

Evaluative Report

All Hands on Deck: How LA's AAPI CBOs Addressed Health Inequities through Culturally Competent Covid-19 Outreach and Education Strategies

An Evaluation of the Community Health
Worker Outreach Initiative (CHWOI),
2020-2022



April 2023

Partners



AAPI Equity Alliance

AAPI Equity Alliance is dedicated to improving the lives of Asian American and Pacific Islanders through civic engagement, capacity building, and policy advocacy.



Asian Resources, Inc

Asian Resources, Inc. is a non-profit, community-based organization established in 1980 with offices in Sacramento and Los Angeles. ARI is dedicated to providing outreach, education, multiple social services and advocacy on behalf of Asian Americans, Native Hawaiians and Pacific Islanders, immigrants, refugees and communities who are limited-English proficient across California.



Pacific Asian Counseling Services

Pacific Asian Counseling Services (PACS) provides culturally responsive and trauma-informed mental health services to low-income individuals, families, and communities in Los Angeles County. As one of the few community mental health agencies specializing on Asian Americans and Pacific Islanders, PACS works collaboratively with our clients, community partners, and stakeholders to advocate for language justice, equity, and systemic change.

Community Partners



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About CHWOI

In the fall of 2020 (a little more than 6 months after the first stay-at-home order in Los Angeles), the California Community Foundation (CCF) reached out to AAPI Equity Alliance (formerly Asian Pacific Policy and Planning Council or A3PCON) and requested a proposal to conduct COVID-19 outreach and education in the diverse Asian American & Pacific Islander (AAPI) communities. CCF was acting as an intermediary between the LA County Department of Public Health (DPH) and community-based organizations (CBOs), by streamlining DPH's contracting and monitoring processes, so that it could disburse federal funding for COVID-19 relief (under the CARES Act) as quickly as possible to organizations to educate hard-to-reach communities about COVID-19 mitigation efforts. The outreach funding had to be dispersed quickly for the work to be completed immediately in the three months between October and December 2020.

With no one organization serving all ethnic AAPI populations across the vast region of Los Angeles (LA) County, CCF approached AAPI Equity Alliance because of its longstanding history as a membership coalition serving diverse AAPI communities and subgroups. Comprised of over 40 AAPI serving CBOs, AAPI Equity Alliance has a storied history of coalescing quickly, often through its committee structure, to address issues such as health, mental health, youth development, substance use, and hate crimes. In fact, the need for diverse organizations with ethnic and regional specializations banding together in collaboratives to serve the complex pan-ethnic AAPI population in LA was the bedrock for the founding of the AAPI Equity Alliance in 1976.



In response to the CCF request, Manjusha Kulkarni, AAPI Equity Alliance's Executive Director, reached out to Doreena Wong, Policy Director and Leslie Toy, Program Director at Asian Resources, Inc. (ARI) and Myron Dean Quon, then-Executive Director at National Asian Pacific American Families Against Substance Abuse (NAPAFASA), to pull together a collective of outreach and education partners for this project. As recently as the previous summer, Manjusha, Doreena and Myron had already started discussions of resurrecting the Health Committee at AAPI Equity Alliance. This project nicely dovetailed with that discussion. Over the course of the project, Myron transitioned to become the Executive Director of Pacific Asian Counseling Services (PACS), and PACS became one of three lead agencies for this initiative, along with AAPI Equity Alliance and ARI.

With \$1 million in funding and just three months to complete the goals of the project, the three leads had to pull together a coalition quickly to support the Community Health Worker Outreach Initiative (CHWOI). This project was only possible because of the collective experience, trust and longstanding relationships substantive leads had developed with the outreach partners. They were familiar with their capacity, expertise and trusted relationships with their community members, and knew they were currently conducting the needed outreach, education and navigation services related to health coverage programs and other public benefits, including COVID-19 in LA County. Because of the existing and strong networks, creating the CHWOI collaborative only required communicating, sometimes through phone calls, to gauge the interest and bandwidth of their peer directors at each of these organizations.

After that, the leads negotiated the number of community health workers (CHW) each organization could take on or be willing to hire to support this short-term (at the time) project. This initial funding yielded 51.5 full-time equivalents (FTE) of CHWs, spanning across 15 CBO outreach partners.

The outreach partners believed that the work was so important (especially with the introduction of the vaccines in late 2020) that they wanted to continue it after the funding period ended in December 2020. However, DPH was not able to commit to additional funding until later in January 2021. This funding gap resulted in some of the partners having to lay off their CHWs. The second round of CHWOI funding would run again for another three months until the end of March 2021, for a much smaller funding amount of \$308,796.35. By then, because of the funding gap, the collaborative lost five outreach partners but enlisted two additional CBOs, resulting in the 12 outreach partners that are included in this report.

Table 1. CBO outreach partners in the first two CHWOI funding periods

CHWOI Outreach Partners	Oct - Dec 2020	Late Jan - Mar 2021
Asian American Drug Abuse Program (AADAP)	✓	✓
Access to Prevention Advocacy Intervention & Treatment (APAIT)	✓	✓
Asian Pacific Counseling & Treatment Centers (APCTC)	✓	
Asian Pacific Islander Forward Movement (APIFM)	✓	✓
Asian Youth Center (AYC)	✓	✓
Chinatown Service Center (CSC)	✓	
Empowering Pacific Islander Communities (EPIC)		✓

Table 1. Cont. CBO outreach partners in the first two CHWOI funding periods

Families in Good Health (FIGH)	✓	✓
Korean American Coalition (KAC)	✓	✓
Korean American Family Services (KFAM)	✓	
National Asian Pacific American Families Against Substance Abuse (NAPAFASA)	✓	
Pacific Asian Consortium in Employment (PACE)	✓	✓
Pacific Asian Counseling Services (PACS)	✓	✓
Search to Involve Pilipino Americans (SIPA)		✓
South Asian Network (SAN)	✓	✓
Southeast Asian Community Alliance (SEACA)	✓	
Thai Community Development Center (Thai CDC)	✓	✓

In addition, AAPI Equity Alliance hired Michelle Sewrathan Wong to serve as the Managing Director of Programs and lead this project during the new phase. By this time, the partnership was also able to secure other funding sources. With the advent of the COVID-19 vaccines, they were able to secure \$350,000 of funding from the Public Health Institute for the CHWOI partners to include the promotion of vaccines and hosting vaccine clinics in their outreach activities between April and July 2021. The partners also successfully applied for DPH's County Community COVID-19 Equity Fund Project (EF) program using funding from the Centers for Disease Control and Prevention for COVID-19 outreach and education.

This funding of \$399,000 helped bridge the funding gap in April and May 2021, with continued funding until November 30, 2021. DPH extended the CHWOI funding period for the second time; the third iteration started from June to December 2021, for \$1,455,871.

One of the major challenges with having these two sources of DPH funding (CHWOI & EF) was that the collaborative had to identify distinct partners to support each funded initiative, as there could be no overlapping funding between the same community partner. As a result, the collaborative transitioned AYC and KAC to be the subcontractors of the EF grant starting in June 2021, while the other 10 outreach partners remained part of the original CHWOI cohort. This caused a great deal of work and negotiation between the collaborative leads, partners, and DPH.

In 2022, for the fourth iteration of the CHWOI project, DPH approved both a no-cost extension and an additional funding amount of \$994,915, so that the partners could continue their outreach and education work until June 2022. Also, the partners received a second iteration of the EF funding between April and June 2022, but this time, AYC was the lead agency for this contract, due to additional negotiations with DPH and our partners. "Because of the timing of the funding, it was already hard for our partners to plan and train their staff when the funding was so brief and temporary," reflected one of the leads. "But these funding gaps complicated it even more. It was also a lost opportunity because we lost many trained CHWs and their expertise and had to spend time training new staff."

The trust between the leads and the outreach partners was the key ingredient in how the collaborative was able to get the project off the ground so quickly at the outset of the pandemic in the Fall of 2020. The trust factor was also salient throughout the initiative when funding was uncertain, with the work of community partners becoming more urgent as the pandemic continued to devastate their communities. The outreach partners not only represented different geographical regions and ethnic communities, but also different areas of work. The urgency of the pandemic required all hands on deck. The initiative allowed each CBO to leverage their unique strengths to conduct their outreach, not forcing a one-size-fits-all model. But these outreach partners were more than mere subcontractors to the leads. The collaborative held (and continues to hold) monthly meetings to share best practices, coordinate efforts and provide important updates with the entire Health Collaborative.

The Health Collaborative consists of outreach partners from the CHWOI, Community Equity Fund and Pediatric

Vaccine Initiative; all DPH funded projects. In addition to these monthly meetings, health leads also meet bi-weekly with grant specific partners to provide targeted support and resources.

This was also a space where the leads listened to the partners' challenges. In turn, the outreach partners trusted the leads to provide support and technical assistance, as well as advocate on their behalf for additional funding and to streamline the County processes from subcontracting to monitoring and payment. When the funding in the last round was less than in previous iterations, the leads had open and honest conversations about equitable distribution of the funding for CHWs across all outreach partners. These difficult conversations could have derailed many collaboratives, but the level of transparency, along with a shared commitment to protect all the AAPI communities in the county, the leads believed, made this collaborative successful and able to thrive.



"Outreach partners trusted the leads to provide support and technical assistance, as well as advocate on their behalf for additional funding and to streamline the County processes from subcontracting to monitoring and payment."

About This Report

The evaluation report describes the plethora of outreach strategies to educate the Asian American and Pacific Islander communities in Los Angeles, and documents the innovations, successes and lessons learned from the leads and subcontracting CBO “outreach partners” that made up the CHWOI collaborative and EF.

Data sources used to develop this report include 1) monthly reports submitted by each partner to AAPI Equity Alliance; 2) outreach data submitted by each partner to the Department of Public Health, and 3) key informant interviews with each outreach partner and the leads in the CHWOI collaborative.

