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Practitioners Essay

Addressing AAPI Health Needs in the Context of COVID-19

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Abstract

The COVID-19 pandemic has exacerbated existing challenges Asian Americans and Pacific Islanders (AAPIs) face in accessing healthcare: language access, barriers for immigrant populations, lack of data disaggregation, and lack of community resources. AAPIs also have increased vulnerability to COVID-19 due to higher representation in specific labor sectors. These challenges take place in the context of increasing anti-Asian hate and xenophobia. This article focuses on one organization addressing these challenges: the Asian & Pacific Islander American Health Forum (APIAHF). We will describe how APIAHF is using narrative change, structural change, and community change to address pandemic-related emergent and longer-term needs and how funding structures and critical partnerships with a variety of stakeholders support these efforts.

Introduction

The COVID-19 pandemic has deepened challenges to achieving health and well-being that Asian American and Pacific Islander (AAPI)¹ communities have long struggled to address. It has also created new and unique challenges. The Asian and Pacific Islander American Health Forum (APIAHF) has been serving AAPI populations for more than thirty-five years by influencing policy, mobilizing communities, and strengthening programs and organizations to improve the health of AAPIs. This legacy provides us with the experience and expertise to address emergent challenges. Critical partnerships with funders allow us to use general operating funds to pivot and modify programming,

expand policy focus, and address multiple crises at once, while new targeted funding allows us to extend resources quickly to the communities we serve through our network of more than 100 community organization partners in thirty-five states. Partnerships with a variety of coalition and community stakeholders provide us with the breadth, depth, and leverage to collectively lead the nation in addressing the health equity needs for AAPI communities in the face of COVID-19.

The Pandemic Has Exacerbated the Challenges AAPIs Face in Achieving Health and Well-Being

AAPIs face four primary challenges in achieving health and well-being: lack of language access, barriers to healthcare for immigrant communities, lack of disaggregated data, and lack of community resources.

Lack of Language Access

More than sixty-one million people in the United States speak a language other than English at home. More than twenty-five million are Limited English Proficient (LEP), meaning they speak English less than very well. One-third of the LEP populations in the United States are Asian American or Pacific Islander. Federal civil rights laws² require insurance companies and hospitals to provide in-language assistance, but in reality, LEP populations encounter many problems, from low-quality translations to LEP patients being unaware of their right to request an interpreter. Health insurance, including public programs like Medicaid and Medicare, usually does not reimburse providers for the cost of language services, so they often do not adequately prioritize language services (U.S. Census Bureau, 2015, 1). These challenges can also be present in seeking services related to the social determinants of health, such as housing and economic resources.

How COVID-19 Exacerbated This Challenge

In-language materials and communications assistance in a patient's primary language are necessary, especially when accurate and timely information is the difference between life and death (Galvin, 2020; Ponce, Hays, and Cunningham, 2006). Patients should not face treatment without understanding what doctors are telling them, but that is often what happens.

A ProPublica investigation revealed that in New York City, LEP patients are subject to delays and miscalculations due to the lack of understanding between them and their physicians (Kaplan, 2020). Language

access also has relevance for the disability community, with the *Los Angeles Times* reporting difficulties for sign language interpretation (Miller, 2020). Interpretation services are even harder to implement in a COVID-19 environment when physical distancing is required for health and safety. Access to in-person professional interpreters, the highest quality standard, is often impossible for LEP hospital patients (Aguilera, 2020). Meanwhile, documents about the crisis, the best public health standards, and how to get assistance also must be translated. While the Centers for Disease Control and Prevention (CDC) has been improving its efforts, to date, it has translated its COVID-19 website to only four languages, in addition to American Sign Language videos.

