National Council of Asian Pacific Islander Physicians

June 9, 2020

Ways and Means Committee
U.S. House of Representatives
Washington DC 20515

Dear Chair Richard Neal, Ranking Member Kevin Brady, and Committee Members:

The National Council of Asian Pacific Islander Physicians (NCAPIP) submits this statement for inclusion in the record for your May 27, 2020 hearing on the Disproportionate Impact of COVID-19 on Communities of Color. NCAPIP commends the House Ways and Means Committee for highlighting the disproportionate impact of COVID-19 on communities of color, specifically on Black,[1] Latinx,[2] American Indian,[3] Native Hawaiian, and Pacific Islander populations.[4] We urge this Committee to ensure the allocation of the necessary federal government resources and support to reduce these avoidable disparities.

About NCAPIP
The National Council of Asian Pacific Islander Physicians (NCAPIP) is a national health policy organization that represents physicians committed to the advancement of the health and well-being of Asian American, Native Hawaiian, and Pacific Islander communities. NCAPIP's board members and physician networks include leaders of national, state, and local physician organizations, medical groups, and independent practice associations. NCAPIP's board members and physician networks include both primary care physicians (general internists, family physicians, and pediatricians) as well as specialty physicians. NCAPIP's board members and physician networks practice in a variety of settings, including solo and small group physician practices, multi-specialty medical groups, community health centers, local health departments, private and public hospitals, integrated health delivery systems, and academic health centers. The physicians represented by NCAPIP serve patients from diverse racial and ethnic backgrounds, and are committed to the elimination of racial and ethnic and other disparities in health care and health status for all Americans.

Understand the Disproportionate Impact of COVID-19 on Asian Americans and Pacific Islanders
NCAPIP has compiled data from state and county health departments that shows the disproportionate impact of COVID-19 on Asian Americans, and on Native Hawaiians and Pacific Islander, where the reported percentage of COVID-19 cases and/or deaths exceed the percentage of Asian Americans, or Native Hawaiians and Pacific Islanders, residing in that state or county:

[1] Eligon J, Burch ADS, Searcey D, Oppel RA. Black Americans face alarming rates of coronavirus infection in some states. New York Times, April 7, 2020, https://www.nytimes.com/2020/04/07/us/coronavirus-race.html; Thebault R, Tran AB, Williams V. The coronavirus is infecting and killing African Americans at an alarming rate. Washington Post April 7, 2020, https://www.washingtonpost.com/nation/2020/04/07/coronavirus-is-infecting-killing-black-americans-an-alarmingly-high-rate-post-analysis-shows/?arc404=true; Yancy CW. COVID-19 and African Americans. JAMA. 2020;323(19):1891-1892
[2] Jordan M, Oppel RA. For Latinos and COVID-19, doctors are seeing an 'alarming' disparity. New York Times, May 9, 2020, https://www.nytimes.com/2020/05/07/us/coronavirus-latinos-disparity.html
[3] Akee R. COVID-19 impact on indigenous people in the U.S. EconFact, May 12, 2020, https://www.pbs.org/newshour/nation/how-covid-19-is-impacting-indigenous-peoples-in-the-u-s
[4] Pacific Islander COVID-19 Response Team, https://pi-copce.org/covid19response/

National Council of Asian Pacific Islander Physicians

National Council of Asian Pacific Islander Physicians
COVID-19 Data for Asians Reported as of May 25, 2020

State	Asian Percent of State Population	Number of Asians Residing in the State	Percent of Cases	Number of Cases	Percent of Hospital-izations	Number of Hospital-izations	Percentage of Deaths	Number of Deaths
Alaska	6.3	46,381	11.7	46	No race data reported		No race data reported	
Arkansas	1.6	47,548	1.1	61	No race data reported		No race data reported	
Caiifornia	14.7	5,821,585	9.9	6,571	No race data reported		14.8	531
Colorado	3.2	180,277	2.7	650	No race data reported		3.9	52
Hawaii	37.6	534,479	33.0	199	No race data reported		No race data reported	
Idaho	1.5	27,026	2.3	45	No race data reported		2.6	2
Iowa	2.5	79,971	9.0*	?	No race data reported		No race data reported	
Kansas	2.8	82,444	7.8	575	No race data reported		1.7	3
Kentucky	1.5	65,300	5.7	?	No data reported		No race data reported	
Nevada	8.2	250,137	11.8	603	No data reported		No race data reported	
New Hampshire	2.7	36,048	3.0	80	3.5	11	0.0	0
Oregon	4.6	190,680	4.1	135	No race data reported		No race data reported	
South Dakota	1.7	15,023	11.5	525	No race data reported		No race data reported	
Tennessee	1.8	119,046	2.6	390	No race data reported		2.1	7
Utah	2.4	75,898	2.4	203	?	12	No race data reported	
Washington	8.8	661,781	7.7	1,073	8.8	206	9.6	91
Wisconsin	2.8	165,380	3.8*	586*	No race data reported		2.5*	13*

