



1700 K Street, NW | Suite 740 | Washington, DC 20006

T 202.293.2856

www.agingresearch.org

[@Aging_Research](https://twitter.com/Aging_Research)

June 26, 2020

The Honorable Lamar Alexander
United States Senate
455 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Chairman Alexander,

The Alliance for Aging Research appreciates the opportunity to provide input on the white paper “Preparing for the Next Pandemic” and for your leadership in creating recommendations to address future pandemics based on the lessons we’ve learned from COVID-19.

The [Alliance for Aging Research](http://www.agingresearch.org) (Alliance), is the leading nonprofit organization dedicated to accelerating the pace of scientific discoveries and their application to vastly improve the universal human experience of aging and health. The Alliance believes that advances in research help people live longer, happier, more productive lives and reduce healthcare costs over the long term and that access to the latest scientific information empowers people to take control of their health. The Alliance strives to advance science and enhance lives through a variety of activities and initiatives – from policy issues to provider and consumer health programs – that generate knowledge and action on age-related matters.

As you know, older Americans have been disproportionately impacted by the pandemic, with people age 65 and older making up 80 percent of all COVID-19 deaths. Individuals age 65 and over are more likely to have comorbid conditions that place them at high-risk for complications from COVID-19. Older individuals are also more likely to require the services of a nursing facility or assisted living facility, where a lack of access to tests, personal protective equipment (PPE), and early limitations on understanding the transmission of COVID-19 have contributed to increased mortality.

The Alliance appreciates the Chairman’s efforts to address policies that can contribute to increased resiliency during the current pandemic and in future public health emergencies (PHEs). Our comments reflect the unique needs of aging Americans and our desire that learnings from current experience affect positive change in future policy.

Feedback on Selected White Paper Recommendations

Disease Surveillance – Expanding Ability to Detect, Identify, Model and Track Emerging Infectious Diseases

Recommendations 2.1 and 2.4

Reliable data is critical in tracking, containing, and responding to infectious disease outbreaks. As noted in the white paper, delays and incomplete reporting during the COVID-19 pandemic “challenged state

health departments and the CDC alike.” Reporting amongst the states has not been consistent or uniform. For example, many states have mixed viral and antibody tests in reporting, both of which provide important but distinct data points that paint an inaccurate picture of current infection rates when combined.¹ The Centers for Disease Control and Prevention (CDC) also combined different results that distorted metrics, leading many leaders to turn to other sources for reliable information. States and local governments were forced to rely on flawed data when making decisions about closing and reopening, advising their citizens about risks and proper safety precautions, and implementing measures to respond to the pandemic.

The absence of clear national guidelines unquestionably led to confusion on what data elements should be submitted and how to best report data. **We support Recommendation 2.1 and the principles reflected in Recommendation 2.4 to modernize public health data collection and support accurate data collection on disease tracing and tracking. Additionally, we recommend mandatory and uniform data reporting.** Standardized, compulsory reporting will help avoid data-related challenges observed in the current PHE, including the possibility of states delaying or blocking the release of data elements that could undermine public-facing statements by elected officials. The uniform data requirements should also incorporate demographic data—age, ethnicity, race, etc.—to allow policymakers, researchers, and the public to better understand disproportionate impacts on certain communities and appropriately target public health interventions.

Ensuring Efficient, Appropriate Criteria for Distribution of Equipment, Treatments, and Vaccines **Recommendation 3.2**

We strongly agree with Recommendation 3.2 and further recommend that the federal government provide guidance and facilitate the distribution of needed PPE. Older adults are much more susceptible to contracting infectious diseases and are more likely to have pre-existing conditions. The community-based nature of nursing and long-term care facilities facilitates the spread of these diseases. Underlining this point, nursing facility residents have accounted for more than 40 percent – or approximately 50,000 – of total COVID-19 related deaths thus far.²

One of the largest failures of our healthcare system during the COVID-19 pandemic has been the inability to source PPE to nursing homes. Early during the COVID-19 pandemic, many nursing facilities had difficulty obtaining the PPE necessary to prevent nursing home staff from bringing the virus into the facility or preventing the spread from resident to resident. It was clear that nursing homes were not provided with a sufficient supply of N95 masks, gloves, and other PPE to protect health care workers and nursing home residents from infection.

