American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

March 25, 2021

The Honorable Patty Murray
Chair
Senate Health, Education, Labor & Pensions Committee
428 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Richard Burr
Ranking Member
Senate Health, Education, Labor & Pensions Committee
428 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Chair Murray and Ranking Member Burr:

On behalf of the American College of Emergency Physicians (ACEP) and our 40,000 members, I would like to commend you for holding a hearing on how the nation may improve health equity and outcomes related to COVID-19 by addressing health disparities. The emergency department often reveals the disparities and inequities that exist in our society, and COVID-19 has brought many of these into sharp relief. As emergency physicians who have been on the frontlines combating this pandemic since it first arrived in the United States last year, we are acutely aware that certain populations, especially racial and ethnic minority groups, warrant special consideration when screening and treating this disease.

ACEP has put significant resources into developing and maintaining the ACEP COVID-19 Field Guide to support emergency physicians' efforts to treat this disease and provide better, more informed care to patients. While these recommendations do not indicate an exclusive course of treatment or set a standard of medical care, they do provide information that can help supplement the individual's clinical judgment based on the unique circumstances of the case and availability of resources. I would especially like to acknowledge and thank my colleagues, Megan Hoffer, DO, and Aisha T. Terry, MD, MPH, FACEP, who authored the section of the field guide on "Racial and Ethnic Minority Groups." The following information is derived from their work.

Background

In the United States, which is perhaps the most ethnically diverse country in the world, emerging statistics from epicenter cities are showing significant disparities in rates of COVID-19 infection and mortality in Latino/Hispanic and African American populations.

These disparities have been demonstrated in New York City, which showed the highest mortality rates among Latino/Hispanic Americans, followed by African Americans, disproportionate to their representative populations. Although they make up 29% of the population, 34% of COVID-19 deaths in New York City were among Latino/Hispanic Americans, and although they make up 22% of the population, 28% of deaths were among African American patients.[i] Similarly in Chicago, 50% of the reported infections were in African Americans and up to 70% of COVID-19–associated deaths were among African Americans, although they represent only 29% of the Chicago population. In Chicago, Latino/Hispanic Americans did not see the same elevated mortality rates, representing just 15% of deaths in a city where they make up 28% of the population.[ii]

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The disparities persist in states as well. In Michigan, 40% of COVID-19 mortality was among African Americans, despite the fact that they make up only 14% of the population. In Louisiana, 70% of deaths have been among African Americans, despite them making up 30% of the population. These patterns have also been reported in Wisconsin, North Carolina, and Georgia.

There is little published information about the effects of COVID-19 on these populations, as other epicenter cities in China and Italy have more ethnically homogenous populations compared to the United States. Additionally, during the SARS outbreak in 2003, there were approximately 8,000 cases worldwide, and the majority were in China, leaving minimal information about how these groups were affected during a similar outbreak.

Early reports published in China show that the greatest risk factors for COVID-19 infection are diabetes and coronary artery disease (CAD). Analysis of data collected during the SARS outbreak in 2003 demonstrated that diabetes and heart disease were independently associated with mortality.[iii] In China this year, data analyzing mortality rates and comorbidities from 1,590 patients with COVID-19 showed the most prevalent risk factors associated with mortality were hypertension, diabetes, COPD, and malignancy.[iv]

African American and Latino/Hispanic Americans have higher rates of type 2 diabetes, obesity, and heart disease. The prevalence of diabetes mellitus is 21% in African Americans, compared to 11% in non-Hispanic whites.[v] One study published in JAMA in 2017 showed that African Americans have nearly double the rate of development of type 2 diabetes during middle adulthood compared to non-Hispanic white Americans. The same study also demonstrated that biological factors, including fasting blood glucose levels and body mass index, were the most strongly associated with the disparity when adjustments for behavioral, socioeconomic, and psychological factors were made.[vi] Forty-two percent of African American men and 44% of African American women have diagnosed or undiagnosed hypertension, which is 10% higher than other racial groups in the US and one of the highest rates worldwide.[vii] Rates of CAD are not significantly statistically different between African Americans (6.5%) and non-Hispanic white Americans (5.8%), as reported by the Centers for Disease Control and Prevention (CDC). When analyzed further, rates of CAD were slightly higher in non-Hispanic white men at 7.7%, compared to African American men at 7.3%. However, African American women had a higher rate of CAD at 5.9%, compared to non-Hispanic white women at 4%.[viii]

