

**THE COVID-19 PANDEMIC AND SENIORS:
A LOOK AT RACIAL HEALTH DISPARITIES**

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THE COVID-19 PANDEMIC AND SENIORS: A LOOK AT RACIAL HEALTH DISPARITIES

TUESDAY, JULY 21, 2020

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

The Committee met, pursuant to notice, at 9:32 a.m., in room SD-562, Dirksen Senate Office Building, Hon. Susan M. Collins, Chairman of the Committee, presiding.

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

OPENING STATEMENT OF SENATOR SUSAN M. COLLINS, CHAIRMAN

The CHAIRMAN. The Committee will come to order, and we are already having some technical problems. There we go. Thank you.

Before I begin my opening statement this morning, I want to acknowledge the loss over the weekend of Congressman John Lewis, a Civil Rights icon who changed history at great personal sacrifice. In 2015, I was honored to be among those who joined him in Selma to commemorate the 50th anniversary of the Bloody Sunday March, which he led. I sent my deepest condolences to his family and his loved ones.

Today's hearing comes at a time when our Nation is experiencing the confluence of a health crisis and economic depression and a series of killings that laid bare the racial injustice that still taints our country.

Our focus today is on COVID-19's disproportionate health impact on black and Latino seniors, as well as seniors from other racial and ethnic minority communities.

According to the New York Times analysis, black and Latino residents are infected with the virus at three times the rate of their white neighbors, and they are nearly twice as likely to die from COVID-19.

The State of Maine has the worst racial disparity in COVID cases in the country. Although blacks comprise less than 2 percent of Maine's population, they account for approximately 23 percent of all cases. Like many other States, many of Maine's outbreaks have occurred in nursing homes and congregate care settings.

Nationwide, 43 percent of black and Latino workers are employed in service or production jobs that, for the most part, cannot be done remotely, while only about one in four white employees

hold such jobs. One such field is long-term care, where one in four employees is black, according to the Kaiser Family Foundation.

At this Committee's May hearing, Dr. Tamara Konetzka recommended routine history of long-term care residents, to testing of long-term care residents and employees, a suggestion that was echoed at the Senate HELP Committee hearing last month with former CDC Director Julie Gerberding. Dr. Gerberding described long-term care facilities as, "intrinsic hot spots," and suggested that we need to test often and test everyone who comes and goes from those centers.

There is still a great deal that we do not yet know about COVID-19, but we do know that individuals with chronic kidney disease, serious heart conditions, obesity, sickle cell disease, and type 2 diabetes are at increased risk of severe illness from COVID-19, and that black Americans experience these conditions at disproportionate rates.

Diabetes provides a clear example. Patients hospitalized for COVID who have diabetes account for more than 20 percent of individuals admitted to intensive care units according to the Journal of Clinical Endocrinology and Metabolism.

According to a survey conducted by the Centers for Medicare and Medicaid, although black Medicare beneficiaries were just as likely as white beneficiaries to perform diabetes self-management activities, they were less likely to have their blood sugar well controlled.

As the founder and co-chair of the Senate Diabetes Caucus, I have worked with my co-chair, Senator Jeanne Shaheen, on legislation to expand Medicare diabetes self-management training as well as a pilot program to test the impact of virtual training services.

We have also introduced legislation to create a special task force to eliminate Medicare coverage barriers in accessing the latest diabetes treatments.

We have also worked hard for an extension of the Special Diabetes Programs that benefit Native Americans and children and adults with type I diabetes.

Another factor in the disproportionate impact of the virus on black Americans appears to be a distrust of the health care system. A study from a California health system observed that black patients were more likely to have been tested at a hospital than in an ambulatory environment and that patients' prior negative experiences with the health care system can lead to distrust and a decision to seek care only in the most extreme circumstances.

Historical injustices with medical experimentation have also left a legacy of mistrust and skepticism among many African Americans that we need to work to resolve. Part of the solution may be found through community partnerships and greater health care workforce diversity.

Blacks make up 13 percent of the U.S. population, but only 5 percent of physicians in the United States according to a recent report from the Association of American Medical Colleges.

We are so fortunate today to have such a distinguished panel of experts with us to help us better understand the challenges and, more important, to identify meaningful solutions.

I will introduce our witnesses momentarily, but first, let me turn to the Committee's Ranking Member, Senator Casey, for his opening remarks, and as I indicated, he is joining us by WebEx.

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

Senator CASEY. Chairman Collins, thank you very much for this hearing.

As you noted, as we begin this important work period in the Senate, we mourn the passing of United States Representative John Lewis. Congressman Lewis was a brave Freedom Rider. He was a giant in the Civil Rights movement, who literally shed blood for the right to vote. Of course, we know that he served in the U.S. House of Representatives for over 33 years. His life was a testament to the cause of justice.

Now as Members of Congress, in the wake of his passing, we must ask ourselves at least one major question: What must we do—what must we do in the Senate to fulfill our obligation to further that cause of justice, especially as it relates to the challenges we face right now?

Our witnesses today will help us answer that basic question. They will offer solutions, amid the pandemic and for the future, to bring about health equity for older Americans of color.

Older Americans of color, as we know and as the Chairman outlined, have spent a life time enduring the structural inequities in racism that has plagued our country since its inception. We must own up to that simple and shameful truth, and we must not only acknowledge these injustices, but we are summoned by the example of John Lewis to take action, to do something about it, as he so often urged us to do throughout his life.

What are those injustices? Let me just name a few, but they are searing in their impact.

The injustice of a lack of affordable housing. Based upon data from 2015, 46 percent of black households spent more than one-third of their income on rent compared to 33 percent of white households.

The injustice of food insecurity, right now, black and Hispanic households with children are twice as likely—twice as likely to struggle with food insecurity as white households, number three, the injustice of the education gap. According to the Census, 40 percent of white individuals have a college degrees or higher, compared to just 26 percent of blacks and 18 percent of Hispanics.

The injustice of unemployment itself. In June, the unemployment rate for black Americans was 15.4 percent, compared to 10.1 percent for whites, a gap that is not unique, as we know, to the current crisis.

Of course, we have been reminded so horrifically lately, the injustice of police misconduct against black Americans.

It is no wonder that older adults of color are diagnosed with COVID-19 at higher rates than whites and are dying—dying from COVID-19 at higher rates than whites.

The New York Times recently reported on data from the Centers for Disease Control and Prevention that Hispanic and black individuals have been three times as likely to become infected with the

virus and twice as likely to die—twice as likely to die as whites, a gap that only widens with age.

A New York Times analysis of nursing home data from 22 States found that facilities serving significant numbers of black and Hispanic residents are twice as likely to have COVID-19 infections, even after controlling for facility size, location, and quality rating.

We have a chance right now, in the next 3 weeks, to begin to address these injustices, and we hope to put ourselves on the road to actually correcting these injustices and thereby to advance the cause of justice for communities of color all across America and as we focus on older Americans in this hearing.

Now, we have been told that the Senate will finally consider additional legislation to respond to the ongoing threat of COVID-19. Here is what we need to do in the near term. This is just for the near term, the next couple weeks and months: 1) we need a national testing strategy; 2) we need more funding for personal protective equipment; 3) we need a specific plan to keep nursing home residents and workers safe and the dollars to make it work so that we do not have another 56,000 Americans dead in nursing homes; 4) we need an expansion of long-term services and supports in the community; 5) pandemic premium pay for the heroes on the front lines who are helping to care for our aged loved ones; and 6) a guarantee of access to quality affordable health care.

There is more I could say, but we must do all of these, all of these, and more to protect older Americans of color from the worst public health crisis in a century. However, the actions we take in the short run are not a substitute for enacting policies to address the injustices that have plagued communities of color for generations—not decades but generations.

Taking action on these racial health disparities that we are here to talk about today is what the cause of justice demands of us in the U.S. Senate.

Thank you again, Chairman Collins, for convening the hearing. I look forward to hearing from our witnesses.

The CHAIRMAN. Thank you, Senator Casey.

Our first witness today is Dr. Dominic Mack. Dr. Mack is director of the Morehouse School of Medicine, National Center for Primary Care, the Nation's first congressionally sanctioned center to develop programs that strengthen the primary care system for health equity and sustainability.

Last month, the U.S. Department of Health and Human Services announced a partnership with the Morehouse School of Medicine to fight COVID-19 and racial and ethnic minority, rural, and socially vulnerable communities. We look forward to learning more about this partnership and how this work will translate into better data and best practices to better serve seniors in those communities.

Our next witness will be Dr. Mercedes Carnethon. Dr. Carnethon is the Professor of Epidemiology and Vice Chair of the Department of Preventive Medicine at the Feinberg School of Medicine at Northwestern University. Her research focuses on the epidemiology of cardiovascular disease, obesity, diabetes, lung health, and cognitive aging in population subgroups defined by race and ethnicity, geography, socioeconomic status, gender, and sexual orientation and gender identity.

I am going to turn from introducing the witnesses myself to calling on Senator Burr to introduce a witness from his State.

Senator Burr, thank you for joining us.

Senator BURR. Thank you, Madam Chairman and Ranking Member Casey, for holding this hearing today, and to all of our witnesses, welcome.

It is a distinct honor to be able to introduce Mr. Gene Woods from Charlotte, North Carolina.

In his current role as president and CEO of Atrium Health, Mr. Woods is responsible for one of North Carolina's major health systems that manages 14 million patient interactions each year. Atrium encompasses 26 hospitals, 900 care locations, and employs nearly 70,000 people. He spent much of his career focused on the issues before the Committee today, decreasing health care disparities, and providing high-quality care to all members of our communities.

Mr. Woods has gained over 30 years of experience in health care administration. Prior to his move to Atrium, he served as president of CHRISTUS Health System and CEO of St. Joseph's Health System. He also previously held a leadership role, Madam Chairman, of the hospital here in Washington, serving as CEO of MedStar Washington Hospital Center.

He holds an MBA and a master's of health administration as well as a bachelor's degree in health planning and administration, all from the University of Pennsylvania.

Gene, I want to thank you for all the important work you have done on behalf of North Carolinians and your tireless efforts during this pandemic. I look forward to hearing your perspective on coronavirus response thus far and what you think is around the next corner in our effort to stop the spread of COVID-19.

Thank you, Madam Chairman, and welcome, Gene.

The CHAIRMAN. Thank you very much, Senator Burr. You have been a real leader in this area for many years, and I appreciate you being with us.

I would now like to turn to Senator Casey to introduce our fourth witness.

Senator CASEY. Thank you, Chairman Collins.

I am pleased to introduce Mr. Rodney Jones of Pittsburgh, Pennsylvania. Rodney serves as the CEO of the East Liberty Health Center. East Liberty Health Center provides care to underserved populations in the Greater Pittsburgh Area.

Mr. Jones will share with us the work that the East Liberty Health Center is doing to ensure that patients stay safe from COVID-19.

He will also discuss the threat that the pandemic has to the overall health and well-being of patients served by the health center. As we know, stay-at-home orders and social distancing requirements have caused many older adults and people with underlying health conditions to fear leaving their home to get the care that they need.

Mr. Jones has been working at various health centers and hospitals in Pennsylvania and Ohio for his entire professional life.

Mr. Jones, we want to thank you for testifying today, for being with us, for sharing your expertise with this Committee.

Thank you.
 The CHAIRMAN. Thank you, Senator Casey.
 Dr. Mack, we will start with you.

**STATEMENT OF DOMINIC H. MACK, MD, MBA,
 PROFESSOR OF FAMILY MEDICINE AND DIRECTOR
 OF THE NATIONAL CENTER FOR PRIMARY CARE,
 MOREHOUSE SCHOOL OF MEDICINE, ATLANTA, GEORGIA**

Dr. MACK. Chairman Collins, Ranking Member Casey, and members of the Special Committee on Aging, thank you for convening this important hearing today.

I am Dr. Dominic Mack and am presenting testimony on behalf of Morehouse School of Medicine, one of four historically black medical schools in the Nation. I bring greetings to you from our president and dean, Dr. Valerie Montgomery Rice.

At MSM, I serve as a professor of family medicine, director of the institution's National Center for Primary Care, and co-lead on our innovative partnership with the U.S. Department of Health and Human Services' Office of Minority Health entitled the National COVID-19 Resilience Network: Mitigating the Impact of COVID-19 on Vulnerable Populations.

The daunting news that black Americans in the U.S. are disproportionately suffering and dying from the novel coronavirus, unfortunately, is not a surprise to those of us at Morehouse School of Medicine. We serve on the front lines of medically underserved communities and understand the Nation's health disparities and overall health status.

According to the Centers for Disease Control and Prevention, as of late June, blacks, Native Americans, Alaska Natives, and Hispanics are impacted by the coronavirus at a rate reaching five times that of non-minority Americans. In my State of Georgia, blacks have accounted for nearly 50 percent of coronavirus deaths, and throughout this Nation, seniors experienced disproportionate morbidity and mortality across all racial and ethnic groups. These facts are a surrogate for the glaring lack of health infrastructure in medically underserved communities.

Chairman Collins and Committee members, we are grateful for the opportunity to partner with OMH to do the meaningful work that will address the disproportionate impact of COVID-19 on communities of color.

The National COVID-19 Resiliency Network, NCRN for short, will mitigate the impact of COVID-19 on racial and ethnic minorities, rural communities, and other vulnerable populations. Related to COVID-19, we will: 1) identify and engage vulnerable communities through local, State, territory, Tribal, and national partners; 2) establish and active information dissemination network; 3) disseminate culturally and linguistically appropriate messaging; 4) use technology to link communities to health care services, including testing, vaccination, and behavioral health counseling; 5) monitor and evaluate the success of NCRN services and measure quality outcomes; and 6) use broad and comprehensive dissemination methods to show lessons learned and best practices among vulnerable communities.

NCRN is a significant step in the right direction, but a great need remains in underserved communities. The fundamental

health needs of vulnerable populations will require specifically targeted measures that address the breadth of health disparities and the determinants which lie underneath. Without significant action as with the past pandemic, COVID-19 will continue to disparately impact vulnerable populations now and long after this pandemic is gone.

With your leadership, we can realize an equitable policy response to the crisis we are now facing. We are calling on Congress and the administration to include the following measures in the COVID-19 stimulus legislation. One, resolve the funding disparity from the CARES Act that short-funded the historically black graduate institutions like Morehouse School of Medicine. We are on the front line and facing real and substantial financial shortfalls. Two, provide robust funding for the improvement and development of health care infrastructure, including hospitals in medically underserved communities. Three, double funding for Title VII health professions training programs at HHS's Health Resources and Services Administration to increase diversity in the health care workforce. Four, invest \$100 million in new annual COVID-19 research funding to NIH's National Institute on Minority Health and Health Disparities, specifically targeted at minority-serving institutions.

We stand ready to work with you. If there was ever a time to meaningful act to address racial and ethnic health disparities and health inequities in the United States, it is now.

Thank you for this opportunity, and I am pleased to respond to any questions.

The CHAIRMAN. Thank you very much, Doctor.

Our next witness is Dr. Carnethon.

**STATEMENT OF MERCEDES R. CARNETHON, Ph.D,
PROFESSOR OF EPIDEMIOLOGY AND VICE CHAIR
OF THE DEPARTMENT OF PREVENTIVE MEDICINE,
NORTHWESTERN UNIVERSITY, CHICAGO, ILLINOIS**

Dr. CARNETHON. Am I being heard? Okay, great. Thank you.

Good morning, Chairman Collins, Ranking Member Casey, and other distinguished Senators of the Committee on Aging. Thank you for the opportunity to share my observations and recommendations to address disparities in COVID-19 among older adults in my capacity as a research expert.

I am an epidemiologist in the Departments of Preventive Medicine and Medicine at the Northwestern University Feinberg School of Medicine where I have studied the risk factors for chronic disease for the previous 18 years.

My research, which has been funded by the National Institutes of Health, the American Heart Association, and the American Lung Association, has described an earlier onset and more severe course of hypertension, diabetes, heart and lung disease among blacks, Latinx, Native American/Pacific Islanders, and some Asians subgroups as compared with non-Hispanic whites. These statistics are borne out in my personal experience.

I never met my maternal grandmother, because when she was 62 years old, she suffered a stroke followed by a fatal heart attack. While I knew and loved my paternal grandmother, she did not know me for the last 10 years of her life, because she battled vascular dementia following years of high blood pressure.

The relevance of my story is that the vascular diseases that affected my grandparents are the same conditions that are associated with the worst outcomes from COVID-19.

Early scientific reports from countries that preceded us in the pandemic described the characteristics of individuals with COVID-19 who were more likely to be hospitalized and to die. Immediately, we realized that non-whites and ethnic minorities in the U.S. would be disproportionately affected.

As States and municipalities began collecting sociodemographic data from individuals diagnosed with COVID-19, racial and ethnic disparities emerged that were the most acute in the younger ages. Although these disparities appear to decrease with aging in community dwelling older adults, nursing homes with a greater proportion of black or Latinx residents have doubled the rate of COVID-19 infections than their predominately non-Hispanic white counterparts.

Against the backdrop of this pandemic, I understand the urgency for our country to return to normal. In our research, we have described the link between economic factors and health. A strong economy that allows for stable housing, access to healthy food, and health care access to manage chronic conditions is likely to be of even greater benefit to elderly vulnerable populations.

However, we cannot return to normal by prioritizing the economy over the people without offering strategies to mitigate the impact of COVID-19 on minority older adults, and so I offer three recommendations based on my experience as a population science researcher.

First, is to expand the digital infrastructure and training available to older adults to support videoconferencing for telemedicine. The CARES Act provided provisions to expand coverage and offer grants to support broader use of telehealth services. However, while this can be carried out by telephone, there is likely to be an even greater benefit via videoconferencing. Almost half of all older adults have a smartphone with video capability, and ownership is similar by race and ethnicity.

Accessibility is one step, but in my experience, technology-naive adults require training to maximize these technologies. When a patient and provider can see one another, patients can maximize the social connection with their providers, and providers have more information in the form of visual cues to gauge whether in-person visits or other home-based supports are needed.

Second, the NIH needs additional financial support to address the short-and long-term manifestations of the SARS-COV2 infection. The majority of the \$1 billion infusion of support to the NIH through the CARES Act went to the NIAID to accelerate study of the virus and vaccine development. We have learned since that time that the SARS-COV2 infection damages multiple organs, including the heart, lung, blood, kidneys, and the brain.

Further, we know that adults who are obese and have diabetes have the worst outcomes, and that underrepresented minorities and older adults are overrepresented in those populations. As additional financial support is considered, other institutes at the NIH need to be on equal footing when it comes to the allocation of resources.

Third and finally, we need to engage the communities who have been hardest hit by COVID-19 as we develop strategies for prevention and treatment. Progress toward a vaccine to prevent COVID-19 is encouraging; however, drawing on parallels from the annual flu vaccine, non-white and ethnic minorities are less likely to get vaccinated than non-Hispanic whites. Without building rapport and trust in these communities, there is no guarantee that the highest-risk populations will get the vaccine or that they will even want the vaccine.

Thank you for allowing me the opportunity to offer these suggestions today in hopes that we can offer our most vulnerable older adults our very best science and medical care.

The CHAIRMAN. Thank you very much.

Mr. Woods?

**STATEMENT OF EUGENE A. WOODS, MBA, MHA, FACHE,
PRESIDENT AND CHIEF EXECUTIVE OFFICER,
ATRIUM HEALTH, CHARLOTTE, NORTH CAROLINA**

Mr. WOODS. Yes. Good morning, and, Senator Burr, thank you for that kind introduction and for being a friend of Atrium and also a champion for the communities we serve in North Carolina, both rural and urban.

Chairman Collins and Ranking Member Casey and members of the Senate Special Committee on Aging, my name is Gene Woods, and I am president and CEO of Atrium Health. While I have had the privilege of meeting Senator Collins during my time as chair of the American Hospital Association, it is an honor to now present my testimony on behalf of Atrium Health.

As Senator Burr shared, Atrium Health is headquartered in Charlotte, North Carolina. We are one of the largest not-for-profit health organizations in the Nation and have had the privilege of serving our community for more than 80 years. We are the largest provider of Medicaid, for example, in North Carolina, and further, we provide more than \$2 billion in community benefit annually to those that we are privileged to serve.

As I reflect back on the past few months of combating COVID, we have had to really rethink everything that we do as a health system. I will remember the faces of my leadership team the first time we reconvened to recognize the dimensions of this crisis, serious faces, resolute faces, but I am so proud of the team and of our frontline caregivers for the selfless dedication in keeping our patients and community safe, and our mission to care for all has never shined brighter.

That said, we realized the road ahead is long, and there were many challenges that remained. We, for example, can do 4,000 COVID tests at Atrium every day because we are one of the few systems in the Nation that had special in-house lab equipment that can process our own testing; however, due to a national supply shortage in reagents, we are only doing one-fifth of our capacity, so opportunities remain to significantly expand testing supplies so that we can care for more people, especially the elderly, and we stand ready to be part of that solution.

That said, in many other ways, we have taken health care to a new impact level and accessibility that will outlast this pandemic.

Take our COVID virtual hospital, for example, which has allowed us to care for patients in the comforts of their own home while preserving critical capacity inside of our hospitals, and to date, our virtual hospital has cared for more than 11,000 patients at home and I believe this is a glimpse of the future of health care, using technology to increase access, including for the most vulnerable among us, closest to where they live.

As another example to help our minority communities, we used analytical capabilities to pinpoint geographic hotspots where there were disparities in COVID testing and treatment, and partnering with local churches and community organizations, we deployed our roving health units to the most vulnerable underserved areas and I am proud to share that in a matter of weeks, we were able to completely eliminate any racial testing disparities that existed in the Charlotte region.

