Experiences of Enhancing AAPI Healthcare as a DEI Manager and Licensed Social Worker

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Abstract: This personal narrative conveys my lived experience as a licensed social worker who served as a diversity, equity, and inclusion manager at a major hospital system in the American Mid-Atlantic/Northeast region. Recognizing inequities in best meeting the needs of Asian American and Pacific Islander patients and clients, this narrative explores a personal account of lessons learned and implemented in a diversity, equity, and inclusion healthcare setting. Topics such as racism, historical trauma, health insurance, mental health, and assistive technology are explored.

***Keywords*:** diversity, equity, healthcare, inclusion, macro practice, medical social work

During the first year of the COVID-19 pandemic, I was hired in a leadership capacity to serve at one of America's most prominent academic healthcare systems. In this role, my primary tasks were coordinating, implementing, and overseeing strategic cultural competence and diversity efforts within the system's Office of Diversity, Equity, and Inclusion (DEI). While in this capacity, I immediately recognized various areas of concern that I knew firsthand would make my work and this role more complex.

While immersed in this experience, I specifically recall multiple local and national news reports discussing increased rates of trauma and violence toward the Asian American and Pacific Islander (AAPI) community and how this diverse community of color is often forgotten about regarding their historical challenges in the United States and across the globe. Unfortunately, no public statement of allyship was written on behalf of our system or the DEI office. I found this quite surprising, considering that the increase of Asian hate and trauma in the United States was so high that it spearheaded the creation of the COVID-19 Hate Crimes Act (2021), also known as the Anti-Asian Hate Bill.

As I grew in this position, I better understood the critical need to effectively advocate for and support our diverse clients, particularly those who identify as international and non-English speaking patients. One year into this role, I realized that much of our attention toward DEI work primarily focused on health disparities impacting Black, Latinx, and LGBTQIA+ communities. As important as each of these populations are, I grasped that very little attention had been geared toward the cultural and immediate needs of AAPI patients and communities. I found this true in regions outside California, New York, and Texas, where each state has an AAPI population between 1.6 million to 6.7 million (Budiman & Ruiz, 2021). As an African American male social worker with various intersecting identities, I find it quite unethical to solely devote strategic DEI initiatives to the exclusive needs of Black and Brown people of color. In fact, doing so is counterproductive to social work's mission, values, and vision, as well as the DEI profession. As the needs of AAPI populations—and the populations themselves—continue to grow in the United States, social workers and DEI professionals must also continue exploring

best practice solutions to meet needs and celebrate their unique culture, their distinct heritage, and—most importantly—their humanity.

Recognizing a Growing Patient Population

Working in a DEI leadership role first required me to check my own understanding of the broader AAPI community. Therefore, I decided to take a deep dive into better learning the current trends of this population in the United States and our local metropolitan region. I must say, prior to further research, my knowledge of understanding the AAPI community was relatively intermediate. This process assisted me in better understanding demographic trends in the United States and worldwide. Here is what I discovered:

The Asian American population in the United States comprises people from East Asia, Southeast Asia, and the Indian subcontinent (Jayaram, 2021). According to the 2020 United States Census Bureau (2021), over 20 million AAPI individuals live in the United States. The AAPI population is one of the fastest-growing diverse groups in America, and this trend continues to rise; between 2010 and 2019, the AAPI community in the United States increased by more than five million people, or an increase of 27 percent (Jayaram, 2021). This diverse community accounts for over five percent of the nation's population and has a bi-coastal distribution between the west and east coasts of the country (Jayaram, 2021). This population also represents one of the nation's most culturally diverse community groups, comprised of over 100 speaking languages from 30 countries (Asian Pacific Institute on Gender-Based Violence, 2021). Nationally, states such as California, Hawaii, New Jersey, New York, and Texas are home to over half of the nation's AAPI population (Jayaram, 2021).

