Community Engagement: A Strategic Learning Approach

In its drive toward health equity, Kaiser Permanente listens to and learns from underserved and vulnerable communities. This methodology is fundamental to the Community Health Needs Assessment (CHNA) process. In 2018, in order to dive deeply into the lived experience of service area residents, KFH-Los Angeles applied a strategic learning approach, characterized by a set of hyper-relevant questions (strategic learning questions) designed for a sample of underserved communities in the service area. This approach provided KFH-Los Angeles the stories and data needed to better understand and support the health of these communities. The figure below illustrates the communities that were targeted in this strategic learning approach, and the numbers of residents and organizational leaders that were engaged in interviews, focus groups and group feedback sessions.

Who Was Engaged in the CHNA Strategic Learning Process and Why

Engagement Counts

Through focus groups, a total of 256 residents were engaged, as follows:

- 120 Latino youth residents at an East LA high school
- 24 Latino youth and adult residents in East LA
- 19 Latino youth and adult residents in Hollywood
- 55 LGBTQ youth, adult and senior residents in Hollywood
- 15 African American youth residents in Northwest Pasadena
- 15 African American youth residents in South Park

Through key informant interviews and focus groups, a total of 45 organizational leaders and elected officials’ offices were engaged. Seventy three percent represented the nonprofit and service sectors, serving low-income and minority populations.

KFH-Los Angeles Medical Center community engagements focused on understanding the lived experience of some of the most underserved and vulnerable residents of the service area: low-income Latino immigrant youth and adults, low-income African American youth and adults, temporarily or chronically homeless residents, and LGBTQ residents. These particular subpopulations were selected as the focus of the strategic learning process because they are disproportionately impacted by lack of access to health care and by health issues that reduce life expectancy.

1 See Appendix A on page 5 of this report for detailed answers to each of the strategic learning questions.
Health Needs: Lived Experience

The main themes that emerged with respect to residents’ lived experience are described here. We heard from community members and organizational leaders that many KFH-Los Angeles service area residents are experiencing several factors that together constitute chronic strain. This chronic strain is a consequence of factors including economic insecurity and structural exclusion, and underlies poor mental, physical and behavioral health.

Stress
In focus groups and interviews, stress emerged as a common theme in the lived experience of members of all of the groups we engaged. The stress they feel may stem from immediate realities, like a lack of funds to pay bills, or from broader contextual realities, like ongoing political controversy over immigration policies. They explained that chronic stress leads to mental and physical illness in themselves and their families.

Trauma
Trauma impacts the lived experience of many service area residents through various pathways. For example, many chronically homeless individuals experience physical and sexual violence while living on the streets, often compounding trauma they carry with them from youth. It is not uncommon for immigrants from Central America to have experienced physical and sexual trauma in their home countries as well as during their journey immigrating north. Additionally, many people of color experience trauma due to the racism they encounter every day. A person with a history of trauma can be very protective of their space and less equipped to persevere in the face of setbacks and their mental and physical health suffers.

Social Isolation
Isolation emerged as a shared theme among our engagements. Service area residents, particularly the homeless, LGBTQ seniors and homeless LGBTQ youth, and non-English speaking low-income seniors are acutely impacted by social isolation. At the same time, across all engagements, participants expressed in different ways that they feel disconnected from others in both their own communities and communities in which they interact. The feeling of disconnection seems to be exacerbated by social and economic stressors like gentrification and the current political climate. This lack of social connection or cohesion erodes mental and physical health.

Lack of Leisure Time
Across engagements, we heard that the lack of time for leisure activities--including meditation, recreation and exercise--contributes to anxiety and poor physical health. This issue was raised in particular by Latino teens living on the East side of the KFH-Los Angeles service area who explained that time spent outdoors with friends and family is essential to wellness, but unfortunately restorative outdoor leisure time is very difficult to attain in the dense urban environments and economic realities they currently live in.

