

**ASIAN AMERICAN AND NATIVE HAWAIIAN PACIFIC ISLANDER  
COVID-19 POLICY & RESEARCH TEAM**

**NATIONAL PACIFIC ISLANDER COVID-19 RESPONSE TEAM**

**NHPI COVID-19 RESOURCE TEAM**

July 9, 2020

The Honorable Gavin Newsom  
Governor of California  
Office of the Governor  
1303 10th Street, Suite 1173  
Sacramento, CA 95814

Dear Governor Newsom,

As members of the Asian American and Native Hawaiian Pacific Islander COVID-19 Policy & Research Team, the National Pacific Islander COVID-19 Response Team, and the NHPI COVID-19 Resource Team, we write to respectfully request the state's assistance and attention to addressing the disproportionate impact of COVID-19 on Asian American (AA) and Native Hawaiian and Pacific Islander (NHPI) Californians. We commend you for your leadership as our state and country continue to fight the spread of coronavirus. We encourage your administration to ensure that health agencies across the state appropriately and consistently report timely, accurate, disaggregated COVID-19 data by race, ethnicity, and primary language, to identify emerging disparities during this pandemic.

**The Disparities and Need**

AA and NHPI communities have been severely impacted by COVID-19. As of July 5, 2020, 11,013 Asian and 1,029 NHPI Californians have tested positive for the disease, which is 21% of the nation's Asian and 16% of the nation's NHPI COVID-related cases. These statistics, however, are likely underrepresented, as 34% of cases in our state are Unknown race/ethnicity.<sup>1</sup> Recent research has shown that Asian Americans have a **higher death to case ratio** than other races in San Francisco and to an extent throughout California.<sup>2</sup> As of June 26, similar elevated death to case ratios are evident in the entire state of California and in Los Angeles in particular, where death to case ratios are highest among Asian-American and Black COVID-19 cases. These disparities can be due to inadequate testing or disease severity or both. Furthermore, AAs and NHPs are often misclassified when they are tested. For example, as of June 10, 2020, California reclassified many reported NHPI cases leading to fewer reported NHPI cases but increases in AA cases. Yet, much of the data on testing is missing; in Alameda

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<sup>1</sup> COVID Racial Data Tracker of 7/5/20, downloaded 7/7/2020

<sup>2</sup> <https://www.sfchronicle.com/health/article/Why-has-coronavirus-taken-such-a-toll-on-SF-s-15282096.php>

County, which is among the counties with the highest number of cases, nearly half of those tested have unknown race/ethnicity, making it difficult to assess racial disparities in testing access.

While community leaders continue encouraging AA and NHPIs to get tested, stigma and fear of anti-Asian hate are significant barriers to more robust testing in our communities. Asian Health Services, a federally qualified health center in Oakland, recently conducted a community survey with 1,306 AA and NHPIs in the San Francisco Bay Area, and found that only 3.1% of them have gotten tested, compared to the state's average of 10%.<sup>3</sup> These results underscore the issue of inadequate testing in Asian Americans.

## Recommendations

We commend the California Department of Public Health for the framework it is establishing for collecting disaggregated COVID-19 race/ethnicity data through the COVID-19 confidential morbidity report form.<sup>4</sup> With the requirement that **all states and all labs report race/ethnicity of COVID-19 tests** by August 1, 2020, it is important to **ensure that the race/ethnicity and primary language data is based on client self-identification of race/ethnicity and primary language using as a minimum standard the Institute of Medicine<sup>5</sup> roll-up into the six OMB racial/ethnic** reporting categories required of organizations receiving federal funds. Preliminary analysis of public hospital cases in New York City has demonstrated that accounting for patients' language spoken increases identification of Asian race by approximately 10%.

