Good morning Chairman Neal, Ranking Member Brady, and Members of the Committee. Thank you for the invitation to testify before you today. My name is Alicia Fernandez. I am a physician and a professor of medicine at UC San Francisco (UCSF) and a health services researcher with expertise in immigrant health and language barriers in healthcare. As a Latina immigrant myself, it has been wonderfully rewarding to be an internist at Zuckerberg San Francisco General (ZSFG), the public hospital for San Francisco City and County, as I care there for a highly diverse patient population. It is an honor to share with you today my thoughts on Latino and immigrant disparities in health and healthcare associated with the COVID-19 pandemic.

As you know, states throughout the country are reporting disproportionate COVID-19 hospitalizations and deaths among Latinos. This disparity is even starker when the data are adjusted for age. [1] Our experience in San Francisco, an area of the country that was spared from the worst effects of this pandemic, may provide a window to understand and mitigate COVID-19 health disparities.

Early on, the physicians at ZSFG realized that there was a significant outbreak among Latinos in our city. When my colleagues analyzed data from the first 70 COVID-19 patients hospitalized at ZSFG, they found that 83% were Latinx. By comparison, only 35% of hospitalizations at ZSFG are typically Latinx. The majority of the patients were men; their median age was 47y; and nearly all were working despite the shelter in place order. [2] The prototypical COVID-19 patient in our

hospital is a Latino middle age man with diabetes, a low-wage worker who is continuing to work.

This stunning over-representation of Latinos prompted UCSF researchers to partner with a coalition of community groups to conduct an important study. The Unidos en Salud study, led by UCSF's Dr. Diane Havlir, set out to test everyone living or working in one specific census tract in the Mission District, San Francisco's historically Latino neighborhood. [3] Over four days, the study tested about 3000 people in tents set up in local parks. They successful reached over 57% of household in the census tract.

Their results are telling. In this ethnically diverse, rapidly gentrifying area, while only 44% of those tested were Latino, 95% of those who tested positive were Latinos. The COVID-19 prevalence among Latinos was about 5%. By contrast, the prevalence among their white neighbors was 0%. A short questionnaire revealed that 90% of those testing COVID-19 positive were unable to work from home, compared to 57% of the entire sample. In fact, the rate of infection was highest among who came to the area to work. The most common occupations among the COVID-19 positive participants was restaurant and janitorial jobs.

COVID-19 has laid bare the great health impact of how we work and live, the 'social determinants of health'. The need to leave home to work, because of both the demands on essential workforce and low-wage worker's intense financial need, is the clearest driver of COVID-19 disparities among Latinos and among many immigrants. Emerging data indicate that the need to leave home to work drives infection throughout the country; it is equally true in

food processing plants in the mid-west and among front-line nursing home workers in the hard-hit northeast.

The second important driver of Latinx disparities is congregate living. Those who tested positive in the Unidos en Salud study had larger household sizes than those who tested negative. This partly reflects larger families and multigenerational living. A working family member might bring home the virus to vulnerable elders. In other cases, economic necessity drives congregate living among unrelated adults. One of my own patients, recently extubated after 2 weeks on a ventilator, rents a single room with her daughter in a flat that they share with eight other unrelated adults, sharing one kitchen and two small bathrooms. She believes she contracted COVID-19 from one of the men who needed to go out to work. Dense housing occupancy, often because of low-wages and high rents, is most likely the second driver of Latino disparities nationally.

Understanding these drivers of these disparities points us toward mitigation strategies. The key elements of COVID-19 management for all are prevention, testing and treating, isolation and quarantine, and contact tracing. In considering Latinx or immigrant disparities, I believe there are 5 important points to consider.

Monitor Disparities and Target Public Health Interventions by Race, Ethnicity and Language

1. Require complete and comprehensive data on testing, infections, hospitalization and deaths by race, ethnicity and preferred language, so called REAL data. Race and ethnicity data are essential. We must also require comprehensive data on preferred language. Language, already mandated for collection in healthcare settings, offers

invaluable guidance to public health departments targeting prevention and testing education or contact tracing, and can additionally inform our understanding of the virus' paths among social networks.