We continue to be deeply troubled by the statistics that have been mentioned, the percentage of positive cases and deaths among our Hispanic and African American neighbors, so we recently launched a public-private partnership to collect and distribute 2 million face masks in North Carolina. We at Atrium partnered with businesses like Bank of America, the Carolina Panthers, Honeywell, Lowe's, Wells Fargo, and others, including the health department, and I am proud to say in the past 3 weeks along, we have already distributed nearly 500,000 masks with a specific focus on minority and elderly communities.

This partnership is an example of how health professionals working in concert with businesses and government can help us open up our economy as safely as possible.

We also have focused on another very important vulnerable population, our seniors and especially those in nursing homes. Atrium Health was one of the first in the Nation to cohort elderly COVID-infected patients to a single designated site for advanced treatment in care, with half of our patients coming from other nursing homes who were not part of a larger system like ours and therefore lacked the capacity to provide the support needed, including with respect to infection prevention resources, respiratory care therapists, and PPE.

To date, while the national mortality rate for COVID in long-term facilities is nearly 40 percent, our skilled nursing facility has a mortality rate of 8 percent, and with regards to racial demographic mix, we cared for more than 35 percent of minority patients, with most being Latinx.

I would also like to acknowledge and thank Senator Casey for his leadership in helping secure more funding through S. 3768. Senator, that has definitely saved lives.

Whether through virtual technology, hospital at home, roving mobile vans in minority communities, or through our skilled nursing facilities that are focused on the vulnerable elderly, I am especially proud that we have worked tirelessly to care for the most vulnerable among us during these times.

We certainly cannot do it alone, and that is why we appreciate forums like this that continue to explore real solutions.

On behalf of Atrium Health, thank you for the opportunity to share our experiences and insights regarding how to mitigate the

impact of this pandemic and one day, hopefully soon, look to eradicate it.

Thank you.

The CHAIRMAN. Thank you very much, Mr. Woods. I will now call on Mr. Jones.

**STATEMENT OF RODNEY B. JONES, SR.,
CHIEF EXECUTIVE OFFICER, EAST LIBERTY
HEALTH CENTER, PITTSBURGH, PENNSYLVANIA**

Mr. JONES. Chairman Collins, Ranking Member, and members of the Committee, thank you for this opportunity to testify before you today. I am CEO of East Liberty Family Health Care Center, which is a Federally Qualified Health Center located in the East End of Pittsburgh, Pennsylvania. Federally Qualified Health Centers, or FQHCs, are also community health centers in which the mission is to enhance primary care services in underserved, urban, and rural communities. They provide services to all persons, regardless of the ability to pay, and charge for services on a community-based, board-approved, sliding fee scale that is based on family size and income.

FQHCs serve as a safety net for patients who are uninsured, underinsured, and underserved. Health centers are staples in their communities. There are nearly 1,400 health centers across the country that approximate 120,000 service delivery sites in underserved communities across the country.

East Liberty Family Health Care Center service area encompasses 69 ZIP codes and has a population of over 11,000 unduplicated patients which yield approximately 40,000 visits annually. Of the patients we see, one-third are over the age of 50, 1,300 are over the age of 65. Approximately 18 percent have no insurance, 57 percent are at or below 100 percent of poverty guidelines, and 86 percent are at or below 200 percent of poverty guidelines. Thirty-nine percent are insured through Medicaid, and 13 percent have Medicare. The remainder are insured through Managed Care.

Seventy-seven percent of the patients we treat are part of a racial or ethnic minority. Sixty-six percent of the total population we serve are black. Ten percent are Latino or Hispanic.

Our data shows that half the patients we treat who are over the age of 50 have hypertension. Over 800 patients we treat in this age group have diabetes, and nearly 650 patients are overweight or obese.

Research shows that underlying health conditions, like the conditions I just mentioned, are more prevalent in minorities due to social determinants of health, which are conditions in which people are born, grow, live, work, and age. They include such factors as socioeconomic status, education, neighborhood and physical environment, employment, social support, and access to health care and housing.

These social determinants of health are medical conditions they bring about are major factors contributing to the disproportionate number of low-income individuals and people of color testing positive and dying from COVID-19 along with age.

The virus has become a flashpoint on racial inequities, financial inequities, and social determinants of health. COVID-19 has ex-

posed our health care system's vulnerabilities and revealed our inability to respond effectively to a pandemic. It has also highlighted the fact that low-income older adults and older adults of color have suffered in significantly greater proportion than their white counterparts.

As a result of the pandemic, ELFHCC providers have seen a significant decrease in the patients who are receiving critical primary and preventative care as well as treatment for acute illnesses.

In response to this concern, ELFHCC has initiated a comprehensive telehealth program. Since March 2020, approximately 85 percent of all the patients have been treated through telehealth. We also started performing COVID-19 testing in March. In addition to the testing, we use this as an opportunity to educate patients regarding the importance of having a medical home and preventative care, because of the ACA, ELFHCC has been able to reach an event larger population, including older adults of color, and deliver the care they need.

As of July 2020, more than 780,000 individuals have coverage for health care services because of Medicaid expansion. Pennsylvania's uninsured rates fell from 10.2 percent in 2010 to 5.5 percent in 2018, the lowest rate on record.

Medicaid expansion is a lifeline for people who otherwise would not be able to access quality health care. It is critical that health centers continue to receive funding to continue to serve our patients.

Thank you for recognizing the role of health centers and making this investment in patients through the CARES Act. However, a strong public health system requires a strong commitment of community health centers, which include long-term stable funding for those community health centers. Community health centers will be critical in recovering from COVID-19 pandemic.

I look forward to answering any questions from the Committee about how to further the goals of health equity, including older adults, which is a major goal for ELFHCC to strive to achieve each and every day.

Thank you.

The CHAIRMAN. Thank you, Mr. Jones.

We will now turn to questions, and I want to explain to those who are watching this hearing that we have many members who have joined us by WebEx in addition to the members who are here physically, as Senator Braun, Senator Burr, and Senator Blumenthal. Apparently, if your name begins with "B," you come personally to the hearing.

We will be recognizing members to ask their questions in order of seniority. I will turn to alternating between the majority and minority.

If a Senator is not present or logged into WebEx when it is his or her turn to ask questions, then that person will go to the end of the queue, and we will go to the next person. Senators will be given 5 minutes each on this first round.

I am going to start with my questions, and my first one is for Dr. Mack. Dr. Mack, I mentioned in my opening statement that Maine has the largest racial disparity in the Nation in terms of COVID-19 infection. Many in our State's black community are im-

migrants from Somalia, Congo, and other African countries as well as from Haiti. Expanding our State to overall testing capacity and reaching these individuals are critically important to staying ahead of this virus, and it is imperative that those who are most at risk for contracting the coronavirus are able to access training.

I know that your school of medicine has been tapped by the U.S. Department of Health and Human Services to start collecting and presenting data that will lead to best practices for minority populations.

My question for you is, are you taking a look at recent immigrant populations, such as those in Maine, as well as African Americans or black Americans who have lived in this country their entire lives?

Dr. MACK. Thank you, Chairman, for the question.

Yes, we are. Likewise in Georgia, I think there was an article in one of the major publications earlier this week that the migrant population within Georgia were experiencing barriers to being tested and leaving the hospital. Those who could access care were leaving the hospital with these major bills, so we are suffering some of those same issues among vulnerable populations outside of the African American population. It is happening all across the country, so not only insurance is a barrier, education, training, and as you stated in your opening statement, mistrust of the system—and some of this mistrust lies on a historical path of issues that happen within these communities that have left this mistrust within their hearts, so we are looking at that, the importance of education, overcoming the stigma of vaccination. We know there is a lot of misinformation out there, and this has no boundaries with education, however, when you talk about that, so, yes, with all populations.

One part of the program—and I will end with this—is to make sure that everything is culturally and linguistically appropriate for those audiences. A major part of the effort is to have focus groups but also community partners who have what we call boots on the ground ability within those populations and within those communities to actually work with that population, people who live in that population like community health workers who actually understand the barriers to testing, to care, to vaccinations, et cetera, so we are looking at a diverse approach to diverse communities.

The CHAIRMAN. Thank you, and that is a great segue to my next question, which I am going to ask the remainder of the panel to respond to.

We just heard Dr. Mack mention the importance of having culturally and linguistically appropriate services to reach people, particularly in the immigrant community, and this is particularly important for contact tracing.

In Maine, the organization serving our immigrant community suggests that contact tracing will be most successful if it is accomplished in a culturally and linguistically appropriate way by people who are leaders of that community, and we talked with one such leader just last evening.

How do we better activate, recruit, and tap into the expertise of these community partners who may not have established relationships with traditional public health agencies so that we can better

reach and target testing and followup services to these at-risk communities?

We will start with Dr. Carnethon.

Dr. CARNETHON. Thank you, Senator Collins, for this critical question.

The need to engage communities is one of the recommendations that I highlighted in my statement, and the reasons for engaging communities are exactly what you described. It is so that when it comes time for contact tracing, one of our critical strategies to prevent the spread of COVID-19, it is so that we can use individuals from that community who are trusted to go around asking questions.

As you can imagine, in the current climate, suggesting that someone from the Government is calling to ask questions about where you have been, that can create a lot of anxiety and concern, particularly in immigrant communities, and so that if we can actually find ways to build partnerships through our academic, between our academic institution and community leaders, between our health care organizations and community leaders, we can bridge that gap and be able to reach people in order to promote prevention, and reaching people in their language is critical. One of the most challenging features of this is that we have got to try to build trust in an urgent situation where the very individuals who are experiencing the worst outcomes are the most concerned about trust within the health care system. I think this can best be done through community partnerships.

The CHAIRMAN. Thank you very much.

My time has expired. I am going to ask the other two witnesses to respond in writing with their suggestions and call on Senator Casey.

Senator CASEY. Chairman Collins, thanks very much.

I wanted to start with the issue of health insurance and health coverage. We cannot talk about the health disparities among seniors and communities of color without talking about health insurance coverage.

We know from many sources, one of them being the Commonwealth Fund that indicated that, "the ACA's coverage expansion," has led to historic reductions in health disparities since 2013.

Just a couple of examples, the gap between black and white adults, uninsured rates dropped by 4.1 percent. The difference between Hispanic and white uninsured rates fell by 9.4 percent, and third, black adults living in States that expanded Medicaid report coverage rates and access to care as good as or better than what white adults experience.

Unfortunately, the pandemic is wiping away some of these hard-won gains. With job loss that so many Americans are experiencing right now, millions and millions of people that have lost their job, we also know that has an impact on health care; 5.4 million Americans have lost their health insurance just from February to May.

On top of that, we know the administration is not only opposed—or supportive, I should say, of the case in the Supreme Court to repeal and, I would argue, destroy the Affordable Care Act, but it just filed, the administration did, an 82-page brief indicating support for repealing the ACA.

I think at a time like this, that is unconscionable, and I think there are more words that can be used to describe it.

I have got two bills that I think speak to this. One is a bill that would automatically be matching dollars the Federal Government pays for help for States with Medicaid, and it would match—it would connect, I should say, those dollars to the States' unemployment level, so that Federal aid would be adjusted based upon the State's economic condition and protect coverage, and it has wide support.

Mr. Jones, I will start with you, not only because you are a Pittsburgher, but that certainly helps.

Can you explain, Mr. Jones, in your experience, the work you have done in Pittsburgh and in Ohio? Can you explain the role that Medicaid and the Affordable Care Act has played in insuring that people, including older adults of color, that they have the care that they need? That is question one.

Question two is, What would be the implication for communities of color if these programs were in jeopardy?

Mr. JONES. First of all, thank you for the question, Senator Casey.

Medicaid is critical. Before COVID times, 20 percent of Pennsylvanians received coverage through Medicaid. However, that is not all who benefit from Medicaid. One in three children in our State also benefited. Two-thirds of all nursing home residents in Pennsylvania benefit from Medicaid, and two in five people with disabilities depend on Medicaid in our State.

I mentioned in my testimony that at my own organization, 57 percent of our patients are at or below 100 percent of poverty, and 86 percent of our patients are at or below 200 percent of poverty. Nearly every patient we treat, 77 percent of whom are people of color, is eligible for Medicaid or subsidies to the marketplace to help with coverage.

Back during the recession, people lost their coverage through their employer. Medicaid was there to help, and that is the reason we have it.

In 2008 and 2009, what we saw then is going to be reflecting of what we see now if things do not change. I do not think it should take an act of Congress to make sure that States that can respond to the need. I do not think that States should be allowed to cut Medicaid just when we need it.

I would like to thank you for introducing legislation that will protect Medicaid coverage for individuals and families and ensure Pennsylvania by extension, community health centers like East Liberty Family Health Care Center continue to have resources to meet the need.

As far as the Affordable Care Act is concerned, that expanded Medicaid has given people the opportunity to seek health care as a preventative measure, not just when there is an acute condition. People forget about the fact that an ounce of prevention is worth a pound of cure, and we do not focus as much on prevention as we should.

The group of people that are overrepresented in this area are blacks and Hispanics. Expanded Medicaid also produces economic

benefits for both the individuals and cover society as a whole, but what are the implications if this were to go away?

You know, let me just say human lives matter. The implications are that human beings will not be able to get affordable health care, and from a business perspective or economic perspective, that is going to be a significant cost. There is a significant human cost and a significant financial cost.

Senator CASEY. Thank you.

Thank you, Chairman Collins.

The CHAIRMAN. Thank you.

Senator Burr?

Senator BURR. Thank you, Madam Chairman.

This first question is for Gene Woods. Gene, your success in Charlotte is, in large part, your health system's reliance on the data helping in real time to direct the care provided both to patients and to the broader Charlotte community. What are some of the key metrics that provided early warning signs of the disproportionate impact of the pandemic on minority populations in Charlotte?

Mr. WOODS. Thank you, Senator, for the question, because of the nature of our organization, we have our own internal scientists and data specialists, and early on, we were trying to make sense of where exactly this disease was growing.

What we have, geospatial hotspotting analytics that allowed us to really focus on mostly the six ZIP codes in Charlotte that we were finding out that had disproportionate incidence of COVID, and also, we realized early on that they did not have adequate testing, so that went to my opening statement.

In a matter of three days when we saw that data, because it is about action, not just about data, we had two roving vans, and we went directly to those communities.

To the earlier comment, the reason where we knew where to go is really working with the faith community and working with community leaders. We worked, engaged with the Hispanic community on an initiative called "Para Tu Salud," for Your Health, and so we engaged people in the community to really help us with that.

Some of the data early on was a bit noisy, and we were trying to get data from all kinds of sources initially and we realized we have to do that internally. We refined our ability not just to pinpoint what communities need our care, but also this data was important to analyze our staffing needs, our PPE needs, and so forth, so this analytical capability also we provided to the public health department here in Charlotte. One of the recommendations we would have is there is organizations like ours that have the capabilities and the expertise to do this by ourselves, but there are many communities throughout the country that do not have that, so we would encourage an investment in public health with respect to analytical capabilities. As I said, we were providing that data to public health versus the other way around, but it is critical to be able to manage this going forward, to have that type of capability to really respond to communities in need.

Senator BURR. Thank you, Gene.

My second question is to Ms. Carnethon. North Carolina has been reporting facility-level COVID-19 data for nursing homes and

other congregate living facilities throughout the whole in coronavirus responses. What information or metrics would be most useful for researchers to study the impact of the outbreak in nursing homes and other congregate settings?

Dr. CARNETHON. Thank you for that question.

The burden of COVID-19 in nursing homes emerged very early on as a significant problem that we are facing. As I described in my testimony, we know that nursing homes with a higher proportion of black and Latinx residents have higher death rates.

However, there is not universal reporting of the race and ethnicity of those individuals within nursing homes who have been affected by COVID, and that presents for us a significant challenge when it comes to targeting resources in order to prevent the transmission of COVID, because when COVID-19 enters a nursing home, it is because somebody has brought it in, a care provider, a loved one, and really what it is telling us, that if those nursing homes are following the same safety procedures of restricting visitors, of ensuring that providers have clean PPE every time they are coming in, then we should not see these disparities; however, we do, and the likelihood that leads to disparities in rates of COVID infections within nursing homes are going to occur are going to be even higher in communities with a higher burden of COVID-19.

What we are seeing in the nursing homes is really a snapshot of what is going on in a community, and so we really need the data coming out of the nursing homes on who, on the sociodemographic characteristics of who is contracting COVID in order for us to stop this transmission and prevent these disparities.

Senator BURR. Just to clarify, have the disparity in congregate setting outbreaks been similar or different from what you are seeing in the broader population?

Dr. CARNETHON. The disparities in congregate care settings are quite similar to what we are seeing in the broader population; however, I will offer the caveat that at community-dwelling older adults, the disparities tend to be smaller than they are younger ages, and the disparities that we see in younger ages are likely due to a higher burden of earlier onset cardiovascular diseases, kidney diseases, and diabetes.

By the time we have older adults living in communities, those rates tend to even out a little bit more; however, the intensity of the disparity is still significantly higher in congregate care settings, two to five times higher for black and Latinx residents than for white congregate care residents.

Senator BURR. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Senator Blumenthal?

Senator BLUMENTHAL. Thank you, Chairman Collins. Thank you, Senator Casey, to both of you, for having this hearing on such a critically important topic, and it could not be more timely.

Like many of my colleagues, over the last few weeks in Connecticut, I have been to a number of demonstrations, peaceful and passionate, and more than seventeen myself all across the State. I have been so inspired and impressed by the cries for justice not only in policing but also in housing, education, health care, mater-

nal mortality, addressing the disparity that exists in so many areas of health care.

In Connecticut, black and Latinx residents are more than three times as likely to have tested positive for COVID-19 as white people, and black residents are more than two and a half times as likely to have died from the disease as white people. Latinx people are more than one and a half times as likely, and just one last statistic, almost 60 to 70 percent of all our deaths from this insidious disease have occurred in nursing homes, so if you are older and you are black or Latinx, this disease has a target on your back, not one that you have created, but one that has results from lack of proper health care, housing, maybe education, and that is a kind of injustice that this Nation must overcome.

I thank all of the witnesses for your testimony, and I want to begin by asking Dr. Carnethon. You mentioned in your testimony the lack of trust and rapport that must be overcome if vaccines are to be effective. What specifically would you recommend doing to overcome lack of trust and rapport?

Dr. CARNETHON. Yes. There is an historic lack of trust in the health care system going back to the days of the Tuskegee syphilis experiment, which is cited most often, and even more recently, there is evidence to suggest that non-white minorities are not receiving the same evidence-based care in certain settings as non-Hispanic whites, so building trust, what my colleagues who are working most heavily in this space—and I believe Dr. Mack can likely speak to this as well—building trust involves spending time with the community, ensuring that we are explaining the why along with the how of what we are doing to community members, and most of all, spending time to listen to members of the community so that we are addressing their needs as well as our own.

What we really need to do is put ourselves in the shoes of community members to try to understand what those barriers are to wanting to engage in preventive health behaviors, to wanting to accept these vaccines.

Senator BLUMENTHAL. Thank you.

I want to focus, Dr. Jones, on an issue that I think is tremendously important to our Federally Qualified Health Centers.

I visited with our seventeen Federally Qualified Health Centers in a call on Friday, and I have visited physically almost all of them over the last couple of years, and I know how critical they are.

In fact, you mentioned that 77 percent of the patients you care for are from racial or ethnic minorities. In Connecticut, we have 17 of those kinds of centers, and the numbers are almost the same. Nearly 75 percent of Connecticut community health center patients are from racial or ethnic minority.

The HEROES Act was passed by the House not that long ago, with an additional \$7.6 billion in emergency funding for community health centers. It is month later, but we still have not voted on it. It is a critical bill.

Can you tell us how those additional resources would be used by your health centers and others?

Mr. JONES. Sure. Thank you for the question.

I hear people talking about building trust and how do we reach people. I am proud to represent over 1,400 FQHCs across 120,000

sites across the country. That is who we are, and that is what we do. The trust is there.

Our focus is just a safety net for the uninsured, underinsured, and underserved. I think that FQHCs need to be more involved with getting people into the community. We have relationships with community leaders, churches, businesses, etc.

The funding should be set up in such a way that there are resources available, so that people can have access to care, there is resources available so that everyone has PPE, there is resources available so that people can be tested; and there is also resources available so that people can find medical homes and get preventative care, so the money that we have received thus far has been used to keep our staff employed so that we can treat this vulnerable population. Without that money, a lot of my peers across the country would have had to downsize, and the amount of care that we would have been able to deliver would have been significantly less.

Senator BLUMENTHAL. Thank you, Mr. Jones.

Mr. JONES. One last thing, people respond to people that look like them, and the idea of being comfortable with people that look like me and understand me is significant.

Thank you.

Senator BLUMENTHAL. Thank you very much.

Thank you, Madam Chair.

The CHAIRMAN. Thank you.

I am uncertain whether Tim Scott has returned yet, and it looks like he has been a bit delayed. We will next call on Josh Hawley.

Senator HAWLEY. Thank you. Thank you, Madam Chair, and thank you for holding this hearing today. I also want to thank the Ranking Member for his participation and help in setting this hearing up. Thanks to all of the witnesses here for your testimonies.

Like other regions, my home State of Missouri has seen and continues to see disproportionate rates of infection and death among our seniors and also among communities of color, and this is a tragic reality that merits attention by Congress and action by Congress, and so I want to thank again Madam Chairwoman and the Ranking Member for holding this hearing.

Mr. Jones, I would just like to come back to a question that Senator Blumenthal was just asking you a moment ago about community health centers. The CARES Act provided—I believe it is \$127 billion supplemental funding for public health and social services emergencies, including funding for community health centers.

