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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.