of older adults who live in affordable housing with a service coordinator remain in their communities receiving services from community-based organizations.[8] The connection to community supports and services that service coordinators provide prevent many vulnerable older adults from prematurely moving to facilities that provide higher levels of care. The financial cost of moving to a nursing home or assisted living is 66% higher than that of affordable housing with services aimed at supporting individuals to age in place within their communities. The social cost has increased in the face of COVID-19 as these facilities become hot zones for the virus. Long-term care residents and employees have accounted for one-third of all virus-related deaths in the country[9] and ever far higher in some states, such as Maine.[10]

As trusted community leaders, service coordinators are collaborating with local health officials and drafting reopening plans at their properties to prevent the spread of the virus. Service coordinators were also valuable contributors to their ownership companies' preparations to combat the pandemic in its early stages when strict social distancing was being put into place.

In addition to creating protocols in response to restrictions related to COVID-19, service coordinators have worked with community partners to obtain donations of face masks, hand sanitizer, gloves and other protective and cleaning supplies for all property staff and residents. Service coordinators have been deemed Essential Critical Infrastructure Workers during COVID-19 by the U.S. Dept. of Homeland Security[11] and most have continued working during state lockdowns. However, they are not among those working closely with high-risk populations who are eligible for personal protective equipment provided by some state or federal governments.

The American Association of Service Coordinators is thankful for the timely emergency resources you provided for HUD senior housing in the CARES Act and we are hopeful that those funds as well as any future support can help offset the costs of the supplies and other resources needed to reduce exposure to the virus in federally funded properties.

Lessening the Impacts of COVID-19

Service coordinators, particularly during this crisis, have proven to be essential to the communities and older adults they serve. **However, about half of all federally funded properties eligible for a service coordination program do not have access to the funding needed to provide this imperative resource to residents.**

Additional service coordinators and further support for existing service coordinators are essential to efforts to care for independent older adults during the COVID-19 pandemic. Vulnerable older adults living in affordable housing will remain impacted by this pandemic for the unforeseeable future. Service coordinators will continue to assist older residents through social isolation support, modifications to services and vital access to healthcare through telehealth. Deploying service coordinators in every federally funded senior property would provide certainty that residents have a clear pathway to critical resources, at least one social connection, reassurance and reliable information.

Flexibility and additional resources for the properties in which they serve would also be beneficial to meet the quickly evolving needs of residents and ensure the safety of staff work environments during this time.

Thank you again for the opportunity to share how service coordinators are working to lessen the negative impacts of COVID-19. We encourage you to learn more about the service coordination programs in your states as you consider ways to improve how our nation is caring for older adults living independently during COVID-19. The American Association of Service Coordinators stands ready to work with the committee to strengthen the resources available to vulnerable older adults.

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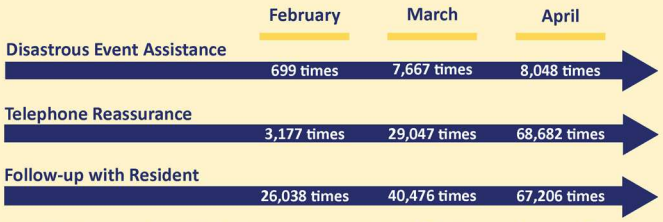
AASC
American Association of Service Coordinators

Service Coordinator Response to COVID-19

Service coordinators are trusted leaders on properties throughout the country. In times of crisis residents turn to their service coordinators for reassurance, assistance and reliable information. At this time, service coordinators are, among other actions:

- Navigating through statewide and community stay-at-home orders to ensure continued access to regular food deliveries and prescriptions.
- Calling, emailing and leaving notes on the doors of residents to ensure they maintain social connections, receive reliable information about the virus and have services in place to meet their basic needs.
- Informing residents about stimulus payment requirements, healthcare delivery and Medicare coverage changes, and coronavirus related scams.

In April, service coordinators using AASC Online* reported providing residents with information about infectious disease screenings 15,913 times and infectious disease prevention 40,600 times. They also reported 121,673 infectious disease wellness checks in April. Overall service coordinator outreach has increased since COVID-19 began spreading rapidly throughout the U.S. in March.



Comparison of Crisis Intervention and Monitoring category reporting in AASC Online month to month. These numbers are expected to rise further in the coming weeks and months as the number of COVID-19 cases in the country continues to increase.

Risk Vulnerability Assessment

AASC, in collaboration with the Pangea Foundation, has created a Resident Vulnerability Tool that considers key data points that may indicate a resident is at higher risk of having negative outcomes linked with COVID-19. This assessment is helping service coordinators and property management understand which residents may have needs that will require prioritization throughout this pandemic. It may also be distributed to local health and emergency professionals if COVID-19 were to become active at a property.

