Prioritizing Equity video series: COVID-19 & Asian American & Pacific Islander Voices

Explore the ways COVID-19 may uniquely impact Asian American and Pacific Islander communities during the latest installment of our YouTube health equity series. Hear from East Asian, Pacific Islander and South Asian health care leaders on topics such as the pandemic’s impact on Asian communities, data trends and health equity concerns.

Panel

- **Julie Morita, MD**—Executive vice president of the Robert Wood Johnson Foundation
- **Jay Bhatt, DO, MPH**—Internist, ABC News contributor, former health equity leader and chief medical officer of the American Hospital Association
- **Ignatius Bau, JD**—Policy consultant for the National Council of Asian Pacific Islander Physicians
- **Manisha A. Sharma, MD, FAAFP**—California Health Care Foundation, leadership fellow
- **Ray Samoa, MD**—Assistant professor at the City of Hope Medical Center in Duarte, California
- **Ryan Huerto, MD, MPH, MA**—Family medicine physician and health service researcher

Moderator

- **Aletha Maybank, MD, MPH**—Chief health equity officer, group vice president, Center for Health Equity, American Medical Association

Transcript

July 16, 2020

**Dr. Maybank:** Good afternoon, everyone. Welcome back to the Prioritizing Equity series hosted by the Center for Health Equity at American Medical Association. My name is Dr. Aletha Maybank, and I'm Chief Health Equity Officer at the American Medical Association. We've had some amazing
conversations, and I'm really looking forward to today's conversation with the guests that we have. Just a few reminders, the Center for Health Equity, our goal is really to work to embed and facilitate a process to embed health equity across the entire enterprise into our performance and practice. All that it is that we do, as well as evolving on transforming the culture that we have at the American Medical Association.

There's been lots of work and activity around COVID, so if you haven't checked out our website, there's a health equity resource center for COVID-19 that is there. For our previous conversations that we've had, you can go on the AMA YouTube site and find the categories. There's lots of information and lots of videos, but you can also find the previous episodes that we've done. So I encourage you all to do that.

And so as we move forward in today's conversation, early in May, and actually as the pandemic began and it being labeled and the narrative around it being a virus, and a China virus more specifically, that has been used by our top level administration, has absolutely been harmful. Harmful to mindsets, harmful to just how we are advancing in this country as it relates to equity, harmful for our patients and harmful for us as physicians. AMA definitely released a statement at some point in May about racism and xenophobia and how it must stop, and we don't condone it at all, clearly. But it still continues. I was expressing before we got on this conversation, I had a statement re-issued about World Heath Organization, our withdrawal from it and the danger of that. And some of the posts that really were elevating or the comments were, "Well, it's owned by China, and so this is why we shouldn't do it." And so this sentiment is pervasive throughout many aspects of our country and our society.

We are, just to let folks know, working on a survey, actually, right now to survey physicians that are minoritized and marginalized in this country. There is not much asking about our experience, and so we've taken it upon ourselves to do so. If anybody is interested, actually, in completing the survey, we're going to put the link in the chat box so that you can also complete the survey. But this is a way for us to learn more about AAPI communities and the voices of all of us, truthfully. I just want to acknowledge the diversity. I may use the term Asian but understanding that there is tremendous diversity within that term. Whomever's on this conversations can speak to however folks like to use in terms of narrative, but that we really fully recognize the diversity within the community.

So, now introducing our panelists, we have Ignatius Bau who is a JD, policy consultant for the National Council of Asian Pacific Islander Physicians. If you can just wave your hand just a little bit, that'll be awesome. Thank you. We have Dr. Jay Bhatt who is an internist and an AVC News contributor, a former health equity leader and chief medical officer at the American Hospital Association. Jay, awesome. We have Dr. Ryan Huerto who is a family medicine physician and health service researcher. Ryan, that's good. We have Dr. Julie Morita, who is executive vice president of the Robert Wood Johnson Foundation. I think she did it while I was reading. Okay, great. We have Dr.
Ray Samoa, who is assistant professor at the City of Hope Medical Center in Duarte, California. If you could wave your hand, Dr. Samoa, that’d be great. Awesome. We have Dr. Manisha Sharma, who is in California with the California Health Care Foundation, and she is a leadership fellow there.

Thank you all for joining today in this wonderful series. You all are tremendous leaders, highly dynamic and just so excited to speak with you. I'm going to open it how we usually open it. An hour is never enough time, but that's we all have. But what I want to hear from you is, again, where are you, literally in this country, and how have you been doing over the last four or so months? Where are you now? How are you feeling right now? Let's start with Julie.

Dr. Morita: Great. Aletha, thanks so much for inviting me to participate in this and also for denouncing xenophobia and racism. I think the AMA made a strong statement when you all did that and came out strongly. I am, as you said, the Executive Vice President for the Robert Wood Johnson Foundation which is housed in Princeton, New Jersey. I was commuting back and forth between Chicago and Princeton for the first month of the pandemic. But then in March, we shut down, and I've been in Chicago since then. In terms of how I'm doing, I think both professionally and personally I'm feeling highly motivated by both the pandemic but also by the anti-Black racist events that have occurred recently. I think these two things, in general, have just led me to believe that the work that we're doing at our foundation is really the right work to be doing. We're focused on building a culture of health and advancing health equity, and it couldn't be more relevant than it is right now.