Difficulty Accessing Resources
Throughout our engagements we heard stories attesting to the difficulties people have connecting with and accessing resources designed to provide economic, social and health care support. Barriers to accessing resources are often multilayered, and effectively addressed by collaboration among community members, service providers and institutions that shape health care access.
Health Needs: Contributing Factors

Focus group and individual interview participants outlined the historical, social, political and economic factors shaping the lived experience of the specific communities highlighted in this strategic learning process.

Rising Costs and Stagnant Wages

We heard stories about the factors contributing to economic stress from working, unemployed, and homeless adults and young people across the service area. Increasing housing costs, the gentrification of historically working class communities, and stagnant wages have created very difficult circumstances for a large swath of service area residents. Making enough money to survive has become all-consuming: working two or three jobs no longer provides enough to pay rent, let alone access basic needs like healthy food and transportation. Many residents experience daily a fear of losing their home and being unable to afford another place to live.

Racism and Prejudice

In focus groups we heard stories illustrating how racist policies and racial bias affect the day-to-day experiences of African American youth and their communities. Many of the youth we spoke with grew up without fathers because of a system that disproportionately incarcerates Black men, and they themselves fear being targeted by police and incarcerated. Additionally, many of the youth expressed discouragement and anger in response to seeing how hard their family members have worked to advance themselves, only to hit setbacks in education and employment that people from other racial groups don’t experience in the same way. Ultimately, enduring racism on a daily basis results in racial trauma; structural racism results in generational poverty and lack of upward social mobility.

Stigma and Social Marginalization

We heard that for the chronically homeless, not only is daily life chaotic and potentially dangerous, it is also dehumanizing: homeless individuals’ experience with most others is one of stigma and invisibility. This makes it hard to build trusting relationships with service providers, believe in a positive future and set personal goals, and stay engaged in services and programs. Members of other groups, including LGBTQ youth, and socially isolated seniors, have similar experiences of invisibility and rejection in interactions with others. For this reason, peer navigators with similar life experiences to, and deep empathy for, those experiencing marginalization are very effective at supporting individuals as they access and navigate systems and adhere to programs over a long period of time.

“If I lose my apartment I won’t be able to afford to live here anymore, but I can’t afford to move. I’m very stressed.”
-Service area resident and mom speaking at a parent focus group in Hollywood

“I think that a sewer rat is a good analogy. We are like sewer rats crawling around in the sewer. Everyone else is up there, where the opportunities are. Just lifting up the manhole cover to let some light seep in isn’t going to help us. We need to be able to get up there. But how?”
-Black teen speaking at a youth focus group in South Park

“When I got to the ER they took one look at me and told me they couldn’t help. I feel like they refused me because I’m homeless and they knew I didn’t have insurance. It’s like people don’t see me as a person.”
-Homeless teen speaking at a youth focus group in Hollywood
Health Needs: Opportunities and resources to respond

Through our community engagements we learned about approaches that are effective at countering inequities in opportunity and health outcomes for the communities focused on in our strategic learning process.

Support Community Leaders by Giving them a Platform to Lead

Residents and service providers explained that the lack of representation and power of underserved communities at decision-making tables explains in part the perpetuation of policies and practices that exclude or negatively impact these groups. The lack of a platform for self-representation was immediately called out in resident engagements, particularly with youth: the first thing youth asked at each focus group was “Why are you here to collect our stories? Why can’t we just speak for ourselves?” Importantly, our engagements shed light on a lack of connection between political and organizational leadership, and grassroots organizing and interests. There is great opportunity to achieve significant positive impact on health needs by investing in coalitions of community leaders and institutional power brokers. Additionally, there is great opportunity in training community leaders to effectively influence policies and practices, and, conversely, training organizational leaders to engage and include communities in decision-making.

Build Culturally-Rooted Resource Hubs

Our engagements brought to light numerous resources that—in culturally and socially responsive ways—address economic, housing and food insecurity, and difficulty accessing health care. For example, a community-based health clinic just south of Downtown Los Angeles uses a “mind, body and heart” model to help clients cope with chronic strain and build relationships with peers while also attending to their mental and behavioral health needs. The programming is rooted in Latino and African American cultural values, which signals to clients that they are seen and accepted, and helps clients build self-esteem and resilience. Furthermore, this organization partners with other like-minded organizations to provide wraparound services and function as a resource hub that is open seven days a week so that community members can access services regardless of work schedules and other commitments.

