



**Statement of**

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**Before the**

**Ways and Means Committee**

**U.S. House of Representatives**

**Washington, D.C.**

**May 27, 2020**

Chairman Neal, Ranking Member Brady, and Members of the Committee, my name is Dr. Raynald Samoa. I am a clinical research endocrinologist at the renowned cancer center City of Hope located in Southern California. I lead research studies to help cancer survivors optimize their metabolism in the fight to beat cancer. But today I address you as the Clinical Lead for the National Pacific Islander Covid-19 Response Team (NPICRT). Please note that this testimony reflects my own views alone and not necessarily the views of organizations with which I have been or am currently affiliated.

My father served in the U.S. Army for 30 years retiring as Chief Warrant Officer and instilled in me as in many Pacific Islanders, the importance to serve and protect all of our communities. U.S. Pacific Island territories have some of the highest rates of recruitment into the U.S. armed forces reflecting the commitment of our men and women who are willing to die in defense of the freedoms we Americans so richly enjoy [1].

As the other speakers you will hear today will attest, Covid-19 has ripped through America at alarming speed and the death toll has ravaged communities of color. Today, I am here to report the devastatingly disproportionate impact of Covid-19 on Pacific Islanders (PIs). Native Hawaiian and Pacific Islanders have the highest rate of confirmed Covid-19 cases in California, King County in Washington state, Clark County in Nevada and the second highest in Utah, Oregon, Arkansas and Colorado as displayed in Table 1. In Los Angeles County, the death rate for PIs is 12 times higher than it is for whites, 9 times higher than for Asians, 7 times higher than for Latinos, 5 times higher than for African Americans [2].

Table 1. NHPI cases rate ranking (1 = highest or "worst") from the Pacific Islander COVID-19 Response Data Hub housed at the UCLA Center for Health Policy Research.

<b>Week</b>	<b>April 28, 2020</b>	<b>May 5, 2020</b>	<b>May 12, 2020</b>
<b>California</b>	1	1	1
<b>King County, WA</b>	1	1	1
<b>Oregon</b>	1	1	2
<b>Clark County, NV</b>	1	1	1
<b>Colorado</b>	1	1	2
<b>Arkansas</b>	2	1	2
<b>Hawaii</b>	2	1	1
<b>Utah</b>	2	2	2

## **Predisposition for Pacific Islanders to Covid-19**

PIs have extremely high rates of chronic disease such as diabetes, certain cancers, and heart disease, which increases their risk of death if they contract COVID-19 [3]. Compared to non-Hispanic whites, PIs are 80% more likely to be obese, 30% more likely to have asthma, 2.5 times more likely to have a diabetes [4]. 20% of PIs do not have medical coverage when compared to 11.4% of non-Hispanic whites [5, 6], which affects their timely access to needed health care services. Further complicating timely access to care, PIs report also experiencing discrimination in healthcare settings and a mistrust in seeking health care services [7, 8].

PIs are more likely than other racial and ethnic groups to have fewer financial resources and to live in large multi-generational households and densely populated neighborhoods [9-11]. As much as 24% of PIs work in essential jobs, such as in the military, security, service-related industry, and healthcare [12], placing them at higher risk of infection.

## **The Call to Action**

I am very familiar with the risk of Covid-19 that my community faces. In March 2020, I contracted Covid-19 and I adhered to all the CDC recommendations like frequent hand washing and social distancing when possible. But like so many in my community I am an essential worker.

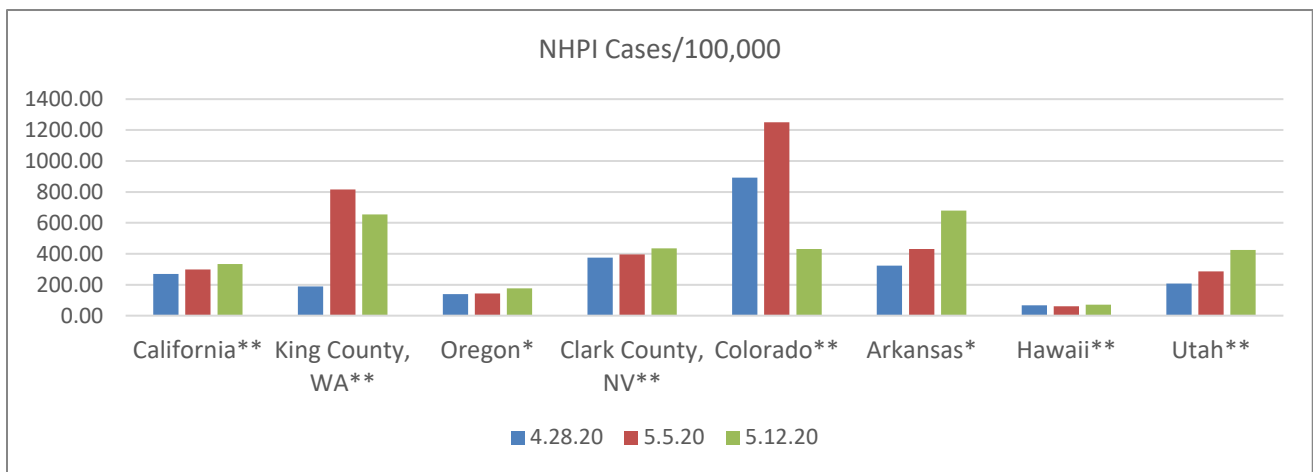
When I became aware of the alarming rates of Covid-19 that was ripping through PIs in California in mid-April 2020, I searched feverishly for an advocacy group to volunteer my services to slow down transmission of the virus in my community. My search ended with the sobering realization that there is no voice for Pacific Islander health on the national level. PIs were being disproportionately devastated by Covid-19 and many of the public health agencies charged to protect all of us had no idea what our community was experiencing.