And then from a personal perspective, with the anti-Asian racism that was experienced early on with the pandemic, I think it just really struck a note with me, just struck a chord with me that I felt like where in the past I might have been more likely to turn the other cheek and to look the other way and just to keep moving, I didn't feel like it was appropriate to do that anymore. I was inspired a bit by my parents. I think I wrote an op-ed earlier this year related to their experience in determining how they often were stoic and didn't really speak out about it. But then when 9/11 occurred and with anti-immigrant problems that have happened recently, they started speaking out. I think the COVID and the anti-Black racism really have motivated me to do more and to speak out more. So I'm feeling highly motivated both professionally and personally.

Dr. Maybank: Wonderful. Thank you. I'm doing that commute. I'm the reverse of you, so I was in Chicago and now I'm in Brooklyn, just housing out here in Brooklyn, so I understand that. Jay? You're on mute. You're on mute.

Dr. Bhatt: Great. Sorry. Thank you. Great to be with all of you, and Aletha, thanks to you and the American Medical Association for the opportunity to come together and talk about this work and really just echo Julie's comments about lifting up these issues and really creating both conversation and opportunity for sharing that fuels the fire to do more to make a difference. And so really grateful for that.
I'm in Chicago, and I'm a community public health physician. I'm taking care of patients on the South Side in a community health center which I really care deeply about. It gives a real lens and perspective into the challenges that our communities are facing, and particularly those that are underserved and vulnerable. I'm also spending some time helping the state with their long-term nursing home response to COVID. As a geriatrician, that piece is close to me. I think those communities are so vulnerable, again, giving us more insight on how we might chart a different course for the future to help lift up health of those communities in equity.

I am also trying to, through AVC News, comment and lift up issues and tell the stories of those folks, the people who are experiencing the pandemic but also those that are finding ways to fight it effectively and learning through it. These issues that we talk about today have paramount in the conversations that have been happening there. Professionally, I feel really good about the work I'm doing. It's, I think, so full, and it's really given me a sense to connect back with the front lines of care, which I've been away from for some time, in a meaningful way. That's really given me a different perspective and lens than I had at the American Hospital Association and a systematic way of what was going on. That's really been interesting, from tents outside the community health center to home visits to testing in churches and in other community venues. You really see how people are experiencing their lives in this moment and in a very challenging way, including the folks that are essential workers that are there for so many in many different ways, including our colleagues that are clinicians and working on care teams.

Personally, I am fired up and echo Julie's motivation. I think there's a window of opportunity here that we have that hopefully just becomes larger and not smaller, as we've seen in other moments in history where they have become larger and they have, both civil rights, suffrage, voting, and numerous other along the way. But we've been here before in some ways, around the issues of racism and police brutality in 2016, in the summer of 2016. I didn't necessary see the kind of sustainable action, and I hope that is—but I'm also struggling with the toughness and the challenges and now we're back at the place we were several months ago, and struggling with the issues and conversation I'm having with my own communities of friends, family, parents. My dad was a pharmacist on South side of Chicago for most of his life, and it's now interesting to talk to him and others in terms of the anti-Black sentiment, or also those that have been supporting these communities within our culture and—

Dr. Maybank: We're going to come back to that, Jay. We're going to come back.

Dr. Bhatt: So that's part of what I'm struggling with—And working through.

Dr. Maybank: Thank you. Thank you. Dr. Samoa?

Dr. Samoa: Where am I at? I'm exhausted. Just so you know, I'm an endocrinologist, and my
research is in the interplay between diabetes and cancer. Most of my work is in optimizing metabolism in cancer survivors. But I'm also the lead for the National Pacific Islander COVID-19 Response Team. What's not really publicized often is that in many of the states that report segregated data, Native Hawaiians and Pacific Islanders have the highest rates of disease.

One may ask, "Why is an endocrinologist heading an infectious disease task force?" Well, I think the major reason is because our every day is chronic disease. That's what leads to death in the majority of our community. A lot of the socio-economic inequities that have led to poor access and social determinants of health that lead to chronic disease are leading to the higher predisposition to COVID-19 in these communities. That chronic disease infrastructure is the only thing in place right now for Pacific communities to address COVID. We haven't had a national voice, and we've realized how that has been really detrimental when advocating for a community that's very disparate.

So I get what Julie's saying. I'm seeing patients full time and just finishing a manuscript and writing a protocol on top of Zoom meeting after Zoom meeting after Zoom meeting. I appreciate this opportunity because I'm out of my depth. I loved my silo. It was comfortable. I had a research team. People had designated jobs. And now I have audience with public and state health departments and the CDC, and we're talking about budgets, contact tracing, community health workers and social determinants, and I have not that training for it. It's been a really steep learning curve. I feel like, physicians especially, we're called—I'm the Where's Waldo? For some reason, I keep showing up in places that I look around and I'm like, "What am I doing here?" And I think that's the nature of our profession, is that our capacity in certain fields leads us to leadership in many areas. Yeah, it's been tiring, so I appreciate being able to vent with the group that understands fully.

