Special Issue: Equitable Pandemic Response & Recovery

Journal of Humanistic Psychology
1–30

DOI: 10.1177/00221678221125330
journals.sagepub.com/home/jhp
SAGE

"A Voice to Uplift Other People": A Case Study of Integrating Organizing Methods in an FQHC-Based COVID-19 Vaccine Initiative in Latinx Communities

Rosa Vazquez[1], Aileen Navarrete[1], An Thien Nguyen[1], and Gloria Itzel Montiel, Ph.D.[1]

Abstract

The COVID-19 pandemic added another layer of trauma for working-class communities who have experienced trauma from systemic inequity and racism. Early pandemic response efforts failed to reach the most vulnerable Latinx communities in the United States due to historic disinvestment in these communities. Federally Qualified Health Centers (FQHCs) were uniquely positioned to respond to the pandemic through testing and vaccine implementation because of their footprint in these communities. However, to advance equitable COVID-19 recovery and long-term, trauma-informed community resilience, FQHCs need to expand their role beyond immediate response through testing and vaccine deployment. Applying Freirean principles of liberation to an integrated model for crisis recovery and community resilience-building, this article presents a case study of the implementation of a COVID-19 vaccine outreach and education initiative at AltaMed Health Services, one of the largest FQHCs in the United States. Findings suggest that leveraging organizing and empowerment strategies to

[1]AltaMed Health Services, Los Angeles, CA, USA

Corresponding Author:
Gloria Itzel Montiel, Ph.D., AltaMed Health Services, 2035 Camfield, Los Angeles, CA 90040, USA.
Email: gmontiel@altamed.org

implement COVID-19 vaccine distribution in working-class communities contributes to pathways for community health and well-being, infrastructure for crisis response and recovery, equitable service and information delivery ecosystems, and engaged and empowered communities. Lessons from this study can provide a blueprint for integrating strategies for long-term community resilience, capacity-building, and empowerment in crisis response and community harm mitigation initiatives. Findings from this study also present a model for enhancing the role of FQHCs to facilitate community organizing and engagement for health equity.

Keywords
community empowerment in health promotion, community organizing for COVID-19 pandemic response, community organizing for health, COVID-19 community empowerment models, COVID-19 recovery, COVID-19 response in Latinx communities, COVID-19 vaccine initiative, COVID-19 vaccine initiatives

Introduction

The COVID-19 pandemic unveiled and exacerbated the long-standing, disproportionate impacts of structural racism experienced by Latinx communities (Enriquez et al., 2021; Sáenz & Garcia, 2021). Latinx communities comprise 18.45% of the U.S. population but make up 24.2% of COVID-19 cases and 16.5% of deaths (Centers for Disease Control and Prevention, 2022). Low-income communities are at a higher risk for severe COVID-19 illness and at a heightened risk of experiencing long-term economic and social consequences as indirect effects of the pandemic (Bertsimas et al., 2021; Strully et al., 2021). Furthermore, the pandemic added a layer of trauma to communities that have experienced systemic inequities and exclusion (Liu & Modir, 2020). Griffin (2020) points to "toxic stress" produced by the pandemic, which created or elevated anxiety and other symptoms. U.S. institutions were massively unprepared, as demonstrated through the politicization of containment and mitigation measures (Alexander et al., 2022), limited-capacity testing sites, and infrastructure unfit to support social services.

COVID-19 vaccines introduced a pathway for COVID-19 prevention and harm-reduction for working-class communities of color who are overrepresented in the essential workforce (Grills et al., 2022; Roberts et al., 2020). However, infrastructure and crisis response systems were unprepared to reach these communities effectively and equitably (Wolfe et al., 2021). As vaccine eligibility expanded, the Latinx community was labeled as "vaccine hesitant,"

yet limited initiatives attempted to take a community-engaged approach to address the barriers to vaccine access and utilization (Kearney et al., 2021; National Public Radio, 2021; Reyes-Velarde, 2021).