In April, APIAHF surveyed forty-five of the AAPI-serving community organizations in our network to assess their COVID-19-related needs. We found that nine out of ten organizations needed in-language / culturally appropriate resources and updates on physical distancing, public health, applying for benefit programs, and other COVID-19-related topics. APIAHF also works to lift up specific examples from our community organization partners. For example, Melisa Laelan, Founder and Executive Director of the Arkansas Coalition of Marshallese (ACOM) reported the language access challenges her community is facing to APIAHF Network Innovations Manager Lauren Pongan. Due to the lack of in-language resources from the CDC and local health departments, ACOM had to hold an emergency fundraiser using their Facebook site to translate a CDC flier on “what to do if you’re symptomatic.” The translator is working well below her standard rate to make this possible. There has been a significant delay in getting this information out in Marshallese. ACOM anticipates that they will need to step in to spread the word to community quickly and in-language.

Barriers to Achieving Health and Well-Being for Immigrant Communities

Oftentimes, non-U.S. citizens are left out of legislation impacting health and well-being, and this is particularly true for relief bills. Despite immigrants paying taxes and being a part of our community, they are still forgotten.

People living in the United States under the Compacts of Free Association (COFA), which is made up of the Republic of the Marshall Islands, the Federated States of Micronesia, and the Republic of Palau, have had to fight for Medicaid access despite an agreement between the United States and these communities to live and work in the United

States in exchange for military use and strategic positioning on their lands (APIAHF, 2019). ACOM has had to dip into its emergency fund to pay for the medical bills of an uninsured COFA community member who went to the hospital with COVID-19.

How COVID-19 Exacerbated This Challenge

Low-income COFA communities cannot access testing, treatment, or an eventual vaccine because of their inability to access insurance. Many work in “essential” jobs, such as in the meatpacking and nursing home industries, and, at the same time, live in multigenerational households. They also experience many health disparities that could be potential comorbidities with COVID, as a result of systemic racism and colonization, including U.S. nuclear testing in the Marshall Islands. This relationship between lack of insurance, high-risk jobs, existing health disparities, and inability to self-quarantine is an experience faced by many noncitizens and, unless addressed, will exacerbate the public health crisis.

The APIAHF survey of our community organization partners revealed several critical needs for the communities they serve. Many of these needs can be exacerbated for immigrant communities. Eighty percent of organizations reported their communities need assistance with unemployment benefits, 72 percent need assistance for small businesses, 72 percent need food support, and 82 percent need benefits application assistance. One respondent described a story of a family they serve, “A family of seven who have recently moved to the United States is left with no benefits and no support. The father was working at a local grocery store. He was earning cash and, therefore, is not able [to] file for unemployment. The family does not speak English and is not able to seek out other benefits.”

Data Disaggregation

Data disaggregation is the foundation of health equity (Rubin et al., 2018). Without race, ethnicity, and primary language data, health and social determinants of health needs and challenges that affect communities cannot be addressed (Islam et al., 2010). Good public health requires disaggregated data. Disaggregated data allows us to make evidence-based decisions and is a powerful tool to target limited resources of time and money to reach the most people to have the greatest impact in the country.

APIAHF was founded due to the lack of disaggregated data. Over

the years, AAPI scholars and advocates have fought to demonstrate that the community is far from monolithic: From federal standards in 1997 that, for the first time, separated out data on Asian Americans from Native Hawaiians and Pacific Islanders to Section 4302 of the Affordable Care Act that requires federal health data collection to include details on AAPI subgroups (Ponce et al., 2009; Ramakrishnan and Ahmad, 2014). To date, the community is still often lumped into an “other” category in reports on health and economic welfare.

How COVID-19 Exacerbated This Challenge

We have already seen very serious health disparities reported for COVID-19. African Americans in particular have been in the spotlight, but limited data has shown that, in some states like Oregon and Utah, Pacific Islanders have had some of the highest infection rates of any race group. Public health agencies have not released data on specific AAPI subgroups, so our government response may be failing to address disparities in certain communities. Public health officials and community organizations need this data to learn from it, to use their limited resources to target disparities where they are happening, and to help stop this pandemic.