In Pittsburgh, the demographics are changing rather quickly. Previously referenced as one of the Whitest metropolitan regions in the nation, the Asian (+47.4 percent), Native Hawaiian, and Pacific Islander (+26.3 percent) populations in our city have increased by nearly 75 percent between 2010 and 2020 (Wolfson, 2021). Statewide, the AAPI community represents four percent of our total population (Asian Pacific Institute on Gender-Based Violence, 2021). Over the past 10 years, this demographic shift has directly correlated with the increase of AAPI patients across our healthcare system. Therefore, our system has encountered a rising need to recruit more culturally competent providers with expertise in meeting the healthcare needs of diverse AAPI populations. This need is not just abstract; as part of Pittsburgh's health system, I have observed personally that our number of employees self-identifying as members of the AAPI community is lacking, particularly in contrast to the number of bedded patients who self-identify similarly (which, in logical turn with our demographic shift, is high and growing higher).

Unfortunately, some patients and employees I've worked with have reported striking accounts of bedside discrimination and racism, which can adversely impact patient care and health outcomes. I clearly recall an incident where a self-identifying AAPI patient and their family reported experiencing blatant racism while receiving care at one of our largest hospitals. Such reports are often investigated with DEI leadership to assess strategies for improving the patient experience related to DEI goals, internal policies, and law. As a part of my responsibility, our

team would review these incidents to see how we can best provide supportive services for patients and staff from a DEI lens. After co-investigating this incident and many others, I unexpectedly determined four recurring themes frequently found as ongoing challenges: health disparities and their various root causes; racism and historical trauma; lack of health insurance; and low English proficiency. As a result of these findings, our team decided to leverage our current strengths and strategies to better assist our healthcare system in meeting the health equity needs of our AAPI patients.

Rethinking Health Disparities Training

Our first course of action included reexamining our current training modules to include more information about health disparities and how they impact diverse cultural and ethnic groups such as the AAPI community. According to the Centers for Medicare & Medicaid Services (n.d.), health disparities are defined as "differences in the incidence, prevalence, mortality, burden of diseases, and other adverse health conditions or outcomes that exist among specific population groups" (para. 1). The second commonly known definition of health disparities comes from the Agency for Healthcare Research and Quality (2021), which identifies a health disparity as "a difference between population groups in the way they access, experience, and receive healthcare" (p. D-1). The third prominent definition is provided by the American Psychological Association (n.d., as cited in Olden & White, 2005), which describes that "health disparities are caused by a complex interaction of multiple factors, including individual, genetic, and environmental risk factors" (para. 1). For training purposes, we agreed to consider all three definitions, emphasizing how health disparities often display complex, systemic inequalities that can be defined in several ways. We also discussed how substantial barriers to accessing consistent and quality healthcare exist in the AAPI community, which can significantly impact individual, family, and community health outcomes. Such significant barriers may include consequences of discrimination (in the form of xenophobia and/or racism) leading to stigma, denial of care, or violence; limited English proficiency or knowledge of local healthcare options and procedures; limited or absent health insurance; and intersections with mental illness, transgender identity, or nonheterosexual orientation and how those may strain community and family ties, among other social determinants of health.

Our DEI team also incorporated the value of fostering a strong sense of mental health and well-being among the AAPI population and all diverse communities. This information is critical to increasing awareness of this community's needs among healthcare professionals. As the American Psychological Association discusses, prevalence rates of mental illness among AAPI individuals are believed to be comparable to other American patients (Iwamasa, 2012). Nevertheless, type of psychopathology, ethnicity, generational status, acculturation, and cultural background may influence the manifestation of psychological distress among AAPI groups. For instance, rates of depression are similar among AAPIs and White Americans, while the prevalence of substance abuse is lower among AAPI populations. In contrast to domestically born AAPI individuals, immigrants who experienced violence, war, or economic oppression before their arrival to the United States often appear to suffer more psychological distress (Iwamasa, 2012). This, too, is important to acknowledge and recognize as our system continues to serve AAPI patients from around the world. Integrating more trauma-informed care strategies

into required employee training has been critical for us to intervene in such traumatic encounters when most appropriate.