In April, I asked Secretary Azar at HHS to prioritize funding for community health centers in my home State of Missouri, and I did this after speaking with representatives of the health care community, pastors, and others who emphasized to me the vitally important role that community health centers can play in meeting the needs of underserved communities that are being disproportionately affected by this virus.

I just wanted to give you the opportunity to expand on the line of answers that you started with Senator Blumenthal a moment ago. Could you just tell us more about why community health centers play such an important role and what they can do in helping

to address some of the needs that we are seeing here, some of the unique needs faced by older Americans and historically underserved communities?

Go ahead.

Mr. JONES. Thank you for the question.

It centers around social determinants of health. We have been plagued as a race, as human beings, with this overall arching concept, and what it simply means is that people are at a disadvantage based on housing, education, where they live, the environment by which they matriculate.

The way the funding has helped is the fact that we have been able to reduce the barriers by which people can seek health care. Most of the health care centers across the country run about a 30 to 40 percent no-show, meaning that people are scheduled for appointment. They do not call. They do not count. They just do not show. More often than not, it is because of things they cannot control, also, the other issue that people need to think about, people are focusing on living, no life. Health care is important, but it is not important if you do not have a way to put a roof over your head or to feed your family.

The thing that has been really important for FQHCs is that we have moved from a culture or process of seeing people in our health centers to telehealth. Telehealth has been significant in this way that we are trying to address the disparities and primary health care. We are now able to see people in their own homes, able to remove the barriers that have been in place that would stop them from seeking health care, so the funding not only provides ways to break down the barriers associated with social determinants of health, but it allows us to provide health care in an environment by which we were not able to do before. It also gives us the funding to get into our mobile vans and get out into the community and provide the care that we need.

As I said before, let us not forget the fact that this pandemic has—and I say this in my testimony. It is a flashpoint on the health inequities and also the inequities of our overall health care system, that there needs to be a way that everyone has access to care, and again, the funding will allow us to broaden our scope and to deepen our resources to provide the care for people that need it.

Senator HAWLEY. Thank you very much for that.

Let me pick up on the telehealth points that you mentioned just now and that you also mentioned in your written testimony and about how vital that can be, telehealth can be, to expanding health care access during the pandemic, this pandemic, and in general.

Of course, one of the things we know, however, is that many elderly, low-income, communities of color, rural communities have significant barriers to accessing telehealth, and this is certainly true in my own State where we have a very significant rural population and where all of those things are true.

Tell me a little bit about how you have addressed concerns related to technology access and what more you think we can do to improve that so we can improve this vital tool.

Mr. JONES. Sure. Back when I was a young child, I used to laugh because our doctor used to carry a little black bag and actually walk up and down our street and see people in their homes.

We have a division in our organization called Homebound Outreach. Our Homebound Outreach, we have nurses that we send into the community, and they see people who for whatever reason cannot come into our health center, and also they are the eyes and ears of our providers, so one of the things we have done to those people that do not have the technology, we send the nurse into the home, and we use the technology of our laptops to communicate with our providers in the office.

I know at our particular health center and I know my peers in western Pennsylvania, we have applied for funding so we can get technology into the home of the aged and the feeble, so they have the opportunity to turn on a computer to be able to see what is going on. That is only half the battle because the technology is still a challenge, so there needs to be staffing. There needs to be community Ambassadors. They do not have to be medical people. They have the ability to get into the community and get into the homes with people that need care. It could be a very inexpensive proposition. They are not the highest-paid people, and they can be the ears and eyes of providers to provide timely care, which again we are doing that on a small scale at our health center. We plan to expand that as we continue to identify the needs.

Senator HAWLEY. Well, thank you very much, Mr. Jones. Thanks for the tremendous work you are doing. Thanks to the other witnesses for being here, and I will have a few questions for you in the record.

Thank you, Madam Chair.

The CHAIRMAN. Thank you.

Senator Warren?

Senator WARREN. Thank you very much, Madam Chair, and thank you very much for putting together this hearing. Seniors are bearing the brunt of the COVID-19 pandemic. People over 65 account for just 18 percent of coronavirus infections, but they make up 80 percent of the deaths.

Nursing homes, where 1.3 million seniors live, have emerged as hotspots of infection, and systemic racism has put seniors of color at even greater risk of catching and dying from COVID-19. We are nowhere near controlling this pandemic.

Public health officials are reporting tens of thousands of new cases and hundreds of deaths every day. Congress must act fast, really fast, to protect our seniors and contain this virus. We need to ramp up testing. We need to create a national contact tracing program. We need to stabilize our supply chain, and we need better data to ensure that communities of color are getting the COVID-19 resources that they need.

Let me start with you, Mr. Woods. In your testimony, you talk about how Atrium Health developed a COVID-19 dashboard to track cases and deaths in real time. All of this data was stratified by race and ethnicity as well as additional factors like geography, so, Mr. Woods, what did the data reveal about how communities of color were experiencing the COVID-19 pandemic?

Mr. WOODS. Thank you for the question, Senator, and for your leadership in this regard.

I think, quickly, we realize—and some of what the testimony of some of the other panelists is those social determinants of health

have—the cracks have been laid bare. The issues of lack of access to food, lack of access to health care, all of those in these communities, we found that they were magnified during this COVID pandemic, so I think what we are realizing is that it is years of lack of investment in core communities, the things we have talked about, affordable housing. We have invested \$10 million in affordable housing before this pandemic because we knew if you do not have a warm place and a warm home, you are not going to be healthy.

We have fed about 10,000 kids through our Kids Eat Free program because we realize that if you do not have food, you cannot be healthy, so I think it has just magnified the social and economic and health care disparities that we have known for a long time, and we have been fortunate to have been part of a coalition to help address that straight on.

Senator WARREN. I really do appreciate your work in this, and what I am hearing you say is the demographic data you collected showed that communities of color face barriers and accessing COVID-19 resources and then the responses, so let me just followup with this, though, Mr. Woods. It is one thing to detect disparities, but it is another to actually tackle them. Did the data allow you to actually reduce racial inequity in your coronavirus response?

Mr. WOODS. We did, and as I mentioned in my testimony, because we have the unique ability to run our own internal COVID tests, we were able to launch very quickly when we saw this data and the six different ZIP codes in Charlotte area. We were able to work with the churches, work with Hispanic community, and we said rather than you come to us, we have nine fixed testing sites. Let us go to you, but we do not want to assume we know where to go, so please tell us where it is, so we were in church parking lots. We were at YMCA parking lots, and we also—it was mentioned earlier. The one thing I want to focus on as much as anything, we have invested this past year, \$7 million just on interpretive and language services. We know that, for example, that is a really important part of reaching this community, so it is not just taking the data, going to where the communities or needs are, but really making sure we had the language to be able to speak to people on their terms.

Senator WARREN. Right, so in other words, by collecting detailed demographic data, you could develop a targeted data-driven response to COVID-19 and send resources where they were most needed and send the appropriate kind of resources to those places, so from the outset of this pandemic, the Trump administration should have collected demographic data to guide its COVID-19 response, but it did not, so instead, my colleagues and I have spent months pushing HHS to publicly report race and ethnicity data, and in the end, we had to force HHS to issue a report on COVID-19 racial disparities.

Still, only 55 percent of cases reported to CDC to date include information on race and ethnicity, so let me ask it a different way, Mr. Woods. Without up-to-date, comprehensive demographic data about COVID-19, do you believe that the Federal Government will

be able to craft a pandemic response that provides communities of color with the resources that they need?

Mr. WOODS. What I can do is speak from our experience. Without the data that we had to respond to this community in real time—our data is updated actually every 2 hours. We know exactly where the disparities are, where the incidents of COVID. We have a map that I look at every single day in terms of how it is spreading, so from our experience, without that data, without that real-time data, it is really difficult to contain and ultimately eliminate the COVID.

Senator WARREN. That is really important, so it is part of the reason why I am still fighting for comprehensive coronavirus data.

Just last week, Ranking Member Casey and I asked HHS to report demographic data on residents and workers in nursing homes to better track COVID-19 infections and better track deaths among seniors. We need to put the public health impacts of systemic racism at the very heart of the CDC's work—and I am working on legislation to do this—in this pandemic and beyond.

If the Trump administration does not start taking this virus seriously, tens of thousands more Americans will die, and a disproportionate number of those seniors will be people of color. That outcome is unacceptable. Congress must act.

Thank you, Madam Chair.

The CHAIRMAN. Thank you.

Senator Braun?

Senator BRAUN. Thank you, Madam Chair.

This is just another topic regarding health care. I have spent so much time on the issue prior to becoming a Senator, and social determinants, underlying issues with chronic conditions as well as how minorities are being treated through an epidemic like this, to me, still begs the question of what is wrong with our health care system before we got to this junction.

In my opinion—I am going to ask the question of Mr. Woods and Mr. Jones. Our issue with health care when it comes to access, to covering preexisting conditions, no caps on coverage, all the things, 80 Senators weighed in prior to COVID coming along are still there, and to me, the number one issue—it has been referred to as the “tapeworm on our economy”—is the high cost of health care. Eighteen to 19 percent of our GDP here in this country and, of course, nearly half that in 20 to 25 other countries with results that are as good as ours, so, to me, in my own business in trying to tackle this 12 years ago, until I engaged the individual in his or her own well-being and tried to provide transparency, so you could see what things cost, whatever we decide to do here, whatever we can accomplish through the Federal Government to maybe look at disparities, we still get back to the same old system. It is dysfunctional. It is run increasingly by large corporations that have no interest in fixing the system.

I want to ask you this. Transparency. President Trump, by the way, has been the most aggressive individual in trying to reform certain dysfunctional parts of our health care system. Every time it occurs, it lands up in the courts because the industry takes him to court.

We here as Senators, I think, tiptoe around the industry too often.

What about basic reforms to actually not only address issues like we are talking about here, like transparency? What value would transparency give us?

The hospitals recently took the President to Court on a directive to where he wanted to make the charge masters transparent. Now I think it has been overturned by a judge. Thank goodness, we are making headway.

The question is directed to Mr. Woods. Do you believe transparency would be the tool to not only fixing health care in general, but also to help us better navigate through a disaster like a micro-organism that is confronting us now?

Mr. WOODS. Thank you, Senator, for the question.

I think transparency is certainly one of the solutions, and we are like other health systems that have provided charges online, so I think that is one avenue, but I think, fundamentally, the issues that we deal with, at least in our communities as a safety net provider, go back to some of the things that were alluded to earlier. We are the safety net provide for the entire State of North Carolina. We see more Medicaid, more compensated than anyone else in the State, and so I think we still—there is a lot of opportunities to continue to fix health care and through the health system lens.

We have got to come together to deal with some of these, which was referred to earlier, some of the social determinants of health that really are being magnified in this crisis. The lack of affordable housing, that is fundamental to dealing with the health care cost and crisis in this community, because ultimately, these patients are showing up in our facilities, so I think it is a multifactorial equation that we have to solve. Transparency is certainly part of it, but there is a lot of other pieces, I think, that needs to be addressed and the one thing that I would just suggest is that these things can only be addressed through private-public partnerships, such as the one that I just mentioned earlier; for example, for masking, where we have big business and also health systems working together and I think working together with the health department, so I think it is a complex equation. The President said health care is complicated. I certainly agree with him. Transparency is one of many ways to help address those.

Senator BRAUN. Imagine the dividend we would get from saving that we could invest in some of the other things you were talking about.

Mr. Jones, would you briefly comment on it as well? My time is about up, but please tell me what you think.

Mr. JONES. Sure. Transparency is only part of it.

It is under the broad umbrella of socioeconomic status. As I mentioned before, this pandemic has served as a flashpoint, but the bigger picture is we have to get fundamentally into the situation of why is there disparity. It all has to do with education, neighborhood, housing, social supports, access to health care.

The broader picture is we need to take care of this pandemic. It needs to be a Federal global approach, but once we get on the other side of this, we need to peel it all the way back and get to the root

of what the issues are and, again, it is about people not having equity and equality in accessing jobs, education, and health care.

Senator BRAUN. Thank you so much.

The CHAIRMAN. Thank you, Senator.

Senator Jones?

Senator JONES. Thank you, Madam Chairman, and thank you, Ranking Member Casey, for holding this really important hearing. This is especially, I think, significant in all of our States, but I have been acutely aware of the problems in Alabama.

You know, Mr. Woods, I would like to kind of followup with you initially about some—Senator Casey made some comments about Medicaid.

You practice. You have got hospitals, I think, in both North Carolina and Georgia, and like Alabama, those States did not expand Medicaid. You are one of the largest providers of Medicaid services.

Every study that I have seen has indicated that health outcomes are raised in States that have expanded Medicaid, but yet we still seem to have a great deal of political pushback on Medicaid expansion, not only in our States, but also in the Congress. We have got billions of Federal dollars that we are putting into every State right now that deal with this pandemic, and it only makes sense to me that we try to do that in a way to give States the incentives to expand Medicaid.

We have made a lot of strides. The Commonwealth Foundation indicated that black working-age adults across the country have greatly benefited from Medicaid expansion, and there is a huge proportion of those folks that reside in our State, so I would like to ask you about Medicaid expansion and the benefit that the population that you serve, how it would benefit, how it would improve your hospitals if we can go forward and try to get something in this next package to give States the incentives to expand Medicaid.

Mr. WOODS. Thank you for the question, Senator Jones.

One real live example of what we are seeing, especially during this COVID, is one out of five Americans have behavioral health issues, dealing with mental health issues, and we are seeing our outreach, especially right now with behavioral health, has magnified significantly.

One of the things that Medicaid expansion would do is provide additional funding for care of mentally ill patients. I think that is just one example that were we to have that coverage now, we would be able to expand our efforts significantly.

The other thing I would just say, as a safety net provider, as I alluded to earlier, if you look at we never turn anyone away, irrespective of ability to pay, right now we probably cover about 2 cents for every dollar of cost that we have for someone who is uninsured. Medicaid expansion would probably increase that to about 11 or 12 cents, and what do we do with those additional funding as we continue to reinvest in the community through skilled nursing facilities, through outreach to minority communities, etc.

It is important, I think, to continue to explore Medicaid expansion in States like ours because I think it will help the community be healthy.

Senator JONES. Great. Well, thank you very much. I completely agree with you about the mental health aspect of this. I think folks

often forget as we focus so much on this virus right now that I think a lot of the mental health outcomes or mental health issues are going to be with us for a long time based on this virus.

Dr. Mack, let me ask you a little bit about Morehouse. Since coming to the Senate, I have been a pretty strong advocate for additional funds for HBCUs. We got additional funds for the first 2 years, and then we were able to get some permanent funding.

In the CARES package, we had a billion dollars that went to HBCUs, and recently, I have joined a letter with my colleagues, Senator Harris and Senator Booker, to try to encourage an additional \$6.5 billion to HBCUs and particularly graduate institutions like yours.

If we could get only a portion of that, how would that benefit colleges like Morehouse? How would you use additional funds in the middle of this pandemic to help us get out, and how would it benefit the college and the communities that you serve?

Dr. MACK. Thank you, sir.

As I stated earlier, we are on the front lines with these communities not only from the experience aspect, but what we are doing today with the testing, also with the treatment, and also with the push to give vaccinations. If we would have that additional funding, it could help us educate and train providers and MDs who actually work within the underserved communities.

At Morehouse School of Medicine, almost 50 percent of our graduates actually work in the State of Georgia. The State of Georgia is mostly a rural place, so our graduates actually go into these underserved communities of multi-cultures and actually work in those communities.

I think it would benefit from a training perspective, benefits when it comes to scholarships, to provide training for the students, but also the care that we provide on the frontline.

As you stated, quickly, I would like to say about the insurance around COVID today. The lines are longer in those communities that are uninsured or underinsured, and also the testing sites happen not to be in those underserved communities, so it is really affecting us today when it comes to access to care, so it could help us in many ways.

Senator JONES. Great. Well, thank you all for being here with us today. Thank you for the work you are doing in all of this.

Thank you, Madam Chair, for this hearing, the important hearing today. Thank you.

The CHAIRMAN. Thank you.

Senator Tim Scott?

Senator TIM SCOTT. Good morning, Chairwoman, and thank you for all your hard work and dedication on so many of these issues that are important to the Nation. Frankly, you have been the leading voice in our Congress and, I mean, either the House or the Senate, so in our Congress for issues around disparity and around taking care of people who simply need help. You have been the type of chair who looks only at Americans, not at parties, not at color, but at people in need, so thank you for being that kind of chairman, and I really appreciate your leadership.

Let me just say this. As we have looked at the numbers in South Carolina, 27 percent of the population happens to be black. About

43 percent of the fatalities are African American. Thirty-two percent of the diagnoses are. Those numbers were alarming to me initially, and as I looked around the country, I found that 14 percent of Michiganders are African American, but 41 percent of the mortality were black.

I started realizing that there seems to be a racial impact, and I asked HHS to step up and start giving us more information broken down by racial categories, and they did that. I asked my Governor to do the same thing, and he did that, so we were able to then start targeting more of our energy and our focus on these health care outcomes and disparities, number one. Number two, as I spoke with NIH, Dr. Collins started talking about the importance of programs like the RADx, so we could put more resources, more testing in communities.

Frankly, I pushed my Governor and our health care apparatus in South Carolina. I am so thankful that they responded so constructively and positively. We have had pop-up sites for testing at churches and at schools in minority communities. These are really important.

One of the things that I see as headwinds is that even with all of the new ground that we are making up—and there is a whole lot of ground to make up—that when you look at the confidence within our communities, particularly the communities of color, as it relates to taking a vaccine, 25 percent of African Americans say they are willing to take the vaccine, 37 percent of Hispanics.

To the panel, what can we do to increase those numbers?

Mr. JONES. I would like to take a stab at that, Senator.

Senator TIM SCOTT. Thank you, Mr. Jones.

Mr. JONES. Again, the issue has to do with trust, and you do not start trust during a pandemic. The trust starts way before then, and I needs to give a shout out to FQHCs. That is who we are; that is what we do. We are in the communities. People trust us. People come see us. They are treated with dignity and respect. It does not matter if they have insurance or they do not have insurance, so the way we can do that is identify agencies, organizations, and churches that people trust. Once you get the trust, then you can start the conversation of convincing people the value of getting the things that they need to have.

Senator TIM SCOTT. Thank you, Mr. Jones.

Dr. CARNETHON. I would like to follow with that. This is Dr. Carnethon.

We right now are working through a cross-NIH initiative led by NHLDI as well as NIMHD, minority health and health disparities, because we understand. Certainly, as Dr. Jones has stated, it would have been ideal to start sooner; however, we have to start now and we have to get out there. We have got to build these bridges, and I think what is going to be critical is to communicate the urgency and also to really empower community members to understand that they have to be the ones to step up to help us stop the impact that we are having on minority communities, so what I would really like to do with our messaging is really promote this partnership that we have to step up in order to help ourselves.

Senator TIM SCOTT. Let me just make this comment before I hear from other panelists.

On the Paycheck Protection Program, one of the things that I saw as a small business owner or at least a previous small business owner was the importance of having a marketing mechanism in place, so I went to the Minority Business Development Agency, the MBDA, and said, "I am going to put \$10 million in the MBDA so that we have the type of marketing that reaches specifically into communities of color and targets the outcomes that we are looking for," which is higher utilization of the PPP.

What I hear, I would say that I hear the need for something similar, and if that is true, where is that similar organization? Certainly the churches. I know the HBCUs. I have worked with them, and frankly, our office led the charge to get more resources for the HBCU in the CARES Act, and frankly, according to the UNCF, we have record-breaking dollars coming in during the last 3 years, so how do we find those one or two organizations that penetrate so deeply that we can have that kind of focus?

Mr. WOODS. Senator, this is Gene Woods.

One thing, I think we just got to recognize that part of the issue is after 3 million cases of COVID and 140,000 deaths, we still have a fundamental—just a general in the country—50 percent of people still do not want to get vaccinated.

If you look at even during flu season, last flu season, we had 40 percent of the population that said, "We are not going to get a flu shot."

I think the messaging has to occur on multiple levels. There should be a national strategy right now, a PR campaign, as you mentioned, that touts the benefits of vaccination. I think that is layer one, and then with respect to your suggestion, what we have done here and in the communities we serve is we have partnered with media outlets that specifically focus on minority communities. I think there could be a national strategy, but there has to be a local strategy as well because different outlets have different insights into the particular community. I think it has got to be a multi-factorial type of campaign, but that begins that vaccinations are important as part of containing COVID but also influenza.

Senator TIM SCOTT. I would love to talk to you after this is over if you have time, 1 day this week. I would love to continue this conversation.

Mr. WOODS. Absolutely.

Senator TIM SCOTT. Yes, sir.

Dr. MACK. Senator, if I could say one thing quickly. I think we have to stop funding the usual suspects all the time. We have to look for new organizations that have deep tentacles within the community, and that is the initiative we are doing now.

There are organizations that the community respects as leaders. I think we have to partner with those organizations, as we have said earlier, and make sure some of the resources empower those organizations to do the work and be the lead for that work within the community.

Senator TIM SCOTT. Thank you, sir.

I look forward to reaching out to some of the panelists, if you all are interested in engaging in this conversation further when we are not limited to 5 minutes of questions and answers. I read through your backgrounds, and frankly, an incredibly impressive group of

folks who are dedicating a lot of your life to making a difference. I would love to just partner with those who may be interested in doing so.

Thank you.

The CHAIRMAN. Thank you very much, Senator Scott.

Senator Rosen?

Senator ROSEN. Well, good morning, everyone. Thank you, Senator Collins, Ranking Member Casey, for holding this important hearing, and of course, like Senator Scott said, for the impressive group of panelists. You have spent so much of your life and efforts on health care in so many areas and particularly this one.

I want to address the racial health disparities and how we can work through education, training, and resources to make things better, because racial and ethnic health disparities, they persist because of longstanding inequities and working, living, health, and social conditions.