**Dr. Maybank:** Thank you. I'm glad we took this opportunity to do that because oftentimes, especially in our professional lives, honestly I think the Whiteness in how to come to the space of having to be closed and not talk about what's really happening and what's going on in our experience through it, we've internalized that so much. It's harmful, and it's exhausting. I think it's really important that we're able to be candid and to speak our truth because it is fully who we are. It doesn't take away from what we can do, I think it actually completely adds. So I definitely acknowledge and appreciate the authenticity that you just brought to that moment. Thank you to everybody that's brought so far actually, but thank you. Ignatius, how's it going for you where you are and all of that?

**Bau:** So I'm here in San Francisco, California. I am the proud son of a refugee from China, and who, in her own way, ended up being what I would consider a civil rights pioneer because she was one of the first Chinese bilingual teachers in the San Francisco Unified School District, to really make sure that Chinese-speaking students could get a quality education. I spent 10 years as an immigration lawyer and worked with a lot of different immigrants and refugees from all over the world, and then did a career turn and worked on HIV and AIDS in the Asian and Pacific Islander communities and really learned how communities can be invisible in the midst of a pandemic and really try to lift up the voices
of Asian American and Pacific Islander and Native Hawaiian communities during that time.

So it feels a little bit deja vu to now be in COVID-19 and, again, be on the forefront of trying to lift up the needs and the issues for Asian American, Native Hawaiian and Pacific Islander communities with the National Council of Asian Pacific Islander Physicians and other Asian and Pacific Islander groups that I'm working with. But it feels also like this really important moment of opportunity. One of the things that I've been saying is, we're not going to go back to normal, we need to redefine what normal is. This is an opportunity for us to think about these issues in a bigger and bolder way, to think about... We'll talk a lot about data collection. I think we've broken open this conversation where nobody can protest anymore to say, "Data isn't important by race and ethnicity and so many other factors." The question is, how do we use that data, and how do we make sure that that data is in the hands of the community so that we can advocate for what we really need?

Dr. Maybank: I got to unmute myself. Dr. Sharma? Thank you very much, Ignatius. Dr. Sharma, Manisha, where are you?

Dr. Sharma: Yeah, so first I just want to say thank you, Aletha, for having me on and having us on to have this conversation. I really want to put out there that I am social justice family medicine physician who didn't join the AMA because of the history of the AMA, and I literally joined the AMA because of you. It's the truth, and actually got a lot of other physicians of color to actually join the AMA because you give us hope. And so I just wanted to put that out there.

Dr. Maybank: Thank you.

Dr. Sharma: I told that to your producer, but I'm saying it out loud because it's really important, because you elevate with intentionality the conversation about health equity. It's not even just a conversation, there's an actionable component to it and that it makes me have hope that the AMA is shifting from its history to a place of true awareness and wokeness, if you will.

So, where am I? I am actually currently in Kansas City. I am originally in San Diego, but I'm in Kansas City with my family trying to pick up the pieces from the death of my sister pre-COVID in February. We're trying to seek justice for her killing. So that's where I am here on a personal level. I'm also in Trumpland, which is also a little anxiety provoking, just because I think it's really amazing geographically to see the differences of where you are and just having signs of Trump and bumper stickers. It's actually a PTSD-ish, if you will, just to see it.

On a personal level, it's sort of I'm in a space of exhaustion. As Ray said, I'm in a space of being tried. I'm also in a space of self-preservation. A lot of the work that I'm doing on social justice level has really—we started votehealth2020.com to get people to vote. If you really are enraged by the anti-Black racism that's existing in this country, if you are enraged over how COVID has been handled in this country, the way to do this is to be actionable in your right to vote and then wanting to preserve
folks' ability to vote, but also to fight for folks to actually be able to be champions of voting. We're doing it through the lens of health care championship, if you will. If you are a health care provider, we are trusted folks that we can actually be part of the voting. That's what we're working on on the outside.

As a mom, I'm a mom of to a Black son, so I'm also trying to—very proud mom of my son. But he's four, and trying to help him navigate through what he sees on TV, what he hears as conversations and being intentional about helping him understand his amazingness as being a Black young man, and also that we're here to protect him and also to help him be part of the change. He wears a Vote mask. He tells people that he's amazing, and I think that's the steps that we can take. And so it's the space that I'm in. It's a smorgasbord, if you will.

Dr. Maybank: Thank you. I think I'll just keep myself unmuted. Appreciate that. All right. Ryan, I want you to say where you are, and then I'm going to continue a question after you finish, and it might continue with you say. But go ahead, let's hear.

Dr. Huerto: Absolutely. First of all, thank you for having me. It's an honor to be on such a awesome panel with folks that I admire so much. But in terms of where I am, I'm currently a national clinician scholar at the University of Michigan. Originally I'm from California. I grew up in Los Angeles. In terms of how I'm doing, I think Dr. Samoa said it the best, I'm tired. I'm frustrated. I'm feeling overwhelmed. I think relatively speaking, though, I'm doing well. I'm healthy, my family is healthy. So things could definitely be worse. I do sense a collective sense of loss in my community given everything that's happening with the pandemic, with systematic racism. On a lighter note, I do want to highlight some things that are giving me life right now.

Dr. Maybank: Great.

