MAY 2021 - A JOINT STATEMENT FROM THE UCSF ASIAN AMERICAN & PACIFIC ISLANDER (AAPI) COALITION TO THE UCSF CHANCELLOR AND PRESIDENT & CEO OF UCSF HEALTH

AGAINST RACISM, XENOPHOBIA, BIGOTRY, MICROAGGRESSIONS, PREJUDICES AND OTHER DISCRIMINATING PRACTICES AFFECTING THE UCSF AAPI COMMUNITY

Since the COVID-19 pandemic began in early 2020, a sharp rise in anti-Asian violence and hate speech has affected the AAPI community across the United States. Partially driven by the blaming of the origination of SARS-CoV-2 (the virus that causes CoVID-19) from China, as well as having roots in the long-standing discrimination and race tensions between Asians and other Americans, assaults and killings of Asians in Chinatowns and across the nation have become regular occurrences. In the March 2021 Atlanta shootings, a gunman drove to three separate Asian-owned spa and gym businesses and intentionally killed eight people, six of whom being Asian American women.

These unprovoked, targeted attacks on Asians also fueled a reckoning and re-examination of the long existing racism, xenophobia, bigotry, microaggressions, prejudices, biases, the bamboo ceilings (a combination of individual, cultural, and organizational factors that impede Asian Americans' career progress inside organizations), scapegoating, and other discriminatory practices against Asian Americans and Pacific Islanders (AAPI).

Violent acts of hate against any group are an attack on all of us. We stand united and act in solidarity with our Black, Indigenous, and People of Color (BIPOC) communities to advocate for equity and demand zero tolerance for targeted crimes, racism, xenophobia and discrimination in all their forms.

History of Asian Americans and Downstream Negative Impacts

Xenophobia, racism, and hate are sadly not new to AAPI - this nation has a history of racism against Asians from the Chinese Exclusion Act during the Gold Rush, the Immigration Act of 1924, Japanese American Internment in World War II, racial profiling of South Asians (especially those of Sikh or Islamic faiths) after September 11, 2001, and to the more recent weaponizing of the COVID pandemic against Chinese and other AAPI community. As recently stated in The New Yorker: "It is possible that being scapegoated might constitute one of the community's few shared experiences."

U.S. history is littered with deliberate acts of racism by the government as well as organizations. For AAPIs, this has been perpetuated through federal, state, and organizational laws and policies leading to the exclusion of AAPI, language and other forms of discriminations, limiting access to services and protections, and contributing to data scarcity and lack of disaggregated data for the Asian subgroups. Aggregated data mask the many health inequities and social injustices faced by different AAPI communities.

These discriminative structural practices have fueled the lack of understanding of the different AAPI cultures and the nature and scale of their problems, resulting in otherizing AAPI and causing them to be seen as perpetual foreigners and the invisible minority.

The Anti-Asian Climate Today

Systemic racism and invisibility allow institutions and individuals to "normalize" violence and hate crimes against Asian Americans. The recent escalation of assaults has stirred up intense personal anguish in the Asian American communities. Many AAPI experience racism but have not spoken up or are not heard, a challenge exacerbated by a cultural stereotype that Asians are tolerant,

undisruptive, compliant, and passive. By not ensuring our voices are heard, we collectively contribute to the invisibility of anti-Asian racism.

The "model minority" label has been used as a wedge to pit Asian Americans against other marginalized BIPOC communities: fueling anti-Black racism among Asian Americans and anti-Asian racism among African Americans. The model minority myth of universal success among Asian Americans also obscures the fact that many AAPI are struggling and face discriminations in job markets. Thus, there is no singular monolithic AAPI experience, and no model minorities. The model minority expectations have created a lot of pressures in the AAPI community and cause a high rate of mental health issues. According to the American Psychiatric Association, suicide was the 8th leading cause of death for Asian-Americans, whereas it was the 11th leading cause of death for all racial groups combined.

Anti-Asian racism manifests in implicit, subtle biases and stereotypes that diminish our humanity and reinforce the bamboo ceiling. We are seen as capable of working hard, following directions to get the job done, but are viewed as incapable of having vision, judgement, creativity, emotional intelligence and other traits required for organizational leadership. The presence of an Asian accent has often been erroneously equated with lack of competency. These stereotypes cause many Asian Americans to get passed over for promotion and training for leadership roles. The current available UCSF workforce data show a drastic drop of AAPI managers in M3 level and above.

An important, recent report by LAAUNCH, the first report of its kind in 20 years, examines attitudes and stereotypes towards Asian Americans. This report found that nearly 80% of Asian Americans say they do not feel respected and are discriminated against in the U.S. This problem I, however, underrecognized among white Americans, 37% of whom are not aware of an increase in hate crimes and racism against Asian Americans over the past year, 24% indicating anti-Asian American racism isn't a problem that should be addressed.