To my knowledge, I am the only endocrinologist of Pacific Islander descent on the U.S. continent. One may ask why a diabetes specialist is leading an infectious disease pandemic taskforce. A major reason is that a network of advocates from around the country working on PI health already exists aimed at fighting chronic diseases such as diabetes and cancer. This network has prolific experience in navigating

the obstacles faced by PI communities and knowing that our friends and family members are contracting and dying from COVID-19, we are not willing to stand idly by for others to plan and implement a response.

The NPICRT is a consortium of researchers, physicians, public health experts, elected officials, and community advocates created to respond to the pandemic to protect PI communities. The team developed a comprehensive strategy based on initiatives used by other countries that were successful in beating back the pandemic. Such as New Zealand, a country that has a large PI population, genetically identical with a socioeconomic profile and chronic disease prevalence that mirrors that of the diaspora in the U.S. New Zealand has a lower rate of disease and has yet to report a single death from Covid-19 in the PI population there. The difference between the experience of our community in the US and our cousins across the ocean have been how well these protective initiatives engage vulnerable communities. The continued rise in in the already high rates of Covid-19 demonstrated in Figure 1 unfortunately suggest that these strategies have yet to reach many in the PI community residing in the US.

Figure 1. Covid-19 rates of confirmed disease in NHPIs



For this reason, we believe our existing community infrastructure is not only capable but is the most effective means of ensuring these strategies are in place to protect PI populations in America from Covid-19. Our regional taskforces were directly responsible for much of the availability of the data I present today. Our taskforces urged local health departments to report disaggregated data [2], which

directed more available testing in neighborhoods known to have a higher concentration of PI residents. We have also identified significant disproportionate rates of Covid-19 affecting PIs that have not been publicly reported as of yet.

All though this is progress, but there is still a considerable amount of work that needs to be done to improve these alarmingly high rates. Such as more contact tracing but for it to be effective, positive cases must trust public health officials, but PIs report also experiencing discrimination in healthcare settings and a mistrust in seeking health care services [7, 8]. Conducting social support assessments with effective linkages to needed resources as well effective community health messaging and supportive policies to optimize the isolation of positive cases. Incorporating the existing trust equity of the community to augment local health departments' efforts have high potential for improved outcomes regarding engagement with PI positive cases. This incorporation informs the NPICRT strategy to optimize collaboration between local health departments and regional PI Covid-19 taskforces.

The NPICRT comprehensive strategy is located on the team's convening organization, the Pacific Islander Center of Primary Care Excellence (PI-CoPCE) website (<https://pi-copce.org/>). Resources are needed to support this work such as an electronic data collection system that speaks to public health department systems and other agencies such as community health clinics. Another crucial resource is an easy to access electronic directory of supportive resources to support infected individuals and their families to safely quarantine.

## **CONCLUSION**

To conclude, I'd like to offer up two concrete steps Congress can take to help end the disproportionate devastation experienced by PI communities in the U.S. First, allot funding for this evidence-based community-driven comprehensive initiative to fight Covid-19 in PI communities. The NPICRT's convening organization, PI-CoPCE is working on a MOU with the HRSA funded Association of Asian Pacific Community Health Organizations (AAPCHO). Second, we urge Congress to fix a legislative oversight that has led to inequitable access to health care for thousands of Pacific Islanders in the United States. Since the passage of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), people residing in the United States under the Compacts of Free Association (COFA) have been categorically

ineligible for Medicaid. This has caused thousands of PIs to be denied basic access to health care and causing worse health outcomes for COFA families in the U.S.

Lastly, let me close by giving a couple of quick shout-outs. On April 17, 2020, a group of approximately 25 Pacific Islanders from 5 different states with no idea what to expect joined a zoom call armed with hope to help their community during a crisis. Today, this amazing resourceful group is a cadre of over 300 volunteers and counting from 10 different states set with a laser focus to end this pandemic. And lastly to my fellow PI essential workers. You, Chamorro servicemen in Texas, Tongan postal workers in Utah, Marshallese poultry workers in Arkansas, Micronesian meat handlers in Illinois, and Samoan nurses in Orange County, thank you for risking your health and the health of your families to serve the American public. I hope in return America honors that sacrifice by granting you the tools to defend our vulnerable communities from the ravaging effects of Covid-19.

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