Senate Special Committee on Aging
The COVID-19 Pandemic: A Look at Racial Health Disparities
July 21, 2020
9:30 AM, Senate Dirksen Office Building 562

Purpose
The purpose of this hearing is to examine the racial health disparities that exist among communities of color and explore what can be done to better assist this population.

Members Present
Chairman Collins, Ranking member Casey, Senators Burr, Blumenthal, Hawley, Warren, Braun, Jones, Scott, Rosen, Scott, McSally, Sinema

Witnesses
Dominic H. Hack, MD**.,** Professor of Family Medicine and Director of the National Center for Primary Care, Morehouse School of Medicine, Atlanta, GA
Mercedes Carnethon, PhD., Professor of Epidemiology and Vice Chair of the Department Of Preventive Medicine, Northwestern University, Chicago, IL
Eugene A. Woods., President and Chief Executive Officer. Atrium Health, Charlotte, NC
Rodney B. Jones, Sr., Chief Executive Officer, East Liberty Health Center, Pittsburgh , PA

Opening Statements
(16:40) Chairman Collins said that today's hearing comes at a time when the nation is experiencing the confluence of a health crisis, an economic depression, and a series of killings that laid bare the racial injustice that still taints the country. The focus today is on COVID-19's disproportionate health impacts on Black and Latino seniors, as well as seniors from other racial and ethnic minority communities. According to a 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 two 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 employee's hold such jobs. One such field is long-term care, where one in four workers is Black, according to the Kaiser Family Foundation. There is still a great deal that we don't 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 & 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. 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.

(24:10) Ranking member Casey said that older Americans of color, have spent a life time enduring the structural inequities of racism that has plagued the country since its inception. We must own up to that simple and shameful truth. And we must not only acknowledge this injustices but we are summoned by the example of Rep. 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's just name a few. The injustice of a lack of affordable housing. Based on Census data from 2015, 46 percent of Black households spent more than a 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 to struggle with food insecurity as white households. The injustice of the education gap. According to the Census, 40 percent of white individuals have a college degree 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 white Americans – a gap that is not unique, as we know, to the current crisis. And 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 dying from COVID-19 at higher rates than whites. There is a chance – right now, in the next three weeks, to begin to address these injustices. And we hope to put ourselves on the road to actually correcting these injustices and thereby advancing the cause of justice for communities of color all across America.

Testimony

(35:35) Dr. Hack said the daunting news that Black Americans in the US are disproportionately suffering and dying from the novel coronavirus unfortunately is not a tremendous surprise. 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. 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.

(40:15) Dr. Carnethon said that her 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. 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. 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. Therefore, she offers 3 recommendations based on her experience as a population science researcher. First, is to expand the digital infrastructure and training available to older adults to support videoconferencing for telemedicine. Second, the NIH needs additional financial support to address the short- and long-term manifestations of the SARS-COV2 infection. 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.

(45:50) Mr. Woods said that Atrium Health urges Congress 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. In addition, 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, Atrium believes 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. Furthermore, 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. Hospitals and providers across the country are 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. 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. 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. Congress should consider providing Medicare and Medicaid payment for interpreters and translators. Finally, Congress should use this time to enable private-public communications partnerships to move the trust needle on vaccination.

(51:25) Mr. Jones said that 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. Most patients treated are from disparate backgrounds. Research shows that underlying health conditions are more prevalent in minorities due to Social Determinants of Health – conditions in which people are born, grow, live, work and age. 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. 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. 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. Research shows that gaining coverage is a significant factor in improving access to care. 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. 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.

<u>Questions and Answers</u>
(57:25) Chairman Collins asked if immigrant populations are being included in studies that look at the impact of COVID-19. **Dr. Mack** said yes. **Chairman Collins** asked how to better coordinate with community leaders to better deliver diagnostic and treatment services. **Dr. Carnethon** said that primarily, these communities need to be engaged with. It starts by opening up a dialogue with community leaders. Academic institutions can be essential in promoting this.

(1:04:15) Ranking member Casey asked what role Medicaid and the ACA has played in ensuring that older Americans can get access to the care they need. **Mr. Jones** said that Medicaid is critical. Before COVID-19, 20% of Pennsylvania residents received coverage through Medicaid. This includes 2/3 of all nursing home residents. Furthermore, many individuals are able to access marketplace subsidies thanks to the ACA. Expanded Medicaid through the ACA has also been critical in delivering care to older communities of color.

(1:09:50) Sen. Burr asked what metrics provide evidence for racial health disparities amid COVID-19. **Mr. Woods** said geospatial hot spotting analytics identified six zip codes in Charlotte that had higher incidence rates of COVID-19 than expected. Upon further analysis these communities did not have anywhere near the necessary levels of diagnostic supplies. **Sen. Burr** asked what information would be most useful for researchers to study the outbreak in nursing homes. **Dr. Carnethon** said there should be universal reporting on race and ethnicity of all COVID-19 positive patients in a nursing home. **Sen. Burr** asked if the outbreaks in congregate care settings are similar to the outbreaks in the general population. **Dr. Carnethon** said yes, although there are fewer disparities in older adults.

