UAB MEDICINE
PULMONARY, ALLERGY & CRITICAL CARE

Testimony of Anand S. Iyer, MD, MSPH

Assistant Professor, Division of Pulmonary, Allergy, and Critical Care Medicine

University of Alabama at Birmingham

and

Recipient, Paul B. Beeson Emerging Leaders Career Development Award in Aging

National Institute on Aging, National Institutes of Health

Submitted for the record at a hearing on:

"COVID-19 One Year Later: Addressing Health Care Needs for At-Risk Americans"

Before the

United States Senate Special Committee on Aging

March 18, 2021

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

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

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

People in my clinic are at highest risk for poor outcomes due to COVID-19 and are now facing immense barriers to COVID vaccine access. Eighty percent are Black, 20% are older than 65, and most are uninsured. One of my patients is a woman in her 70s with COPD. She lives alone in public housing, requires supplemental oxygen, has very limited mobility, and has no internet, no family caregivers, and no transportation. Every trip outside her home is a huge ordeal.

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

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

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

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

While caring for people in the ICU at UAB, I was keenly aware of the struggles faced by colleagues at small, rural facilities. Our telehealth ICU services improved outcomes at these hospitals, and telehealth ambulatory care improved outreach across the state. Early on in the pandemic, I brought telehealth pulmonary and palliative care from UAB to a woman in

her 80s who lived miles away from Birmingham and was isolated due to debilitating COPD. The “Telehealth Modernization Act (S.368)” continues many of the emergency provisions enacted during the pandemic to support in-home visits, reimburse audio and video visits, and cover people from both rural and urban areas. The pandemic accelerated the need for innovative ways to safely improve healthcare outreach, and telehealth offered a solution. Still, barriers to equitable broadband access created a hurdle for many.

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

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

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

COVID-19 also exposed significant geographic disparities in access to healthcare, especially in the rural South. When I was young I joined my father, a family physician, on

house calls to farms in northeast Alabama. He listened to his patients' lungs, and I brought home baskets of tomatoes that his patients gave to us. I witnessed early on the isolation they experienced, the struggles they faced accessing care in rural Alabama, and the ways that our visits lifted their spirits.

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

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

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

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

Second, simplify vaccine registration and administration processes and make them much more age- and disability- friendly. Many registration systems are internet-based and have used lengthy and complicated online forms that are impractical for older Americans who have no internet access, no email accounts, and low digital literacy. Instead, use telephone-based registration and proactively reach out to people through programs like the “Senior Buddies” in Washington, D.C. and the pilot “Vaccine Community Connecters” going door-to-door to schedule vaccinations and arrange transportation.

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

Finally, get the vaccine out to where people live. Federally-supported mass vaccination sites will help to increase overall vaccination numbers. However, equity must be ensured by

setting up vaccination sites directly in the hardest hit communities. Leaders at UAB prioritized vaccine equity from the beginning of the planning process and partnered with the city to set up a vaccination site in an underserved area of Birmingham. These efforts helped deliver vaccines to local minority communities at four times the state and national averages.[8] Getting the vaccine out also involves more mobile vaccination programs and vaccinating people in their homes. Geriatricians are doing this across the country for those who are homebound. We should learn how they are succeeding and replicate their efforts.

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

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

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

We must reach out and support them.

Thank you.

References

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

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

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

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

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

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

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

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