

**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS)
COVID-19 HEALTH EQUITY TASK FORCE (HETF)**

4th MEETING (Virtual)

May 28, 2021

Members Present

Marcella Nunez-Smith, M.D., M.H.S. (Chair)
Mayra Alvarez, M.H.A.
Sara Bleich, Ph.D.*
Jessica Cardichon, Ed.D, J.D.*
James Hildreth, Ph.D., M.D.
Pritesh Gandhi, M.D., M.P.H.*
Andrew Imparato, J.D.
Victor Joseph
Joneigh Khaldun, M.D., M.P.H., F.A.C.E.P.
Rachel Levine, M.D.*
Octavio Martinez, M.D., M.P.H., M.B.A., F.A.P.A.
Tim Putnam, D.H.A., E.M.S.
Vincent Toranzo
Homer Venters, M.D.
Bobby Watts, M.P.H., M.S.
Haeyoung Yoon, J.D.

Members Absent

Richard Cho, Ph.D., M.P.A.
Jo Linda Johnson, J.D.*
Mary Turner, R.N.

*Federal ex-officio members

Federal Staff

CAPT Samuel Wu, Pharm.D., Designated Federal Officer, Office of Minority Health
Martha Okafor, Ph.D., Executive Director, Office of the Assistant Secretary for Health

Invited Presenters

VADM Vivek H. Murthy, M.D., M.B.A.
U.S. Surgeon General
Department of Health and Human Services
Winston Wong, M.D., Scholar-in-Residence
UCLA Kaiser Permanente Center for Health Equity
David Williams, Ph.D., Chair
Harvard T. H. Chan School of Public Health

Call to Order, Welcome and Introductions

CAPT Samuel Wu

Designated Federal Officer, Office of Minority Health

CAPT Wu opened the fourth meeting of the COVID-19 Health Equity Task Force (HETF) by welcoming attendees to the meeting and wishing them a happy Asian American, Native Hawaiian, and Pacific Islander Heritage (AANHPI) month. CAPT Wu thanked Dr. Minh Wendt for serving as the Designated Federal Officer for the past two meetings while he was on deployment. CAPT Wu also thanked the leadership of the Office of Minority Health (OMH) to include RADM Felicia Collins, CAPT Danny Nguyen, Ms. Roslyn Holliday-Moore, and Dr. Martin Mendoza for their support during his absence. He reminded attendees that the meeting was being live streamed and recorded and that the recording would be available for viewing at a later time. Additionally, all materials presented in the meeting would be available at minorityhealth.hhs.gov/hetf. CAPT Wu noted that American Sign Language (ASL) interpreter services were available for the meeting and closed captioning was available at both hhs.gov/live and the OMH YouTube channel. CAPT Wu welcomed members of the public to provide comments as stated in the meeting notice published in the Federal Register by emailing COVID19HETF@hhs.gov no later than 7 days after the meeting.

Opening Remarks

Marcella Nunez-Smith, M.D., M.H.S.

Chair, COVID-19 Health Equity Task Force

Dr. Nunez-Smith introduced the meeting by stating its objective: to discuss interim recommendations to address xenophobia and discrimination. She highlighted that xenophobia and discrimination drive COVID-19 and other health inequities at the structural level. She noted that a long history of racialized and targeted policies and practices in this country in housing, nutrition, education, healthcare, policing, immigration, and employment has functioned to marginalize too many, systematically limiting access to opportunity. Further, she stated that history remains all too present in the current COVID-19 landscape as communities of color have been overrepresented in COVID-19 infections, hospitalizations, and deaths and underrepresented in access to lifesaving therapies and vaccinations.

She reminded Task Force members that today's meeting marked 1 year after Mr. George Floyd was killed by Minneapolis police and 100 years since the Tulsa Race Massacre, in which a thriving Black community known as the Black Wall Street was violently destroyed by White residents. Dr. Nunez-Smith acknowledged that the year-long conversation and reckoning following the collective witnessing of Mr. Floyd's murder should be inseparable from the Task Force's shared understanding of the effects of the COVID-19 pandemic and from the work of the Task Force.

Dr. Nunez-Smith acknowledged that while experiencing discrimination and racism is not new to the AANHPI communities, the COVID-19 pandemic has heightened inflammatory and xenophobic rhetoric and tragic action. These events called for President Biden to issue a memorandum condemning racism, xenophobia, and intolerance against the AANHPI

communities, followed by the Department of Justice's agency-wide initiative to address and prevent race-based hate crimes. Further, she mentioned that the COVID-19 Hate Crimes Bill was recently passed into law, the Centers for Disease Control and Prevention (CDC) declared racism as a public health threat, and that over 208 Federal, State, and local entities have declared racism a public health crisis or emergency.

In closing, Dr. Nunez-Smith reminded the Task Force that xenophobia and discrimination affect all citizens. She then reviewed the meeting agenda and recognized the contributions of the Federal staff, Task Force members, subcommittee members, and subject matter experts who have contributed to the body of interim recommendations thus far.

After Dr. Nunez-Smith's opening remarks, CAPT Wu performed a roll call of the HETF members and announced a quorum for the meeting.

Updates from HHS

VADM Vivek H. Murthy, M.D., M.B.A.
U.S. Surgeon General

VADM Murthy expressed gratitude to the Task Force for their work and for being invited to attend the meeting. He shared his own personal experience as an immigrant child growing up in Miami. At times, he felt different from others and reminded the Task Force and audience of our collective responsibility to remedy injustices. Xenophobia and discrimination affect health outcomes and are mediating factors to loneliness and isolation. He explained that whether from physical trauma or emotional trauma as an adult or child, the results profoundly impact the likelihood of developing substance use disorder, depression, anxiety, and/or other physical illnesses and conditions.

VADM Murthy noted that people respond to trauma in different ways. Trauma induces shame and powerlessness, and it can prevent someone from seeking help when they need it the most. Persons who experience racism and xenophobia are at increased risk of feeling isolated and lonely but may also face mental health complications, increased incidence of dementia, experience sleep disturbances, and meet premature death. He stated that a growing body of research tells us that in the face of trauma, including deep trauma, one of the greatest sources of healing we have is community and connection. VADM Murthy reminded the Task Force and audience that our relationships with one another have the power to heal. As agents of healing, through the power of our relationships, we can address some of the deep trauma that so many people have experienced in our country.

Regarding priorities for the country, VADM Murthy stated that COVID-19 will remain a primary focus, with three additional issues being mental health, substance use disorder, and equity. He explained that while these issues were certainly present prior to the pandemic, they have been exacerbated by COVID-19. In closing, VADM Murthy stated that equity is more than providing people with equal access to care or ensuring that people have good health outcomes. Equity is a statement of value. It's an affirmation of who we are as a community and the standards we choose to live by. VADM Murthy shared that equity should be a lens through which we examine issues. It should be a metric that we use to guide our progress when

addressing the COVID-19 pandemic or any other public health challenges that our country might face.

Panel Presentation and Discussion

Two invited speakers, Dr. Winston Wong and Dr. David Williams, presented on xenophobia and discrimination and how they drive COVID-19 and other health inequities for racial and/or ethnic minority communities. The presentations were followed by a brief discussion period.

Winston Wong, M.D.

Scholar-in-Residence

UCLA Kaiser Permanente Center for Health Equity

Through interactive dialogue with the Task Force members, Dr. Wong addressed how the Task Force subcommittees should take on the questions regarding xenophobia and some of the specific issues around AANHPI health.

Dr. Wong shared the following data points for the Task Force to consider:

- The majority of Asian Americans (59%) are foreign born, but when you add in Native Hawaiians, Pacific Islanders, and other populations that have compacts with or were under the governance of the United States since World War II, assumptions can be misleading.
- Thirty percent of Asian American households are intergenerational, with potentially three generations living in one household, which is atypical of American households that are predominantly nuclear and one generation. This has implications for how to address issues with COVID-19 contact, screenings, and vaccination follow-up as these require looking at the individual within his or her household context.
- Although about 20 percent of medical students are of Asian descent and approximately 21 percent of the actual medical workforce, Asian Americans still experience issues accessing healthcare due to language barriers. An estimated 33 percent of the Asian American population is considered limited in English proficiency.

Dr. Wong also added that in 2020, one in eight Asian Americans experienced some form of anti-Asian hate incident.

These factors, along with socioeconomic status and access to interpreter services, have a profound impact on the risk of infection and access to and utilization of care and resources as it pertains to COVID-19 and other issues. Dr. Wong elucidated that some data suggest that the Asian American population case fatality rate is disproportionately higher than that of the general population.

Dr. Wong recommended that the Task Force deliberately address factors associated with exacerbating xenophobic ideology and action considering the White House's recent declaration to accelerate the examination into the origins of COVID-19 and any association with the Wuhan Virology Laboratory. He explained that historically, when international fears rise between the United States and a country in Asia, it has had a direct and profound impact on the relationships of Asian Americans and the general community.

To further illustrate the sensitive nature of this issue, Dr. Wong reminded the Task Force of the killing of Vincent Chin by a group of disgruntled autoworkers in Michigan who associated the industrial downturn of the U.S. car industry with Japanese inroads into the auto industry. He also pointed to the relationship between Japan and the United States during and post World War II that resulted in the incarceration internment of Japanese Americans.

Dr. Wong emphasized the important role of the Task Force to examine, anticipate, and find ways to mitigate any xenophobic response to the investigation and/or potential findings of the origins of COVID-19. Another recommendation is to intentionally engage local leaders of diverse AANHPI communities in the planning and execution of efforts and to be proximal to smaller groups of AANHPI communities to effectively mitigate COVID-19 discrimination and xenophobia.

Dr. Wong noted that marginalization is a keystone of operative discrimination of AANHPI public health efforts. When we marginalize the contributions of Asian American mortality to overall mortality rate, we effectively say that this population does not matter. Further, when we say that not enough people speak a specific language to reach out to members of a community, we are marginalizing and effectively discriminating against that community. When we say that the community can care for its own people with its own resources, we are effectively marginalizing the population. When we say we don't have enough data to reach conclusions, it provides us cover to discriminate against smaller populations, which could result in devastating consequences.

Dr. Wong explained the importance of understanding the history and economic and political context of Native Hawaiians and Pacific Islanders specifically, as they are frequently blanketed under the larger Asian American category.

Another recommendation made by Dr. Wong to the Task Force is to avoid subliminally expecting Asian American healthcare professionals to subjugate or subsume any comment or perspectives they have on the discrimination or personal attacks on their ethnic background as a member of the AANHPI community.

In closing, Dr. Wong emphasized the need to acknowledge that some members of the AANHPI community are not only critical parts of essential health workers but essential workers in general. However, the prevailing narrative of a college-educated, socially mobile workforce of Asian Americans does a disservice to the diversity of socioeconomic backgrounds across the AANHPI population.

Interpersonal Stress Linked to Racism: Racial Bias and its Health Consequences

David Williams, PhD

Chair, Department of Social and Behavioral Sciences

Harvard T. H. Chan School of Public Health

Dr. Williams discussed aspects of racism that have direct consequences for health with a specific focus on interpersonal stress linked to experiences of racial discrimination.

Dr. Williams explained that when referring to racism, there are three main mechanisms by which it impacts health: (1) the structure of society and larger social forces, (2) mechanisms of institutional or structural racism, and (3) the role of residential segregation, which shapes access to opportunity in American society. Dr. Williams noted an emphasis on individual discrimination, the subjective experience of being treated unfairly or poorly, recognizing that racism is deeply embedded in American culture, which leads to implicit biases and triggers discrimination. He noted that these processes are interrelated and support each other.

Detailing the large body of evidence that points to disparities experienced by members of racial and/or ethnic minorities, Dr. Williams noted that persons of racial and/or ethnic minority communities tend to live in disadvantaged, segregated neighborhoods and have higher levels of exposure to acute and chronic stressors. Whether financial stress, work-related stress, or major life events or traumatic experiences, racial and/or ethnic minority communities have higher levels of these stressors. Not only do racial and/or ethnic minorities have high levels of stress and experiences of trauma, research supports that there is greater clustering of stresses in these communities, resulting in multiple stressors and/or traumatic experiences.

While the psychosocial and economic stressors are well known, Dr. Williams noted that we often downplay the effects of physical and chemical stressors like exposure to air pollution. He emphasized that all these factors profoundly shape health outcomes for racial and/or ethnic minority populations.

The most widely used instrument to measure the impact of discriminatory-related stress on health is the Everyday Discrimination Scale, a scale developed by Dr. Williams, that has over 450 papers published globally documenting the role of discrimination and stress from the little day-to-day indignities.

Dr. Williams shared that in 2015, the American Psychological Association utilized the measure in its annual report on stress in America. Findings revealed that 1 in 3 Native Americans experienced everyday discrimination at least once a week or almost daily, whereas 1 in 4 African Americans, 1 in 5 Hispanics or Latinos and, 1 in 10 Whites and Asians reported those same experiences. Dr. Williams expanded on these findings which revealed that not all experiences are attributed to race alone. Further, he shared that research reveals that attribution of discrimination is not a determining factor on health outcomes, but that simply the experience of discrimination has negative health effects. In general, anyone who reports these experiences has poorer health outcomes irrespective of racial ethnic background. Dr. Williams noted that high levels of everyday discrimination are linked to an increased incidence of metabolic syndrome, cardiovascular disease, obesity, breast cancer, type 2 diabetes, adult-onset of asthma, high blood pressure, poorer sleep quality, shorter sleep duration, diagnosed mental health complications, emotional distress, and higher risk-taking behaviors. He went on to explain that everyday experiences of discrimination are attributed to lower levels of engagement with the healthcare system and follow through on physician's recommendations. Dr. Williams explained that exposure to high levels of everyday stress is linked to multiple indicators of subclinical cardiovascular disease such as intima media thickness, coronary artery calcification, and visceral fat leading to atrial fibrillation or heart rate variation. Additionally, everyday discrimination is

linked to other indicators of biological dysregulation such as increased inflammation and cortisol as well as lower levels of telomere length.

Dr. Williams expounded on the empirical evidence that everyday discrimination is an independent contributor. It is independent of income and education of socioeconomic status and to racial ethnic disparities in health. Indeed, he explained that the research suggests that there are hidden ways in which stressors linked to race and racism adversely impact health. For instance, he shared that high levels of online discrimination predict increased risk of depressive and anxiety symptoms independent of a global measure of adolescent stress and experiences of discrimination in offline context. Further, among Black and Latino adolescents ages 11 to 19, those who have seen someone from their racial group being arrested, beaten, and/or shot by the police reported higher levels of posttraumatic stress disorder and depressive symptoms in the following year.

Noting data from 1990 to 2015, Dr. Williams shared that suicide rates among elementary school students have been stable for Latinos and for Asian Americans, declined for Whites, but have doubled for African Americans. These data are from vital statistics that do not shed light on the causes of increased incidences of suicide but do raise questions for us to explore the causes and drivers of these patterns. Dr. Williams noted that these data raise the question of what it means to be raised Black in America today.

Pointing to increasing research attention to negative experiences with the police, Dr. Williams shared that for many minority children in the United States, especially African American or Latinx children, these negative experiences appear to be a rite of passage. He noted recent research findings revealed that 70 percent of Black mothers that were interviewed reported being “very concerned” that their children might be harmed by the police or their children might get stopped in a predominantly White neighborhood.

Dr. Williams shared data recently published from the Fragile Families study of young people in 20 cities across the United States. This study revealed that 23 percent of urban youth are stopped by the police by the age of 15. He noted that mothers of these youth who were stopped are twice as likely to report sleep difficulties linked to symptoms of depression and anxiety. Dr. Williams shared that these incidents have a spillover effects on the health of African American adults.

In another study led by Dr. Williams, the research team looked at a database of every police shooting in the United States over a 3-year window. Then, the team linked it to data from the CDC on the mental health of the population in every State. Dr. Williams explained that every police shooting of an unarmed Black person led to worse mental health of the entire Black population, not just the family and friends but the entire Black population in the State in which it occurred for the next 3 months.

Dr. Williams shared that there is documented adverse impacts of police shootings on the community. However, he noted that the effect is specific to police shootings of unarmed African American males. In cases where the African Americans were armed, there was no negative effect on mental health. He stated that these data suggest that it’s the perception of vulnerability that

comes from seeing someone being shot and the injustice that produces the negative health impact.

The consequences of these higher levels of exposure to psychosocial and economic stressors in general and the stress of discrimination have a profound impact on indicators of biological aging. Indeed, Dr. Williams noted that African Americans are 7.5 years physiologically older than Whites. Some studies have found as much as a 10-year gap in biological aging. Indeed, data from the CDC show that by age 50 to 64, early onset of diseases such as high blood pressure, is observed among 61 percent of African Americans adults, compared to 41 percent among White adults.

These factors have a profound impact on the health of persons affected by COVID-19. Dr. Williams shared data from a study of 12 New York City hospitals, which included nearly 6,000 patients experiencing comorbidities. While only 6 percent of persons with COVID-19 were hospitalized, 88 percent had comorbidities. For instance, 57 percent had diagnosed hypertension, 42 percent were obese, one third had a diagnosis of diabetes mellitus, and 18 percent had heart disease.

Dr. Williams explained the challenges he has experienced throughout his career in researching and documenting the impact of racism, discrimination, and environmental stressors on the health of racial and/or ethnic minority communities. He illustrated that academic journals have been dismissive of the research. Indeed, he had been advised by reviewers that the term “racism” does not belong in a scientific paper. He went on to explain that the reviewer told him that “racism is an ideological concept that cannot be measured.”

Dr. Williams noted that there is a need to balance what we now know as evidence of the effects of racism and discrimination with greater attention to identifying the protective factors that shape health outcomes as well.

Concurring with the Surgeon General’s comments earlier in the meeting, Dr. Williams highlighted findings from a study he conducted among African American teenagers in Georgia and exposure to discrimination at ages 16, 17, and 18. He revealed that by age 20, the teenagers exhibited higher levels of stress hormones including cortisol, epinephrine, and norepinephrine. Additionally, high levels of blood pressure, inflammation, and elevated body mass index were observed. He added that the research uncovered the association between discrimination and biological dysregulation at age 20 and the extent to which high social support is a mitigating factor to some of the negative effects of exposure to discrimination and racism. Dr. Williams noted that a national study also found that religious engagement among African Americans helped to reduce some of the negative effects of discrimination on health.

Dr. Williams challenged the Task Force to think of ways to prevent the occurrence of racism and discriminatory experiences among racial and/or ethnic minority communities as a means of preserving and restoring good health through supporting a sense of community, respect, and dignity. In closing, Dr. Williams shared a quote by Martin Luther King, “True compassion is more than flinging a coin to a beggar; it understands that an edifice which produces beggars needs restructuring.”

Discussion

Dr. Wong asked Dr. Williams if there were any data to suggest that communities of color who experience racism and discrimination have a predilection toward long-term sequelae of the diseases noted. Dr. Williams replied that while he is unaware of any published research, there is reason to believe that long-term sequelae may exist as the evidence is clear on the adverse impacts from high levels exposure. Additionally, communities of color have a disproportionate rate of mortality and experiences of grief, a well-known source of stress.

Dr. Williams referred to a recently published opinion piece in the *Journal of the American Medical Association* that illustrated that communities of color have been disproportionately affected by the economic stress of the pandemic in addition to illness and loss of life. He explained that the research suggests that populations of color and persons with an income of less than \$40,000 have been disproportionately impacted by the pandemic, regardless of racial or ethnic background. Dr. Williams noted that the data support the assumption that communities experiencing racism and discrimination have a predilection toward long-term sequelae from illness and disease.

Dr. Khaldun asked Dr. Williams if he could speak on the matter of maternal and infant morbidity and mortality in addition to the concept of social support as a mitigating factor as it relates to maternal and infant health outcomes.

Dr. Williams replied that while there is some evidence to suggest that social support can be a source of stress, the evidence supports that social ties can be protective of a broad range of stressors, including the stress of discrimination. In terms of the effects of racism and discrimination on maternal and infant health, Dr. Williams explained that there is a well-documented linkage between discrimination and poorer maternal outcomes. Additionally, there is a larger growing body of studies that document experiences among pregnant women and the negative effects on maternal and infant health. He pointed to data documenting the association between poor health during the first year of life and maternal experiences of discrimination. Additionally, both paternal and maternal experiences of discrimination have been associated with poorer health outcomes during the first year of life. Dr. Williams noted that there has been less emphasis on protective mechanisms on paternal, maternal and infant health.

Mr. Imperato asked both Dr. Williams and Dr. Wong if there are any long-term implications for the field of psychiatry and other mental health clinicians in response to stressors and if traditional psychiatry is sufficient for responding to racial and discriminatory stress.

In his reply, Dr. Williams noted that healthcare providers should screen for experiences of racial and discriminatory stressors. He cautioned that patients may not volunteer their experiences if the provider is not of similar race and/or ethnicity because of fear of judgment. He also expounded on the paradox in the mental health literature that African Americans have historically demonstrated lower rates of depression and anxiety than their White counterparts. While we are seeing higher rates of suicide among our young African American population, for hundreds of years suicide was not prevalent. We are now seeing the gap narrow among young African Americans, reflecting increasing rates of suicide among African American young people.

Dr. Williams pointed to the largest study of African American and Caribbean immigrants in the United States and mental health. He explained that these data showed lower rates of current, last year, and lifetime rates of depression; once depressed, their symptoms were severe enough to induce impairment. Additionally, he added that they were less likely to receive treatment and their depression was both chronic and persistent. Dr. Williams noted that while there seem to be some resources to protect individuals from the onset of depression, once symptomatic the outcomes are suggestive of the need for improved access to mental health treatment and to reduce the stigma of mental health among the African American and Caribbean immigrant communities.

