

## Supporting All Americans as We Age Questions for Candidates and Elected Officials

The American Geriatrics Society (AGS) is committed to improving the health, independence, and quality of life of all older people. In clinics, classrooms, and communities across the U.S., an important part of that commitment is understanding what programs and policies our elected representatives are championing so that federal, state, and local government support older Americans continuing to contribute to our communities in new and innovative ways.

We believe it is important that Americans ask questions of *any* candidate for public office so that we all have an understanding of where our candidates stand on issues important to older Americans and caregivers. Learning about a candidate's commitment to older Americans *now* can help us elect leaders with clear, actionable visions to support health, safety, and independence for all older Americans. This compendium of questions also works for meetings with Members of Congress or Congressional staff and for hometown town halls. In addition to asking these important questions, this document serves as a vehicle for sharing policies and programs aimed at improving care of older adults.

### *Topics Important to Supporting All Americans as We Age*

- **Ensuring Access to Geriatrics Health Professionals**
- **Expanding Title VII Geriatrics Training Programs**
- **Ensuring Our Workforce is Competent to Care for Older Americans**
- **Reducing the Toll and Impact of Chronic Diseases**
- **Ensuring Access to Adequate Pain Relief for Older Americans Living with Advanced Illness**
- **Supporting American Women**
- **Supporting American Families**
- **Addressing Complexity in Caring for Older Americans**
- **Addressing Structural Racism and Ageism**
- **Addressing COVID-19 and Public Health Emergencies**

*Do you have ideas for additional topics?*

Submit your ideas for additional topics to [info@americangeriatrics.org](mailto:info@americangeriatrics.org)  
or tweet us at @AmerGeriatrics.

## Issue 1: Ensuring Access to Geriatrics Health Professionals

### What policies and programs would you champion that would increase access to geriatrics health professionals for older Americans?

#### Why It Matters...

Geriatrics health professionals are pioneers in advanced-illness care for older individuals, with a focus on championing interprofessional teams, eliciting personal care goals, and treating older people as whole persons. When these professionals are in short supply, too many older Americans receive care that is not well-coordinated and that often leads to adverse outcomes for us all as we age.

#### Policy Approaches that Work...

Two policy approaches that would address the shortages and increase access are:

- Restoring and making permanent the 10% primary care bonus that was included in the Affordable Care Act as a mechanism for addressing the shortage of primary care clinicians. This would be an important incentive for geriatrics, given that it is among the lowest-paid specialties according to the Medicare Payment Advisory Commission (MedPAC).
- Creating loan repayment programs at the federal and state levels that are specific to geriatrics. In particular, such programs would address the significant barrier that student loan debt creates for clinicians who want to pursue primary care careers in geriatrics, while helping to expand the workforce we need to care for the growing population of older Americans. At the federal level, the program would complement existing loan repayment programs offered by the Health Resources and Services Administration for primary care medical, dental, and mental and behavioral health care providers. A separate loan forgiveness program should be established by the Department of Veterans Affairs (VA) to incentivize geriatrics health professionals to pursue careers caring for older veterans.

#### What's at Stake...

The Health Resources & Services Administration (HRSA) documented the current and growing shortage of geriatricians (physicians who specialize in geriatrics), forecasting that by 2025 there will be an insufficient number of geriatricians to meet the needs of the U.S. population. This could leave thousands of older adults without access to geriatrics care. There are similar shortages of health professionals specializing in geriatrics across other disciplines.

#### Learn More...

- [The Geriatrics Workforce by the Numbers](#)

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## Questions for Our Candidates and Elected Officials on Supporting Us All as We Age

### Issue 2: Expanding Title VII Geriatrics Training Programs

**How would you work to expand the reach of federal training programs so that all older people have access to health professionals who are competent to meet our needs as we age?**

#### Why It Matters...

Title VII of the Public Health Service Act is the federal mechanism for supporting health professions education/training. Title VII has made two critical programs possible benefitting us all as we age:

- The Geriatrics Workforce Enhancement Program (GWEP) educates and engages the broader frontline health workforce to improve care and connections with older adults.
- The Geriatric Academic Career Awards (GACAs) support professional development for clinician-educators who train the future workforce we need as we age.