The evaluator conducted two rounds of interviews with each of the ten subcontracting partners. In one case, the partner consisted of two teams targeting different populations, and the evaluator conducted separate interviews with each team. The first round took place in October/November 2021, and the second round, in February/March 2022. In addition, two other community-based organizations, Asian Youth Center and Korean American Coalition, were part of this collaborative in late 2020, but were moved to a different funding source (EF) in mid-2021. The evaluator conducted only one interview with each of these two agencies in January 2022. Finally, the evaluator interviewed the leaders of the three lead agencies (AAPI Equity Alliance, Asian Resources, Inc., and Pacific Asian Counseling Services) together in April 2022. In total, 25 interviews were conducted for this report. Quotes from all interviews used in this report have been edited for clarity and conciseness.



Because all the partners conducted their outreach differently, each leveraging their unique strengths, relationships, and cultural competence, in their respective ethnic and geographic target populations, the report includes an appendix with a program profile for the ten partners as well as the two agencies who have transitioned to the EF grant in mid-2021. Each program profile was reviewed and approved by the respective outreach partner in April 2022.

This report lifts up unique and innovative contributions from each of the outreach partners and makes recommendations about future community health worker (CHW) strategies based on the cross-cutting lessons learned.

Outreach Overview

As of July 1, 2022, the CHWs from the ten CHWOI partners conducted 7,491 outreach activities. Of these, 62% were conducted in person and 38% virtually. That accounted for 283,787 people reached (31% in-person and 69% virtual). The outreach data from the Community Equity (EF) grant included an additional 5,375 outreach activities to 451,051 individuals. The EF outreach was overwhelmingly virtual and telephonic, accounting for over 94% of outreach activities. Figures 1 and 2 further break down the different outreach categories for the two types of outreach for CHWOI and EF outreach partners combined, reflecting a total of 54.6% of outreaches conducted in-person and 76.2% of outreaches conducted virtually.

During this time, CHWOI outreach partners distributed 28,354 printed materials, 132,805 face masks, and 33,627 hand sanitizers. EF outreach partners distributed an additional 8,453 printed materials, 79,870 face masks, and 7,436 hand sanitizers. (See Table 2.) In early 2022, during the Omicron surge, many partners also began to distribute antigen home testing kits, which had become scarce and exorbitantly expensive (even if one could be located in the marketplace) to many community members at that time.

As the outreach data suggest, the partners reached more people via virtual outreach than in person, primarily due to COVID-19 restrictions. In late 2020 and early 2021 (before the vaccines became widely available) and the following summer (during the Delta surge), most outreaches were limited to virtual (e.g. phone-banking, social media, etc.) to keep both CHWs and community members safe from close contact. Many

in-person outreach activities also aimed to build deeper relationships with individual community members and could be more time-consuming. For instance, one social media post could be viewed by hundreds or even thousands of people, whereas an in-person encounter reached much fewer people and could take an hour or even more.

"The strength of the CHW model relies on outreach that is deep, strategic, and culturally specific."

The CHWs in this collaborative highlighted the distinction between the number of encounters and outreach effectiveness, as the outreach and education numbers on their own do not necessarily reflect our effectiveness since multiple efforts were needed to truly reach and inform their community members. Each method is necessary to create a "surround sound" effect to reinforce health messages for community members who are diverse not only in geography and race/ethnicity, but also age, immigration status, preferred language, employment status, religious affiliation, technological proficiency and past experience with public health institutions. As the report will show later, the strength of the CHW model relies on outreach that is deep, strategic, and culturally specific.

Figure 1. Outreach Activities by Type (In-person)

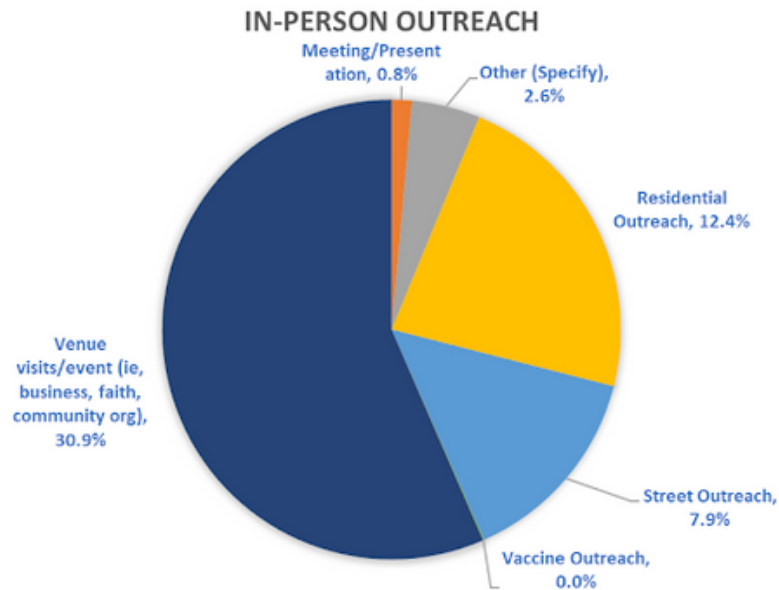


Figure 2. Outreach Activities by Type (Virtual)

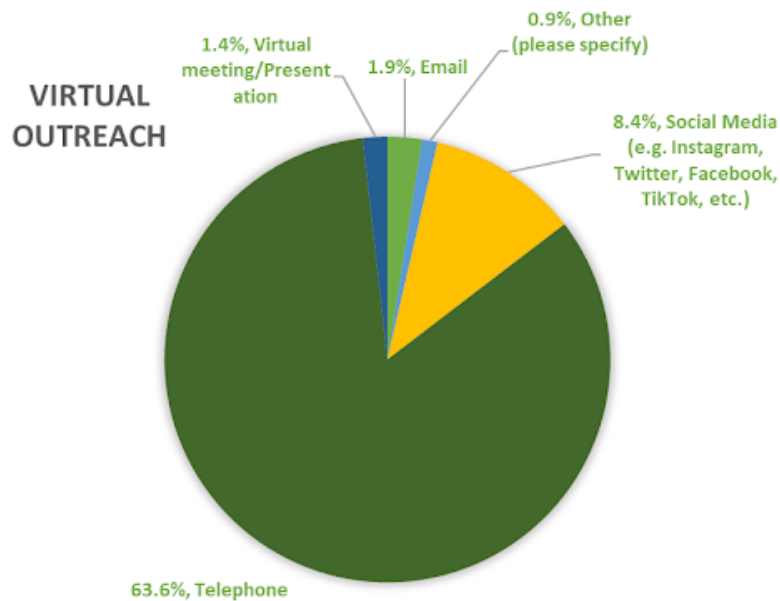


Table 2. Materials Distributed by Partners

	CHWOI	EF	TOTAL
Printed Materials	28,354	8,453	36,807
Face Masks	132,805	79,870	212,675
Hand Sanitizers	33,627	7,436	41,063

Target Populations

The CHWOI partners collectively penetrated many parts of Los Angeles County. Their COVID outreach and education went beyond their traditional target populations and service areas. Although many partners are headquartered in the ethnic enclaves of their respective target AAPI communities, these enclaves were also home to Black, Latinx, and other immigrant communities (such as Armenian) who were most vulnerable in the pandemic. These enclaves could also contain areas disproportionately impacted but were too small to be identified by epidemiological data. In addition, AAPI communities are geographically dispersed and not limited to one place or zip code, with ethnic communities penetrating neighborhoods throughout LA County.

This report includes combined geographical outreach data from both CHWOI and EF grants because the partners from both funding sources coordinated to cover LA County as widely as possible and only showing CHWOI data would not tell the whole story. As of July 2022, 2,935 of the 7,802 outreach activities did not specify their areas. The remaining included outreach in the following areas:

- Long Beach region - 54.5%
- Metro LA - 14.2%
- South Bay & Beach Cities (Carson, Gardena, Hawthorne, Torrance, etc.) - 10.4%
- San Gabriel Valley - 6.7%
- South LA - 6.7%
- Southeast LA County (Artesia, Bell, Bellflower, Cerritos, Downey, Lakewood, Norwalk, Paramount, South Gate, etc.) - 5.6%
- San Fernando Valley - 1.4%
- West LA - 0.6%

"Because the AAPI communities are very diverse, with many different ethnic subgroups, dozens of different cultures and languages, different immigration histories and levels of trust with government agencies, aggregated data masked many inequities faced by our subpopulations, especially during the COVID-19 pandemic."

Originally, DPH assigned neighborhoods through block codes that had the highest COVID-19 case rates, but the partners knew that the approach was not adequate to identify AAPI communities. Both the state and DPH used a geographically-based tool, the Healthy Places Index (HPI), which was used to identify specific areas and zip codes that were most disproportionately impacted by the pandemic and based the allocation of resources for outreach, education and vaccination distribution locally on HPI. The HPI did not originally take into account race and ethnicity, and it did not disaggregate racial and ethnic categories. "Because the AAPI communities are very diverse, with many different ethnic subgroups, dozens of different cultures and languages, different immigration histories and levels of trust with government agencies, aggregated data masked many inequities faced by our subpopulations, especially during the COVID-19 pandemic."