Dr. Wong underscored the critical importance of understanding the cultural and linguistic context of the population being served. As an example, he noted that the term “depression” does not exist in the Cantonese vocabulary despite historically elevated rates of suicide among elderly Chinese women. He added that the rates of individuals expressing experiences of social isolation is high among this same population, leading to the assumption that there is a need to bridge cultural competency within the Western framework around issues of depression. Dr. Wong also mentioned that in Japan, the rates of suicide are high among younger Japanese women. Therefore, there may be a need to validate cultural differences among newly immigrated Japanese women within the cultural and social sciences as they apply to classic psychiatry.

Introduction of Ex-officio Members

The new HETF member, Dr. Pritesh Gandhi briefly introduced himself, summarized his background, and highlighted experiences relevant to the HETF charge.

Dr. Pritesh Gandhi, Chief Medical Officer at the Department of Homeland Security, is an internist and pediatrician by training with a background in public health.

Subcommittee Presentations and Discussion

Dr. Martha Okafor shared the topic for this month’s sprint, discrimination and xenophobia that are related to and either caused or worsened by the COVID-19 pandemic.

Dr. Okafor introduced the four HETF subcommittees: (1) Healthcare Access and Quality; (2) Communications and Collaboration; (3) Data, Analytics, and Research; and (4) Structural Drivers and Xenophobia.

This Task Force—under the Executive Order—is responsible to make recommendations for mitigating the health inequities caused or exacerbated by the COVID–19 pandemic and for preventing such inequities in the future.

The four sub-subcommittees work intensely and effectively to provide:

- (1) Recommendations for how agencies and State, local, Tribal, and territorial officials can best allocate COVID-19 resources, in light of disproportionately high rates of COVID-19 infection, hospitalization, and mortality in certain communities and disparities in COVID-19 outcomes by race, ethnicity, and other factors, to the extent permitted by law;

- (2) Recommendations for agencies with responsibility for disbursing COVID-19 relief funding regarding how to disburse funds in a manner that advances equity; and
- (3) Recommendations for agencies regarding effective, culturally aligned communication, messaging, and outreach to communities of color and other underserved populations in addition to addressing equity data shortfalls.

Dr. Okafor lifted the following common themes.

Mandate Data Collection, Harmonization, and Integrity

- Adopt a common definition of a hate crime, develop a standardized database and forms for surveillance
- States, Tribes, and territories should continue to support and expand reporting mechanisms
- Improve data related to hate crimes, experiences with discrimination, and racist acts
- Acknowledge that racial and ethnic groups are not homogenous and collect data that allow a more granular understanding of impacts with subgroups of broad populations, such as AAPI
- Establish efforts to track and report, in real time, population health and health outcomes of persons who are incarcerated and other minoritized groups

Expand Services in Marginalized Communities

- Strengthen housing assistance programs and enforce housing and lending discrimination laws, including restoring the Affirmatively Further Fair Housing (AFFH) rule
- Increase investments in full-service community schools and support State-level cross-agency partnerships to provide free meals
- Increase funding under Title IV of the Elementary and Secondary Education Act
- Invest in American jobs and American families, and rebuild and fund equitable childcare and early learning systems
- Fully fund services to Tribal communities (Indian Health Service [IHS], the Food Distribution Program on Indian Reservations)

Engage Communities

- Launch a formal partnership with national medical associations and allied health professional organizations on inclusion and equity
- Increase resources that accurately include the contributions of marginalized and minoritized communities in history

Increase Awareness and Access to Services

- Proactively communicate eligibility for new and existing programs to minority, marginalized, and minoritized groups
- Increase awareness and access through partnerships and providing information in multiple languages, in various accessible formats, and locally
- Combat misinformation on health and public health measures, such as vaccines

Healthcare Access and Quality Subcommittee

Tim Putnam, D.H.A., E.M.S.

Problem Statement 1: The COVID-19 pandemic has worsened structural racism and has increased conscious and unconscious bias in healthcare access, coverage, and treatment. This has particularly affected marginalized populations who, due to identity, geography, and economic status, are less likely to receive the highest standard of care or any care at all.

To address the first problem statement, the subcommittee presented the following recommendations:

- (1) Fund research to understand (a) the impacts of structural racism, including the processes of implicit bias and (b) test interventions that disrupt and change these processes toward sustainable solutions.
- (2) Create funding and incentives to research, identify, and implement interventions to address internet and food deserts and expand social service support to affected communities.
- (3) The Federal Government should collaborate with local municipalities to assist with appropriate housing regulations for migrant workers.

Problem Statement 2: Healthcare interventions, research, and clinical guidelines are biased and not tailored to several minoritized or rural populations.

To address the second problem statement, the subcommittee presented the following recommendations:

- (1) Encourage the removal of legal and policy barriers that impede discrimination-free healthcare.
- (2) Require transparency in reasoning and computer coding as well as equity analyses for racial, ethnic, gender, and other biases in clinical practice guidelines as they relate to health-related algorithms and artificial intelligence and health information technology.
- (3) Assess clinical practice guidelines, health-related algorithms and artificial intelligence, and health information technology and correct for discrimination, racism, and biased practices, e.g., require pulse oximeters to accurately read every patient's oxygen saturation regardless of skin thickness or pigmentation.

Problem Statement 3: During the COVID-19 pandemic, State and local governments have denied testing and vaccine access to several vulnerable groups and have shifted resources to preferential groups. This exacerbated existing health disparities, contradicted best public health practice, and is prolonging the pandemic.

To address the third problem statement, the subcommittee presented the following recommendations:

- (1) Decisions related to vaccination distribution locations should be made by an independent authority that drives equity and the best interests of public health. This independent authority should establish mechanisms to hear regularly from diverse stakeholders to help inform their decision making.

- (2) Federal, State, and local authorities should ensure that people in carceral settings are afforded access to testing, care, and vaccination and that release/decarceration is utilized as a public health intervention.

Problem Statement 4: America's healthcare system with coverage tied to employment has caused hospitals and physicians to leave areas with low employment rates and vulnerable populations, which further hindered access during the pandemic.

To address the fourth problem statement, the subcommittee presented the following recommendations:

- (1) Declare healthcare access and coverage a human right and align federal policies and funding to secure this right.
- (2) Examine healthcare funding approaches that allocate resources for building and staffing healthcare facilities based on need and eliminate financial barriers to care, including premiums, deductibles, and copayments.
- (3) Increase funding for public health infrastructure and staff, targeting areas with the greatest healthcare disparities.
- (4) Support federal funding for community purchase of distressed hospitals and provide financial and technical support to ensure that they can continue operating.
- (5) Increase federal funding for IHS so that, at minimum, IHS has the resources to match the U.S. National Health Expenditure per person annual spending rate.
- (6) Require all Medicaid plans to reimburse Critical Access Hospitals at a minimum of the Medicare cost-based reimbursement rate.

Discussion

Dr. Vincent Toranzo highlighted issues regarding the politicization of the pandemic and a lack of equity within the COVID-19 response in several States, specifically the withholding of vaccines and testing from communities in need. This has resulted in these same communities being disproportionately affected by COVID-19, which has prolonged the pandemic.

Dr. Homer Venters touched on equal access for people who are incarcerated. There are outbreaks just starting behind bars all over the country because these individuals have been denied equitable access to the most basic testing and vaccines because they happen to be in a detention or carceral setting.

Relating to structural racism and unconscious bias in healthcare, Dr. James Hildreth thought it important to recognize that large datasets will be used in the future to develop algorithms and predictive algorithms to treat various disorders and diseases. Some of these algorithms are biased because the datasets used were incomplete in terms of having minority representation. So, it is important going forward to make sure that these algorithms apply equally well to minority populations as they do to majority populations.

Communications and Collaboration Subcommittee

Mayra E. Alvarez, M.H.A.

Problem Statement 1: Historical and continuing structural discrimination and racism, including bias among medical and allied health professionals, leads to physiological, social, and economic factors that increase risk for COVID-19. The pandemic unmasked and exacerbated underlying inequities in healthcare, housing, education, criminal justice, and finance systems and impacted the well-being of all communities, particularly those who are marginalized, minoritized, or medically underserved.

To address the first problem statement, the subcommittee presented the following recommendations:

- (1) The Federal Government–led multipronged public-private awareness, education, and communications campaign focused on clarifying misinformation associated with vaccines and rebuilding trust in government will be strengthened and informed by stakeholders from diverse communities through regular engagement in order for the government to have a more comprehensive understanding of incidences of misinformation. It will also include a robust paid media strategy targeting communities who are marginalized, minoritized, or medically underserved.
- (2) The Federal Government should launch a formal partnership with national medical associations and allied health professional organizations to acknowledge racism and ensure we are inclusive and advancing equity.
- (3) Federal civil rights enforcement agencies should develop crisis standard of care guidelines that do not violate Federal civil rights laws. The Federal Government should work with States, Tribes, territories, and local governments to help them be better prepared for the next pandemic so that we can avoid shortages that lead to crisis standards of care.

Problem Statement 2: References to the COVID-19 pandemic by the geographic location of its origin have stoked unfounded fears and perpetuated stigma about AAPI persons and have contributed to increasing rates of violence, harassment, and hate crimes against AAPI persons. Inflammatory and xenophobic rhetoric has put AAPI persons, families, communities, and businesses at risk.

To address the second problem statement, the subcommittee presented the following recommendations:

- (1) The Federal Government should lead a multipronged public education campaign to educate and raise public consciousness about anti-Asian hate and ensure transparent, accurate communications to AAPI communities to support access to vaccines and other related supports and services.
- (2) The Federal Government should collaborate with State, Tribal, territorial, and local law enforcement partners and community groups to educate the public about available resources related to pandemic-related hate- or bias-related incidents (including best practices for reporting such incidents).

- (3) The Federal Government should launch a public-private partnership to disseminate information and provide support to AAPI-owned small businesses to access COVID-19 related assistance and support their economic recovery.

Problem Statement 3: The national narrative, including terminology and rhetoric used by media and politicians around the portrayal of immigrants, refugees, and asylees as vectors of COVID-19 has led to dehumanization and support for restrictive immigration policies, placing such populations at greater risk of COVID-19.

To address the third problem statement, the subcommittee presented the following recommendations:

- (1) The Federal Government, through agencies like the CDC, should develop best practices for testing and vaccination sites in areas with large immigrant populations including but not limited to
 - (a) Avoiding having any military, National Guard, law enforcement, or other uniformed personnel present onsite;
 - (b) Providing vetted, translated information on arrival and having trained and culturally competent interpreters onsite;
 - (c) Providing access to in-person or telephonic language services and advertising that these services are available for patients who have limited English proficiency or are more comfortable speaking another language and ensuring family members or untrained staff do not provide interpretation unless in an emergency; and
 - (d) Partnering with trusted faith and community organizations that are already providing aid to sites.
- (2) The Federal Government should launch a formal partnership with farmworker unions, whose members are disproportionately from immigrant backgrounds, to distribute testing- and vaccine-related information and related supports and services.
- (3) The Federal Government should release specific guidance that further clarifies that the CDC will not seek Social Security numbers, driver's license numbers, or passport numbers from vaccine providers. The base CDC data agreement should further clarify how the CDC will ensure that personal data is not inappropriately used or shared, such as retained or sold by third party contractors.

Problem Statement 4: Many Americans are unaware of our country's history of structural racism and xenophobia and do not recognize the ongoing massive disparities in wealth and access to healthcare, to education, and to clean air and water that continue to threaten the health and well-being of millions of Americans.

To address the fourth problem statement, the subcommittee presented the following recommendations:

- (1) The Federal Government should create a Truth and Reconciliation Commission to recognize "the dignity of individuals, the redress and acknowledgment of violations, and the aim to prevent them from happening again," as put forward by the International Center for Transitional Justice. The Commission would acknowledge the long history of racism in the United States, its persistence into the present, including its connection to COVID-19 inequities, and the millions of living Americans who could be considered

victims. As such, the Commission would address issues ranging from the history of slavery to school segregation to policing to disability to employment and wealth disparity.

- (2) The Federal Government should launch a robust initiative centered on uplifting the diversity of Americans and highlighting the multiple cultures, ethnicities, backgrounds, and experiences that contribute to American society. The initiative will
 - (a) highlight how equity is critical to our collective success and
 - (b) build on the Biden Administration’s Executive Order on Advancing Racial Equity, including the creation of an Interagency Task Force to work across executive departments and agencies to engage in efforts to educate the American public on the value of equity.
- (3) The Federal Government should partner with national youth-led organizations and influencers to increase direct education and promote authentic messaging around pandemic preparedness, immunizations, and vaccine safety toward the youth population.
 - This includes age-appropriate channels of communication including sharing information via television, online videos, mobile apps, educational shows as well as social media campaigns with personalized messages focused on youth interests and motivations, and informative videos with celebrities.

Discussion

Dr. Vincent Toranzo encouraged more direct education and authentic messaging to youth populations, who were largely ignored during pandemic-related communications early on. He praised the current mass vaccination campaign targeting young people and encouraged the government to further partner with national youth-led organizations and influencers as well as young leaders within our communities.

Mr. Andy Imparato lifted the recommendation related to crisis standards of care. He advised the Task Force to engage the Office of Civil Rights of the HHS and other civil rights enforcement agencies across the government ensure equitable standard of care.

Dr. Octavio Martinez highlighted the importance of communication, collaboration, and community partnerships in coordination with the Federal Government and its efforts.

Data, Analytics, and Research Subcommittee

Joneigh Khaldun, M.D., M.P.H., F.A.C.E.P.

Problem Statement 1: The current data infrastructure does not capture the full extent of hate incidents, has inconsistencies across jurisdictions, and has a significant delay in release of national data. Systemic racism and a lack of trust in the criminal justice system leads to fear, uncertainty, and underreporting of interpersonal violence, including hate crimes, in marginalized and minoritized communities. This creates a lack of understanding of the extent of hate crimes in these communities and a subsequent lack of targeted resources to address the problem.

To address the first problem statement, the subcommittee presented the following recommendations:

- (1) Create a coordination mechanism on hate crime data collection, adopt a clear definition of hate crime, develop a standardized database and reporting forms, use data to inform policy, and publicize data.
- (2) States, Tribes, territories, and local jurisdictions should continue to support and expand reporting mechanisms through helplines, online systems, interagency centers, and partnerships with academic institutions and nonprofits.
- (3) The Federal Government should promote deployment of more-robust victimization surveys to assess the extent and causes of hate crime underreporting.
- (4) Efforts should be made to partner with trusted community members and organizations to help build trust in the criminal justice system and facilitate reporting.

Problem Statement 2: Many forms of systemic and interpersonal racism exist within healthcare, yet there remains a gap in applying a data-driven approach to enable health systems, organizations, and public health professionals to combat racism. Existing datasets fail to identify the scope of outcomes and instances of discrimination and racist acts or how the pandemic and COVID-19 misinformation have contributed to discrimination against marginalized and minoritized communities. There is a lack of robust data on how racism and discrimination may have impacted outcomes in COVID-19, including access to testing, hospitalizations, and deaths.

To address the second problem statement, the subcommittee presented the following recommendations:

- (1) A national survey should be conducted to understand people's experiences of discrimination and racist acts, whether their experiences have changed during COVID-19, and how it may have impacted their experiences seeking and receiving healthcare services during the pandemic.
- (2) Existing national surveys such as the Behavioral Risk Factor Surveillance System (BRFSS) and the National Health Interview Survey should be expanded to include questions about discrimination and people's experiences with it across the lifespan. Oversampling of certain demographic groups should be done to ensure data can be disaggregated.
- (3) Existing administrative datasets should be linked to allow for data disaggregation.
- (4) As the CDC, several States, Tribes, and local jurisdictions have acknowledged racism is a public health issue, it should be incorporated into the work of Federal, State, local, Tribal, and territorial governments through tracking, evaluation, reporting, and implementing prevention and mitigation measures. Funding to understand and prevent hate crimes and other racist acts should be made available to local health departments for these efforts.
- (5) The Federal Government should incentivize and promote research to understand healthcare discrimination, such as by measuring effects of interpersonal racism in healthcare, evaluating organizations' adherence to antiracism efforts, and developing better methods of quantifying discrimination, including settings that may be missed by current health surveys, such as carceral and inpatient psychiatric settings.
- (6) Federal, State, Tribes, territories, and local governments should incentivize and promote initiatives that educate people about their civil rights so that discrimination and racist acts can be properly reported and addressed.

Problem Statement 3: Racial and ethnic groups have broad subgroups and are not homogeneous. Lack of disaggregated data or categorization of “other” as an ethnicity promotes the model-minority myth in AAPI communities, ignores the impact of discrimination and racism on AAPI subgroups, and inhibits the ability to understand and implement strategies that support American Indian (AI)/Alaska Native (AN) and other marginalized and minoritized communities.

To address the third problem statement, the subcommittee presented the following recommendations:

- (1) The Federal Government should support large-scale, rigorous research on the prevalence, patterns, causes, and long-term implications of COVID-related anti-Asian discrimination.
- (2) The Federal Government should ensure oversampling in existing national surveys and disaggregate reporting and surveillance data to enable full documentation of the Asian American, AI, and AN subgroups most affected by the pandemic.
- (3) The Federal Government should improve AAPI representation in research through inclusion and disaggregation of Asian American data, funds to increase diversity in research populations, and addressing linguistic barriers.
- (4) The Federal Government should make large investments in Tribal research and promote over-sampling in Tribal public health and Tribal-led research.
- (5) The Federal Government should collaborate with marginalized and minoritized people in the governance, analysis, and sharing of research involving their communities.

Problem Statement 4: During the surges in the pandemic, many States struggled to design crisis standards of care that did not discriminate based on age, body weight, disability or a combination of these, creating unknown impacts on access to care or health outcomes for certain communities.

To address the fourth problem statement, the subcommittee presented the following recommendations:

- The Federal Government should support research to better understand the ways in which States’ crisis standards of care intersect with ableism and ageism as well as disproportionately impact disadvantaged populations.

Problem Statement 5: The health outcomes of people in jails, prisons, and other carceral settings are not tracked or addressed in real time or by our public health agencies and structures, contributing to preventable death. This failure to measure the health and health outcomes of incarcerated people is a potent and harmful example of racism in health.

To address the fifth problem statement, the subcommittee presented the following recommendations:

- (1) The CDC and State Departments of Health should establish efforts to track and report in real time the health and health outcomes of incarcerated people and develop evidence-based programs to protect and improve their health.
- (2) The Federal Government should promote research on the effectiveness of interventions to prevent death in carceral settings during COVID-19, such as early release.

Discussion

Dr. Homer Venters, Dr. Octavio Martinez, and Mr. Bobby Watts remarked on the following:

- Health data is not well documented and reported by criminal justice entities and should be.
- Inequalities exist among persons who are incarcerated, which lends an opportunity for the Task Force to evidence-based health structures and data to bear.
- Missing disaggregated data prevents us from recognizing and solving problems related to racial and ethnic health disparities.
- Mental health complications among the incarcerated population was a significant issue prior to COVID-19. The pandemic has exacerbated this parity.
- The Task Force should ensure that policies and practices are viewed through a health equity lens for the incarcerated population as well as the general population.

Dr. Victor Joseph noted that many of the edits and recommendations made regarding problem statement number 3 were not reflected in the presentation. He noted that the corrections could be addressed in the final report. However, regarding recommendation number four, he suggested it should read that the Federal Government should make large investments in Tribal research and promote AI/AN oversampling in public health surveys and research.

Structural Drivers and Xenophobia Subcommittee

Haeyoung Yoon, J.D.

Problem Statement 1: AAPI, NH, and Black, Indigenous, and People of Color (BIPOC) communities and businesses are facing high rates of economic instability due to unemployment and COVID-19 effects on the economy. Existing structural inequities in the channels that spur economic recovery, such as Paycheck Protection Program loans and debt relief programs, will leave these communities and businesses in a more protracted economic recovery.

To address the first problem statement, the subcommittee presented the following recommendations:

- (1) Examine existing COVID-19–related Federal Government support for AAPI-operated small businesses to identify any key barriers to utilization and develop and implement a plan to address identified barriers to maximize effectiveness for economic recovery.
- (2) Plan, identify, and address any application or administrative barriers unique to AAPI farmers receiving debt relief under the American Rescue Plan.
- (3) Translate web-based Small Business Administration financial-relief services into the most spoken Asian languages.

Problem Statement 2: AAPI communities have seen an increase in hate incidents and discrimination against individuals and businesses. This is underreported and can go unrecognized by first responders and law enforcement.

To address the second problem statement, the subcommittee presented the following recommendations:

- (1) Develop and disseminate new web-based resources and training for State, Tribal, territorial and local law enforcement and first responders on how to identify pandemic-related hate- or bias-motivated incidents.
- (2) Develop and disseminate best practices for reporting crimes.
- (3) Encourage cities, States, Tribes, and U.S. territories to implement safe and convenient reporting channels and protocols for investigation/prosecution informed by best practices.

Problem Statement 3: Implicitly racially targeted housing policies and practices have contributed to BIPOC communities suffering from greater housing insecurity and homelessness. The long-term effects of these policies and practices in “redlined” neighborhoods has caused them to suffer from greater poverty, denser housing, poorer air and water quality, poorer health, and higher incidence of chronic disease, which are risk factors for COVID-19.

To address the third problem statement, the subcommittee presented the following recommendations:

- (1) Continue to fund assistance programs for missed rent/utilities during eviction moratoria and borrowers exiting forbearance (including housing counseling, loss mitigation) and fund additional legal services to those facing eviction.
- (2) Strengthen and enforce housing and lending discrimination laws, including restoring the AFFH rule that the Trump Administration cancelled.
- (3) Increase the supply of affordable, accessible housing, supportive housing, and supports that enable people to remain housed.
- (4) Prohibit discrimination by landlords based on prospective and current tenants’ housing vouchers or source of income.

Problem Statement 4: Given the economic impact of COVID-19 on families, ensuring access to integrated student support services and programs meeting basic student health, well-being, and nutritional needs are critical to mitigating the impact of COVID-19 on students. For immigrant families, willingness to access to these critical programs requires documentation of income-eligibility and has been discouraged by prior administration anti-immigration rhetoric and policies.