Dr. Huerto: There's an organization known as AF3IRM, which is a trans-national, anti-imperialistic feminist organization. They actually created a website called kanlungan.net, that's K-A-N-L-U-N-G-A-N.net, where they're literally tracking Filipinx essential or front-line health care workers that have passed away from coronavirus. It just blows my mind that they're doing this on a volunteer basis based on news article reports in order to honor those who've passed away amongst our community as essential workers. Just like the renewed and straightened focus on combating anti-Black racism in the AAPI community is really giving me hope.
**Dr. Maybank:** Thank you. You're all are taking the conversation in a direction and so I'm going to follow with it, because four of you have mentioned anti-Black racism or three of you. I just want for you all to explain what that is and how it shows up, because I don't want to make the assumption that everyone who is watching this really understands what that means, and why is it important, in the context of talking about Asian Americans, that this is being elevated. I think Julie, Ryan and Manisha, you all elevated that. If others did, please speak to it as well. Go ahead, Julie.

**Dr. Morita:** Well, I can start. The Robert Wood Johnson Foundation has focused on building this culture of health and advancing health equity. What that really means is providing an opportunity for all Americans to have an opportunity for a fair and just life and eliminating obstacles to health and well-being. And those obstacles include racism, whether it's anti-Black or anti-Asian racism. With those systematic racism factors that have been in play for many, many years, that's what's contributing to the health inequities that we see with baseline. But then also we see this play out in every single public health emergency.

When I think back over my time in the Department of Public Health, I look at measles epidemics, I look at heat waves, and I look at who was most severely impacted. What I see is that it was people of color who are dying or most likely to be infected. And so COVID is no different than any other public health crisis. It exacerbates the underlying poor health of people of color. Why are they having more problems with poor health is because of systemic racism and things in the past that have contributed to the conditions that are living in so that their health is worse at baseline and then they do worse during a public health emergency.

What I feel now in this pandemic and with the anti-Black racism, the outrage that is occurring because of anti-Black racist events recently, I'm feeling an openness. I'm feeling like there's an opportunity for us to tear down some of these structures and these systems that have been in place for so long and actually do something about them. Because in past emergencies, those systems may have been touched a little bit, but we really didn't address the issue, as you can see playing out through this pandemic and ongoing racist events. And so I think it's related. Structural racism contributes to poor health overall, and the foundation is really focused on addressing and improving health overall. Unless we start tearing down some of this structural racism and rebuilding, I think Ignatius mentioned that we really have to build new systems, we can't just fix the old systems. We have to rebuild systems and structures so that we aren't in the same place when the next pandemic comes along.

**Dr. Maybank:** Thank you. Manisha or Ryan?

**Dr. Sharma:** Yeah, I'd like to add too. I think the reason I'm calling out as anti-Black racism in terms of just being a South Asian and the lived experiences South Asian communities, I mean, there's no secret that there's an anti-Blackness in my community, at least, in the South Asian community. It's built into the culture. There's colorism, there's casteism, there's a lot of these things that are ingrained
socially. What is important is, as a South Asian women and immigrant's child, there's a myth that success is equated to Whiteness. So for me to call out there's racism and then there's anti-Black racism. As a non-Black person of color, I have privilege as being a South Asian woman where in my family, just as immigrants, immigration and just the notion of immigration was built on the backs of African Americans and the history of African Americans in this country.

I think it's important to call out it out. I think you and I have talked about this before, about you got to name it to change it. I think that it's not that racism isn't important, it is. But anti-Black racism and calling it out and being able to dismantle it actually benefits everyone. And so I think the reason I distinguish between those two is because even in a non-Black person of color community, it's important to understand it. And then there's that lived experience, my husband is Black. My son is blended, right? I don't want the future of my child to be in jeopardy the way that children are living right now and PTSD and just living in this racist that we are in in 2020. It's atrocious.

So I think it's important to acknowledge it, to talk about it, and to take this opportunity to actually move us to a new normal, really truly dismantling with intentionality. That's the reason why I bring up both of those components.

**Dr. Maybank:** Thank you. Ryan?

**Dr. Bhatt:** I'll just build on what has been said. I think for us as immigrants, health care is a huge domain for Asian American Pacific Islanders, South, South East and East Asian immigrants. There's a transporting of the culture of highly-respected professions from our countries among the first generation, before us, and in my personal experience and that doctors, engineers, professors and others come into this country. When I think about our own South Asian community but also other Asian American Pacific Islanders communities, those immigrants, clinicians and professions ended up working in safety net hospitals, in public systems, in government. It's peril to training clinical back home.

And so who are the people that they were taking care of? They were taking care Black, Brown and all kinds of people with different backgrounds. But particularly in my own experience, probably with Black people in South Side of Chicago. I think for some of those communities, the power structures have been easier to maintain and that there's this sense that one of the things we've got to do is—we think about racism as a chronic condition that upstream action and systematic action, but there are also particular communities, Black communities in particular, that are disproportionately impacted. And now, I think, as Asian American/Pacific Islanders of different generations, we have an opportunity, a privilege, and a responsibility to, I think, make that power structure different, more horizontal and not colonial.

