
Community Engagement Summary Report 2019



Kaiser Permanente Downey Medical Center

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*Evaluation and organizational
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PURPOSE

The purpose of this document is to present a deeper picture of health needs shared during community input sessions held for Kaiser Permanente Downey Medical Center’s Community Health Needs Assessment (CHNA) process. Community level data from a variety of credible sources was analyzed to produce high-level findings about community health needs. These findings were used to create targeted lines of inquiry (table 1) intended to learn more about the story of community health by exploring the lived experience of community members, the causes of health needs, the racial or geographic disparities in health needs, and the community resources available to address health needs. Questions were posed to community residents, community leaders, and government and public health department representatives through focus groups and in-depth interviews. Please see the full CHNA report available publicly at <https://www.kp.org/chna> for more information on how community engagement data was collected, coded, and organized.

Table 1: Target Questions for Community Engagement

Focus Area	Question
Access to Care	1. How do inequalities and disparities affect the community’s access to health care (not insured as well underinsured)? Probe: How is this experienced by the community?
Access to Care	2. What are the barriers to accessing health care (e.g., education, navigating the health care system, access to specialty care, other)?
Access to Care	3. How are immigration laws impacting the communities willingness to access resources they may need (e.g., health care, food assistance)? How do you address those fears?
Education and Employment	4. How does economic insecurity impact the daily lives of low-income community members, and what factors contribute to economic insecurity?
Education and Employment	5. How do the low high school graduation rates impact individuals’ ability to achieve economic security in the community? Probes: Are community members able to get a job? What opportunities exist for those who don’t have a high school diploma?
Education and Employment	6. What factors are impacting high school graduation rates in communities where the graduation rate is below the county average?
Education and Employment	7. To what extent is educational attainment a priority where graduation rates are lower than the county average? Probes: What other needs/issues take priority? What additional support do families need to help their students?
Food Security	8. What factors contribute to food insecurity?
Food Security	9. What external assets, capacities and resources are available to address the issue of food insecurity?
Housing and Homelessness	10. What work is being done in the community to address homelessness? What opportunities exist to partner with large anchor institutions and other community organizations?
Mental Health	11. When thinking about mental health, what is the most pressing concern (e.g., access, specific mental health issues, stigma) for the school age population? Probe: What factors contribute to these issues?
Mental Health	12. What barriers exist to accessing mental health care services?

LEARNING FRAMEWORK SUMMARY

Kaiser Permanente organized the findings from community engagement using a learning framework to highlight key learnings around lived experience of community members, the causes of health needs, the racial or geographic disparities in health needs, and the community resources available to address health needs. The main themes from this framework that surfaced during community engagement are reported below.

Lived Experience

During community input session residents and service providers painted vivid pictures of the lived experiences of individuals and their families living in the KFH-Downey service area. A cross-cutting theme among all engagements was **growing concerns and frustration** with the **violence, unmet social needs, and financial hardships** community residents face daily. These experiences negatively impact their overall quality of life as well as mental and physical health.

“One of the clinicians at work always shares a story about how he works at a community clinic, he's an MD. He talks about this Black male who was hypertensive, and he was overweight. So he said, "Why don't you lose like 20 pounds, and we'll see what happens, before I try to increase your medication." That's sort of what he prescribed him. When he came back, I think he had lost like 15 pounds, and he was like, "Why didn't you lose all the weight?" He was like, "Because I'm not going to look like a chump in my neighborhood. If I lose any more weight and look any skinnier, I'm going to get beat, or I'm going to get in trouble.”

-Community leader

Causes/Contributing Factors

A common cause or contributing factor shared across health needs was **economic insecurity or poverty**. Community input from multiple stakeholders revealed that residents struggled with having enough income to sustain their financial obligations (e.g., rent, food, transportation). This was attributed to the social inequities that exist in the community including lack of jobs, affordable housing, and community resources. Transportation was also discussed as a factor contributing to poor outcomes across health needs. Lack of or the cost of transportation made it challenging for residents to access the care and resources they need.

“The first story that comes to mind is a mom who lives in Nickerson Gardens [housing development]. She had a full-time job. She had five kids. She worked at a factory. She didn't have a car...Even with a full-time job and kids, she couldn't provide food and just basic needs. She talked about how she reflected on those challenges. She had to pay transportation, pay for food, pay for rent, and so much. She couldn't make ends meet.”

-Service provider

Disparities across Race/Place

Racial disparities emerged as a theme across all health needs. **Specifically, Hispanic/Latino and African American residents were disproportionately impacted.** These groups were poorer than average residents of KFH-Downey service area and had higher prevalence rates of many poor health outcomes, such as obesity, diabetes, and stroke.

“I struggle with this because Watts is that example of inequity. It’s what happens when we provide opportunities to one neighborhood versus another. But it’s not just a place, it’s the people that we enable to live in that area. We concentrated poverty in Watts for Black and brown people.”