(1:15:50) Sen. Blumenthal asked how to build trust in the Medical community. **Dr. Carnethon** said the lack of trust in the health system can be traced back to the Tuskegee experiment. The medical community needs to spend time in the community that they serve and take the time to listen to their patients. Providers should be similar to the community they serve. **Sen. Blumenthal** asked how additional funds would be used by health centers. **Mr. Jones** said additional funding can be used to expand access to care, procure PPE, and keep staff employed.

(1:22:40) Sen. Hawley asked why community health centers are so important. **Mr. Jones** said community health centers help to mitigate the impact of social determinants of health. Community health centers reduce the barriers that prevent individuals from accessing healthcare. **Sen. Hawley** asked what can be done to improve technology access to encourage the use of telemedicine. **Mr. Jones** said there need to be community ambassadors that can help to install the technology necessary in beneficiaries' homes.

(1:29:09) Sen. Warren asked what the data reveals about how communities of color are dealing with the COVID-19 pandemic. **Mr. Woods** said that social determinants of health have been severely exposed during this pandemic. The lack of appropriate investments in these communities has led to these conditions. **Sen. Warren** asked if data has allowed Atrium health to reduce the impact of racial disparities. **Mr. Woods** said yes. **Sen. Warren** asked if the federal government will be able to craft an appropriate pandemic response without racial and ethnic data. **Mr. Woods** said that the data is essential. Without real time data it will be really difficult to contain and eliminate COVID-19.

(1:35:50) Sen. Braun asked if transparency is the tool to fix healthcare and navigate a disaster like COVID-19. **Mr. Woods** said that it is one avenue but not a cure all solution. **Mr. Jones** said the bigger picture is that we need to address why health disparities exist. This means addressing social determinants of health.

(1:42:50) Sen. Jones asked how Medicaid expansion would improve care for communities of color. **Mr. Woods** said that 1 out of 5 Americans have a mental health issue. Medicaid expansion would provide additional funding for delivering mental health care. This is just one example of how Medicaid expansion could help. **Sen. Jones** asked how colleges like Morehouse would use additional funds to assist in the COVID-19 pandemic response. **Dr. Mack** said that Morehouse is already working on the front lines. Additional funding would allow Morehouse to recruit and train medical providers to work in underserved communities.

(1:47:40) Sen. Scott asked what can be done to combat vaccine hesitancy. **Mr. Jones** said that vaccine hesitancy is a problem due to the lack of trust in medical communities. Unfortunately, trust cannot be built during a pandemic, it has to be done before hand. At this point, community organizations that are trusted should be leveraged to deliver public health messages. **Dr. Carnethon** said that it is critical to begin building bridges in underserved communities. Community leaders need to be empowered.

(1:55:20) Sen. Rosen asked how to best train medical professionals to better understand implicit bias. **Dr. Mack** said that training should sensitize a physician to the totality of an individual's health. It is known that only 20-30% of an individual's health comes from direct health care experience. The rest is determined by social determinants of health, and providers must be aware of this. **Dr. Carnethon** said that providers need to have more direct experience with at risk communities. Holding conversations with patients will improve health outcomes.

(2:01:30) Sen. Scott asked how the business of health centers have changed since the beginning of COVID-19 **Mr. Jones** said health centers are now primarily serving patients through telehealth platforms. **Sen. Scott** asked if overall volume has gone up or down. **Mr. Jones** said volume has gone down. **Sen. Scott** asked if Mr. Jones has enough protective gear. **Mr. Jones** said it was difficult but his health center has acquired PPE. **Sen. Scott** asked if Mr. Jones has access to rapid tests. **Mr. Jones** said that he hopes to have them within a week.

(2:10:00) Sen. McSally asked about the importance of maintaining and treating conditions like diabetes during COVID-19. **Dr. Carnethon** said that underlying conditions are leading to adverse health outcomes after a COVID-19 exposure. It is important to continue to support research that supports the management of these conditions. Telehealth can be essential in this support. **Sen. McSally** asked how important medical monitoring is in conjunction with telehealth. **Dr. Carnethon** said that it is critically important. **Sen. McSally** asked what challenges do minority care givers face. **Dr. Mack** said that minority care givers tend to have less resources. Unemployment in these communities is also very high. These care givers often cannot take time off work or have to miss important days of school to complete the duty of care giver.

(2:18:35) Sen. Sinema asked how a lack of access to basic services can impact public health during a pandemic. **Dr. Mack** said that the lack of access to these basic services makes communities more vulnerable to infectious diseases. **Mr. Woods** said that these challenges are exacerbated because most of these communities have limited access to basic health care. **Sen. Sinema** asked how important it is to design COVID-19 resources that are culturally relevant. **Mr. Woods** said that it is essential.

(2:25:00) Sen. Collins asked how to ensure that the actions taken to defer routine healthcare do not create a second healthcare crisis downstream. **Mr. Woods** said the solution comes in inspiring confidence at the health system level to explain that everything is being done to ensure patients are safe when they come into a facility.

(2:32:00) Sen. Casey asked how additional Medicaid dollars for home and community based care would help older adults. **Dr. Carnethon** said it would be critical in reducing infections and improving self-sustainability among patients.

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