I think we've seen some of the examples of how folks have shown up. The Gandhi Mahal restaurant located just three doors down from a Third Precinct, which was burned down in Minneapolis. Those
restaurant owners, as Bangladesh immigrants, just approached this very differently. "Let my building burn. Justice needs to be served," the owner said. They talked about continuing to amplify the importance of solidarity with Black communities and undo anti-Blackness within our own people, and that means explaining how White supremacy and racism are devastating to all people of color, including our communities. And so I think we've also seen this in D.C. with Rahul Dubey, who housed 70 protesters on Swan Street, and that conversation about what it means to be human and how do we show up with our humanity in these moments but also for the long term. And so that's part of what, I think, we all collectively have to come together around.

Dr. Maybank: Thank you. Ryan?

Dr. Huerto: I'll add to that. I think when I think of anti-Blackness in the Asian community, I try to think very concretely. There's these more abstract notions, and I'm sure we'll get into things such as the modern minority myth. But I also want to acknowledge that as Asian Americans and Pacific Islanders, we have the potential to also cause harm directly to other communities. I think of Latasha Harlins, since I grew up in Los Angeles. Latasha Harlins was a young Black girl that was shot in the '90s, in the head by an Asian grocery store owner over a bottle of orange juice. I think of Rodney King, who the police who beat him were acquitted and that jury had Asian Americans on that jury. I think of George Floyd, and I think of the complicity of the Asian American community directly with White supremacy and anti-Black racism. I think for us to get free, we really have to dismantle racism and really think about what that means, not just on an abstract level, but tangibly in our everyday lives.

Dr. Maybank: Thank you. And so I'm going to come to ask, what does mean, tangibly, at this point in time? But I wanted to come to Ignatius at this point and speak to the data parts of it, you mentioned data. I think this connects slightly with the modern minority myth as well, and so some reflection on that. But the reality is, what is the harm that ends up happening when folks are othered, like literally othered, right, or lumped into one group or the data is just absolutely missing, which we know is existing right now? It's existed well before COVID as well. And so just want you to speak a little bit more about the data efforts that's you've been engaged in, and how are you elevating those challenges, what are your thoughts about closing those gaps and then those connections to being the modern minority as well?

Bau: Sure. So just a little bit of background, as of yesterday when I checked again, 32 health departments are not reporting data on Native Hawaiians and Pacific Islanders. Seven health departments across the country are not reporting data about Asians and COVID-19. And so we have a long way to go just to get to that very, very basic out of the other category and actually see ourselves in that data. But what the point I made is it's not just about COVID-19. We need that race, ethnicity, language, sex, sexual orientation, gender identity, disability, et cetera, et cetera, data on every condition and every diagnosis. We have in every hospital now electronic health records that are supposed to be collecting race, ethnicity, language and all this other data, and the question is those
fields are still optional but electronic health records are still not fully operational at that level to actually document what those patient demographics are. And so we'll never really understand truly all the complicated risks, all the causations of why we're seeing those disparities, particularly.

I would say part of the anti-Black racism is not doing this comparing oppression and comparing disparities, and I think it's really important as advocates for better data to say, "The data tells us that the disparities are most glaring for African Americans, for Black communities," and we need to lift that up and to lift up the need for more resources, not to diminish the need for resources for our communities, but to say, "We need to follow the science. We need to follow the data."

I think the pieces are in place to make this happen, and the question is really the will. We have the standards, we have the capacity, and it's really, I think, taking this moment in time when we have the consciousness of why this is important to say, "We need this data across communities, across all these intersectional identities to really understand how disease happens and then more importantly, how to prevent it and how to go upstream in the way that Robert Wood Johnson Foundation has to really think about those community solutions that lessen those disparities and improve our health overall.

Dr. Maybank: Thank you for that, that's helpful. And then going back to the data, clearly the data shows the impacts and the severity of impact as it relates to Black communities as well as Indigenous communities who also—it's highly impacted those communities—oh, and Latinx communities. But the assumption’s made as it relates to being the modern minority, I think oftentimes moves us away from the conversation of what is happening with the Asian community and going deeper. So what do we do in order to go deeper and to move away those assumptions as it relates to being the modern minority? Dr. Samoa, do you have any thoughts? Oh, go ahead, Ignatius. Go ahead. Go ahead.

Bau: So there's two levels. One is, and Dr. Samoa can obviously speak to this, simply separating out the broad category of Native Hawaiians and Pacific Islanders from Asians. Those are smaller populations with much greater health disparities than the Asian population as a whole. And then within the Asian American population, knowing the difference between Filipinos and Vietnamese and Koreans, with all the diversity of our Asian American populations. Hawaii is the only state that is reporting data at that disaggregated level, separating out Filipino from Chinese and Japanese. It can be done, and that's why I'm saying, again, it's not a question of capability, it's a question of will at this point.

Dr. Maybank: Absolutely. I agree. The advice at the New York City Department of Health, we did a health of Latinx and where we looked at more country of origin and health outcomes and we also did it for the Asian community in New York City, so it's possible. For my team who's putting links up, can you put links up to show people on the YouTube? Dr. Samoa, do you have any comment or reflection at this point?
Dr. Samoa: Yeah, I wish this was a three-day conference. I'm learning a ton. As Ignatius alluded to, yeah, there are higher rates. My impetus to be involved, I needed a really strong reason to devote more time to another project that I really don't need in my life right now. When the rates started to come out in California, we touched base with our advocates in other states, and in every state we looked at that had disaggregated data, Native Hawaiian, Pacific Islanders was either the highest or the second highest rates.