Lack of Community Resources

A 2018 survey of 3,400 nonprofit leaders found that 75 percent of nonprofits do not have sufficient cash reserves to provide financial stability, while 86 percent say demand for services keeps rising (Nonprofit Finance Fund, 2018). Meanwhile, of the total dollars invested by foundations, investments in AAPI communities have remained persistently and alarmingly low, hovering around 0.3 percent for nearly thirty years (Asian Americans/Pacific Islanders in Philanthropy, 2015).

How COVID-19 Exacerbated This Challenge

Charities Aid Foundation of America reports that 73 percent of nonprofits have already seen a decline in contributions due to the pandemic (CAF America, 2020). Fifty percent expect that the pandemic will reduce their revenue by 20 percent over the next year. Forty percent say their expenses have increased. Sixty percent say they need unrestricted funding the most. APIAHF found that three-fourths of the surveyed organizations in our network need funding to avoid losing programming and/or staff.

Additional Challenges for AAPIs Due to the Pandemic

Higher representation of AAPIs in specific labor sectors can lead to increased exposure to COVID-19, especially without access to adequate personal protective equipment.

Asian American Representation in the Healthcare Workforce

Asian Americans have a higher representation in the healthcare workforce than their proportion of the U.S. population. They represent 34 percent of critical care fellows, 22 percent of pharmacists, 21 percent of physicians and surgeons, and 9 percent of registered nurses (Augoustides et al., 2017; “Pharmacists,” n.d.; “Physicians and Surgeons,” n.d.; “Registered Nurses,” n.d.). Filipino nurses, in particular, have a specific history tied to their profession (Choy, 2003; Shyong, 2020). Today, 18 percent of registered nurses in California are of Philippine descent (Spetz et al., 2017).

Pacific Islander Representation in Meat and Poultry Processing Plants

Pacific Islander communities have concentrated in areas related to available employment. Many of those jobs are in essential industries, such as home healthcare and meat and poultry processing. In addition, with multigenerational households, the conditions for initial exposure to the essential worker and then another exposure to the family creates a challenging set of conditions for prevention. Add to that language and access to care barriers. Preliminary data from areas of high Pacific Islander population concentrations are showing disproportionately high rates of infection and mortality (Koran, 2020; PI-CoPCE, 2020).

Anti-Asian Hate and Xenophobia

COVID-19 anti-Asian rhetoric from government officials and campaign ads has fueled a backlash of hate crimes and incidents against the AAPI community. More than 1,900 reports of hate-motivated incidents against AAPIs have been recorded (“Hate Incidents,” 2020). This perpetuates the ways in which Asian Americans have been targeted in the past, including the Chinese Exclusion Act, Japanese American internment, downturn of the auto industry and the murder of Vincent Chin, and anti-Muslim and anti-brown hate after 9/11.

These additional challenges add to the complexity and intensity of the pandemic for AAPI communities. Thus, interventions to address pandemic-related needs of AAPI communities must be multipronged and flexible enough to accommodate these complexities.

Ways to Address These Challenges

Narrative Change

A dominant narrative promoted in American culture and media about Asian Americans is the “model minority myth,” which suggests that Asian Americans are doing as well as or better than whites, and therefore do not require any additional support or resources. This myth uses the perceived advancement of Asian Americans to minimize the impact of structural racism on the struggles of other racialized groups, namely Black or Latinx Americans, and pervasively frames “Asian Americans” as an aggregate group that is uniformly successful and healthy. This invisibilizes complex social and economic differences among ethnic subgroups that differentially impact health outcomes. Moreover, the use of the term “Asian Americans” often erases the Native Hawaiian and Pacific Islander needs and experiences completely from the conversation. Educating policy makers, funders, and the public of AAPI needs is essential to building the support for structural and community change to occur.

Advocating for disaggregated data is one way to highlight the invisible realities many AAPI communities are facing and change the narrative. For example, aggregated uninsurance rates by race suggested that Asian Americans were the most insured of any racial group. Disaggregating the data not only revealed that this was not true for all Asian subgroups, it also helped to identify how to target limited resources to those with disparities, incorporating specific language access and ethnic-specific efforts to address uninsurance.