It should remain the role of the federal government to adequately stockpile and plan for a pandemic. **As part of its pandemic preparedness, the federal government should work with states and local governments to develop specific plans to source PPE for nursing facilities and other long-term care facilities.** As the federal government works to develop these plans and build up the Strategic National Stockpile, it also needs to better define the demand and needs of PPE for nursing homes. Such plans should better estimate the PPE needs of our nation’s nursing homes for 30 days, 60 days, and 90 days.

¹ Madrigal, Alexis C. and Robinson Meyer. “How Could the CDC Make That Mistake?” The Atlantic. 21 May 2020. <https://www.theatlantic.com/health/archive/2020/05/cdc-and-states-are-misreporting-covid-19-test-data-pennsylvania-georgia-texas/611935/>

² Kamp, Jon, and Anna Wilde Mathews. “As U.S. Nursing-Home Deaths Reach 50,000, States Ease Lockdowns.” The Wall Street Journal, 16 June 2020, www.wsj.com/articles/coronavirus-deaths-in-u-s-nursing-long-term-care-facilities-top-50-000-11592306919.

These plans should also establish criteria to ensure that PPE from federal reserves is allocated to the locations and settings of care facing the most imminent critical shortages that could lead to additional community spread.

Additionally, in the event of future shortages of PPE during a pandemic, state governments need to ensure that each nursing home facility utilizes federal guidance on optimizing their PPE supply. The CDC has PPE-type specific guidance on optimizing PPE use.³ Last, Congress should provide sufficient appropriations to nursing homes to effectively comply with state surveyor regulatory directives set by the Centers for Medicare & Medicaid Services (CMS). CMS increased requirements in March 2020,⁴ but additional funding was not included for nursing homes in the relief packages until May.

Recommendation 3.4

There are well over 100 vaccine candidates being explored for COVID-19, and almost a dozen have been approved for human testing. At least one of those candidates may prove effective in producing an immune response and be available in early 2021.⁵ However, due to consumer demand and the potential of manufacturing and distribution delays, an initial shortage of any U.S. Food and Drug Administration (FDA) approved COVID-19 vaccine is likely. As a result, it will be many months before the vaccine can be broadly administered within the population. To reach the point of herd immunity, approximately 70 percent of Americans will need to either have built an immunity through environmental exposure or vaccination.⁶

In the early stages of approval production of an approved vaccine, the federal, state, and local governments will need to decide who should be prioritized for the administration of the vaccine. The CDC will issue guidelines, which will be interpreted by state and local health departments and hospitals. **An effective immunization strategy will prioritize immunization among populations of people who are most likely to spread the virus to others and people most at risk of morbidity after exposure to the virus.** The CDC should develop a plan with state input to ensure the vaccine is available for the populations where it is needed most, namely front-line medical workers, immunosuppressed older adults – especially those in long-term care facilities at higher risk of community infection and depression due to the current need for isolation⁷ – and people in essential front-line jobs. The demand for the vaccine will be extraordinarily high, so a critical job of our public health systems will be effectively communicating why these groups are prioritized among others.

After the vaccine is produced at a mass-scale, the government needs to ensure the vaccine is easy for people to access, much like the flu vaccine. Any approach to making sure the vaccine is widely available should include specific instruction, rather than only general principles. Agencies should actively develop detailed operational blueprints on the best way for a vaccine to be deployed upon mass production.

³ "COVID-19: Strategies for Optimizing the Supply of PPE." CDC, Centers for Disease Control and Prevention, 18 May 2020, www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html.