¹ <https://www.latimes.com/california/story/2020-07-19/california-pacific-islander-native-hawaiian-communities-hit-hard-by-coronavirus>

For example, Pacific Islander communities have experienced one of the highest infection and death rates due to COVID-19, but Pacific Islanders are dispersed throughout LA County, and the block-code approach missed many of them. The block-code approach focused on where those most vulnerable to COVID-19 lived, but it did not account for smaller, dispersed populations, such as Asian Americans or Pacific Islanders, which could be hidden within the larger zip codes. Moreover, it did not account for the actual living patterns of community members, who do not always receive public health information only in or near their places of residence. For instance, CHWs at Search to Involve Pilipino Americans (SIPA) explained that while Filipinos could be found in many different parts of Los Angeles County, many who live outside of Historic Filipinotown still maintain a connection to that part of the city and relied on SIPA for information such as vaccine resources and other pandemic updates. Similarly, the Korean CHWs at Pacific Asian Consortium in Employment (PACE) and Korean American Coalition (KAC) said that while many Koreans reside outside of Koreatown, they still commute to this part of the city where they work, eat, shop, worship, and socialize. In fact, they were more likely to come across COVID-19 information in Koreatown than in the neighborhood where they reside.

Sometimes, a partner was able to expand their outreach areas because of new connections made for this project. A CHW at Empowering Pacific Islander Communities (EPIC) met a community member who lived in Monrovia through their virtual outreach and that encounter led to a new collaboration that took EPIC to the Micronesian community in the foothill community in the San Gabriel Valley. CHWs at both Families in Good Health (FIGH) and Pacific Asian Counseling Services (PACS) explained that many clients who live outside of

their service areas often come to their offices for services, including clients who had started receiving services when they were residing in the neighborhood served by these organizations but had since been pushed out by gentrification and rising housing costs in Long Beach. CHWs sometimes leveraged these relationships to expand their outreach to these clients' new community neighborhoods and networks, where health disparities often follow.

Early on in the initiative, the collaborative was able to negotiate improvements in the HPI tool and DPH's assignment of targeted populations. After discussions with both the Public Health Alliance (the lead organization invested in and charged with developing the HPI) and DPH, the County agency realized that including a population-based approach would be more effective to reach AAPI communities rather than limiting the collaborative to certain areas or block codes.



A selfie of the PACE CHWOI team at an outreach tabling event.

As a result, our outreach partners were able to identify their targeted geography, and in many cases, their outreach transcended their traditional geographical service areas, as documented in Table 3.

Table 3 captures the primary and secondary target populations and geographic regions for each CHWOI or EF partner. (The EF partners were noted with an asterisk [*].) Secondary targets represent many of these new or strengthened connections to populations the partners developed beyond their traditional service areas and as a result of the outreach project.

Table 3. Target Populations

Outreach Partners	Target Populations		Geographical Regions	
	Primary	Secondary	Primary	Secondary
AADAP	Vietnamese, Cambodian, Filipino, Latinx, Black	Homeless	South LA (2nd supervisorial district). Compton, South Bay, Long Beach	
APAIT	LGBTQ people of color, homeless		Central LA (Koreatown, Hollywood), South LA	Long Beach, West Hollywood
AYC*	Asian (Chinese & Vietnamese) & Latinx Immigrants		San Gabriel Valley (SPA 3) - Alhambra, Arcadia, Monterey Park, Rosemead, San Gabriel, Temple City	
EPIC	Native Hawaiians & Pacific Islanders		South Bay, Compton	Long Beach, Lakewood, Wilmington, Monrovia/ Pasadena
FIGH	Cambodian, Latinx	Chinese	Long Beach	Carson, Lakewood, Cerritos, Paramount, Downey, Cudahy, Hawthorne, Rosemead, El Segundo, Lomita, Gardena, San Pedro & Wilmington

Table 3. Target Populations

Outreach Partners	Target Populations		Geographical Regions	
	Primary	Secondary	Primary	Secondary
KAC*	Korean		Los Angeles County	
PACS	Cambodian, Filipino	Korean, Latinx	Long Beach, South Bay, San Pedro	
PACE	Japanese, Korean, Latinx		East LA, Koreatown	
SAN	South Asians		Artesia, Little Bangladesh, University Park (USC)	La Mirada, Cerritos, Norwalk, Torrance, Culver City, Pacoima and Long Beach
SIPA	Filipino	Latinx, Cambodian, Korean, Armenian	Historic Filipinotown, East Hollywood, Highland Park, Echo Park, Silver Lake, Westlake	
Thai CDC	Thai, Latinx	Restaurant & massage workers, Armenian	Hollywood, North Hollywood, Sun Valley	La Puente



Photo from SIPA's Holiday Event where they provided COVID vaccines and boosters and celebrate with their community.

Outreach Insights

OUTREACH INSIGHT #1:

CHWs Had to Be Nimble in Response to the Evolving and Unpredictable Pandemic

CHWs had to contend constantly with the ever-changing conditions of the COVID-19 pandemic. Initially (late 2020 and early 2021), because of the holiday surge and the extension of stay-at-home orders, CHWOI outreach partners were constrained in the type of outreach they could conduct. Shortly thereafter, the Moderna and Pfizer vaccines became available for the older adult population and essential workers in January 2021. That month, Los Angeles County became the first county in the U.S. to record a million COVID-19 cases. In early March 2021, the FDA authorized the Johnson & Johnson one-dose vaccine to be another option for eligible populations. All the vaccines became eligible for people with underlying health conditions by the middle of that month. As the positivity rate in California dipped below 2% in March, some California businesses, including sports and concert venues, theme parks, theaters, and breweries, prepared to reopen with some restrictions. The state also implemented an age-based vaccine protocol, starting with people over the age of 50 becoming eligible on April 1. With renewed optimism, Governor Gavin Newsom announced on April 6 a plan to reopen California's economy by June 15. Later that month, the state, following CDC guidelines, relaxed the mask mandate in outdoor venues. That mandate would be eased for indoor settings the following month. In late May, in anticipation of the reopening of the California economy (15

months into the pandemic), Governor Newsom announced a plan to incentivize California who had not been vaccinated yet to do so, including a lottery program called "Vax for the Win."

On May 31, 2021, the positivity rate was at a record low of 0.7% for the state, but that did not last for long. Less than two months later, that rate rocketed to over 5.0%, prompting Los Angeles County to reinstate the indoor mask mandate on July 18. This marked the beginning of the Delta surge that summer. Vaccines would be mandated for some sectors, including state, health care, and some private sector workers as well as college students and customers at certain establishments, like restaurants.

Conditions improved in early Fall and many restrictions eased. The booster shots were authorized by the FDA and became available in November for anyone who had received their vaccine at least six months before. Also by November, children as young as 5 were eligible to receive their first vaccine, just in time not only for the holiday season but also the first documented case of the Omicron variant in California in early December. In the same month, Omicron became the dominant COVID strain in the U.S. The positivity rate in California went from 2.3% on December 15 to 11.2% on December 29 (just two weeks later) and almost doubled to 22% in the first week of January 2022. The positivity rate plateaued the following week and dropped below 2% by early March.

By May 2022, the first wave of teenagers receiving the vaccines last year became eligible for the booster, and people over the age of 50 who had their first booster

six months before could receive the second booster. In mid-June, the FDA granted emergency use authorization for both Pfizer and Moderna for young children as young as 6 months, as the hyper-infectious subvariant BA.5 of the Omicron strain continued to spread across the country.

"With a pandemic this unpredictable, the constantly changing requirements and information dictated what types of outreach were possible at a given time, and the outreach partners had to be nimble and creative in response." The ongoing uncertainties also created anxiety and confusion among community members. They had legitimate questions about the discrepancies in policies across different jurisdictions, efficacies of different vaccines, boosters and treatments, their eligibility during the rollout process, and so forth. The rampant spread of misinformation on ethnic social media networks, (including on social media channels that are popular with immigrant AAPI communities), CHWs had to help community members steer clear of "fake news," and craft clear, reassuring and practical messages about how community members could protect themselves. Messages had to evolve over time as well. With constant updates, a message that was delivered just weeks (or even days before) could become outdated quickly. Several partners learned to add dates on their flyers and social media posts, so that community members could see how old the information was and make their health decisions accordingly.

"With a pandemic this unpredictable, the constantly changing requirements and information dictated what types of outreach were possible at a given time, and the outreach partners had to be nimble and creative in response."



Staff from PACE tabling at a health outreach event

"COVID-19 outreach and education was about continuous relationship-building to keep community members in conversation throughout the pandemic."

The complexity of the pandemic illustrates that COVID-19 outreach was not a "one-and-done" strategy. Outreach was more than a single encounter that the quantitative data might suggest. The rational "theory of change" of accurate information leading to health-seeking behavior was not nearly adequate. Instead, outreach partners all believed that COVID-19 outreach and education was about continuous relationship-building to keep community members in conversation throughout the pandemic, especially those who had the least access to health resources and/or were "on the fence" about getting the vaccine.

OUTREACH INSIGHT #2:

Trust and Collaboration Was the Key to Effective Outreach

During periods when the case rate was low, CHWs resumed in-person outreach, including street outreach, door-knocking, canvassing, and community meetings and events. Outreach partners unanimously agreed that outreach was most effective when they collaborated with other local groups, including faith institutions, cultural groups, schools, and other community-based organizations. These collaborations brought different strengths from each partner, including access to venues, staffing, connections to diverse constituencies, and collateral materials that attracted people's attention and even incentivized vaccinations. Through these collaborations, outreach partners were able to amplify their messages with other trusted messengers and bring pop-up vaccine clinics to underserved areas.



A youth community member getting vaccinated at SAN's COVID vaccination event.

For instance, SIPA staff acknowledged that many immigrant residents in Historic Filipinotown were skeptical of the vaccine initially because there had not been a clinic in their neighborhood and that this exclusion gave them the feeling that “the vaccine was not for them.” In response, SIPA staff worked with Asian Americans Advancing Justice-Los Angeles to bring the first pop-up clinic to this community. They also worked with a local school to host the clinic, handled the promotion in the community, and helped community members get to the site. This not only provided the first 33 local vaccinations in this community, but it also began to change people's minds about the importance of vaccination.