APIAHF has engaged in numerous interviews with regional news sources in California, Connecticut, Colorado, New York, Oregon, and Washington; national news sources such as NBC News, US News & World Report, and Politico; and ethnic news media reaching an international audience, to build awareness of these needs and challenge these dominant narratives. Our thirty-five-year legacy has allowed us to develop visibility as an organization and to cultivate relationships with the media that facilitate engagement in narrative change.

Structural Change through Legislative Solutions

APIAHF is deeply concerned that the communities we work with are being left out of the government’s policy and implementation COVID-19 response, and it is leading to deadly health and economic consequences. APIAHF has used policy analysis and developed relationships with key advocacy organizations and policy makers to identify and remedy unmet AAPI needs in COVID-19 legislation. These efforts fall

into the categories of the four primary challenges for AAPIs to achieve health and well-being: lack of language access, barriers to healthcare for immigrant communities, lack of disaggregated data, and lack of community resources.

One area APIAHF has identified is the lack of culturally competent and linguistically appropriate COVID-19 outreach and treatment. Under federal civil rights laws, the government and entities receiving its funding must provide equal access to LEP communities. We need leadership from the government to require and fund all consumer-facing documents to be translated, and interpretation services for frontline health providers, so LEP populations can be fully informed and communicate about the pandemic. Our policy recommendations include funding all federal agencies involved in the COVID-19 response to translate all materials, provide reimbursement under public health insurance programs for interpretation services, and fund state and local agencies to coordinate language-access assistance, including supporting the community-based organizations that work directly with LEP populations.

No one should be unable to access COVID-19–related care because of where they were born. This is why we support including all immigrant families in programs facilitating access to COVID-19 testing, treatment, and vaccination. Not doing so risks undermining the public health response. Medicaid should fully cover, without cost-sharing, all COVID-19–related testing, contact-tracing, and treatment for immigrants. In addition, Congress must start to undo systemic barriers to Medicaid, including restoring coverage for COFA communities. The HEROES Act takes steps to achieve these goals.

In the initial stages of the COVID-19 pandemic, the data-collection system failed communities at all points. Three-fourths of COVID-19 cases reported by the CDC lacked any information about a person’s race. To date, 20 percent of case data still lacks race information. We need to ensure that disaggregated data on race, ethnicity, primary language, sex, age, sexual orientation, gender identity, disability status, and other demographic groups is collected and reported, by local public health departments, hospitals, and testing sites. That information all needs to be shared up to CDC and reported out, publicly and regularly. The HEROES Act takes some steps in this direction, such as requiring reporting of some data groups, and additional recent legislation has expanded these requirements (U.S. Department of Health and Human Services, 2020). However, we believe there are improvements to be made. The race and ethnicity data needs to be disaggregated. What data is required

to be collected and how often it is reported needs to be more consistent. The HEROES Act also addresses the systemic problems that, in part, have led to the dearth of demographic data, stemming from the continual disinvestment in the public health surveillance and data systems by including significant financial investment in the long-neglected data infrastructure at federal, state, and local levels. We recommend requiring CDC to collect, analyze, and report disaggregated race, ethnicity, and language data about key COVID-19 trends through its surveillance systems.