You see the manifestations of such disparities everywhere. For example, during COVID-19, data from my home State, the Southern Nevada House District, shows that Latinos are dying at a higher rate than any other group in the region. In Northern Nevada, the Latino population has the highest number of COVID-19 patients in Washoe County, even though the Latinos only make up a quarter of the county's total population, so, of course, we know too often, inadequate access to care, underlying biases, both ethnic and racial minorities, and especially seniors of color at greater risk of complications due to COVID-19 and other diseases as well, so research also suggests that provider actions could be influenced by implicit biases, which impact the delivery of over all medical care, sometimes without medical providers even realizing it.

I am glad to see that the University of Nevada Reno's Sanford Center for Aging is taking the steps to combat the impact of implicit racial bias by requiring staff to attend trainings on the subject. The Sanford Center is also taking steps to review all of its internal policies and the gerontology academic program curriculum overall to ensure that they include economic, social, and policy content that address the impact of racial disparities.

To Dr. Mack and Dr. Carnethon, as both researchers and educators, how can we best train our medical students and, in fact, all of our medical professionals to identify and understand their own implicit biases, so that they can recognize how this contributes to their decisionmaking and delivery of care? What types of practices do you think are worth us investing in to make the most success?

Let us start with Dr. Mack, and then we can go to Dr. Carnethon, please.

Dr. MACK. Thank you.

Well, when we consider the practicing, we have always focused on the importance of primary care and the behavioral health component that it actually highlights within primary care, and that is what we are talking about.

There is a larger aspect to the training which should provide the sensitivity of the student to the total patient and the health care of the patient. We realize that only 20 to 25 percent is contributing to health care, so it is very important that we take in consideration those socioeconomic determinants, and that includes the bias of

physicians, the bias of the health system when it comes to treating patients, so that has to be put into the curriculum. It has to be expressed and to train, whether it is in the ambulatory setting or it is in the hospital, and some of that training means we have to train the trainers. Educators have to be aware of the biases, and while there, the student that is shadowing them, they have to also make sure that they are addressing that.

I think we have to make sure it is in the curriculum, it is taught on the wards, but also that the academicians, including myself, professors and associates, etc, are aware and are properly trained to train the students properly to be aware of those biases.

Senator ROSEN. Thank you.

Dr. Carnethon?

Dr. CARNETHON. Thank you for this opportunity. These are discussions that we are actively having right now at our medical school about how best to incorporate these critical skills and the ways in which we teach our clinicians to treat patients and how to interact with them.

My experience in the educational field suggests that experiential learning is one way to really cement the lessons that are out there. I think that the ability for medical students and training to actually hear directly from patients, the ability to hold panels or even invite community members to share their experiences, providing recordings so that health care providers can hear the very subtle languages, language that they may use that does seem to imply that the problem lies with the patient.

Consider the example of managing somebody with diabetes to say, "You need to eat more fresh fruits and vegetables." To hear directly from a community member about how difficult it is for them to access those fresh fruits and vegetables in the neighborhoods where they live may help to guide the ways in which they hold conversations with patients, so I think this content, it should be required, and I think experiential learning is an excellent technique in order to train medical providers on how to best pay attention to these factors.

Senator ROSEN. Well, thank you. I appreciate that. I do agree. The way that we listen and respond and the way that we offer advice, all of us can learn from those kinds of conversations. I appreciate that.

Thank you, Senator Collins.

The CHAIRMAN. Thank you.

Senator Rick Scott?

Senator RICK SCOTT. Well, first, I want to thank Senator Collins and Ranking Member Casey for holding the hearing. I want to thank all the witnesses for being here today.

This is an unprecedented time in our country. One of my concerns has been all along that we do not have enough testing, and I have also heard that health insurers are limiting or denying coronavirus testing coverage for some of their enrollees, which that is clearly unacceptable and dangerous.

I introduced a bill, the Affordable Coronavirus Testing Act, that will make sure every American could have access because I think it is going to be hard to get back to a normal life if we cannot make sure everybody can get a test that feels that need to get a test, and

I hope we can get something like that done to make sure that happens.

Mr. Jones, can you talk about how the business of our Federally Qualified Health Centers have changed since the coronavirus started back in, really, I guess February, but early March?

Mr. JONES. Absolutely. In a word, we went from seeing people in our health center to doing telehealth. In my own health center, we were seeing, starting in the middle of March, about 85 percent of the people we saw was through telehealth, and as I mentioned in my statement, it was because we knew the practice of social distancing need to protect our patients, need to protect our staff, so the best way for us to do that was doing it remotely.

The other way out of this change that we have included in our scope of practice testing every day. In addition to treating patients the way we normally do—and incidentally, when a patient—when a lot of patients come to our health center, oftentimes they are coming way beyond the acute stage. It is not unusual for a typical patient to have three to five comorbidities. They come into the health center for high blood pressure, and you find other things.

That being said, in addition to doing that, we are doing our testing, and we are trying to make sure that we get the testing back in a reasonable amount of time, so that when you start looking at contact tracing, you can figure something out, so our whole model has changed significantly. Even though our staffs are working, a lot are working remotely because it is changed significantly, so we have gone into a space that we are not comfortable with, but we have adapted very quickly, and amidst to all of this, we have people that are afraid to come out of the house. We have people that are afraid to actually get tested and people that are still trying to wonder how do I get back to normalcy.

Senator RICK SCOTT. Have your overall volumes gone down or gone up?

Mr. JONES. They have gone down. There are more in my presentation I had to take out because of 5 minutes, but we have gone down by approximately 33 percent on the medical side. The dental side is nonexistent, because of all of the CDC guidelines our dental team is helping doing the testing. They are not really seeing patients because it is really unsafe. They are only doing emergent cases and a little bit of denture, so our volume has gone significantly.

The PPP has enabled us to keep going and not lose the level of care that we have had, so without that funding, we would have had a very difficult time having a viable organization to address this problem.

Senator RICK SCOTT. How are you doing on getting your protective gear?

Mr. JONES. We are fortunate in the western part of the State. We partner with various vendors. We collaborate as FQHCs in the western part, so we have not had a lot of difficulty getting PPEs and really have not had a lot of difficulty getting the testing.

Our difficulty has come in getting the test results. In some situations, it has taken 7 to 10 days, so we are working feverishly trying to find tests. If we can get the results a lot quicker, then we can

actually communicate that to people so that they will know what to do in order to protect themselves.

Senator RICK SCOTT. So you have not had access to any of the rapid tests that may not—

Mr. JONES. It is interesting. I just received an email this morning from my supply department saying, “we are going to be getting those tests in like the next week,” so prior or that, we did not have them available to us, no.

Senator RICK SCOTT. All right. Well, thank you for what you do. In Florida, we have a lot of great Federally Qualified Health Centers in Florida, and I know they are a safety net for a lot of communities, so thank you for what you do.

Mr. Woods, can you talk about how you are doing with regard to getting protective equipment and gear and how you are doing with regard to testing at your facilities?

Mr. WOODS. Thank you for the question, Senator.

You know, back in March because we were looking at peak, we had canceled all of our electives. We actually did it before there was any requirement to do so, so, actually, we took that time to really reinforce our PPE.

For the most part, we are in a much better situation than obviously we were several months ago. With isolated challenges, we have a predominantly female workforce. We need more small N95 masks, so that is something. There are some supply items we have months of supply for, but that is something that on a weekly basis, we make sure that we focus on.

On testing, I shared earlier we do have our special lab equipment, so we can run our own tests. We could probably do four times the amount of tests and have close to the same-day turnaround. The challenge is reagents, and so some of the—and still, in some respects, swabs, so I think we really need to continue to beef up the supplies of reagents so that we can expedite the testing. That would be our request.

The other thing—and there has been some conversation on testing about a national registry and how that testing and those reagents are distributed to hotspots, so I think that is something that we are having some conversation, about opportunities to do that as well.

Senator RICK SCOTT. Hopefully, this will pass, right? What will you do differently from the standpoint of making sure you have whether it is the issues you are dealing with now, the protective equipment, the reagents, the swabs? What are you going to do differently in the future to make sure you do not have the same problem again?

Mr. WOODS. Yes. Well, we certainly have significantly expanded our sources of supplies. A lot of times, you are buying in bulk to get savings. Organizations like ours, you do that and you get a lot of savings, but we realized that we need to have a good diversified supply line, so we have vendors that we might have never had before, before COVID, and obviously our par levels are where might have been several months now, in some respects, extended to a year or beyond, so we have invested probably about \$45 million or so just to make sure we have stockpiles of PPE, because this thing

could be with us for a while, so those are some of the things that we have been focused on.

Senator RICK SCOTT. Is your elective surgery coming back?

Mr. WOODS. It is. Probably right now, it is about 85 percent on some of the elective surgeries. Our inpatient surgeries are pretty much pre-COVID levels.

Where we are seeing some challenges mostly is on the emergency room, probably about 70 percent. That concerns us because a lot of people that are in their homes, there is a lot of studies, as you know, that people are having heart attacks at home, and they are afraid of coming into the emergency room. We are really focused on our own campaign. We call it our COVID-Safe Campaign. We are sharing with the community exactly what we are doing to keep people safe.

The other thing we have, we are doing rapid cycle surveys of patients, and so when they come in, so far 95 percent of patients have said they felt safe when they come in and for the 5 percent that have questions, what we do is we take that data and rapid cycle improvements to make sure that people feel more comfortable, but right now, we are seeing it coming back. Now, we will see what happens in the fall when influenza comes, how the trends continue then, but right now our focus, our main concern is emergency room

Senator RICK SCOTT. Well, thank you, each of you, for being here, and thank you for what you are doing to take care of patients.

Thank you, Chairman Collins, for putting this together.

The CHAIRMAN. Thank you.

Senator McSally?

Senator MCSALLY. Thank you, Chairwoman Collins. Thanks to all of you for your expertise during this very unprecedented time.

I first want to echo I am a cosponsor of Rick Scott's bill that is focused on testing and ensuring that people can get free testing during this once-in-a-century pandemic, and insurance companies are not denying that to people where there is a financial burden. Hopefully, that is something that everybody can agree upon, and we need to get that passed. We should just not have finances be a barrier for people getting tested.

I want to talk about the impact of the coronavirus on Native American communities. As you have all mentioned, underlying health conditions such as diabetes, we know is one of the strongest risk factors for COVID-19.

We also know diabetes is far more prevalent in minority communities, and we have 22 Native American Tribes in Arizona. They have a greater chance of having type 2 diabetes than any other population.

In fact, in Arizona, the Gila River Indian Community has the highest rate of type 2 diabetes in the world, so we have established, Congress has established the Special Diabetes Program for Indians, the SDPI, in 1997 to provide funds for diabetes prevention and treatment services. Through the SDPI grant programs, Tribal communities have been able to develop much needed diabetes programs and increase access to quality diabetic care.

While this is very popular and effective, it suffered from short-term reauthorizations and stagnant funding, which is why I introduced legislation along with my colleague from Arizona, Senator

Sinema, to reauthorize the Special Diabetes Program for Indians for an additional 5 years and increase the funding to \$200 million per year.

Dr. Carnethon, in the midst of a pandemic where there is a multitude of, obviously, health care funding priorities, can you talk about the importance of maintaining focus and treatment for underlying conditions like diabetes and the importance of programs like the SDPI?

Dr. CARNETHON. Absolutely. Thank you so much for bringing up this important point.

Pre-COVID, I spent most of my time on diabetes, cardiovascular disease, and lung disease, and these conditions are not going away and are the conditions that are leading to these adverse health outcomes from COVID-19 exposures.

One thing that is not going to happen is that COVID is not going to magically go away. We are going to be living with COVID for a long period of time, and there is no indication that the underlying health conditions are going to become less problematic for people who are exposed to COVID.

Using that rationale, we need to continue to support research that prevents the development of chronic diseases such as diabetes, hypertension, chronic kidney disease, heart disease that are predisposing to worse outcomes. We need to provide strategies for managing those conditions.

In my testimony, I mentioned the use of telehealth and telemedicine, particularly via video. I think this is critical because older adults may find themselves skipping their maintenance visits, and the opportunity to be on a call or, better yet, a video call with their physicians to make sure that they are managing their chronic conditions is going to be critical throughout this so that we can protect them from developing the worst outcomes, so I think the work that you have done so far to provide support for these resources, particularly in Native communities who are suffering mightily, definitely needs to continue.

Senator MCSALLY. Thanks, Dr. Carnethon. That actually brings up a follow-on for me.

I have legislation with Senator Doug Jones, also on this Committee, about medical monitoring, especially for rural communities, so it is not just the telehealth. It is the actual medical monitoring. If you have continuous glucose monitoring and things like that, you can transmit that information without having to take transportation long distances to get to the doctor, so how important is the medical monitoring as well as the telehealth?

Dr. CARNETHON. I think the medical monitoring is critical, and you bring this up at a time when we are working to adapt our research programs to use Bluetooth-enabled devices, so that we can have blood pressure measurements sent regularly to a physicians, glucose monitors sent regularly to treating physicians and clinicians, so that we can monitor. I mean, it has always been a wonderful strategy for those in rural areas who are far away from health care providers to be able to track more regularly, and these are critical things that need to happen, but in addition to making the technology available, "If you build it, they will come," is not enough. We need to leverage people who can go out and teach our

older adults to use it. I have gotten a number of Zoom explanation with my family members, and I know that people need help with these technologies and even how to set them up, but all of that is really critical to making sure that we can keep the population as healthy as possible.

Senator MCSALLY. Great. Thanks.

Madam Chair, before I forget, the Navajo Nation has submitted a statement on the COVID-19 impacts for Navajo elders in particular. I would like to submit this to the record.

The CHAIRMAN. Without objection. Thank you.

Senator MCSALLY. Thank you.

I want to shift to Arizona that has a growing Hispanic population. According to the American Psychological Association and National Survey looked at people 70 years and older. Forty-four percent of Latinos received home-based family caregivers compared to 25 percent of non-Hispanic whites, and epic differences were found among those with regard to the care recipient. Among those age 70 and older who required care, whites are more likely to receive help from spouses compared to Hispanics more likely to receive help from their adult children.

The instance of the adult children being caregivers for more likely for the Hispanic population, we know anyone who is a caregiver, you are also taking time off from your job to care for your loved one. That impacts your livelihood and support for your own family.

Dr. Mack, can you talk about just these issues with caregivers specifically? What other challenges to minority caregivers face and preventative measures we can take to ensure the protection of both the caregivers and the elderly?

Dr. MACK. Yes. Thank you.

Minority caregivers tend to, of course, have less resources, as you know, Unemployment is usually high in those communities, less time to take off work, and oftentimes the kids are engaged. Sometimes the children are actually missing school.

I think those goes into more resources to not only care for the populations in a preventative manner to make sure that they do not get sick, but also have those too such as telehealth, etc, but also those social programs that help support families, whether it is around meals or whether it is around caregivers.

As you know, today if you are elderly and ability to actually go into a nursing home—I have people in my family that have Alzheimer’s disease. People had to retire early, and they are looking for resources because the insurance does not pay or we do not have any way to pay for them to put them in a personal care home.

I think, again, we talked about those social determinants. The health care system itself cannot take care of those. We have to put resources in those areas of prevention but that are outside the walls of the facility to support these and not only health care services but also social services that the kids can continue to be educated, and etc.

Let me just say this, The Wi-Fi gap, we call it the “homework gap.” It is also the telehealth gap, so the same folks who cannot get the homework, especially during this time, they are going to fall behind, so education is an indicator of health.

Senator MCSALLY. Wonderful. Thank you.

Thank you, Madam Chair, for having this hearing.

The CHAIRMAN. Thank you.

Senator Sinema?

Senator SINEMA. Well, thank you, Madam Chair and Ranking Member, and I want to thank our witnesses for being with us today for this critical coronavirus hearing.

Arizona is currently experiencing one of the worst outbreaks in the Nation. Our State is also home to many communities that are in high-risk groups. We think they are more likely to become severely ill should they contract the virus.

In Arizona, many of our communities of color have been disproportionately impacted by the virus, both from a public health perspective and an economic one.

Arizona is home to many groups that are considered high risk, including seniors and our Hispanic and Latino communities and amongst our Tribal populations. It is clear that policymakers must address the existing disparities that exist in different communities if we are to effectively combat this pandemic.

My first question is for Dr. Mack, but I welcome everyone's thoughts.

Dr. Mack, I was struck by the part of your testimony that called for increased investment in our health care infrastructure. Native Americans face increased risk relative to COVID-19 and other illnesses in part because some communities do not have access to running water for sanitation and other basic needs.

Tribes in Arizona have been particularly hard hit by this pandemic. The Navajo Nation at one point had the highest rate of coronavirus rates in the country, and nearly 1 in 10 residents of the White Mountain Apache Tribe have tested positive for the virus. These health care challenges exist in other underserved communities as well.

Could you elaborate on how a lack of access to basic services like running water and other resources can impact public health during a pandemic, especially for vulnerable seniors?

Dr. MACK. Yes. Thank you.

That is entailed in the conversation about what happens outside of the walls of the health facility. That is a significant impact to health, and that is why prevention is so important and resources for prevention that extend into the homes of the Native Americans and other underserved populations.

How much can we save if we provided that water, we provided the food assets, if we provided equitable living for those communities? That in and of itself—and education and those things—improves the health of the population. It has been proven. It has been studied, so that is an extension of the health system. That is what the health system is called upon to do.

To your point, it is not only testing. It is very important, the testing, but the uninsured and those who are on Medicaid are standing in longer lines. They are sleeping overnight to get tested, and then the test results are coming delayed, so, to sum it up, we have to consider to extend health into the home and health care into the home and more around preventative services in addressing the social determinants of the health as opposed to waiting until people get sick before we start to take care of them.

Senator SINEMA. Thank you.

Would any other members of the panel like to respond?

Mr. WOODS. Senator, what I would add is, also, because in many of these Native communities, access to basic health services is also a big challenge and having to travel. I think it does speak to continuing to invest and fund telehealth services well beyond this pandemic so that we can reach those communities with respect that they are getting the right physicians and caregivers into those communities without them having to travel sometimes for basic care, so I think that is another part of the solution to help those in need in many of these Tribal communities.

Senator SINEMA. Thank you.

Actually, my next question is for you, Mr. Woods. Your testimony mentioned different strategies to help break down barriers to testing information amongst our communities of color. One recommendation was to ensure the availability of culturally relevant information and access to language interpretation services. I can see how this would be important not just for public health information, but also to help seniors access other social services or avoid coronavirus-related scams.

That is why I have made it a priority to have my press releases and other resources that we share in my office translated into Spanish and to work for local community organizations to reach more people.

When it comes to our aging populations, how important is it to design coronavirus information services that are both culturally relevant and specific to their needs as a member of a high-risk population?

Second, how can culturally relevant information access to language services help combat the socialized isolation that many seniors in high-risk populations are experiencing when they are unable to see family and friends due to the pandemic?

Mr. WOODS. Yes, it is absolutely essential.

One of the things you mentioned, actually what we are finding out, that it is—and I am half Spanish and half African American, and what we are finding out is it is actually a problem sometimes to translate both English to Spanish, so really, when we are writing out our PR and our public service communications and speaking, we are really doing it in the Native language, so that is one thing I would just add.

The other thing is class or culturally linguistically appropriate services has been a requirement for about 10 years. We only have 10 States that provide Medicaid support for that. Medicare does not.

I mentioned earlier we have invested about \$7 million this past year just on translation and interpretative services.

Then when we have gone out to these minority communities with testing, it was very, very important to have on our mobile vans, people that can speak the language.

I think one of the panelists mentioned that people are sometimes more comfortable with others that are caring for them that look like them also speak like them is really important.

I think this is an essential fundamental way of addressing this, and I do think providing funding, Medicare and Medicaid funding

for interpreters and translators, could go a long ways, not just for this pandemic, but for dealing with some of the things that you brought up, including social determinants of health that extend beyond this pandemic in vulnerable communities.

Senator SINEMA. Thank you.

Thank you, Madam Chairman.

The CHAIRMAN. Thank you, Senator.

We are about to start some votes, but I am hopeful that the Ranking Member and I can ask just a couple more quick questions before we adjourn the hearing.

My first one is for Mr. Woods. I have had many health care providers in Maine tell me that they are very concerned that the delayed and deferred health care screenings and elective procedures, which while they are called elective are still necessary, will produce downstream effects where people will have increased cancers, heart disease, strokes, undiagnosed diabetes as a result of the delay of health care during this pandemic and it is interesting because researchers found that after Hurricane Maria hit Puerto Rico, the leading cause of death was due to that interrupted access to health care.

Similarly, after Hurricane Sandy shutdown the Veterans Affairs hospital in Manhattan for 6 months, veterans had worse blood pressure control for at least 2 years after reopening compared to veterans in Connecticut, whose access was uninterrupted.

For those who are already struggling within equitable access to health care in general, how can we ensure that the actions taken to defer routine health care do not create a second health care crisis downstream?

Mr. WOODS. Senator, thanks for that question, and that really is keeping many of the people in my seat awake at night.

I mean, the lockdown, for example, that we have had in different areas has had a large impact on routine screenings, mammographies, colonoscopies, and there was a story of a senior, a patient who had actually needed hip surgery, put it out for 4 months, and the pain that she experienced until she was able to get in and be taken care of, so I think it is a real concern.

I think part of the solution comes in inspiring confidence both at the health system level, as I alluded earlier, that we are doing everything possible to really keep a patient safe when they come into our facilities. We are testing staff. We are giving PPE to patients as they come in. We are temperature checking, and we are doing all the things with cleaning between rooms that are taking two and three times longer than we would otherwise do, but we are really sharing with the community that we are doing everything we can to keep them safe.