*2,527 Service coordinators using AASC Online reported serving 259,977 residents on 3,281 properties in 2019.

Adapting to Social Distancing

Service coordinators are on the front lines of COVID-19. The majority of service coordinators work in elderly properties where residents are most at risk of suffering dire consequences from contracting the virus. In normal times, service coordinators are connecting the most vulnerable residents with food, healthcare and socialization. The demand for these efforts has expanded significantly in response to the pandemic as service coordinators are uniquely skilled at solving complex challenges and swiftly connecting residents to resources.

Access to Healthy Food

In a typical year, service coordinators who use AASC Online report connecting nearly 50,000 residents to food programs. Many of HUD's senior affordable housing properties serve as congregate meal sites, which cannot occur during state or local lockdowns. Fortunately, the food is still being delivered in bulk and must be distributed to residents in their units. Service coordinators on these properties are helping to box up food items and leave them on residents' doorsteps to avoid direct contact. This has given service coordinators the opportunity to leave with the food personal notes of encouragement.

Service coordinators are working with local Meals on Wheels providers to expand services to their residents who weren't enrolled prior to the pandemic. As meals resources become scarcer, some service coordinators have found financial support to create food pantries with basic items for those residents who can't receive Meals on Wheels and/or fear visiting the grocery store.

Healthcare and Prescription Drug Changes

CMS has announced several changes to healthcare delivery and Medicare coverage. Service coordinators are monitoring these changes and explaining options to residents. They're helping residents determine how best to connect with their healthcare providers and oftentimes training residents on how to use technology that enables telehealth when phone conversations aren't possible. This is essential as residents of HUD-assisted senior housing who are participating in service coordinator programs report having an average of four chronic health conditions.

At Diocese of Camden properties in New Jersey, service coordinators are assisting residents with setting up prescription delivery to ensure they can remain safely in their homes during the pandemic.

Service coordinators in all properties also continue to educate residents about the rash of scams with a new focus on those related to COVID-19 testing and Medicare benefits. As the virus spreads locally and worldwide, concerns and anxiety are high. This concern, combined with new information daily, creates a situation ripe for fraud.

Social Isolation Prevention

To keep residents engaged during stay-in-place orders, service coordinators on properties throughout the country are delivering interactive activities and personal messages to residents' doorsteps. KMG Prestige service coordinators in Michigan, Illinois and Ohio are among those getting creative to stay in touch with residents. "Thinking of You" cards with a special note are allowing residents to stay connected while maintaining safe boundaries. The team has also left care packages near the residents' apartments, and shared senior-friendly jokes, habits for happiness, word puzzles, and exercises to reduce anxiety.

Like many of their peers, service coordinators at St. Mary Development Corporation properties in Ohio are calling residents daily to touch base and ensure they are safe and their needs continue to be met.

American Association of Service Coordinators
489 Village Park Drive, Powell, OH, 43065
614-848-5958 | servicecoordinator.org

April 3, 2020

The Honorable Mitch McConnell, Majority Leader
The Honorable Chuck Schumer, Minority Leader
United States Senate
Washington, DC 20515

The Honorable Nancy Pelosi, Speaker
The Honorable Kevin McCarthy, Minority Leader
United States House of Representatives
Washington, DC 20510

Dear Majority Leader McConnell, Minority Leader Schumer, Speaker Pelosi, and Minority Leader McCarthy:

The American Association of Service Coordinators (AASC) represents more than 3,500 members across the country who are connecting low-income families and older adults living in affordable housing to vital resources. Service coordinators assist many of their residents with access to health care and reduce barriers to living well. In doing so, they play integral roles in the nation's efforts to reduce health care costs, improve outcomes and connect individuals with appropriate care.

Coronavirus is both a health and an economic threat to already vulnerable Americans, particularly older adults and those with serious health conditions. We greatly appreciate your response to this crisis through previous legislation. As you consider additional supports to address the pandemic, we urge you to take a comprehensive approach that provides adequate funding for affordable housing and services. Any further response should include resources to ensure housing stability, access to services that allow older adults to age in community, and protections and supports for those who care for older adults in their homes.

On behalf of those we serve, we ask that you consider the following needs:

Service Coordination

$300 million for Multifamily Service Coordinators – Of this amount, $10 million is needed for more than 1,600 existing grant-based service coordinators and $20 million is needed for an estimated 3,500 budget-based service coordinators to address immediate COVID-19-related costs.

Statutory language is also needed to ensure speedy access to these resources and that the eligible uses for Service Coordinator funds are expanded to include flexibility for COVID-19-related costs that support residents' health and wellness needs.

The remaining $270 million investment is needed to enable communities without a service coordinator grant to employ one. Fewer than half of HUD-assisted senior housing communities have the resources they need to employ a service coordinator.