Previous COVID-19 legislation has not provided resources to the entities with the most direct relationships with people impacted by disparities. Congress can invest in resources to community-based organizations who serve as connection points between providers, government agencies, and community members. The Affordable Care Act Navigator Program funds community organizations to help people understand the availability of and enroll in health insurance, which is an important need when so many are losing their jobs and may be facing a complex web of options and applications.³ Congress can also restore funding to the Racial and Ethnic Approaches to Community Health Program, which is the only CDC initiative to support AAPI community organizations in addressing disparities in chronic illness, which have been linked to COVID-19 severity.⁴ Congress can also invest resources into building up our diverse healthcare workforce. The Health Equity and Accountability Act has dozens of ideas to address health disparities, including grant programs targeted on recruiting and maintaining doctors and other healthcare providers from communities of color.⁵

While we recommend Congress take action, many of these issues can also be addressed through executive branch advocacy. For example, APIAHF joined the Legislative Conference on Civil and Human Rights, Southern Poverty Law Center, and Florida Legal Services on a COVID stakeholder call hosted by the Federal Emergency Management Agency (FEMA) and Health and Human Services (HHS). The call included 500 callers from across the country, plus senior officials from FEMA and HHS. APIAHF has sent letters on these priorities to Congress and the Trump administration.

Partnerships with national coalitions, local community organizations, multiracial coalitions, and an individual base of e-mail and social media followers, all provide us with various stakeholder audiences to engage and leverage for these structural change priorities. Unrestricted donations from individuals support us when we engage in direct lobby-

ing efforts.

Community Change

Community change across the country can only occur in collaboration with a set of national intermediaries who have the reach and trust of vulnerable populations. APIAHF is such a trusted source and bridge between the government and community. Since March 2020, APIAHF has launched or co-led many programs and initiatives to build out a national response to COVID-19, particularly across AAPI communities.

APIAHF's COVID-19 response programming consists of three levels: providing support and resources to APIAHF's network, building a national AAPI response, and building a national COVID-19 response across all four communities of color.

Support and Resources for a Network of AAPI-Serving Community Organizations

An effective national AAPI COVID-19 response requires in-language materials and information that can be quickly disseminated. APIAHF's e-mail list reaches 16,400 people, and we work with a network of more than 100 community-based organizations in thirty-five states and across the Pacific that are trusted community resources.

APIAHF has established an online Community Library of crowd-sourced in-language resources for COVID-19.⁶ As of May 20, 2020, there were almost 400 materials in thirty-nine AAPI languages and Spanish that had been uploaded by the community. The site has received more than 7,000 hits. It not only provides access to materials to our network for rapid dissemination but also has circulated widely, and we believe it is the only such centralized source of AAPI-in-language COVID-19-related materials in the United States at this time.

On April 2, we launched a five-week Community Care Package program to provide resources, tools, and weekly updates to our network for timely, accurate information on COVID-19. Some of our resources include links to culturally competent, in-language resources and information on how to manage these fast-paced and ever-changing times.

National Asian American Native Hawaiian Pacific Islander COVID-19 Health Response Partnership

APIAHF has had a long-standing and unique relationship with the CDC continuously for more than twenty-five years as a grantee and cooperative agreement holder. Over the decades, this has meant that, in ad-

dition to ongoing work in key public health areas of HIV / AIDS, chronic disease, and primary prevention, CDC turns to APIAHF in times of public health crises and epidemics. Whether H1N1, Zika, or now COVID-19, APIAHF has a well-established relationship and track record with the CDC to reach deeply into AAPI communities.

We have received funds to support two CDC COVID-19 response projects to help build the National AANHPI COVID-19 Health Response Partnership, which builds upon APIAHF's networks, as well as those built through the ACA enrollment Action for Health Justice network.⁷ Those efforts will now be organized under the banner of the National Council of Asian Pacific Americans (NCAPA), co-chaired by Asian Americans Advancing Justice (AAAJ-AAJC), Association of Asian Pacific Community Health Organizations (AAPCHO), and APIAHF.

This partnership has three components: (1) the CDC-funded National AAPI Healthcare Workforce Education and Training Initiative; (2) CDC funding for the partnership to respond to and reach populations of highest impact to COVID-19; and (3) the NCAPA-centered National AAPI COVID-19 Task Force and Emergency Response Network (ERN).

CDC-funded National AAPI Healthcare Workforce Education and Training Initiative.