Recognizing Racism and Historical Trauma

The topics of racism and historical trauma—especially in an environment where both social problems may exist—are typically challenging to discuss among employees. Therefore, as a diversity team, we had to acknowledge that various definitions exist and that we are responsible for thoroughly defining these terms. For example, the American Medical Association (2021) recognizes racism as an urgent threat to public health and lack of health equity as a barrier to excellence in delivering healthcare. Since this definition is accurate and bold, we incorporated this perspective on racism into our training. As we continued to update our training approach, we also included general information regarding select historical policies and social movements involving the AAPI community in the United States. In one of our Zoom sessions, I recall a nurse discussing the bigotry and discrimination she witnessed in her unit regarding the physical presentation and ethnic features of individual AAPI patients. I could relate to this discussion because I have witnessed such bigotry in a work environment. For example, although the AAPI community is vastly diverse regarding physical characteristics and presentation, I have encountered clients who appear Japanese and are often misidentified and misrepresented as Chinese. However, their nation of origin may be Korea or Vietnam. Unfortunately, similar stereotypes and examples of bigotry and miseducation perpetuate unconscious bias and the misrepresentation of AAPI communities. Not recognizing AAPI individuals or anyone according to their preferred identity completely discredits their culture, heritage, historical challenges, and unique experiences that their ancestors and resilient communities have experienced. I find this true, as I would be offended by a healthcare worker not acknowledging my ethnic and racial identity as an African American or young Black male. Therefore, incorporating such topics into our training has been critical to working towards dismantling the effects of historical trauma, implicit bias, and unconscious bias in our system.

As a person of color, social worker, and DEI professional, I often think about the community and health effects of historical trauma, racial hate, and their connection to current and historic public policy practices in the United States. In graduate school, I recall learning about the Chinese Massacre of 1871 and other historic policies formed by our government as prominent examples of Asian hate. This horrific event was an act of racial genocide that occurred on October 24, 1871, when approximately 500 White and Latinx individuals entered Old Chinatown in Los Angeles and bullied, robbed, attacked, and murdered innocent residents who appeared to present as Chinese (Grad, 2021). Due to this hateful event, 10 percent of Los Angeles' Chinese immigrant population was lost (Grad, 2021). Unfortunately, additional discriminatory policies continued to form, such as the Page Act of 1875, the first restrictive federal immigration policy in the United States, which banned the immigration of Chinese women (Rotondi, 2021). As an extension of this policy, the Chinese Exclusion Act of 1882 prohibited all immigration of Chinese laborers. This Exclusion Act was the first federal law to prevent all members of a specific race or ethnic group, such as Asians, from immigrating to the United States (History Channel, 2019). Another discriminatory policy included the Johnson-Reed Act, commonly known as the Immigration Act of 1924 (United States Office of the

Historian, n.d.-a), which established quotas on the number of immigrants from the East and provided federal funding and legal enforcement to maintain the longstanding ban on Asians and other international immigrants. The Magnuson Act, known as the Chinese Exclusion Repeal Act of 1943, permitted Chinese immigrants to become naturalized citizens in the United States (United States Office of the Historian, n.d.-b). Nonetheless, the Magnuson Act supported the ban of Chinese Americans and other Asian immigrants from owning property and establishing new businesses. I passionately believe that each of these policies are rooted in institutional racism, and the effects of such policies can be found in the current social conditions of today. Contemporary forms of racism are also connected to hate crime incidents resulting in severe injury or death. Between 2019 and 2020, the overall hate crime rate in the United States witnessed a steady decline of seven percent (Yam, 2021). However, hate crimes targeting Asians increased from 3 to 28 people in New York City and from 7 to 15 in Los Angeles (Yam, 2021). Considering the impact of COVID-19, over 3,800 Anti-Asian-American acts of violence have been reported since the beginning of the pandemic in 2019 (Stop AAPI Hate, 2022). With the increasing levels of discrimination experienced by the AAPI community, social workers and DEI professionals in healthcare are responsible for protecting clients and patients from harm by formally reporting and following up on patient care and community protection incidents.

Access to Mental Healthcare and Adequate Insurance

According to our team's assessment and internal institutional data, we recognized an increased need for more culturally competent mental health providers with expertise in serving AAPI patients. Such culturally competent providers must be conscious of interethnic differences among AAPI communities due to the manifestation of mental disorders influenced by cultural, generational, and acculturation factors. These treatment providers must also assess these cultural factors while working with diverse patients, and they must understand the role of cultural values such as interpersonal harmony, loss of face, and filial piety on their AAPI patients' beliefs about psychological distress and the implications for mental health services (Iwamasa, 2012).