Latino/Hispanic Americans are now one of the largest ethnic minorities in the United States. Overall, less data exists analyzing Hispanic American risk factors, as they represent both a younger population as well as a population more recently immigrated to the United States. However, trends in younger populations indicate that Latino/Hispanic Americans are at higher risk for cardiovascular complications. Latino/Hispanic Americans have a 17% rate of diagnosed and undiagnosed diabetes, compared to 10.7% of non-Hispanic white men and 19.1% of non-Hispanic African Americans. Latino/Hispanic women have a 16.4% rate of diabetes, while non-Hispanic white Americans have a rate of 8.4%. African American women have a rate of 18.7%. Furthermore, the rate of pre-diabetes among Latino/Hispanic Americans is among the highest of any ethnic group at 44%.[ix] This may be representative of Latino/Hispanics generally being young and may indicate that future cardiovascular risk will increase as the population ages.

Socioeconomic status, independent of race, may be a significant risk factor for primary COVID-19 infection. Middle-class and upper middle-class Americans are more easily able to telecommute, and they receive a salary that is more resistant to economic downturns. By contrast, working class Americans rely on their ability to work a consistent number of hours to maintain their pay. As a result, working class individuals are far more likely to continue to work, use public transportation, and risk health-related complications for economic stability.

Population statistics from Chicago demonstrate this phenomenon, where the rate of infection is highest in African Americans, correlating with poverty levels in that city. African Americans make up 36% of those living in poverty in Chicago, yet they represent 50% of COVID-19 infections. Latino/Hispanic Americans in Chicago have poverty rates of 23%, which is lower than both African American and non-Hispanic white Chicagoans.[ii,x] In New York City, Latino/Hispanic Americans have the highest mortality rate from COVID-19 as well as the second highest poverty levels at 22%. Asian Americans have the highest percentage of poverty in New York City at 23%. African Americans have the third highest with 20%, with non-Hispanic white New Yorkers at 12%.

Asian Americans have been the subject of intense scrutiny over the course of the pandemic, with some experiencing racism due to the origin of the virus in Asia. However, as a minority population in the U.S., they have had the lowest infection rates of any

racial or ethnic group. In New York City, Asian Americans are reported to have the highest poverty levels, making up 23% of those living in poverty. However, their rate of death from COVID-19 in New York City has been significantly lower, representing just 7% of the mortality while making up 14% of the population.[i] In Chicago, Asian Americans have the lowest poverty levels of any race, with 4% of Asian Americans living below the poverty level, and they had similarly low rates of COVID-19 infection at 3.6%.[ii,x]

Strategies for Prevention, Screening, and Mitigation of Disparity in the Emergency Department

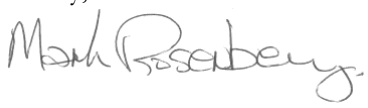
ACEP is working with its members to raise awareness of these epidemiological trends in the U.S., so they can better screen, test, and treat patients. We have encouraged our members to have a heightened suspicion for COVID-19 prevalence and disproportionate morbidity and mortality among underserved minority populations. We have further urged prioritization of aggressive education, adequate access to screening and testing, and proactive management strategies. All patients with mild symptoms who are discharged from the emergency department or hospital should be questioned about the people with whom they live and any risk factors they may have. It is critical to ensure that there is adequate understanding of recommendations among patients who speak a language other than English. A translator should be used to communicate with such patients, and they should be provided with educational material in their own language. Patients who are to be admitted to the hospital should have standard management of COVID-19 as outlined by published official recommendations.

In addition to our broader efforts to address health care disparities and inequities, ACEP has worked to raise awareness during the pandemic that some underserved racial and ethnic groups may have underlying comorbidities that may not be diagnosed or treated due to limited access to primary care. Certain populations have unique health considerations and should be treated as higher risk for developing severe COVID-19 infection. These populations benefit from more specific screening and treatment in the emergency department, in addition to other diagnostic management.

ACEP urges Congress and federal agencies to develop and support robust tracking of granular demographic data relative to COVID-19 incidence, morbidity, and mortality. This information is necessary to better understand the factors associated with the disproportionate impact of this disease on underserved racial and ethnic minority groups. Furthermore, this data should be collected and accessible in order to foster research and analysis of this phenomenon.

Identifying, reducing, and eliminating health care disparities is an essential part of our collective efforts to improve patient outcomes and ensure greater health equity, and it is a key priority for emergency medicine and ACEP as an organization. Once again, we appreciate the Committee's attention to this important issue, especially in the context of the greatest public health challenge of our time, and we stand ready to work with you to develop effective policy solutions to improve equity and outcomes in our health care system.

Sincerely,



Mark Rosenberg, DO, MBA, FACEP
ACEP President

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