The 48 GWEPs and 26 GACAs are working to ensure that older Americans and those who care for them have access to a healthcare workforce with the requisite skills and geriatrics competencies to meet our needs as we age. That work took a significant step forward as part of the Coronavirus Aid, Relief, and Economic Security (CARES) Act, which provided more than \$40 million in funding for the GWEPs and GACAs as long-term solutions serving older adults.

#### Policy Approaches that Work...

CARES Act appropriations of \$40.7 million for the GWEPs and the GACAs still falls short of what older Americans need today, and what we all will need tomorrow. The AGS continues to advocate for increased funding totaling at least \$51 million, which would do much to close the current geographic and demographic gaps in geriatrics workforce training.

Long-term, we also must work to ensure geriatrics training programs continue to receive adequate, ongoing federal support for the impact we need as more Americans age.

#### What's at Stake...

Overall, the healthcare workforce receives very little geriatrics training. This leaves our health professionals ill-prepared to care for older Americans, many of whom have multiple chronic conditions and complex social and medical needs.

#### Learn More...

- [A National Survey on the Effect of the GACA in Advancing Academic Geriatric Medicine](#)
- [The GWEP Coordinating Center](#)

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### Issue 3: Ensuring Our Workforce is Competent to Care for Older Americans

## Questions for Our Candidates and Elected Officials on Supporting Us All as We Age

**How would you reform graduate medical education (GME) to address the gap between training requirements and our nation's need for a workforce that is prepared to care for us all as we age?**

### **Why It Matters...**

Medicare is the largest funder of GME, spending an estimated \$10.3 to \$12.5 billion annually on training the next generation of health professionals. Yet there are no federal requirements that training funded with Medicare dollars prepare trainees to care for older people.

### **Policy Approaches that Work...**

One policy approach would be to mandate that all Medicare-supported training include geriatrics principles in order to prepare a workforce that is competent to care for us all as we age.

### **What's at Stake...**

More of us than ever before are benefitting from increased longevity and the prospect of contributing to our communities as we age. Our health care across all disciplines and specialties needs to keep pace with how our country is changing as more of us grow older. We need to be sure the whole of our health workforce is equipped to support our health, safety, and independence as we age.

### **Learn More...**

- [The Geriatrics-for-Specialists Initiative](#)
- [AGS Advancing Geriatrics in Surgical and Medical Specialties](#)

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## Questions for Our Candidates and Elected Officials on Supporting Us All as We Age

### Issue 4: Reducing the Toll and Impact of Chronic Diseases

- **How would you prioritize aging research across federal agencies and institutions so that we can address the human and economic toll of chronic diseases on older Americans?**
- **What will you do to ensure that Americans trust scientists and experts in other disciplines?**

#### Why It Matters...

Chronic diseases related to aging, such as diabetes, heart disease, and cancer, continue to affect 80% of people 65 and older. They also account for more than 75% of Medicare and other federal health expenditures. Yet in a recent analysis of research, investigators found that 33% of federally funded clinical trials had an upper age limit, with one-quarter of those studies not allowing people 65 and older to participate. Of the 623 trials reviewed in this analysis, all listed exclusion criteria with comorbid conditions (e.g., hypertension, neurologic disorders, cardiac disease) frequently cited as a reason for not including a participant.

There also are serious physical, financial, and social costs associated with inaction. When medical evidence is generated from idealized study populations that don't resemble most of the people who actually need care, we miss opportunities to learn how to optimize health and resilience—and avoid suffering and unnecessary costs—in the real world.

#### Policy Approaches that Work...

The recently implemented National Institutes of Health (NIH) [Inclusion of Individuals Across the Lifespan policy](#) will begin to address the toll and impact of chronic diseases for older people by removing artificial and arbitrary upper age limits for clinical trial enrollment. Additionally, a “moonshot” approach that addresses health across the lifespan will be key to radically rethinking how research, education, clinical practice, and public policy serve Americans' needs as we grow older.