⁴ Centers for Medicare and Medicaid Services. "Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in Nursing Homes." 13 Mar 2020. <https://www.cms.gov/files/document/3-13-2020-nursing-home-guidance-covid-19.pdf>

⁵ Nunez, Elissa. "Out of the Lab and into People's Arms: A List of COVID-19 Vaccines That Are Being Studied in Clinical Trials." ABC News, 9 June 2020, abcnews.go.com/Health/lab-peoples-arms-list-covid-19-vaccines-studied/story?id=71145250.

⁶ D'souza, Gypsyamber, and David Dowdy. "What Is Herd Immunity and How Can We Achieve It With COVID-19?" Johns Hopkins Bloomberg School of Public Health, 22 Apr. 2020, www.jhsph.edu/covid-19/articles/achieving-herd-immunity-with-covid19.html.

⁷ Chidambaram, Priya. "Data Note: How Might Coronavirus Affect Residents in Nursing Facilities?" Kaiser Health News. 13 Mar 2020. <https://www.kff.org/coronavirus-covid-19/issue-brief/data-note-how-might-coronavirus-affect-residents-in-nursing-facilities/>

Governments and public health systems should create plans well in advance of FDA-approval to deploy a vaccine once mass production has been achieved. Such a plan should include, but not be limited to, details on:

- How a vaccine could be made widely available among health care facilities, including physician offices, local health departments, urgent care facilities, and long-term care facilities
- The creation of mobile teams of healthcare workers who can administer the vaccine within the community
- Funding structures that support the widespread adoption of a vaccine
- Educating the public on how to obtain the vaccine
- Prioritization of developing vaccines that could be self-administered

Furthermore, in future pandemics, the federal government should establish Pandemic Testing Boards, akin to the Federal Emergency Management Agency's (FEMA) [Supply Chain Stabilization Task Force](#). A Pandemic Testing Board would be tasked with developing a plan for at-scale diagnostic testing needed to identify who within the population has been exposed to an infectious disease. The Pandemic Testing Board should be given the authority to procure materials necessary to manufacture diagnostic tests and mandate the production of materials. Additionally, a Pandemic Testing Board should be tasked with developing plans for the deployment of tests, including information on how governments will work with local communities to ensure widespread testing and provide recommendations on tracking disease spread.

Promoting Resiliency and Access During Public Health Emergencies

Recommendation 4.1

The current pandemic has illustrated the need for flexibility, creativity, and advance planning to allow continued access to providers and ensure resiliency in the U.S. healthcare system. Consumer behavior in seeking healthcare changed rapidly as the spread of COVID-19 accelerated. A limited preliminary supply of PPE also presented a barrier to the provision of routine care. Demand for in-person services has also dropped, with individuals preferring to remain at home, rather than risk exposure to COVID-19 in a public healthcare setting.

Some states ordered hospitals to stop elective procedures during the initial weeks and months of the pandemic amid concerns that COVID-19 admissions would quickly outstrip the availability of hospital beds and medical personnel. This policy step was important in helping curb community spread in the early stages of the pandemic. CMS also issued recommendations on elective procedures starting in March⁸, but provided little detail on type of procedure by Tier⁹—we would like to see more detail on this for hospitals moving forward. At the same time, an elective procedure typically represents a medically necessary surgery. For many patients, elective procedures should be performed as soon as possible to ensure positive long-term health outcomes. Utilization rates of other important maintenance care, such

⁸ Centers for Medicare and Medicaid Services. "CMS Releases Recommendations on Adult Elective Surgeries, Non-Essential Medical, Surgical, and Dental Procedures During COVID-19 Response." 18 Mar 2020. <https://www.cms.gov/newsroom/press-releases/cms-releases-recommendations-adult-elective-surgeries-non-essential-medical-surgical-and-dental>