For many years, outreach partners had provided culturally and linguistically appropriate services in their respective service areas and communities. They built trust and goodwill in the community by cultivating working relationships with community partners. In fact, this “social capital” was why they were asked to be part of the CHWOI collaborative. They were able to leverage these relationships quickly against a very aggressive and unpredictable pandemic early on. They were ready, at a moment's notice, not only to host their own outreach events but also to show up at health fairs, community meetings, cultural events, and other local events organized by their community partners. For instance, right after the first stay-at-home order in March 2020, Thai CDC launched its CARES Program (COVID Aid Rapid Response Relief and Emergency Services) to provide cash assistance and fresh produce (through a partnership with API Forward Movement, another CHWOI partner) in order to address the immediate basic needs of vulnerable community members. In the two years since the pandemic, this program distributed over \$2 million to more than 2,000 households through 30 “COVID relief days” at their office.

Many outreach partners especially built on their existing relationships with faith-based organizations. Faith-based leaders were often the most trusted messengers in a community. Churches, temples, and mosques were organic places for community gatherings, often attracting co-ethnicities from all over Los Angeles County. Some who might have trouble asking for help elsewhere felt more comfortable accessing resources or processing grief there. CHWs at South Asian Network (SAN) had built robust relationships with various mosques. Even before the pandemic, they had conducted health workshops at these venues on different topics, such as cancer awareness. When the pandemic began, mosque leaders actually invited them to talk to their members about how to protect themselves against COVID-19. Thai Community Development Center (Thai CDC) also worked with Buddhist temples to host vaccine clinic sites. In addition, their work with a Seventh Day Adventist (SDA) church in Hollywood led to partnerships with two other SDA churches in the county, and Thai CDC was asked to train their missionaries to incorporate COVID-19 information in their own local outreach.

In some populations, the faith community was divided in their response to the pandemic. As one CHW in the Pacific Islander communities explained, some church members might adopt a fatalistic attitude of “God’s will” as an excuse not to get the vaccine. To this, the CHW replied, “The Lord takes care of those who take care of themselves.” This illustrates the importance of collaborating with religious allies in these communities. That CHW acknowledged that when she came across a community member who was hesitant about the vaccine, she asked the pastor where this community member attended church to talk directly to the community member. This strategy successfully persuaded that person to get vaccinated, and when he came back for

the second dose, he brought his wife (a cancer survivor) and his elderly uncle for their first shot. Working with faith leaders has been fruitful in numerous other instances.



SAN staff at a check-in table for their vaccination event.

In addition, many outreach partners expanded their network of community collaborators and developed new relationships that could lead to future collaborations. Sometimes, the CHWs who hailed from the community they worked in, activated their own personal networks. Collectively, the CHWs were an eclectic mix, composed of faith leaders, sport coaches, artists, fitness instructors, and they often came up with innovative ways to reach different sectors in their target communities.

One of the CHWs at Asian & Pacific Islander Forward Movement (APIFM), for instance, was a football coach at Mount San Antonio College. He was not only able to outreach to the players and staff on that team, but he was able to access the network of community sports in the Pacific Islander communities to talk to families with young people, at a time when the vaccine was becoming available to youth. One CHW at EPIC was an artist, and they leveraged their relationship with the Pacific Islander Ethnic Art Museum to hold events there for children and families that allowed them to process their grief and share coping strategies during the pandemic through artistic activities. This CHW also curated an exhibit at the museum called TOE FO`I: The Return (March - August 2022) that showcased five Pacific Islander artists “as healers who move us collectively through this hurdle of misinformation, fear, mistrust and entitlement.” Another EPIC CHW was a pastor’s wife, and she was able to connect with the vast network of Pacific Islander churches locally, not only for EPIC, but also for APIFM. She also innovated doing COVID-19 outreach at bingo halls in some of the churches. The Korean CHW at PACE was a reserve police officer, and he collaborated with the local police department to conduct outreach at community events organized by the department in Koreatown.



Kiana "Kiki" Rivera, storyteller at EPIC and the guest curator for the TOE FO`I: The Return exhibition.

OUTREACH INSIGHT #3:

Community Members Were Most Receptive to Outreach When They Were Treated as Whole Human Beings

The COVID-19 pandemic was a public health crisis where misinformation was as contagious and virulent as the coronavirus itself, provoking an array of polarizing reactions. Whether dealing with fatigue, confusion, or outright distrust from the target populations, CHWs had to be very creative, empathetic and strategic in how they talked to and built relationships with community members, as the pandemic raged on. If they hosted a workshop on only COVID-19, few people would show up. Asian Youth Center (AYC) staff shared that their first online COVID-19 workshop in March 2021 (when the vaccines became available to most adult populations) attracted over fifty participants because of their curiosity about the vaccines, but that attendance dwindled steadily over time and by summer, the organization stopped COVID-19 only workshops altogether. Similarly, if a CHW approached a community member directly about whether they had been vaccinated, they would likely be ignored or greeted with a dismissive wave instead.

Many CHWs recognized that, in order to get to the COVID conversation, they needed to show interest in other areas of the community member's life. Community members wanted to be viewed as not just a vaccinated or unvaccinated body, but a whole human being with complex needs, hopes and concerns. Especially for vulnerable communities, COVID-19 brought not only the potential of illness and death, but, even for the uninfected and vaccinated, also grief, anxieties, job insecurity, food and housing instability, and economic woes - pretty much all the basic needs in

the hierarchy of needs that make help-seeking behavior difficult when they are not met.

All the outreach partners accomplished this by integrating COVID-19 outreach not as a stand-alone program, but as an integral part of a plethora of services and programs that they had already been providing to the community. For instance, food distribution was an organic venue for CHWs to educate some of the most vulnerable people in the community on how to protect themselves and provide them with PPE, including masks and hand sanitizers. APIFM distributed fresh produce to many food-insecure community members. Not only did they include COVID-19 flyers and other information in their outreach, but they also supported other outreach partners' efforts who used APIFM's produce distribution in their outreach efforts. During the pandemic, AYC expanded its monthly food pantry to an almost daily operation. These are some examples of program integration. Other outreach partners had their own unique configuration of programs, including public benefits enrollment, employment support, youth development, small business outreach, mental health and wellness, alcohol, tobacco and other drug prevention, homeless outreach, civic engagement, and worker's rights education. For instance, Access to Prevention Advocacy Intervention & Treatment (APAIT) incorporated COVID-19 education in Midnight Stroll, their regular outreach to those living and working in the streets of Hollywood and Koreatown, passing out masks, hand sanitizers, and COVID information, along with other regular swag, like snacks, while referring people to different services.

Leading an outreach encounter by addressing basic needs not only provided community members with immediate relief, but it also allowed CHWs to build more authentic relationships with them.

Over time, it could even disarm those who were skeptical or even resistant to COVID-19 information. Many CHWs shared stories about how, by keeping the communication channel open, these resistant community members began to see that the CHWs truly cared about their well-being. As a result, the CHWs gained enough trust and credibility to convince them to practice safer behavior, including getting vaccinated. Some skeptical community members even felt safe to finally approach CHWs on their own for other types of help, such as seeking mental health and substance addiction services.



Staff from SAN at their vaccination event.

This often meant that the actual roles that CHWs performed went beyond mere outreach and education. Passing out information is a one-way communication, not a solid foundation for relationship building. In reality, like an intake worker, CHWs assessed the unique and multiple needs of individual community members and helped them craft a path to well-being. Like a community liaison, CHWs facilitated partnerships between their organization and other public and private entities to cobble together a multifaceted outreach program. They connected and referred community members to resources and programs, and like a case manager or system navigator, they followed up to make sure they accessed

these resources and/or these resources were working for them. For instance, CHWs at Pacific Asian Counseling Services (PACS) were the go-to resource for many small business owners in Cambodia Town (Long Beach), because they had helped these ethnic businesses apply for the Paycheck Protection Program (PPP) and Small Business Administration (SBA) loans, without which many of these local businesses would have closed permanently. Because of the essential systems navigation work CHWs did for these business owners, many became vocal cheerleaders of the CHW's COVID-19 outreach efforts in the community. (See Spotlight: Small Business Outreach.) Like a social worker, CHWs also lent a sympathetic ear to people's grief and hardships, especially when community members were reluctant to seek mental health support. They helped community members overcome any language, transportation and technology barriers in order to navigate complicated systems. And like an interpreter or a translator, CHWs provided critical language support to limited English proficient community members as they navigated a complicated registration system to secure vaccination appointments, as well as while they were at the vaccination clinics. CHWs also performed this language support function to help community members enroll in any program that could address their basic needs during the pandemic. Because a lot of public information - including collateral materials from DPH - were not available in Asian languages, the outreach partners had to spend a lot of their own resources in translating these materials. The collaborative had also asked some outreach partners to review materials translated by other sources. All of these roles were essential in building trust in the community.

In one case, a CHW was even a parking valet. At a vaccine clinic in Hollywood organized by Thai CDC, a CHW saw a former client dropping his wife off to get vaccinated. The client had been “on the fence” about getting the vaccine. When the CHW greeted him at his car and encouraged him to come in with his wife, the man gave the excuse that he couldn’t find parking. Before he could drive away, the CHW took away that excuse and offered to drive his car and find parking for him. The man eventually agreed. This story illustrated not only the length CHWs took sometimes to get one person vaccinated, but also the importance of trusting relationships in this work.

Collectively, CHWs from across the outreach partners reflected on the key attributes that helped them to approach their community members holistically. They include active listening, patience, non-judgment, humility, and availability (i.e. letting them know that they are there for the community member’s different needs). Some CHWs even gave out their cell phone numbers so community members could have direct access to them.