$10 Million for Self-Sufficiency Coordinators – Resident Opportunities and Self Sufficiency service coordinators and Family Self-Sufficiency service coordinators need immediate access to additional funds to address increased needs and costs related to COVID-19.

Technology

$2 million for a unified communications platform to enhance coordination and delivery of community services to vulnerable seniors – Real-time communication connecting a broad spectrum of the care ecosystem – from service coordinators, residents, nurses, first responders, service providers and others—supports comprehensive wellness for vulnerable seniors and ensures all communities get equal access to vital services.

This investment would fully fund rapid enhancements to a platform, which is already used in more than 5,000 of America's senior housing properties, to ensure more seamless care delivery and provide access to tools that will be essential for service coordinators and other affordable housing staff to manage the COVID-19 health crisis.

Among the enhancements needed is a safe, reliable and flexible way for service coordinators already using the platform to communicate in real time with the more than 575,000 vulnerable, low-income residents they serve nationwide.

$50 million for WiFi for federally-assisted senior housing – There is a need to install WiFi in federally-assisted housing communities, and to help residents pay for internet in their units. Most federally assisted senior housing communities do not have building wide WiFi, which would allow for telehealth services in common spaces, in individual apartments, and to help residents from outside the building. WiFi would also help Service Coordinators assist and engage residents and help combat social isolation.

Affordable Housing

$1 Billion for New Section 202 Homes - This infrastructure investment would result in short- and long-term jobs, as well as 3,800 affordable senior homes with service coordinators in the affordable community. When only Section 202 dollars are used to build and operate these homes, their building can be rapid rather than bogged down in the multiple processes and timelines when other resources must be used.

$450 million in emergency assistance for HUD-assisted senior housing communities – Specifically, this should include the following allocations:

- $295 million for replacement and supplemental staffing. This would provide the approximately 6,700 HUD Section 202 Housing for the Elderly communities with extra staffing (three per property) for 14 weeks at an hourly rate of $30.
- $150 million for each senior community to secure supplies for preparedness, disinfection, and personal protective equipment.
- $5 million to support mandatory meal programs – These programs are paid for by residents whose income may decrease during the pandemic. Regardless of their abilities to pay, these older adults will continue to rely on access to these meals.

$400 million for rent supports - These resources are needed to make up for decreased rents from HUD- and USDA-assisted older adult residents, necessary vacancies and emergency housing assistance to ensure housing affordability.

$1.4 billion for federally assisted housing supports – These resources are needed to make up for decreased rents from HUD- and USDA-assisted older adult residents, to cover the costs of necessary vacancies, for COVID-19 costs, and for emergency housing assistance to ensure housing affordability for residents of Low Income Housing Tax Credit housing, etc.

Ensure that vulnerable populations and entities that serve those populations receive priority access to Personal Protective Equipment – These entities include nursing homes, assisted living, home health, hospice, home and community based providers, and senior housing (affordable HUD housing, continuing care retirement communities, and market-rate housing for seniors and persons with disabilities).

AASC urges Congress to adopt these measures in order to promote stability and well-being for low-income Americans and those who serve them.

Sincerely,

Janice Monks, President and CEO

STATEMENT FOR THE RECORD

SENATE SPECIAL COMMITTEE ON AGING
"Caring for Seniors Amid the COVID-19 Crisis"
May 21, 2020

Chairman Collins, Ranking Member Casey, and distinguished Members of the Special Committee on Aging, thank you for the opportunity to share the perspectives of the American Health Care Association and the National Center for Assisted Living (AHCA/NCAL) regarding caring for seniors amid the current COVID-19 crisis.

AHCA/NCAL represents more than 14,000 non-profit and proprietary skilled nursing centers, assisted living communities, and homes for individuals with intellectual and developmental disabilities. The 2.5 million Americans our long-term care providers serve every day are some of the most threatened by the coronavirus. They are typically the oldest-old (85+ years) and have multiple comorbidities that leave them especially vulnerable to the virus and subsequent complications. The price of inaction is alarming.

COVID-19 is currently impacting many nursing facilities across the U.S. and continues to spread rapidly across the country. As a result, long term care providers are facing immediate and dire circumstances. It is our utmost priority to provide safety and protection for our residents, patients and healthcare workers by doing everything possible to work with your committee to eliminate infections within our facilities and to flatten the curve of this pandemic. The greatest and most immediate crisis we face is the lack of healthcare workers and an increased need for essential supplies in all settings.