Geriatrics is well-positioned to move that moonshot forward, since our discipline embraces care well beyond the walls of hospitals and clinics, reflecting the diversity of places and people we need for medical, functional, cognitive, and social well-being with age. To increase the evidence base for prevention and treatment that supports all of us as we age would require:

- Increasing our investment in aging research across federal agencies, including the National Institutes of Health (NIH), the Agency for Healthcare Research and Quality (AHRQ), the Veterans Affairs (VA) Administration, and the Patient-Centered Outcomes Research Institute (PCORI).
- Establishing a National Advisory Council and Action Plan at the National Institute on Aging (NIA) charged with monitoring and assessing progress toward increasing attention to older adults with multiple chronic conditions across agencies.
- Increasing our investment in the NIA and VA, including efforts to recruit and support the next generation of aging researchers. Doing so would ensure our ability to implement whole-person-focused studies of the diseases and conditions older adults face.

## Questions for Our Candidates and Elected Officials on Supporting Us All as We Age

### What's at Stake...

Federal investments in research have led to discoveries that have contributed to increased longevity (lifespan) and helped to delay the onset of chronic diseases (healthspan). Two notable examples include reductions in mortality and delayed onset for heart disease and cancer. Recent evidence also suggests cognitive impairment may be delayed.

Despite these advances in preventing and treating individual diseases, however, a 2010 study of Medicare beneficiaries found that 68.4% of older Americans live with two or more chronic conditions; 36.4% have four or more such conditions. Excluding older Americans from federal-funded clinical trials aimed at treating or preventing these concerns jeopardizes lifespan and healthspan for us all.

### Learn More...

- [Multiple Chronic Conditions & Older Adults](#)
- [Achieving Age-Friendly Health Care](#)
- [Action Steps for the AGS Guiding Principles on the Care of Older Adults with Multimorbidity](#)

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### Issue 5: Ensuring Access to Adequate Pain Relief for Older Americans Living with Advanced Illness

**What policies would you champion to ensure frail older Americans living with advanced illness (typically those 85+ with multiple chronic conditions) have access to adequate pain relief?**

#### Why It Matters

Even as we live longer, diseases and conditions that impact health for older people remain serious concerns. This is particularly true for people 80-years-old and older, who are at the highest risk for multiple health problems and constitute the fastest growing age group in the U.S. Managing pain is a key concern for many of these individuals.

More than 52% of older adults report experiencing bothersome pain in a preceding month. Additionally, there's a growing body of evidence that organ impairments in older adults impact the safety of common treatment options like non-steroidal anti-inflammatory drugs (or NSAIDs) and anxiolytics. Finally, there is growing evidence that efforts to address the opioid crisis have resulted in reduced access to adequate pain relief for people living with advanced illness, a population that includes frail older Americans living with multiple chronic conditions.

#### Policy Approaches that Work

Policy approaches that would address inadequate pain management in older adults include the following:

- The Centers for Disease Control and Prevention (CDC) should add frail older adults who are living with advanced illness to the populations currently excluded from the recommendations in its guideline, "Prescribing Opioids for Chronic Pain."
- The Food and Drug Administration (FDA) should implement policies that require meaningful inclusion of older adults, particularly those with multiple chronic conditions, in clinical trials, similar to the policy that the National Institutes of Health (NIH) implemented in 2019. This will improve the evidence base that informs clinical decision-making for management of persistent pain in older people.
- The NIH should support studies that enroll older adults with additional conditions common in this population (e.g., multi-morbidity, polypharmacy, and frailty) with a special emphasis on recruiting adults age 75+ and those with multiple chronic conditions. Such studies should examine the efficacy of non-pharmacologic and pharmacologic approaches to treating pain. Further, studies should examine the efficacy of alternative approaches to managing post-operative pain at hospital discharge.
- The Drug Enforcement Agency (DEA) should allow nurses in long-term care facilities to act as the physician's "agent" by recording the physician's verbal order of scheduled controlled substance medications, used for pain relief, in the resident's medical record. In addition to this process (also known as creating a "chart order"), the nurse should then be allowed to transmit that same order to the pharmacy. Chart orders are necessary in facilities such as nursing homes because residents are admitted at all times and because

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physicians are not onsite 24 hours a day, 7 days a week. Nurses in other care settings like hospitals already do this for scheduled controlled substances. The current DEA policy affecting long-term care facilities falls short in ensuring long-term care residents in severe pain receive adequate and timely access to pain relief medication.