SPOTLIGHT: SMALL BUSINESS OUTREACH

At least half of the outreach partners included assisting small businesses as part of their targeted outreach. These small businesses are an important part of many AAPI communities. Small businesses - for both owners and employees - are often one of the very few options for immigrants and refugees who have been shut out of the mainstream job market. Some of these businesses were also key sites of public information for their co-ethnic customer base. Yet, many of them were struggling to stay afloat during the pandemic. For example, SAN staff pointed to a January 2022 article in *Los Angeles Times*² about how the pandemic had compounded the economic woes in Little India (Artesia), reducing the vibrant community to “an empty husk,” questioning whether the community would return to its pre-pandemic shape when the pandemic would be over. Similarly, many other ethnic enclaves had not been spared.

CHWs tried to help these businesses stay in business for the community in different ways. PACS staff helped business owners apply for PPP and SBA loans. One CHW explained, “certification and follow-up during the application process happened online and through email. Not everyone understood the process. We helped navigate and translate. Each client I helped could take months and months to get the funding because it required a lot of documentation. We’d take the opportunity to talk about the vaccine and booster during the follow-up.”

² <https://www.latimes.com/california/story/2022-01-02/little-india-already-struggling-before-the-pandemic-is-at-a-crossroads>

In collaboration with the agency's small business program, SIPA developed a prepaid debit card that could only be used in local businesses in Historic Filipinotown, such as bakeries, restaurants and corner stores. This provided economic relief to both residents and small business owners in the community during a very difficult economic time.

In other instances, CHWs helped business owners comply with changing rules in order to stay open during the pandemic so that they would not be cited. A CHW at Thai CDC educated restaurant owners that they should not turn on a television in the dining room because the government did not want people to congregate for too long. CHWs at Asian American Drug Abuse Program (AADAP) focused on small businesses in their target areas because "big-name stores usually have signs and info about COVID-19 from their corporate offices, but small business owners need a lot more support." All the outreach partners brought signage, masks and hand sanitizers to these small businesses as part of their outreach. Owners welcomed these items because procuring these items themselves would have cut into their already thinning profits.

By supplying PPE, outreach partners were protecting the workers at these businesses, too. Many of them had no choice but to continue working through the pandemic because they needed the income, especially if they were undocumented and not eligible for federal and state unemployment payments. Overcrowded housing made them and their families even more vulnerable. Many of them lived in multi-family and/or multi-generational households, so anyone in these households would be disproportionately exposed to the virus even if they "stayed at home." With a long history of worker

advocacy, Thai CDC incorporated COVID-19 health and safety messages as part of their workers' rights education and helped business owners and workers get on the same page on the safest way for everyone to work and keep businesses open.

In turn, these ethnic businesses supported CHWs COVID-19 outreach efforts. They normalized the use of masks and social distancing by enforcing them in their businesses. They allowed CHWs to talk to their customers and put up flyers about local vaccine clinics and other health messages. Several business owners also donated food and other incentives for vaccine clinics and outreach events.



OUTREACH INSIGHT #4:

Vaccine Resistance Was Often Linked to a History of Neglect in AAPI Communities

In general, CHWs encountered mostly positive and appreciative responses to their outreach. Even when community members were distrustful, many knew that the outreach partners cared about them through their “whole-person” approach, so they understood that the CHWs were not interested in only pushing a public health agenda. CHWs working in Chinese, Korean and Thai communities generally reported higher receptivity and vaccination rates, while other communities, like Pacific Islanders, were more divided - though there were exceptions in all the communities.

No matter their ethnic background, those who were hesitant or even resistant were not a monolithic group. Some CHWs mentioned isolated instances of community members, fed by misinformation, who believed that COVID-19 was a hoax. Most, however, were not conspiracy theorists. There were those, like the Japanese seniors that PACE outreached to, who were afraid of the needle and concerned about the vaccine’s side effects on their ailing bodies. Younger people thought initially that the coronavirus was not different from the flu and that they could keep themselves safe with measures other than vaccination. The 2021 Delta surge changed some people’s minds, but, as both outreach partners working in the Pacific Islander communities (APIFM & EPIC) attested, even witnessing other people in their own community falling ill and dying (and attending their funerals) could not convince many of the value and efficacy of the vaccines.

The resistance from many in the AAPI communities was different from the libertarian embrace of individual freedom and critique of government overreach. Rather, their resistance could be traced to a long history of neglect and exploitation by the U.S. government in these communities, similar to experiences in other communities of color. For instance, a CHW at APIFM explained, “The distrust in government is historical in our [Pacific Islander] community. We come from places that have been colonized by the U.S. People have been displaced. I think there is distrust in the government from the elders, too, but because they are more vulnerable, they’re willing to get vaccinated. For young people, they’re willing to draw that line.” One young Marshallese community member told this CHW how the U.S. tested nuclear bombs on their island, that his brother had a skin disease as a result of it, and his family had to be relocated to Hawai`i. When they came to America, they were relegated to poor neighborhoods with underfunded schools and police harassment. The CHW explained, “There are a lot of layers to it. They don’t feel supported. Not getting the vaccine is almost like their way of defiance against authorities.”

In a similar vein, the historical lack of access and familiarity with the health care system, among especially undocumented immigrants, also deterred them from trusting the public health system during the COVID-19 crisis. For those who had access, many endured negative experiences that also discouraged them to prioritize vaccination. For instance, CHWs at FIGH explained that many of the Cambodians did not trust the public health facilities to get vaccinated there, but would be willing to get it through their family doctors. In other words, these community members were not anti-science. Their hesitation had to do with trust. (The



opposite reinforced this point about trust: Those who had learned to navigate the health care system over the years - because they or their loved ones had underlying medical conditions, including, for instance, the people living with HIV that APAIT serves - tended to be more trusting of the vaccines and COVID messages.)

In many ways, the process to get vaccinated exemplified how intimidating and discouraging the public health bureaucracy was, especially initially when the vaccine supply was limited. When the State began using the My Turn appointment system, it was only initially in English and Spanish. Even when it was available later to include eight Asian languages, it still did not cover the many languages needed. Collectively, CHWs listed a host of challenges that any community member would encounter throughout the process: confusion about eligibility, registration available online and not in their preferred language, screening questions being very personal

or complicated, limited options for vaccination sites, confirmation and reminders communicated mostly electronically, long wait times and unclear processes at the vaccination sites (sometimes requiring long periods of standing in the sun), inaccessible sites by public transportation, and so forth. These challenges were enough to intimidate any assimilated Americans. For immigrants who were elderly, disabled, with limited English proficiency, unfamiliar with computers or the Internet, and without a car, it was almost impossible for them to navigate the system without the help of a CHW every step of the way. Even programs that aimed to reduce these barriers, including free rides through Uber and Lyft, could be futile to some community members, if they did not have smartphones, did not know how to manage their rides on the phone, did not have credit cards, or did not trust the drivers. These challenges were exacerbated by the rise of anti-Asian hate incidents, which escalated in 2020, making many in the community afraid to leave their homes.

As a CHW at PACS explained, “We helped so many people schedule their vaccine appointment. It wasn’t enough just to give them the link or the address. That wouldn’t have led them to get vaccinated. The website was complicated and asked a lot of questions. I helped them from A to Z. In the process, they told us very personal information, which builds trust.”

A CHW at Thai CDC shared this story about her experience at a pop-up vaccination clinic she helped organize at a Buddhist temple, where they had expected 200 people to show up: “They all came in the morning. We almost had a mob! Our staff had to go person-to-person to get online and ask all the screening questions, and the questions are not in Thai. They’re not tech-savvy. We had to do it on their phone for them

in many cases. It was so time-consuming. Some people [who came for the second shot] did not bring their vaccine cards. So I had to use the Wat Thai's monk's office and his computer to access the state's database and print out the information. One lady was in a wheelchair. We had to navigate her to that office. It was also hard to locate some people on the database because some immigrants do not have a consistent English spelling of their names. Thai CDC bridges all these gaps."

Outreach partners also tried to "bridge all these gaps" by co-hosting vaccine clinics at trusted community venues where their target population congregated. Churches and temples in the previous example were often cited. AADAP collaborated with a senior housing complex and vaccinated over a hundred older adult residents who could not leave their homes easily. AADAP and SIPA worked with local schools to host the clinics, while FIGH collaborated with Long Beach City College. Community members were grateful for these efforts to bring vaccine clinics closer to home because up until then they felt like "no one else was talking to them."

A 2021 Los Angeles Times article illustrates how Asian immigrant older adults in Chinatown had been neglected by public health officials who thought Asians were not underserved and older adults in Chinatown could access the vaccine supersite at Dodgers Stadium about a mile³ away. But to get to the Dodgers Stadium, they would need a car, which many older adults in Chinatown lacked. Finally, two CBOs (who were part of the first round of CHWOI funding) convinced the City to host a clinic at the parking lot of one of the hosts. Over four days, the pop-up clinic exceeded their initial goal of 800 doses and they had to

borrow additional doses from other clinics that were not using their allotment, which resulted in vaccinations for close to 1,000 people in Chinatown, including Pacific Islander community members APIFM had reached out to. Over time, CHWs were able to move those who were hesitant ("on the fence") to get the vaccine, but they also recognized that it had become increasingly difficult to change the mind of those who were resistant. Even in the face of more evidence of the COVID devastation and the effectiveness of the vaccines, some of those who were resistant became so entrenched in their resistance, which, as one CHW said, "was so ideological that it almost became part of their identity." At the same time, CHWs understood that everyone, regardless of their ideological positions (but especially those who were unvaccinated) needed to be protected. This was another reason why keeping communication channels open as long as possible was so important.

Some CHWs talked about using more harm reduction approaches, like those used in other public health crises, such as AIDS and drug abuse cases, and started talking about how to stay safe during key moments in the pandemic (like the holidays) and taking other precautions, including wearing masks, staying away from large groups, and keeping social distance. A CHW at SAN observed that, even when mask mandates were rolled back, people in the South Asian community continued to be cautious and wore their masks in public. Another CHW at AADAP talked about the shift in social norms of wearing masks in public as evidence of the success of this harm reduction approach.