To address the fourth problem statement, the subcommittee presented the following recommendations:

- (1) Encourage eligible schools to participate in the United States Department of Agriculture Community Eligibility Program to allow high-poverty schools to provide meals free of charge to all their students.
- (2) Increase investments in full-service community schools that partner with a broad array of social service agencies and trusted community-based organizations to provide a one-stop shop for enrolled students and families to access services that can address the impact of COVID-19 and prioritize their expansion in underserved communities.
- (3) Support State-level cross-agency partnerships to provide students with free meals during afterschool and summer learning and enrichment programs without the requirement of additional documentation.

- (4) Encourage States, Tribes, territories and districts to provide information and maps of meal sites in multiple languages, in multiple accessible formats, and using community partnerships.

Problem Statement 5: The schedules for childcare, out-of-school time, and early learning programs do not align with those of K-12 education and many workplaces. This makes these programs less accessible for families of color, negatively impacting them as they try to return to or remain in the workforce during COVID-19.

To address the fifth problem statement, the subcommittee presented the following recommendations:

- (1) Work with Congress to pass the American Families Plan into law to rebuild and invest in our nation's childcare and early learning system to allow families to access quality and affordable childcare and rejoin the workforce.
- (2) Increase funding under Title IV of the Elementary and Secondary Education Act to increase the availability of before and after school and summer learning programs for students to align with different work schedules.
- (3) Increase funding for programs that support greater integration of health and social services with early learning programs in order to strengthen families' access to a continuum of services.

Problem Statement 6: Historic underfunding and complexity of federal funding streams for health, nutrition, and infrastructure have challenged Tribal communities' ability to effectively and efficiently address the disproportionately high rates of COVID-19 infection, hospitalization, and mortality among AIs/ANs. Specific examples include the IHS and the Food Distribution Program on Indian Reservations.

To address the sixth problem statement, the subcommittee presented the following recommendations:

- (1) Fully fund IHS as recommended by the IHS budget formulation committee.
- (2) Expand the 638 authority of Tribes to administer Supplemental Nutrition Assistance Program (SNAP) and determine whether all Tribal children have access to pandemic electronic benefit transfer.
- (3) Invest in national monitoring and surveillance systems that include socially disadvantaged populations to promote equity.
- (4) Provide sustained and increased funding to Tribes for environmental health infrastructure to better address community needs and prioritize delivery of necessary supplies for those exposed to COVID-19.
- (5) Direct more and equitable resources to IHS, including funds to reduce administrative, cultural, and linguistic barriers to healthcare; bring the workforce to required level; and address the health professional shortage.
- (6) Provide \$1.1 billion of additional nutrition assistance for the territories in the American Rescue Plan that operate nutrition assistance block grants to support those hard-hit by the pandemic. Further assess the feasibility of transitioning three U.S. territories to SNAP instead of the Nutrition Assistance Program.

- (7) Provide funding directly to Tribes and avoid using the States as mechanisms for funding and resources, honoring the government-to-government relationship.

Problem Statement 7: Women, women of color, people with disabilities, and BIPOC workers have shouldered a disproportionate impact of pandemic economic devastation. These workers are overrepresented in low-paid, nonunionized jobs with inadequate policies regarding workplace safety and unlawful retaliation and discrimination. Additionally, the increased burden of unpaid care during COVID-19 has been one of the main drivers of disparity in economic impact and has disproportionately fallen on women.

To address the seventh problem statement, the subcommittee presented the following recommendations:

- (1) Work with Congress to pass the American Jobs and Families Plan and the Protecting the Right to Organize Act of 2021. This would ensure meaningful investments in the care economy and mechanisms to empower workers in the workplace.
- (2) The CDC and other federal agencies must: (a) fully recognize aerosol transmission of COVID-19 by updating all COVID-19 guidance and OSHA Emergency Temporary Standards to effectively prevent inhalation exposure to the virus and (b) end all crisis standards, including guidance that allow for the reuse, rationing, extended use, and/or decontamination and reuse of single-use personal protective equipment.
- (3) Federal labor and employment agencies should dedicate more resources to investigate and prosecute antidiscrimination and other workplace violations.

Discussion

Dr. Martha Okafor commended all the Task Force members for their hard work and recognized the interns an amazing job behind the scenes. Dr. Okafor also extended thanks to the staff teams.

Public Comments

Ms. Elena Ong, National AA, NH, & PI COVID-19 Policy and Response Team

Thank you for your amazing work, your amazing equity centered work. I'm going to focus on Asian Americans because I would like the Native Hawaiian Pacific Islanders to have the opportunity to present their own experience with this issue. I presented last time on the whole issue about United Against Racism and how our communities came in solidarity with Asian Americans. And when six Asian American women were murdered on March 16, I worried that xenophobic racism would prevent Asian Americans throughout the United States from safely and equitably accessing the COVID vaccine.

In terms of hate, the number of cumulative hate incidents reported to Stop AAPI Hate surged from 3,800 over 1 year to 6,600 in 1 month. In terms of vaccinations, CDC reports that 11 percent of vaccination-eligible Asian Americans received at least one dose of the vaccine by March 16 and 32 percent by May 27. [It is] kind of amazing that people got their vaccines, and I don't know the reason. I can't tell you for sure. But I can tell you that the groups that I work with, the Asian American researchers and community groups, worked closely with their local health departments and with Asian American-serving FQHCs to increase the number of

vaccinations available at places that Asian Americans trusted and felt safe going to. Also, it's extremely important to involve them in identifying sites. It took unwavering partnership, innovative and tenacious coordination, personal drive, and concerted political will. That said, I want to thank President Biden for signing the COVID-19 Hate Crimes Act. As the act is implemented, however, I hope it will ensure equitable access for persons with limited English proficiency, limited paid time off, limited income, and limited transportation.

Number two, I would like to recommend prioritized funding for Asian American and Native Hawaiian Pacific Islander efforts aimed at achieving equitable herd immunity at the neighborhood level. According to the CDC, only 32 percent of vaccination-eligible Asian Americans have received at least one dose of vaccine. So, we still have about 40 to 68 percent to go. And that's why we need to prioritize funding to reach the hardest-hit, and the hardest-to-reach Asian Americans: the 6,000 hate victims, the 7.8 million limited English proficient, the 2.2 million poor, the 1.7 million undocumented, the 1.5 million uninsured, and the many Asian Americans who lack paid time off, transportation, and Wi-Fi. And I'll give you a list of programs I'd like to recommend, and I'll submit that to you in writing.

Number three, I truly value having a national dashboard where the public can go that provides COVID statistics in real time. So, I was actually asked to review a COVID dashboard. That scrapes race and ethnicity vaccination data directly from the states. And they told me they found that there were 8.4 million Asian Americans received at least one dose of the vaccine on May 17 or by May 17. CDC reported 5.2 million by that same day. So, there was a difference of about 3.2 million.

So, that made me realize how important it is for this Task Force, the Health and Human Services secretary, the CDC director, and the new census director to work together with experts from our respective communities to harmonize the disaggregated data that's used to guide equitable resource allocation to achieve herd immunity, reopen our economies, and close the vaccination gap at all of these geographic levels.

So, I want to thank you so much for your consideration and your time. Again, I'm always in awe of your meetings. You do such amazing work, and I'm so humbled by you. I just have three minutes to give you highlights, but I will give you a detailed report. Thank you.

Ms. Rachel Morrison, Ethics & Public Policy Center

Hello, my name is Rachel Morrison. And I'm an attorney and a policy analyst at the Ethics and Public Policy Center where I work on EPPC's HHS accountability project. Thank you for the opportunity today to provide public comment. All comments are my own, and they focus on discrimination in COVID-19 vaccine distribution. The executive order establishing this task force states that your mission and work shall be conducted consistent with applicable law. Section 1557 of the Patient Protection and Affordable Care Act guarantees that no individual can be excluded from participation in, denied benefits of, or be subject to discrimination under any federally administered or funded health program or activity because of race, color, or national origin as prohibited under Title VI of the Civil Rights Act of 1964.

HHS's website explains programs that receive federal funds cannot distinguish among

individuals on the basis of race, color, or national origin, either directly or indirectly in the types, quantity, quality, or timeliness of programs services, aides or benefits that they provide, or the manner in which they provide them. This prohibition applies to intentional discrimination as well as to procedures, criteria, or methods of administration that appear neutral but have a discriminatory effect on individuals because of their race, color, or national origin.

States that receive Federal funding for COVID-19 vaccines are subject to these nondiscrimination requirements. Despite this, the focus on equity has encouraged several States to discriminate based on race, color, and national origin in their vaccine distributions by prioritizing racial minorities or Black, Indigenous and people of color. For example, a vaccine provider in Washington State required applicants to mark whether they were a person of color or White. Automatically placing all White applicants on the standby list. New Hampshire allowed Asian college students to receive the vaccine. While at the same time, denying White residents in their 20s, 30s, and 40s the ability to do so. Rhode Island reserves certain vaccine doses for non-White residents only leading to many doses being wasted when not enough racial minority showed up in despite demand from White residents. There are similar stories out of Montana, Vermont, and Virginia. Such actions are illegal and invidious discrimination.

Just yesterday, a Federal Circuit Court found that similar racial preferences used by the Small Business Administration and its consideration of COVID relief grant applications for restaurants were impermissible race discrimination in violation of the Equal Protection Clause of the 14th Amendment. HHS and the task force have a legal duty to prohibit race, color, and national origin discrimination, even discrimination for the purpose of equity. I urge the task force to ensure that your efforts to promote equity do not encourage or enable illegal discrimination and to make clear to States that such discrimination in their federally funded COVID-19 vaccine programs will not be tolerated. Thank you.

Ms. Ruqaiyah Yearby, Center for Health Law Studies at the Saint Louis University

Hello, thank you for allowing me to speak with you today. I am a professor of health law and the executive director of the Institute for Healing Justice and Equity at St. Louis University, which aims to eliminate disparities caused by systemic oppression and to improve individual and community health and well-being through system change and community partnership. My academic work focuses on structural racism, which you talked about today, but I want to provide a definition and some solutions to address it throughout the COVID-19 pandemic and afterwards.

So, structural racism is the ways that laws, policies, and processes advantage Whites while disadvantaging racial and ethnic minorities by limiting their equal access to healthcare, including the way they trade associations and institutions work together to influence the government's pandemic response, which we have seen throughout this response in terms of the lack of paid sick leave, the lack of access to clean water, [and] the lack of access to health and safety protections.

During COVID-19, structural racism has limited racial and ethnic minorities equitable access to testing and treatment and vaccines, and it continues today. Some solutions that I want to provide for you are based on the health justice framework that I have developed with Emily Benfer, Seema Mahopatra, and Lindsay Wiley, which provides a mechanism for systems level of

transformation of government responses to health inequities and three overarching principles structural, supportive, and empowering, and really tries to integrate the social determinants of health intentionally into our pandemic response.

First, interventions to address inequity must change the structures and systems of healthcare to ensure that the needs of racial and ethnic minorities are explicitly addressed to eradicate racial health inequities; for example, if the pandemic response needs to address the social determinants of health as well as addressing the spread of the pandemic, ensuring that health care facilities serving these communities have the supplies and the workforce necessary to treat the higher rates of COVID-19 infections and hospitalizations, which did not occur.

Second, interventions must be accompanied by legal protections, financial supports, and accommodations, including access to clean water throughout the pandemic, providing money for people to miss work if they are suffering systems for the vaccine. And finally, one thing that wasn't mentioned in the recommendations by the subcommittees is that these communities need to be empowered—meaning that there needs to be a national formal partnership with racial and ethnic minority communities, not just the people serving them, but the actual communities that gives them a voice in power and making these decisions.

These suggestions are included in the article that we wrote together, which I've already forwarded to you. Thank you.

Dr. Keri Norris, National Hemophilia Foundations

Thank you, CAPT Wu, Madam Chair, and task force members for this opportunity. I am the Vice President of Health Equity, Diversity, and Inclusion at the National Hemophilia Foundation, and our statement reads as follows. The COVID-19 pandemic has exposed deep health inequities and treatment affordability challenges that exist within our healthcare system and made it clear how much patient communities rely on copay assistance programs to afford their medications. According to a new National Hemophilia Foundation National Survey of patients and caregivers, 1 in 3 of those who reported being unable to afford their medications or treatments because their copay assistance ran out was a person of color, and more than 10 respondents reported difficulty affording their prescriptions due to COVID-19.

One of the strongest solutions to ensure patients and others can afford their medications is to ensure that the copay assistance that patients rely on counts towards their out-of-pocket costs. Unfortunately, nothing stops health plans from instituting policies known as copay adjusters—I'm sorry, known as copay accumulators—that don't count the value of copay coupons and vouchers towards a patient deductible or out-of-pocket maximum. These policies force patients to pay higher out-of-pocket costs or even abandon their treatment.

HHS and the Biden administration can take a step towards ensuring treatment affordability and health equity by requiring commercial health insurance companies to count the value of all copay assistance programs towards patient cost sharing requirements. More than 9 out of 10 patients and caregivers surveyed by NHF agreed that the federal government should require health plans and pharmacies to count the value of copay assistance programs towards patient out-of-pocket costs. Thank you.

Mr. John Agboola, Western Illinois University

Thank you very much for the opportunity given to me to provide public comment. I'm an international graduate student at Western University in Macomb, Illinois. And I'm active member of the Health Equity Section of Illinois Public Health Association. My comments are personal, not on behalf of the association. I want to encourage everyone to join hands together in reducing discrimination and xenophobia, not just the government, but as individuals we have roles to play. It's pertinent to realize that these issues are not peculiar to the United States alone, but they exist in various forms in different countries and nations globally. However, I am happy and it's good thing that United States is making efforts to combat these problems and find solutions to them, and to reduce the effects on those affected.

Today, I want to call your attention to our children. I have noticed that children are not born with the capacity to discriminate. Rather, I would say that they are born colorblind, because most children interact with people easily, regardless of where they come from or how they look. So, adults need to hold themselves responsible for the attitudes that these children adopt as they grow up. Therefore, I want to suggest to everyone and to this country that we be careful when we discuss matters related to discrimination in the presence of our children or children generally. These children get cues from us. They may not fully comprehend the details or the concepts of our conversations, but they subconsciously imbibe our attitudes and reactions.

I suppose that one significant thing we can do about the issues of discrimination and xenophobia is to ensure that our children henceforth grow up with the right attitudes and better understanding of these concepts. I want to encourage the committee to look into how to influence the next generation positively through the school system and through the parents and also through the media. Likewise, I would urge us all to use the terms for what we want to see more frequently than what we do not want. By this, I mean, we should use more of these words, *impartiality, fair treatment, health equity, equal rights, xenophilia*, in our statements. It will help to orientate us the listeners and surely our children, towards what we desire and away from what we don't. Thank you very much.

Dr. Don Garcia, Clinica Monsignor Oscar A. Romero Community Health Center

Thank you. Good day. My name is Dr. Don Garcia. I am present today as a fellow community friend and a colleague from the Los Angeles, California, Latinx community. Thank you for the opportunity allowance to provide vital granular, granular information from the Los Angeles California local federally qualified health center. Clinica Monsignor Oscar Romero serves a marginalized primary population of undocumented and uninsured individuals from the northern triangle in Mexico, as well as other areas of Latin America. Today's comments are from a year of public health experience of the COVID-19 viral pandemic disaster in the Latinx population in Los Angeles County.

I am a medical director at the federally qualified health center in the middle of the fire created by this viral pandemic which Clinica Monsignor Oscar Romero has experienced since February March of 2020—a infectivity-positive rate of 35 to 40 percent consistently until this early year, while the Los Angeles County rate was between 9 to 13 percent. This story has not been told; it needs to be repeated. The public health viral pandemic experience is one of the blue flames of

the burning flame where we sit as a federally qualified health center.

The Latinx community is in the middle of the fire disaster, and the buckets of water were delayed in delivery to the fire. And more often, the fire was expected to be taken to the buckets of water for extinguishing while the land community was being decimated. As per Jo Linda Johnson, who is the director of Equal Rights for FEMA advice at the CDC conference, her marching orders for the federally qualified health centers were to take to the policymakers the solutions of the ground troops and boots on the ground with true viral pandemic disaster solutions not very well known by those not at ground zero.

The biologic pandemic disaster has been overly traumatic here in Los Angeles as well as throughout the country for the Latinx community. We have the highest rates of infection, the highest rates of deaths, the highest rates of hospitalization, and yet the lowest rates of testing and vaccination in the Latinx communities, in particular those Latinx communities who live in the highest poverty zip codes. And the highest poverty zip codes continue to suffer with the lowest rates.

In summary, the Los Angeles California federally qualified health center disaster experience with patients with the highest social insecurity such as residency, employment, employment benefits to leave work to receive the vaccine without losing their job security, housing insecurity, transportation insecurity, financial insecurity, multigenerational insecurity for caretaking, language insecurity, digital technology gap insecurity, health insecurity, and, most importantly, the highest risk disparities insecurity.

The public health care at Clinica Monsignor Oscar Romero has been more than a necessary painstaking activity from a viral pandemic disaster which is not experienced in other communities not served by federally qualified health centers. The participation disparity of the local neighborhood federally qualified health centers in solutions and development of policy and programs to defeat the viral pandemic is described as a disparity equal to the health disparities known to our Latinx communities of color. More importantly, there has been minimal public health attention to health literacy. Health literacy is an effective tool to extinguish the fire disaster in the Latinx communities [inaudible] HHS at the CDC and is presently supported with funding by the Office of Minority Health. Yet we do not hear anything with regards to health literacy as a source of the remedy of health equities, disparities, and a racism structure of health care.

So, what is our mission today? The mission of today is for a local neighborhood Los Angeles federally qualified health center in the Latinx community to gain inclusion. To gain inclusion and not exclusion as a committed trooper to extinguish the burning fire in the Latinx communities in Los Angeles. Traditionally, historically, federally qualified health centers are not only health services solution for marginalized communities, but experts as well in delivering solutions for public health pandemic disasters as well in the policy and program solutions to turn back the highest viral pandemic morbidity and mortality of the Latinx community since 1531 when the native indigenous Mexican natives experience a viral pandemic from tuberculosis, smallpox, and measles were 30 million of the 60 million of that population was decimated within 30 years.

Once again, we as a community are facing a repetitive history of a viral pandemic that is destroying our community. Gracias for the testimony opportunity. And I'm prepared to take and answer appropriate questions over the above presentation. Thank you, again.

Interim Recommendations Vote

Dr. Nunez-Smith introduced the voting phase for HETF members to vote on each set of interim recommendations and whether the recommendations should move forward to the next stage for refinement. Dr. Nunez-Smith opened the floor for consideration of the following interim recommendations:

- Healthcare Access and Quality Subcommittee recommendations
- Communications and Collaboration Subcommittee recommendations
- Data, Analytics, and Research Subcommittee recommendations
- Structural Drivers and Xenophobia Subcommittee recommendations

Each recommendation received a motion to approve that was seconded. Each motion carried with a majority vote to approve. The four subcommittees will consider the friendly amendments noted in the discussion sections above as they further refine the recommendations.

Closing Remarks and Next Steps

Marcella Nunez-Smith, M.D., M.H.S.

Dr. Nunez-Smith thanked the HETF members, guest speakers, public commenters, Federal staff team, and ASL interpreters for making the fourth HETF meeting a success. She also thanked the HETF subcommittee members for developing their interim recommendations and noted that the four subcommittees will continue to refine their recommendations prior to the next HETF meeting. Dr. Nunez-Smith wished everyone a safe holiday weekend as we remember and honor the fallen and adjourned the meeting.

Appendix A. Written Public Comments



June 04, 2021

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National Advocates for Asian
American, Native Hawaiian &
Pacific Islander Health

Dr. Marcella Nunez Smith

Chair

COVID-19 Health Equity Task Force

Office of Minority Health

United States Department of Health and Human Services

1101 Wootton Parkway

Rockville, Maryland 20852

Submitted via email at COVID19HETF@hhs.gov

**RE: Request for Comments: COVID-19 Health Equity Task Force
Recommendations to Address the Discrimination and Xenophobia Impact of
COVID-19**

Dear Dr. Nunez-Smith:

The Asian & Pacific Islander American Health Forum (APIAHF) submits this response for the record for the May 28, 2021 meeting of the COVID-19 Health Equity Task Force focusing on recommendations to address the discrimination and xenophobia impact of COVID-19.

APIAHF is the nation's leading health policy organization working to advance the health and well-being of over 20 million Asian Americans, Native Hawaiians, and Pacific Islanders (AANHPI) across the U.S. and territories. APIAHF works to improve access to and the quality of care for communities who are predominantly immigrant, many of whom are limited English proficient, and may be new to the U.S. healthcare system or unfamiliar with private or public coverage. We have longstanding relationships with over 150 community-based organizations across 34 states and the Pacific, to whom we provide capacity building, advocacy and technical assistance.

For nearly 35 years, we have focused our policy efforts on: 1) improving access to health insurance and care for AANHPI and immigrant communities; 2) ensuring the collection, analysis and reporting of detailed demographic health data; and 3) protecting and advancing the language rights of the 1 in 3 AANHPIs who are limited English proficient.

APIAHF has led national efforts, including as a long-term provider to the Center for Disease Control and Prevention (CDC), to ensure the federal COVID-19

response addresses the needs of AANHPI communities including identifying critical gaps in data and infrastructure, language access, and barriers for immigrant communities.

As such, we have a strong understanding of the needs and barriers to good health that were already experienced by AANHPI communities across the country and ways in which COVID-19 is magnifying inequities among communities of color. It is imperative that the Task Force, Administration, and Congress continue to take action to address these disparities as they threaten to undermine our collective national response and recovery.

COVID-19 Contributed to Rise in Discrimination and Xenophobia in AANHPI Communities

The COVID-19 virus is a national crisis that demonstrates that public health has no boundaries. Yet the impact is being unevenly felt among communities of color who, due to a combination of structural, economic, social and environmental disparities and discrimination, are experiencing higher burdens associated with the pandemic. As a result, COVID-19 is disproportionately leading to severe illness and mortality within these communities.