County	Asian Percent of County Population	Number of Asians Residing in the County	Percent of Cases	Number of Cases	Percent of Hospital-izations	Number of Hospital-izations	Percentage of Deaths	Number of Deaths
King County, WA	17.9	399,090	12.5	742	12.1	150	13.6	72
San Francicso County, CA	34.3	302,795	19.0	307	No race data reported		47.4	18
San Diego County, CA	12.0	401,745	7.2	391	7.8	90	7.6	18

Rates higher than Asian percentage of population
American Community Survey 2018 1-Year Estimates Table DP05 Asian Race Alone (undercount without Asian in combination with other races)
https://data.census.gov/cedsci/table?tid=ACSDP1Y2018.DP05&hidePreview=true&vintage=2010&table=DP05
https://covidtracking.com/data
? Case count or percentage unknown because demonimator not provided
*Combined Asian and Native Hawaiian and Pacific Islander

National Council of Asian Pacific Islander Physicians
COVID-19 Data for Native Hawaiians and Pacific Islanders Reported as of May 25, 2020

State	Native Hawaiian and Pacific Islander Percent of State Population	Number of Native Hawaiians and Pacific Islanders Residing in the State	Percent of Cases	Number of Cases	Percent of Hospital-izations	Number of Hospital-izations	Percentage of Deaths	Number of Deaths
Alaska	1.1	7,598	3.6	14	No race data reported		No race data reported	
Arkansas	0.3	9,398	3.3	183	No race data reported		No race data reported	
Caiifornia	0.4	155,739	0.9	573	No race data reported		0.8	28
Colorado	0.1	7,585	0.4	99	No race data reported		0.3	4
Hawaii	10.2	144,971	17.0	102	No race data reported		No race data reported	
Idaho	0.2	2,763	0.2	4	No race data reported		No NHPI data reported	
Iowa	0.1	3,463	Combined with Asian		No race data reported		No race data reported	
Kansas	0.1	2,929	No NHPI data reported		No race data reported		No NHPI data reported	
Kentucky	0.1	4,943	0.1	?	No data reported		No race data reported	
Nevada	0.6	19,612	No NHPI data reported		No data reported		No race data reported	
New Hampshire	0.0	515	No NHPI data reported		No NHPI data reported		No NHPI data reported	
Oregon	0.4	18,758	1.4	47	No race data reported		No race data reported	
South Dakota	0.0	51	No NHPI data reported		No race data reported		No race data reported	
Tennessee	0.1	5,494	No NHPI data reported		No race data reported		No NHPI data reported	
Utah	0.9	29,362	3.7	319	?	40	No race data reported	
Washington	0.7	53,924	2.3	322	2.1	50	0.7	7
Wisconsin	0.0	1,961	Combined with Asian		No race data reported		Combined with Asian	

County	Native Hawaiian and Pacific Islander Percent of County Population	Number of Native Hawaiians and Pacific Islanders Residing in the County	Percent of Cases	Number of Cases	Percent of Hospitaliza-tions	Number of Hospitaliza-tions	Percentage of Deaths	Number of Deaths
King County, WA	0.8	17,343	2.5	146	1.9	24	0.8	4
San Francisco County, CA	0.2	2,126	1.9	30	No race data reported		No NHPI data reported	
San Diego County, CA	0.4	13,943	0.8	43	1.2	14	1.3	3

Rates higher than Native Hawaiian and Pacific Islander percentage of population
American Community Survey 2018 1-Year Estimates Table DP05 Native Hawaiian and Pacific Islander Race Alone
(undercount without NHPI in combination with other races)
https://data.census.gov/cedsci/table?tid=ACSDP1Y2018.DP05&hidePreview=true&vintage=2010&table=DP05
https://covidtracking.com/data
? Case count or percentage unknown because denominator not provided

In summary, as of May 25, 2020, these data show that in fourteen states, the percentage of COVID-19 cases and/or deaths among Asian Americans is higher than the percentage of Asian American residents in that state. In addition, in eight states, the percentage of COVID-19 cases and/or deaths among Native Hawaiians and Pacific Islanders is higher than the percentage of Native Hawaiian and Pacific Islander residents in that state. Better understanding of these data is vital to controlling the spread and reducing the disproportionate impact of COVID-19 among racial and ethnic communities.