That prompted us to put together a strategy and to work with regional coalitions to talk to the health departments, but also to advocate for all these things that we know we'll help with the pandemic, such as contact tracing, such as social support, safe quarantine. And so when we started, we noticed the biggest problem we had, that Ignatius alluded to, was the lack of data. Although California State had reported, at that time we had no county data, right? California's huge, and so it's hard to gather where do you need to start with.

I apologize to Ryan and Jay, I know nothing about public health, but I'm going to speak something to it right now. The public health cycle that I understand starts with data and then it leads to the justification of allocation of resources. And then that goes to programming and then that's re-evaluated as data. Invisible communities such Native Hawaiian, Pacific Islanders, Native Americans, Asian populations, we are invisible. So there is no data, so there's no way for us to even partake in any of the downstream benefits of that cycle. We're in the midst of a pandemic, we realize that our health info cycle starts with coalition building. Coalition building leads to advocacy, advocacy then brought about data. Because once we got that information and the community went out and started prompting data to be reported, we found out data in Oregon, we found out data in Arkansas, we found out data in Washington state, in Hawaii, in Illinois. All of them, across the board, they all said the same thing, right?

So what that brought about was media attention. They started asking, "Well, what's the predisposition? What is it about Pacific Islanders that is making the rates so high?" And then there was some tendency to ask me questions about biologic predisposition. The diaspora in the rest of the Pacific, in New Zealand, that is genetically identical, that has the same socio-economic factors as the one in the US, is not suffering from this. And so I was so happy that my vocabulary has increased with words such as anti-racism, because this is anti-racism example, that there's a diaspora that is thriving that has access to these opportunities and a diaspora that is suffering that does not have access, based purely on their socio-economic status, which is basically largely determined by our race and ethnicity.

What we've also realized is that the truth in data helps all of us. Some of our data has been mixed up with Asian populations, but what we've realized is that our advocating for data to be truthful, it doesn't hurt us. What it did make us realize that the further disaggregation of Asian data will help a lot of populations. Most of the re-categorized data was from Filipino communities, so it tells us that there is
a problem with the Filipino community, that's pretty much unpublicized. Not to beleaguer this, but that's what we've been dealing with.

**Dr. Maybank:** Yeah, I appreciate that, many of us—Julia, I wanted to chime in a little while ago.

**Dr. Morita:** Yeah, thanks so much. I think we could talk for days on this topic. But at Robert Wood Johnson Foundation feels very strongly about the need for disaggregation of data. Because from our perspective, having those data really give power. I heard Ray was talking about this need for power building within community to advocate for change, and having the data really allows groups to actually do that kind of advocacy. End of May, we actually issued some health equity principles because we have this as a state and local leaders, we're talking health equity but didn't really know how to operationalize it. So our number one principle is really encouraging data disaggregation by age, by race, by gender, by ethnicity, by disability, by geography, and other socio-demographic characteristics, because that kind of information really does allow us to know where resources need to go, identify where the problems are but also engage those communities to help build the solutions.

Because the second principle that we have is really the communities that are most affected really need to be part of the solution-making. And unless we know who those communities are, we can't fully do that kind of engagement. So that's our second principle. But it really relates to what you were talking earlier, Aletha, in terms of the lack of data feeds into this concept of Asians as modern minorities. Because as long as the data aren't disaggregated by ethnicity, Asians are lumped together and our numbers and our health status, our health behaviors, the conditions within our communities look great. But the reality is that they are not consistent across the board as it relates to Asians, Pacific Islanders, Native Hawaiians. We can't just be lumped together as one big group because it's very, very widely different in terms of what those conditions are, what the behaviors are and what the health outcomes are. And so it is critical that data are really disaggregated.

**Dr. Maybank:** Absolutely. Ryan, go ahead.

**Dr. Huerto:** Yeah, so something I want to say is—it's top of all these wonderful panelists. But what I want to say is a lot of the disparities amongst the AAPI community in terms of chronic non-communicable disease, Dr. Samoa alluded to this, is in terms of diabetes, hypertension, so on and so forth, were known. But I think the difference now is that with coronavirus, it's accelerating these inequities, these disparities because now you have this biologic pandemic that is literally killing folks at a faster rate. So there's a renewed sense of urgency for this data so that we can meaningfully reallocate things such as PPE, housing for safe quarantine. You can reallocate ventilators, potentially if ICUs in hospitals are being overwhelmed.

I remember when I was making a decision towards the end of my residency of what I was going to do for a fellowship and had decided to pursue a health services research fellowship. One of my close friends said, "Data doesn't matter, because people are going to believe whatever they want to
believe." But if you take a step back from it, not only are researchers and physicians and clinicians and lawyers such as us shouting for these numbers. As I alluded to in the beginning, there's grassroots organizations who are literally on a volunteer basis looking at, "All right, so there's a death of one Filipino nurse here. Let me confirm that with another newspaper just to be absolutely sure." People would not be pouring in all this energy and effort to this issue if it wasn't meaningful and if we didn't believe it potentially could save lives.