Adopt a Trauma-informed Care Approach

Given the detrimental impact of trauma on one’s ability to form relationships, engage in programs, and maintain good mental and physical health, it is very important for service providers to learn about causes of trauma and strategies for identifying and supporting individuals who have experienced trauma. Our engagements identified numerous service providers who have made significant efforts to integrate a trauma-informed approach into their organizations, training all staff at all levels. These organizations are tailoring trauma-informed care guidelines to be culturally responsive and population-specific. For example, a service provider in Central Los Angeles with deep experience serving immigrants has developed and now trains others to employ a trauma-informed approach specific to the experiences of Central American immigrants who have recently arrived in the U.S. having fled community, physical and sexual violence in their home countries. Additionally, an LGBTQ service provider has developed a trauma-informed approach that responds to the unique experiences of lesbian, gay, bisexual, trans and queer people of color.
Appendix A: Answers to Strategic Learning Questions

As described in this report, Kaiser Permanente listens to and learns from underserved and vulnerable communities in order to advance health equity. In 2018, in order to dive deeply into the lived experience of service area residents, KFH-Los Angeles applied a strategic learning approach, characterized by a set of hyper-relevant questions (strategic learning questions, or SLQs) designed for a sample of underserved communities in the service area. This approach provided KFH-Los Angeles the stories and data needed to better understand and support the health of these communities. The following appendix builds on this report by providing additional information gathered through engagements with residents, organizational and agency leaders. This information is organized by SLQ.

**SLQ #1: In what ways do housing and other neighborhood factors affect the lived experience and health of Black residents?**

Our focus groups and interviews revealed that the majority of African Americans living in poverty and dense housing in the Los Angeles service area have grown up in neighborhoods that have been systematically under resourced and marginalized for a long time. The long-term lack of material and developmental resources, combined with the emotional and psychological consequences of structural and individual racism, are conditions that allow community violence to take root and generational poverty to persist. All of these factors together prevent many individuals from achieving in their own lives something that would break the cycle of poverty for their families.

One community-based organizational leader explained, “When you talk about dense housing … it is a huge issue. When you live in a marginalized community, you have a prevalence of activities such as substance abuse and several factors. There is a lot of domestic violence that occurs. When you combine all of these issues, on top of lack of mentorship guidance or leadership that helps individuals cope with the issues associated with it, you end up with conditions that are detrimental to health.”

Another community-based organizational leader explained, “These issues of chronic adversity are not addressed. This school year alone I have had over 30 calls from schools asking us to come speak to a young person--they have gotten into some trouble. However, it is due to having witnessed some community violence (brother, friend, etc.)…you saw some people get killed yesterday, but you have to go to school anyway. Without the support, how!”

A direct service provider explained that racism is so prevalent it can become invisible, even to the subject: “What we’re finding out is that [Black] women have become so numb to racism, they don’t realize it. When they fill out our assessment they say they don’t experience it, but after we talk about it in classes they realize that yes, they do experience it, every day.” However, for many Black community members, racism is ever-present. Young Black men participating in a focus group explained, “You (a White interviewer), you do one thing wrong in front of the police and probably nothing will happen. We do anything wrong, and we get arrested or shot.” These focus group participants explained that their mothers and they themselves are constantly vigilant and fearful. They are always conscious of the risks entailed in being Black and male in the United States. This consciousness is oppressive and demoralizing, and makes it hard to believe in an alternative reality. One young Black man explained, “I think that a sewer rat is a good analogy. We are like sewer rats crawling around in the sewer. And everyone else is up there, where the opportunities are. Just lifting up the manhole cover to let some light seep in isn’t going to help us – rats hide from the light. We need to be able to get up there. But how?”
SLQ #2: What factors inhibit or promote attaining or maintaining comfortable, healthy and/or improved housing among Black residents?

