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, Latinx, American Indian, Native Hawaiian, and Pacific Islander populations. 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:

### National Council of Asian Pacific Islander Physicians

**COVID-19 Data for Asians Reported as of May 25, 2020**

<table>
<thead>
<tr>
<th>State</th>
<th>Asian Physicians, Residents in the State</th>
<th>Percent of Cases</th>
<th>Number of Cases</th>
<th>Percent of Hospitalizations</th>
<th>Number of Hospitalizations</th>
<th>Percentage of Deaths</th>
<th>Number of Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alaska</td>
<td>6.2</td>
<td>46,381</td>
<td>11.9</td>
<td>46</td>
<td>No race data reported</td>
<td>No race data reported</td>
<td></td>
</tr>
<tr>
<td>Arkansas</td>
<td>1.6</td>
<td>47,548</td>
<td>1.1</td>
<td>61</td>
<td>No race data reported</td>
<td>No race data reported</td>
<td></td>
</tr>
<tr>
<td>California</td>
<td>14.7</td>
<td>5,821,586</td>
<td>9.9</td>
<td>6,671</td>
<td>No race data reported</td>
<td>14.8</td>
<td>531</td>
</tr>
<tr>
<td>Colorado</td>
<td>3.2</td>
<td>180,277</td>
<td>2.7</td>
<td>650</td>
<td>No race data reported</td>
<td>3.9</td>
<td>52</td>
</tr>
<tr>
<td>Hawaii</td>
<td>37.6</td>
<td>534,479</td>
<td>33.0</td>
<td>199</td>
<td>No race data reported</td>
<td>No race data reported</td>
<td></td>
</tr>
<tr>
<td>Idaho</td>
<td>1.3</td>
<td>27,026</td>
<td>2.9</td>
<td>45</td>
<td>No race data reported</td>
<td>No race data reported</td>
<td></td>
</tr>
<tr>
<td>Iowa</td>
<td>2.8</td>
<td>79,971</td>
<td>9.0*</td>
<td>755</td>
<td>No race data reported</td>
<td>1.7</td>
<td>3</td>
</tr>
<tr>
<td>Kansas</td>
<td>2.8</td>
<td>82,444</td>
<td>7.8</td>
<td>575</td>
<td>No race data reported</td>
<td>No race data reported</td>
<td></td>
</tr>
<tr>
<td>Kentucky</td>
<td>1.5</td>
<td>65,300</td>
<td>5.7</td>
<td>7</td>
<td>No race data reported</td>
<td>No race data reported</td>
<td></td>
</tr>
<tr>
<td>Nevada</td>
<td>8.2</td>
<td>250,137</td>
<td>11.8</td>
<td>603</td>
<td>No race data reported</td>
<td>No race data reported</td>
<td></td>
</tr>
<tr>
<td>New Hampshire</td>
<td>2.7</td>
<td>36,048</td>
<td>3.0</td>
<td>80</td>
<td>5.5</td>
<td>11</td>
<td>0</td>
</tr>
<tr>
<td>Oregon</td>
<td>4.6</td>
<td>190,680</td>
<td>4.1</td>
<td>135</td>
<td>No race data reported</td>
<td>No race data reported</td>
<td></td>
</tr>
<tr>
<td>South Dakota</td>
<td>1.8</td>
<td>15,023</td>
<td>11.8</td>
<td>525</td>
<td>No race data reported</td>
<td>No race data reported</td>
<td></td>
</tr>
<tr>
<td>Tennessee</td>
<td>1.8</td>
<td>119,046</td>
<td>2.8</td>
<td>390</td>
<td>No race data reported</td>
<td>2.1</td>
<td>7</td>
</tr>
<tr>
<td>Utah</td>
<td>2.4</td>
<td>75,898</td>
<td>2.4</td>
<td>203</td>
<td>No race data reported</td>
<td>No race data reported</td>
<td></td>
</tr>
<tr>
<td>Washington</td>
<td>8.8</td>
<td>661,781</td>
<td>7.7</td>
<td>1,073</td>
<td>8.1</td>
<td>296</td>
<td>91</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>2.8</td>
<td>165,380</td>
<td>3.8*</td>
<td>586*</td>
<td>No race data reported</td>
<td>2.5*</td>
<td>13*</td>
</tr>
</tbody>
</table>

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)