**Dr. Maybank:** Yeah, and it's a fascinating comment of what your friend said, because there are people in the country who are saying that that data is not important. We're not going to believe that data. We're not going to believe that science and are creating decisions based on that, and it's harmful as well, but it also speaks to justice, and the root of movements and justice are always led by those who are experiencing it, right? And that's, I think, what you're kind of elevating, Ryan.

I think as physician, how are we connecting to those movements, and how are we leading those movements are really important. Manisha, I know you wanted to say something as well. But I would love for you all, as we move and shift towards that last 10 minutes of the show, what are those solutions that we need to put forward? What are those opportunities as leaders, lawyers, physicians that we need to be screaming about, that you all are screaming about. We don't want to have to scream, but that we are calling upon other folks to be committed along with us? What are those things that need to happen? Julie, you mentioned some of them already, but I would like to expand on that with Dr. Sharma.

**Dr. Sharma:** Yeah, so I love what Ryan and Julie, everyone is saying, because I think as a ground doc and an activist, one of the things is there's the academic components of data, right? Data tells the story. But a lot of times when I engage with community-based organizations, they're so thankful that us, as physicians or nurses or social workers, who actually come and talk to them about the data but then help them find ways to use the data to elevate their voice.
So to your point about movement, I think we have an opportunity, we've always had it, but I think now more so, where we can actually get out of the exam room or get out of the telemedicine video and be able to get on the street. This is an opportunity for us to take the knowledge that we have and share it in a way that's meaningful, so to Ryan's point, help folks understand and connect the dots on how to use the data so they can elevate in a justice way. Health is everyone's work. Racism and dismantling racism is everyone's work. It should be all of our personal work. I think as a physician, one of the things that I try to encourage younger physicians coming up is to get them to understand that medicine is also following Virchow and just being able to think about medicine as the fact that it's about being able to pay attention to your society. It is about politics. It is about policy. It's about getting involved in those spaces, and not in an academic way, but in an intentional, sustained way, and then being able to bring people along. And so I just say that the data is part of the story, but now it's about how to apply the data in actionable items. And so I just wanted to put that out there.

Dr. Samoa: Can I add to that?

Dr. Maybank: Please.

Dr. Samoa: I agree fully with you, Manisha. There's a tendency of physicians to advise the community, but in this time and space, we now need to become the community. I was diagnosed with COVID right before the data was pushed out, and so there was a lot of comments about income. But it dawned upon me that I'm at a level of privilege, but I'm in an ethnic demographic that has high numbers of essential workers. Let's not forget that and that doesn't erase it because I'm a physician. And so let things that have to deal with socio-economics, deal with—let us find solutions to that. But things that are based in racism, we need to find solutions to that.

And so that's pushed me into this realm of leading community because, like you said, the data tells a story. But what happened when we got the data, was public health officials looked at us and said, "Well, what do we do? What's the plan?" Because they weren't able to engage the community before the pandemic, nothing's changed about that. They still have obstacles in regards to delivering interventions to us. One of the things that we had to do with the strategy was once we get the data, what do we do? What's the plan? Luckily for us, the strategy is held up in all the regions and so these community groups have increased testing to, you know, community-led testing has exponentially increased testing. There's community health worker contact tracers that are being hired all over the place. But I got to tell you, there's so many aspects of it. I'm leading a faith-based group to do weekly updates by language and leveraging the existing podcasters to do it. Particularly because we have 300 people volunteering their efforts because there's not a lot of funding streams and we have to be very innovative in supporting this work.

And so, yeah, there's, and then on the policy side too, we've had to push—I hate policy. I have no business talking about policy, so I lean on Asian, Black, Latinx policy aspects to take us into those
spaces. Because like you said, the story is our story, but we need to do a better job of navigating that story. It's time for physicians to get our hands dirty.

Dr. Maybank: Yeah. So speaking of that, in a way, so let's round robin it in a sense. Ignatius, what are those solutions? And then I'm going to move to Jay, and then I'm going to flow up my screen, it'll tell you where you are located. But Ignatius and then Jay, what are your recommendations at this point in time? I'm asking for them to be succinct so that we can get through everybody.

Bau: I just want to lift up all the front-line workers, and particularly in the physician community, those that are working in community health centers and public hospitals, those in solo and small practices that often don't get a whole lot of attention. These are the folks that are providing a lot of care to Asian American, Native Hawaiian and Pacific Islanders communities, don't have access to the technology, don't have access to other kinds of supports that larger systems and medical groups have. And so I think really supporting those physicians to provide information to their communities, to support the contact tracing that's going to be needed and to really keep lifting up the disparities that they're seeing every single day so that they do get the resources that they need to serve their patients.

Dr. Maybank: I'm just going to dig a little deeper there, what does support look like? So if you all can answer that as we go through because support to me is like one of those words like community. It's like one of those words like access. It's very broad and can be many things. I think specificity to what we mean and how to do that is really important. Jay?