NCAPIP would like to commend the Hawaii Department of Health for being the first state health department to disaggregate its COVID-19 data by Asian American and by Native Hawaiian and Pacific Islander subgroups, which highlights the disproportionate impact on Pacific Islanders (13% of cases compared to 4% of state residents):[5]

Race	Case Count	Case %	State Population %	State Population
White**	160	28%	25%	350,642
Native Hawaiian†	76	13%	21%	291,645
Pacific Islander	72	13%	4%	56,304
Filipino	122	21%	16%	222,369
Japanese	65	11%	15%	208,338
Chinese	24	4%	4%	62,505
Other Asian	25	4%	4%	51,304
Black	7	1%	2%	31,557
Other	17	3%	8%	118,087
Grand Total	568	100%	100%	1,392,751

However, NCAPIP notes that many state health departments are still not reporting COVID-19 data about Asian Americans, or about Native Hawaiians and Pacific Islanders:

National Council of Asian Pacific Islander Physicians
Missing COVID-19 Data for Asians Updated 6-8-2020

State/Jurisdiction	Asian Percent of State Population	Number of Asians Residing in the State	Percent of Cases	Number of Cases	Percentage of Deaths	Number of Deaths
Alaska	6.3	46,381	9.4	53	No race data reported	
Florida	2.8	593,634	No race data reported		No race data reported	
Hawaii	37.6	534,479	42.8	236	No race data reported	
Louisiana	1.6	76,255	No race data reported		0.8	16
Missouri	2.0	121,417	No Asian data reported		No Asian data reported	
Montana	0.8	8,517	No race data reported		No race data reported	
Nebraska	2.4	45,779	No race data reported		No race data reported	
New Mexico	1.6	34,155	1.3	55	No race data reported	
New York	8.5	1,666,133	No race data reported		5.0-7.0	?
North Dakota	1.8	13,749	No race data reported		No race data reported	
Rhode Island	3.4	36,064	No Asian data reported		No Asian data reported	
South Dakota	1.7	15,023	11.6	639	No race data reported	
Utah	2.4	75,898	2.4	301	No race data reported	
Virginia	6.5	555,422	No Asian data reported		No Asian data reported	
West Virgina	0.7	13,459	No Asian data reported		No race data reported	

American Community Survey 2018 1-Year Estimates Table DP05 Asian Race Alone
(undercount without Asian in combination with other races)
https://data.census.gov/cedsci/table?tid=ACSDP1Y2018.DP05&hidePreview=true&vintage=2010&table=DP05
https://covidtracking.com/data
Percentages exclude cases/deaths with unknown race when full data available
? Case count unknown because demonimator not provided

[5] https://health.hawaii.gov/coronavirusdisease2019/what-you-should-know/current-situation-in-hawaii/#race (as of June 8, 2020)

National Council of Asian Pacific Islander Physicians
Missing COVID-19 Data for Native Hawaiians and Pacific Islanders Updated 6-8-20

State/Jurisdiction	Native Hawaiian and Pacific Islander Percent of State Population	Number of Native Hawaiians and Pacific Islanders Residing in the State	Percent of Cases	Number of Cases	Percentage of Deaths	Number of Deaths
Alabama	0.0	1,797	No NHPI data reported		No NHPI data reported	
Alaska	1.1	7,598	2.8	16	No race data reported	
Arizona	0.2	15,661	Combined with Asian		Combined with Asian	
Connecticut	0.0	1,017	No NHPI data reported		No NHPI data reported	
Delaware	0.1	896	Combined with Asian		Combined with Asian	
District of Columbia	0.1	397	0.3	23	No NHPI data reported	
Florida	0.1	12,841	No race data reported		No race data reported	
Hawaii	10.2	144,971	26.9	148	No race data reported	
Indiana	0.1	3,470	No NHPI data reported		No NHPI data reported	
Iowa	0.1	3,463	Combined with Asian		Combined with Asian	
Kansas	0.1	2,929	No NHPI data reported		No NHPI data reported	
Kentucky	0.1	4,943	0.2	?	No NHPI data reported	
Louisiana	0.0	1,133	No race data reported		0.3	5
Maryland	0.1	7,311	No NHPI data reported		No NHPI data reported	
Massachusetts	0.0	2,775	No NHPI data reported		No NHPI data reported	
Michigan	0.0	3,907	Combined with Asian		Combined with Asian	
Mississippi	0.0	1,372	No NHPI data reported		No NHPI data reported	
Missouri	0.1	7,385	No NHPI data reported		No NHPI data reported	
Montana	0.1	990	No race data reported		No race data reported	
Nebraska	0.1	1,289	No race data reported		No race data reported	
Nevada	0.6	19,612	No NHPI data reported		No NHPI data reported	
New Hampshire	0.0	515	No NHPI data reported		No NHPI data reported	
New Jersey	0.0	2,909	No NHPI data reported		No NHPI data reported	
New Mexico	0.1	2,465	No NHPI data reported		No race data reported	
New York	0.0	9,424	No race data reported		No NHPI data reported	
North Dakota	0.0	339	No race data reported		No race data reported	
Oklahoma	0.1	3,859	Combined with Asian		Combined with Asian	
Pennsylvania	0.0	5,008	No NHPI data reported		No NHPI data reported	
Rhode Island	0.1	863	No NHPI data reported		No NHPI data reported	
South Carolina	0.1	4,004	Combined with Asian		No NHPI data reported	
South Dakota	0.0	51	No NHPI data reported		No race data reported	
Tennessee	0.1	5,494	No NHPI data reported		No NHPI data reported	
Texas	0.1	21,483	No NHPI data reported		No NHPI data reported	
Utah	0.9	29,362	3.9	478	No race data reported	
Vermont	0.0	139	No NHPI data reported		No NHPI data reported	
Virginia	0.1	5,659	No NHPI data reported		No NHPI data reported	
West Virgina	0.0	451	No NHPI data reported		No race data reported	
Wisconsin	0.0	1,961	Combined with Asian		Combined with Asian	
Wyoming	0.2	1,111	No NHPI data reported		No NHPI data reported	