³ <https://www.latimes.com/california/story/2021-04-21/chinatown-vaccine-clinic-asian-american-seniors>

OUTREACH INSIGHT #5:

There Was No One “Magic Bullet” COVID Message (Or Messenger)

To motivate community members who had very different reasons to be hesitant or resistant, CHWs had to be creative with their messages. There was no one message that worked for everyone. The appeal to protect their family members, especially the elderly, was convincing to some, while travel and employment mandates ultimately convinced others to get vaccinated. A CHW at EPIC shared how a woman who had been hesitant eventually changed her mind because she thought that she would need to be vaccinated in order to fly home and visit her family in American Samoa. Yet, other CHWs related stories about community members who would rather quit their job when confronted with a vaccine mandate at work. Sometimes, the consistent visibility of the outreach partners paid dividends. A CHW at EPIC explained, “It matters that we’re always there and them knowing that there is always a place that they can go to.” Another CHW at PACE talked about how some community members, after seeing his presence many times in the community, finally came in to get vaccinated. Peer influence and word of mouth were huge for some community members, as they saw their families and friends getting vaccinated (with little or no side effects).

Because many Asian immigrants still maintained ties to their homelands through their families or ethnic media, outreach partners sometimes added “transnational” messages and influences to their arsenal. The CHW at PACE who worked with the Korean community made this observation: “In Korea, they’ve started to shift their thinking to ‘how to live with the virus.’ People don’t think 90% vaccination rate is an attainable goal

so the mentality that COVID would be eradicated is not realistic. They’re trying to get back to normal and open everything up as safely as possible. That is shared with the Korean community here. We’re more resigned about the precautions, like wearing masks. That’s probably better for the well-being of the people.” CHWs also pointed out the fact that local community members should take advantage of the vaccine, especially when many in their home Asian countries did not have vaccines as widely available as in the U.S. The Thai newspapers advertised vaccine tourism to entice Thai nationals to come to LA to get vaccinated while visiting family and friends. In the Cambodian community, CHWs highlighted the hardships many refugees endured to come to the U.S. One CHW at PACS explained, “We told them, people back home [Cambodia] would pay thousands of dollars to get the vaccine that we get for free. We left Cambodia and went through so many terrible things, like the Killing Fields and refugee camps, to be here. It’s not like we just got on a plane. If you don’t get the vaccine, you’re going to get sick and may not make it. Remember why we struggled to make it here.” Although the message did not work for everyone, for many it was effective in building some peer pressure for vaccination. “They paused and really thought about it,” the CHW said.



Each ethnic community was not a monolith either. The diversity required outreach partners to employ different methods to address *intersectional* identities. To reach the low-income population, FIGH conducted in-person outreach at laundromats and car washes (amenities often lacking for renters at home). For the homeless population, AADAP outreached to transit centers and APAIT conducted street outreach at night. A few organizations like AYC and Thai CDC also relied on phone apps, such as Line, WhatsApp and WeChat, which many immigrants used to communicate with each other. For the younger population, social media tended to be more effective than traditional ones (See Spotlight on Social Media Outreach). On the other hand, limited-English-speaking older adults continued to rely on ethnic media (especially print and radio) for information. KAC regularly sent press releases to Korean newspapers and radio broadcasts (and occasionally TV stations) to inform the community that they could contact KAC staff for help, which prompted an increase in inquiries after each press release. Similarly, AADAP noticed an uptick in calls and requests after the Vietnamese press covered their Public Service Announcements (PSAs). AYC also issued press releases to ethnic Chinese media to spread the word about COVID-19 protection. Staff said that older immigrants tended to trust the newspapers in particular, and any mention of AYC and their staff in print articles about COVID-19 also elevated their stature as experts and raised their credibility with this population.

Just as there was no one-size-fits-all message or medium, CHWs employed different messengers to create a more comprehensive, “surround-sound” community environment to promote healthy behavior against the coronavirus. This report already discussed the many collaborations with faith leaders in different communities. As discussed in

the spotlight on social media outreach, APAIT worked with queer icons and celebrities like Margaret Cho and Laverne Cox to deliver the messages to LGBTQ people of color, and PACS leaned into the credibility of doctors and health care professionals in the Cambodian community and heavily featured them in their PSAs and videos. SIPA and EPIC collected stories from everyday community members talking about the impact of COVID on their lives. Storytelling will be discussed in the next section of the report.



While mainstream media often showed young people as being less cautious during the pandemic, youth were actually a huge asset and vital messengers for many outreach partners. CHWs believed that many young people, while they were less concerned about getting sick or dying of COVID-19, were exhausted from the social isolation and therefore motivated to contribute to ending the pandemic. One CHW said, “They wanted to go back to school. They wanted to see their friends.” Outreach partners who specialized in youth development programs also used COVID-19 outreach as a way to develop leadership for young people. As discussed in the spotlight on social media outreach, AADAP youth were involved in the video production of sketches showing how to be safe during the holidays. AYC trained young people to be phone-bankers to call community members. KAC connected young people they worked with to KFAM (a direct services provider in Koreatown, also part of the first CHWOI cohort) and produced a series of videos on mental health, which is a topic that was considered too taboo for many adults in the Korean community. FIGH had a long-standing youth development program called the Educated Men with Meaningful Messages (EM3), and the Cambodian and Latinx youth in the program became Youth Ambassadors who conducted COVID presentations in the community and generated Instagram posts. Youth involvement in outreach became a viable way for community building, at a time when many youth development activities had to be suspended. Even those who did not directly work with youth commented on how youth often were effective messengers, especially in convincing their families to become vaccinated. As the vaccine became more available to younger people, many were motivated to become protected and nudged their families to do the same. Some CHWs began to see families showing up together at a vaccine clinic for their first shot together.

SPOTLIGHT: SOCIAL MEDIA OUTREACH

All the outreach partners had existing social media platforms that they used for this project to share official public health updates during the pandemic from sources like DPH and CDC. Facebook was the most common platform used, though partners also mentioned using Instagram, TikTok and YouTube in their outreach. Social media was a much more flexible platform to share more up-to-date information than traditional methods, like flyers. However, the posts that generated the most reactions and sharing were original content produced by the outreach partners. Many CHWs said posts that featured community voices in the preferred language of the community caught the most attention. And for community members who could not read, videos were more effective. Some CHWs also leveraged their personal networks on social media to amplify their outreach.

For example, APAIT regularly posted videos about staff and clients talking about how the pandemic was impacting them and how they practiced self-care (where one staff even showed off their dance moves). These posts humanized the staff and built trust. A CHW said, “We tried to not only be consistent with our social media posts but to also make it interactive so our audience would engage with [us] and find our services.” Most posts were planned at least two weeks in advance. For instance, anticipating that transmission would increase during the holidays, staff posted tips on how to have a safe Christmas. Later they created a post to address COVID fatigue after the holidays.

A parody music video on its TikTok went viral (338,000 views to date), and it was shared by followers, reaching audiences across the country, including Texas and Florida, where the vaccination rates lagged behind the nation. As part of the project's social media strategy, COVID-19 was also incorporated into the agency's mental health campaign, "My Wellness Journey." A significant part of this campaign featured celebrities like Alec Mapa, Margaret Cho, Laverne Cox and RuPaul to discuss the importance of mental health, especially the ways in which the pandemic had affected them personally. A post with actress Kelly Hu was also shared on her platform and attracted over 9,000 views.



Similarly, AADAP hired a media consultant to produce two PSA videos on how to gather safely during Thanksgiving and Christmas. They had a humorous tone and featured some of the youth and staff as actors, and one of them was staged at one of the staff's home. The videos were posted on AADAP's YouTube channel as well as the network of the media consultant, which had an even larger following. The YouTube channel also featured Dr. Yelba Castellon Lopez, AADAP's Medical Director, who gave regular COVID-19 updates to staff and the community.

With separate funding sources, PACS staff partnered with the Cambodian Health Professionals Association of America (CHPAA). PACS approached CHPAA because of the critical role health care professionals played as messengers in the Cambodian community. The joint project led to the production of 15 PSAs and five longer interviews, where all of the featured doctors are CHPAA members. These were done either in Khmer or English, with subtitles, and were primarily shared on various social media platforms by PACS and other organizations. These posts generated many views, reactions, and shares. Similarly, in the Filipino community, PACS collaborated with a media consultant to make about a dozen videos (PSAs and interviews) in Filipino dialects. One of the earlier videos was a humorous skit about taking precautions at family get-togethers during the holidays. Staff reported posting these videos and other COVID information and resources on a Southern California Filipino Facebook group with 38,000+ members.

OUTREACH INSIGHT #6:

Messages Needed to Reach the Audience's Heart as Well as Their Mind

In a public health crisis as rapidly changing as the COVID pandemic, scientific facts and information are vital and life-saving. But scientific facts and information are often not enough to change attitudes and behavior. Relaying facts and information only - essentially a one-way conversation - could shut off the possibility of dialogue, especially with those who are already skeptical. The avalanche of information also added to the pandemic fatigue.

Also, much of the official information was not translated into the languages that community members could understand. Words like “booster” could be confusing when not translated correctly. Having materials only in English and a few threshold languages often made other community members feel that these messages were not meant for them, adding to the feeling of neglect described in an earlier section. As a result, the outreach partners had to spend some of their limited resources to translate these materials or create their own.

Many CHWs realized early on that their messages had to be engaging. In the spotlight on social media outreach, a CHW at APAIT explained that one of their TikTok videos went viral because “people enjoy the combination of comedy with information. It gained momentum and is still gaining views.”