APIAHF will support CDC's national healthcare workforce infection prevention and control (IPC) training collaborative. The collaborative will develop and disseminate IPC training to bring the workforce up to speed and ensure that practices are consistent during this ongoing epidemic. The target audience will be the AAPI healthcare workforce, such as frontline nurses, related care providers, and other staff employed in healthcare facilities, including but not limited to nursing homes, dialysis facilities, and community health centers.

To build out a COVID-19 response to an AAPI healthcare workforce, APIAHF will work with our national partners: AAPCHO for linkages to Federally Qualified Health Centers, Institute for Asian Pacific American Leadership and Advancement for linkages to AAPI healthcare workers, Center for Study of Asian American Health for linkages to New York City health navigators, and Philippine Nurses Association of America Foundation for linkages to Filipino American nurses.

This eleven-month grant will help to build a greater understanding of how to reach an AAPI healthcare workforce quickly with urgent and critical COVID-19 information.

CDC-Funding for the Partnership to Respond to COVID-19.

APIAHF will support a national partnership between AAPI communities and the CDC to enhance the CDC's ability to support the needs of the AAPI communities in response to COVID-19. The project will focus on deepening an understanding of healthcare needs, language barriers, and cultural practices; strengthening local partnerships; and identifying promising practices for reducing AAPI risks for COVID-19 infection. This project is still in refinement with CDC.

NCAPA COVID-19 Task Force and NCAPA Emergency Response Network.

In a complementary and coordinated fashion, our national coalition, the National Council of Asian Pacific Americans (NCAPA) has established two formations, which fit together (1) the NCAPA AAPI COVID-19 Task Force, for our thirty-six NCAPA-member national organizations across many policy areas, co-chaired by AAAJ/AAJC, AAPCHO, and APIAHF, and (2) the AAPI Emergency Response Network (ERN), which includes other national AAPI organizations that are not NCAPA members. Among the broader ERN is the Asian Pacific American Public Affairs organization (APAPA), that will also be a subgrantee to APIAHF for the second CDC grant. There are many components to this network being formed, but the critical components already established are (1) protecting against anti-Asian hate, (2) in-language public health information, and (3) congressional advocacy to assure that AAPI communities are not left out of relief and recovery solutions whether by design or lack of access and opportunity.

One benefit of organizing under the NCAPA banner and its thirty-six member organizations is the expanded reach to forty-four states and a network of more than 500 local organizations, working across all fields and disciplines because COVID-19 and its impacts will have lasting effects well beyond health and civil rights. Both the immediate impacts and the recovery may be deeper, require more resources, and take longer in communities of color.

A Multiracial COVID-19 Response That Centers Communities of Color

Since 2010, the Racial Equity Anchors⁸ have worked together in a collaborative funded by the W. K. Kellogg Foundation (WKKF) to build The Beloved Community as Dr. Martin Luther King Jr. envisioned. We have worked closely on building an inclusive democracy and on multiracial solidarity.

In the face of COVID-19, we are developing a plan for a COVID-19 response that is multiracial, is national in scale, and a response that centers communities of color that are differently and disproportionately impacted by the pandemic in health, economic, and civil rights dimensions. With a combined network of local partners in 2,800 communities in all fifty states and U.S. territories, including in the U.S.-affiliated Pacific jurisdictions, as well as in 650 tribal governments and tribal entities, the Racial Equity Anchors represent an unparalleled network that is close to the ground, trusted, and able to deploy and disseminate resources to hard-to-reach communities and populations.

The Multiracial COVID-19 Response Plan includes four stages: relief, recovery, reconstruction, and repair. Key features include:

(1) Relief: Regranting millions of dollars to local communities for immediate relief in all four communities of color, housing and food supports, assistance with unemployment and other benefits, and sustaining essential service providers on the ground facing added technology expenses and financial cuts due to the pandemic.

(2) Recovery: Building the communications infrastructure to quickly disseminate multiracial, culturally competent, linguistically appropriate, and timely and accurate information, resources, and materials to nearly 3,500 communities across the country. Accurate and timely information about personal protection and prevention, testing, contact-tracing, accessing care, and appropriate isolation have been missing and communities of color have been most significantly impacted by this void.