- We should do more to assure that all health professionals, particularly those in primary care, have sufficient training in geriatrics and palliative care to be competent in the comprehensive evaluation and treatment of older adults with complex histories, multiple pain problems, and medical comorbidities.
- We must address the nationwide shortage of primary care practitioners, particularly in rural areas, by increasing reimbursement. This would ensure that healthcare professionals who provide essential comprehensive evaluation and treatment planning for older adults with complex histories, multiple pain problems, and medical comorbidities receive the reimbursement and recognition they need.

### What's at Stake

Persistent pain is a common problem for older adults. Older people are more likely to live with chronic conditions associated with persistent pain, including arthritis, bone and joint disorders, and cancer. As described by many older people, including many who have cancer, pain can be difficult to manage even when working with a palliative care team. Under-treatment of pain has serious medical consequences that include loss of appetite, weight loss, inability to sleep, depression, anxiety, decreased socialization, impaired mobility, and increased costs associated with healthcare utilization. In short, failure to address pain in a frail older adult living with advanced illness can begin the downward spiral that leads to decline and death.

### Learn More...

- [CDC Guideline for Prescribing Opioids for Chronic Pain](#)
- [AGS Comments to the U.S. Department of Health and Human Service on Pain Management Best Practices: Updates, Gaps, Inconsistencies, and Recommendations Draft Report](#)

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### Issue 6: Supporting American Women

- **What will you do to ensure women receive equal pay for equal work?**
- **What are your plans for ensuring women are vibrant parts of your Administration?**

#### **Why It Matters...**

Across the U.S. workforce (including in geriatrics and health care), women continue to earn 85% of the compensation provided to men in similar positions. Discrepancies in pay not only make it more challenging to make ends meet but also reinforce a culture that sees women frequently passed over for major assignments, leadership opportunities, senior mentoring, and promotions.

#### **Policy Approaches that Work...**

Ending gender discrimination across fields and practices means:

- Addressing discriminatory practices.
- Addressing pay discrepancies.
- Addressing family and medical leave.
- Advancing women in leadership positions.

#### **What's at Stake...**

In the past decade, women leaders have made significant strides aimed at shattering the “glass ceiling.” At the AGS alone, the percentage of female presidents increased to 70% between 2009 and 2019, with women now comprising 60% of the AGS membership overall. Still, women in the workforce continue to receive less leadership recognition than their male counterparts, in part because women often are passed over for management positions but also because a culture of discriminatory harassment and “micro-aggressions” (indirect statements or actions that reflect subtle or even unintentional bias against members of a marginalized group) can make leadership feel out-of-reach.

#### **Learn More...**

- [AGS Position Statement on Achieving Gender Equity in Geriatrics](#)

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### Issue 7: Supporting American Families

**How would you ensure that all Americans, including all those employed by the federal government, have access to paid family leave?**

#### Why It Matters...

The federal Family and Medical Leave Act (FMLA) entitles eligible employees to as many as 12 weeks of annual unpaid leave to recover from a serious illness or care for a newborn, newly adopted child, or seriously ill family member. However, roughly 40% of workers remain ineligible for FMLA coverage, and millions who are eligible still struggle to afford unpaid time off.

#### Policy Approaches that Work...

Ensuring that federal protections can empower employees to recover from a serious illness or care for a newborn, newly adopted child, or seriously ill family member is key to building a system that serves us all as we age.

#### What's at Stake...

Under current policy, the overwhelming majority of the U.S. workforce is without access to paid family leave for children and other relatives. Even new legislation that extended parental leave benefits to federal employees fell short, since it does not allow care for other family members such as parents—a key consideration as our country continues to age. A lack of federal protections for all forms of family leave remains a barrier to recruiting geriatrics health professionals into careers serving older adults.