UCSF AAPI Coalition Recommendations

The recommendations outlined below build on efforts of an earlier letter submitted to Chancellor Hawgood and President & CEO Laret by the Asian Faculty Leadership Group and the Asian Health Institute, as well as APASA's communications with Vice Chancellor Navarro. Please refer to the appendix for more details on the proposed action plan.

1. **Raise Awareness:** Increase the awareness and understanding of the AAPI history and culture, dispel AAPI-related myths, and to affect changes in the perception of AAPI. Ensure inclusion of adequate representation of AAPI membership in the various UCSF groups and initiatives.
2. **Collect & Disaggregate AAPI Data:** Improve data transparency and reporting by race on a regular basis, with the AAPI data further disaggregated for students/learners, employees, patients and research participants.
3. **Strengthen Language Access for Patients:** Improve AAPI threshold language translation and interpreting around patient access, healthcare, research and business practices.
4. **Break the Bamboo Ceiling for AAPI Faculty and Staff and Salary Equity:** Increase AAPI representation at the senior and executive level management positions across the institutions, along with training and support.
5. **Stop indiscriminate use of the "URM" term in DEI initiatives and communications:** Assess how AAPI faculty and staff have been excluded or experienced barriers to advancement and promotion due to indiscriminate use of the URM term.

6. **Build Student Pipelines and School Admissions:** Assist students to use internship to build pipelines of future bilingual healthcare workers more in concordance with the language needs of the 35% AAPI in San Francisco (where half experience language barriers).

All actions count and matter. The above recommendations will enable UCSF to embrace our principles of community and PRIDE values. To quote Dr. Renee Navarro from the recent Annual Chancellor's Leadership Forum on Diversity and Inclusion on 5/19/2021, "We are not in a moment, we are in a movement."

APPENDIX
Proposed Action Plan for AAPI in UCSF

The UCSF AAPI community includes our students/learners, staff, faculty, patients, researchers and research participants. We have drafted an initial proposed action plan intended to make a positive impact on the learning, clinical, research and working environment for AAPI, and to further advance the DEI initiatives at UCSF.

1) **Raise Awareness**
   Increase the awareness and understanding of the AAPI history and culture, to dispel AAPI-related myths, and to affect changes in the perception of AAPI individuals. Ensure inclusion of adequate representation of AAPI membership in the various UCSF groups and initiatives. AAPI has paid a minority tax through unequal treatment and are doubly punished through the neglect of recognition of their minority status.
   a) We ask that members of the Chancellor's Cabinet, the ODO, and DEI groups to recognize in UCSF Health communications and in the quarterly DEI town halls, and any appropriate venues deemed appropriate, the past neglects and systematic discrimination of AAPI members at UCSF, inadvertently contributing to their invisibility
   b) Include AAPI in all DEI action plans as a corrective action. More specifically, include AAPI in the ODO led Anti-Racism Initiative by meeting with AAPI leadership representatives to discuss the specific items unique to the AAPI community
   c) Incorporate AAPI history and culture in the U.S., AAPI history at UCSF, and relevant AAPI details in the following trainings: Foundational Diversity, Equity and Inclusion Training and Differences Matter Diversity, Equity, and Inclusion Champion Training requirements for UCSF staff, faculty and students
   d) Include specific materials about AAPI in the Chancellor's Cabinet's own ongoing education and training plan in anti-racism
   e) Include adequate representation of various AAPI leaders as speakers in town halls for the Anti-Racism Initiative
   f) Include adequate AAPI membership and representation in the following groups and others and sanction work time for their participation:
      - UCSF DEI and Anti-Racism Initiative (https://diversity.ucsf.edu/antiracism-initiative) committees
      - All committees appointed by the Chancellor, or by members of Chancellor's Cabinet e.g., Chancellor's Community Advisory Group
      - Safety Task Force
      - Patient Education Committee
      - Nursing leadership and DEI groups within UCSF Health
      - Any current and future leadership groups appointed by senior executive leaders

2) Collect & Disaggregate Data

Improve data transparency and reporting by race on a regular basis, with the AAPI data further disaggregated for students/learners, employees, patients and research participants. Here are some key recommendations related to data:

a) Disaggregate AAPI data into Asian subgroups (Chinese, Filipino, South Asians, Vietnamese, Koreans, Japanese, other AAPI) for all patient data and reports, as well as the UCSF Staff Engagement Gallup Survey
b) Patient safety and clinical outcome data for inpatients and outpatients respectively
c) Patient's 30-day readmission data by race, preferred language, and principal diagnosis
d) Patient data from patient discharge surveys by race
e) Student's admission data from all schools by race and language proficiency
f) Nursing Department data on RN staff and management levels by race and language proficiency
g) Nursing data on RNs by language proficiency and medically certified interpreter status
h) Clinical providers (MD, PA, NP, PT, etc.) data by language proficiency and medically certified interpreter status
i) Form a Data Oversight & Recommendation Committee to review the above data and utilize them to make recommendations to improve patient care, access to care, care outcomes, as well as institutional equity for all