Factors associated with generational poverty inhibit Black residents’ ability to “get ahead” enough to attain improved housing. Low-income Black residents in the service area live in food deserts where they have no choice but to eat affordable junk food, which detrimentally impacts their physical health and wellbeing. The stress of their lives contributes to poor mental and physical health. Community and police violence contributes to a shortened life expectancy. Given the constraints of growing up in generational poverty, many families are reliant on social programs and economic entitlements that are designed to help families avoid destitution—but not move out of poverty for good. Furthermore, individual and community chronic and complex trauma stemming from racism, community violence, and other factors associated with poverty impacts access to opportunities for low-income African Americans. All of this combined makes it very hard for families to accumulate wealth and attain the housing, careers and life goals they would like to pursue.

Consequently, a disproportionately high number of Black individuals and families experience homelessness. A community-based organizational leader explained that in his organization, which serves low-income young Black men, “40% of the young people who come into our center our homeless. Maybe not traditionally homeless, maybe couch surfing. This is an alarming number of young people being homeless. It is a sign of some of the other issues we are talking about.”

Factors that promote attainment of improved housing include policies and practices that address and reverse structural racism, programs and policies that advance educational and employment opportunities, programs that build community through organizing, mentorship and individual development, and sustained, planned collaboration among direct service providers, policy-makers, funders and community members.

SLQ #3: In what ways do housing and other neighborhood factors impact the lived experience of Latino residents?

There is great variation in the communities with high concentrations of Latino families in Los Angeles. Our engagements focused on residents and providers who represent very low-income Latino communities in the service area. These communities are largely made up of first- and second-generation Latinos and their families, many of which are “dual status” where the parents are foreign-born and undocumented, and the children are born in the US and American citizens. In these families, the parents have comparatively low educational attainment and comparatively low English (and sometimes low Spanish) literacy which limits their access to employment and services. Additionally, compared to a decade ago, it is much more difficult to find work due to heightened stigmatization of immigrants—fewer employers are willing to employ undocumented and/or foreign-born immigrants for fear of legal repercussions.

Therefore, the neighborhood factor that all interview and focus group participants immediately pointed to as having a huge impact on lived experience is rising housing costs and overall cost of living. Some of the densely populated immigrant communities are rapidly gentrifying. Some communities are not experiencing gentrification, but costs of rent, good and services are increasing nonetheless. The consequence is that daily life becomes a struggle to make enough money to pay rent, and families are getting by through sharing small living spaces with 4, 5, 6 other people. The overall stress of finances combined with actual living situation takes a toll on physical and mental health through various pathways.

One service provider in the Westlake community explained, “When you are living in poverty, there is constant stress around everything. How will you pay your rent, how will you eat, it’s a constant battle. It gets in the way of having normal healthy relationships and emotions. The families build up walls, they don’t really communicate with their kids as well as they can, because they are in a state of survival. They have never gotten to actually thrive. When you have the opportunity to thrive, you can think about other things like self-care, mental health, how to de-stress. They don’t have the space and privilege to really think about these things.”
A parent focus group participant explained, “I have two children, one that comes to this school and another that is eight years old. I have 19 years of being in this country. It is hard to pay the rent. For the moment the only ones that has health insurance is my children. I don’t have health insurance. It is difficult as one has many needs. I know that we have to make sure we are okay, however, after paying the rent making sure that you are okay is secondary…. The way we live, even the kid’s health is affected. Living in a small place, enclosed, it affects their health.”

**SLQ #4: What factors inhibit or promote attaining or maintaining comfortable, healthy and/or improved housing among Latino residents in the service area?**

Aside from the real costs of housing in the service area, there are issues unique to immigrants and, particularly undocumented immigrants, that prevent service area families from keeping their current housing, let alone attaining improved housing.