#### Learn More...

- [Caregiving & Older Adults](#)
- [AGS Position Statement on Achieving Gender Equity in Geriatrics](#)

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### Issue 8: Addressing Complexity in Caring for Older Americans

**How would you work to improve both the quality and efficiency of care delivered to the increasing number of Medicare beneficiaries with multiple chronic and complex conditions? Additionally, how would you improve care and care coordination across health care settings important to individuals who have dual eligibility for both Medicare (controlled by the federal government) and Medicaid (which is largely controlled by the states)?**

#### **Why It Matters...**

Older people with chronic illnesses and geriatric conditions frequently do not receive optimal care. This not only reduces overall well-being but also contributes to disproportionately high healthcare costs for these older Americans compared with other groups. Improved care for patients with multiple chronic conditions is one approach that has high potential for cost savings and improved care quality by reducing preventable hospitalizations and helping older adults with multiple chronic conditions have a higher quality of life and age in place. This can be especially important for older people served by two of our nation's largest social support programs: Medicare (administered by the federal government to provide health care for all Americans 65-years-old and older) and Medicaid (a program controlled largely by individual states and intended to support those who live in poverty). Although those who qualify for both programs account for only 20% of the older adult population, these "dual-eligible" individuals account for 34% of spending for each program.

#### **Policy Approaches that Work...**

- Incentivize innovative care models that value and support teams for complex high cost patients; provide infrastructure support and funding.
- Improve beneficiary access (with a focus on high-quality integrated care), especially for individuals who have dual eligibility for both Medicare and Medicaid.
- Identify the high-risk beneficiaries and as needed, provide outreach and services in the site of care that is most appropriate.
- Support person-centered care that addresses the comprehensive needs of those with multiple chronic conditions, including medications, behavioral health, and social needs/function. Focus on better outcomes and beneficiary satisfaction.
- Better align payment incentives with the care needs of the complex older adult.

#### **What's at Stake...**

Providing high-quality care for individuals with complex medical conditions requires skilled management of complex medical and medication regimens, coordination among care providers, support for social service providers, and work with older adults and their families to define individuals care goals. Older adults with complex healthcare needs receive care in multiple care settings, each structured based on funding and federal/state rules. Delivering high-quality, effective, efficient, and coordinated care requires policy solutions that will promote innovations, including the development of care models employing interdisciplinary geriatrics teams demonstrated to make a critical difference. These models are particularly

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effective for people living with multiple chronic conditions, since they help with preventing complications and enhancing the quality and efficiency of care across the healthcare continuum. Many existing programs (Comprehensive Primary Care Plus (CPC+), Hospital at Home (HaH), and Programs for All-Inclusive Care for the Elderly (PACE)) show great promise but are limited in scope and not universally available. We need to support expanding existing programs shown to improve care while also continuing to learn about best practices in providing quality care for older adults with complex needs.

### Learn More...

- [SNP Alliance: Integration of Medicare and Medicaid for Americans Dually Eligible for Both Programs](#)
- [Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid](#)

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### Issue 9: Addressing Structural Racism and Ageism

- **How do you plan to address the significant impact racism has on the health and well-being of people of color as they age?**
- **How will you ensure federally funded health research appropriately reflects the diversity (including race, ethnicity, age, and gender) of the American population?**
- **What are your plans for ensuring traditionally underrepresented racial and ethnic groups are vibrant parts of your team?**

#### **Why It Matters...**

A just society should strive to treat everyone as equals. Sadly, our society is marginalizing too many older people of color and minimizing their contributions. To live up to our ideals, we must work for justice and changes to policies that have allowed racism to persist.

Inequities in everything from the social determinants of health to care, medical research, and instances of violence not only expose inequities but also emphasize why action is critical. And though that action is vitally important to older people of color, it also does not begin at old age. Throughout their lives, people of color have poorer access to health care and receive services of lower quality than the general population. Starting in middle age, the toll becomes evident. Among Black people, for example, that means more chronic medical conditions, which worsen over time, and earlier deaths.