3) Strengthen Language Translation & Interpretations

Language discrimination is a form of racial discrimination. Additionally, language has significant implications around patient access, health outcomes, research outcomes and business outcomes. Here are some recommendations to make positive impacts:

a) Define and identify patients' threshold languages (threshold set at 5% of patient's preferred languages) at UCSF for both inpatients and outpatients – similar to the process used by the City of San Francisco to identify and define threshold languages in its Language Access Ordinance.
b) Review the Interpreter Department's financial and staff data separated in accordance with UCSF's threshold languages.
c) Interpreter Department to share its fees and program of medical interpreters' certification and re-certification, and plan of identification and outreach to staff to invited medical interpreter certification and provide a list of staff certified medical interpreters for the current year for each threshold language identified for UCSF.
d) Patient Education Committee and all clinical Service Lines – reports of the total number of patient education documents and translated patient documents in UCSF's threshold languages.
e) Incorporate meeting of the language threshold requirements for each department offering patient care as one of the IAP goals.
f) Improve access to care and quality of care for UCSF patients with limited English proficiency (LEP) by mandating the hiring of at least one bilingual frontline contact staff who can speak each threshold language in various patient care and service areas.
g) Provide salary incentives for bilingual frontline contact staff who can speak one or more of UCSF's threshold language(s) with patients.
h) When the term "under-represented in medicine" is used, language congruence of healthcare providers needs to be added as one of the criteria to assess with relevance to the proportion of the ethnicity/race groups in San Francisco and the identified threshold languages of patients in UCSF.

i) Conduct marketing outreach in different media formats in the threshold AAPI languages.
j) Install multilingual signages that minimally include Chinese and Spanish in all patient care areas and directional signs.
k) Install QR codes/signs for instruction (in threshold languages) for making positive comments/complaints in prominent patient care areas within each clinical department.

4) Break the Bamboo Ceiling for AAPI Faculty and Staff and Salary Equity

Thirty-nine percent of UCSF employees self-identifies as AAPI; however, that proportion of AAPI is not represented at the senior and executive management levels. Senior faculty leadership also lacks behind the proportion of Asian faculty at UCSF in the schools and clinical departments. Furthermore, the Economic Policy Institute found that AAPI women face a double pay penalty, and that on average AAPI women earn 8% less than their corresponding white male counterpart.

a) HR to develop an action plan to address diversification of faculty senior leadership positions and executive management levels to adequately include not just BIPOC, but also immigrants in whom English is not their first language. Furthermore, incorporate the actions into the Faculty Equity Advisor Program and the Staff Equity Advisor Program
b) Inclusion of AAPI in the UCSF-wide process improvement to disrupt the unconscious bias present in our hiring and promotions processes
c) HR to make salary review a transparent process for AAPI staff, especially AAPI women,   to achieve salary equity

5) Stop indiscriminate use of the "URM" term in DEI initiatives and communications

There has rightly been much attention to minoritized groups that are under-represented in medicine (URM). There is not an under-representation of AAPI faculty and staff at the non-senior and non-executive levels at UCSF. However, AAPI faculty and staff have barriers to advancement and promotion related to implicit biases and structural racism, as well as experience racism and microaggressions in the workplace. Thus, "URM" can inadvertently become a term that discriminates against AAPI. Furthermore, by using the term "URM" indiscriminately, UCSF also inadvertently perpetuates the invisibility of Asian Americans.

a) As a correction practice, we recommend UCSF to adapt more nuanced language around inclusion of the specific minoritized groups. There are circumstances by which using alternative language to "URM" would be more appropriate (e.g., BiPOC, minoritized) to include Asian Americans.

6) Student Pipelines and School Admission

To meet the diverse language needs of our patients, in addition to the considerations for BIPOC, applicants' bilingual skills in the threshold languages (especially Cantonese - a language deficit which has a huge gap between providers and patients) need to become an additional preference. This will help UCSF to be more in concordance with the language needs of the 35% AAPI in San Francisco (with about half of the AAPI immigrants experience language barriers).

a) Build student pipelines of future healthcare providers with bilingual abilities from the existing high school outreach programs, summer college internship programs, as well as clinical internship, residency and fellowship programs.
b) School admissions: Each school will incorporate Asian language ability, especially the threshold Asian languages, as one of the admissions criteria for considerations. Data on the language ability of the students, in addition to their race and ethnicity, will be reported annually

by all UCSF schools with a clinical and patient service focus, e.g., Nursing, Medicine, Pharmacy, Dental, Physical Therapy, etc.

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We, the undersigned groups and individuals, endorse the Joint Statement above:

AHC – Asian Health Caucus
AHI – Asian Health Institute
APAMSA – Asian & Pacific Islander American Medical Student Association
APASA – Asian & Pacific Islander American Systemwide Alliance
UCSF Center for Child and Community Health
UCSF Center for Community Engagement
UCSF Committee on the Status of Women
UFA - Filipinx Steering Committee

(Other groups and individual UCSF faculty, staff and learners to be list below)

To Endorse this Statement : **Click   SUBMIT**