*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**

<table>
<thead>
<tr>
<th>State</th>
<th>Native Hawaiian and Pacific Islander Physicians, Residents in the State</th>
<th>Percent of Cases</th>
<th>Number of Cases</th>
<th>Percent of Hospitalizations</th>
<th>Number of Hospitalizations</th>
<th>Percentage of Deaths</th>
<th>Number of Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alaska</td>
<td>1.1</td>
<td>7,598</td>
<td>3.6</td>
<td>14</td>
<td>No race data reported</td>
<td>No race data reported</td>
<td></td>
</tr>
<tr>
<td>Arkansas</td>
<td>0.3</td>
<td>9,398</td>
<td>3.3</td>
<td>183</td>
<td>No race data reported</td>
<td>No race data reported</td>
<td></td>
</tr>
<tr>
<td>California</td>
<td>0.4</td>
<td>155,739</td>
<td>0.9</td>
<td>573</td>
<td>No race data reported</td>
<td>No race data reported</td>
<td>0.8</td>
</tr>
<tr>
<td>Colorado</td>
<td>0.1</td>
<td>7,585</td>
<td>0.4</td>
<td>99</td>
<td>No race data reported</td>
<td>No race data reported</td>
<td>0.1</td>
</tr>
<tr>
<td>Hawaii</td>
<td>10.2</td>
<td>144,971</td>
<td>17.0</td>
<td>102</td>
<td>No race data reported</td>
<td>No race data reported</td>
<td></td>
</tr>
<tr>
<td>Idaho</td>
<td>0.2</td>
<td>2,763</td>
<td>0.2</td>
<td>4</td>
<td>No race data reported</td>
<td>No NHPI data reported</td>
<td></td>
</tr>
<tr>
<td>Iowa</td>
<td>0.1</td>
<td>3,463</td>
<td>Combined with Asian</td>
<td>No race data reported</td>
<td>No NHPI data reported</td>
<td>No race data reported</td>
<td>0.4</td>
</tr>
<tr>
<td>Kansas</td>
<td>0.1</td>
<td>2,929</td>
<td>No NHPI data reported</td>
<td>No NHPI data reported</td>
<td>No NHPI data reported</td>
<td>No race data reported</td>
<td></td>
</tr>
<tr>
<td>Kentucky</td>
<td>0.1</td>
<td>4,943</td>
<td>0.1</td>
<td>7</td>
<td>No data reported</td>
<td>No race data reported</td>
<td></td>
</tr>
<tr>
<td>Nevada</td>
<td>0.6</td>
<td>19,612</td>
<td>No NHPI data reported</td>
<td>No NHPI data reported</td>
<td>No NHPI data reported</td>
<td>No race data reported</td>
<td></td>
</tr>
<tr>
<td>New Hampshire</td>
<td>0.0</td>
<td>155</td>
<td>No NHPI data reported</td>
<td>No NHPI data reported</td>
<td>No NHPI data reported</td>
<td>No race data reported</td>
<td></td>
</tr>
<tr>
<td>Oregon</td>
<td>0.4</td>
<td>18,758</td>
<td>1.4</td>
<td>47</td>
<td>No race data reported</td>
<td>No race data reported</td>
<td></td>
</tr>
<tr>
<td>South Dakota</td>
<td>0.0</td>
<td>51</td>
<td>No NHPI data reported</td>
<td>No NHPI data reported</td>
<td>No NHPI data reported</td>
<td>No race data reported</td>
<td></td>
</tr>
<tr>
<td>Tennessee</td>
<td>0.1</td>
<td>5,494</td>
<td>0.0</td>
<td>9</td>
<td>No race data reported</td>
<td>No NHPI data reported</td>
<td></td>
</tr>
<tr>
<td>Utah</td>
<td>0.9</td>
<td>29,362</td>
<td>2.7</td>
<td>319</td>
<td>7</td>
<td>7</td>
<td>40</td>
</tr>
<tr>
<td>Washington</td>
<td>0.7</td>
<td>53,924</td>
<td>2.3</td>
<td>322</td>
<td>2.1</td>
<td>50</td>
<td>0.7</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>0.0</td>
<td>1,961</td>
<td>Combined with Asian</td>
<td>No race data reported</td>
<td>Combined with Asian</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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)

*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

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

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:

![Table](https://health.hawaii.gov/coronavirusdisease2019/what-you-should-know/current-situation-in-hawaii/#race)

(As of June 8, 2020)

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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-19 data for Asian Americans and for Native Hawaiians and Pacific Islanders combined, in violation of Office of Management and Budget (OMB) data standards.

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.

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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. 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. Solo and small group practice physicians are essential health care providers, especially in racial and ethnic communities.

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. However, many solo and small group physician practices have struggled to remain open and economically viable.

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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Solo and small group physician practices need more intensive and more sustained technical assistance to implement practice improvement activities successfully. Accordingly, NCAPIP strongly encourages 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. 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. 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, 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.

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

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


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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20 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.youtube.com/watch?v=aV990fAGeOk&feature=youtu.be
23 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 HHS26 or Census27 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.

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”. 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.”

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. 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. 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. 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. 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.

33 Santa Clara Department of Public Health, https://www.sccgov.org/sites/covid19/Pages/contact-tracing.aspx
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,\textsuperscript{36} cultural humility, and implicit bias.\textsuperscript{37} The California Pan-
Ethnic Health Network also recommends training on trauma and trauma-informed approaches.\textsuperscript{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.\textsuperscript{39}

\textbf{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
\texttt{winston.f.wong@kp.org}, or NCAPIP Communications Consultant David Lee Hawks at
dhawks@ncapip.org.

National Council of Asian Pacific Islander Physicians
711 W. College Street Suite 210
Los Angeles, CA 90012

\textsuperscript{36} U.S. Department of Health and Human Services Office of Minority Health, Cultural Competency Program for Disaster Preparedness and Response, \url{https://thinkculturalhealth.hhs.gov/education/disaster-personnel}
\textsuperscript{38} California Pan-Ethnic Health Network (CPEHN) Letter to California Governor and Department of Public
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, \url{https://store.samhsa.gov/product/SAMHSA-s-Concept-of-Trauma-and-
Guidance-for-a-Trauma-Informed-Approach/SMA14-4884}
\textsuperscript{39} Duncan WL, Horton S. Serious challenges and potential solutions for immigrant health during COVID-19.
Health Affairs Blog, April 13, 2020, \url{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,