I think also there is an opportunity for policymakers for some of the conversations we have had today of testing and contact tracing and so forth to give a measure of confidence to the communities that we are also doing everything we can to keep them safe.

We share that concern. Every day, we see the manifestations of delayed care, and as you indicated, at one time, it might have been called "elective." It goes quickly to urgent, then to emergent, so we are reaching out to the community through many, many different forums to say, "If you think you have elective care needs, come to

us. We will help guide you,” but it is that sense of confidence that is important that we provide the communities and we are doing everything possible to keep them and their loved ones safe.

The CHAIRMAN. Thank you so much.

My final question is for Dr. Carnethon, and it has to do with clinical trials. Making clinical trials more inclusive of women and minority groups has been an issue that Senator Warren and I worked on and became part of the 21st Century Cures Act, but we know that many older black Americans are reticent to participate, given past medical exploitations such as the misappropriation of cancer cells belonging to Henrietta Lacks, for example.

My question to you, Doctor, is, what recommendations do you have to help ensure that clinical trials are more representative of those who face the highest risk of COVID-19?

Dr. CARNETHON. Thank you so much for pointing out that significant challenge that we face when it comes to making sure that the therapies that we develop work for everybody.

There are cases through our history where we have shown that not including women in clinical trials left us with a gap in understanding about the biological mechanisms of action of a given drug.

I think we are in a similar—we face the risk of being in a similar position here when we talk about vaccine trials for managing and preventing the infection, and the ways that we have worked to try to engage communities to participate in observational research are the partnership strategies that I described earlier. I think we need to start that now so that we can prime communities to be ready to partner with the medical and research establishment so that we can test strategies that will protect us.

I think messaging around a shared sense of responsibility to protect ourselves may help to motivate individuals who may be reticent to join.

I think putting forth spaces that the community trusts, the faith-based spaces that Dr. Jones mentioned, engaging Federally Qualified Health Centers, as well as HBCUs can help to lend a bit of understanding and trust.

Finally, really seeing the investigators behind this work, we do have a diverse biomedical workforce. It is not as diverse as we would certainly like to have, but there are key individuals out there who represent the very communities who are the hardest hit.

I think putting these individuals at the forefront of messaging, the shared responsibility that we have to participate in science, will help us achieve our goals of developing therapies that work for all.

The CHAIRMAN. Thank you so much.

Senator Casey?

Senator CASEY. Thank you, Chairman Collins.

I just had a quick question for Dr. Carnethon. I know you just had a question. I just have one more, and then I know we have to wrap up.

It is on home-and community-based services. We have referred to all of the deaths in long-term care settings. Part of the answer to getting those deaths down is to have care settings that are not congregate, and one of the ways to do that, of course, is home-and community-based services.

I wanted to ask you, Doctor, about explaining how additional Medicaid dollars for these home-and community-based benefits would be critical for older adults.

Dr. CARNETHON. Yes. I really appreciate that, especially your efforts on behalf of shoring up the financial resources for these home-and community-based workers because, as you point out, keeping seniors in their home can be safer. Providing them with opportunities to receive the care that they need and maintain their independence is critical.

I think there are two key issues here. One is the need to protect the home care workers. Essentially, they need to have the same level of protective equipment that we are providing for our health care providers within health care settings. They are going from home to home. The last thing we want is for those individuals to be transmitting disease from home to home.

While many professionals within health care settings have protection about their income if they happen to be sick or unable to work, a number of home-and community-based workers do not have those protections, and so their incentive to be conservative about symptoms is lowered when if they do not go to work, they do not get the care that they need.

I think those are critical ways in which money can be used to protect those individuals.

Senator CASEY. Thank you.

Thank you, Madam Chair.

The CHAIRMAN. Thank you very much, Senator Casey.

I want to thank all of our witnesses for joining us today and sharing your extraordinary dedication and expertise. I particularly appreciated that each of you focus so much on recommendations, on practical solutions that we can pursue in order to lessen the disparity, the racial disparity in the COVID infections and also in general in our health care system.

This week, the overall death toll in the United States from COVID-19 now stands at more than 140,000 deaths. More than 3.7 million have been infected. Nearly one in three black Americans knows someone personally who has died from the coronavirus, far exceeding their white counterparts.

As I have mentioned, it is appalling to me that my State of Maine has the worst rate of COVID racial disparities in the Nation, and I know that is of concern to the people of Maine and to health care providers as well as to the Governor. We face many of the same core challenges and risk factors that are present throughout the country, how to drive down COVID infections among populations where many hold jobs as frontline or essential workers who may not be able to easily engage in the same level of social distancing as some of their white neighbors due to transportation or housing arrangements and those who may have cultural or linguistic barriers, particularly among our immigrant population.

I particularly appreciate the suggestions for how to ensure that Federal dollars committed to prevent or mitigate COVID actually reach all members of our communities as we intend.

Support for translation and interpreter services, direct engagement of trusted community partners, telehealth services which we heard a lot about today can enhance that response. For seniors who

are at the highest risk of severe complications or even death, the value of these interventions is even greater.

I hope that our Committee will continue to work together on policies that not only can help change the trajectory of this current pandemic but also solve some of the disparities that have become so evident during the COVID pandemic.

Senator Casey, I would like to turn to you for any closing remarks.

Senator CASEY. Chairman Collins, thank you for this important hearing, and I want to thank, of course, our witnesses for their testimonies and the ideas they gave us for solutions.

We know that over the next several weeks, the Senate will negotiate legislation to provide help, a measure of help to tens of millions of Americans who are suffering from the COVID-19 disease and the job crisis. This legislation is an opportunity to advance the cause of justice for older Americans and communities of color as well as many other Americans.

This bill should include policies to save the lives of nursing home residents and nursing home workers. The bill should also guarantee access to affordable quality health care. The bill should also recognize and pay the heroes on the front lines.

I hope that we will pass this test that our national challenges have presented to us and that we will also pass the bill that strives to achieve a measure of justice for our seniors in communities of color.

Thank you.

The CHAIRMAN. Thank you.

Again, my thanks to all of our witnesses, to the many Committee members who participated in today's hearing, and to our staff which worked so hard to bring these witnesses to us and to put this hearing together.

Committee members have until Friday, July 31st, to submit any additional questions for the record.

Again, my thanks, and this concludes our hearing. We are adjourned.

[Whereupon, at 11:55 a.m., the Committee was adjourned.]

APPENDIX

Prepared Witness Statements



Testimony of

Dominic H. Mack, MD, MBA

Director, National Center for Primary Care

Professor of Family Medicine

Morehouse School of Medicine

Atlanta, GA

Before the
Senate Special Committee on Aging

Hearing:

The COVID-19 Pandemic and Seniors: A Look at Racial Health Disparities

July 21, 9:30 AM

Room 562 Dirksen Senate Office Building



Chairwoman Collins, Ranking Member Casey, and members of the Special Committee on Aging – Thank you very much for convening this important hearing on COVID-19, seniors, and racial health disparities.

I am Dominic Mack, MD, MBA and am presenting testimony on behalf of Morehouse School of Medicine (MSM). MSM is one of four historically black medical schools in the nation. I bring greetings to you from our president and dean, Dr. Valerie Montgomery Rice. At Morehouse, I serve as professor of family medicine, director of the institution's National Center for Primary Care, and co-lead on an innovative partnership between the US Department of Health and Human Services' Office of Minority Health and Morehouse School of Medicine entitled: *The National COVID-19 Resiliency Network (NCRN): Mitigating the Impact of COVID-19 on Vulnerable Populations*.

The daunting news that Black Americans in the US are disproportionately suffering and dying from the novel coronavirus (COVID-19) unfortunately is not a tremendous surprise to those of us at Morehouse School of Medicine, who are on the front lines in our medically-underserved community, and regularly monitor and understand health status disparities in this nation.

According to the Centers for Disease Control and Prevention (CDC), as of late June, Blacks, Native Americans, Alaska Natives and Hispanics are impacted by the coronavirus at a rate reaching 5 times that of non-minority Americans. Today, the top five counties with the highest death rates in the nation are all predominantly Black. And in my state of Georgia, Blacks have accounted for nearly 50% of the coronavirus deaths across the state, and national statistics



are similar. Black and other minority seniors are disproportionately represented among those who are sick and dying.

While this information tracks consistently with well-known health status and health care challenges faced daily by racial and ethnic minorities, it also represents a surrogate for the glaring lack of health infrastructure in medically underserved communities.

Our partnership with the HHS Office of Minority Health is a step in the right direction. To mitigate the impact of COVID-19 on racial and ethnic minorities, rural communities, and other vulnerable populations, MSM will establish the **National COVID-19 Resiliency Network** (NCRN). The NCRN COVID-19 national dissemination platform will consist of six foundational areas in which the network will:

- 1) Identify and engage vulnerable communities through local, state, and national partners.
- 2) Nurture existing and develop new partnerships to address the COVID-19 pandemic and ensure the NCRN is an active information dissemination network with whom to collaborate.
- 3) Partner with vulnerable communities and national, state, local, and government organizations to provide and disseminate culturally and linguistically appropriate information throughout states, territories, and tribal nations.
- 4) Use technology to link members of the priority vulnerable communities to community health workers, COVID-19 healthcare, social services and behavioral



health services, including testing, vaccinations, counseling, and links to primary care practices.

- 5) Monitor and evaluate the success of the services and measure outcomes using process improvement methods to improve the quality of the overall program.
- 6) Use broad and comprehensive dissemination methods, including mainstream media (including social media), white papers, and publications as resources and strategies to bring awareness, participation, education, and training directly to vulnerable communities impacted by COVID-19.

Chairwoman Collins and committee members, we are grateful to partner with the HHS Office of Minority Health to address the disproportionate impact of COVID-19 on communities of color and know its work will be meaningful, but I want to be clear about the need in minority and medically underserved communities.

Congressional leaders and the administration have enacted, literally, trillions of dollars of support for economic stimulus, worker protections, testing and treatment funding, academic relief, and other benefits, but this effort falls short in addressing the fundamental need to provide significant and targeted measures to resolve the above-stated health disparities playing out in this pandemic.

Now is the time to act in a significant way to reverse this latest example of how the lack of meaningful health infrastructure in medically underserved communities does currently and will continue to produce the same poor results. Without significant action, we can expect more of



the same the next time the nation faces a similar health crisis. With your leadership, we can realize an equitable policy response to the crises we are facing.

We are calling on Congress and the administration to include the following measures in the upcoming COVID-19 stimulus legislation:

- Resolve the funding disparity from the CARES Act that short-funded the Historically Black Graduate Institutions (HBGIs). While most HBCUs received a significant level of support in CARES, because of the Pell Grant-based calculation used by the Department of Education (graduate programs generally do not utilize Pell Grants), HBGIs—most of which are health schools like Morehouse School of Medicine that are on the front lines of the pandemic—received only a modest CARES Act allocation. We are facing real and substantial financial shortfalls and need a significant allocation in the next package.
- Provide robust funding for the improvement and development of health care infrastructure in medically underserved communities, specifically focused on building hospitals and other health care facilities designed to respond to the unique health care needs of Black Americans and other minorities.
- Double funding for existing Title VII health professions training programs at HHS's Health Resources and Services Administration that are targeted at increasing diversity in the health care workforce, including Minority Centers of Excellence, the Health Careers Opportunity Program, Scholarships for Disadvantaged Students, Minority Faculty Loan Repayment, and the Geriatric Training Program.



- Invest \$100 million in new, annual research funding dedicated through the NIH's National Institute on Minority Health and Health Disparities, specifically targeted at enabling minority-serving institutions to conduct research that is responsive to reversing the health disparities associated with the existing COVID-19 pandemic, and preventing the next episode from taking a similar toll.

We stand ready to work with you to facilitate these efforts. If there was ever a time to meaningfully act to address the stark racial and ethnic health disparities that have been and continue to prevent us from realizing health equity in the United States, it is now.

Thank you for the opportunity to share our views with you. I am pleased to respond to any questions.

Mercedes R. Carnethon, Ph.D.
Mary Harris Thompson Professor and Vice Chair of Preventive Medicine (epidemiology) and Professor of
Medicine (Pulmonary and Critical Care)
Northwestern University Feinberg School of Medicine

July 21, 2020

Good morning Chairman Collins, Ranking Member Casey and other distinguished Senators of the Committee on Aging. Thank you for the opportunity to share my observations and recommendations to address disparities in COVID-19 among older adults in my capacity as a research expert.

I am an epidemiologist in the Departments of Preventive Medicine and Medicine at the Northwestern University Feinberg School of Medicine where I have studied the risk factors for chronic disease for the previous 18 years. My research, which has been funded by the National Institutes of Health, the American Heart Association and the American Lung Association has described an earlier onset and a more severe course of hypertension, diabetes, heart and lung disease among Blacks, Latinx, Native American/Pacific Islanders and some Asians subgroups as compared with non-Hispanic whites.

These statistics are borne out in my personal experience. I never met my maternal grandmother because when she was 62 years old, she suffered a stroke followed by a fatal heart attack. While I knew and loved my paternal grandmother, she did not know me for the last 10 years of her life because she battled vascular dementia following years of high blood pressure.

The relevance of my story is that the vascular diseases that affected my grandparents are the same conditions that are associated with the worst outcomes from COVID-19.

Early scientific reports from countries that preceded us in the pandemic, described the characteristics of individuals with COVID-19 who were more likely to be hospitalized and to die. Immediately, we realized that nonwhites and ethnic minorities in the US would be disproportionately affected. As states and municipalities began collecting sociodemographic data from individuals diagnosed with COVID-19, [racial and ethnic disparities](#) emerged that were the most acute in the younger ages. Although these disparities appear to decrease with aging in community dwelling older adults, [nursing homes](#) with a greater proportion of Black or Latinx residents have double the rate of COVID-19 infections than their predominately non-Hispanic white counterparts.

Against the backdrop of this pandemic, I understand the urgency for our country to return to normal. In our research, we have described the link between economic factors and health. A strong economy that allows for stable housing, access to healthy foods, and healthcare access to manage chronic conditions is likely to be of even greater benefit to elderly vulnerable populations.

However, we cannot return to normal by prioritizing the *economy* over the *people* without offering strategies to mitigate the impact of COVID-19 on minority older adults. And so I offer 3 recommendations based on my experience as a population science researcher.

First, is to [expand the digital infrastructure and training available](#) to older adults to support videoconferencing for telemedicine. The CARES act provided provisions to expand coverage and offer grants to support broader use of telehealth services including Medicare. While this can be carried out by telephone, it can be even better via videoconferencing. Almost half of all older adults have a

[Smartphone](#) with video capability, and ownership is similar by race and ethnicity. Accessibility is one step, but in my experience, technology naïve adults require training to maximize these technologies. When patient and provider can “see” one another, patients can maximize the social connection with their providers, and providers have more information in the form of visual cues to gauge whether in person visits or other home-based supports are needed.

Second, [the NIH needs additional financial support](#) to address the short- and long-term manifestations of the SARS-COV2 infection. The majority of the \$1 billion dollar infusion of support to the NIH through the CARES act went to the NIAID to accelerate study of the virus and vaccine development. We have learned that the SARS-COV2 infection damages multiple organs including the heart, lung, blood, kidneys and the brain. Further, we know that adults who are obese and have diabetes have the worst outcomes, and that underrepresented minorities and older adults are overrepresented in those populations. As additional financial support is considered, other institutes at the NIH need to be on equal footing when it comes to the allocation of resources.

Third and finally, we need to [engage the communities who have been hardest hit by COVID-19](#) as we develop strategies for prevention and treatment. Progress towards a vaccine to prevent COVID-19 is encouraging. However, drawing on parallels from the annual flu vaccine, nonwhite and ethnic minorities are less likely to get [vaccinated](#) than non-Hispanic whites. Without building rapport and trust in these communities, there is no guarantee that the highest risk populations will get the vaccine or that they will even want the vaccine.

Disparities in COVID-19 among older adults are complex and my suggestions will not address the structural and institutional factors that are at the root of disparities in health. However, thank you for allowing me the opportunity to offer them today in hopes that we can offer our most vulnerable older adults our very best science and medical care.



Written Testimony of Eugene A. Woods, MBA, MHA, FACHE
President and Chief Executive Officer, Atrium Health
Charlotte, North Carolina

Before the United States Senate Special Committee on Aging

The COVID-19 Pandemic and Seniors: A Look at Racial Health Disparities
Tuesday, July 21, 2020

Chairman Collins, Ranking Member Casey and Members of the U.S. Senate Special Committee on Aging:

My name is Gene Woods and I am the president and chief executive officer for Atrium Health, one of the most comprehensive and highly integrated, not-for-profit healthcare systems in the nation. With nearly 30 years of healthcare experience, I joined Atrium Health in April 2016, having overseen non-profit and for-profit managed hospitals, academic and community-based delivery systems and rural and urban facilities, as well as serving as the previous chair of the American Hospital Association (AHA). As a multi-racial healthcare executive, I am most passionate about protecting and expanding access and coverage to all Americans, better engaging with our communities to advance positive health outcomes and achieving equity of care by eliminating health disparities.

It is now my great honor to present my written testimony to the U.S. Senate Special Committee on Aging on behalf of our 70,000 Atrium Health teammates, detailing some of the many successes we have achieved and lessons we have learned during this unprecedented pandemic period, including about the racial health disparities of our aging population.

About Atrium Health

It's quite remarkable to think back to our humble beginnings in 1940 when a group of ambitious, young clinicians, not being satisfied with the services available to the public, relentlessly lobbied for a new hospital to better meet the needs of the community. Over time, we have evolved from these simple roots, understanding that our responsibilities are becoming less about what happens inside our hospitals and more about what happens in our communities; less about what our clinicians are telling our patients and more about what patients are telling us. In fact, it is less about healthcare and more about health. Today, we're proud to be known as one of the nation's leading health organizations. Our mission to improve health, elevate hope and advance healing – FOR ALL is forever bound to our rich heritage.



When it comes to keeping populations healthy, we know that our responsibilities do not begin or end at the hospital door. This important work starts in our own backyard and particularly within vulnerable neighborhoods – areas that do not have enough access to health services or fresh foods and where the rates of diabetes and heart disease are above the national average. So, we're bringing people and organizations together in new ways and collaborating on what matters most.

With 41 hospitals located across the Carolinas and Georgia and a \$11.5 billion net operating revenue, we serve a population of 7.8 million. We are also the largest provider of community benefit (i.e., the value we give back to our community in uncompensated care, medical education, cash and in-kind contributions, community-building activities, etc.) in North Carolina. In recent years, we have provided over \$2 billion annually in total community benefit to the communities we serve, which translates to roughly \$5.7 million every day. And with world-class service lines in Cancer, Children's, Heart & Vascular, Neuroscience, Musculoskeletal and Surgery & Transplant, we are recognized by our patients and industry experts to be among the best of the best, demonstrating that healthcare can be both exceptional and compassionate at the same time.

Atrium Health has also been recognized as one of the Best Employers for Diversity, for new grads and for Women by *Forbes*; number one on the list of Best Places to Work for Women & Diverse Managers by DiversityMBA; one of the 150 Top Places to Work in Healthcare by *Becker's Healthcare*; and the number one military-friendly employer in the country. In addition, our organization has been recognized by *U.S. News & World Report*, Leapfrog Group and the American Nurses Credentialing Center as among the very best in the nation and honored by the American Hospital Association with the Equity of Care Award and one of its first-ever Quest for Quality honors.

Most recently, Atrium Health was recognized by the Centers for Medicare & Medicaid Services (CMS) as a 2020 CMS Health Equity Award recipient for its dedication to health equity by reducing disparities, enabling communities to achieve the highest level of health. Atrium Health is one of only two organizations to win this prestigious award this year and is the only non-profit healthcare system in the nation to be recognized by CMS in this manner.

[Our COVID-19 Journey](#)

Eighty years ago, our organization rose from the ashes of the Great Depression as Charlotte Memorial Hospital. It was a time when institutions of every kind were struggling economically, and our country was being further strained by war. And while born in the midst of uncertainty, through all the twists and turns in our storied history, we have become stronger in the face of each new challenge.



Fast forward to today – facing the challenges brought by the novel coronavirus, COVID-19 – our resolute perseverance and passion to help others have never shined brighter. From within our care facilities to the makeshift offices now set up within their homes, every single member of our Atrium Health family is playing a unique role in protecting the health and safety of our patients, loved ones, friends and neighbors throughout this pandemic. Working together, during some of the largest and hardest days, our teammates are bringing health, hope and healing – FOR ALL front and center in new and remarkable ways, demonstrating undeniable courage and dedication.

From where each of you sit, it may be hard to see the tremendous difference you, our elected officials, are making in our ability to care for the American public. The COVID-19 emergency funding has helped keep our teammates employed and enabled us to seamlessly provide care for all of our patients and the communities we serve. Government actions have enabled us to come together to purchase and secure vast quantities of critical materials in short supply. Your policies have also allowed the deployment of financial resources to where they are most needed. As you begin debate on the next relief package, Atrium Health would like to thank you for what you have done for this country these past few months. As you know, we are not out of the woods and ask for your continued, ongoing support for emergency funding for healthcare.

Policy Recommendation #1:

We urge you to support Medicare Advanced Payment loan forgiveness as part of the next COVID-19 relief package. By allowing providers to retain funds which have already been deployed is a straightforward way to keep the healthcare infrastructure solvent in this emergency period.

Situational Update

While we have been combatting COVID-19 for over five months now, it seems like yesterday when our Infection Prevention, Emergency Management and clinical teams began preparing for the arrival of the pandemic, shortly after the first of the year. By early March, we had activated our emergency operations incident command center and shifted all operational and organizational protocols to adjust for the expected demands of COVID-19. On March 9, we admitted our first COVID-19 patient.