Dr. Bhatt: Thanks, and this has been really rich conversation. I'll just build on what's been said. One, I think we've got to accept responsibility in a meaningful way, and accepting responsibility for enabling shared purpose in the face of uncertainty. And so that means understanding where as an organization we are, where as an individual we are, where as a community we are and then saying, "Well, what do we need to do to get better?" And so an assessment of sort. That needs to happen internally, you're got to have work in own house to then improve the community also around you. And that's, I think, important, and I think the Robert Johnson Foundation has been really great in helping move that notion forward as well.
The other is educating and communicating with individuals in your communities in the ways that resonate with them. Not all communities will take in or engage in information and interactions in the same ways, so understanding that. Building and strengthening the community partners and organizations that through COVID and through the economic downturn they’ve been impacted, so how do we help support them all. Identifying policies, systems, and environmental changes that can address racism and inequities. And then on the data piece, I'll agree with what's been said. The other thing I'll point out, in this moment, where we see technology accelerating, uses of data through machine learning, predictive analytics and AI accelerating, Asian American, Pacific Islanders are still invisible. So that data is becoming intelligence that's turning into action, and we're driving action on invisible people.

So organizations and individuals need to ask themselves and check that before making decisions based on that data. And then sharing what we learn. Those things that are working, we need to AMP harvest and amplify and advance, contextually, in the ways that work for communities.

**Dr. Maybank:** Thank you. Ryan?

**Dr. Huerto:** Okay, I was—

**Dr. Maybank:** I think we have a few minutes, so I want to get through all of you.

**Dr. Huerto:** Okay, I'll be concise. I think just thinking more structurally in terms of as an Asian American/Pacific Islander community supporting anti-racist policies, the Green New Deal, food sovereignty, housing, universal health care, we can't do that unless we shed our own, in my opinion, anti-Blackness. Because how do we build coalitions with other groups and build at the momentum to get these things passed? So I think a lot of that has to do with knowing the history of systematic and structural anti-Black racism even within our professions, reading Medical Apartheid, studying the work of David R. Williams, and really unlearning this myth of meritocracy. I think it really starts there, and then that's how you build meaningful coalitions, and that's how you translate that into power shifts and policies.

**Dr. Maybank:** Thank you. Manisha?

**Dr. Sharma:** Yeah, I want to amplify what everyone has said. But one thing I would also say, make this your personal work, every day. Also, if you have spaces of privilege and opportunity, bring someone along. I think that's the other piece of this, is to amplify voices that are not being able to be heard or have been screaming but never being heard. I've made it a constant for me to actually make this personal work, stopping ignorance where I hear it, see it, and also being able to not alienate, but help people see their own implicit biases and then being able to move them forward. I agree with what Ryan is saying. But it's also about providing opportunity, if you have one, then share the opportunity.
and move it forward.

**Dr. Maybank:** Thank you. Julie?

**Dr. Morita:** Yes, when I think about the audience, we're speaking to physicians. I think of physicians having numerous roles in their lives, as clinicians who take care of patients. My suggestion is really as a clinician taking care of patients to think about the individuals and their conditions rather than just what their race is, not looking at them as, and I think Ray mentioned the biologic aspects that's associated with race and whether or not we attribute disease or poor health outcome to biologic factors, thinking about actually the conditions that are contributing to these people’s health outcomes and health behaviors. So shifting that kind of frame. And also focusing on educating the patients so they understand themselves in this current context, what are resources that are valuable and appropriate and safe to use, because I think there’s so much misinformation out there. So relying on CDC guidance or documentation and recommendation is really important. Because though they may be undermined for political reasons, they are really the best public health recommendations that we have.

The other role that physicians actually play is as researchers, so using equitable approaches to research, so that when we're doing research, we're doing it in an equitable way. And then the other area is, as physicians, we are leaders, and we have voice, and we have power, so to use that to advocate for equitable policies, deconstructing systems and structures and policies that have contributed to structural racism over the decades. These are the things that we can do as physicians. So as clinicians, as researchers, as leaders and advocates, there’s many roles that we can play.

**Dr. Maybank:** Awesome. Well, we are at the very end. I just want to thank all of you because I have learned through this show, and it's going to be one of my favorite ones, and one day I'll tell you why. But there's something that Dr. Samoa said that I, as a public health person, and your mentioning of the public health cycle and your framing of how you said it was so poignant. I talk a lot about, and I have this vision of public health and health care coming better together. It's critical, I think, for our country, instead of having these silo systems. And Dr. Samoa, you point out why. I think there are opportunities like that, of learning in both systems. But if we don't come together in better and more intentional ways and find out how to pull our leaders on the health care side and on the public health side together in consistent ways, we're going to lose those opportunities. I'm putting that out there, because that is definitely some of the work and the intention of the center and anybody who likes to join along, is helping to support that, we are all for it.
Thanks a lot for everyone today for your voice, for your leadership, your advocacy and just demonstrating what it means to really step into this justice space and to center and prioritize equity. So thanks a lot and thanks to all who have tuned it. This will be available. Honestly, a lot of the ways these shows have been shown have been post the actual taping. We highly recommend for it be shared, but it will be available by the end of today. Thanks a lot to everyone.

Dr. Huerto: Thank you, Dr. Maybank.

Dr. Sharma: Thank you.

Dr. Samoa: Thank you.

Dr. Bhatt: Thanks so much.

Dr. Maybank: Thanks.

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