Often, mental healthcare and general healthcare are associated with adequate medical insurance coverage, and ensuring this coverage exists is essential to improving and sustaining health equity for all. In 2020, the National Asian Pacific American Women's Forum (NAPAWF, 2021) surveyed over 3,537 adult AAPI women, producing the largest nationwide poll ever conducted among AAPI women in the United States. It is interesting but unsurprising that survey results revealed healthcare was the primary concern and political issue for AAPI women voters in 2020. According to NAPAWF's Medical Expenditures Panel survey data analysis, approximately 17 percent of Asian, Native Hawaiian, and Pacific Islander women who immigrated to the United States less than five years ago reported being uninsured in 2019. This uninsured rate is 10 percent higher than White Americans born in the United States during the same timeframe (NAPAWF, 2021). It is also estimated that the COVID-19 pandemic significantly increased uninsured rates among non-United States citizens in 2020 due to rising national unemployment rates (NAPAWF, 2021). As a diverse team, we understood that uninsured and underinsured access to quality healthcare could exacerbate all populations' current, future, and underlying health conditions. Creating better access to care, providing affordable health insurance, and eliminating language barriers continue to be our primary goals for improving health equity.

Utilizing Technology to Assist in Limited English Proficiency

Throughout my experience, I learned to appreciate the importance of incorporating technology into patient care to better meet the needs of non-English speaking or limited-English speaking patients. I found that integrating such technology is vital to addressing equity gaps where language misinterpretations are barriers to patients' general understanding of their care and services. I was fascinated to learn that for over 25 years, CyraCom Language Interpretation Services has been the leading provider of language interpreter services in the healthcare industry. Healthcare technology platforms such as CyraCom offer telephone and video interpretation, translation and localization services, on-site interpretation, and assessment resources for all types of clients. CyraCom has been valuable in connecting our diverse patients to highly proficient and skilled interpreters who provide high-quality interpretation services in over 25 languages, including American Sign Language. This technology's most impressive feature is that all services are provided virtually on a tablet built into a mobile kiosk. Our diverse patients tend to appreciate the accessibility and mobility of the kiosks, which can be moved into any room to meet the patient's needs. Conveniently, this technology operates 24 hours a day, seven days a week, as a critical resource for our employees and patients who require language interpretation services. I specifically recall when one of our patients had the opportunity to use this technology for the first time. The excitement that filled the room was incredible as the grandchild of this patient was glad that she no longer had to translate basic conversations between the doctor and her grandmother any longer. I often think about how this service has impacted the lives of many of our AAPI patients and their families by connecting them to critical internal and external resources throughout our network.

Final Thoughts

At the intersection of DEI and the social work profession, I firmly believe that part of our ethical responsibilities include a better understanding of advocacy and equity gaps that may impact the lives of diverse clients and patients. Frequently, I tend to reflect on my formal social work training and think about how my BSW and MSW programs shaped my lens for advocacy, DEI, and social justice work. As professional social workers, our formal training acquired at Council on Social Work Education–accredited programs is designed to readily equip us to meet the needs of various diverse clients through our competency-based education and our Code of Ethics, which guides our professional core values and ethical standards.

I occasionally reflect on how this training differs from other career fields, including DEI and various healthcare professions. As social workers, we hold an ethical responsibility to continue to educate ourselves about various cultures, customs, social justice movements, traditions, values, and demographic trends associated with diverse patient groups. However, through lifelong learning and professional development, we must continue educating ourselves, our communities, our social systems, and the broader society to sustain such advocacy and equity efforts. Like social workers, DEI professionals in healthcare understand complex social problems related to diverse client populations. Yet, most DEI professionals in healthcare typically emphasize their work achieving strategic plan goals and supporting initiatives in human resources departments.

In closing, I recommend that all healthcare social workers and DEI professionals continue to expand their knowledge on integrated healthcare, assistive technology, trauma-informed care, and the effects and history of racism and historical trauma in America and worldwide. Doing so will assist all of us in best understanding the needs and history of emerging and diverse patient groups, such as the broader AAPI community, to best prepare for a more equitable, healthy, and inclusive future.

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