We wish to emphasize that, in the face of narratives to the contrary, these communities facing disparities are in no way to blame. COVID-19 has exposed what advocates for health equity have known for decades, if not centuries: our history of racism and prejudice has led to serious health consequences that continue today. This includes the experiences of AANHPI communities, as we are often left out of the conversation while our communities suffer.

In addition to longstanding inequities concerning access and quality of care, consideration should be given to the rise in anti-Asian hate when addressing COVID-19 related disparities in AANHPI communities. AANHPI communities face both a public health emergency and a spate of violence and xenophobic hate since the beginning of the pandemic.

Rise in Hate Crimes and Hate Incidents

As the number of COVID-19 cases and related deaths soared in the US, the cases of anti-Asian harassment and hate incidents also increased significantly. Asian American¹ communities are experiencing the dual blow of COVID-19 disparities and misplaced blame for the pandemic. Use of xenophobic rhetoric, like “China Virus”, “Wu Han Virus”, and “Kung Flu” by the Trump administration fueled the flame of hate and blame that came at the cost of the health and safety of Asian American communities.

¹ Here, the term “Asian American” is intentionally distinguished and disaggregated from “AANHPI.”

Since March 2020, AANHPI organizations have documented over 6,600 hate incidents in the US.² Although many of these hate incidents include verbal attacks and shunning, an alarming percentage of attacks are becoming violent, including the violent attacks of Asian American women, elders, and essential workers.

Mass Shootings Affecting Asian American Communities

The rise in violence against Asian American communities is evident in the recent mass shootings in the Atlanta-area that took the lives of six Asian American women,³ and in Indianapolis where four Sikh American lives were lost.⁴

As these hate crimes and incidents increase at a staggering rate, Asian American women are disproportionately targeted. Asian American women are over two times as often than Asian American men to report hate incidents, pointing to the frequency of these hate incidents.⁵ Although Asian American women have historically faced substantial discrimination and violence due to their race, ethnicity, and gender, the COVID-19 pandemic saw the rates rise since Asian American women make up a large proportion of essential frontline and low-wage workers.⁶

The ugliness of hate has also continued to ravage the Sikh American community. Since the attacks of 9/11, Sikh, Muslim, Arab, and South Asian American communities have felt racist backlash caused by xenophobic political rhetoric.⁷ With their religious garments as an outward expression of faith, Sikh American communities have become targets of bigoted violence as seen in the gurdwara shooting in Oak Creek, WI, and most recently, the FedEx shooting in Indianapolis where the majority of victims were from the Sikh American community.

Attacks on Asian American Elders

² Russell Jeung Ph.D., Aggie Yellow Horse, Ph.D., Tara Popovic, and Richard Lim, "National Report", Stop AAPI Hate (May 6, 2021). Available at: <https://stopaapihate.org/wp-content/uploads/2021/05/Stop-AAPI-Hate-Report-National-210506.pdf>

³ Bill Chappell, Vanessa Romo, "Atlanta Shooting Suspect Charged In Spa Killings," NPR (March 17, 2021). Available at: <https://www.npr.org/2021/03/17/978141138/atlanta-shooting-suspect-is-believed-to-have-visited-spa-he-targeted>.

⁴ Jeanette Muhammad, Emma Bowman, "Indianapolis Sikh Community Mourns 4 Of Its Members Killed In Shooting" (April 18, 2021). Available at: <https://www.npr.org/2021/04/17/988382654/indianapolis-sikh-community-mourns-as-4-of-its-members-are-killed-in-shooting>.

⁵ Russell Jeung Ph.D., Drishti Pillai, Ph.D., MPH, Aggie Yellow Horse, Ph.D., "The Rising Tide of Violence and Discrimination Against Asian American and Pacific Islander Women and Girls," National Asian Pacific American Women's Forum and Stop AAPI Hate (May 20, 2021). Available at: https://stopaapihate.org/wp-content/uploads/2021/05/Stop-AAPI-Hate_NAPAWF_Whitepaper.pdf

⁶ *Id.* at 2.

⁷ "Communities on Fire: Confronting Hate Violence and Xenophobic Political Rhetoric," South Asian Americans Leading Together (SAALT)(2018). Available at: <https://saalt.org/wp-content/uploads/2018/01/Communities-on-Fire.pdf>

The violent attacks of Asian American elders have also recently caught the attention of the American public. These attacks are particularly egregious as they are targeted toward some of the most vulnerable members of our communities and have caused serious injuries and even death. Only a day after the Georgia shooting, Xiao Zhen Xie, a 76 year-old Chinese American, and Ngoc Pham, an 83 year-old Vietnamese American, were viciously punched in the face by the same assailant in San Francisco.⁸ Several other elders have died from injuries sustained from these recent violent and hateful attacks.

Frontline Workers

As we applaud the work of frontline healthcare workers for their daunting and tireless task of caring for COVID-19 patients, AANHPI healthcare workers, who are at the epicenter of the fight against COVID-19, have also become targets of racism and have higher rates of COVID-19 cases and deaths.

An estimated 1.4 million AANHPIs are essential healthcare workers in the US, valiantly serving the American public.⁹ However, the pandemic has not spared these health care workers. Health care workers of color, especially AANHPI workers, experience a higher risk of contracting and dying from COVID-19. Of the 3500 health care workers who have died from COVID-19, nearly 20 percent are AANHPI.¹⁰ Additionally, more than a third of the healthcare workers who died were born outside the United States, of which the vast majority were born in the Philippines.¹¹

As AANHPI healthcare workers risk their lives to care for patients, they are also faced with hostility, harassment, and violence because of their race. In separate incidents, both Dr. Luci Li, a Chinese American doctor in Boston; and Dr. Amy Zhang, a Chinese American doctor in Seattle, were followed and harassed to and from their shifts treating COVID-19 patients.¹² Dr. Audrey Cruz and Dr. Christina Chen created a video to share the stories of sixteen AANHPI doctors who were verbally attacked and harassed on the frontline. One doctor was called a “disgusting filthy bat eater,” while another was told that she was a “selfish disease carrier.”¹³ These instances of hate and prejudice have caused many AANHPI healthcare workers to fear for

⁸ C Mossburg, S Chan and D Williams, “A 75-year-old Asian woman says she fought back after being attacked in San Francisco,” CNN (March 18, 2021). Available at: <https://www.cnn.com/2021/03/18/us/san-francisco-asian-woman-attacked-trnd/index.html>.

⁹ “Asian Americans and Pacific Islander Americans on the Frontlines,” New American Economy (May 21, 2020). Available at <https://research.newamericaneconomy.org/report/aapi-americans-on-the-frontlines/>.

¹⁰ The Guardian, “Key Findings About US HealthCare Workers To Date,” (Feb. 10, 2021). Available at: <https://www.theguardian.com/usnews/ng-interactive/2020/dec/22/lost-on-the-frontline-our-findings-to-date>.

¹¹ Id.

¹² Tracy Jan, *Asian American doctors and nurses are fighting racism and the coronavirus*, Washington Post (May 19, 2020). Available at: <https://www.washingtonpost.com/business/2020/05/19/asian-american-discrimination/>.

¹³ Nicole Pelletiere, *Asian American front-line workers share powerful anti-racist messages amid COVID-19*, ABC News (March 8, 2020). Available at: <https://abcnews.go.com/GMA/Living/asian-american-front-line-workers-share-powerful-anti/story?id=70582315>.

their and their family's safety. Others have considered quitting their jobs amidst a healthcare worker shortage in the middle of a global pandemic.¹⁴

APIAHF Response

In the wake of the recent surge in violent attacks on AANHPI communities, and the lack of in-language resources on hate crimes and reporting, APIAHF and the National Asian Pacific American Bar Association (NAPABA) collaborated on a "Combat Hate Crime Toolkit" that provides basic and critical information for victims, community based organization, and community leaders.¹⁵ Translated into 25 different languages, this information provides background on: understanding the difference between a hate crime and hate incident; working with law enforcement and the media; checklist for community organizations; and frequently asked questions.

APIAHF was also a supporter of the COVID-19 Hate Crimes Act. We applaud the Task Force, Congress and President Biden, for taking swift action to address COVID-19-related hate. While the COVID-19 Hate Crimes Act will improve disaggregated data collection related to the social determinants of health equity and provide a path for criminal justice, we must continue to take action to address the racist and xenophobic systems and structures that perpetuates discrimination of all forms.

Recommendations:

1. Include the experiences and narratives of AANHPI communities in all discussions of health disparities and other social inequities;
2. AANHPI experts and leaders must continue to be invited to give witness testimony in future meetings and hearings;
3. Resources, such as community-based mental health services, must be allocated to specially impacted communities (e.g. health care workers, victims of hate);
4. Research on the disproportional rate of COVID-19 infections and deaths within health workers of color must be conducted.

Federal COVID-19 Response is Leaving out Millions of Limited English Proficient Americans

Existing federal law and regulation requires protections for limited English proficient (LEP) communities, which is critical for the 25 million Americans, including over 6 million Asian Americans and over 100,000 NHPs who speak English less than very well.¹⁶ These protections

¹⁴ *id.*

¹⁵ More information on the Combat Hate Crime Toolkit can be found here: <https://www.apiahf.org/hate-crime-resources/>.

¹⁶ APIAHF analysis of American Community Survey, 2018 data.

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 HHS. In practice, however, due to lack of available resources, few documents are translated into other languages and interpreters are rarely available. Currently the CDC has translated their COVID-19 website into only four languages, while their print resources are translated sporadically and not widely disseminated.

Federal disaster policies, developed after recent national incidents, emphasize the need to support LEP populations in disaster response, including the National Response Framework and National Disaster Recovery Framework. The COVID-19 pandemic is a natural global disaster that should trigger this disaster response framework. The Recovery Framework notes that “Care must be taken to assure that actions, both intentional and unintentional, do not exclude groups of people based on race, color, ethnicity, national origin (including limited English proficiency), religion, sex, sexual orientation, gender identity, age, or disability.” In 2015, the U.S. Department of Justice issued joint guidance with Homeland Security (DHS), Housing and Urban Development (HUD), HHS and Transportation (DOT) stating: “Hurricane Katrina and subsequent emergencies and disasters highlight a recurring lesson: we need to take proactive measures to ensure that all members of our communities are appropriately incorporated into emergency management activities.”¹⁷

APIAHF has received several stories from community-based partners that highlight the lack of meaningful access for LEP persons. In a survey APIAHF conducted of 45 community-based organizations, 89% reported needing in-language and culturally appropriate resources about the virus.¹⁸ Further, a recent report from ProPublica¹⁹ raises serious concerns that language barriers could lead to rationing of care, undermining civil rights and the Office for Civil Rights at HHS bulletin issued March 28, 2020.²⁰

¹⁷ “Guidance to State and Local Governments and Other Federally Assisted Recipients Engaged in Emergency Preparedness, Response, Mitigation, and Recovery Activities on Compliance with Title VI of the Civil Rights Act of 1964,” The United States Departments of Justice, Homeland Security, Housing and Urban Development, Health and Human Services, and Transportation (Aug. 16, 2016). Available at: <https://www.justice.gov/opa/pr/federal-agencies-issue-joint-guidance-help-emergency-preparedness-response-and-recovery>.

¹⁸ “What Asian American, Native Hawaiian, and Pacific Islander Community Organizations Need in the Face of the COVID-19 Pandemic,” APIAHF (July 2020). Available at: <https://www.apiahf.org/resource/covid-19-need-to-know/>.

¹⁹ Kaplan, Joshua, “Hospitals Have Left Many COVID-19 Patients Who Don’t Speak English Alone, Confused and Without Proper Care,” ProPublica (March 31, 2020). Available at: <https://www.propublica.org/article/hospitalshave-left-many-covid19-patients-who-dont-speak-english-alone-confused-and-without-proper-care>.

²⁰ “OCR Issues Bulletin on Civil Rights Laws and HIPAA Flexibilities That Apply During the COVID-19 Emergency,” U.S. Department of Health and Human Services, Office for Civil Rights (March 28, 2020). Available at: <https://www.hhs.gov/about/news/2020/03/28/ocr-issues-bulletin-on-civil-rights-laws-and-hipaa-flexibilities-that-apply-during-the-covid-19-emergency.html>.

In addition to the in-language hate crimes toolkit mentioned earlier, APIAHF is supporting CDC COVID-19 Response projects by launching the National AANHPI Health Response Partnership (the Partnership) to offer culturally and linguistically accessible resources for AANHPI communities.²¹ The Partnership builds upon networks created by APIAHF and other national partners, representing a constellation of 27 national and local organizations with over 100 affiliates/chapters and nearly 300 CBOs that reaches across over 40 states and the Pacific.

APIAHF also partnered with NAPABA to create fact cards for those who may be unsure of their rights to a COVID-19 vaccination.²² Translated into 26 different AANHPI languages, this resource educates community members on the benefits of getting vaccinated and encourages them to receive their free COVID-19 vaccinations regardless of immigration status, health insurance coverage, and/or Social Security identification.

Although APIAHF and our partners have made efforts to help LEP persons, we are still deeply concerned that LEP persons are not receiving accurate and timely information in a culturally and linguistically accessible manner about COVID-19 and access to life-saving treatment and testing.

Recommendations

1. Ensure that all agencies receiving federal COVID-19 relief funding to translate documents into at least the 19 languages identified in the FEMA language access plan;
2. Provide grants or contracts with community and faith based organizations in relationship with LEP and immigrant communities for the purposes of culturally tailored outreach, language assistance and connections to services;
3. Create resources so that health providers have access to interpretation services at testing and treatment centers;
4. Provide oversight over all agencies receiving and granting funds for COVID-19 to ensure they and recipients of federal funding are complying with civil rights protections.

Federal, State, and Local COVID-19 Demographic Data Must Be Consistent for Successful Response and Recovery

One year into the COVID-19 pandemic, the national emergency has magnified longstanding inequities that continue to undermine the health and well-being of AANHPI communities. To date, the true impact COVID-19 on AANHPI communities is not accurately or completely captured. Inconsistencies with federal, state, and local data collection and reporting have hampered our federal response at a time when the limited data that is available clearly shows that

²¹ More information on the National AANHPI Health Response Partnership can be found here: <https://www.aanhpihealthresponse.org/>.

²² “Know Your Vaccine Rights,” APIAHF and NAPABA (May 2021). Available at: <https://www.aanhpihealthresponse.org/updates>.

AANHPI communities are being impacted. These discrepancies must be resolved -- danger of incomplete data collection and reporting runs the risk of causing further disparities in underserved populations.

Currently, 62 percent of COVID-19 cases reported to the CDC offer any information on race -- a notable increase from months ago.²³ However, of those jurisdictions providing racial data, AANHPI data is often missing or aggregated together, despite federal standards requiring disaggregation of AANHPI data.²⁴ Some states combine Asian Americans with NHPI, while other states label AANHPI as “other” or misclassify them. Texas, for example, has one of the largest AANHPI populations, but only has racial data on three percent of COVID-19 cases.²⁵ Similarly, New York, which has the second largest AANHPI population, does not report racial data on COVID-19 cases.²⁶ Other states, like Florida, categorize all AANHPI communities as “other race.”²⁷

A closer examination of data from states and localities that do collect data on AANHPI communities show alarming rates of COVID-19 infection and deaths. According to the UCLA COVID-19 Racial Data Tracker, NHPIs are the most likely of any race or ethnic group to have contracted COVID-19 in 2020.²⁸ Recent estimates indicate a high burden of COVID-19 deaths among Asian Americans, with almost 14,000 excess deaths, and Asian Americans have the second-highest increase in deaths following Hispanic Americans.²⁹

In San Francisco, Asian Americans make up 18 percent of COVID-19 cases, but 37.5 percent of COVID deaths.³⁰ And although the NHPI population is small in San Francisco, NHPIs have the

²³ “Demographic Trends of COVID-19 cases and deaths in the US reported to CDC,” Center for Disease Control and Prevention (Accessed June 1, 2021). Available at: <https://covid.cdc.gov/covid-data-tracker/#demographics>.

²⁴ “COVID-19 State Data and Policy Actions Tracker,” Kaiser Family Foundation (Accessed March 24, 2021). Available at: <https://www.kff.org/coronavirus-covid-19/issue-brief/state-covid-19-data-and-policy-actions/#raceethnicity>.

²⁵ Id. See also “Texas: All Race & Ethnicity Data,” The COVID Tracking Project (Last Updated March 7, 2021). Available at: <https://covidtracking.com/data/state/texas/race-ethnicity>.

²⁶ “New York: All Race & Ethnicity Data,” The COVID Tracking Project (Last Updated March 7, 2021). Available at: <https://covidtracking.com/data/state/new-york/race-ethnicity>.

²⁷ “COVID-19: characteristics of 2,284,500 Florida resident cases,” Florida Department of Health (Last Updated June 6, 2021). Available at: http://ww11.doh.state.fl.us/comm/partners/covid19_report_archive/cases-monitoring-and-pui-information/state-report/state_reports_latest.pdf.

²⁸ UCLA Health, “COVID-19 exposes how Native Hawaiians and Pacific Islanders face stark health care disparities,” Press Release (Aug. 25, 2020). Available at: <https://www.uclahealth.org/covid19-exposes-how-native-hawaiians-and-pacific-islanders-face-stark-health-care-disparities>; See also UCLA Center for Health Policy Research, “Native Hawaiian and Pacific Islander COVID-19 Data Policy Lab.” Available at: <https://healthpolicy.ucla.edu/health-profiles/Pages/NHPI-COVID-19-Dashboard.aspx>.

²⁹ Flagg A, Sharma D, Fenn L, Stobbe M. “COVID-19’s Toll on People of Color Is Worse Than We Knew,” The Marshall Project (Aug. 21, 2020). Available at: <https://www.themarshallproject.org/2020/08/21/covid-19-s-toll-on-people-of-color-is-worse-than-we-knew>.

³⁰ San Francisco Public Health Department, *COVID-19 Deaths by Race & Ethnicity* (data from June 1, 2021), available at: <https://data.sfgov.org/stories/s/9cs7-wv53>.

highest rate of COVID-19 cases among all races and ethnicities.³¹ These stark numbers highlight the often overlooked low-income AANHPI families in San Francisco whose members often live in overcrowded multigenerational households, work in service industries, and do not often have access to in-language or culturally competent health care.³² Similarly, in the state of Hawaii, Asian Americans make up 31 percent of COVID-19 cases, but 56.8 percent of deaths.³³ And while only making up 11 percent of Hawaii's population, NHPs make up 41 percent of COVID-19 cases.³⁴

Tracking demographic data for those who have been tested, infected, hospitalized, recovered, and died from COVID-19 helps the government and public health workforce identify groups that may have a higher likelihood to get sick and experience severe illness from COVID-19. This data is essential in helping state, tribal and local agencies, health systems, hospitals, and health care providers invest in and direct resources to provide access to testing, healthcare, and social services for diverse populations with different needs. Without accurate data collection, reporting, and analysis, AANHPI communities will likely miss out on critical information and access to life saving resources.

Recommendations:

1. Urge the passage of the Equitable Data Collection and Disclosure on COVID-19 Act;
2. HHS must update the COVID-19 surveillance systems to collect data on patients' race, ethnicity, sex, age, primary language, sexual orientation, disability status, gender identity, and socioeconomic status in line with ACA Section 4302 standards;
3. Provide oversight over HHS and CDC, ensuring their data collection and reporting is in compliance with ACA Section 4302 standards;
4. Ensure data is collected and reported using all appropriate privacy standards.

Conclusion

While we respond to the ongoing COVID-19 crisis, focus must continue to be on communities hardest hit by the pandemic: communities of color, and in particular immigrant and limited English proficient communities. It is also imperative to respond to the complex crisis that AANHPI communities are experiencing, both in the rise of acts of hate and incomplete data collection and reporting. Failing to address these oversight threatens to perpetuate existing

³¹ *Id.*

³² Marco della Cava, *Asian Americans in San Francisco are dying at alarming rates from COVID-19: Racism is to blame*, USA Today (Oct. 21, 2020), available at: <https://www.usatoday.com/in-depth/news/nation/2020/10/18/coronavirus-asian-americans-racism-death-rates-san-francisco/5799617002/>.

³³ "COVID-19 State Data and Policy Actions Tracker," Kaiser Family Foundation (Accessed March 24, 2021). Available at: <https://www.kff.org/coronavirus-covid-19/issue-brief/state-covid-19-data-and-policy-actions/#raceethnicity>.

³⁴ *id.*

barriers, as recent data suggests is already happening, and undermines our collective national response.

Thank you for the COVID-19 Health Equity Task Force's leadership during this extraordinary time and for receiving these comments and recommendations. Please do not hesitate to contact me at policy@apiahf.org if you have any questions or need any further information.

Sincerely,

A handwritten signature in black ink, appearing to read 'JK Choi', with a stylized flourish at the end.

Juliet K. Choi
President & Chief Executive Officer

THE NATIONAL ASIAN AMERICAN, NATIVE HAWAIIAN & PACIFIC ISLANDER COVID-19 POLICY & RESEARCH TEAM

June 4, 2021 (this has been updated from May 27, 2021)

Chair Marcella Nunez-Smith, MD, Chair and
Members of the Biden-Harris COVID-19 Health Equity Task Force
c/o US Department of Health & Human Services
200 Independence Avenue SW
Washington, DC 20201

Dear Dr. Marcella Nunez-Smith & Members of Biden-Harris COVID-19 Health Equity Task Force,

The National Asian American, Native Hawaiian and Pacific Islander COVID-19 Policy & Research Team (AANHPI-CPRT) greatly values and respects the Biden-Harris COVID-19 Health Equity Task Force's (HETF's) leadership addressing the impact of the dual epidemic of COVID-19 and anti-Asian hate. We thank you for being inclusive, and for inviting members of the Team to present before the HETF: Dr. Nadia Islam, Dr. Winston Wong, Dr. Tung Nguyen, and Elena Ong, MS.