American Community Survey 2018 1-Year Estimates Table DP05 Native Hawaiian and Pacific Islander Race Alone (undercount without NHPI in combination with other races)
https://data.census.gov/cedsci/table?tid=ACSDP1Y2018.DP05&hidePreview=true&vintage=2010&table=DP05
https://covidtracking.com/data
Percentages exclude cases/deaths with unknown race when full data available
? Case count unknown because denominator not provided

As of this week, ten state health departments are still not reporting COVID-19 case data for Asian Americans, and thirteen state health departments are still not reporting COVID-19 deaths for Asian Americans. An additional seven health departments continue to report COVID-18 data for Asian Americans and for Native Hawaiians and Pacific Islanders combined, in violation of Office of Management and Budget (OMB) data standards.[6]

Most concerning is the fact that twenty-seven state health departments are not reporting COVID-19 cases for Native Hawaiians and Pacific Islanders, and thirty-two state health departments are not reporting COVID-19 deaths for Native Hawaiians and Pacific Islanders.

[6] Office of Management and Budget, Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity, 62 Fed. Reg. 58782-58790, October 30, 1997, https://www.govinfo.gov/content/pkg/FR-1997-10-30/pdf/97-28653.pdf

NCAPIP urges the Centers for Disease Control and Prevention to work with, and provide technical assistance to, territorial, tribal, state, and local health departments in collecting and reporting data about COVID-19 cases, hospitalization, and deaths for Asian Americans and for Native Hawaiians and Pacific Islanders.[7] At a minimum, data should be reported for all six OMB race and ethnicity categories, including Native Hawaiians and Pacific Islanders. NCAPIP also encourages collection and reporting of more granular race and ethnicity, primary language, disability, sexual orientation, gender identity, and social and behavioral risk factor data related to COVID-19.

Address Impact of COVID-19 on Asian American and Pacific Islander Physicians
The disproportionate impact of COVID-19 is not just being experienced by Asian American and by Native Hawaiian and Pacific Islander patients and communities but also by the Asian American and Pacific Islander physicians that NCAPIP represents. NCAPIP has highlighted the unique contributions and importance of solo and small group practice physicians, especially in communities of color. Three out of every four ambulatory care visits are made to physician practices with five or less physicians.[8] Solo and small group practice physicians are essential health care providers, especially in racial and ethnic communities.[9]

The emergency economic relief measures enacted by Congress and implemented by the Department of Health and Human Services, including the Medicare Provider Relief Fund, advance Medicare payments, and eligibility for the Paycheck Protection Program and Economic Injury Disaster Loan, have provided some limited, short-term relief to solo and small group physician practices.[10] However, many solo and small group physician practices have struggled to remain open and economically viable.[11]

For example, while large medical groups and physician practices affiliated with hospital and health systems have been able to shift much of their office-based visits to telehealth and virtual visits, solo and small group physician practices, especially in racial and ethnic communities, do not have the infrastructure and technology to make such a shift.

In recent years, NCAPIP has documented the significant barriers and challenges that solo and small group physician practices faced in adopting electronic medical record systems, and then in implementing practice transformation through initiatives such as the Centers for Medicare and Medicaid Services (CMS) Transforming Clinical Practices Initiative (TCPI), and payment mechanisms such as the Quality Payment Program (QPP) established by the Medicare Access and Children's Health Insurance Program Reauthorization Act (MACRA).