-Community leader

Capacity, Gaps, and Opportunities

The need for **more affordable housing** was identified as being related to all health needs. The high cost of rent/mortgage made it challenging for residents to meet other needs. Participants of the community engagement sessions talked about the increase in market rate rent, which was often not fully covered through available subsidies like housing vouchers. Community input highlighted the limited success of case management as an intervention to support individuals navigating the health care system, addressing immigration concerns and misinformation, and staying housed. However, the lack of resources for comprehensive case management accessible to more people was seen as a gap. Increase case management services for those who need it could provide an opportunity to improve overall health and wellbeing of individuals and families within the community.

“I’m paying almost 50% of my rent right now when it’s supposed to be 30% because my landlord had raised my rent on me and it went above the subsidization.”

-Formerly homeless resident

RESPONSES TO TARGETED LEARNING QUESTIONS

The findings below highlight aggregated responses from community engagement sessions for each of the questions outlined in Table 1. Questions and responses have been grouped by health outcome or social predictor of health.

Access to Care

How do inequalities and disparities affect the community's access to health care? How is this experienced by the community?

Participants highlighted racial/ethnic inequalities in treatment of people of color within the healthcare system.

“There's another lady who told a story about how her husband got hurt at work, and he ended up getting back surgery. Years later, he started getting really, really sick. He was presenting typical symptoms that a Latino male of his age would present having a heart attack. But he wasn't having a heart attack. He was having issues related to his back surgery. The physician, instead of asking his medical history, I think it was in the ER, ended up giving him some sort of shot or something really quickly to control him because he presented some typical symptoms. He ended up in a coma for a while because of those assumptions.”

-Community leader

What are the barriers to accessing health care (e.g., education, navigating the health care system, access to specialty care)?

Language, literacy, and education were identified by participants as barriers to accessing care and makes navigating the healthcare system harder.

“It's so complicated they [community residents] don't understand how are they are supposed to get healthcare and it's just been really challenging. And I think that sometimes it's so complicated that a well-educated person has a hard time with it, but when you're talking about someone who has less formal education, where English is not their first language, it's really difficult to understand what they're supposed to do.”

-Service provider

How are immigration laws impacting the community's willingness to access resources they may need (e.g., health care, food assistance)? How do you address those fears?

Current political climate around immigration causes fear, detouring some from accessing services they are qualified for.

"I think a challenge that wasn't as prevalent last time the assessment happened was the fear of deportation. I think that's gonna be a [challenge], I don't know if you'll be as successful this time going around at gathering information from that population [immigrants]."

-Service provider

Education and Employment

How does economic insecurity impact the daily lives of low-income community members, and what factors contribute to economic insecurity?

Employment does not guarantee economic security, as employed residents still struggle with unmet social needs.

"The first story that comes to mind is a mom who lives in Nickerson Gardens [housing development]. She had a full-time job. She had five kids. She worked at a factory. She didn't have a car...Even with a full-time job and kids, she couldn't provide food and just basic needs. She talked about how she reflected on those challenges. She had to pay transportation, pay for food, pay for rent, and so much. She couldn't make ends meet."

-Community leader

Systemic barriers in the community contribute to economic insecurity.

"Watts has the lowest life expectancy in the city of LA. How is it that we're a 2.12 square mile neighborhood with the most dense low income housing? There's four developments in the neighborhood. Whoever planned or designed the area already set it up to be really high poverty concentrated. The policies that have designed that created the neighborhood. Then the symptoms and the outcomes of that poor public policy are poverty, limited [English] proficiency, and low educational attainment."

-Community leader

How do the low graduation rates impact individuals' ability to achieve economic security in the community? Are community members able to get a job? What opportunities exist for those who don't have a high school diploma?

Participants focused more on the importance of workforce development services for securing a job and having economic security.

“We have a job developer here [non-traditional high school], so that's something that's very helpful because he [job developer] has a lot of connections and that connectivity makes things a lot easier.”

-Youth resident

To what extent is educational attainment a priority where graduation rates are lower than the county average? What other needs/issues take priority? What additional support do families need to help their students?

Participants shared that students face many competing priorities, including working to contribute to the household income and caring for siblings or their child(ren).

“Some had to drop out to go to work to support family. And, others have dropped out to take care of younger brothers and sisters as the mom has had to go to work. So, a lot of it is coming from home, in one way or another.”

-Youth resident

Food Security

What factors contribute to food insecurity?

Fixed income and low or lost wages were mentioned by participants as contributors to food insecurity.

“I've been working with several food banks, and what you see also is a lot of the elderly participating in those programs because their income is so limited that they're not able to get by just with the income they might be getting from Social Security.”

-Service provider

Participants also shared that lack of affordable housing in the community contributes to food insecurity.