As of Wednesday, July 15, Atrium Health has tested more than 108,000 patients for COVID-19, and we are now performing up to 2,300 tests per day. We are fortunate to be one of the few hospital systems in the nation that can process test results at our own, in-house laboratory. That has enabled us to better serve our community, despite the continued challenges of an insufficient supply of the reagents needed to complete the testing process.



With our in-house laboratory, we have the capacity to process more than 4,000 tests per day. International shortages of reagents and specialized plastics needed for collection have limited us to well below capacity on a daily basis. We have explored all avenues to secure additional supplies, however, manufacturers simply do not have anything more to give.

Policy Recommendation #2:

A short-term remedy to the testing supply shortage may be to provide visibility into where supplies are being deployed. Much in the same way that the hospital industry reallocated ventilators during the early days of the pandemic, we believe a national registry would allow public health experts to allocate testing supplies based on need. Please consider calling on the Department of Health and Human Services to provide a report on testing supply availability and allocation to enable a sophisticated public health-oriented testing supply distribution strategy.

Policy Recommendation #3:

This Committee should consider using its oversight authority to ensure the country is prepared for mass vaccinations and well-positioned to mitigate challenges, such as supply shortages.

Recent weeks have been extremely difficult. Within our system, the number of lives COVID-19 has claimed has climbed, with more than a death per day over the past month. However, in terms of equipment and supplies, with more knowledge, experience and therapeutics we are using ventilators less often and lengths of stay for COVID-19 patients has decreased. We are also in a much better place with our personal protective equipment (PPE) than we were in March. During North Carolina's stay-at-home orders this spring, we delayed all non-essential surgeries and procedures. However, following clinical reentry, we are catching up on delayed care and are now at our "normal" pre-COVID occupancy levels, despite the increasing number of COVID-19 cases in our system and our communities.

Atrium Health COVID-19 Virtual Hospital

As we continue to look ahead, preparing for a potentially growing number of people in our community with COVID-19, we've had a laser-like focus on expanding hospital capacity. And beyond physical space, we have also been embracing virtual care like never before. So much so that Atrium Health is leading the country with our efforts. Our new Atrium Health COVID-19 Virtual Hospital, which we opened on March 20, is enabling us to care for hundreds of patients at a time from the comfort of their homes.



The Atrium Health COVID-19 Virtual Hospital consists of two levels of care: an observation unit for patients with mild symptoms and an acute unit for patients experiencing symptoms that would typically require inpatient hospitalization. Principal components of this model of care include telephonic assessment and monitoring by a registered nurse, as well as daily provider virtual visits and in-home care provided by community paramedics for the most acutely ill.

To date, the Atrium Health COVID-19 Virtual Hospital has cared for nearly 11,000 COVID-19 positive patients, with an average daily census of over 2,000 patients. In addition to the significant impact on improved clinical outcomes, the virtual hospital has created additional inpatient bed capacity, resulted in less PPE use and helped limit the community spread of the virus. Patient feedback has been overwhelmingly positive as they report feeling less fearful and alone throughout their illness.

Policy Recommendation #4:

We are joined by hospitals and providers across the country in calling for permanent coverage for telemedicine services. Access to quality care is a persistent challenge for urban, at-risk and rural communities. Transportation is also a top barrier to caring for our aging population. Payment and coverage parity for virtual care is essential to reducing health disparities. CMS's decision to cover virtual care in parity with traditional settings has allowed us to maintain care for thousands of our patients throughout the COVID-19 lockdown. We urge you to maintain Medicare coverage and payment parity telemedicine policies past this national emergency.

Impact on Minority Populations

At Atrium Health, we are wired for health equity and believe deeply that to do the greatest good, we have to venture beyond our walls to meet people where they are – where they live, work and play – because all three of these social determinants affect people's health (and their lives). So, as it has become increasingly clear that minority populations are being disproportionately affected by COVID-19, we took an innovative and advanced approach, providing urgent, targeted and easy-to-access care directly to underserved communities.

Data Infrastructure

When the first COVID-19 cases appeared in our region in early-March, Atrium Health invested in our data infrastructure and built our own COVID-19 Electronic Dashboard, which provides a variety of analytics, updated every two hours, including COVID-19 positive cases and mortality, all stratified by race, ethnicity, age and test location.

We also created a COVID-19 GIS (Geographic Information System) Map, which includes COVID-19 geographical spread and hot spots, as well as geographical testing density, so that



we can better understand which communities may be experiencing barriers to testing. Included in this is the ability to view a variety of social factors such as population density, median income, higher poverty zip codes, the concentration of Blacks or Hispanics geographically, as well as the location of churches, schools and bus routes. We also developed features within our GIS map to analyze the home addresses of patients tested on specific testing days and mobile locations in order to assess the neighborhood footprint and geographical reach of our marketing outreach and grassroots communications efforts.

By the end of March, our data clearly showed there were gaps in testing for communities of color and that the majority of tests among the Black population were taking place in the Emergency Department. We then quickly developed an aggressive set of efforts to intervene and a Multi-Disciplinary COVID-Disparities Task Force was formed.

Policy Recommendation #5:

Because of our ability to operate as a system, Atrium Health was able to deliver a robust data analytics capability to ensure that our community-based programing is having an impact. These resources are often not available to communities not served by a hospital system. We urge Congress to reinvest in public health analytics to support the use of data driven, community-based interventions more consistently across the country.

Minority Testing

To address the testing disparity among underserved and minority communities, we launched our nationally leading, innovative testing model, integrating actionable GIS data with our mobile medical units. With our GIS data, our mobile units target COVID-19 hotspots in underserved neighborhoods and break down barriers to screening and testing for COVID-19 in low-income communities of color by:

- Not requiring an appointment or provider referral
- Ensuring the ability to pay is not an inhibiting factor to screening and testing
- Screening for social determinants of health and connecting community members to services
- Staffing the units with interpreters
- Offering alternate operational hours on certain days to accommodate essential workers
- Making it clear that Atrium Health will not share an individual's immigration status nor report if a patient is undocumented
- Leveraging minority media partnerships as well as grassroots communications channels, such as church emails.
- Holding testing at locations trusted by underserved communities, such as churches and community service organizations.



- Applying a lower threshold of testing criteria, such as asymptomatic workplace exposures or participating in a protest, well before these recommendations came from the North Carolina Department of Health and Human Services.

To date, our mobile units focused on underserved communities have screened and tested nearly 13,000 community members, including nearly 3,100 interpreted encounters and nearly 650 social worker consults. We have also partnered with roughly 55 community host sites, including a variety of churches and organizations, that serve large Black and Hispanic populations.

With these efforts, by April 20 – less than a month after the start of the initiative – Atrium Health closed the gap in testing for the Black population in our area. By May 4, the gap in testing had been closed for Hispanics as well. Both populations are now being tested at higher percentages than they represent in our general patient population, respectively.

While we are proud that we have prevented and even eliminated disparities in testing among communities of color, we continue to be deeply troubled by the disparities in the percentage of positive COVID-19 tests and deaths among our Hispanic and Black neighbors. To put it into perspective, in looking at test results since the beginning of the pandemic, the percent positive rate for Blacks has been roughly double that of Whites, and the percent positive among Hispanics have been more than three times that of Blacks. According to the Brookings Institute, Black and Hispanic/Latino death rates are at least six times higher than for Whites. This shows that there is clearly more work to be done.

Policy Recommendation #6:

Health systems are able to share resources and best practices across their respective regions and have a strong track record of reducing health disparities. In addition to reinvesting in our national public health infrastructure, please reduce barriers to establishing hospital systems.

“Para Tu Salud”

In May, we convened a Hispanic COVID-19 Response Roundtable that included many key stakeholders from the Hispanic and Latino community. The goal was to hear from the community about gaps in the COVID-19 response and to get feedback about how to more effectively communicate messages and conduct additional community outreach to the Hispanic and Latino community related to the pandemic.

The result of this meeting, as well as some smaller community discussions, was the launch of our new initiative, *“Para Tu Salud”* – simply translated to “For Your Health” – to further educate



and inform Hispanic communities on how to stay safe and healthy relative to COVID-19. Since the launch of this initiative, we have deployed several communications tactics to target Hispanic and Latino populations. This includes developing educational materials for social media; creating videos in Spanish featuring Atrium leadership and physicians; and partnering with local Hispanic news outlets and community leaders and influencers.

Policy Recommendation #7:

For non-English speaking patients, culturally competent care begins with overcoming language barriers. This is particularly true for our aging population. Interpretation and translation services are an unfunded necessity. We encourage you to consider providing Medicare and Medicaid payment for interpreters and translators.

Impact on Aging Populations

Across the country, many skilled nursing facilities (SNFs) have been at the center of COVID-19 outbreaks due to limited resources and confined building layouts. In North Carolina, 54% of the deaths attributed to COVID-19 have come from a nursing home or residential care facility. Given widespread concerns to protect some of our most vulnerable citizens from this pandemic, Atrium Health was early to establish a set of best practices and strategies specifically designed for skilled nursing facilities.

Atrium Health Huntersville Oaks

Several months ago, our skilled nursing facility team began planning their COVID-19 response with two key objectives – (1) reduce the virus risk, spread and mortality rates for long-term care communities and (2) support reentry to facilitate hospital capacity by transferring all of our skilled nursing facility-level COVID-19 infected patients to a single, designated site. Atrium Health Huntersville Oaks skilled nursing facility was selected to fill this need as it is one of only a few skilled nursing facilities in North Carolina capable of caring for these patients.

Huntersville Oaks offers four distinct wings, each with separate air units and exterior entrances, as well as private rooms and private bathrooms – all of which made this an ideal environment to best care for COVID-19 patients who need skilled nursing facility care. Relocating these patients to Huntersville Oaks is a plan that has – and will continue to – save lives.

To prevent the spread of COVID-19, residents and teammates are tested if any coronavirus symptoms are exhibited. All teammates must don masks before entering the facility and are screened prior to their shift. In addition, teammates must wear masks and eye protection throughout their shifts and practice social distancing and "COVID-Safe" care standards at all times. They have been appropriately trained and use enhanced personal protective equipment



and protective measures if a resident is receiving aerosolizing procedures, such as nebulizer treatments.

Our skilled nursing facility teammates are truly on the front lines of this fight and, as such, we have ensured they have all the resources and supplies they need – including a significant increase in staff and a focus on teammate engagement for those employees dedicated to caring for this population. This includes frequent food donations from local restaurants, paid hotel stays if they have compromised family members at home and prize giveaways to build morale – all of which, we believe, have contributed to the success of this work and lives saved.

American Health Care Association President and CEO Mark Parkinson publicly applauded our approach, stating: "Atrium Health is setting an example for how to protect the health and safety of residents and staff in our nation's nursing homes."

Policy Commendation:

We commend Senator Casey for his leadership in helping to secure emergency funding for SNFs. As envisioned in Senate Bill 3768, Atrium Health Huntersville Oaks cares for COVID-19 positive SNF residents in an environment most appropriate for their needs.

COVID-19 and Economic Reentry

It's unbelievable to think that, in the United States, the number of confirmed COVID-19 cases has already surpassed the three million mark, just five months since the very first case was reported.

Here in the Greater Charlotte region, over the past several weeks, our community has gone through the first two phases of economic reentry. At the same time, we've also seen large gatherings spring up, as more of our friends and neighbors in the community step out of their homes to celebrate holidays and family milestones or participate in community demonstrations against racial injustices. So, rather than the plateau in new infections and down-trending hospitalizations that we experienced in April, we are now experiencing a steady growth in the number of COVID-19 cases, though slower than at the outset in March. This reminds us that it's a marathon, not a sprint and, most likely, we are likely to continue to see sustained growth in cases and hospitalizations for the foreseeable future.

Clinical Reentry

In planning Atrium Health's clinical reentry in April, we established four principles to direct our work, as well as developed data analytics to monitor our status in each of these four domains:

- that we maintain the capability (beds, equipment, staff) to safely and effectively care for both COVID and non-COVID patients alike



- that we can ensure sufficient supplies of PPE to protect our caregivers
- that we can test those in need of testing
- that we can continually track behavior of the pandemic in our community

We officially launched "clinical reentry" on April 27 by first lifting limitations to in-person access to our office locations. Stepwise resumption of elective procedures came online over the subsequent two weeks. We have now completed the twelfth week of our reentry work and to date, 95% of patients have given us the highest marks when surveyed if they feel safe with the care we have provided throughout reentry.

Going forward, our work will continue to be informed by region-specific data on COVID-19 activity. (Note: We calculate daily the Effective Reproduction Number (RT) for 11 counties in the Greater Charlotte Region.) We plan to adjust the scope of our reentry work as necessary, based on this region-specific information.

Policy Recommendation #8:

It is notable that after three million cases and 140,000 deaths, only half of Americans intend to get vaccinated (AP-NORC poll). A public relations campaign is needed to create acceptance of ongoing social distancing and confidence in vaccination. While we wait for vaccines to come to market, we encourage you to use this time to enable private-public communications partnerships to move the trust needle on vaccination.

"COVID-Safe" Care Standards

In April, we were among the first health systems in the nation to establish "COVID-Safe" care standards for all of Atrium Health facilities and locations. These extensive safety measures and initiatives, such as mandatory screening, testing, masking, cleaning and operational changes, were created to provide peace of mind to our patients and teammates as we moved into clinical reentry. Specific examples of these efforts include disinfecting public areas (elevator buttons, chairs in waiting areas, etc.) every hour; elimination of self-service food stations like salad bars; reducing staff visiting rooms; and offering chaplain services via virtual means.

Atrium Health's "COVID-Safe" care standards build upon our deep clinical expertise to contain COVID-19 and ensure the safest environment possible at each location. Ultimately, the health and safety of our patients and teammates are our top priority, and we will continue to set the national standard, while expanding our services, to provide the hope and healing our community is seeking during these challenging times.



Two Million Mask Initiative

Most recently, at a June 26 Statehouse news conference, North Carolina Governor Roy Cooper issued a statewide requirement for citizens to wear masks while in public in order to slow the spread of COVID-19. Alongside Governor Cooper and Secretary of the North Carolina Department of Health and Human Services Dr. Mandy Cohen, Atrium Health proudly announced our leadership in a private-public partnership with the state's largest businesses and organizations – including Bank of America, Blue Cross Blue Shield of North Carolina, The Carolina Panthers, Honeywell, Lowe's, Red Ventures and Wells Fargo – to collect and distribute one million face masks across the region. This partnership is a great example of how health professionals, working in concert with businesses, can help get everyone back to work and spur the economy -- and be a key pathway to recovery.

Our initial emphasis has been providing masks to our underserved communities through our deep, existing relationships with Hispanic, Black, elderly, millennial and faith communities. In the days following our initial announcement, Mecklenburg County – where Charlotte is located – joined our effort, pledging an additional one million masks and bumping our supply to two million masks for the region. In just a few weeks, we have distributed nearly 400,000 masks, all while modeling and encouraging COVID-19 safety and best practices.

And as local school districts plan for students to return this fall, we're also working closely with our community partners to ensure we're not only advocating for COVID-19 safety and best practices, but we are also part of the solution to help create the safest environments possible through the distribution of these two million masks.

How Health Policy Makers Can Help

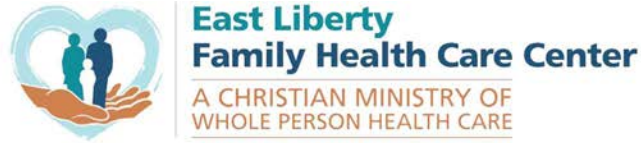
To summarize the above policy recommendations, it is our request of you and your distinguished colleagues to please:

- Enact additional COVID-19 funding for healthcare providers
- Make coverage for telehealth services permanent
- Reinvest in Public Health
 - Support a national testing supply registry
 - Provide oversight and prepare for nationwide vaccination
 - Conduct data analytics that enable communities to effectively address health disparities
 - Amplify the value of regional community health programming by supporting hospital systems and their ability to grow
 - Provide coverage for interpreter and translation services
 - Invest in a public relations campaign to grow trust and confidence in vaccination.



Closing

On behalf of Atrium Health, I would like to thank the Committee for this opportunity to provide additional insight into the current pandemic situation and to share our experiences and concerns. The so-called "new normal" is still to be defined. We all hope for the day when this type of gathering can again occur in one room, face-to-face. We also hope that the information we have shared will be helpful to you and lead the way forward as you develop solutions that address the challenges we, as a nation, face together. We believe that by learning from one another and applying available expertise, we can improve health, elevate hope, and advance healing – FOR ALL.



**U.S. Senate Special Committee on Aging
The COVID-19 Pandemic and Seniors: A Look at Racial Health Disparity
July 21, 2020**

**Testimony of Rodney B. Jones, Sr.
Chief Executive Officer, East Liberty Health Center, Inc.
Pittsburgh, Pennsylvania**

Chairman Collins, Ranking Member, Members of the Committee, thank you for the opportunity to testify before you today. My name is Rodney Jones and I am CEO of East Liberty Family Health Care Center (ELFHCC), which is a Federally Qualified Health Center located in the East End of Pittsburgh.

Federally Qualified Health Centers' (FQHCs) mission is to enhance primary care services in underserved urban and rural communities. They provide services to all persons regardless of ability to pay, and charge for services on a community-based, board-approved sliding fee scale that is based on family size and income. FQHCs serve as a safety net for patients who are uninsured, underinsured and underserved. Health centers are staples in their communities. There are nearly 1,400 health centers operating approximately 120,000 service delivery sites in underserved communities across this country.

East Liberty Family Health Care Center Service Area encompasses 69 zip codes and has a population of 11,294 unduplicated patients that yield more than 40,000 visits annually. Of the patients we see, 3,656 or one-third of all patients are over the age of 50 and 1,304 are over the age of 65. Approximately 18% of our patients have no insurance, 57 percent of our patients are at or below 100 percent of the poverty guidelines and 86 percent of our patients are at or below 200 percent of the poverty guidelines. Thirty-nine percent are insured through Medicaid and 13 percent have Medicare. The remainder are insured through Managed Care.

Most patients we treat are from disparate backgrounds. Of our total patient population, 77 percent of the patients we care for are part of a racial and/or ethnic minority. Sixty-six percent of the total population we serve is African American or Black and 10 percent is Latino or Hispanic.

We maintain very precise records of the medical conditions of our patients, as well. This data shows that half of all of the patients we treat who are over the age of 50 have hypertension and over 800 people we treat in this age group have diabetes, and nearly 650 patients are overweight or obese.

Research shows these are underlying health conditions, like the conditions I just mentioned, are more prevalent in minorities due to Social Determinants of Health – conditions in which people are born, grow, live, work and age. They include factors such as: Socioeconomic Status, Education, Neighborhood and Physical Environment, Employment, Social Support, and Access to Healthcare and Housing.

These Social Determinants of Health and the medical conditions that they bring about are major factors contributing to the disproportionate number of low-income individuals and people of color testing positive and dying from COVID-19, along with age.

The virus has become a “flashpoint” on racial inequities, financial inequities and Social Determinants of Health. COVID-19 has exposed our healthcare system’s vulnerabilities and revealed our inability to respond effectively to a pandemic. It has also highlighted the fact that low income older adults and older adults of color have suffered in significantly greater proportion than their white counterparts.

In addition to the immediate impact that we are seeing from the virus, particularly the heightened rates of illness and deaths among older adults from racial and ethnic minorities, there are potential long-term implications to the virus on overall health and wellness of our patients. As a result of the pandemic, East Liberty Family Health Center providers have cared for one-third fewer patients in our Medical Department. There has been a 75 percent decrease in patients seen in our Dental Department. That is a significant decrease in people who are receiving critical primary and preventive care, as well as treatment for acute illnesses.

For populations of color – who are already predisposed to have multiple chronic conditions due to the Social Determinants of Health I spoke about previously – this is particularly concerning. It is likely that people are putting off getting the care that they need and may lead to a deterioration in an underlying health condition and further complications down the road.

In response to this concern, ELFHCC has significantly increased the availability of telehealth services. Since March, approximately 75 percent of all our patients have been treated through telehealth services. This has been critical to evaluating the needs of our patients and triaging care for illnesses that may require services in person. However, for older adults, providing health care services through tele-health can be challenging. Older adults, particularly older adults of color who are low-income, are less likely to have the technology necessary to schedule a tele-health appointment. This can have two effects: either older adults must leave their home to visit one of our health center sites even though they are encouraged to stay home to remain safe from the virus or they must go without the primary and preventive care they need. We also started performing COVID-19 testing in March 2020. We use this as an opportunity to educate patients regarding the importance of having a Medical Home and preventative health care.

We can continue to respond to the needs of patients during these trying times due to action taken by Congress on a variety of fronts. First, I would like to thank Congress for continuing to provide community health centers with the resources necessary to meet the ever-changing needs of patients, particularly during the worst public health crisis this country has experienced in a century. Second, much of the care that providers have delivered over the past decade has been

bolstered because Congress took action to expand access to health coverage through the Affordable Care Act. It is with this coverage, that ELFHCC has been able to reach an even larger population, including older adults of color, and deliver the care they need. In Pennsylvania, and for health center patients that is especially so due to the Governor's decision to expand Medicaid.

As of July 3, 2020, more than 780,000 individuals have coverage for health care services because of Medicaid expansion. More than 1.4 million people – or about one in seven Pennsylvanians aged 19 to 64 – have been covered due to Medicaid expansion at some point since February 2015. Pennsylvania's uninsured rate fell from 10.2 percent in 2010 to 5.6 percent in 2016 and continued falling to 5.5 percent in 2018 — the lowest rate on record.