⁹ Centers for Medicare and Medicaid Services. "Non-Emergent, Elective Medical Services, and Treatment Recommendations." 07 Apr 2020 <https://www.cms.gov/files/document/cms-non-emergent-elective-medical-recommendations.pdf>

as routine pediatric vaccinations and cancer screenings, have sharply declined since the onset of the pandemic.^{10, 11}

While most states have returned to permitting elective procedures, a resurgence in COVID-19 hospitalizations and ICU utilization may result in another temporary stoppage for these interventions. The first stoppage highlighted the need for stakeholders to collaborate to ensure greater resiliency in the face of future pandemics. In support of Recommendation 4.1, the **Department of Health and Human Services (HHS) should immediately convene with providers, payers, and manufacturers to develop contingency plans to ensure that elective and routine care remains accessible and safe throughout the current PHE and in future pandemics.**

In addition to the providers previously mentioned in Recommendation 4.1, **nursing and long-term care facilities must be incorporated when ensuring that health care services remain available during a pandemic.** Nursing facilities constitute a key piece of the healthcare infrastructure for aging Americans. 2.4 million Americans currently reside in nursing facilities and other long-term care facilities,¹² while a 2017 RAND study found “among persons age 57 to 61, 56 percent will stay in a nursing home at least one night during their lifetime.”¹³ Nursing facilities’ ability to provide post-acute and long-term care serves to support the home as the primary site of residence for most seniors.

The COVID-19 response has brought stark attention to the challenges faced by nursing facilities as they care for an aging population that often has pre-existing medical conditions. A lack of uniformity in best practices to limit the spread of COVID-19 led to differing guidelines between states on visitation, patient isolation, and staffing in nursing facilities in early 2020. To support sufficient hospital capacity, some states followed an initial directive from CMS that stated, “Nursing homes should admit any individuals that they would normally admit to their facility, including individuals from hospitals where a case of COVID-19 was/is present.”¹⁴ This guidance contributed to the additional spread of the virus both in the facility and in the community. **Congress should direct CMS to identify alternatives for ensuring a sufficient supply of inpatient beds and refrain from issuing any future guidance that contributes to the introduction of a highly infectious disease to a nursing facility.** At present, most nursing facilities are unable to provide post-acute rehabilitative services to limit the risk of introducing COVID-19 to residents, thereby limiting what is often part of the standard course of care for procedures such as hip and knee replacements.

As with other healthcare settings, Congress and HHS should ensure that nursing facilities and long-term care facilities are included in a robust preparedness and response effort. Guidance and clinical protocols for nursing and long-term care facilities during various potential types of PHEs should be researched, established, and widely disseminated. Providers should also have the opportunity to engage in training and exercises to ensure readiness for future PHEs.

¹⁰ McCarthy, Moira. “COVID-19 Is Causing a Reduction in Child Vaccinations.” Healthline. 19 May 2020. <https://www.healthline.com/health-news/covid19-causing-decrease-in-child-vaccinations>

¹¹ Mastroianni, Brian. “Important Cancer Screenings Have Decreased During COVID-19.” Healthline. 11 June 2020. <https://www.healthline.com/health-news/important-cancer-screenings-have-decreased-during-covid-19>

¹² Kwiatkowski, Marisa, et al. “A National Disgrace’: 40,600 Deaths Tied to US Nursing Homes.” U.S. News and World Report. 2 June 2020. <https://www.usatoday.com/story/news/investigations/2020/06/01/coronavirus-nursing-home-deaths-top-40-600/5273075002/>

¹³ Hurd, Michael D., et al. “Distribution of Lifetime Nursing Home Use and of Out-of-Pocket Spending.” RAND Corporation. 29 Aug 2017. https://www.rand.org/pubs/external_publications/EP67296.html

¹⁴ Centers for Medicare and Medicaid Services. “: Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in Nursing Homes.” 13 Mar 2020. <https://www.cms.gov/files/document/3-13-2020-nursing-home-guidance-covid-19.pdf>