Federally Qualified Health Centers (FQHCs) serve as the health care safety net in working-class communities of color, serving 29.8 million individuals in medically underserved areas throughout the United States (Cole et al., 2022). As such, they are uniquely positioned to reach these communities, albeit requiring intentional resource allocation and infrastructure mobilization. Ultimately, equitable vaccine implementation serves as only the beginning of an equitable recovery. Addressing the long-term impact of COVID-19, including the trauma it produced in working-class communities of color, requires also addressing the systemic inequities present in these communities long before the pandemic. However, few empirical studies show how to respond to the COVID-19 pandemic while setting the foundation for equitable community recovery and long-term community resilience (Koliou et al., 2018).

To bridge this gap, the present case study aims to (a) describe the implementation of AltaMed Health Services' local COVID-19 vaccine outreach and education initiative using an organizing and empowerment model and (b) analyze the ways in which this initiative sets the foundation for COVID-19 community recovery and long-term community resilience in its service area. Lessons from this study can provide a roadmap for integrating community empowerment and resilience-building strategies in crisis response and community harm mitigation initiatives. Findings from this study also present a model for enhancing the role of FQHCs to facilitate community organizing and engagement for health equity.

Positionality Statement

We engage in this work as first-generation professionals and community scholars from working-class backgrounds. Three of us identify as Latinx and grew up in immigrant households in the communities where our current work takes place. Nguyen is the eldest child of Vietnamese immigrants and identifies as a first-generation Vietnamese non-binary person. As a collective, we have experienced—firsthand—intersecting structural inequities and systems of oppression and their impact on health care access and health outcomes in our families and our communities. Our professional backgrounds span the sectors of health care, education, and political organizing, which provided us interdisciplinary approach to our work. Combined, our lived experiences and shared values of equity and community are the foundation for our work. We frame and implement this initiative not only as a vaccine equity project but

also as a mechanism to create community capacity and community power as a core strategy for health equity and liberation.

Literature Review

COVID-19 Impact

The COVID-19 pandemic disproportionately impacted racial/ethnic minorities in the United States, particularly Black, Latinx, and Native American communities. As of February 2022, there have been over 78 million confirmed cases and over 945,000 deaths from COVID-19 in the United States (CDC, 2022). According to the Centers for Disease Control and Prevention, 24% of COVID-19 cases in the United States were Latinx, although Latinxs in the United States represent 18% of the population (CDC, 2022; Hill & Artiga, 2022). Due to systemic inequities, disparities in the prevalence of comorbidities, such as diabetes, coronary artery disease, hypertension, and obesity, made Latinx communities vulnerable to the impacts of COVID-19 (Johnson-Mann et al., 2020; Macias Gil et al., 2020; Webb Hooper et al., 2020).

Social Determinants of Health

Interlacing social determinants of health (SDoH) as a result of structural racism (Yearby, 2020) contribute to COVID-19 disparities (Egede & Walker, 2020; Flagg & Campbell, 2021). In addition, low-income jobs accessible to these communities—often in the service sector—increases their risk of exposure without providing workplace protections for individuals who do become ill, such as sick days or the flexibility to work from home (Burström & Tao, 2020; Galdamez et al., 2020). Working-class individuals are also more likely to live in multi-family or multigenerational households due to inequitable access to housing (Cardoso et al., 2004; Reitsma et al., 2021), complicating the ability of individual family members to self-isolate when they do become ill and increasing the risk for others in that household (Ghosh et al., 2021; Rollston & Galea, 2020; Tinson & Clair, 2020). Latinx communities are also less likely to have access to health care compared with other racial and ethnic groups in the United States; presently, 20% of non-elderly Latinx individuals are uninsured in the United States, compared with 4.3% of their non-elderly White counterparts (Artiga et al., 2020). These and other compounding SDoH exacerbate the COVID-19 pandemic's impact in communities of color, resulting in additional mental health stressors in these communities due to disproportionate financial stress, illness, and loss of life during this time (Gibson et al., 2021; Purtle, 2020; Smith et al., 2020).