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With a CHW who is also an artist, EPIC fully leaned into storytelling as a primary mode of outreach. EPIC collaborated with the Pacific Islander Ethnic Art Museum (PIEAM) in Long Beach for the “Recipe for Joy” exhibition and Celebration in July 2020. “I was thinking about who we are not reaching. Whose voices are missing from our outreach? And it was the kids and youth,” said the EPIC CHW. “We tried to make it fun and focus on joy: What they did to bring themselves joy during the lockdown. It started off as an educational engagement first.” Before the event, the CHW led an online

informational session with children and youth who signed up for the event. Young people, from age 5-12, talked about singing, getting hugs from their parents, playing with their favorite toys, watching YouTube, etc. as different ways to cope with the pandemic. At the event, young participants drew on banana leaves and talked about death and passing. Staff hung their works on trees outside the Museum. “That brought in a lot of people, and the media came as well,” said the CHW. “It was a way to work through some serious topics with young people.” EPIC also employed storytelling with adults in the Pacific Islander community. As mentioned earlier in the report, the EPIC CHW continued to collaborate with the Museum as the guest curator for their current exhibit (March-August 2022), *TOE FO`I: The Return*, working with five community artists to “engage the power of storytelling to humanize the numbers behind those lost to COVID-19.”



Storytelling not only created an opportunity to share public health information, but it also gave the community a way to process their difficult emotions during the pandemic in a collective way. EPIC’s Talanoa series on Facebook brought people together every Wednesday. Some of the focus was on elders, mothers (on Mother’s Day), college students, and the LGBTQ+ community. COVID-19 was a regular topic in this series. “We talked about how COVID was impacting them,” said the CHW. “We’re talking about the vaccine and the impact of the pandemic, without drilling it into their heads and making them feel bad about themselves. People are experiencing loss in different ways. There are these opportunities for grieving and storytelling at these online circles, and the artists responded to them with their pieces we’re going to put up at the exhibit.” In addition, staff also collected community testimonials during the vaccine clinics. With consent from the participants, staff shared some of these stories on their social media and with funders and policymakers. Through storytelling, EPIC also made inroads to new partnerships with Pacific Islander communities that they hadn’t worked very much with before. One of the Micronesian participants in the Talanoa series led to a very productive introduction into that community in Monrovia and nearby foothill cities in the San Gabriel Valley.

To the CHWs who incorporated storytelling in their outreach work, joy and humor did not take away from the seriousness and severity of the pandemic. Rather, by humanizing the pandemic impact, it fostered a sense of community and gave many community members some sense of hope and strengthened their resolve to endure very challenging times.

OUTREACH INSIGHT #7:

The Pandemic Will Have Long-Lasting Repercussions for Community Members, Including Effects on Their Economic Well-Being and Mental Health

As the CHWs deepened their outreach during the pandemic, all of them expressed concerns about continuing challenges in their communities that would persist beyond the pandemic. Some CHWs listed community needs, like transportation, access to health care, and hate crimes against AAPIs as persistent community needs beyond the pandemic. The two major challenges facing the AAPI communities that all of the outreach partners mentioned are: economic well-being and mental health.

Economic Well-Being:

Many community members experienced job loss or economic insecurity during the pandemic, either temporarily (during lockdowns) or permanently. This has sometimes put them at risk of being unhoused, especially in neighborhoods, like Long Beach, Historic Filipinotown, Koreatown, and South LA, that had been in the process of gentrification even before the pandemic. Government public relief programs, including the extension of unemployment benefits, rent relief programs, and the eviction moratorium, kept many of them afloat for a while, but many of these programs have expired. Undocumented immigrants were disproportionately impacted since many were not eligible for many of these relief programs in the first place. While some CHWs were seeing employment opportunities bouncing back in their communities, they also believed that their communities had yet to see the worst economic repercussions from the pandemic.

On the other hand, many CHWs observed that some low-wage sectors with a traditionally immigrant workforce, including the service industries, such as restaurants, have had job openings for extensive periods of time. Even within the nonprofit sector, a couple of outreach partners acknowledged that they had to raise their wages for entry-level positions, and even then they were having trouble filling their job vacancies, receiving fewer applicants, and resulting in some positions remaining unfilled for a long time. Some CHWs believed there were different factors for this “labor shortage.” Some workers might not want to risk being exposed to COVID-19 for a low-wage job. Older workers especially were likely to opt for retirement for this reason. For those who were eligible for the unemployment and stimulus benefits early on, they might have saved enough to hold off employment for a little longer. Some who were not eligible for these public benefits (i.e. undocumented immigrants) had turned to the underground or cash-based sectors for income. CHWs also witnessed some community members turning to driving for shared rides and delivery services. Minimum wage requirements (\$15/hour) had driven up wages in more competitive industries, such as construction, that were absorbing some of this workforce but making labor scarce for other low-wage sectors. A few CHWs had stated that the pandemic and past administration had stemmed the flow of immigrants, including undocumented immigrants, into the U.S., which has long been the backbone for many low-wage industries. This could also have created a significant gap in the workforce.

As mentioned above, because some Asian immigrants were shut out of traditional job markets, they resorted to self-employment that put them at economic risk. As of early 2022, CHWs observed that businesses in many areas, like Artesia,

Long Beach, and Compton, have not recovered from the pandemic. In addition to public health outreach, some CHWs, like those at PACS, supported these ethnic small business owners by connecting them to resources, like the PPP loans.

Unemployment or underemployment affected other basic needs. Food insecurity was one of the most immediate concerns for many low-income families in the outreach partners' target populations. CHWs mobilized quickly to provide relief. Some expanded their pantries or added CalFresh application assistance as part of their services, while others collaborated with local food banks to address their communities' nutrition needs. Thai CDC joined a program that would deliver hot meals from local restaurants to its elderly residents. SIPA built an innovative program that provided cash aid to local residents and connected them with local businesses in Historic Filipinotown. A few outreach partners also relied on APIFM in this collaborative to bring fresh produce to their community members.

Housing insecurity proved to be a tougher problem to address. Applications to rental relief programs were so bureaucratic and required so much documentation, from both landlords and tenants, that many failed to complete the process successfully or even were deterred from starting. There have also been long delays in the actual rental payments promised by the state and local rental assistance programs, with some applicants still waiting for rental relief. Although the eviction moratorium has since been lifted, some CHWs mentioned instances where eviction notices were illegally issued and they had to mediate between a tenant and their landlord. CHWs working in gentrified neighborhoods, such as Long Beach (PACS and FIGH), Historic Filipinotown (SIPA), Koreatown/Hollywood (APAIT,

PACE, Thai CDC) and South LA (AADAP), were noticing an increase in homelessness. They were worried that as the pandemic eased, the speed of gentrification would speed up again. Gentrification, some CHWs observed, could continue to rend the fabric of the communities they serve long after the pandemic. A CHW at FIGH noted that they were still supporting clients who had moved out of Long Beach but to places where the community support and nonprofit infrastructure were not as strong.



Mental Health:

CHWs observed that the pandemic had worsened the mental health for many community members. Their mental health could be impacted by a number of factors: anxieties from the fears and uncertainty of the pandemic, the rise of anti-Asian hate incidents, depression from social isolation, especially for the elderly who were shut in or for young people whose social development was stunted by the lack of peer interactions, and grief from the loss or suffering of loved ones impacted by COVID-19. CHWs at a few outreach partners also reported upticks in substance use during the pandemic. These factors were compounded for those who experienced financial stress, and the CHWs believed that these mental health problems would likely linger long after the pandemic.



As noted previously, like case managers, CHWs connected these community members to resources that could ease the burdens that caused their anxieties, depression and grief. Often, CHWs functioned like a social worker; many community members leaned on them for a sympathetic ear. Others initially had trouble opening up, not wanting to be a burden to share their challenges, but many in this group started to confide in the CHWs as their relationship deepened. CHWs noticed that, in their navigation role to help community members apply for programs or register for a vaccine appointment, they had to share a lot of personal stories with the CHWs. Because these applications asked for a lot of private information, these conversations would open up topics that community members might not otherwise be ready to discuss.

Some outreach partners provided communal spaces to promote their clients' mental health and wellness. APAIT, for instance, offered yoga and meditation classes regularly, and as described in a previous section, EPIC used storytelling to help build community and reduce social isolation. However, most community members were still reluctant about seeking more clinical help, primarily because of the mental health stigma in the various ethnic communities, as well as the perception that not being able to handle life's hardships or provide for one's family is a weakness or the cultural belief to keep certain matters private.

Recommendations

As torturous as the pandemic has been in the past two-plus years, COVID-19 is not just a one-time and temporary public health crisis, but it also highlights ongoing health and racial inequities that have existed in AAPI communities for decades, inequities that need to be addressed now, more than ever. As one CHW noted, “even if the pandemic goes away tomorrow, the adjustment to a new reality is going to be a challenge for many community members.” Neither will COVID-19 be the last crisis, public health or otherwise, that will plague our communities. To be ready for the next crisis and based on the reflections by the CHWOI agency leads and outreach partners, this report offers the following recommendations to strengthen the local public health system to adequately address existing health and racial disparities, for both those working with communities who are the most directly impacted on the grassroots level and those working at the policy and philanthropic level who want to address current inequities.

RECOMMENDATION #1:

Invest in Funding to Sustain the CHW Infrastructure beyond the Pandemic

All of the outreach partners leveraged their existing relationships with community leaders and members and other organizational partners as a strong foundation to build out their COVID outreach and education. Their foundation was built on previous work, such as the outreach infrastructure they had developed for Census 2020 and ACA implementation. For those outreach

partners who were involved in Census 2020, using similar technology (like text banking) made COVID-19 outreach and education easier. In turn, the COVID-19 outreach strengthened other infrastructure, such as any new community relationships during this initiative that many CHWs believe will be helpful in any type of public health response needed in the future. But these relationships need to be cultivated continuously, not just during an emergency. DPH and other funders need to keep investing in this strong community-based CHW program, now that it has been established and honed, and not leave it to wither. In other words, the CHW infrastructure needs to be sustained and nurtured beyond the COVID-19 pandemic, so that they can be mobilized at a moment's notice with the next health crisis or can be used to respond to any possible public health issue or provide needed health education to vulnerable communities on an ongoing basis.