(3) Reconstruction: Developing a 10-Point Policy Plan to lead the nation in addressing the structural gaps that have been revealed by COVID-19 in our healthcare, education, economic, housing, and social support (non-) systems. By working together on legislative, regulatory, and litigation strategies, the anchors will address structural barriers in policy in all three branches of government.

(4) Repair: Addressing the trauma that the pandemic has wreaked on our communities and how to heal. Healing circles have been a key means of racial healing, in partnership with WKKF, and offer one way of healing from the trauma of the pandemic, as well as the racism that has been so clearly revealed to the country.

We have already experienced the importance of this multiracial solidarity in addressing the anti-Asian hate that has arisen with the pandemic, and the joint anchor collaborative has released a statement on COVID-19.⁹

Recent events, such as the murders of George Floyd, Breonna Taylor, Tony McDade, and Ahmaud Arbery, and the ensuing Black Lives Matter movement activities, have caused this multiracial coalition to pivot in ways that combine COVID-19 efforts with recognition and calls for action to also address racism and police brutality as intersectional crises. This has allowed APIAHF to further explore and strengthen our internal and external commitments to Black, Indigenous, and other People of Color communities.¹⁰ APIAHF signed on to a joint statement with the anchors calling for the nation to declare a state of emergency due to racism and to commit immediate resources to address it.¹¹

Specifically for our WKKF support, but also that of other funders, our community change work would not be possible without the critical support of our funders. General operating funds allowed us to pivot and modify programming to address multiple crises at once. New targeted funding that resulted from long-standing relationships with other funders allows us to extend resources quickly to the communities we serve through our network of more than 100 community-based organization partners in thirty-five states.

Summary

The COVID-19 pandemic has exacerbated challenges AAPIs were already facing in accessing healthcare and uncovered new vulnerabilities. Addressing these challenges requires change at multiple levels: narrative, structural, and community. Organizations like the APIAHF can engage in this changemaking through critical partnerships and specific funding structures.

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Notes

1. The Asian & Pacific Islander American Health Forum prefers the term “Asian American, Native Hawaiian, and Pacific Islander (AANHPI)” communities.
2. These protections include Title VI of the Civil Rights Act of 1964, Executive Order 13166, Section 1557 of the Affordable Care Act, and the Language Access Plans generated by agencies, including FEMA and the U.S. Department of Health and Human Services.
3. <https://www.apiahf.org/resource/act-to-fund-health-insurance-outreach-and-enrollment/> (accessed May 30, 2020).
4. <https://www.apiahf.org/resource/racial-and-ethnic-approaches-to-community-health-reach-program/> (accessed May 30, 2020).
5. <https://www.apiahf.org/focus/health-equity/heaa/> (accessed May 30, 2020).
6. The Community Library is available at <https://www.apiahf.org/public-health-alerts/covid-19-resources/> (accessed May 30, 2020).
7. Co-led by Asian Americans Advancing Justice-LA; Asian Americans Advancing Justice-AAJC; and the Association of Asian Pacific Community Health Organizations (AAPCHO), with seventy-two partner federally qualified health centers and community-based organizations in twenty-three states, which operated from 2013 to 2018 to assist in enrolling more than one million AAPIs in fifty-six languages.
8. Advancement Project–National, APIAHE, Demos, Faith in Action, NAACP, National Congress of American Indians, National Urban League, Race Forward, and Unidos US.
9. <http://bit.ly/APIAHFPR031720> (accessed May 30, 2020).
10. <https://www.google.com/url?q=https://www.apiahf.org/press-release/community-unity-and-solidarity-black-lives-matter/&sa=D&ust=1592101684542000&usg=AFQjCNEUWw8bYYMOoCGpXxKBgoHoBQT00A> (accessed June 2, 2020).
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