In addition to high case rates among our communities, the pandemic has also devastatingly claimed the lives of thousands of AAs and NHPIs across the country. Nearly 5,000 AA and 122 NHPI lives have been lost due to COVID-19.<sup>6</sup> In terms of proportionate mortality, the percent of all deaths due to COVID-19 is two times higher among Latinx, Asian and Black populations, than it is for Whites.<sup>7</sup> The death toll is significant for California, which held funerals for 13% of COVID-related NHPI deaths and 18% of AA COVID-related deaths in the nation. These deaths are more painful knowing that many were not accompanied by family or loved ones in their final hours because of quarantine and prohibitions on visitors in health care facilities. It is vital that physicians and coroners honor Asian American and NHPI culture by connecting with next of kin and respecting how AAs and NHPIs self-identified themselves throughout their life and at death.

**Language access** is an important component of improving access to care for many Californians. About 44.6% of Californians above the age of five speak a language other than English at home, including 9.6% of Californians who speak an Asian or Pacific Islander

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<sup>3</sup> <https://coronavirus.jhu.edu/testing/states-comparison>  
<https://www.sfchronicle.com/health/article/Why-has-coronavirus-taken-such-a-toll-on-SF-s-15282096.php>

<sup>4</sup> <https://www.cdph.ca.gov/CDPH%20Document%20Library/ControlledForms/cdph110d.pdf>

<sup>5</sup> <https://www.nap.edu/catalog/12696/race-ethnicity-and-language-data-standardization-for-health-care-quality> (pages 183-198)

<sup>6</sup> COVID Racial Data Tracker of 7/5/20, downloaded 7/7/20.

<sup>7</sup> NCHS, COVID Mortality, 6/24/20, downloaded 6/24/20.

language.<sup>8</sup> Preliminary analysis of public hospital cases in New York City has demonstrated that accounting for patients' language spoken increases identification of Asian race by approximately 10%. **Identification of primary language could also improve community engagement in prevention, testing, treatment, contact tracing and vaccination.**

The COVID-19 pandemic has brought the light the inadequacies of federal guidelines on data disaggregation. While we appreciate the CDPH's efforts, we encourage you to go beyond federal guidelines and ensure that all **AA and NHPI communities in California can be appropriately disaggregated**. In 2015, the California State Legislature and then-Governor Jerry Brown enacted AB1726 that would require the Department of Public Health to further disaggregate data for AA and NHPI communities. While we recognize the effective date for this law is not until July 1, 2022, the extraordinary circumstances posed by the COVID-19 crisis necessitates immediate implementation, at least for data related to the pandemic. We encourage you to **use your administrative authority to immediately disaggregate public health data related to COVID-19 by the categories established by AB1726.**

We believe that our proposal for disaggregated data can be implemented in a **cost-neutral way**, if such data collection is tied to the expeditious release of federal CARES Act dollars to counties and cities with health departments that report disaggregated data via CDPH's COVID-case forms. Data disaggregation will be required by August 1, 2020, and it is likely that additional federal assistance related to COVID-19 testing and treatment will be contingent on a state's proportion of COVID-19 cases. By requiring further data disaggregation, we believe that California will better position itself for additional federal assistance, improve targeted intervention for AA and NHPI communities, reduce stigma associated to COVID-19 testing, and use disaggregated data to improve in-language and in-culture testing, contact tracing, treatment, and care. Moreover, we hope that in addition to the immediate emergency funds related to COVID-19, we encourage you to prioritize Californians' participation in the 2020 Census.

We appreciate your steadfast leadership as our state continues to navigate the COVID-19 pandemic. We are confident that we will overcome challenges it poses, and we hope California will lead the nation in disaggregating data so we can better serve all our communities, including six million AA and NHPs who call California home. We stand ready to assist you in these efforts. Should you have any questions, please have your staff contact Dr. Tung Nguyen ([Tung.Nguyen@ucsf.edu](mailto:Tung.Nguyen@ucsf.edu)) or Dr. Raynald Samoa ([rsamoa@coh.org](mailto:rsamoa@coh.org)).

Respectfully,

Tung Nguyen, MD, School of Medicine, University of California, San Francisco  
Raynald Samoa, MD, City of Hope

and

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<sup>8</sup> <https://www.migrationpolicy.org/data/state-profiles/state/language/CA>

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