Medicaid expansion serves working Pennsylvanians, students, and Pennsylvanians not yet eligible for Medicare. It is a lifeline for people who otherwise cannot access quality health coverage. Services covered by Medicaid help people maintain their health, access treatment for a substance use disorder, and identify potentially life-threatening illnesses and treat them without fear of financial ruin.

Research shows that gaining coverage is a significant factor in improving access to care. We are seeing that at ELFHCC. In 2019, for the first time ever, the percentage of patients nationally age 65 and older served by Federally Qualified Health Centers reached double digits and is now 14 percent of patients served by health centers in Pennsylvania. As further evidence of this upward trend, the number of patients 65 and older served by health centers increased by 13 percent from the 2016 to the 2018. The impact of the Affordable Care Act yielded a 13 percent increase in insurance coverage for patients age 50 to 64 from 2013 through 2016, but only a seven percent increase in coverage from 2016 through 2018. This decreasing trend line is concerning for access to health care amid a pandemic. Further concerning is that as people are losing their jobs, they are also losing access to coverage. It makes coverage that people can secure through Healthcare.gov and Medicaid even more critical.

It is also critical that health centers continue to receive funding to continue to serve our patients. In addition to providing health centers with supplemental appropriations, the CARES Act extended the Community Health Center Fund, at the currently funding level, through November 30, 2020. Thank you for recognizing the important role of health centers and making this investment in patients.

However, a strong public health system requires a strong system of community health centers, which must include long-term stable funding for those community health centers. CHCs will be critical in the recovery from the COVID-19 pandemic with an increased number of unemployed and uninsured community members and an increased demand for essential primary care services. To ensure they are there, health centers need long-term financial stability, past November 30, 2020, to maintain current services, recruit and hire providers, and plan and deliver reliable, quality services. Managed growth of health center capacity will allow expansion of services to additional medically underserved patients in high need areas, in response to the COVID-19 aftermath and provide services to ALL regardless of ability to pay.

I look forward to answering any questions from the Committee about how to further the goal of health equity, including among older adults, a goal that ELFHCC providers strive to achieve each and every day.

Questions and Responses for the Record

U.S. Senate Special Committee on Aging
The COVID-19 Pandemic and Seniors: A Look at Racial Health Disparities
Questions for the Record
from Senator Josh Hawley
July 21, 2020

To Mr. Woods:

I would like to hear more about the work Atrium Health did to close the testing and service gap among minority and underserved populations in your service areas.

1. Can you describe in greater detail the steps your organization took to reach out to and expand testing in these communities? Which community partners did you engage?
2. What did you learn from this experience, and how could Congress better support similar efforts across the country?
3. In what ways could the lessons your organization has learned during COVID-19 be applied to the testing and health challenges faced in rural communities?

To Dr. Carnethon:

1. What interventions have you seen effectively protect residents in long-term care facilities, particularly in underserved areas? What can this Congress do to promote such efforts, especially given the disproportionate rates of infection and death in these facilities?

While COVID-19 continues to be a threat—and we will hopefully have a vaccine sooner rather than later—the flu season is right around the corner. This poses a significant challenge, especially if we experience a further resurgence of COVID-19 in the fall.

1. How important will it be for older Americans and at-risk individuals to get a flu vaccine this season?
2. How are health care providers and health systems preparing for the flu season in light of the ongoing COVID-19 pandemic?

To Dr. Mack:

You mentioned plans to engage in targeted information dissemination and awareness campaigns among underserved and minority communities in your forthcoming work with the National COVID-19 Resiliency Network.

1. Could you speak to best-practices in this regard, and how Congress can support state and local officials in making sure high-risk communities have the best information possible?

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



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July 29, 2020

The Honorable Susan Collins
 Chairwoman
 Special Committee on Aging
 U.S. Senate
 G31 Dirksen Senate Office Building
 Washington, DC 20510

The Honorable Bob Casey
 Ranking Member
 Special Committee on Aging
 U.S. Senate
 G31 Dirksen Senate Office Building
 Washington, DC 20510

Dear Chairwoman Collins and Ranking Member Casey:

AARP, on behalf of our 38 million members and all older Americans nationwide, appreciates the opportunity to submit a written statement for the hearing, “The COVID-19 Pandemic and Seniors: A Look at Racial Health Disparities”. While the COVID-19 virus can affect people of all races and ethnicities, there is a striking divide in how the pandemic has affected people by race across the country, broadly reflecting historical injustices.

COVID-19 has claimed the lives of over 147,000 people in the U.S. However, longstanding discrimination has placed some members of certain racial and ethnic groups at greater risk for hospitalization or death from COVID-19 compared to non-Hispanic white people. The death rates among African American/Black, Hispanic, and American Indian and Alaska Native people are deeply alarming. The disproportionate impact on people of color is not random, but a result of inequality due to a systematic lack of social and economic opportunities, including access to health care, living conditions, and work circumstances. Over time, this contributes to underlying health conditions, which the Centers for Disease Control and Prevention (CDC) has identified as factors that increase the risk of serious illness from COVID-19. The pandemic has emphasized the need for immediate and meaningful action to address our nation’s health disparities.

We are also seeing a disparate impact of COVID-19 in long-term care facilities. *The New York Times* now reports over 59,000 resident and staff COVID-19 deaths at nursing homes and other long-term care facilities, representing over 40 percent of all COVID-19 deaths nationwide. Recent data show that nursing homes with a significant number of African American/Black and Hispanic residents have been twice as likely to be infected by the coronavirus. We are deeply alarmed by these appalling numbers and the tragic racial disparities that exist in nursing homes and communities across the country. This is a national disgrace. AARP is urging immediate action to protect the health and safety of residents so that individuals

Alabama | Alaska | Arizona | Arkansas | California | Colorado | Connecticut | Delaware | District of Columbia | Florida | Georgia | Hawaii | Idaho | Illinois | Indiana | Iowa | Kansas | Kentucky | Louisiana | Maine | Maryland | Massachusetts | Michigan | Minnesota | Mississippi | Missouri | Montana | Nebraska | Nevada | New Hampshire | New Jersey | New Mexico | New York | North Carolina | North Dakota | Ohio | Oklahoma | Oregon | Pennsylvania | Puerto Rico | Rhode Island | South Carolina | South Dakota | Tennessee | Texas | Utah | Vermont | Virgin Islands | Virginia | Washington | West Virginia | Wisconsin | Wyoming

can live a life of dignity regardless of race, age, or income. It is a matter of life and death. We appreciate the Committee's attention to these important issues and for your current focus on the impact of the virus on communities of color.

Action Needed to Ensure Health and Save Lives

Long-term care facilities are ground zero in the fight against the coronavirus, representing a shockingly high share of deaths. Much more is needed now to protect residents, staff, their loved ones, and the surrounding communities from this disease. AARP urges action on a five-point plan to slow the spread and save lives:

1. Ensure regular and prioritized testing of staff and residents, in accordance with CDC guidelines, and provide personal protective equipment (PPE) to staff and residents and ensure their proper use;
2. Require transparency around COVID-19 data (cases and deaths) in nursing homes and other long-term care facilities, transfer and discharge rights, how provider relief funds are used, and establish guardrails to ensure funds are used for testing, PPE, staffing, virtual visitation, and other items that directly relate to resident care, well-being, prevention, and treatment;
3. Require facilities to provide and facilitate virtual visitation;
4. Ensure adequate staffing levels and ensure that Long-term Care Ombudsmen have in-person access to do their jobs to advocate for residents and families; and
5. Reject blanket immunity for nursing homes and other long-term care facilities related to COVID-19.

Collect and Report Demographic Data

The COVID-19 pandemic has shed light on the stark racial disparities affecting health outcomes for communities of color across the country. There is a growing body of data that shows African Americans/Blacks, Hispanics, and American Indians and Alaska Natives are disproportionately impacted by the pandemic with higher rates of infection and death, and they are more likely to experience serious illness from COVID-19, but as outlined below, more data is needed. Furthermore, there is insufficient data to demonstrate the impact of COVID-19 on Asian American and Pacific Islander (AAPI) communities. While racial and ethnic disparities long existed before this crisis, the ongoing coronavirus pandemic has sent a clear message—perhaps louder than ever—that now is the time to work collectively to address the systemic inequities, discrimination, and harmful social determinants of health that have led to these disparities.

In order to address health disparities across the country, including those occurring within nursing homes and other long-term care facilities, it is important that the federal government gather data and publicly report on COVID-19 cases, deaths, co-morbidities, and testing rates broken down into multiple demographic categories—while protecting patient privacy—including race, ethnicity, age, socioeconomic status, sexual orientation, gender identity, spoken/written language and disability. Data should also include venues such as hospitals, nursing homes, assisted living facilities, residential homes, and other locations. The information, disaggregated for all groups, should also be contrasted with 2019 numbers in order to truly understand the impact of COVID-19 on all communities. Collection, analysis, and regular public reporting of the detailed disaggregated information will help us effectively understand and respond

to the crisis in a timely and focused way so that we can improve outcomes and minimize the spread of the virus.

AARP has been calling for increased transparency of COVID-19 cases in long-term care facilities, and we appreciate the guidance and interim final rule with comment from the Centers for Medicare & Medicaid Services (CMS) that take steps towards achieving greater transparency and ensuring nursing homes are better prepared to respond to the public health emergency. Under the rule, nursing homes must report confirmed COVID-19 cases and deaths among residents and staff, as well as other information to CDC, at least on a weekly basis. That information is provided to CMS and made public by CMS. In addition, facilities are now required to alert residents, their representatives, and families when there is a single positive infection of COVID-19 or three or more residents or staff with new-onset of respiratory symptoms that occur within 72 hours of each other.

While the new reporting requirements are a necessary step, we believe care facilities must also report publicly on a daily basis whether they have confirmed COVID-19 cases and deaths, and that reporting should include demographic data. AARP [commented](#) on the CMS May 8 interim final rule to suggest additional improvements to these reporting requirements. AARP has endorsed S. 4182, the Emergency Support for Nursing Homes and Elder Justice Reform Act of 2020, and S. 3768/H.R. 6972, the Nursing Home COVID-19 Protection and Prevention Act, that require data reporting and collection, including important demographic data. We also support the language included in H.R. 6800, the HEROES Act, that requires long-term care facilities to report demographic information relating to COVID-19 cases and deaths, including race and ethnicity. This data will provide a clearer picture to help effectively minimize the spread of the virus and fight the high share of deaths in facilities and among communities of color.

Testing and Contact Tracing

The staggering racial disparities in infection and death rates underscore the need to make resources available for the areas and communities facing the highest risk of COVID-19 spread, complications, and mortality. AARP urges action to make testing and contact tracing readily available in these communities. It is critical that testing is available where people work and live to meet those who are most in need where they are. Successful efforts to reduce racial disparities in infection and death rates, including through testing and contact tracing, will require the engagement of trusted community partners. Additionally, detailed demographic data collection, as referred to in the above section, will help ensure that testing and contact tracing resources are directed appropriately and that action can be taken quickly.

Families and communities all across the country are looking to Congress for swift action to protect the health and safety of their loved ones. Thank you for your attention to this urgent challenge. If you have any questions, please feel free to contact me or have your staff contact Nicole Burda at nburda@aarp.org.

Sincerely,



Bill Sweeney
Senior Vice President
Government Affairs



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

United States Senate Special Committee on Aging Hearing on "The COVID-19 Pandemic and Seniors: A Look at Racial Health Disparities"

July 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 hearing entitled "The COVID-19 Pandemic and Seniors: A Look at Racial Health Disparities." 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 how Alzheimer's and other dementia disproportionately affect diverse communities and how COVID-19 exacerbates existing health disparities.

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.

COVID-19 Impact on Health Disparities

The Alzheimer's Association is committed to the inclusion of all communities and the advancement of health equity through conversations, work, and partnerships. The COVID-19 pandemic has further exposed health differences that exist between racial and ethnic groups due to economic and social conditions. During public health emergencies, these conditions can isolate people from the resources needed to prepare and keep their families safe.

Alzheimer's and other dementia disproportionately affect older blacks/African Americans and Hispanics/Latinos than older whites. Black/African Americans are two to three times more likely to develop Alzheimer's than whites, and Hispanics/Latinos are one to two times more likely to develop Alzheimer's than whites. In addition, people living with Alzheimer's and other dementia are at increased risk of having serious complications relating to COVID-19 due to their typical age and likelihood of coexisting conditions.

A higher prevalence of Alzheimer's and dementia among blacks/African Americans and Hispanics/Latinos can also mean a higher likelihood of living in long-term care facilities, resulting in greater exposure to COVID-19. 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. The Alzheimer's Association and AIM have released policy recommendations, [Improving the State and Federal Response to COVID-19 in Long-Term Care Settings](#), to increase testing, reporting, surge activation, and provide urgent support, like access to personal protective equipment (PPE). It is important that data on race and ethnicity are also included in the required reporting, and that data is made publicly available. This will be especially important in ensuring preparedness and targeted support for a potential second wave of COVID-19.

A range of behavioral, social, economic, and environmental determinants influence health status and these health determinants are heightening the impact of the COVID-19 crisis on diverse racial and ethnic populations. For example, blacks/African Americans and Hispanics/Latinos are more likely than whites to experience poverty and discrimination and receive lower-quality healthcare and education which contribute to disparities in health, including cognitive health. Poor diets and malnutrition are also associated with cognitive impairment. We urge the Subcommittee to advance policies to better understand and adequately respond to the determinants that create and sustain these disparities.

Health Disparities in Research

It is also critical to note that while the field of Alzheimer's biomedical research has made great gains over the years in understanding the brain changes associated with the disease and how the disease progresses, much of the research to date has not included sufficient numbers of blacks/African Americans, Hispanics/Latinos, Asian Americans/Pacific Islanders, and Native Americans to be representative of the U.S. population. Moreover, because blacks/African Americans and Hispanics/Latinos are at increased risk for Alzheimer's, the underrepresentation of these populations hampers the conduct of rigorous research to understand these health disparities. Additional research involving individuals from underrepresented ethnic and racial groups is necessary to gain a comprehensive understanding of Alzheimer's and other dementia in the U.S. It is important that this research incorporate environmental, sociocultural, and behavioral determinants to more fully understand these disparities. This is consistent with the National Institute on Aging's *NIA Health Disparities Research Framework*.

In order to increase the recruitment and retention of diverse populations in clinical trials, researchers must understand how to foster and maintain partnerships with trusted community-based organizations, ensure that members of their research team reflect underrepresented groups, and budget adequately for recruitment and retention efforts. Clinicians and researchers must also be able to implement culturally appropriate research methodologies across different ethnoracial groups.

Additionally, accurate diagnoses are critical to better understanding and addressing disparities, yet the tests currently used to measure cognition are not sensitive to the impact of education and culture, resulting in incomplete and inaccurate data on cognitive impairment and decline in diverse individuals. Validated tools to capture these impacts are needed, as is training for clinicians who work with racially and ethnically diverse populations.

Finally, efforts to address health disparities must also include caregivers since they are often an integral part of their loved ones' participation in research and clinical trials. Developing and disseminating relevant educational materials specific to caregivers from diverse groups is important and these caregivers must be included in scientific inquiries addressing caregiver and family needs.

Conclusion

The Alzheimer's Association and AIM appreciate the steadfast support of the Committee and its continued commitment to advancing legislation important to the millions of families affected by Alzheimer's and other dementia. We look forward to working with the Committee and other members of Congress in a bipartisan way to advance policies that would help address the longstanding health disparities in the Alzheimer's and other dementia community, both during the COVID-19 pandemic and beyond.



U.S. Senator Susan Collins, Chair
 U.S. Senator Robert Casey, Ranking Member
 Senate Special Committee on Aging
 G-31 Dirksen Senate Office Building
 Washington, DC 20510-6520

July 28, 2020

Dear Senators Collins and Casey:

On behalf of the American Psychological Association (APA), I am sending this letter to be entered into the record of the hearing, "The COVID-19 Pandemic and Seniors: A Look at Racial Health Disparities." APA is the leading organization of scientific and professional psychologists in the United States, including 121,000 members, affiliates, and students.

We thank you for convening this hearing to examine the disparate impact of the COVID-19 pandemic on older adults in racial and ethnic minority communities. It is clear from the data that COVID-19 has exacerbated existing disparities in our society. These disparities are magnified and reflected in our health care system and have long been present; the pandemic has only highlighted the discrepancies. Psychological science can help demonstrate the impact of these disparities and also point the way toward solutions.

Older adults are disproportionately affected by COVID-19, and if they are minorities, they are impacted most of all. Recent data produced by the Centers for Medicare & Medicaid Services (CMS) show African American Medicare beneficiaries have been hospitalized four times as often as Caucasians,, and also contracted the virus nearly three times as often as Caucasians of a similar age. Hispanic and Asian people were also more likely to become infected and hospitalized than Caucasians. People on both Medicare and Medicaid were far more likely to get the coronavirus.¹

A recent [Brookings Institute report](#) provides mortality rates of African Americans for each age group, including older adults. The report notes that "Death rates among Black people between 55-64 years are higher than for white people aged 65-74, and death rates are higher for Blacks aged 65-74 than for whites aged 75-84, and so on. In every age category, Black people are dying from COVID at roughly the same rate as white people more than a decade older. Age-specific death rates for Hispanic/Latino people fall in between."²

Several points deserve emphasis from the Committee on this topic:

¹ [Preliminary Medicare COVID-19 Data Snapshot Medicare Claims and Encounter Data](#): Services January 1 to May 16, 2020, Received by June 11, 2020 p. 6

² Tiffany Ford, Sarah Reber and Richard V. Reeves, "[Race gaps in COVID-19 deaths are even bigger than they appear](#)," Brookings Institution Tuesday, June 16, 2020.

- **Health disparities are very costly.** A robust body of research demonstrates the significant costs of health inequalities. One analysis found a potential economic gain of \$135 billion per year if racial disparities in health were eliminated, comprised of \$93 billion in excess medical costs and \$42 billion in untapped productivity. Policies that address underlying causes of health disparities such as poverty, discrimination, lack of access to good employment, substandard housing and unsafe environments are not only sound policy, but they are also cost-effective.³

The Pandemic Has Highlighted the Inequity of Healthcare for Minority Populations. Given the disproportionate number of COVID-19 related deaths in minority communities, it is evident how disproportionate healthcare and access to healthcare is among Americans. This is especially relevant given the rise in number of minorities for the older population. More specifically, racial and ethnic minority populations have increased from 7.5 million in 2008 (19 percent of the older adult population) to 12.3 million in 2018 (23 percent of the older adult population) and are projected to increase to 27.7 million in 2040 (34 percent of older adults).⁴

- **Addressing these serious health conditions among vulnerable populations may be the start to solving many of the issues that result from health inequities.** The pandemic presents a window of opportunity for achieving greater equity in the health care of all vulnerable populations.⁵ Minority populations also have a high rate of underlying health concerns such as diabetes, cardiovascular disease, asthma, HIV, morbid obesity, liver disease and kidney disease.⁶
- **Health care expenditures are important, but in isolation cannot eliminate health disparities, because disparities are fed by social inequality.** Experiences of bias and discrimination have been found to directly and negatively affect the health and mental health of African Americans.⁷ Inequities also increase African Americans' risk for exposure to COVID-19. African Americans disproportionately work in jobs that require interpersonal contact and are less likely to be able to work from home. In a study of how job characteristics interact with household composition, Selden and Berdahl found that "Blacks at high risk of severe illness were 1.6 times as likely as whites to live in households containing health-sector workers. Among Hispanic adults at high risk of severe illness, 64.5 percent lived in households with at least one worker who was unable to work at home, versus 56.5 percent among blacks and only 46.6 percent among whites."⁸
- **COVID-19 is creating stress and trauma, further exacerbating the existing disparities in access to mental health services.** Mental health is frequently an unaddressed matter in racial and ethnic minority communities due in part to stigma, and a lack of access to a qualified mental health practitioner or provider discrimination. Congress must ensure quality and affordable

³ Ani Turner (2018). The business case for racial equity: a strategy for growth. *or Growth*. W.K. Kellogg Foundation and Altarum, Washington, DC

⁴ The Administration for Community Living. (May 2020). 2019 Profile of Older Americans p.3.

⁵ Monica Webb Hooper, Anna Maria Napoles, Eliseo J. Perez-Stable. (June 23/30, 2020). COVID-19 and Racial/Ethnic Disparities. *The Journal of the American Medical Association*, Volume 323, Number 24.

⁶ Ibid

⁷ Chae DH, Nuru-Jeter AM, Adler NE, Brody GH, Lin J, Blackburn EH, and Epel ES. (2014). Discrimination, racial bias, and telomere length among African American men. *American Journal of Preventive Medicine*, 46, 103111

⁸ Thomas M. Selden and Teresa Terceira Berdahl, "[COVID-19 And Racial/Ethnic Disparities In Health Risk, Employment, And Household Composition](#)", *Health Affairs* July 14, 2020.

mental health diagnosis and treatment is available in hard-hit low-income and minority communities.