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[7] National Council of Asian Pacific Islander Physicians, Recommendations for Comprehensive Patient Demographic Data Collection and Reporting for COVID-19 Testing and Treatment, April 2020, https://mcusercontent.com/d7f02dd24377959c916d14de6/files/52d07c5c-2317-433c-ab3a-a7639cb8ed21/NCAPIP_Recommendations_for_Patient_Demographic_Data_Related_to_COVID_19_April_2020.pdf

[8] Rui P, Hing E, Okeyode T. National Ambulatory Medical Care Survey: 2014 State and National Summary Tables, http://www.cdc.gov/nchs/ahcd/ahcd_products.htm

[9] NCAPIP, Asian American Physicians in Solo and Small Group Primary Care Practices: Essential Health Care Providers for Our Communities, 2012, http://s3.amazonaws.com/NCAPIPportalDocfiles/NCAPIP_Report_Asian_Primary_Care_Practices.pdf; NCAPIP, Accessible and Affordable Health Care for Asian Americans: Post-Marketplace Challenges and Recommendations from Physicians, 2016 http://www.ncapip.org/resources/REGIONAL-MTGS-REPORT-APRIL-2016.pdf

[10] American Medical Association, Financial & business operations during COVID-19: Guidance for physicians, https://www.ama-assn.org/practice-management/sustainability/financial-business-operations-during-covid-19-guidance

[11] Shelley D. Chang JE, Lai AY, Nguyen A, Berry C. Independent primary care practices are small businesses, too. Health Affairs Blog, May 21, 2020, https://www.healthaffairs.org/do/10.1377/hblog20200518.930748/full/; Abelson R. Doctors without patients: 'Our waiting rooms are like ghost towns'. New York Times, May 5, 2020, https://www.nytimes.com/2020/05/05/health/coronavirus-primary-care-doctor.html

Solo and small group physician practices need more intensive and more sustained technical assistance to implement practice improvement activities successfully.[12] Accordingly, NCAPIP strongly encourages that that additional technical assistance to support telehealth be specifically provided to solo and small group physician practices, practices in rural areas, and practices in Health Professions Shortage Areas (HPSAs) and Medically Underserved Areas (MUAs), similar to the Small, Underserved and Rural Support Initiative in the MACRA QPP.[13] NCAPIP also encourages CMS to contract with and directly fund independent practice associations and medical groups, local medical associations, and racial and ethnic medical associations to provide such technical assistance.[14] NCAPIP also supports the funding and provision of such technical assistance through quality improvement organizations, regional and local extension centers, and regional health collaboratives. We also urge CMS to encourage its existing technical assistance providers to subcontract with racial and ethnic medical associations to engage their members and support their participation in activities such as transitioning to telehealth. Finally, NCAPIP urges that funded technical assistance providers be held accountable for successfully conducting outreach, engaging, and completing technical assistance to such practices.

Conduct Culturally and Linguistically Appropriate Community Education Explaining COVID-19 Contact Tracing

As the implementation of COVID-19 contact tracing programs increases nationwide,[15] there is an immediate need for plain language and culturally and linguistically appropriate community education materials in multiple languages and multiple formats explaining what COVID-19 contact tracing is, and how to comply with a contact tracing protocol. The Centers for Disease Control and Prevention (CDC) acknowledges that communication with the public about COVID-19 contact tracing is critical:

> Engagement of the public with contact tracers must be widely accepted in order to protect friends, family, and community members from future potential infections. Key public officials and community leaders will need to be engaged and supportive of contact tracing efforts. Consider reaching out to community leaders as part of the neighborhood-level contact tracing team. To be successful, a community will need public awareness, and understanding and acceptance of contact tracing and the need for contacts to separate themselves from others who are not exposed. Community members need to take responsibility to follow the guidance from public health agencies.[16]

The CDC's interim guidance on COVID-19 contact tracing, issued on May 15, 2020, states:

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[12] National Committee for Quality Assurance, Supporting Small Practices: Lessons for Health Reform, 2009, https://www2.massgeneral.org/disparitiessolutions/z_files/NCQA_Small_Practices_Report.pdf; Weinick RM, Byron SC, Han ES. French JB, Scholle SH. Reducing disparities and improving quality: Understanding the needs of small primary care practices. *Ethn Dis.* (2010);20(1):58–63; Takach M, Gauthier A, Sims-Kastelein K, Kaye N. Strengthening Primary and Chronic Care: State Innovations to Transform and Link Small Practices, National Academy for State Health Policy, 2010, http://www.nashp.org/sites/default/files/state.innovations.to_.transform.link_.small_.practices_0.pdf

[13] https://qpp.cms.gov/about/small-underserved-rural-practices

[14] Lake TK, Higgins TC, Ginsburg PA. Fostering Health Information Technology in Small Physician Practices: Lessons from Independent Practice Associations. National Institute for Health Care Reform Research Brief Number 5, 2011, http://nihcr.org/wp-content/uploads/2015/03/NIHCR_Research_Brief_No._5.pdf; Abrams M, Schor EL, Schoenbaum S. How physician practices could share personnel and resources to support medical homes. Health Aff. 2010; 29(6);1194-1199; Highsmith N. Creating Physician-Support Entities in Medicaid. Center for Health Care Strategies Policy Brief, 2011, http://www.chcs.org/usr_doc/CMWF_Shared_Support_Practices_FINAL.pdf; Highsmith N, Berenson J. Driving Value in Medicaid Primary Care: The Role of Shared Support Networks for Physician Practices, Center for Health Care Strategies, 2011, http://www.chcs.org/media/PCP-Shared-Support-Networks-Report.pdf