Racism also extends well beyond personal well-being to encompass professional advancement, too. In 2015, for example, only 7% of science and engineering doctorate holders employed as full-time, full professors at all institutions were from underrepresented racial and ethnic groups. Even the research that can shape both health and academic careers can be jeopardized by marginalization: Racial and ethnic minorities currently make up nearly 40% of the U.S. population, but estimates place their rates of inclusion in research studies at between 2% and 16%.

#### **Policy Approaches that Work...**

Everyone—including members of the public and private sectors—must do their part to stand against discrimination, harassment, prejudice, systemic injustice, and violence targeting any individual because of who they are—including their age, ancestry, creed, cultural background, disability, ethnic origin, gender, gender identity, immigration status, nationality, marital and/or familial status, primary language, race, religion, socioeconomic status, sex, and/or sexual orientation.

In health care, that means valuing the significant contributions of colleagues from diverse backgrounds to the care we all need as we age and ensuring they are vibrant members of organizational leadership. For the millions of older adults and caregivers living in the U.S., it also means opposing discrimination or disparate treatment of any kind in any healthcare or research setting because of age, ancestry, creed, cultural background, disability, ethnic origin, gender, gender identity, immigration status, nationality, marital and/or familial status,

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primary language, race, religion, socioeconomic status, and/or sexual orientation. Discriminatory policies—especially when they are perpetuated across the healthspan and lifespan—have a negative impact on public health for us all.

### What's at Stake...

Racism structures opportunity and assigns value inappropriately based on how a person looks. The result: Conditions that unfairly advantage some and unfairly disadvantage others. Racism hurts the health of our nation by preventing some people—including many older adults—from pursuing the opportunity to attain their highest level of health.

Racism may be intentional or unintentional. It operates at various levels in society. Racism is a driving force of the social determinants of health (like housing, education, and employment) and is a barrier to health equity. Even small and subtle acts of racial bias, such as being treated with less respect due to race, can lead to a host of health problems, including heart disease, clinical depression, low-birth-weight infants, poor sleep, obesity, and even mortality. The link between experiences of discrimination and illness has been documented among a variety of groups, including people who identify as African, Asian, Black, Latino, and Native American. These problems also do not go unnoticed by the general population: A 2015 poll found that an overwhelming 91% of Americans felt that racism remained a problem in the U.S.; 49% described it as a “big problem.”

### Learn More...

- [Addressing Unmet Caregiver Needs in Diverse Communities](#)
- [Racism and Health](#)
- [Addressing Law Enforcement Violence as a Public Health Issue](#)
- [Racial Profiling is a Public Health and Health Disparities Issue](#)

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## Questions for Our Candidates and Elected Officials on Supporting Us All as We Age

### Issue 10: Addressing COVID-19 and Public Health Emergencies

- **What will you do to protect the health, safety, and dignity of older adults residing in congregate living settings like nursing homes and assisted living facilities, where viral pandemics and their complications are often most pronounced?**
- **What will you do to empower health professionals, public health and infection control experts, patient advocates, and family representatives as those best positioned to mitigate the impact of lockdowns and restrictive visitation on mental and physical well-being for older adults residing in congregate living settings?**
- **How will you support caregivers and the direct care workforce during pandemics like COVID-19?**
- **How will you strengthen pay, benefits, and job stability for the direct care workforce in long-term care settings such that workers, residents, and facilities are more resilient to future public health threats, capable of providing high-quality care, and prepared to increase capacity as our population ages?**
- **What will you do to ensure we have adequate public health infrastructure and an expanded role for public health workers—particularly those with geriatrics expertise—in addressing future public health emergencies?**

#### Why It Matters...

No community has been left untouched by the devastating impact of COVID-19—but perhaps none more so than our older adult population. Among adults, the risk for severe illness from COVID-19 increases exponentially with age, as do serious health consequences. In fact, the risk for death and hospitalization is highest among older adults who have three or more underlying health conditions (such as hypertension, obesity, diabetes, cardiovascular disease, neurologic disease, chronic lung disease, renal disease, asthma, immune suppression, gastrointestinal/liver disease, and autoimmune disease) compared to all other populations.

