ASIAN HEALTH SERVICES
ADMINISTRATIVE OFFICES
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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:

Asian Health Services (AHS) 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. AHS is a federally qualified health center in Alameda County, California, providing comprehensive primary care, dental, behavioral health and preventive services to 50,000 patients in English and 14 Asian languages. Founded in 1974, we have grounded our work in our two pillars – service and advocacy – to provide health, social, and advocacy services for all regardless of income, insurance status, immigration status, language, or culture. We witnessing the impacts that COVID-19 has had on our diverse communities, many of whom are Asian Americans and Pacific Islanders. We urge this Committee to ensure the allocation of the resources to address these emerging and hidden disparities.

Asian Health Services On the frontlines
We are witnessing a spectrum of issues from anti-Asian racist attacks to the serious isolation of the Asian Pacific Islander and Native Hawaiian communities, and language/cultural barriers. As we reach out to our top 1,500 vulnerable patients to ensure they are getting appropriate care and stay out of the Emergency Department, we are hearing from them heartbreaking stories first hand. We have discovered the sheer level of isolation and fear has kept the majority locked in their homes. Public Charge, anti-Asian racism, and fear of contracting COVID-19 have paralyzed our community. Patients and are afraid to come in for face-to-face care and have refused to go out to pick up prescriptions. High rates of depression and anxiety are manifest in increased demand for behavioral health, including specialty mental health (moderate to severe) services.

We have raised our patient visits to 90% of pre-COVID period (1800 visits per week), by quickly implementing in-language and in-culture outreach, telehealth, redesigned protocols, and consolidated sites, we have sustained access to care for our vulnerable populations in this new environment. Our care includes 600 elderly patients with whom we manage chronic conditions and prevent hospitalizations; routine care with 500 patients who otherwise would have been lost to follow-up; continued care and treatment for 100% of our HIV patients; identified and conducted recent visits with 400+ “high risk” patients in our managed care; have had strong performance in post-hospital discharge measure to prevent readmission; and provided case management and referral services to address the social needs (e.g., food assistance, housing, unemployment assistance, and legal/immigration) to 130+ community members. Our redesign includes:

- A dedicated Respiratory Unit was established to preserve PPE and keep some distinction of risk environments.
- Aggressively researching the technology of HEPA filters, UV equipment and even ionized cleaners as we consider moving the dedicated Respiratory Unit.

- Dental care -- as you can imagine the most challenging to provide -- as it does not lend itself to telemedicine. Dr. Huong Le has already piloted drive by sealant treatment for pediatric patients. It is a must see.

- Messaging in the community has been a huge problem. Many Chinese rely on WECHAT as their main source of news. AHS recently secured its own account (very difficult vetting process) in order to put out correct information. We are thinking of creating a You Tube Channel so that we can record short You Tube Videos, instructive and educational, in each Asian and Pacific Islander language to bridge the huge divide.

AHS Quality Care and Outreach:
The demand for testing has been extremely low in our AAPI communities, in large part due to fear of contracting Covid, the stigma of Covid in the rising anti-Asian landscape, and the cost of health care should they be tested positive. AHS has immediately stepped into the space of continuing to provide high quality care, responding to rising social needs, sounding the alarm on Anti-Asian racism, and advocating for better data collection and disaggregation. In response, AHS has has developed a comprehensive response plan that includes these four components:

I. **Outreach for testing:** The demand for testing has been extremely low in our AAPI communities, due to fear of contracting Covid, the stigma of Covid in the rising anti-Asian landscape, and the cost of health care should they be tested positive. We need to invest in outreach and education to encourage more to come in for testing, especially as many are essential workers. AHS is well-positioned given our language and cultural expertise, long track-record of high quality health care, and established trust with immigrant and refugee communities.
II. **Testing:** AHS is set up to do testing and examination for vulnerable patients at our site as well as being able to refer healthier and/ or asymptomatic patients to community testing sites.
III. **Contact Tracing:** AHS will lead an population-based team approach to work collaboratively with the County to do an integrated approach to reach out to AAPI vulnerable communities.
IV. **Case Management and Support:** AHS will enhance our rapid response plan to respond to the growing social needs (e.g., food, housing, unemployment, health care, mental health referral, and immigration/ legal) for the AAPI community, particularly after they have tested positive.

Better Data Needed
The Asian American and Pacific Islander (AAPI) population is diverse in language, culture, and immigration experiences; all of which affect how they are responding to the pandemic as well as surviving the crisis. Yet, due to language barriers and limited data collection, the disparities for this population often remain hidden.

The demand for testing appears to be extremely low in our AAPI communities. However, we need better data, disaggregated by ethnicity, language, immigration status, and many important social determinants of health, to explore disparities in testing access, incidence, and mortality. Based on hundreds of patient stories that we have gathered, we believe this is due to fear of contracting COVID, the stigma of COVID in the rising anti-Asian landscape, and the cost of health care should they be tested positive. In a recent survey that we did with over 714 AAPI local community members, we have found that only 4% are getting tested, despite having concerns about symptoms or being exposed. Nearly 1 in 13 are experiencing discrimination and anti-Asian hate, but nearly none of them have reported these incidents. Furthermore, nearly 1 in 5 are experiencing depression.

High COVID-19 Mortality among Asian Americans

In the past month, AHS has worked with a national network of researchers to understand some of the hidden disparities, often caused by lack of disaggregated data. Recently, the UCSF Asian Research Center for Health (ARCH) researchers, led by Dr. Tung Nguyen, have released suggestive data from San Francisco that Asian Americans have high death rates among those who are tested positive for Covid. In San Francisco, Asian Americans comprised one-third of the population, yet over 50% of the COVID-19 deaths are among this racial population. Further assessment shows that Asian Americans may have a mortality disparity. These researchers found a similar pattern among a number of states and counties where Asian Americans comprise at least 5% of the population. In California, the case fatality rate among Asian Americans is double that of the overall population (8.1% vs. 3.9%), and the findings hold true for Los Angeles County, San Francisco County, and Santa Clara County. For New Jersey, the rate is 13.8% vs. 7.3%, Washington, 8.5% vs. 5.2%, and Illinois 7.4% vs. 4.5%. Nevada, Massachusetts, Clark County (NV), Chicago (IL), and New York City (NY) which combine Asian Americans and Pacific Islanders data show similar trends.

Importantly, the case fatality rate does not mirror the population infection rate, which tends to be lower in Asian Americans. For instance, Asian Americans comprise just 13% of positive cases in San Francisco yet account for half of deaths. A higher case fatality rate indicates that either Asian Americans lack sufficient diagnostic testing, face a higher risk of death from COVID-19 on average, or both.

Furthermore, Native Hawaiians and Pacific Islanders are experiencing disproportionate rates of cases and deaths. In the Los Angeles area, these groups are experience six times the confirmed cases and three and a half times the death rate, compared to White residents. These trends have been observed in other regions, including in the state of Hawaii.

These preliminary findings that are repeated throughout different geographic areas across the nation underscore the need for more research and surveillance attention. Otherwise, as has been repeated many times in the past, this population may remain understudied, with hidden health disparities, that lead to them continually being underserved.

AHS remains on the frontlines to serve our diverse population. Yet, we know that disaggregated data and research attention are urgently needed to highlight the disparities and unmet needs that we are seeing among our patients on-the-ground. The data that is being put out does not match with the many patient stories that we have come across. We urge you to adopt policies that support data collection, data disaggregation, and needed resources to examine the hidden disproportionate impact on Asian Americans and Pacific Islanders.

Sincerely,

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