One provider explained, “Housing is a huge issue especially for undocumented individuals. You aren’t eligible for section 8 if you don’t have a social security number. In addition, rent is skyrocketing, so we see 5-6 people living in a household and everyone is working to help pay the rent. This is a whole different trauma, because you don’t have your individual space, very crowded. There is a lot of eviction, because the number of people in the home breaks the rental contracts. People who can’t work are trying to find ways to earn cash. Shelters are not an option – people don’t want to move in to them, they are full, some shelters require social security numbers. It is very very time consuming trying to find shelters that are a good fit for families – I spend sometimes many many hours making calls trying to find a fit.”

Latino immigrants who are legal residents face similar challenges in holding on to their current housing. A student focus group participant explained, “My parents have been offered money to move out because the building owners want to convert the building. My parents are fighting the landlord: they don’t want to move out no matter how much money they get offered. Where would they move?”

The factors that promote housing security among Latino immigrant communities include legal rights advocacy services, and organizations that serve as hubs to affordable and accessible educational, health and employment resources.

**SLQ #5: Considering that the Latino population served by KFH-LA is comparatively low income, has a low level of formal education, and lives in crowded housing, why are the health outcomes better than for similarly situated Black populations? Is there important intra-group variation among Latinos (e.g. 1st vs 2nd generation status/immigrant status) that is overlooked when we average all subgroups of Latinos together? Are there protective factors we can nurture? What is the lived experience of each of these Latino subgroups?**

This strategic learning question was formulated to help us learn more about the “Latino paradox”--the observation that at a population level in the United States, first-generation low-income Latino immigrants are much healthier than their socioeconomically similar peers of other ethnic/racial backgrounds. Responses to this question during community engagements revealed that further exploration is necessary to understand this pattern. While overall, Latinos may be healthier than their Black peers, there are important differences between Latino subgroups. Even among first-generation Latinos, there are important differences in health status related to the conditions in their home countries and their immigration experience that can further be explored.

Through our engagements we learned that many Central American immigrants arriving in the current wave of immigration come from experiences of extreme poverty and carry a very heavy burden of trauma with them. For this reason, they lack a foundation of good health. A direct service provider explained, “People have left their countries because there is no food, and many of them have left because of violence through gangs. Gangs have killed family members, burned homes, have extorted them for money that they don’t have. A lot of times they have to hide their family members in other towns. They come here seeking for asylum. Individuals coming to the US seeking relief … a lot of people come from the bestia, or the train. In this process, they have
no food, they encounter gang members, and they can’t sleep because they are always vigilant of their surroundings. And then they are detained at the US border. They aren't necessarily expecting that they would be detained – because they are misinformed. They are seeking relief, and then they go through another very difficult process. If not detained, they are here and they have an open case with immigration. They can’t work, their family members are pushing them to contribute but the law says that they can’t work. If they came with children, the children are going to school but they don’t speak English and get put in ESL classes.”

Further exploration of the “Latino paradox” would shed further light on important differences among subgroups of Latinos, and further inform efforts to support the health and wellbeing of Latino communities in the region.

SLQ #6: How does (lack of) social support and stable housing relate to rising rates of STI incidence among the LGBTQ people of color in the service area?

We learned from engagements with providers that there is a disproportionately high rate of LGBTQ people of color who are also homeless in the service area. This trend is the result of complex social forces. Many LGBTQ people of color face structural and individual racism and discrimination that limits connections with friends and family and access to sustainable employment and housing. Therefore, many end up “couch surfing” (staying in homes of strangers or acquaintances) or living on the streets. Both scenarios dramatically increase one’s vulnerability to sexual assault or engaging in “survival sex,” which increases the risk of contracting STIs.

We also heard in our engagements that drug use is extraordinarily common among individuals living on the streets—it functions as a vehicle for building community and it is a tool for staying safe (e.g. staying awake at night). Injection drug use further contributes to the risk of contracting an STI, particularly for individuals who don’t know about or have access to safe drug use resources. A homeless LGBTQ youth service provider explained, “Youth not housed in 24 hours their first day on the streets, will have survival sex and use drugs to stay awake.”

SLQ #7: What factors inhibit or promote finding stable, comfortable, healthy and/or improved housing, and stable social networks for LGBTQ people of color in the service area?