In this memo, we'd like to identify concerns and propose solutions on three topics: (1) systemic "isms" and anti-Asian hate, (2) funding safe and equitable vaccination uptake to achieve equitable herd immunity at the neighborhood-level and equitable inclusion in the pandemic and post-pandemic economy, and (3) equitable resource allocation to ensure that people are "safely accessing the COVID-19 vaccine" by consistently collecting and using disaggregated data in equity-centered information, resource allocation, and evaluation, systems.

1 Redressing Systemic "Isms" & Anti-Asian Hate

At the April 9, 2021 HETF meeting, NYU Professor Nadia Islam, PhD, presented "[Achieving Health Equity for Asian American and Native Hawaiian and Pacific Islander Communities: If Not Now, When?](#)" and Elena Ong, PHN, MS, presented [Standing United Against Racism and Xenophobia](#).

In their comments, they identified how systemic racism and anti-Asian hate have an adverse impact on Asian Americans (AAs), Native Hawaiians (NHs) & Pacific Islanders (PIs). Not only do AAs (and NHs & PIs) feel unsafe leaving their homes to work, shop, pray, and receive health services, anti-Asian hate may have affected whether or not Asian Americans presented for COVID-19 testing, and may have resulted in a lower number of reported Asian American COVID-19 case rates. As a result, Asian Americans were not prioritized for equitable COVID-19 vaccine distribution. The need for action is significant, and we applaud the HETF, the US Congress and US President Biden, for taking swift action to address COVID-19-related hate.

The [COVID-19 Hate Crimes Act](#) will improve disaggregated and intersectional data collection related to the social determinants of health equity and provide a path for criminal justice. The Act also has the potential to prevent future acts of hate, improve mental health, and re-engage Americans in getting fully vaccinated against COVID-19. At the same time, we need to ensure equitable access to justice for persons with limited English-speaking proficiency, limited income, limited experience with and limited paid time off to pursue criminal justice, and limited transportation. We also need to ensure that anti-Asian hate and other structural barriers to access (e.g., limited English-proficiency and immigration status) won't deflate AA, NH & PI vaccination intent, deter safe and equitable vaccination receipt, and adversely impact equitable inclusion of AAs, NHs & PIs in COVID-19 rescue funding, COVID-19 recovery funding, and re-inclusion in a post-COVID-19 economy. We must also think, act, and do, upstream, to address the racist and xenophobic culture that perpetuates and exacerbates discrimination of all forms - individual, institutional and structural.

We look forward to working with the HETF to re-dress historical inequities, by co-designing policies that will lead to a more equitable future, in the social and economic justice space, as well as the criminal justice space.

2 Funding Safe & Equitable Vaccination Uptake & Ensuring Equitable Inclusion in Economic Rescue & Recovery

We cannot afford to take our eyes off the urgency of achieving herd immunity and re-opening our economies. With equity as our priority and North Star, APIAHF is working with the Congressional Asian Pacific American Caucus (CAPAC) to develop inclusive and equitable public policy; AAPCHO is working with Federally Qualified Health Clinics to increase equity-centered in-language and in-culture vaccine access; NCAPIP is working with AA, NH & PI physicians and clinicians to increase equitable vaccine access; the National Pacific Islander COVID-19 Task Force is working with their member teams to conduct a survey on COVID-risk and COVID-19 vaccination intent; UCSF, UCSD, UCLA & UCI Professors are working with trusted messengers, trusted community-based organizations, trusted faith leaders, and committed local health jurisdictions to increase vaccine uptake among the highest-risk and hardest-hit communities; and Asian Health Services, PIVOT and AAPCHO worked together to develop www.AsianAmVoices.org to provide a mechanism for persons experiencing linguistic barriers to COVID-19 treatment, an opportunity to be heard, and counted. We are working together to co-develop and co-implement customized strategies to increase and improve COVID-19 vaccination access and uptake in the AA, NH & PI communities, and beyond.

We respectfully request that the HETF recognize these model strategies, and work with Congress, the White House, federal agencies, and as appropriate, with foundations, to prioritize short-term and long-term funding for innovative, empowering and “community-up” activities:

- **“See One–Do One–Help One” Invite a Friend – Tell a Friend – Bring a Friend Activities**

Prioritize funding for in-language and in-culture social media campaigns (e.g., TikTok, WeChat, Zoom-inars with AA, NH & PI Medical Providers/Community Leaders/Celebrities) that engage persons who have already been vaccinated to share their lived experience with persons who are still contemplating whether or not to get vaccinated, or persons who have had difficulty accessing a COVID-19 vaccine/vaccination, (e.g., what to expect, what to do pre- and post-vaccination to protect selves/family/co-workers, what documents are not required vs. what documents are required, and most importantly, how they are enjoying life with friends/family and at work/church/play now that they are fully vaccinated, how getting sick or dying from COVID-19 is far more economically and socially devastating than the inconvenience/side effects associated with getting vaccinated, etc.).

Equip the vaccinated with “I’m Vaccinated and Loving It! Would You Be Interested in Learning More About Getting Vaccinated Too?” in-language, in-culture “tool-kits,” appointment apps, links to Lyft or Uber for free rides to and from vaccination sites, www.AsianAmVoices.org, etc.). Adequately fund the development of culturally and linguistically outreach strategies for vaccine administration in at least: Spanish, Arabic, Cambodian, Chinese, Haitian Creole, French, Hindi, Italian, Japanese, Korean, Laotian, Russian, Tagalog, Urdu, Vietnamese, Greek, Polish, Thai, and Portuguese; work with community based organizations to identify and produce culturally and linguistically appropriate outreach services in additional languages such as Bangladeshi and NHPI languages like Hawaiian, Tongan, Samoan, Marshallese, and Chuukese.

- **Increase Safe & Accessible Vaccination at Locations/Sites AAs, NHs & PIs Trust**

During this time of anti-Asian murder and hate, when Asians – and non-Asians - are coming to grips with “It could have been me,” ensure the HHS COVID-19 and Flu Public Education Campaign and CDC Vaccinate with Confidence Campaign includes messaging on countering stigma, shame, and anti-Asian sentiment regarding the virus and improve factual awareness of the COVID-19 and its origination.

Prioritize funding of safe and accessible vaccine distribution, so persons who are actual and/or potential victims of anti-Asian hate, and/or persons who are fearful of being deported and/or losing their benefits, can safely receive their COVID-19 vaccinations from trusted entities (e.g., community-based FQHCs; pop-up vaccination sites at a consulate; a mobile vaccination sites / ice cream trucks that have been “adopted” by AA, NH & PI community-based service organizations, AA, NH & PI social club/benevolent associations/citizenship assistance organizations/language schools/affinity groups/faith-based institutions; at ethnic shopping center/ethnic festivals, and/or via AA, NH & PI clinicians who are willing to make home health visits with home-bound elderly/disabled persons, etc.).

Make access to vaccinations “user-friendly” (e.g., by providing in-language and in-culture education; by assisting with accurate and consistent race/ethnicity classification

recording and reporting; by being open between 6 PM – 6 AM weekdays and weekends, so people who have to be at work can have equitable access to the vaccine, etc.). At the federal level, quickly expand HRSA’s Health Center COVID-19 Vaccine Program to all HRSA-funded health centers; ensure that health centers with significant Black, Latinx, Asian, and Native Hawaiian and Pacific Islander patient populations have adequate vaccine supply and resources for cultural and linguistic support services and staff.

- **Increase “Get Out The Vaccination” Calls and Door Knocks via In-Language Community Health Workers and Health Navigators**

Prioritize funding to pay for the services of trusted, neighborhood-based Community Health Workers and/or community-based in-language and in-culture health navigators who can make Get Out The Vaccination calls and/or go door-to-door to assist persons who are limited English-proficient, home-bound, concerned about their immigration status, have limited wi-fi, have limited access to transportation, have limited or no paid sick time off, and assist in making a vaccination and/or transportation appointment so the not-yet-vaccinated will be able to receive their full course of vaccinations from a trusted vaccination site, using cell-phone based websites and/or apps that CHWs make available and accessible to those who are without the technology to equitably access vaccine appointments.

- **Increase Vaccine Access Through Business-Employee Partnerships**

Encourage employee associations and unions to work with Ethnic Chambers of Commerce, Ethnic Business Associations, and businesses to locate mobile or pop-up vaccination-clinics at, or near, businesses that employ a large number of AAs, NHs, and/or PIs (e.g., restaurants, grocery stores, retail stores, meat packing plants, garment factories, home health agencies, etc.) to make vaccination easier for persons who work in high-risk, essential, occupations and/or have limited sick time/paid time off.

- **Sequence “Family Vaccination Fun Days” So They Align the Holidays & Back to School**

Many AAs, NHs & PIs live in multi-generational families. Now that a broader range of age groups are eligible to receive the COVID-19 vaccine, and many children are looking forward to going to school in the Fall, expand the opportunity for multi-generational families to get vaccinated together. In addition, many families yearn for the days when families celebrated the holidays together, so consider working with the Screen Actors Guild and ethnic-based Cable-TV screenwriters/entertainers to broadcast stories about the trials and tribulations of “Home Alone vs. Getting Vaccinated Together” to motivate the not yet vaccinated to get vaccinated so they can get their vaccination documents and visas in time to enjoy the holidays together with friends and family domestically or abroad. Also, work with Parents Magazine, Consumer Reports & AARP to promote “Family Vaccination Fun Days,” and expand the reach of in-culture GOTV “Hamilton-themed” musical parodies such as [My Shot](#) and [My Shot: Doctors Remix](#).

3 Ensuring Equitable COVID-19 Rescue, Recovery & Re-Imagination by Improving Consistent Reporting & Recording of Disaggregated Race/Ethnicity/Language at the Local, State & National Level and Harmonizing the Data So We Can Continuously Improve Our Attainment of Health Equity

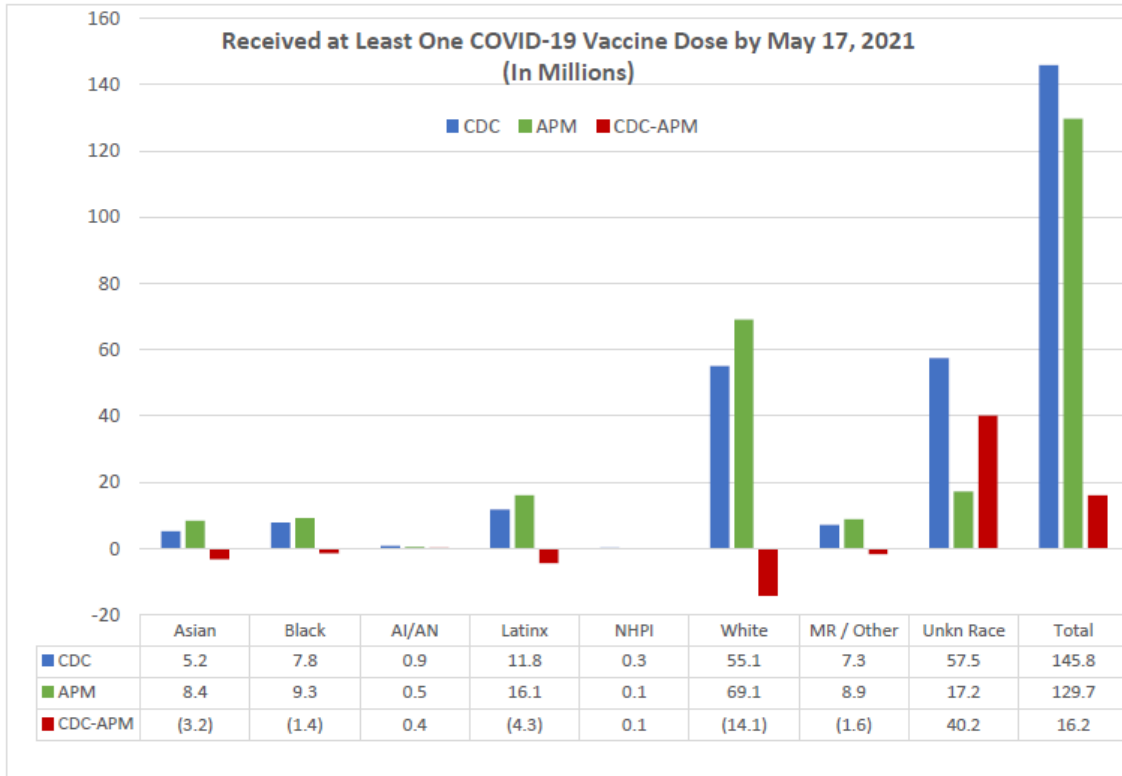
If our goal is equity, we must begin with the end in mind. We must pay close attention to the disaggregated data and metrics that are, and will be, used to monitor and continuously improve out attainment of health equity. With equity as our North Star, we want to bring to the HETF's attention, the need to increase and improve the consistency and visibility of race/ethnicity reporting and recording, and the need to reconcile and harmonize the disaggregated data used to guide equitable resource allocation/funding to achieve herd immunity, re-open our economies, and close the vaccination gap at the national, state, county, city, and neighborhood levels.

On April 9, 2021, Dr. Islam was invited to present on the importance of data disaggregation, and importance of not "invisibilizing, "otherizing" and/or "marginalizing" Asian American, Native Hawaiian, and Pacific Islander, communities. What she addressed was published as a Health Affairs blog on [Asian American Subgroups and the COVID-19 Experience: What We Know and Still Don't Know](#) on May 25, 2021, and provides an [update](#) of what we know about the COVID-19 experience by Asian American ethnic group. This post was compiled by the NYU Center for the Study of Asian American Health team, including Drs. Simona Kwon, Stella Yi, and Lan Doan, who are also members of the AANHPI CPRT.

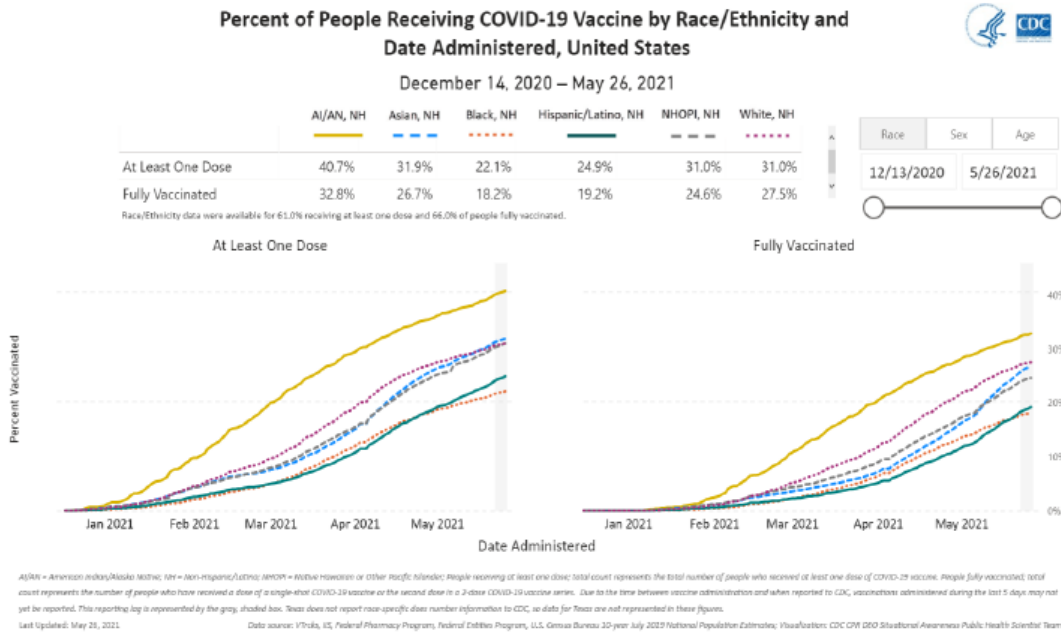
On May 17, 2021, Dr. Nguyen presented graphs from APM Research Laboratory showing that Asian Americans had the highest rate of vaccination success, and graphs from the CDC showing that Asian Americans, Native Hawaiians, and Pacific Islanders, were way behind American Indians and Non-Hispanic Whites (See PPT).

To look into this further, Elena Ong, PHN, MS, contacted APM Research & the CDC, and discovered that when APM Research scraped the data from the 18 to 34 states that had comparable data, 7.8 million Asian Americans received at least one dose of the COVID-19 vaccine on May 6, 2021. In contrast, the CDC, which collects even more vaccination info from the territories, the tribal lands, HRSA, as well as most all of the 50 states, recorded that 4.7 million Asian Americans received at least one dose of the COVID-19 vaccine on the same day. When we looked at the data for May 17, 2021, we found that the race/ethnicity reporting gap for Asian Americans increased from 3.1 million to 3.2 million over 11 days.

The good news is that race/ethnicity recording for NHs & PIs and AI & ANs by the CDC is stronger than what APM is able to scrape from the 18 states that report comparable data for NHs & PIs, the 32 states that report comparable data for Asian Americans, Latinx and Multi-Racial Others, and the 34 states that report comparable data for Black Americans and Non-Hispanic White Americans.



Sources: [CDC COVID Vaccination Data Tracker Time Series](#) and [APM Research Laboratory](#)



- **Harmonize the COVID-19 Data at the Neighborhood, Local, State, National, Federal & Global Levels**

We look to the CDC, for national data that can help us measure vaccination progress, and for national data that can be used to prioritize funding to increase the number of AAs, NHs & PIs, and other communities, that still need to receive the COVID-19 vaccine. However, because of the inconsistency in what APM is able to scrape from the states, and what the CDC reports for vaccinations by race/ethnicity at the national level, we respectfully request that the HETF, the Secretary of Health & Human Services, the CDC Director, and the US Census Director, provide guidelines for harmonizing the numerator and denominator data, and provide guidelines for resolving differences in classifying or recording the race/ethnicity of Asian Americans, Black Americans, Latinx-Americans, Native Hawaiians, Pacific Islanders, Multi-Racial Americans, Others, and Non-Hispanic White Americans, in the vaccination data, the case data, and the death data, by geography. That will help ensure equitable funding for the remaining 2020/2021 COVID-19 vaccination cycle, and lay the foundation for 2021/2022 COVID-19 recovery and re-imagination.

As you develop the model guidelines for the data, we invite you to call upon NCAPIP Advisor Ignatius Bau, JD, and UCLA Professor Ninez Ponce, PhD, MPP (who worked with the [National Academy of Science, Engineering & Medicine](#) to standardize classification of race/ethnicity and language so it is consistent with OMB Directive 15). In addition, the California State Assembly just passed AB 1358, the California Data Disaggregation and Health Equity bill. The bill exemplifies a model approach to building the systems infrastructure needed to collect, standardize and release disaggregated data for all communities of color. The proposed legislation would enable a standardized approach for data disaggregation across state agencies in California and require health equity metrics to include this data with an emphasis on language and race.

We also invite you to call upon Richard Calvin Chang, JD, and 'Alisi Tulua, MS, who staff the [UCLA NHPI COVID-19 Dashboard](#) and have the ability to work with the NH & PI communities to interpret the data, and develop policy and programmatic solutions at the local and national levels. In fact, UCLA Professor Ponce & 'Alisa Tulua just released a new [fact sheet](#) that reveals the need to break down COVID-19 data for ethnic subgroups. This project is part of a larger multi-racial research study that is supported by the National Urban League, a historic civil rights and advocacy organization with 90 affiliates in 300 communities across the country. The full report, *The COVID-19 Communities of Color Needs Assessment Phase 1*, inclusive of components of this study, will be available on the National Urban League's website, <http://www.nul.org>, very soon. The Needs Assessment Phase 1 was funded by from The W. K. Kellogg Foundation, JPB Foundation, Ford Foundation, The California Endowment, Weingart Foundation, and The California Wellness Foundation.

We also want to bring to your attention a survey that was conducted by the Pacific Islander Center of Primary Care Excellence (PI-CoPCE) and the American Association of Psychologists (AAPA) that revealed a high percentage of Native Hawaiian and Pacific Islanders (NHPI) are hesitant to receive the COVID-19 vaccine. Approximately 43% of respondents aged 18 to 44 years noted reservations to the vaccine, which is concerning as 48% of them claimed to be essential workers. Two-thirds of respondents reported having a high school diploma and/or attended some college compared to 17% reporting have a bachelor's degree. 68% of Marshallese and 62% of Samoans reported a loss of income during the pandemic with financial stressors identified by respondents as their top concern during the pandemic. The survey also showed that 68% of NHPI noted difficulty seeing a medical provider during the pandemic. More than 40 % of Marshallese, Native Hawaiians and Samoans reported experiencing anxiety or depression during the pandemic. "Delays in receiving healthcare in our community that already has high rates of COVID-19 predisposes us to poor outcomes. According to Melisa Laelan, Executive Director of the Arkansas Community of Marshallese and Co-Lead of the Pacific Islander COVID-19 Response Team (PICRT) Policy Council, "The reluctance of NHPI essential workers to receive the vaccine hinders the national plan to garner herd immunity."

These examples of disenfranchisement highlighted by the survey finding have prompted the PICRT Policy Council, Data and Research Council, Media Council and Resource and Engagement Workgroup to put forth the following recommendations:

1. Partner with NHPI CBOs to collect data through community and culturally aligned practices, inform policy and to fill in critical gaps in federal, state, and local government especially in regard to improving the likelihood of NHPI to ascertain a COVID-19 vaccine.]
2. Fund poverty reduction programs aimed at increasing the financial autonomy of NHPI families in building wealth to close the wealth gap empowering and work towards closing the educational achievement gap in NHPI communities.
3. Expand all federally-funded benefits such as FEMA Funeral Assistance Program to include "Habitual residents" such as citizens of the Federated States of Micronesia, Palau, and the Republic of the Marshall Islands living in the U.S.

In addition to the above, we also support intersectionality, and the reporting of primary language spoken, nativity, occupational, disability, gender identification, income, housing and other demographic characteristics.

Specifically, HETF should:

Ensure that existing and future COVID-19 data collected from clinical trials, cases, hospitalizations, mortality, and vaccination data sets are in compliance with the current OMB Directive 15 regulations and ACA Section 4302 standards. This data should also be broken down by additional racial subgroups whenever possible.