FQHCs Response to Public Crises

As FQHCs are embedded into their local community, they are well-positioned to lead pandemic identification, outbreak response implementation, and resource management among vulnerable communities (Castro & Sloane, 2022; Kim et al., 2021). Castro and Sloane (2022) found that FQHCs in rural communities were essential in organizing, negotiating, and leading a collaborative effort across multiple stakeholders. A later study (Castro & Sloane, 2022) recommends FQHCs develop a wide array of contacts with workplaces, other health care providers, churches, businesses, governmental bodies, and other local resources to respond to future health crises. One gap in the models above is the lack of community and patient inclusion in the planning and implementation of their responses. Furthermore, an analysis of FQHC's vaccine administration found that FQHCs do not administer vaccines equitably by race and ethnicity (Cole et al., 2022).

However, FQHC's experience with responding to prior crises shines a bright spot for the potential of this sector to play a critical role in creating mechanisms for long-term resilience. For example, one case study of CrescentCare, in New Orleans, Louisiana, showed that their experience with responding to Hurricane Katrina facilitated the rapid ramp-up of COVID-19 testing, clinical evaluations, and walk-in vaccine clinics, as well as mental health counseling and linkages to supportive services (Halperin et al., 2021). Furthermore, the CrescentCare example suggests the effectiveness of combining essential medical services with advocacy for an effective public health response that engages small businesses and local places of worship (Halperin et al., 2021). Although FQHCs' scholarship on community organizing and advocacy is limited, the Neighborhood Health Initiative, a partnership between a medical school, a FQHC, and community-based organizations implemented a community engagement model to improve health outcomes for Latinx residents and communities of color living across two zip codes in Austin, Texas (García, 2022). The present study aims to contribute to the literature on community organizing and capacity-building integration through FQHCs for a more effective response to public health crises, equitable recovery, and community resilience.

Conceptual Framework

This study applies Paulo Freire's Theory of Liberation Education (Friere, 1970) to a model that integrates adapted crisis management (Kapucu, 2008) and community resilience (Pinderhughes et al., 2015) (Figure 1). Freire's Theory calls for creating mechanisms to activate critical consciousness

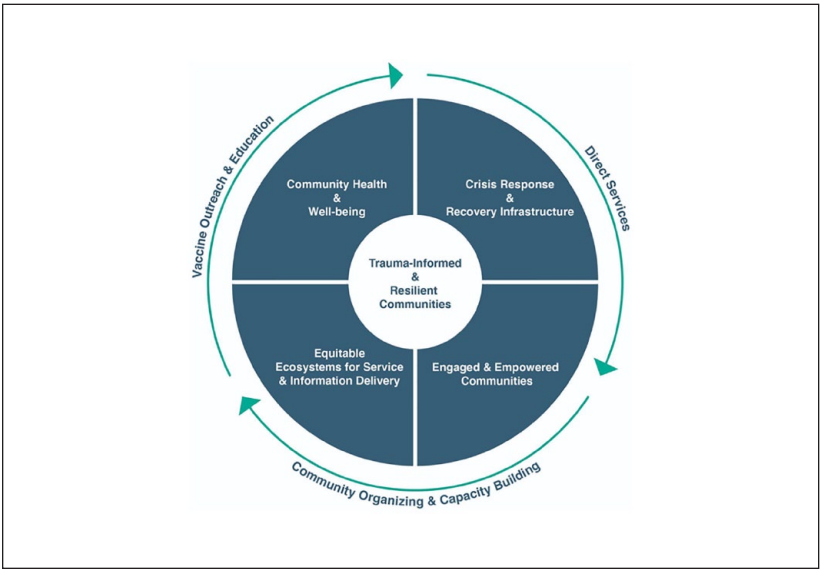


Figure 1. Conceptual Model: Integrating Freirean Concept of Liberation to COVID-19 Vaccine Initiative.

among communities that have been historically oppressed, as well as pathways for these communities to change the conditions that foster inequity (Freire, 1970). Freirean principles have been a cornerstone for public health and community health initiatives that aim to center community voices and experiences as a central strategy for equity (Gharouni et al., 2020; Wallerstein & Bernstein, 1988). In this case study, these concepts are grounded in ethnics of community care (Nolas, 2014) to support individuals to recover from the impacts of COVID-19. At the same time, the project supports individuals' engagement in collective action toward community-wide resilience.