LGBTQ people of color, and particularly those who are disconnected from family and friends, face multiple obstacles to breaking out of a cycle of homelessness or poverty and building stable social networks. Factors that promote the likelihood of LGBTQ people of color to find stable housing include programs that provide job training and access to employment, continuing education, health care, and access to housing assistance. These programs are most successful when designed specifically to work for and support the LGBTQ community. Efforts to educate communities about the LGBTQ community and to advocate for inclusion contribute to the likelihood that more LGBTQ people of color will not become disconnected from friends and family to begin with, but rather accepted and integrated into communities and their families.

SLQ #8: What factors inhibit or promote the secure, consistent access to and use of health care for residents of the service area?

In our engagements, we heard that many service area residents’ lives are very precarious—they work very hard to establish some kind of stability for themselves and their families. Often the work of establishing this balance supersedes all else, including preventive health care. As a resident explained, “When a person is in survival mode, health care issues take low priority.” If the prescribed program of treatment is financially or logistically inaccessible, it can’t be followed. Even with insurance, the costs associated with health care are too high for people to pay, so they don’t go. Effective solutions include reducing the associated costs of health care. For example, very low cost medications and long-term repayment options that allow low-income clients to take advantage of care early—before the need to seek acute care in the emergency room.
Service area residents explained that the health care system is unfamiliar to immigrants from countries with socialized medicine or another type of insurance structure. Furthermore, healthcare settings can be intimidating and people who aren’t literate in English or Spanish might feel embarrassed or unwelcome. Additionally, to qualify for assistance, immigrants often need proof of residency or income, which they don’t have. Finally, the American mental health care system feels foreign. Immigrants bring other sets of values and beliefs around how best to deal with emotional and psychological distress, so often won’t think of seeking mental health care in response to stress, anxiety or depression. When a decision is made to pursue mental health care, it is difficult to find financially accessible care providers that work in a culturally responsive way. Effective solutions include the integration of culturally responsive mental health care services into more holistic community centers and schools, where the emphasis is on community and relationships.

Homeless residents and direct service providers explained that health care is often not accessed because it feels very risky to disclose a lot of personal information to an institution, particularly in the first interaction with a new service provider. We heard that the intimidation inherent in being asked to share personal information is a deterrent for other groups as well, including undocumented immigrants. Solutions include approaches that emphasize building trusting relationships with case managers and case teams, and that provide services first, before asking clients to complete extensive questionnaires and disclose details about personal and family history.

Finally, we heard that the supply of financially and culturally accessible behavioral and mental health care services falls short of the need for these services. Waitlists for services like low-cost mental health care can be discouragingly long. When services are available, they are most effective when tailored to their target populations. For example, many homeless individuals have comorbid mental and physical diseases which prevent them from being able to seek care if it is available at limited times or in limited locations. The most effective approaches to providing care to the homeless include mobile health clinics that meet people where they are to work around many of the limitations inherent in not having a home.

**SLQ #9: What are the strengths and assets of the network of homeless service providers and homeless communities in the Hollywood area that keep temporarily and chronically homeless individuals and families safe, and help them find the resources they need?**

In our engagements, we heard that the homeless coordinated entry system provides a large advantage to all service providers working to support the marginally housed and homeless. Furthermore, we heard that the trauma-informed approach many practitioners are taking is facilitating greater success with service recipients. Additionally, we heard there is a lot of enthusiasm behind current advocacy to change exclusionary program policies. For example, homeless advocates are fighting to change policies so that a client’s failure to follow through with service programs won’t “count against” their opportunity to re-enter the program at a later date. Finally, collective efforts to advocate for the dignity and humanity of the homeless population, and to encourage communities to welcome homeless housing, were lauded as reflective of the strengths of the network of homeless service providers in Los Angeles. Moreover, we heard that a great strength of homeless communities and service providers together is the inclusion of homeless individuals in program planning and leadership roles, and as peer navigators. These practices insure that programs are responsive and inclusive. Furthermore, these practices improve program outcomes because they facilitate the retention of homeless clients in programs and services.