Family members, friends, and caregivers feel the effects, as well—not only in protecting their own health but also in ensuring older adults are treated with dignity, respect, and attention to personal needs and preferences (many of which are not documented until it's too late). Pandemics often limit home-based and congregate support systems—including respite care and home health aides—straining resources and leading to potential burnout. Families sheltering in place with older adults may be serving as full-time caregivers for the first time, without access to supports and training needed to address these new roles.

Professionals who support and care for older people have worked valiantly to address these challenges, but they, too, are at risk. In some states, medical personnel account for as many as 20 percent of known coronavirus cases, not only contributing to the spread of the virus but also jeopardizing their own well-being. Many cases involve direct care workers, who are essential to care for older adults, especially during public health crises.

#### Policy Approaches that Work...

## Questions for Our Candidates and Elected Officials on Supporting Us All as We Age

As we have learned across many healthcare settings, epidemics impacting older people—particularly those in congregate living facilities—are a foreseeable consequence of public health emergencies, even when facilities and health professionals work valiantly and follow all guidelines. Policy solutions that work include those that:

- Address circumstances we can work to control—including the lack of available personal protective equipment and testing.
- Advance public health planning and infrastructure, particularly by involving experts in geriatrics and long-term care in evaluating data, plans, and protocols—especially those that can help keep the public informed in times of need.
- Steps that can support the broad range of health workers responsible for our care as we age. This means promoting recruitment, retention, and leadership for geriatrics health professionals and direct care workers through policies like paid leave, better training, and better screening during public health crises.
- Ensuring that our approaches to resource allocation—particularly when crises strain an already stretched health system—do not implicitly or explicitly discriminate based on age. Age should never be used to exclude someone categorically from a standard of care, nor should age “cut-offs” (or proxies for age, such as “life-years saved” or “long-term life expectancy”) be used in allocating resources. Programs and plans for administering treatments and prevention must be transparent, applied uniformly, and regularly (and rigorously) reviewed to maintain public trust. Ultimately, the just healthcare system we all need should treat similarly situated people equally, as much as possible.

### What’s at Stake...

Eight in 10 COVID-19 deaths in the U.S. claim adults 65 years old and older. Many of these older individuals reside in our nation’s more than 15,000 nursing homes and more than 28,000 assisted living facilities. The spread of coronavirus and other pandemics in these communities is not only pronounced but also pernicious: A majority of nursing home residents live with multiple chronic conditions and unique care needs even absent a pandemic, and have seen key lifelines to friends and family disappear as the virus continues to spread. Overall, people in long-term care facilities make up less than 10 percent of coronavirus cases, nearly half of all COVID-19 deaths.

Sadly, many plans for allocating scarce health resources during times of crisis apply age as a criterion. This disproportionately disfavors older people, raising concerns that we may be treated unjustly as we age when there is an emergent need to ration resources due to a crisis.

Public health challenges like the COVID-19 pandemic equally exacerbate existing gaps in expertise and systemic weaknesses in healthcare systems and services. Staff recruitment and retention in geriatrics and direct care are already difficult and will remain a challenge without increases in wages, provision of benefits, and the development of career ladders. The increase in positive cases also impacts staff capacity, as staff may become sick themselves or need time off to address childcare or tend to sick family members.

### Learn More...



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- [AGS Position Statement: Resource Allocation Strategies and Age-Related Considerations in the COVID-19 Era and Beyond](#)
- [Rationing Limited Health Care Resources in the COVID-19 Era and Beyond: Ethical Considerations Regarding Older Adults](#)
- [AGS Public Comments to National Academies of Science, Engineering, and Medicine Regarding Draft Framework for Equitable Allocation of a COVID-19 Vaccine](#)
- [AGS Policy Brief: COVID-19 and Nursing Homes](#)
- [AGS Policy Brief: COVID-19 and Assisted Living Facilities](#)
- [AGS Experts: Here's What Older Adults Need for a "Reopened" U.S. That Can Serve Us All as We Age](#)

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