“I think our families a lot of times, like 30 or 40 percent [of their income] is just going towards housing just trying to cover and sustain a roof over their heads. So they're struggling, not only are they dealing with food insecurity, but they're also struggling financially.”

-Service provider

What external assets, capacities and resources are available to address the issue of food insecurity?

Food recycling programs may help get food in the hands of those who need it

“I think right now, there's push for food recycling, county-wide or state-wide. I think everyone's on board as they need to deal with their surplus. So that's a big help.”

-Service provider

Participants often mentioned federal food assistance programs as helpful resource for addressing food insecurity.

“CalFresh program has the Farmers Market Match Program that allows them to go get healthy food at a Farmers' Market and they'll match, they'll add money towards ... you could double your money used at the Farmers' Market, sort of.”

-Service provider

Housing and Homelessness

What work is being done in the community to address homelessness and what opportunities exist to partner with large anchor institutions and other community organizations?

Participants gave a few examples of work being done in the community.

- **Free Vaccinations.**

“In the past we've done flu clinics, trying to meet them where they go, at the facilities. One time when we went to St. Mathias we went when their nurse was there. And he would tell them, "Oh, we have our nurses next door giving flu clinic and Hep A vaccines. Since he knows us, and the homeless know him, and they trust us more. So, by us going with people that they already have trust with, that takes down a huge barrier of the whole trust component that we have with the homeless.”

-Service provider

- **Mobile Clinic.**

“Yeah, we do have a little bit of that. We work with St. John's Well Child and Family Center to have a mobile clinic, actually right now in Bellflower today.”

-Service provider

- **Outreach workers**

“We do that, and then some of our E6 outreach teams, which are the interdisciplinary teams, have mental health providers, substance abuse specialists, and nurses that go out.”

-Service provider

Participants shared a variety of ideas for addressing homelessness.

- **Affordable housing**

“Affordable housing. It's hard, because if you think of, for instance, in the city of Whittier we used to have a youth center. That lot was owned by the state, and it was vacant for a long time. And so I know that one of our supervisors for the county was trying to fight to have it become a portion of affordable housing. But then when they sold it to the private company they decided to do senior housing, senior affordable housing, rather than individual affordable housing. The community is much more open to welcoming seniors who are homeless in the community rather than single adults in the community.”

-Service provider

“If I'm homeless in Commerce, the odds are I'm a Commerce resident, so don't tell me I have to move to Huntington Park or South Gate. I want to stay in Commerce. That's another challenge, because our communities don't have affordable housing.”

-Service provider

- **Housing subsidies**

“Without housing subsidies, you have the best outreach programs in the world, best housing navigators in the world. You're not getting the people in housing that they're going to be able to afford.”

-Service provider

- **Ongoing case management support needed to help keep people housed**

“We found when we are able to get somebody into permanent housing, the need for ongoing retention case management to follow up with them and to basically hand hold has been really critical.”

-Service provider

- **Need to provide more education to address nimbyism**

“The thing that is needed is a supportive community that interacts with the people who are homeless, who are really marginalized, who are used to people not willing to make eye contact with them or talk to them, or who continue to make them feel less than human.”

-Parent of formerly homeless resident

Mental Health

When thinking about mental health, what is the most pressing concern (e.g., access, specific mental health issues, and stigma) for the school age population? What factors contribute to these issues?

Safety and violence issues in the community spark concerns about trauma and the need for more mental health services

“There’s a big need for grief groups, because there’s a lot of violence...In my caseload I had a client that had three sons that had been murdered.”

-Service provider

Unmet social needs of families in the community impact mental health

“I just had a client that just said that to me on Friday...I didn’t know that she didn’t have a bed, and she was sleeping on the floor at home and all of this stuff was happening. How they had to sell furniture, or her mom sold the furniture, so that they can have some kind of food.”

-Service provider

Stigma continues to be an issue, particularly for some racial/ethnic groups

“And for the African American family, there’s just the stigma that, you know, what goes on in our house stays in our house. And then there’s the stigma on mental health, that you’re crazy if you go to see someone.”

-Community resident

What barriers exist to accessing mental health care/services?

Frustration with lack of mental health resources and long waitlist

“It’s true, I had to get on a waiting list. And I put my son on the waiting list {for behavioral health services} when he was three months old just to guarantee by the time he turned three he was gonna be able to get in.”

-Community resident

NEXT STEPS

Input provided during community engagement helped to provide a glimpse into some of the community perspective on health outcomes and health drivers, as well as assets and barriers to accessing resources for health issues. Insights shed light on the obstacles and challenges residents in the KFH-Downey service area face to live long and healthy lives including the disparities that exist, and opportunities to address these issues.

This information will become an integral part of the next step of the CHNA process: implementation strategy planning. These findings will inform Kaiser Permanente Downey Medical Center's plans for the next three years as they continue to work on improving the health and well-being of the communities they serve.