Protect Industries, Small Businesses, Workers and Their Families

2. Protect industries, small businesses, and workers by mandating safe distancing and use of appropriate personal protective equipment. Enforcing these key prevention measures safeguards industries with enormous national importance such as healthcare, agriculture and food processing, as well as protecting workers, their households, and the broader community. Small businesses play a particularly important role in many Latinx communities; addressing disparities will require targeted economic relief to small businesses and that we provide them with clear public health guidance to prevent them from becoming vectors for contagion.

3. Extend CARES act paid sick and family leave economic provisions to small businesses, healthcare workers, and large corporations. Without wage replacement, many low-wage workers with mild symptoms will continue to work, as will many asymptomatic contacts who should stay home for 14 days. Wage replacement is a necessary measure to support isolation and quarantine, key public health activities, so these funds must be available to all workers with low household incomes and no access to paid sick leave, regardless of their immigration status.

Public Health Measures Require Trust and Understanding: The Linguistically and Culturally Competent Workforce We Need

4. Support local communities' efforts to test, isolate and quarantine, and conduct effective contact tracing by supporting public health and researchers' efforts to engage authentically and consistently with community organizations, advocacy groups, and underserved communities. Effective contact tracing is key to all virus containment strategies and it depends on trust. Contact tracers call patients and ask them, "tell me everyone you have been in contact with starting two days before you became ill". For many individuals, this question evokes fear and worry. They might wonder: "Should I share the names of others who might be working informally? What if some of the people I work with are undocumented, or live in mixed-immigration status families? What will the authorities do with this information? For immigrants from Latin America, prior experiences with authoritarian governments may make them very hesitate to respond. Choosing to answer this question truthfully requires both trust in public health authorities, and comprehension of the need for complete answers.

   My team's research, and that of others, has found that trust, comprehension and even some medical outcomes are much easier to achieve when the clinician and patient speak the same language. [4] [5] Reports of lack of trust are twice as frequent when patients and doctors do not speak the same language. [6] Conversely, language concordance between patient and physician results in twice as many people reporting understanding emergency room discharge instructions, even when compared with use

of the best of professional interpreters.[7] And, blood sugar control among Spanish speaking patients with diabetes improves when they switch to a primary care doctor who speaks Spanish. [8] In short, for effective contact tracing and community education we need to support health systems and public health departments' efforts to train and deploy linguistically and culturally competent contact tracers and community health workers.

Trust will also be enhanced if contact tracers can attest that all information will be kept separate from immigration authorities and if the US Immigration and Customs Enforcement (ICE) extends its suspension of public charge consequences from COVID-19 testing to also include COVID-19 treatment and services received to support legally mandated isolation or quarantine.

Mitigate Predictable and Preventable Healthcare Disparities Stemming from COVID-19

5. Support health systems so they can provide all patients high quality and equitable treatment along the continuum of care at a time of great economic need. Economic support to safety net, rural, and individual providers who care for these vulnerable populations is critical. New practices require monitoring for disparities. Telehealth, the practice of caring for patients by phone or video, can mitigate some disparities but may exacerbate others.[9] Telehealth heightens the need to self-triage and self-monitor chronic disease, a difficult task made more difficult among communities with low education and health literacy or the poor digital literacy that is commonly associated

with age. Telehealth also exacerbates the difficulties of caring for patients across language barriers. Last week, I cared for a Cantonese-speaking patient by phone, with the assistance of a phone interpreter. It is very difficult to adjust insulin dosing this way, even when you know the patient well and the interpreters are excellent. Health systems need to monitor and address the disparities exacerbated by telehealth and to re-organize their care delivery systems to make telehealth and other broadly used services as accessible and patient centered as possible. Health systems will also need support to identify and address social needs.

Summary

COVID-19 has revealed that how we work and live has enormous impact on health. Reducing health disparities will require a long-term effort to address these social inequities. Yet there are steps we can take now that can help us be more effective in our response to this pandemic. The public health and clinical-care oriented measures I describe could reduce the impact of COVID-19 on vulnerable populations and keep us all healthier and safer. Thank you for your attention.

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