Recommendation 4.2

Telehealth has become an important pathway to access healthcare providers during the current pandemic. Telehealth has long held the potential to help patients overcome barriers to care such as taking time off work to visit the doctor, long travel times, and difficulty in appointment scheduling. HHS extended flexibilities in March 2020 for the provision of telehealth to Medicare beneficiaries during the COVID-19 pandemic, including waivers to guidelines that limited the provision of telehealth to beneficiaries residing in rural geographic areas.¹⁵ Telehealth has since experienced rapid adoption – telehealth claim line volume in March 2020 increased by 4,347 percent in comparison to March 2019.¹⁶ As noted in Recommendation 4.2, **Congress and the HHS should ensure that telehealth flexibilities are extended beyond the end of the current PHE.** Previous restrictions on the use of telehealth were not based on clinical concerns and should be revised. For example, older Americans often face challenges related to accessing public transportation in both rural and urban locales. Telehealth can contribute to lessening barriers to receiving care due to such mobility restrictions. Further, reducing in-person interactions for the diagnosis of routine health conditions can limit exposure to future cases of seasonal influenza and colds, conditions that present enhanced risks for patients with existing comorbidities. As such, **Congress should ensure that the geographic limitations on telehealth are permanently discontinued.** Further, HHS should continue payment parity for telehealth in perpetuity. Other telehealth flexibilities should continue at a minimum until a COVID-19 treatment or vaccine with proven efficacy for all populations has been widely distributed.

*Improving Coordination of Federal Agency Response During Public Health Emergencies***Recommendation 5.1**

Effective coordination and a clear chain of command are necessary when responding to a PHE. However, the early governmental response to COVID-19 illustrated areas for improvement regarding a unified federal response. As the white paper notes, organizational uncertainty resulted in early challenges in responding to the pandemic.

An established structure with a sustained focus on preparedness, rather than ad hoc approaches that differ in each Administration, will help the U.S. remain on solid footing to face PHEs. To support this aim, we strongly support Recommendation 5.1. Further, the unprecedented health, financial, and societal impacts of COVID-19 have shown that investment in prevention and preparedness is necessary to help avoid the most severe impacts of future pandemics. Given evolving budgetary and policy priorities, we call on Congress to establish and protect restricted funding for tracking and responding to public health threats. Additionally, Congress should specify that pandemic response efforts are spearheaded by personnel maintaining substantial expertise in epidemiology and/or medical preparedness.

Conclusion

The Alliance thanks the Chairman for his efforts to advance the conversation on public health preparedness and response through this white paper. While the recommendations, if implemented, will prove beneficial in addressing future PHEs, Congress should act now to implement many of the changes

¹⁵ U.S. Department of Health and Human Services. "Telehealth: Delivering Care Safely During COVID-19." 7 May 2020. Accessed 24 June 2020. <https://www.hhs.gov/coronavirus/telehealth/index.html>

¹⁶ Gelburd, Robin. "The Coronavirus Pandemic and the Transformation of Telehealth." U.S. News and World Report. 2 June 2020. <https://www.usnews.com/news/healthiest-communities/articles/2020-06-02/covid-19-and-the-transformation-of-telehealth>

recommended in our comments to meaningfully impact the continuing response to the COVID-19 pandemic.

The Alliance appreciates the opportunity to provide input on these important efforts to advance public health. If you or your staff would like to discuss these issues in greater detail, please contact us at (202) 688-1230 or mward@agingresearch.org.

Sincerely,

A handwritten signature in brown ink that reads "Michael Ward". The signature is written in a cursive style with a small dash above the "i" in "Michael".

Michael Ward
Director of Public Policy
Alliance for Aging Research

A handwritten signature in black ink that reads "Ryne Carney". The signature is written in a cursive style.

Ryne Carney
Manager of Public Policy
Alliance for Aging Research