"The Disproportionate Impact of COVID-19 on Communities of Color"
United States House of Representatives
Committee on Ways and Means

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Written Testimony Submitted By

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Thank you, Chairman Neal, Ranking Member Brady, and members of the Committee for the opportunity to submit testimony on the disproportionate impact of COVID-19 on communities of color in the United States.

We wish to focus our remarks on the state of the nation's public health data infrastructure, and specifically on addressing challenges related to data collection, reporting, and disaggregation by race, ethnicity, and other critically important demographic characteristics.

We lay out four key solutions, which are not exhaustive, that we believe this committee, the Congress, and the states – along with outside stakeholders and experts – must address swiftly in order to mitigate the immediate impacts of COVID-19 and, in the long-term, rebuild our national public health data infrastructure to help close the nation's unacceptable racial and ethnic health inequities.

What we choose to measure is a values statement. When we fail to comprehensively capture and report information about the impacts of COVID-19 and other morbidities on communities of color, these communities are erased. Why? Because, without accurate and timely disaggregated data, it is impossible for local health systems and policymakers, let alone Members of Congress, to deploy the health and related resources required to treat these communities and save lives. With smart policies created with cultural humility and sustained federal investments – modest by comparison to overall COVID-19 related

appropriations – Congress and the states can rebuild our data infrastructure to be prepared for future COVID-19 waves and address other racial and ethnic health inequities around the country.

Strengthen Data Standards

The Centers for Disease Control and Prevention (CDC) offers data collection and reporting guidelines to the states, but they are not mandated. Congress and outside experts, including many of the witnesses that have appeared before this committee on this topic, should work with the CDC to delineate the "gold standard" in data collection – especially with attention to categories of race, ethnicity, and primary language – and Congress should set that standard for the states to follow. In many areas, the American healthcare system is well served by the vast degree of variability in how states innovate and improve health outcomes based on their situations and needs. Standards for public health data collection and reporting is not one of those areas, especially in the context of a national health emergency. COVID-19 does not care which state you live in.

For the duration of the pandemic states and territories should be required, at a minimum, to collect COVID-19 data and report on race and ethnicity in accordance with current CDC guidelines (5 categories of race, 2 of ethnicity plus subcategories for race and ethnicity) for the amount of time needed to eliminate COVID-19 i.e., until a vaccine is developed and the national level of cases is at 0 for 6 months. Specifically, states and territories should:

- treat race and ethnicity as separate categories;
- include racial and ethnic subcategories; and
- report publicly on their websites and also to CDC in a standardized format.

Improve Reporting, Prioritize Accessibility to the Public

In addition to strengthening data standards, all states should be required to publicly report standardized data on their websites in a format that is accessible by the general public on a daily basis (or some frequency that is feasible and meaningful). At a minimum, this should include:

- COVID-19 confirmed cases, deaths, and testing by race, ethnicity, age, sex, underlying conditions, functional/disability status, and linguistic differences; and
- COVID-19 rates at the county/zip-code level with an overlay of county/zip-code level socioeconomic status, racial and ethnic makeup of the population expressed in percentages.

States should be required to submit this data to CDC on a daily basis. Congress can play an important role in helping to close another gap that directly contributes to some of the missing and inaccurate data currently being reported out of the states: mandate the reporting of racial and ethnic data for all COVID-19 diagnostic tests – from clinician/testing sites to labs; and from labs to states. This data is already in the patient's health record, but it is not being systematically reported with testing orders; or it is not being recorded at the testing site (if the patient's health record is not available); or it is not being reported with test results to state public health agencies.

In addition, states and territories should be required to report on a daily or at most a weekly basis:

- Metrics of health care access to inform resource allocation decisions, including county/zip-code level Health Professional Shortage Areas (HPSAs) and medically underserved areas, testing, screening, contact tracing, PPE availability, essential health and non-health workforce, treatments, and ultimately, vaccinations.

COVID-19 has revealed how poorly we do as a nation in sharing public health information in a digestible way to the public, advocates, non-profits, and other stakeholders working in the health system to improve and save lives. Mapping, dashboards, and other forms of data visualization are needed to not only assist decision-makers in recognizing the current burden and identify hot spots as they emerge, but to ensure transparency about which communities are being impacted by COVID-19 and how. Several notable efforts have launched in recent months to address this challenge, including The COVID Tracking Project and a new effort underway within the Satcher Health Leadership Institute at Morehouse School of Medicine to create a comprehensive, public-facing data platform to enable the real-time COVID-19 collection and study of detailed demographic data about the communities of color that are being hit hardest by the pandemic. This initiative is expected to get to the root causes of why these communities have been so disproportionately harmed by COVID-19.

Grow Cultural Competency in Our Public Health System

For historic reasons and due to persistent racism in the current healthcare delivery system, state and local health officials and other healthcare providers must redouble efforts to overcome deep mistrust in communities of color. Many of the recommendations highlighted above depend in part on the willingness of patients of color to identify and share demographic information with health care providers, test clinicians, contact tracers, and others. Investing in the wider-scale development and use of culturally tailored information, training resources, and linguistically appropriate

interventions – including for people with hearing, visual, and cognitive impairments – is critical. Moreover, Congress must invest in the pipeline of future health care employees, including the frontline clinicians and contact tracers, who must represent the increasingly diverse America of the 21st Century. Cultural congruency of our workforce is a key driver for improved health outcomes going forward.

Sustainably Invest in State and County Public Health Infrastructure

State and community public health infrastructure – the staff and systems needed to carry out these recommendations – have been drastically underfunded for years. This disinvestment by both the federal government and the states serves to compound the barriers to uncovering the full impacts of COVID-19 on communities of color.

Federal funding should go to states and cities to build this capacity – with specific guidelines for the use of funds; for instance, in addition to meeting data collection and reporting standards, increasing epidemiology staff, contact tracing, and investigative staff as well as accessible reporting platforms and dashboards. In addition, the federal government and states must invest in the capacity and funding for their community partners: health workers, nonprofits, and social services agencies, which play a complementary and vital role in reaching the communities who are most at risk of not being counted during this health crisis.

Thank you again for the opportunity to submit testimony.