[15] Alltucker K, O'Donnell J. '50 states, 50 different approaches': States scramble to hire COVID-19 contact tracers. USA Today, May 13, 2020, https://www.usatoday.com/story/news/health/2020/05/13/coronavirus-states-scramble-hire-covid-19-contact-tracers/3088014001/

[16] https://www.cdc.gov/coronavirus/2019-ncov/php/principles-contact-tracing.html

> Culturally and linguistically diverse minority populations are growing in the United States. These populations include racial and ethnic minorities, members of tribal nations, immigrants (i.e., those born outside the United States) and refugees. They may be at higher risk for COVID-19 or worse health outcomes due to a number of reasons including living conditions, work circumstances, underlying health conditions, and limited access to care.
>
> It is important that case investigations and contact tracing are conducted in a culturally appropriate manner, which includes meaningfully engaging community representatives from affected communities, collaborating with community-serving organizations, respecting the cultural practices in the community, and taking into consideration the social, economic and immigration contexts in which these communities live and work.[17]

Physicians from racial and ethnic and other medically underserved communities can be credible and trusted spokespersons to help educate communities about COVID-19 contact tracing. Health departments should be immediately partnering with local medical societies, state medical associations, and racial and ethnic physician organizations to conduct community education about COVID-19 contact tracing.[18]

Provide Culturally and Linguistically Appropriate Information about COVID-19 Contact Tracing

Since the essential elements of any COVID-19 contact tracing program should be the same, there could be standardization of community education materials, both in plain language English, translated into multiple languages spoken throughout the U.S., and made available in multiple formats for individuals with disabilities.

To date, the CDC has made some general community education materials about COVID-19 available in multiple languages, although not all the materials are available in all languages.[19] State and local health departments and community and volunteer efforts have supplemented these CDC materials with materials in additional languages and in alternative formats, e.g, videos, social media-ready graphics, etc.[20] Again, these materials are not yet available in all languages.

However, to date, the CDC has yet to provide any community education materials about COVID-19 contact tracing.[21] Some state and local health departments have begun to describe their contact tracing programs on their websites,[22]including videos.[23] Academic institutions and organizations supporting COVID-19 contact tracing also have information and videos available.[24]

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[17] Centers for Disease Control and Prevention, Interim Guidance for Health Departments for Developing a COVID-19 Case Investigation & Contact Tracing Plan, May 15, 2020, https://www.cdc.gov/coronavirus/2019-ncov/downloads/case-investigation-contact-tracing.pdf (page 31)

[18] National Council of Asian Pacific Islander Physicians, Recommendations for Culturally and Linguistically Appropriate Contact Tracing for the Control of COVID-19, May 2020, https://mcusercontent.com/d7f02dd24377959c916d14de6/files/1d169789-f234-4ef6-b4b2-496e5b0fc2c8/Recommendations_for_Culturally_and_Linguistically_Appropriate_Contact_Tracing_for_the_Control_of_COVID.pdf

[19] https://www.cdc.gov/coronavirus/2019-ncov/communication/print-resources.html?Sort=Date%3A%3Adesc

[20] COVID-19 Information in Languages in Addition to English, May 1, 2020, https://ignatiusbau.com/2020/05/01/covid-19-information-in-languages-in-addition-to-english/

[21] CDC does have a webpage about isolation and quarantine that is available in English, Spanish, Chinese, Vietnamese, and Korean, but the webpage does not refer to, or explain contact tracing: https://www.cdc.gov/coronavirus/2019-ncov/if-you-are-sick/quarantine-isolation.html

[22] Commonwealth of Massachusetts: https://www.mass.gov/info-details/learn-about-the-community-tracing-collaborative; North Carolina: https://www.communitycarenc.org/carolina-community-tracing-collaborative; San Francisco, California: https://sfmayor.org/article/san-francisco-launches-innovative-contact-tracing-program-strengthen-coronavirus-response

[23] Commonwealth of Massachusetts: https://www.youtube.com/watch?v=aV990fAGeOk&feature=youtu.be

[24] Johns Hopkins Bloomberg School of Public Health: https://www.youtube.com/watch?v=dNmk_sL-xyo; Partners in Health: https://www.pih.org/ma-response

None of these materials are yet available in languages other than English. The CDC should immediately make available culturally and linguistically appropriate community education materials about COVID-19 contact tracing in multiple languages.