In accordance with OMB Directive 15, the HETF should ensure states and local health agencies collect and report demographic data by separating the “Asian American” category from the “Native Hawaiian and Other Pacific Islander” category. Identify ways to increase the amount of demographic data that states are able to report on infection rates, hospitalizations, mortality, and vaccinations.

Identify the necessary steps and resources required to update their COVID-19 surveillance system, to collect and report more complete data disaggregated by race, ethnicity, primary language, gender identity, age, disability status, and socioeconomic status, in line with, at least, the [Section 4302](#) promulgated standards under ACA. Ensure all data collected is protected under existing Health Insurance Portability and Accountability Act (HIPAA) privacy protections and from all inappropriate internal use or negative consequences for patients by any entity that collects the data.

In closing, we look forward to working with the HETF and federal and national partners to leverage current funding to address historical inequities that can affect the attainment of health equity, now and in the future. We also hope you will reach out to members of the NH & PI communities so they can share their concerns, stories, insights, and policy/budgetary recommendations. For additional information, please contact Elena Ong, PHN, MS, at 424-901-9037 or theongpartnership@gmail.com. The comments she provided at the May 28, 2021 HETF meeting are also attached.

Respectfully,

Members of the Asian American, Native Hawaiian and Pacific Islander COVID-19 Policy & Research Team, including:

APIAHF

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ELENA ONG, PHN, MS

National Asian American, Native Hawaiian & Pacific Islander Policy & Research Team May 28, 2021 Public Comments, Biden-Harris COVID-19 HETF Meeting

Good afternoon HETF Chair Nunez-Smith and HETF Members. Thank you for your amazing leadership. [I thank you for inviting Dr. Islam, Dr. Nguyen and Dr. Wong - other members of the NAANHPI-CPRT – to present before the HETF and] I'm honored to have this opportunity to provide public comment today. I will focus my comments on the Asian Americans (AA) experience, because I want our Native Hawaiian & Pacific Islander (NHPI) colleagues to use their voice, and experience, to discuss, and propose solutions to, COVID-19, with the HETF.

When 6 AA were murdered on March 16, 2021, I worked with Asian, and non-Asian, colleagues to draft an open letter, [United Against Racism and Xenophobia](#), that shared how the dual epidemic of racism and COVID-19 were affecting Asians in America. At the April 2021 HETF meeting, I read portions of that letter, and shared concerns that xenophobic racism could prevent AAs [and persons who look AAs] from “safely and equitably accessing” the COVID-19 vaccine.

The result? In terms of hate, the number of cumulative hate incidents reported to Stop AAPI Hate surged from 3,800 [between March 2020 to March 2021], to 6,600 in the month of March, 2021, alone. In terms of vaccinations, the CDC reports that 10.5% of vaccination-eligible AAs received at least one dose of the COVID-19 vaccine by March 16, and 32.1% by May 27. [The CDC also reported that 20.9% of vaccination-eligible NHPIs received at least one dose of the vaccine by March 16, and 31.1% by May 27.]

The reason? I can't say for sure, but I can say that Asian American researchers and community groups I work with, worked closely with local health departments, and with Asian-American serving Federally Qualified Health Centers (FQHCs) and Community Based Organizations (CBOs), to increase the number of vaccinations available at sites Asian Americans trust to receive their COVID-19 vaccine. It took unwavering partnership, innovative and tenacious coordination, individual drive, and concerted political will. So, **I thank President Biden for signing the [COVID-19 Hate Crimes Act](#). As the Act is implemented, I hope we will ensure equitable access for persons with limited English-speaking proficiency, limited paid time off, limited income, and limited transportation.**

Two, I would like to recommend prioritized funding for AA & NHPI vaccination efforts aimed at achieving equitable herd immunity at the neighborhood-level.

According to the CDC, only 32% of vaccination-eligible Asian Americans have received at least one dose of the vaccine, and we still have roughly 40% to 68% to go. That's why we need to prioritize funding to reach the hardest-hit, and the hardest-to-reach, Asian Americans – the 6,000+ hate victims, 7.8 million limited English proficient, 2.2 million poor, 1.7 million undocumented, 1.5 million uninsured, and the many AAs who lack paid sick-time off, transportation & wi-fi.

That said, I respectfully request that HHS prioritize funding to increase:

- Safe & Accessible Mobile Vax Clinics at FQHCs, consulates, pop-up clinics and mobile units where Asian Americans naturally congregate;
- “Get Out The Vaccination” Calls and Door Knocks;
- “Invite a Friend – Bring a Friend” Social Media Campaigns & Activities;
- Employee / Business Vaccination Partnerships to Provide Vaccination Access for Essential Workers
- “Family Vaccination Fun Days” to encourage Multi-Generational Families to get Vaccinated Together & Enjoy the Holidays Together in the US and Abroad

Three, I truly value having a national dashboard that the public can “go-to” that provides COVID-19 statistics in real-time. So, when I was asked to review a COVID-19 dashboard that scrapes race and ethnicity vaccination data directly from the states, I was surprised to learn that they found that 8.4 million Asian Americans received at least one dose of the vaccine, compared to the 5.2 million reported by the CDC on the same day - May 17, 2021. [A similar pattern was observed for Black Americans, Latinx and Non-Hispanic Whites].

This made me realize how important it would be for the HETF, the HHS Secretary, the CDC Director, and the Census Bureau Director, to work with experts from our respective communities - to harmonize the disaggregated data that is used to guide equitable resource allocation to achieve herd immunity, re-open our economies, and close the vaccination gap at the national, state, county, city, and neighborhood levels.

Thank you again for this opportunity to present before you today; I will follow-up in writing.

Public Comment of Rachel N. Morrison, Esq., Policy Analyst, Ethics & Public Policy Center—COVID-19 Health Equity Task Force Meeting, May 28, 2021

My name is Rachel Morrison. I am an attorney and policy analyst at the Ethics & Public Policy Center (EPPC), where I work on EPPC’s HHS Accountability Project. Thank you for the opportunity today to provide public comment. All comments are my own, and they focus on discrimination in COVID-19 vaccine distribution.

The executive order establishing this Task Force states that your mission and work shall be conducted “consistent with applicable law.”¹

Section 1557 of the Patient Protection and Affordable Care Act guarantees that no individual can “be excluded from participation in, denied benefits of, or be subject to discrimination under” any federally administered or funded health program or activity because of race, color, and national origin as prohibited under Title VI of the Civil Rights Act of 1964.²

HHS’s website explains:

Programs that receive Federal funds cannot distinguish among individuals on the basis of race, color or national origin, either directly or indirectly, in the types, quantity, quality or *timeliness* of program services, aids or benefits that they provide or the manner in which they provide them. This prohibition applies to intentional discrimination as well as to procedures, criteria or methods of administration that appear neutral but have a discriminatory effect on individuals because of their race, color, or national origin.³

States that receive federal funding for COVID-19 vaccines are subject to these nondiscrimination requirements.⁴ Despite this, the focus on “equity” has encouraged several states to discriminate based on race, color, and national origin in their vaccine distributions by prioritizing racial minorities or black, indigenous, and people of color.

¹ Exec Order No. 13995, 86 Fed. Reg. 7193 (Jan. 21, 2021) (Ensuring an Equitable Pandemic Response and Recovery), available at <https://www.govinfo.gov/content/pkg/FR-2021-01-26/pdf/2021-01852.pdf>

² 42 U.S.C. § 18116 (incorporating Title VI (42 U.S.C. § 2000d et seq.)).

³ *Civil Rights Requirements- A. Title VI of the Civil Rights Act of 1964*, 42 U.S.C. 2000d et seq. (“Title VI”), U.S. DEPT HEALTH & HUM. SERVS. (last reviewed July 26, 2013), <https://www.hhs.gov/civil-rights/for-individuals/special-topics/needv-families/civil-rights-requirements/index.html> (emphasis added).

⁴ Under HHS’s Title VI regulations, recipients of HHS funds may not engage in any of the above prohibited conduct either “directly or through contractual or other arrangements.” 45 C.F.R. 80.3(b)(2) (Discrimination prohibited).

For example, a vaccine provider in Washington State required applicants to mark whether they were a person of color or white, automatically placing all white applicants on the standby list.⁵ New Hampshire allowed Asian college students to receive the vaccine, while at the same time denying white residents in their 20s, 30s, and 40s the ability to do so.⁶ Rhode Island reserved certain vaccine doses for non-white residents *only*, leading to many doses being wasted when not enough racial minorities showed up and despite demand from white residents.⁷ There are similar stories out of Montana,⁸ Vermont,⁹ and Virginia.¹⁰

Such actions are illegal and invidious discrimination. Just yesterday, a federal circuit court found that similar racial preferences used by the Small Business Administration (SBA) in its consideration of COVID relief grant applications for restaurants were impermissible race discrimination in violation of the Equal Protection Clause of the Fourteenth Amendment.¹¹ (The court opinion is attached for your reference in the Appendix.)

HHS and the Task Force have a legal duty to prohibit race, color, and national origin discrimination, even discrimination for the purpose of equity. I urge the Task Force to ensure that your efforts to promote equity do not encourage or enable illegal discrimination and to make clear to states that such discrimination in their federally funded COVID-19 vaccine programs will not be tolerated.

Thank you.

⁵ Jason Rantz, *Rantz: WA Dept of Health Lets Providers Deny Vaccines to White People for Equity*, MYNORTHWEST.COM (Apr. 22, 2021, 5:39 AM), <https://mynorthwest.com/2802297/wa-health-deny-vaccines-white-people/>.

⁶ Sydney Wu, *College Implements Vaccine Partnership with NH, Upper Valley Residents Attend BIPOC Vaccine Clinic*, DARTMOUTH (Apr. 1, 2021, 3:00 AM), <https://www.thedartmouth.com/article/2021/04/college-announces-vaccine-partnership-with-new-hampshire-upper-valley-residents-attend-bipoc-vaccine-clinic>; see also Michael Graham *InsideSources.com*, *NH Using Race-Based 'Equity' Metric in Distributing Early Doses of COVID Vaccine*, N.H. UNION LEADER (Jan. 7, 2021), https://www.unionleader.com/news/health/coronavirus/nh-using-race-based-equity-metric-in-distributing-early-doses-of-covid-vaccine/article_f0e8c27c-4639-56cb-a94e-3e5c0041076e.html.

⁷ Hans Bader, *Rhode Island Wasted Vaccine by Excluding Whites from Big COVID Vaccination Event*, LIBERTY UNYIELDING (Apr. 12, 2021), <https://libertyunyielding.com/2021/04/12/rhode-island-wasted-vaccine-doses-by-excluding-whites-from-big-covid-vaccination-event/>.

⁸ Montana DPHHS HAN Advisory re Update to Implementation of COVID-19 Vaccination in Montana at 2 (Mar. 2, 2021), <https://dphhs.mt.gov/Portals/85/publichealth/documents/HAN/2021/HANAD2021-7.pdf> (Montana prioritized in Phase 1B of its vaccinations "American Indians and other people of color who may be at elevated risk for COVID-19 related complications.").

⁹ Associated Press, *Scott Decries 'Racist Response' to BIPOC Vaccine Eligibility*, U.S. NEWS (Apr. 5, 2021, 7:46 PM), <https://www.usnews.com/news/best-states/vermont/articles/2021-04-05/vermont-opening-covid-19-vaccines-to-those-40-and-older> (Vermont made "Black, indigenous, and people of color of any age eligible for a coronavirus vaccine before residents of other races.").

¹⁰ Hans Bader, *Virginia Left 11,000 Vaccine Doses Unused to Promote Racial 'Equity'*, CNSNEWS (Apr. 8, 2021, 10:04 AM), <https://cnsnews.com/commentary/hans-bader/virginia-left-11000-vaccine-doses-unused-promote-racial-equity> (Virginia "kept at least 11,000 doses of the COVID vaccine unused due to its extreme push for racial 'equity.'").

¹¹ *Vitolo v. Guzman*, Nos. 21-5517/5528 (6th Cir. May 27, 2021), available at <https://www.opn.ca6.uscourts.gov/opinions.pdf/21a0120p-06.pdf>; see also *Greer's Ranch Café v. Guzman*, No. 4:21-cv-00651 (N.D. Tex. May 18, 2021) (granting temporary restraining order, enjoining SBA from using race and sex preferences in distributing COVID relief grants for restaurants), available at <https://assets.documentcloud.org/documents/20773795/order-granting-tro-against-biden-administration.pdf>.

Appendix

UNITED STATES COURT OF APPEALS

FOR THE SIXTH CIRCUIT

ANTONIO VITOLO; JAKE’S BAR AND GRILL, LLC, <i>Plaintiffs-Appellants,</i>	}	Nos. 21-5517/5528
v.		
ISABELLA CASILLAS GUZMAN, Administrator of the Small Business Administration, <i>Defendant-Appellee.</i>	}	

On Emergency Motion for Injunction Pending Appeal and to Expedite Appeal.

United States District Court for the Eastern District of Tennessee at Knoxville;
No. 3:21-cv-00176—Travis Randall McDonough, District Judge.

Decided and Filed: May 27, 2021

Before: NORRIS, DONALD, and THAPAR, Circuit Judges.

COUNSEL

ON MOTIONS AND REPLY: Daniel P. Lenington, WISCONSIN INSTITUTE FOR LAW & LIBERTY, Milwaukee, Wisconsin, for Appellants. **ON RESPONSE:** Marleigh D. Dover, Jack Starcher, UNITED STATES DEPARTMENT OF JUSTICE, Washington, D.C., for Appellee.

THAPAR, J., delivered the opinion of the court in which NORRIS, J., joined. DONALD, J. (pp. 16–27), delivered a separate dissenting opinion.

OPINION

THAPAR, Circuit Judge. This case is about whether the government can allocate limited coronavirus relief funds based on the race and sex of the applicants. We hold that it cannot.

Thus, we enjoin the government from using these unconstitutional criteria when processing Antonio Vitolo's application.

I.

As part of the most recent coronavirus relief bill (the American Rescue Plan Act of 2021), Congress allocated nearly \$29 billion for grants to help restaurant owners meet payroll and other expenses. Pub. L. No. 117-2, § 5003(b)(2)(A), (c) (Restaurant Revitalization Fund). The fund was created to aid small privately owned restaurants, not large chains. *Id.* § 5003(a)(4)(C). The Small Business Administration, a federal agency, processes the applications and distributes the funds. During the application process, restaurant owners must certify to the agency that the grant is necessary to support ongoing operations. *Id.* § 5003(c)(2)(A).

The key to getting a grant is to get in the queue before the money runs out. The Small Business Administration distributes money on a first come, first served basis. But there is a catch. During the first 21 days the agency gives grants to priority applicants only. *Id.* § 5003(c)(1). Priority applicants are restaurants that are at least 51% owned and controlled by women, veterans, or the "socially and economically disadvantaged." *Id.* § 5003(c)(3)(A); *see* 15 U.S.C. §§ 632(n), (q)(3), 637(a)(4)(A). Non-priority restaurants may apply during this time, but they will not receive a grant until the initial period expires. Pub. L. No. 117-2, § 5003(c)(3)(A). If the fund is depleted by then, the non-priority restaurants are out of luck; the Act does not provide for its replenishment.

Antonio Vitolo and his wife own a restaurant called Jake's Bar and Grill. Vitolo is white and his wife is Hispanic, and they each own 50% of the restaurant. Like many restaurants, Jake's Bar has struggled during the pandemic—it closed on weekdays and offered to-go orders on weekends. It lost workers and a considerable amount in sales. So on the first day that the Small Business Administration allowed applications, Vitolo submitted one.

Since the restaurant is not 51% owned by a woman or veteran, Vitolo had to qualify as "socially and economically disadvantaged" to get priority status. *Id.* § 5003(c)(3)(A). The relief bill defines social and economic disadvantage by reference to the Small Business Act. *See id.*

Under the Small Business Act, a person is considered “socially disadvantaged” if he has been “subjected to racial or ethnic prejudice” or “cultural bias” based solely on his immutable characteristics. 15 U.S.C. § 637(a)(5); 13 C.F.R. § 124.103(a). A person is considered “economically disadvantaged” if (1) he is socially disadvantaged; and (2) he faces “diminished capital and credit opportunities” compared to non-socially disadvantaged people who operate in the same industry. 15 U.S.C. § 637(a)(6)(A).

The Small Business Administration has injected explicit racial and ethnic preferences into the priority process. See 13 C.F.R. § 124.103. Under a regulation that predates the pandemic, the agency presumes certain applicants are socially disadvantaged based solely on their race or ethnicity. Groups that presumptively qualify as socially disadvantaged—and thus get to jump to the front of the line for priority consideration—include “Black Americans,” “Hispanic Americans,” “Asian Pacific Americans,” “Native Americans,” and “Subcontinent Asian Americans.”¹ *Id.* § 124.103(b)(1). If you are in one of these groups, the Small Business Administration assumes you qualify as socially disadvantaged. Indeed, the only way not to qualify is if someone comes forward “with credible evidence to the contrary.” *Id.* § 124.103(b)(3).

Applicants who do not get the presumption must prove they have experienced racial or ethnic discrimination or cultural bias by a preponderance of the evidence. *Id.* § 124.103(c)(1). After reviewing that evidence, the Small Business Administration will consider an applicant a victim of “individual social disadvantage” if it determines that (i) the applicant suffered episodes of discrimination; (ii) *each* episode “negatively impacted the individual’s entry or advancement

¹Other than those considered black, Hispanic, or Native American, a person receives a rebuttable presumption of social disadvantage only if he or she has “origins from” a country identified by the Small Business Administration. 13 C.F.R. § 124.103(b)(1). It is unclear what it means to have “origins from” a specific country, but the agency tells us that “[b]eing born in a country does not, by itself, suffice.” *Id.*

Asian Pacific Americans qualify only if they have origins from Burma, Thailand, Malaysia, Indonesia, Singapore, Brunei, Japan, China (including Hong Kong), Taiwan, Laos, Cambodia (Kampuchea), Vietnam, Korea, the Philippines, U.S. Trust Territory of the Pacific Islands (Republic of Palau), Republic of the Marshall Islands, Federated States of Micronesia, the Commonwealth of the Northern Mariana Islands, Guam, Samoa, Macao, Fiji, Tonga, Kiribati, Tuvalu, or Nauru. *Id.*

Subcontinent Asian Americans must have origins from India, Pakistan, Bangladesh, Sri Lanka, Bhutan, the Maldives Islands, or Nepal. *Id.*

in the business world”; and (iii) together, those episodes caused the applicant to suffer “chronic and substantial social disadvantage.” *Id.* § 124.103(c)(6).

The added evidentiary burden faced by white men and other non-presumptively disadvantaged groups stands in marked contrast with lenient evidentiary standards set by the American Rescue Plan Act. Congress recognized the urgency of providing relief to small restaurants struggling to weather the pandemic. So it sought to cut as much red tape as possible. To avoid “imposing additional burdens on applicants,” the Act requires the Small Business Administration to accept the applicant’s “existing business identifiers” to show eligibility for a grant, rather than requiring “other forms of registration or identification that may not be common to their industry.” Pub. L. No. 117-2, § 5003(c)(2)(B). The government relies on restaurant owners to self-certify that they meet these eligibility criteria when applying for a grant. *Id.* § 5003(c)(2)(A).

Vitolo sued to end the race and sex preferences in grant funding, claiming that they violated his constitutional rights. With the funds rapidly depleting, Vitolo asked for a temporary restraining order and ultimately a preliminary injunction that would prohibit the government from handing out grants based on the applicants’ race or sex. The district court declined to issue a restraining order and said that Vitolo was unlikely to succeed on the merits of his claim. Vitolo filed a notice of appeal, and he asked the district court to enjoin the race and sex preferences until his appeal was decided. The district court denied that motion too. Finally, the district court denied the motion for a preliminary injunction.² Vitolo also appealed that order.

Vitolo has filed a motion to expedite the appeal, which we grant. Before turning to the merits of the preliminary injunction, we handle a couple issues the government has raised.

II.

First, during the briefing for the preliminary injunction in the district court, the government argued that the plaintiffs lacked standing to challenge the Small Business

²While we ultimately disagree with the district court, we appreciate the district judge’s diligence in handling this matter. District courts are extremely busy, and this judge is no exception. Yet he moved promptly at every turn and made sure to provide the parties with thorough rulings.

Administration's use of racial preferences because the plaintiffs may not ultimately succeed. But the district court correctly rejected that argument. The injury here is "the denial of equal treatment resulting from the imposition of the barrier, not the ultimate inability to obtain the benefit." *Ne. Fla. Chapter, Associated Gen. Contractors of Am. v. Jacksonville*, 508 U.S. 656, 666 (1993); *see also Parents Involved in Cmty. Schs. v. Seattle Sch. Dist. No. 1*, 551 U.S. 701, 719 (2007) ("[O]ne form of injury under the Equal Protection Clause is being forced to compete in a race-based system that may prejudice the plaintiff." (citations omitted)). The government's use of racial preferences causes that injury. And that injury is redressable by a decision ordering the government not to grant priority consideration based on the race of applicants. *See Lujan v. Defs. of Wildlife*, 504 U.S. 555, 560 (1992); *see also Waskul v. Washtenaw Cnty. Cmty. Mental Health*, 900 F.3d 250, 255 n.3 (6th Cir. 2018) (noting that at the preliminary injunction stage the plaintiff must show "a substantial likelihood of standing").

It does not matter that the plaintiffs might not otherwise qualify for priority consideration. For if the court enjoined use of "the race-based presumption of the SBA regulations or the race-conscious portions of the definition of 'socially disadvantaged,' . . . the playing field in qualifying for the priority period would be 'leveled.'" R. 32, Pg. ID 268. Why? Because the race of the applicant "would not factor into the order in which applications are processed by SBA." *Id.* That is enough to show a substantial likelihood of success on standing—and, indeed, the government has not claimed otherwise on appeal.