Recommendations:

- **Bolster the social safety net for low- and middle-income households and workers.** Decades of psychological science indicate that when basic human needs are threatened or not met, individuals will suffer mental and physical health consequences. According to APA's recent "[Stress in America report](#)," seven in ten adults reported that the economy is a significant source of stress for them.
- **Expand and improve collection of data from CDC and CMS on death rates, severity of illness, and risks of exposure in the home and community. It is critical for Congress to have timely data to make informed decisions about policies to prevent and treat illness.** Age-related data is vital. Congress must maintain the integrity of data on this topic and make it widely available for all. States and localities need resources and technical assistance to collect this data in timely ways, and it is critical for our national response against the pandemic. Congress has made some progress in this effort, but additional efforts are needed. Without accurate and timely data, the response is made blind.
- **Expand access to health and mental health services,** including making permanent the waivers allowing providers to use telehealth across state lines and audio-only telehealth where necessary. Audio-only services are especially critical for mental health access for many older Americans, as this technology is easier for them to use. Congress can increase the number of mental health providers through the Medicare system by enacting H.R. 884, The Medicare Mental Health Access Act which would remove a roadblock that hampers and delays mental health treatment for Medicare beneficiaries by ending unnecessary physician sign-off and oversight of psychologists' services in some Medicare settings.
- **Recommends passage of S. 4812, The Emergency Support for Nursing Homes and Elder Justice Reform Act of 2020.** The legislation includes provisions to improve nursing home care including promoting transparency about COVID-19 related cases and deaths. It also includes recommendations for improving the quality of nursing homes and addresses racial disparities. APA has made recommendations to include further mental and behavioral health provisions in the bill and to alleviate obstacles to improve access to psychological care.
- **Speak out against the specter of ageism in the COVID-19 pandemic.** The population of older adults in the U.S. is very diverse. For example, it includes retired medical personnel who answered the call to volunteer their services in COVID hotspots, caregivers of older and younger family members, and residents of nursing homes. The most concerning manifestation of ageism in this crisis is the consideration of age in the allocation of medical treatments. Such blunt criteria fail to recognize the diversity among older adults and "punish" individuals for their station in life. Fortunately, age has not been widely adopted as a criterion for resource allocation in the United States. The New York State guidelines for ventilator allocation rejected the use of advanced age as a criterion as discrimination against older adults. The guidelines

specified that clinical factors must inform allocation, the use of age as a stand-alone factor is not necessary.⁹ Informally however, such blunt criteria may surface, and this Committee's educating role is very important.

APA has many useful resources on its website on [multicultural aging](#), and [COVID-19 and aging](#). In addition, we commend to the Committee two recent pieces of testimony about the unequal impact of COVID-19 on minority communities. Linked are APA statements for the [House Ways and Means Committee](#) and [House Energy and Commerce Subcommittee on Health](#).

APA will gladly provide additional information about any of these resources. Please contact Pat Kobor at pkobor@apa.org.

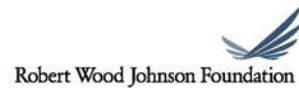
Sincerely yours,



Katherine B. McGuire
Chief Advocacy Officer

⁹ Alexandra DeSanctis, "[Age Discrimination and Rationing During the Coronavirus Crisis](#)," *National Review*, March 25, 2020.

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Princeton, NJ 08540-6614
Tel. 877 843 RWJF (7953)
www.rwjf.org



June 16, 2020

The Robert Wood Johnson Foundation (RWJF) is the nation's largest philanthropy dedicated to improving health and health care in the United States. Since 1972, we have worked with public and private-sector partners to advance the science of disease prevention and health promotion; train the next generation of health leaders; and support the development and implementation of policies and programs to foster better health across the country, including high-quality health care coverage for all. RWJF is working alongside others to build a national Culture of Health that provides everyone in America a fair and just opportunity to live the healthiest life possible.

On May 28, 2020, RWJF issued these [Health Equity Principles for State and Local Leaders in Responding to, Reopening, and Recovering from COVID-19](#):



COVID-19 has unleashed a dual threat to health equity in the United States: a pandemic that has sickened millions and killed tens of thousands and counting, and an economic downturn that has resulted in tens of millions of people losing jobs—the highest numbers since the Great Depression. The COVID pandemic underscores that:

- Our health is inextricably linked to that of our neighbors, family members, child- and adult-care providers, co-workers, school teachers, delivery service people, grocery store clerks, factory workers, and first responders, among others;

- Our current health care, public health, and economic systems do not adequately or equitably protect our well-being as a nation; and
- Every community is experiencing harm, though certain groups are suffering disproportionately, including people of color, workers with low incomes, and people living in places that were already struggling financially before the economic downturn.

For communities and their residents to recover fully and fairly, state and local leaders should consider the following **health equity principles** in designing and implementing their responses. These principles are not a detailed public health guide for responding to the pandemic or reopening the economy, but rather a compass that continually points leaders toward an equitable and lasting recovery.

1. **Collect, analyze, and report data disaggregated by age, race, ethnicity, gender, disability, neighborhood, and other sociodemographic characteristics.**
 - **Pandemics** and **economic recessions** exacerbate disparities that ultimately hurt us all. Therefore, state and local leaders cannot design equitable response and recovery strategies without monitoring COVID's impacts among socially and economically marginalized groups.¹ Data disaggregation should follow **best practices** and extend not only to public health data on COVID cases, hospitalizations, and fatalities, but also to: measures of **access** to testing, treatment, personal protective equipment (PPE), and safe places to isolate when sick; receipt of social and economic supports; and the downstream consequences of COVID on well-being, ranging from housing instability to food insecurity. Geographic identifiers would allow leaders and the public to understand the interplay between place and social factors, as **counties with large black populations** account for more than half of all COVID deaths, and **rural communities** and **post-industrial cities** generally fare worse in economic downturns. Legal mandates for data disaggregation are proliferating, but **11 states** are still not reporting COVID deaths by race; **16** are not reporting by gender; and **26** are not reporting based on congregate living status (e.g., nursing homes, jails). Only three are reporting testing data by race and ethnicity. While states and cities can do more, the federal government should also support data disaggregation through funding and national standards.
2. **Include in decision-making the people most affected by health and economic challenges, and benchmark progress based on their outcomes.**
 - Our communities are **stronger, more stable, and more prosperous** when every person, including the most disadvantaged residents, is healthy and financially secure. Throughout the response and recovery, state and local leaders should ask: *Are we making sure that people facing the greatest risks have access to PPE, testing and treatment, stable housing, and a way to support their families? And, are we creating ways for residents—particularly those hardest hit—to meaningfully participate in and shape the government's recovery strategy?*

Accordingly, policymakers should create space for leaders from these communities to be at decision-making tables and should regularly consult with community-based organizations that can identify barriers to accessing health and social services, lift up grassroots solutions, and disseminate public health guidance in culturally and linguistically appropriate ways.

¹ People of color (African-Americans, Latinos, Asian Americans, American Indians, Alaska Natives, and Native Hawaiians and other Pacific Islanders), women, people living in congregate settings such as nursing homes and jails, people with physical and intellectual disabilities, LGBTQ people, immigrants, and people with limited English proficiency.

For example, they could recommend trusted, accessible locations for new testing sites and advise on how to diversify the pool of [contact tracers](#), who will be crucial to tamping down the spread of infection in reopened communities. They could also collaborate with government leaders to ensure that all people who are infected with coronavirus (or exposed to someone infected) have a safe, secure, and acceptable place to isolate or quarantine for 14 days. Key partners could include community health centers, small business associations, community organizing groups, and workers' rights organizations, among others. Ultimately, state and local leaders should measure the success of their response based not only on total death counts and aggregate economic impacts but also on the health and social outcomes of the most marginalized.

3. Establish and empower teams dedicated to promoting racial equity in response and recovery efforts.

- Race or ethnicity should not determine anyone's opportunity for good health or social well-being, but, as COVID has shown, we are far from this goal. People of color are more likely to be [front-line workers](#), to live in dense or overcrowded housing, to lack health insurance, and to experience chronic diseases linked to unhealthy environments and [structural racism](#). Therefore, state and local leaders should empower dedicated teams to address COVID-related racial disparities, as several leaders, [Republican](#) and [Democrat](#), have already done. To be effective, these entities should: include leaders of color from community, corporate, academic, and philanthropic sectors; be integrated as key members of the broader public health and economic recovery efforts; and be accountable to the public. These teams should foster collaboration between state, local, and tribal governments to assist Native communities; anticipate and mitigate negative consequences of current response strategies, such as [bias in enforcement of public health guidelines](#); address racial discrimination within the health care system; and ensure access to [tailored mental health services](#) for people of color and immigrants who are experiencing added trauma, stigma, and fear. Ultimately, [resources matter](#). State and local leaders must ensure that critical health and social supports are distributed fairly, proportionate to need, and free of undue restrictions to meet the needs of all groups, including black, Latino, Asian, and Indigenous communities.

4. Proactively identify and address existing policy gaps while advocating for further federal support.

- The Congressional response to COVID has been historic in its scope and speed, but significant gaps remain. Additional federal resources are needed for a broad range of health and social services, along with [fiscal relief](#) for states and communities facing historically large budget deficits due to COVID. Despite these challenges, state and local leaders must still find ways to take targeted policy actions. The following questions can help guide their response.

Who is left out? Inclusion of all populations will strengthen the public health response and lessen the pandemic's economic fallout for all of society, but federal actions to date have not included all who have been severely harmed by the pandemic. As a result, many [states](#) and [communities](#) have sought to fill gaps in [eviction](#) protections and [paid sick and caregiving leave](#). Others are extending support to undocumented immigrants and mixed-status families through

public-private partnerships, faith-based charities, and community-led mutual aid systems. Vital health care providers, including safety net hospitals and Indian Health Service facilities, have also been disadvantaged and need targeted support.

Will protections last long enough? Many programs, such as expanded Medicaid funding, are tied to the federal declaration of a public health emergency, which will likely end before the economic crisis does. Other policies, like enhanced unemployment insurance and mortgage relief, are set to expire on arbitrary dates. And still others, such as stimulus checks, were one-time payments. Instead, policy extensions should be tied to the extent of COVID infection in a state or community (or its anticipated spread) and/or to broader economic measures such as unemployment. This is particularly important as communities will likely experience re-openings and closings over the next six to 12 months as COVID reemerges.

Have programs that meet urgent needs been fully and fairly implemented? All existing federal resources should be used in a time of great need. For example, additional states should adopt provisions that would allow families with school-age children to receive added Supplemental Nutrition Assistance Program (SNAP) benefits, and more communities need innovative solutions to provide meals to young children who relied on schools or child care providers for breakfast and lunch. States should also revise eligibility, enrollment, and recertification processes that deter Medicaid use by children, pregnant women, and lawfully residing immigrants.

5. **Invest in strengthening public health, health care, and social infrastructure to foster resilience.**
 - Health, public health, and social infrastructure are critical for recovery and for our survival of the next pandemic, severe weather event, or economic downturn. A comprehensive public health system is the first line of defense for rural, tribal, and urban communities. While a sizable federal reinvestment in public health is needed, states and communities must also reverse steady cuts to the public health workforce and laboratory and data systems. Everyone in this country should have paid sick and family leave to care for themselves and loved ones; comprehensive health insurance to ensure access to care when sick and to protect against medical debt; and jobs and social supports that enable families to meet their basic needs and invest in the future. As millions are projected to lose employer-sponsored health insurance, Medicaid expansion becomes increasingly vital for its proven ability to boost health, reduce disparities, and provide a strong return on investment. In the longer term, policies such as earned income tax credits and wage increases for low-wage workers can help secure economic opportunity and health for all. Finally, states and communities should invest in affordable, accessible high-speed internet, which is crucial to ensuring that everyone—not just the most privileged among us—is informed, connected to schools and jobs, and engaged civically.

Conclusion:

These principles can guide our nation toward an equitable response and recovery and help sow the seeds of long-term, transformative change. States and cities have begun imagining and, in some cases, advancing toward this vision, putting a down payment on a fair and just future in which health equity is a reality. Returning to the ways things were is not an option.



July 21, 2020

The Honorable Susan Collins
G31 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Bob Casey
628 Hart Senate Office Building
Washington, DC 20510

Dear Chairwoman Collins, Ranking Member Casey and Members of the Committee:

I am writing on behalf of Johnson & Johnson (“J&J”) to thank you for holding a hearing on “The COVID-19 Pandemic and Seniors: A Look at Racial Health Disparities.” We share your deep concern about the devastating impact of COVID-19 on diverse communities and Seniors. We have a long history of working to address these disparities, including support for those on the front lines of care and ending preventable maternal mortality and morbidity.

One area where health disparities is evident is the under-representation of communities of color and the elderly in clinical trials. J&J is proud to foster diversity and inclusion in research and has a longstanding commitment to leadership in this space. I am pleased to share information regarding our response to the COVID-19 pandemic and our commitment to diversity in clinical trials.

The values that guide all of our Company’s decisions are established in Our Credo. Since 1943, Our Credo has challenged us to put the needs and well-being of the people we serve first. These core values are embedded in our commitment to diversity and inclusion in clinical trials (“DICT”) and reflected in [Our Ethical Code for the Conduct of Research and Development](#).

Our Response to the Pandemic

J&J has a history of addressing global health crises and is working closely with partners worldwide to combat the current COVID-19 pandemic through a multi-pronged approach. To put our commitment into context, I would first like to outline J&J’s efforts to respond to the COVID-19 pandemic through potential prevention and treatment, and how we are putting the health of all patients at the heart of these efforts, including in clinical trials.

Vaccine Development

Since January, the Janssen Pharmaceutical Companies of Johnson & Johnson (“Janssen”) have been working with governments and health authorities to help end the COVID-19 pandemic through the accelerated development of a possible preventive vaccine candidate against SARS-CoV-2. Janssen is working to accelerate the development of its vaccine through collaboration between Janssen and the Biomedical Advanced Research and Development Authority (BARDA), part of the U.S. Department of Health & Human Services, and other governments, health authorities and global partners.

In March, we announced that Janssen had identified a lead investigational COVID-19 vaccine candidate. Janssen has accelerated initiation of the Phase 1/2a first-in-human clinical trial of its investigational vaccine, which is now expected to begin in the second half of July. We are also in discussions with the National Institutes of Allergy and Infectious Diseases with the objective to start the Phase 3 clinical trials ahead of the original schedule, pending outcome of Phase 1 studies and approval of regulators, with the



anticipation that the first batches of a COVID-19 vaccine could be available for emergency use authorization (EUA) in 2021. We are prepared to rapidly scale the Company's manufacturing capacity with the goal of providing global supply of more than one billion doses of a vaccine. To date, J&J has signed two agreements for U.S. based manufacturing with Emergent BioSolutions and Catalent, Inc.

Our goal is to develop a vaccine that is capable of being manufactured globally to produce large quantities of product with the aim to manufacture one billion doses. We plan to begin production at risk imminently and are committed to bringing an affordable vaccine to the public on a not-for-profit basis for emergency pandemic use.

Therapeutics

In addition to our vaccine development efforts, J&J has also expanded our pre-existing partnership with BARDA to accelerate the ongoing work to screen compound libraries, including from other pharmaceutical companies, to identify potential treatments for COVID-19. By testing the antiviral activity of these compounds against COVID-19, we hope to identify an existing drug that could have the potential to be turned into a new treatment for the virus.

Caring for Health Care Workers, Employees and Current Patients

As we advance our vaccine and therapeutic research, we are also:

- Continuing to supply the critical medicines, devices, and products our customers and patients depend on.
- Taking precautions to support the safety and well-being of our employees, contractors, and the communities in which we live and work.
- Mobilizing to provide equipment, our products and financial donations to support organizations and health care workers on the front lines.

Support for COVID-19 Demographic Data

We recognize the need to demonstrate the disproportionate impact of COVID-19 on diverse communities through health disparity data. Earlier this month, we were pleased to join hundreds of stakeholder groups in signing a coalition letter to Congressional leadership in support of improved collection and reporting of demographic data on COVID-19 patients.

With this background information provided, the following is our approach to ensuring diversity and inclusion in our clinical trials.

Our Janssen Diversity in Clinical Trials Strategy

We have a Company-wide philosophy and approach to diversity and inclusion in research and development, and we have established a dedicated team within our pharmaceutical sector, Janssen, that is focused on advancing diverse and inclusive participation in our clinical trials.

With an emphasis on underserved and underrepresented populations, our Diversity in Clinical Trials strategy is comprised of three main focus areas:



1. *Culture*: Advance internal awareness on the need to successfully recruit underserved and underrepresented patients, and apply new tools to increase enrollment of diverse populations in our clinical trials;
2. *Access*: Increase underserved and underrepresented populations' access to participation in clinical trials through various internal and external initiatives that address barriers to enrollment; and
3. *Awareness & Trust*: Improve awareness and education about clinical trials in underrepresented populations, to facilitate greater trust and participation in clinical trials.

Reducing Barriers to Clinical Trials

There are several systemic obstacles to diverse representation in clinical trials, from mistrust of the medical establishment to a lack of easy and affordable transportation to clinical trial sites. With regard to our company-sponsored COVID-19 clinical trials, we are:

- Leveraging a special engagement strategy that includes a digital and community outreach plan to provide relevant educational information about clinical research to underserved and underrepresented Black, Hispanic, and elderly communities, and to provide resources and links to find opportunities to participate in clinical research;
- Identifying and implementing opportunities to reduce operational barriers and patient burden;
- Applying lessons from other trial recruitment efforts that included a focus on underserved and underrepresented populations; and
- Educating African American, Asian American, and Hispanic communities and the elderly across the United States about clinical trials and the importance of diverse participation.

Heartline Study

J&J has a long history of including Seniors in our clinical trials. In 2020, we announced a collaboration with Apple to reduce the risk of strokes in Seniors. Our [Heartline Study](#) is a nationwide, heart health study for people 65+ to examine how technology like the iPhone and Apple Watch can enable earlier detection of atrial fibrillation (AFib), a leading cause of stroke.

Utilizing Diverse Clinical Trial Personnel

There are many considerations when we evaluate our potential trial sites ability to recruit and enroll diverse populations, including:

- Understanding the cultural competence level of a potential site and its access to and accessibility by diverse populations during our site selection process;
- Leveraging our Medical Science Liaisons' (MSL) networks to identify sites that have access to diverse patient populations that we could leverage for our clinical trials;
- Sponsoring a three-year educational grant for Clinical Research Pathways to provide funding to the Morehouse School of Medicine in Atlanta, Georgia, to encourage, support and grow community physicians into clinical researchers; and
- Amplifying the importance of diverse recruitment and enrollment within Janssen's network of strategic partner sites.



Ensuring Language Accessibility

We recognize that providing clinical trial information in English-language only is not conducive to successful enrollment of diverse participants. Moreover, the use of technical vernacular in clinical trial recruitment can lead to a comprehension gap that hampers participation. As such, we are:

- Ensuring our clinical trial recruitment and other study participant materials use simple language and translated into the languages needed for their patient populations; and
- Assessing additional language/translation needs at our various clinical trial sites.

Investing in Participant Recruitment by Partnering with Minority Health and Community Advocacy Organizations

To bring health to billions of people around the world, we at Johnson & Johnson recognize it is critically important that we invest in, and understand the needs, values and preferences of, the diverse patients and consumers we serve. To that end, we have developed long-standing, strategic partnerships with well-respected, national organizations such as the National Urban League and Unidos US. These partnerships help to accelerate J&J's commitment to:

- Advance a culture of inclusion;
- Develop a diverse workforce for the future; and
- Align diversity and inclusion efforts to our business strategy to drive innovation and enhance the quality and efficacy of products and therapies.

Through grassroots efforts, our African Ancestry Leadership Council and Hispanic Organization for Leadership and Achievement Employee Resource Groups collaborate annually with these organizations to:

- Connect directly with diverse patients and consumers to donate J&J products;
- Provide information on chronic conditions which disproportionately affect diverse communities; and
- Build awareness about the importance of clinical trial participation.

In addition to building general awareness, we are partnering with community and patient organizations to provide education and awareness about our clinical studies and how to participate. We are committed to this same outreach and partnership approach with our COVID-19 clinical trial plans. Since 2018, we have sponsored a community awareness campaign with the Center for Information and Study on Clinical Research Participation (CISCRP), called Journey to Better Health, to provide education and information about clinical research and the importance of diverse participation. We have pledged to continue support of this program through 2025.

Working in Partnership is Critical to our Shared Success

No single stakeholder alone can resolve the issues related to health and economic disparities magnified by COVID-19. That is why Johnson & Johnson has been working internally and externally with partners to use our resources in a broad range of ways to help communities most at risk for COVID-19.



We believe in elevating, amplifying, and accelerating actions that work locally within medical systems to share with community partners facts, best practices, and other relevant health content that can be sent quickly to the people who need it most and can share it widely within communities. For example, American Organization for Nursing Leadership (AONL) has launched [Leading Through Crisis: A Resource Compendium for Nurse Leaders](#), a free compendium comprised of brief online modules designed to equip nurse leaders with practical tips and effective strategies for addressing challenges unique to a crisis. Supported by an independent educational grant from the Johnson & Johnson Foundation / the [Johnson & Johnson Center for Health Worker Innovation](#), the compendium's resources are also beneficial to nurses in clinical roles and other clinical leaders. The materials have been sent to AONL's 43,000 individual members as well as the 5,000 institutional members of the American Hospital Association.

Additionally, we are working with community health partners in a number of markets to support the addition of COVID-19 testing as part of the range of health services delivered through already-established mobile health care service units or "vans." Mobile Healthcare Service Centers (MHSCs) are an innovative and proven intervention that can successfully deliver cost-effective healthcare particularly related to preventive strategies and screening for disease. Among other functions, MHSCs permit rapid upscaling and delivery of COVID-19 testing among vulnerable populations.

From companies to academia, to regulators and to civil society organizations, we all must work together to address disparities in health care and ultimately secure broader societal benefit from medical innovation. We must move away from zip codes determining health outcomes. You can count on Johnson & Johnson to be a committed partner in this critical endeavor as we work to improve data and insights, increase education and awareness, and facilitate access to testing and health services.

Once again, we applaud your attention to this critical issue. If you have any questions, please e-mail Larry Camm at LCamm@its.jnj.com. Please let us know if you may need additional information and we look forward to serving as a resource.

Sincerely,

A handwritten signature in black ink that reads "Jane M. Adams". The signature is fluid and cursive.

Jane M. Adams
Vice President, Federal Affairs