Our employees are on the frontline of this crisis, making personal sacrifices and are voluntarily placing themselves in harm's way to protect and provide quality care for someone's mother, father, grandfather, grandmother, family member, or friend who is unable to live on their own and relies on the assistance of others. Those who are sick with respiratory symptoms consistent with COVID-19 or those exposed must stay home. Many have school-age children and while schools are closed in many areas, they are forced to stay home to provide child care. These factors have combined to place long term care providers in an acute workforce crisis. We need immediate resources to attract and retain more nurses (RNs, LPNs and CNAs) and support personnel including dietary and housekeeping staff.

While our current staff are working multiple shifts and in some cases around the clock, it is simply a matter of time before they burn out, further complicating this crisis. A workforce shortage of this magnitude severely impacts our ability to provide needed care to residents and combat the viral spread. AHCA/NCAL has testified on workforce

shortages on Capitol Hill in the past and has worked on a variety of efforts to recruit and retain quality staff in our centers – including loan forgiveness efforts. During this pandemic, we have worked with other industries that have experienced layoffs to assist those employees with work opportunities in our buildings.

It goes without saying that these staff are truly amazing examples of our nation's heroes that are doing all they can to help the most vulnerable during this pandemic. We encourage you to visit our website at www.carenotcovid.com that shines a light on the nursing homes and assisted living communities that are feeling the weight of COVID-19 every day. There are countless stories from recovered patients and long-term care heroes who are battling this virus. One such example featured on this site is frontline worker Lisa Barlow. Barlow is a Charleston-based care transitions nurse for Genesis Healthcare. She volunteered to work for two weeks in April at a sister nursing facility in Ridgewood, New Jersey, as the pandemic spread throughout the United States. There is also Angelina Friedman who survived cancer, miscarriages, internal bleeding, sepsis and not one, but two pandemics. More than 100 years after living through the 1918 influenza pandemic, the 101-year-old woman just beat coronavirus. An administrator at the Mohegan Lake, New York, nursing home where Friedman lives said Friedman is back to her old self and celebrating life as if nothing ever happened.

Ensuring quality care has been and will continue to be our highest priority for our residents. Many of our long-term care facilities across the country were ahead of the curve in working to beat this virus and keep it out of their centers. Before national guidance was provided on visitation by the Centers for Medicare and Medicaid Services, AHCA/NCAL called for limiting visitors in our nursing homes and assisted living communities to protect our most vulnerable. We also publicly noted from the start how vital it was that long-term care centers be top priority for personal protective equipment (PPE), staffing and funding to help battle this pandemic.

It is important to note that the costs for facilities dealing with COVID-19 are approximately $2.9 billion per month, not including loss of revenue and other costs such as COVID-19 testing and supplementing employee child care, as examples. The costs of additional staffing and PPE, when facilities are able to find it, make up the majority of the costs for facilities directly dealing with COVID-19. That is why we have recently asked the administration for $10 billion from the provider relief funds to provide nursing homes with additional staffing, PPE and other resources. Long term care facilities are facing extreme financial strain as a result of the pandemic and we need additional help from federal and state officials to support our heroes on the frontline.

In addition, the census has dropped dramatically in nearly all nursing facilities and many assisted living communities, for short- and long-term stay residents as well as dementia

care residents. The short-term drop is associated with the cancellation of elective procedures and treatments in hospitals to prepare for the potential surge. In both settings, some families have also taken their family members home from the hospital since they are now able to care for them at home since the families are out of work. The long-term census is also declining as families are not admitting individuals from home since many families are home and able to provide some level of care. These factors have combined to reduce both the number of nursing facility and assisted living residents and a resulting decline in revenue. This is felt in all settings, but particularly for providers who deliver post-acute care.

We greatly appreciate the work done by Chairman Collins in helping our nursing facilities and the long-term care community during these unbelievably challenging times, and for her decades of leadership around issues impacting our nation's seniors. Similarly, we note our appreciation to Ranking Member Casey and Senator Sheldon Whitehouse for introducing the Nursing Home COVID-19 Protection and Prevention Act. The bill would provide $20 billion in emergency funding to states, territories and Indian tribes to support nursing homes, intermediate care facilities and psychiatric hospitals with cohorting based on COVID-19 status, namely to support costs related to staffing, testing, PPE and other essential needs. States would provide nursing homes with technical assistance on implementing infection control protocols, minimizing transfers, facilitating discharges to home and community-based settings and adequate staffing, among other topics. We look forward to continuing to work with the Senators around their efforts and answer questions on matters our centers are facing. More generally, it is important to note that there have been bipartisan, bicameral efforts in both Congressional chambers to help us during this difficult time that we certainly appreciate and need.

In closing, the staff and residents in long term care facilities around the country thank the Committee members for your dedication and leadership during this difficult time. Your ongoing support of our sector means more now than ever before. Ensuring that our long-term care providers have the critical resources and funding is essential to helping us protect our nation's seniors and most vulnerable.
We look forward to continuing to work with you to keep our frail and elderly population safe from COVID-19.

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