As one of the findings demonstrates, significant community distrust in public health is based on the AAPI community's historical lack of access to the health care system, including times when they could access health care but had negative experiences, as well as general governmental neglect. If there were more goodwill, the outreach partners believe that there would be less hesitation with, or resistance to, vaccines or other public health messages. Whether there is a pandemic or not, CHWs are equipped to help community members navigate complicated and bureaucratic public systems, in a way that could help rebuild their faith and trust in public agencies.

However, system navigation is a stopgap measure to address a public system that is broken and does not serve AAPI community members well. CHWs play a critical role in transforming the system so that it could be more responsive to community members. CHWs are the grassroots advocates in system change work to improve and streamline access to health care and other public benefits, which not only can address health disparities and inequities and improve individual health outcomes but also go a long way to create communal receptivity to future public health crises. Furthermore, the CHWOI collaborative model has identified problems on the ground, developed effective strategies to respond to those problems, and implemented policies for systems change. If COVID-19 taught us anything at all, it revealed the lack of an adequate public health infrastructure needed to not only address ongoing public health inequities but its inability to respond to public health emergencies, such as the pandemic, and the devastating consequences for disproportionately impacted communities.

In short, sustained and reliable funding to support CHWs has to be prioritized in order for an effective public health system to function. This investment is especially key to addressing health disparities in the AAPI communities because research has shown that philanthropic funding for organizations serving these communities is dismal.⁴

RECOMMENDATION #2:

Go beyond the Geographical Model When Working with AAPI Communities



Although in some cases, it makes sense for public health efforts to target geographical areas, or hot spots, where the COVID-19 morbidity rate is high or increasing, a more population-based approach may be a more effective way to reach certain geographically dispersed communities and smaller populations, such as the disaggregated ethnic subgroups within the AAPI population. CHWs observed that using the Healthy Places Index and the block code approach was often not effective in reaching some AAPI communities. First, many of the ethnic AAPI communities were scattered throughout Los Angeles County. Vulnerable community members could be found in areas that, on the aggregate, might seem to be doing well. Rendered invisible, these community members were actually harder to reach

⁴ <https://aapip.org/resources/seeking-to-soar-foundation-funding-for-asian-american-and-pacific-islander-communities/> According to Asian Americans and Pacific Islanders in Philanthropy (AAPIP), Foundation funding designated for AAPI communities only accounts for 0.2 percent of all U.S. grantmaking.

than if they were concentrated in the hot spots. Second, even when AAPI community members live in a hot spot, they might not be as connected to their residential neighborhood as they are to more traditional ethnic enclaves, where they work, worship, shop, and/or socialize. These latter communal spaces might be a more effective way to promote health messages than trying to reach them in their private homes.

Official epidemiological data during the pandemic were not nuanced enough for DPH to understand the most vulnerable AAPI populations and to hone its outreach strategies. COVID-19 mortality data for Pacific Islanders, maintained by CDPH Vital Statistics, was initially suppressed due to the small sample size. As mortality rates increased, Pacific Islander data was disaggregated among select ethnic groups. On the other hand, data on COVID-19 incidence and hospitalization did not disaggregate Asian or Pacific Islander subgroups. Even if disaggregated, because of the distrust in our governmental systems, as demonstrated in our findings (usually by the most vulnerable and stigmatized among our communities), self-reported data might even be undercounted and unreliable. Instead, CHWOI outreach partners relied on their community knowledge, backed by existing data on other COVID-19 morbidity factors, such as age, employment (e.g. concentration of essential workers, etc.), language and immigration status (as an indicator of health access), and household and income characteristics. At the outset, this method of leading with grassroots knowledge and triangulating with existing demographic datasets worked well because it allowed outreach partners to get ahead of the pandemic, instead of following its trends. Partners also appreciated the flexibility of this initiative that allowed them to be nimble in finding vulnerable community members in their target populations and a regular space to

share knowledge and make adjustments to their strategies collectively.

However, having disaggregated data on the AAPI subpopulations on a regular basis throughout the pandemic would have allowed the collaborative to be even more nimble and effective in moving resources to where it was needed most as the pandemic raged on. Given the limitations of epidemiological data, we want to reiterate the recommendation from the AANHPI Health Initiative at the beginning of the pandemic to *“engage existing AANHPI researchers and epidemiologists in disaggregating and developing models for AANHPI data to design research methodologies and statistical models that account for the challenges of collecting accurate data from our communities, not just during a health crisis, but also as an ongoing research and data practice.”*



RECOMMENDATION #3:

Adopt Social Determinants of Health for Both Community and Policy Work

As the last outreach insight illustrates, the pandemic amplified access, economic, mental health and other existing challenges in the community, which in turn compounded the impact of COVID-19 on community members. Unfortunately, these challenges will persist even after the end of the pandemic. In fact, another reason to sustain a CHW workforce is to continually support community members to not only address post-pandemic challenges but other chronic health conditions, public health events and emergencies.



Poverty, housing and food insecurity, unemployment, language exclusion, violence, and racism - challenges that were exacerbated during the pandemic - are some of the social determinants of health that create barriers for our community members to seek help and access services they need both during the pandemic and in calmer times. Both community organizations and funders have been investing in initiatives to destigmatize mental illness, to stem hate incidents and crimes against AAPIs, to preserve residents and small businesses that are being pushed out by gentrification, and to protect undocumented and other vulnerable workers, etc. In addition to these separate efforts, adopting an intersectional lens can reduce silos and create opportunities for these different initiatives to support each other and amplify their impact. CHWs have demonstrated during this pandemic that they are skilled in addressing multiple social determinants of health simultaneously. By serving whole persons, CHWs can have a key role in encouraging collaborations across different sectors in order to enhance their effectiveness. Some outreach partners are already thinking of intersectional ways to expand their work in new areas, like small business outreach and mental health and wellness, by either developing programs internally or collaborating with community partners with complementary expertise, some of which were developed from their COVID outreach and education work. Leadership in both grassroots and policy levels need to model this intersectionality and expand their work on the social determinants of health by being inclusive of others at decision-making tables and by fostering a culture of support and collaboration, rather than competition.

RECOMMENDATION #4:

Maximize Collaboration between DPH and Community Partners to Improve Cultural and Linguistic Access to Health and Other Needed Services

DPH and community partners had different but complementary expertise in COVID-19 outreach and education. At the beginning of the pandemic, community partners relied on DPH for basic information about the virus, how it can be transmitted, and what community members can do to protect themselves. This type of information is essential for outreach and education, and many outreach partners would have benefited from timely public health materials in different languages other than English and Spanish. Later on, DPH did provide some materials in other threshold languages, but they did not cover the need in the diverse AAPI communities. In many cases, outreach partners in this collaborative had to translate these materials on their own, not just for themselves, but also for other organizations working with DPH in their target communities. The collaborative had to allocate precious and limited resources away from their other outreach activities for this work.

In addition, as this report shows, the outreach partners are often the best people to develop creative and culturally appropriate messages that their community members were more receptive to than more official messages. CHWs working in the community received real-time feedback from the community about which messages resonated and which did not, and they quickly adapted, and sometimes anticipated, new messages in response to this feedback.

Therefore, it is necessary to have a Language Access Plan and different models of collaboration to enhance the provision of culturally and linguistically competent educational materials. The collaboration between DPH and the Southern California Pacific Islander COVID Response Team to develop outreach materials that are linguistically appropriate and visually appealing to the Pacific Islander community is one such model of collaboration. Moreover, a clearer translation policy would be helpful to ensure educational materials are culturally appropriate. One way to do this is to provide funding for outreach partners in this collaborative to translate the materials or contract with a culturally competent communications firm to develop the materials in more languages, with the outreach partners providing necessary secondary reviews. There should also be dedicated funding for these CBOs not just for translation, but also for original content creation. In many cases, outreach partners can be more nimble and effective in creating their own messages that often incorporate joy, storytelling, humor, etc. that are more appealing to their target populations. Given that each type of message (and messenger) has its own usefulness, this is not an either/or proposition. Funding and technical assistance should be provided to enhance the outreach partners' communications strategy and capacity. Beyond outreach and education materials, many of our CHWs acted as interpreters at DPH testing and vaccination sites on an ad hoc basis because there was no language assistance provided at those sites. A plan where assistance could be provided, perhaps through requests beforehand and to fund such interpreter assistance to our partners would yield many benefits.

Conclusion



In conclusion, COVID-19 highlights many existing health and racial disparities in the AAPI communities that CBO partners in the CHWOI collaborative have addressed for decades, through a variety of programs, services and partnerships.

When the pandemic hit, CHWOI partners were able to not only mobilize these assets, but also built on them with creativity, humility, empathy, nimbleness, and perseverance. Through these hard times, these partners strengthened their relationships with faith leaders, small business owners, ethnic media, and other community organizations, to reach community members who are the hardest to reach.

There was no one magic message or messenger to reach all and convince the hesitant and resistant. In fact, the urgency of the pandemic required all hands on deck. This robust public health and CBO infrastructure needs to be nurtured in order to meet the ongoing inequities confronting our communities after the pandemic and to ensure health equity in the local public health system.

To view the appendix for this report, please visit:
https://bit.ly/AHOD_Appendix



All Hands on Deck: How LA's AAPI CBOs Addressed Health Inequities through Culturally Competent Covid-19 Outreach and Education Strategies

**AN EVALUATION OF THE COMMUNITY HEALTH WORKER
OUTREACH INITIATIVE (CHWOI), 2020-2022**

APRIL 2023