Second, the government argues that the plaintiffs' claim is moot. While this case was on appeal, the 21-day "priority" phase of the grant program ended. The statute now requires the Small Business Administration to begin processing grant requests in the order they were received, without regard to the applicants' race or sex. Thus, the government says, there is no use for a court order requiring it to do the same.

Mootness is a high hurdle. The government must show that a court could order no "effectual relief whatever" for the plaintiffs' injury. *Chafin v. Chafin*, 568 U.S. 165, 172 (2013) (citation omitted). What's more, the government must show that it has "completely and irrevocably eradicated the effects" of the program's race and sex preferences. *Los Angeles Cnty. v. Davis*, 440 U.S. 625, 631 (1979). But the government hasn't cleared the bar. Race and sex

preferences continue to bear on whether an applicant receives a grant before the money runs out. And a court order ending those preferences will relieve the plaintiffs' injury (and allow Vitolo's application to be considered sooner than it otherwise would).

Most fundamentally, the program's race and sex preferences did not end with the priority phase. That just marks when the Small Business Administration starts processing applications from non-priority restaurants. The agency says processing takes approximately 14 days. Miller Decl. ¶ 14. So all of the "priority" applications that were received in the 21-day window are still being processed first. And no application is paid out before going through the 14-day processing window. *Id.* ¶ 15. So with these preferences in place, the fund may be depleted before the plaintiffs' application has been processed. There is an obvious solution to this of course: The agency can simply fund grants in the order they were received—without regard to priority status, and without regard to the processing head start that many applications received on the basis of race and sex.

Turning to this case, plaintiffs continue to suffer a real and concrete injury by having their application considered behind the priority applications because of race and sex. Vitolo submitted his application on May 3. Restaurants that submitted "priority" applications on May 24 will likely receive their grants before the agency has time to finish processing Vitolo's application. Add to this the fact that over half the funds have been approved to be distributed as of May 25, 2021, to priority applicants. Miller Decl. ¶ 22. Since it normally takes 14 days to process an application, this means that the agency should be almost through priority applications received between May 3 and May 11. But that leaves all the priority applications received between May 12 and May 24, which have gotten a processing head start relative to Vitolo's application. There is a real risk that the funds will run out, unless the agency processes Vitolo's application before the May 12 to May 24 batch. For these reasons, the government has failed to show that the case is moot.

III.

We consider four factors in determining whether a preliminary injunction should issue: (1) whether the moving party has shown a likelihood of success on the merits; (2) whether the

moving party will be irreparably injured absent an injunction; (3) whether issuing an injunction will harm other parties to the litigation; and (4) whether an injunction is in the public interest. *Nken v. Holder*, 556 U.S. 418, 434 (2009). In constitutional cases, the first factor is typically dispositive. *Roberts v. Neace*, 958 F.3d 409, 416 (6th Cir. 2020) (order) (per curiam). That’s because “[w]hen constitutional rights are threatened or impaired, irreparable injury is presumed.” *Obama for Am. v. Husted*, 697 F.3d 423, 436 (6th Cir. 2012). And no cognizable harm results from stopping unconstitutional conduct, so “it is always in the public interest to prevent violation of a party’s constitutional rights.” *Deja Vu of Nashville, Inc. v. Metro. Gov’t of Nashville & Davidson Cnty.*, 274 F.3d 377, 400 (6th Cir. 2001) (citation omitted). We thus focus our analysis on the plaintiffs’ likelihood of success on the merits.

Vitolo challenges the Small Business Administration’s use of race and sex preferences when distributing Restaurant Revitalization Funds. The government concedes that it uses race and sex to prioritize applications, but it contends that its policy is still constitutional. We disagree.

A.

We start with race. Government policies that classify people by race are presumptively invalid. U.S. Const. amend. XIV; *Adarand Constructors, Inc. v. Peña*, 515 U.S. 200, 234, 235 (1995) (applying equal-protection principles to federal policies that discriminate by race). To overcome that presumption, the government must show that favoring one race over another is necessary to achieve a compelling state interest. *Id.* at 235. And even when the government can show that it has a compelling interest, it must narrowly tailor its remedy to advance that interest. This is a very demanding standard, which few programs will survive. *See Parents Involved*, 551 U.S. at 720.

The government concedes that strict scrutiny applies to its method of distributing these funds. And for good reason: The policy grants privileges to individuals based explicitly on their race.

Compelling Interest. Because strict scrutiny applies, we must first consider whether the government has a compelling interest in giving some races priority access to the Restaurant

Revitalization Funds, and for presumptively sending men from non-favored racial groups (including whites, some Asians, and most Middle Easterners) to the back of the line. We hold that it does not.

The government says it has a compelling interest in remedying past societal discrimination against minority business owners. The Supreme Court has told us that remedial policies can *sometimes* justify preferential treatment based on race. *City of Richmond v. J.A. Croson Co.*, 488 U.S. 469, 493–94 (1989) (plurality opinion); *Adarand*, 515 U.S. at 237. But the bar is a high one. The government has a compelling interest in remedying past discrimination only when three criteria are met:

First, the policy must target a specific episode of past discrimination. It cannot rest on a “generalized assertion that there has been past discrimination in an entire industry.” *J.A. Croson Co.*, 488 U.S. at 498; *see also Adarand*, 515 U.S. at 226; *Aiken v. City of Memphis*, 37 F.3d 1155, 1162–63 (6th Cir. 1994) (en banc) (explaining that societal discrimination is not enough to justify racial classifications and that there must be prior discrimination by the governmental unit involved).

Second, there must be evidence of *intentional* discrimination in the past. *J.A. Croson Co.*, 488 U.S. at 503 (requiring an “inference of discriminatory exclusion”). Statistical disparities don’t cut it, although they may be used as evidence to establish intentional discrimination. *See Aiken*, 37 F.3d at 1163; *United Black Firefighters Ass’n v. City of Akron*, 976 F.2d 999, 1011 (6th Cir. 1992).

Third, the government must have had a hand in the past discrimination it now seeks to remedy. So if the government “show[s] that it had essentially become a ‘passive participant’ in a system of racial exclusion practiced by elements of [a] local . . . industry,” then the government can act to undo the discrimination. *J.A. Croson Co.*, 488 U.S. at 492 (plurality opinion). But if the government cannot show that it actively or passively participated in this past discrimination, race-based remedial measures violate equal-protection principles.

The government’s asserted compelling interest meets none of these requirements. First, the government points generally to societal discrimination against minority business owners.

But it does not identify specific incidents of past discrimination. And since “an effort to alleviate the effects of societal discrimination is not a compelling interest,” the government’s policy is not permissible. *Shaw v. Hunt*, 517 U.S. 899, 909–10 (1996); see also *Parents Involved*, 551 U.S. at 731 (plurality opinion) (“remedying past societal discrimination does not justify race-conscious government action”).

Second, the government offers little evidence of past intentional discrimination against the many groups to whom it grants preferences. Indeed, the schedule of racial preferences detailed in the government’s regulation—preferences for Pakistanis but not Afghans; Japanese but not Iraqis; Hispanics but not Middle Easterners—is not supported by any record evidence at all.

When the government promulgates race-based policies, it must operate with a scalpel. And its cuts must be informed by data that suggest intentional discrimination. The broad statistical disparities cited by the government are not nearly enough. For example, a witness testified before a congressional committee that 32% of Hispanic-owned small businesses and 41% of black-owned small businesses have gone under during the pandemic, compared to only 22% of white-owned small businesses. When there is a single decisionmaker behind the disparity, extreme differences among races may permit an inference of intentional discrimination—for example, when a city hires one race at a disproportionate rate. See *United Black Firefighters Ass’n*, 976 F.2d at 1011 (noting that “[w]here a gross disparity exists between the expected percentage of minorities selected and the actual percentage of minorities selected, then prima facie [but rebuttable] proof exists to demonstrate intentional discrimination in the selection of minorities to those particular positions”). But when it comes to general social disparities, there are simply too many variables to support inferences of intentional discrimination. See *J.A. Croson Co.*, 488 U.S. at 501–03; *Associated Gen. Contractors of Ohio, Inc. v. Drabik*, 214 F.3d 730, 736–37 (6th Cir. 2000).

Third, the government has not shown that it participated in the discrimination it seeks to remedy. When opposing the plaintiffs’ motions at the district court, the government identified statements by members of Congress as evidence that race- and sex-based grant funding would remedy past discrimination. For example, the government points to a House subcommittee

hearing aimed at “understanding why aid to minority-owned businesses was delayed.” R. 18, Pg. ID 109 (cleaned up). But rather than telling the court what Congress learned and how that supports its remedial policy, it said only that Congress identified a “theme” that “minority- and women-owned businesses” needed targeted relief from the pandemic because Congress’s “prior relief programs had failed to reach” them. *Id.*, Pg. ID 108. A vague reference to a “theme” of governmental discrimination is not enough. To satisfy equal protection, the government must identify “prior discrimination by the governmental unit involved” or “passive participa[tion] in a system of racial exclusion.” *J.A. Croson Co.*, 488 U.S. at 492 (plurality opinion) (cleaned up). An observation that prior, race-neutral relief efforts failed to reach minorities is no evidence at all that the government enacted or administered those policies in a discriminatory way.

For these reasons, we conclude that the government lacks a compelling interest in awarding Restaurant Revitalization Funds based on the race of the applicants. And as a result, the policy’s use of race violates equal protection.

Narrow Tailoring. Even if the government had shown a compelling state interest in remedying some specific episode of discrimination, the discriminatory disbursement of Restaurant Revitalization Funds is not narrowly tailored to further that interest.

For a policy to survive narrow-tailoring analysis, the government must show “serious, good faith consideration of workable race-neutral alternatives.” *Grutter v. Bollinger*, 539 U.S. 306, 339 (2003); *J.A. Croson Co.*, 488 U.S. at 507. This requires the government to engage in a genuine effort to determine whether alternative policies could address the alleged harm. And, in turn, a court must not uphold a race-conscious policy unless it is “satisfied that no workable race-neutral alternative” would achieve the compelling interest. *Fisher v. Univ. of Tex. at Austin*, 570 U.S. 297, 312 (2013). In addition, a policy is not narrowly tailored if it is either overbroad or underinclusive in its use of racial classifications. *J.A. Croson Co.*, 488 U.S. at 507–08; *Gratz v. Bollinger*, 539 U.S. 244, 273–75 (2003).

Here, the government could have used any number of alternative, nondiscriminatory policies. Yet it failed to do so. For example, the government contends that minority-owned businesses disproportionately struggled to obtain capital and credit during the pandemic. But an

obvious race-neutral alternative exists: The government could grant priority consideration to all business owners who were unable to obtain needed capital or credit during the pandemic.

Or consider another of the government's arguments. It contends that earlier coronavirus relief programs "disproportionately failed to reach minority-owned businesses." Gov't Resp. 15 (citation omitted). But a simple race-neutral alternative exists again: The government could simply grant priority consideration to all small business owners who have not yet received coronavirus relief funds. Indeed, the government already requires applicants to disclose what prior assistance they have received—it need only make that criterion dispositive.

Because these race-neutral alternatives exist, the government's use of race is unconstitutional. Aside from the existence of race-neutral alternatives, the government's use of racial preferences is both overbroad and underinclusive. This is also fatal to the policy. *Gratz*, 539 U.S. at 273–75.

The government argues its program is not underinclusive because people of all colors can count as suffering "social disadvantage." Gov't Resp. 17–18. But there is a critical difference between the designated races and the non-designated races. The designated races get a presumption that others do not. And that presumption can only be overcome if someone comes forward with written evidence that the applicant has not been "subjected to racial or ethnic prejudice or cultural bias." 13 C.F.R. § 124.103(a), (b)(3). Since proving someone else has *never* experienced racial or ethnic discrimination is virtually impossible, this "presumption" is dispositive.

The non-designated races start with a much higher hurdle. They must bring forward evidence that they suffered episodes of discrimination, which have "negatively impacted" their "advancement in the business world," and which caused them to suffer "chronic and substantial social disadvantage." *Id.* § 124.103(c)(6). Put this high hurdle against the rapid depletion of the money and the 21-day window, and the hurdle becomes a wall.

The government's policy is plagued with other forms of underinclusivity. Consider the requirement that a business must be at least 51% owned by women or minorities. How does that help remedy past discrimination? Black investors may have small shares in lots of restaurants,

none greater than 51%. But does that mean those owners did not suffer economic harms from racial discrimination? Indeed, the restaurant at issue, Jake's Bar, is 50% owned by a Hispanic female. It is far from obvious why that 1% difference in ownership is relevant. Yet the government fails to explain why that cutoff relates to its stated remedial purpose.

The dispositive presumption enjoyed by designated minorities bears strikingly little relation to the asserted problem the government is trying to fix. For example, the government attempts to defend its policy by citing a study showing it was harder for black business owners to obtain loans from Washington, D.C., banks. Gov't Resp. 15. Rather than simply designating those owners as the harmed group, the government relied on the Small Business Administration's 2016 regulation granting racial preferences to vast swaths of the population. For example, individuals who trace their ancestry to Pakistan and India qualify for special treatment. But those from Afghanistan, Iran, and Iraq do not. Those from China, Japan, and Hong Kong all qualify. But those from Tunisia, Libya, and Morocco do not. This scattershot approach does not conform to the narrow tailoring strict scrutiny requires.

The stark realities of the Small Business Administration's racial gerrymandering are inescapable. Imagine two childhood friends—one Indian, one Afghan. Both own restaurants, and both have suffered devastating losses during the pandemic. If both apply to the Restaurant Revitalization Fund, the Indian applicant will presumptively receive priority consideration over his Afghan friend. Why? Because of his ethnic heritage. It is indeed “a sordid business” to divide “us up by race.” *League of United Latin Am. Citizens v. Perry*, 548 U.S. 399, 511 (2006) (opinion of Roberts, C.J.). And the government's attempt to do so here violates the Constitution.

B.

The plaintiffs also challenge the government's prioritization of women-owned restaurants. Like racial classifications, sex-based discrimination is presumptively invalid. U.S. Const. amend. XIV; *United States v. Virginia*, 518 U.S. 515, 531 (1996). Government policies that discriminate based on sex cannot stand unless the government provides an “exceedingly persuasive justification.” *Virginia*, 518 U.S. at 531. To meet this burden, the government must prove that (1) a sex-based classification serves “important governmental objectives,” and (2) the

classification is “substantially and directly related” to the government’s objectives. *Miss. Univ. for Women v. Hogan*, 458 U.S. 718, 724, 730 (1982) (cleaned up).

The government fails to satisfy either prong. For starters, it fails to show that prioritizing women-owned restaurants serves an important governmental interest. The government claims an interest in “assisting with the economic recovery of women-owned businesses, which were ‘disproportionately affected’ by the COVID-19 pandemic.” Gov’t Resp. 20. But while remedying specific instances of past sex discrimination can serve as a valid governmental objective, general claims of societal discrimination are not enough. *Hogan*, 458 U.S. at 727–29.

Instead, to have a legitimate interest in remedying sex discrimination, the government first needs proof that discrimination occurred. Thus, the government must show that the sex being favored “actually suffer[ed] a disadvantage” as a result of discrimination in a specific industry or field. *Id.* at 728; see *Weinberger v. Wiesenfeld*, 420 U.S. 636, 648 (1975) (“[T]he mere recitation of a benign, compensatory purpose is not an automatic shield which protects against any inquiry into the actual purposes underlying a statutory scheme.”); see also *Craig v. Boren*, 429 U.S. 190, 200–04 (1976) (describing the high bar to using statistics as evidence of discrimination and concluding that “proving broad sociological propositions by statistics is a dubious business”). The government fails that burden here. It gives only a few examples of statistical disparities between women-owned and male-owned businesses. For just one: The government cites a survey that purports to show that women who received Paycheck Protection Program loans asked for 40% less funding on average than their male counterparts. Statements of this nature do nothing to support an inference of intentional discrimination. Without proof of intentional discrimination against women, a policy that discriminates on the basis of sex cannot serve a valid governmental objective.

Additionally, the government’s prioritization system is not “substantially related to” its purported remedial objective. See *Wiesenfeld*, 420 U.S. at 651–53. The priority system is designed to fast-track applicants hardest hit by the pandemic. Yet under the Act, *all* women-owned restaurants are prioritized—even if they are not “economically disadvantaged.” Pub. L. No. 117-2, § 5003(c)(3)(A). So whether a given restaurant did better or worse than a male-owned restaurant next door is of no matter—as long as the restaurant is at least 51% women-

owned and otherwise meets the statutory criteria, it receives priority status. Because the government made no effort to tailor its priority system, we cannot find that the sex-based distinction is “substantially related” to the objective of helping restaurants disproportionately affected by the pandemic.³

The government contends that women “struggled to receive pandemic relief from the Federal government” from prior aid programs. Gov’t Resp. 20 (citation omitted). But as we previously discussed, the government has a ready alternative: Give priority to restaurant owners who did not receive prior aid. There is no need to use sex as a proxy when the government seeks to remedy a problem that is purely economic.

How does the government respond to all this? It faults the plaintiffs for offering “no meaningful argument that a priority period for women-owned businesses is not substantially related to the achievement of that objective.” *Id.* (cleaned up). But that gets things backwards: It was the *government’s* burden to show that its discriminatory policy passes the substantial-relation test. *Virginia*, 518 U.S. at 533 (“The burden of justification is demanding and it rests entirely on the State.”). On this score, the plaintiffs did not need to say a word.

Thus, the government has failed to provide an exceedingly persuasive justification that would allow the classification to stand.

C.

The plaintiffs are entitled to an injunction pending appeal. Since the government failed to justify its discriminatory policy, the plaintiffs will win on the merits of their constitutional claim. And like in most constitutional cases, that is dispositive here. *See Roberts*, 958 F.3d at 416; *Husted*, 697 F.3d at 436; *Deja Vu*, 274 F.3d at 400; *see also Bonnell v. Lorenzo*, 241 F.3d 800, 809 (6th Cir. 2001) (“[W]hen reviewing a motion for a preliminary injunction, if it is found that a constitutional right is being threatened or impaired, a finding of irreparable injury is mandated.”).

³Our court has previously applied strict scrutiny to sex-based affirmative-action programs. *Brunet v. City of Columbus*, 1 F.3d 390, 404 (6th Cir. 1993). A government program that cannot survive intermediate scrutiny surely could not survive strict scrutiny’s more exacting standard. So assuming *Brunet* remains good law after *United States v. Virginia*, the policy would fail under that standard too.

IV.

It has been twenty-five years since the Supreme Court struck down the race-conscious policies in *Adarand*. And it has been nearly twenty years since the Supreme Court struck down the racial preferences in *Gratz*. As today's case shows once again, the "way to stop discrimination on the basis of race is to stop discriminating on the basis of race." *Parents Involved*, 551 U.S. at 748 (plurality opinion).

The government shall fund the plaintiffs' grant application, if approved, before all later-filed applications, without regard to processing time or the applicants' race or sex. The government, however, may continue to give veteran-owned restaurants priority in accordance with the law. This preliminary injunction shall remain in place until this case is resolved on the merits and all appeals are exhausted.

DISSENT

BERNICE BOUIE DONALD, Circuit Judge, dissenting. It took nearly 200 years for the Supreme Court to firmly establish that our Constitution permits the government to use race-based classifications to remediate past discrimination. *See Regents of Univ. of Cal. v. Bakke*, 438 U.S. 265 (1978). It took only seven days for the majority to undermine that longstanding and enduring principle.

The majority’s conclusion that Plaintiffs are entitled to injunctive relief requires us to make several assumptions. The majority’s reasoning suggests we live in a world in which centuries of intentional discrimination and oppression of racial minorities have been eradicated. The majority’s reasoning suggests we live in a world in which the COVID-19 pandemic did not exacerbate the disparities enabled by those centuries of discrimination. The majority’s reasoning suggests that we live in a world in which Congress passed the Restaurant Revitalization Fund (“RRF”) not to aid the nation’s economic recovery, but to arbitrarily provide special treatment to racial minorities and women.

The majority’s reasoning leads it to a puzzling, if not predictable, conclusion that the twenty-one-day priority period in the RRF—a short-term, narrowly tailored, carefully calibrated measure designed to assist businesses most devastated by the pandemic—is unconstitutional. Because I find that the RRF is a carefully targeted measure necessitated by an unparalleled pandemic, and because Plaintiffs have not demonstrated irreparable harm or a likelihood of success on the merits, I dissent.

I.

The constitutional issues involved in this case are controversial, thorny, and unsettled. However, I start by expressing my disappointment in our Court’s use of the emergency appellate docket. Last year, I opined on this issue in the context of a case involving the constitutionality of two COVID-19-related executive orders issued by the Governor of Kentucky. *Pleasant View Baptist Church v. Beshear*, 838 F. App’x 936, 939-42 (6th Cir. 2020). I warned against the “use

of the Court’s emergency docket” as a “forum to advocate for abrupt and sweeping change to well-settled federal law.” *Id.* My concern in that case was with the parties; today, my concern is focused on the Court.

Here, Plaintiffs unsuccessfully sought injunctive relief in the district court averring that the RRF’s 21-day priority period was unconstitutional. During the priority period, the Small Business Administration (“SBA”) provides grants to restaurants that are at least 51% owned and controlled by women, veterans, or “socially and economically disadvantaged” individuals. Pub. L. No. 117-2, § 5003(c)(3)(A); *see* 15 U.S.C. §§ 632(n), (q)(3), 637(a)(4)(A). The RRF—by way of SBA regulation—establishes rebuttable presumptions that individuals of certain races or ethnicities are “socially disadvantaged.” 13 C.F.R. § 124.103. The district court denied Plaintiffs’ request for a temporary restraining order that would have prohibited the government from prioritizing funding based on an applicant’s race or sex. In doing so, the district court rejected Plaintiffs’ claims that the applicable provisions of the RRF violate the Constitution.