Implement COVID-19 Contact Tracing with Culturally and Linguistically Appropriate Communications and Supports

A key step in COVID-19 contact tracing is working with the individual who tests positive to remember and identify all potential contacts that might have been exposed so that the contact tracer can contact them. The CDC interim guidance on COVID-19 contact tracing recommends: "a patient will ideally be interviewed by a case investigator who is fluent in their primary language. If this is not possible, health departments should provide interpretation services, ideally by an individual with an understanding of the patient's cultural background".[25]

Even though the contact tracer will never identify the infected person to the contacts, this process requires trust and understanding of the contact tracing protocol. It is useful to collect as much demographic data about contacts as possible but the individual who has tested positive may not know all the demographic characteristics of the contacts. The CDC interim guidance on COVID-19 contact tracing states: "core demographic variables should be included in case investigation and contact tracing forms, including detailed race and ethnicity, as well as preferred language", and the CDC's sample forms include questions about gender, tribal affiliation, and use of an interpreter, and suggest using either HHS[26] or Census[27] categories for race and ethnicity.[28] NCAPIP strongly recommends the use of disaggregated race and ethnicity categories, with response options for Asian that - at a minimum - include Chinese, Filipino, Asian Indian, Vietnamese, Korean, Japanese, and Other Asian; and response options for Native Hawaiians and Pacific Islanders that - at a minimum - include Native Hawaiian, Samoan, Chamorro, and Other Pacific Islander.

The COVID-19 contact tracer can utilize multiple types of communication (phone, text, email, videoconferencing, in-person visit, etc.) to reach the contacts. The contact tracer must be able to access qualified health care interpreters to communicate with individuals who speak languages in addition to English, and to use communications appropriate for individuals with disabilities, e.g. free telecommunications relay services for individuals who are deaf or hard of hearing.[29] The contact tracer can confirm or supplement the demographic data about the contact through the self-reports of the contacts themselves.

Contacts will be educated about COVID-19, be informed about the availability of testing, asked to self-quarantine and maintain physical distance from others for 14 days since the date of contact. Contacts will be asked what supports they need to successfully complete the period of self-quarantine, and will be offered needed housing, food, childcare, income, and other supports. Contact tracers will follow-up with the contacts, as frequently as daily, to monitor their health and adherence to self-quarantining. Of course, contacts who do test positive or begin to experience symptoms will need referrals and real-time linkages to appropriate treatment.

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[25] Centers for Disease Control and Prevention, Interim Guidance for Health Departments for Developing a COVID-19 Case Investigation & Contact Tracing Plan, May 15, 2020, https://www.cdc.gov/coronavirus/2019-ncov/downloads/case-investigation-contact-tracing.pdf (page 13)

[26] U.S. Department of Health and Human Services Office of Minority Health, Data Collection Standards for Race, Ethnicity, Primary Language, Sex, and Disability Status, 2011. https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=23

[27] U.S. Census, Census 2020: Questions Asked on the Form, https://2020census.gov/en/about-questions.html

[28] Centers for Disease Control and Prevention, Interim Guidance for Health Departments for Developing a COVID-19 Case Investigation & Contact Tracing Plan, May 15, 2020, https://www.cdc.gov/coronavirus/2019-ncov/downloads/case-investigation-contact-tracing.pdf (page 31 and Appendix C: Data Elements for Case Investigation and Contact Tracing Forms)

[29] https://www.fcc.gov/consumers/guides/telecommunications-relay-service-trs

Hire a Culturally and Linguistically Concordant COVID-19 Contact Tracer Workforce

One of the important ways to ensure culturally and linguistically appropriate COVID-19 contact tracing is hiring and using contact tracers who are culturally and linguistically concordant with the communities they will be working in. The CDC references this concordance in its guidance on qualifications for contact tracers, which include: "excellent and sensitive interpersonal, cultural sensitivity, and interviewing skills such that they can build and maintain trust with patients and contacts" and "cultural competency appropriate to the local community".[30] In its recently issued interim guidance on COVID-19 contact tracing, the CDC states more explicitly: "to be effective, case investigation and contact tracing requires staff with adequate training, language skills, cultural sensitivity, supervision, and access to social and medical support for clients and their contacts" and "to help build trust, jurisdictions should try to employ public health staff who are of the same racial and ethnic background as the affected community and are fluent in their preferred language."[31]

Some local health departments are shifting staff from other roles, or staff from other local department such as libraries, into COVID-19 contact tracing positions.[32] Individuals who were in public-facing roles such as librarians have skills and experience that make them effective contact tracers. Others are calling for community-based organizations to partner with them in COVID-19 contact tracing activities, as well as individual volunteers to become contact tracers.[33] If health departments ask community-based organizations to be partners in COVID-19 contact tracing, there should be financial support for such partnerships because those community-based organizations already are experiencing losses of funding while demand for services increases during the pandemic.