This case initially came to us on appeal after Plaintiffs filed an “emergency motion,” contending that they would be irreparably harmed absent immediate intervention from this Court because the pool of money in the RRF was shrinking every day.¹ Specifically, they argued that “[i]f this Court d[id] not promptly halt all payments from the [RRF], the limited available funds w[ould] be fully depleted before the disfavored groups (largely white males) ever have a shot at this much-needed relief.” (Mot. at 23).

At the time of Plaintiffs’ initial filing in this Court, Plaintiffs stated that, as of May 12, RRF applications amounted to a total of \$29 billion in requests, which exceeded the \$28.6 billion that Congress appropriated for the entire program. (Mot. at 9). Plaintiffs conceded, however, that the SBA had only depleted about 20 percent of the available funds. (*Id.* at 9-10). Plaintiffs effectively asked the Court to assume that the government would pay out every application currently pending, such that no funds would remain at the conclusion of the prioritization period. Plaintiffs did not cite to any provision in the American Rescue Plan Act of 2021 (“ARA”), nor any facts in the record, to suggest that such an outcome *was likely* to occur. In short, Plaintiffs

¹As outlined above by the majority, the district court eventually also denied Plaintiffs’ motion for a preliminary injunction, but that came several days later, after Plaintiffs had already filed their appeal in this Court.

had failed to meet their burden of showing irreparable harm. See *D.T. v. Sumner Cnty. Schs.*, 942 F.3d 324, 327 (6th Cir. 2019) (“To merit a preliminary injunction, an injury must be both certain and immediate, not speculative or theoretical.”) (internal quotation marks omitted).²

This Court asked the government for additional facts related to “the status of the [RRF], including but not limited to the amount of unallocated funds remaining, what the daily disbursements have been for the past week, and any projections as to when the fund will run out[.]” (Doc. No. 11). Of course, these facts would help the district court—and then this Court—better understand the priority program framework, and, in turn, whether Plaintiffs were truly at risk of not being able to receive funds. But by requesting that the government provide us with this information, we effectively shifted the burden *to the government* to prove that Plaintiffs *would not* suffer irreparable harm. This perverts the Rule 65 standard for injunctive relief. See *Granny Goose Foods, Inc. v. Bhd. of Teamsters & Auto Truck Drivers Loc. No. 70*, 415 U.S. 423, 443 (1974) (“The burden was on employers to show that they were entitled to a preliminary injunction, *not on the Union to show that they were not.*”) (emphasis added); *N. Am. Coal Corp. v. Loc. Union 2262, United Mine Workers of Am.*, 497 F.2d 459, 465 (6th Cir. 1974) (“[T]he burden of proof remains upon the party seeking the extraordinary relief [...] until all necessary elements to the issuance of an injunction have been established.”).³

Under such novel standards, plaintiffs seeking injunctive relief will only have to show that there is *some possibility* that they *might* suffer possible irreparable harm. Ostensibly, they could label their appeal as an “emergency,” and the appellate court could hold the case

²We could have also dismissed this case on jurisdictional grounds. Plaintiffs’ initial emergency motion addressed only the district court’s denial of their request for a temporary restraining order. “As a general rule, we do not entertain appeals from a district court’s decision to grant or deny a temporary restraining order. That’s because temporary restraining orders are usually of short duration and usually terminate with a prompt ruling on a preliminary injunction, from which the losing party has an immediate right of appeal.” *Maryville Baptist Church, Inc. v. Beshear*, 957 F.3d 610, 612 (6th Cir. 2020) (internal quotation and citation omitted). Before the district court ruled on Plaintiffs’ motion for a preliminary injunction, the government provided sworn testimony to us indicating that it was reserving the full amount of the money Plaintiffs requested. As such, even if we had dismissed Plaintiffs’ initial emergency motion, it would not have affected their ability to obtain relief.

³The impropriety of the burden-shifting aside, it is improper to ask any party to “reinvent the evidentiary wheel and engage in unnecessarily duplicative, costly, and time-consuming factfinding[.]” when only the Court—and not the parties themselves—seeks that additional information. *City of Richmond v. JA Croson Co.*, 488 U.S. 469, 547 (1989) (Marshall, J., dissenting).

indefinitely until the facts develop to the point where imminent harm is discernable. We have never recognized such a low burden for such extraordinary relief; such a process is antithetical to Rule 65. To even consider issuing an injunction on pure speculation that a constitutional violation *might* arise in the future is inappropriate and beyond our role as a reviewing court.

I do not subscribe to new procedures that place this Court in a quasi-fact-finding role, especially where Plaintiffs themselves failed to ask for limited discovery or otherwise explain why any new facts were necessary to the resolution of their claims. They were the party asserting an emergency, and “our adversary system is designed around the premise that the parties know what is best for them, and are responsible for advancing the facts and arguments entitling them to relief.” *Greenlaw v. United States*, 554 U.S. 237, 244 (2008) (internal quotation and citation omitted). *See also Carducci v. Regan*, 714 F.2d 171, 177 (D.C. Cir. 1983) (“The premise of our adversarial system is that appellate courts do not sit as self-directed boards of legal inquiry and research, but essentially as arbiters of legal questions presented and argued by the parties before them.”) (emphasis added).

In any case, the record should be developed before the district court, not here. Simply put, Plaintiffs did not present any evidence with their initial emergency motion that they were at risk of irreparable harm, and it is not our role as a reviewing court to find merit in a claim when it is not apparent from the record.

II.

Other aspects of this appeal concern me as well. If Plaintiffs’ initial emergency motion was limited solely to their request for injunctive relief as to their individual claims, the appeal would have been limited in scope, “allow[ing] us to provide immediate resolution to factually unique circumstances[.]” *Pleasant View Baptist Church*, 838 F. App’x at 942. Moreover, Plaintiffs’ appeal would now arguably be moot, in light of (1) the expiration of the priority period and (2) the SBA’s sworn testimony indicating that the RRF funds are *not* depleted and that the government had set aside the full amount of money that Plaintiffs requested. (Doc. 13).⁴

⁴The majority contends that this case is not moot even with the expiration of the priority period. But that determination rests in part on the assumption that the RRF could be depleted before the SBA processes Plaintiffs’

But in their initial emergency motion, Plaintiffs asked us to go a step further—a big step further—specifically requesting an injunction “ordering Defendants to cease disbursing funds from [the RRF] until this Court or the District Court can rule on a preliminary injunction.” (Mot. at 3). This request was extraordinary and would have had consequences reaching far beyond Plaintiffs’ quest to obtain RRF funding for a single business. The majority properly declined to go that far. With a favorable ruling to Plaintiffs, all eligible restaurant owners within the Sixth Circuit who had already filed applications under the program would have had to wait indefinitely, if not permanently, to learn if they would receive desperately needed monetary aid. These restaurant owners are not parties to this case, and there was no need to subject them to potentially devastating consequences.⁵ After all, courts are arbiters of disputes, not disrupters of emergency relief efforts. The potential nationwide public harm that could have resulted overwhelmingly outweighs any relief that might have inured to Plaintiffs had we granted their claim to freeze the RRF entirely.⁶ For us to even consider granting that type of relief would have been irresponsible without “the careful deliberation that we would normally undertake in a traditional merits case.” *Pleasant View Baptist Church*, 838 F. App’x at 942.

III.

This case also presents dense and delicate issues of constitutional law regarding how courts should scrutinize race-based government action. We should not be addressing these issues

application. While that might be theoretically possible, it looks highly unlikely based on the SBA’s sworn declaration that, as of May 23, 2021, the SBA had disbursed only approximately \$11,345,177,844 of the total \$28.6 billion that Congress appropriated for the RRF. (See Doc. 13 at 3). As we have explained, “[i]f after filing a complaint the claimant loses a personal stake in the action, ‘making it impossible for the court to grant any effectual relief whatever,’ the case must be dismissed as moot.” *Hrivnak v. NCO Portfolio Mgmt., Inc.*, 719 F.3d 564, 567 (6th Cir. 2013) (quoting *Church of Scientology v. United States*, 506 U.S. 9, 12 (1992)). Here, the expiration of the priority period seems to “have completely and irrevocably eradicated the effects of [Plaintiffs’] alleged violation[s].” *Los Angeles Cty. v. Davis*, 440 U.S. 625, 631 (1979).

⁵Although not briefed extensively by the parties, I note that even if there were merit to Plaintiffs’ claims, the Supreme Court has clearly stated that an injunction “should be no more burdensome to the defendant than necessary to provide complete relief to the plaintiffs.” *Califano v. Yamaskai*, 442 U.S. 682, 702 (1979). Plaintiffs have not indicated that any other parties will join this case or that Plaintiffs have attempted to raise any claims on their behalf, so I am not convinced that Plaintiffs even have standing to ask us to declare the entire RRF unconstitutional or otherwise halt the processing of RRF payments. Nevertheless, I make my point above simply to underscore the appropriateness of the emergency motion mechanism for such relief.

⁶This consideration obviously goes to the merits of the case, not just the propriety of addressing the issue on an emergency motion, and, in any event, the majority limits injunctive relief to Plaintiffs’ claims only.

on a whim, particularly when the Supreme Court has informed us that the strict scrutiny analysis as to race-based classifications is not subject to a rigid formula. As Justice O'Connor stated in *Grutter v. Bollinger*, “[c]ontext matters when reviewing race-based governmental action under the Equal Protection Clause.” 539 U.S. 306, 327 (2003). “Not every decision influenced by race is equally objectionable, and strict scrutiny is designed to provide a framework for *carefully examining* the importance and the sincerity of the reasons advanced by the governmental decisionmaker for the use of race in that particular context.” *Id.* (emphasis added); *see also Adarand Constructors, Inc. v. Peña*, 515 U.S. 200, 268 (Souter, J., dissenting) (“[T]he Court’s very recognition today that strict scrutiny can be compatible with the survival of a classification so reviewed demonstrates that our concepts of equal protection enjoy a greater elasticity than the standard categories might suggest.”); *Croson*, 488 U.S. 469, 493 (1989) (plurality opinion) (“Absent searching judicial inquiry into the justification for such race-based measures, there is simply no way of determining what classifications are ‘benign’ or ‘remedial’ and what classifications are in fact motivated by illegitimate notions of racial inferiority or simple racial politics.”); Evan Gerstmann & Christopher Shortell, *The Many Faces of Strict Scrutiny: How the Supreme Court Changes the Rules in Race Cases*, 72 U. Pitt. L. Rev. 1, 34 (2010) (explaining different levels of “deferential scrutiny” applied by courts as to race-based government action).⁷

Here, context matters. The statutory and regulatory provisions at issue are complex, and the RRF is just one component of broad-based emergency legislation designed to fight business fallout that is uniquely and directly tied to the COVID-19 pandemic. In this sense, the RRF is not so much traditional legislation in which the government has sought to encourage a long-term change in public policy but rather a one-off monetary lifeline aimed at ameliorating short-term economic devastation. That distinction is important, and it might call for a different kind of deference to the legislature, even within the broader strict scrutiny framework. We must avoid hurried judicial decision-making under such circumstances.

⁷I also note that although courts have largely operated under the framework that strict scrutiny review applies to “all racial classifications,” *Adarand*, 515 U.S. 200, 227 (1995), even that notion has been called into question. *See, e.g., Johnson v. California*, 543 U.S. 499, 516 (2005) (Ginsburg, J., concurring) (opining “that the same standard of review ought not to control judicial inspection of every official race classification”); *see also Gratz v. Bollinger*, 539 U.S. 244, 301 (2003) (Ginsburg, J., dissenting) (“Actions designed to burden groups long denied full citizenship stature are not sensibly ranked with measures taken to hasten the day when entrenched discrimination and its aftereffects have been extirpated.”).

IV.

Despite my reservations as to whether we have jurisdiction to entertain this appeal—and, more generally, whether this kind of appeal warrants anything other than the narrowest of dispositions—I also conclude that Plaintiffs’ appeal would likely fail on the merits.

Plaintiffs argue that the priority period amounts to impermissible race- and gender-based discrimination in violation of the Equal Protection Clause. “[T]he government has the burden of proving that racial classifications ‘are narrowly tailored measures that further compelling governmental interests.’” *Johnson*, 543 U.S. at 505 (quoting *Adarand*, 515 U.S. at 227). The government asserted “a compelling interest in remedying the effects of past and present discrimination that led to socially and economically disadvantaged business owners having less access to capital and credit, including capital and credit provided through prior COVID relief efforts.” The government also argued that it “has a compelling interest in supporting small businesses owned by socially and economically disadvantaged small business owners who have borne an outsized burden of the economic harms of [the] COVID-19 pandemic.”

Congress heard significant testimony from restaurateurs, economists, experts in finance, and public interest advocates in the lead-up to the passage of the RRF. *See Supporting Small and Minority-Owned Businesses Through the Pandemic* (Feb. 4, 2021) (“*Supporting*”), available at <https://www.congress.gov/117/chrg/CHRG-117hrg43965/CHRG-117hrg43965.pdf>; *Long-Lasting Solutions for a Small Business Recovery* (July 15, 2020) (“*Solutions*”), available at <https://www.congress.gov/116/chrg/CHRG-116hrg41297/CHRG-116hrg41297.pdf>; *Paycheck Protection Program: Loan Forgiveness & Other Challenges: Hearing Before the House Committee on Small Business* (June 17, 2020) (“*Challenges*”), available at <https://www.congress.gov/116/chrg/CHRG-116hrg41293/CHRG-116hrg41293.pdf>.

Those experts offered evidence showing that minority-owned businesses were more vulnerable to economic distress than businesses owned by white entrepreneurs—they were more likely to operate in retail, accommodation, food services, and personal care services industries, which were hardest hit by government shut-down orders and a decrease in foot traffic.

Supporting, at 61. Moreover, minority-owned businesses were more likely to be in areas with higher rates of COVID-19 infections. *Id.*

The district court noted that Congress also considered testimony indicating that, within general historical discrimination in the banking industry, entrepreneurs of color have had specific difficulty in accessing business capital. *Supporting*, at 38, 60-61, 78; *Solutions* at 10, *Challenges*, at 11, 18. Witnesses testified that banks require more documentation from minority applicants but approve loans less often or for lower amounts. *Supporting*, at 48, 60, 80. In addition, witnesses testified that, because of historical difficulties in navigating the banking industry, minority entrepreneurs had lower familial and household incomes, decreasing access to private capital. *Supporting*, at 39, 60.

Moreover, the district court highlighted testimony indicating that minority business owners lagged behind their white counterparts in access even to SBA programs. *See Supporting*, at 62, 78; *Challenges*, at 11, 18. Of particular note to members of Congress, *see, e.g., Solutions*, at 3; 21; 30; *Challenges*, at 3, was the failure of the Paycheck Protection Program (“PPP”)—in which commercial banks were tapped to distribute funds—to reach minority-owned businesses, *see Supporting*, at 8, 11, 38, 48–49, 61, 78–79, 80, 88; *Solutions*, at 10; *Challenges*, at 11.⁸

Taken together, that testimony was enough for the district court to conclude that Congress had a “strong basis in evidence for its conclusion that remedial action was necessary” to address specific past discrimination, particularly as it related to the pandemic. *Associated Gen. Contractors of Oh., Inc. v. Drabik*, 214 F.3d 730, 735 (6th Cir. 2000) (quoting *Croson*, 488 U.S. at 500).

⁸In addition to the ample testimony presented to Congress, history itself speaks to a long tradition of intentional discrimination by the federal government in housing and banking. For example, in 1934, the federal government established the Federal Housing Administration (“FHA”), a government agency that was intended to facilitate the purchase of affordable housing. In practice though, African-American families and other people of color were excluded from the many benefits afforded by the FHA as a result of the discriminatory practice known as redlining. *See generally Laufman v. Oakley Bldg. & Loan Co.*, 408 F. Supp. 489 (S.D. Ohio 1976). Moreover, through the 1990s, the federal government persistently denied African-American farmers applications for farm loans, credit, and other benefit programs. *See Pigford v. Glickman*, 185 F.R.D. 82 (D.D.C. 1999). These actions created generational wealth and stability for white families and generational poverty and instability for African-Americans and other people of color.

The majority mischaracterizes these asserted compelling interests as improper attempts to generally remediate past societal discrimination against minorities. In doing so, the majority overstates and mischaracterizes Congress' objectives in establishing the RRF. As the district court explained, the RRF was specifically targeted to provide aid to businesses who suffered dramatic losses *because of the pandemic*, not simply to provide aid in the abstract to certain minorities who have suffered past discrimination. The analysis does not change simply because some of the factors that might have contributed to general historical discrimination of certain minorities overlap to some degree with Congress' justifications for establishing the priority period.

The majority nevertheless contends that the priority period was overly broad in attempting to accomplish that purpose, because, in the majority's view, Congress did not effectively consider possible race-neutral alternatives to the program. To that end, the majority suggests that Congress could have "simply grant[ed] priority consideration to all small business owners who had not yet received coronavirus relief funds" or that Congress could have more effectively provided relief by "grant[ing] priority consideration to *all* business owners who were unable to obtain needed capital or credit during the pandemic." (emphasis added).

However, completely absent from the majority's analysis on these points is that the priority period was created expressly because the PPP—a prior, race-neutral attempt to assist restaurateurs—failed to reach minority business owners. Moreover, "[n]arrow tailoring does not require exhaustion of every conceivable race-neutral alternative." *Grutter*, 539 U.S. at 339. Legislation is not always perfect, but imperfection does not equate to unconstitutionality.

The majority's suggested alternatives presuppose that Congress had ample time to think of all possible ways in which it could distribute relief to small business owners. In normal times, there may be some force to the majority's position. But these are not normal times, and Congress deemed that it needed to act fast. The principal purpose of the RRF—and the ARA more generally—was to flood the nation with cash in order to keep economic activity moving along. The statute at issue here is benign and not restrictive, and when emergency legislation

meets that standard, we must afford special deference to the legislature, which is far better positioned than the Court to assess what is best for the nation during an emergency.⁹

Further, as the government argues, while the SBA presumes certain races of people qualify as “socially and economically disadvantaged,” that definition does not preclude people of other races from qualifying as well—including white men like Vitolo. On the other hand, because the presumption is rebuttable, individuals who have not suffered the disadvantage targeted by the RRF may properly be excluded during the priority period.

Finally, the district court correctly noted that the twenty-one-day priority period was narrow in scope: it “is time-limited, fund-limited, not absolutely constrained by race” and “does not mean individuals like Vitolo cannot receive relief under this program.” Plaintiffs have not, at this juncture, demonstrated that they are likely to succeed on their argument that the priority period fails strict scrutiny.

V.

Plaintiffs are also unlikely to succeed on the merits of their argument that the RRF’s gender-based priority is unconstitutional. Gender-based discrimination must serve “important governmental objectives” and “the discriminatory means employed [must be] substantially related to the achievement of those objectives.” *United States v. Virginia*, 518 U.S. 515, 524 (1996) (quoting *Miss. Univ. for Women v. Hogan*, 458 U.S. 718, 724 (1982)).

Relevant here, “[s]ex classifications may be used to compensate women for particular economic disabilities [they have] suffered, to promot[e] equal employment opportunity, [and] to advance full development of the talent and capacities of our Nation’s people.” *Id.* at 533 (internal quotation marks and citations omitted) (first and last alterations added). Although the

⁹I am mindful that judicial recognition of race-based classifications based solely on an emergency rationale has, at times, produced unfortunate and unsavory results. See, e.g., *Korematsu v. United States*, 323 U.S. 214, 216, 221, 223-24 (1944) (concluding that government’s decision to “assembl[e] together and plac[e] under guard all those of Japanese ancestry” in “assembly centers” was constitutional based on “[p]ressing public necessity[.]” where “the need for action was great, and time was short.”); see also *Skinner v. Railway Labor Executives’ Ass’n*, 489 U.S. 602, 635 (1989) (Marshall, J., dissenting) (“History teaches that grave threats to liberty often come in times of urgency, when constitutional rights seem too extravagant to endure [W]hen we allow fundamental freedoms to be sacrificed in the name of real or perceived exigency, we invariably come to regret it.”). Had the RRF provision been part of legislation enacted prior to the pandemic, I agree that the analysis *might* be different.

congressional witnesses spent more time discussing how the history of discrimination against minorities led to the need for targeted financial assistance in the wake of the pandemic, they confirmed that much of what they told Congress about minority-owned businesses is also true of women-owned businesses.

Addressing those economic disadvantages by prioritizing access to government funds is a direct way to promote the important government interests of employment opportunities for women and more fully developing the talent and capacity of American businesswomen. *Virginia*, 518 U.S. at 533. Accordingly, Plaintiffs are unlikely to succeed on their argument that the priority for women-owned businesses cannot survive intermediate scrutiny.

Regarding the remaining injunction factors, Plaintiffs argue that they will be irreparably harmed absent the requested relief; they assert that the pool of money in the RRF is shrinking every day and if an injunction is not entered, there will be nothing left for non-prioritized applicants. The government responds that an injunction would delay disbursement of funds to approved applicants. The public interest favors getting relief funds into the hands of business owners as quickly as possible, especially where, as here, Plaintiffs are unlikely to succeed on the merits of their appeal. *City of Pontiac Retired Emps. Ass'n*, 751 F.3d at 430.

VI.

The majority states that “[w]hen the government promulgates race-based policies, it must operate with a scalpel.” But what good is a scalpel if the government is stripped of its other policymaking tools. In this case, the government was uniquely situated to identify a pattern of nationwide discrimination and created legislation designed to provide a temporary remedy. That is not unconstitutional; that is the government doing its job. We are not in the business of telling Congress what it cannot do except in the most extreme of circumstances.

For the foregoing reasons, I would hold that Plaintiffs are not entitled to injunctive relief, and that their emergency motions should have been dismissed.

On a final note, I reiterate that this case should have never come to this point. As I mentioned above, we should have disposed of the initial emergency motion on narrow

jurisdictional grounds. But because of the Court's unusual procedure in handling this appeal, we are now left with a binding published opinion, etched in the stone of time. I urge my colleagues on this Court to consider establishing clear procedures for emergency matters so that we are not again placed in a position where we must address constitutional questions of profound importance on a moment's notice without development of the record.

I dissent.