Community health workers, health insurance enrollment assisters, health care navigators, peer mental health specialists, health educators, health care interpreters, care coordinators, case managers, social workers, and other community-based/peer health workers all would be ideal candidates to become hired and trained as contact tracers. Many of these types of health care workers already work at community-based organizations, community health centers, and solo and small group physician practices, and could be quickly trained and activated as contact tracers. Peace Corps and AmeriCorps workers who may have been recalled from their assignments during the pandemic and who may have cross-cultural skills and experiences also are good candidates to become contact tracers.[34] In diverse communities, being a peer from the local community may be a more important qualification for contact tracers than education level or professional degrees.[35] While each tribal, territorial, state, and local health department needs to make hiring decisions that make sense for their specific context and organizational capabilities, ensuring culturally and linguistically concordant COVID-19 contact tracers will be a key to effectiveness.

Regardless of whether hiring culturally and linguistically concordant contact tracers is feasible, all health departments should include training on culturally and linguistically appropriate communications, outreach, and engagement skills for all COVID-19 contact tracers. The CDC's sample training plan for COVID-19 contact tracers include curricula on language assistance

[30] https://www.cdc.gov/coronavirus/2019-ncov/php/principles-contact-tracing.html
[31] Centers for Disease Control and Prevention, Interim Guidance for Health Departments for Developing a COVID-19 Case Investigation & Contact Tracing Plan, May 15, 2020, https://www.cdc.gov/coronavirus/2019-ncov/downloads/case-investigation-contact-tracing.pdf (pages 5 and 31)
[32] Fortin J. So you want to be a contact tracer? New York Times, May 18, 2020, https://www.nytimes.com/2020/05/18/health/coronavirus-contact-tracing-jobs.html
[33] Santa Clara Department of Public Health, https://www.sccgov.org/sites/covid19/Pages/contact-tracing.aspx
[34] Ortiz E. Contact tracing proposal by Sen. Warren, Rep. Levin would create 'containment corps', NBC News, April 23, 2020, https://www.nbcnews.com/politics/politics-news/contact-tracing-proposal-sen-warren-rep-levin-would-create-containment-n1190331
[35] Wessler J, Feliciano A. Correcting NYC's health disparities starts with how we do contact tracing, CityLimits, May 11, 2020, https://citylimits.org/2020/05/11/opinion-correcting-nycs-health-disparities-starts-with-how-we-do-contact-tracing/

services, communication with the deaf and hard of hearing, health literacy, standards for culturally and linguistically appropriate services,[36] cultural humility, and implicit bias.[37] The California Pan-Ethnic Health Network also recommends training on trauma and trauma-informed approaches.[38] All COVID-19 contact tracers should receive training on how to address issues of trust of public health authorities (especially among Black, Latinx, American Indian, Native Hawaiian, and Pacific Islander communities), language access for individuals who speak languages in addition to English, and inclusive communications for individuals with disabilities. For example, contact tracers should be able to have evidence-based conversations about the racial and ethnic disparities in COVID-19 cases and deaths, and should be prepared to answer questions about those disparities. Moreover, contact tracers should be knowledgeable about the fears and concerns of immigrants, and potential confusion and misinformation, about the relevance of COVID-19 testing and treatment to the Department of Homeland Security public charge test.[39]

Conclusion

The National Council of Asian Pacific Islander Physicians appreciates this opportunity to provide the House Ways and Means Committee this background information and data, and our recommendations for comprehensive demographic data collection and reporting related to COVID-19, and for culturally and linguistically appropriate COVID-19 contact tracing. For more information or questions, please contact NCAPIP Chairperson Winston Wong at winston.f.wong@kp.org, or NCAPIP Communications Consultant David Lee Hawks at dhawks@ncapip.org.

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[36] U.S. Department of Health and Human Services Office of Minority Health, Cultural Competency Program for Disaster Preparedness and Response, https://thinkculturalhealth.hhs.gov/education/disaster-personnel
[37] https://www.cdc.gov/coronavirus/2019-ncov/downloads/php/contact-tracer-sample-training-plan.pdf
[38] California Pan-Ethnic Health Network (CPEHN) Letter to California Governor and Department of Public Health, May 19, 2020, https://cpehn.org/sites/default/files/cpehn_contact_tracing_letter_5.19.2020_2.pdf; CPEHN references the training materials on trauma-informed approaches available from the Substance Abuse and Mental Health Services Administration, SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach, 2014, https://store.samhsa.gov/product/SAMHSA-s-Concept-of-Trauma-and-Guidance-for-a-Trauma-Informed-Approach/SMA14-4884
[39] Duncan WL, Horton S. Serious challenges and potential solutions for immigrant health during COVID-19. Health Affairs Blog, April 13, 2020, https://www.healthaffairs.org/do/10.1377/hblog20200416.887086/full/; Khafagy A. Some immigrants avoid New York hospitals because of the public charge rule. Documented, May 21, 2020, https://documentedny.com/2020/05/21/some-immigrants-avoid-new-york-hospitals-because-of-the-public-charge-rule/