The COVID-19 pandemic's impact on working-class communities of color was exacerbated due to the structural inequities experienced by these communities long before the pandemic (Grills et al., 2022). Forced powerlessness was both one of the main sources of and a result of these inequities (Camacho et al., 2022; Girard et al., 2022). Social justice-oriented scholars and practitioners have called for a pathway to community recovery that does not revert to pre-pandemic times but rather re-builds to address the root causes of health disparities (Ndumbe-Eyoh et al., 2021). This process requires authentic community participation in creating and implementing the blueprint for recovery (Montiel et al., 2021). Freirean principles of liberation,

therefore, provide the theoretical foundation for including community organizing and capacity building in our initiative as a critical mediator of the processes that will sustain trauma-informed and resilient communities over the long term.

Method

Design

This article presents an intrinsic case study (Gutterman & Fetters, 2018; Stake, 1995) to examine how one of the largest FQHCs in the United States leverages COVID-19 vaccination outreach and engagement campaign as a pathway for COVID-19 recovery and community resilience. Case studies are appropriate when conducting real-time (Yin, 2014) in-depth analyses within a particular system (Merriam, 1998). In this study, we define the unique context as FQHCs, as they serve as safety-net clinics for communities that the COVID-19 pandemic has impacted the most. We also analyze the specific phenomenon of AltaMed's approach to COVID-19 community outreach and engagement through organizing and community capacity building and its impact on setting the foundation for crisis recovery and long-term community resilience building. The project was exempt from Institutional Review Board oversight. Program staff also received signed releases for all photographs included in this article.

Description of AltaMed and Priority Population

AltaMed Health Services (AltaMed) is one of the largest FQHCs in the United States, serving more than 320,000, primarily working-class, Latinx patients in the Greater Los Angeles metropolitan area. AltaMed's infrastructure includes 43 medical sites, 8 sites housing the Program for All-inclusive Care for the Elderly (PACE), 10 dental sites, and 10 pharmacies. Service sites are located in densely populated Zip Codes that have been designated as medically underserved areas by the Health Resources & Services Administration. Thirty-four percent of AltaMed patients use Spanish as their primary language. In addition, 44% of AltaMed's patients live at or below 200% of the Federal Poverty Level, and approximately 20% are uninsured, an indicator that may also signal an undocumented immigration status.

AltaMed's mission is to eliminate disparities in health care access and outcomes by providing superior quality health and human services through an integrated delivery system for Latino, multi-ethnic, and often-overlooked communities in Southern California. As such, AltaMed operates a range of

programs beyond providing medical care. AltaMed's full continuum of care includes complete primary care, pediatrics, obstetrics and gynecology, senior services with the Program for All-inclusive Care for the Elderly, dental care, youth services, HIV services, and substance use disorder programs. In addition, the AltaMed Institute for Health Equity houses medical education, a family residency program, health services research, service grants, and community organizing for health equity. The Institute was launched in 2017 to assist the organization in advancing its mission by designing and implementing research, expanding and retaining a culturally concordant workforce, and implementing clinical and community programming focused on addressing critical health outcomes, SDoH, and the root causes of health disparities.

Intervention/Procedure

This case study focuses on Phase I of AltaMed's local COVID-19 vaccine outreach and education between July 1, 2021, and December 31, 2021. Our team hired seven COVID-19 Community Organizing and Research Engagement (CORE) Fellows from AltaMed's service areas. Within the initial 2 months of the program, Fellows completed an initial 24-module curriculum that included: introduction to health equity and SDoH, introduction to community mobilization, conducting outreach and engagement, COVID-19 basics, and addressing vaccine misinformation. We first trained Fellows on equitable community engagement and organizing principles before introducing COVID-19. This process allowed us to ground the work in strategies to address forced powerlessness in the community and set the model for activating and training a local community workforce to respond to any crisis or need to reach the community beyond COVID-19.

Through two Human Resources & Services Administration grants, AltaMed increased its workforce and infrastructure to support the COVID-19 initiative. The original cohort of Fellows became program leads, and we hired an additional cohort of 26 Fellows to expand outreach, education, and community vaccination events. In addition, a field campaign consultant and three data management consultants were contracted to support the initiative.

Among our lead Fellows, 71% identified as female, and 29% identified as male. One hundred percent of the lead research fellows were between 18 and 24 years old. In addition, 100% of our lead Fellows self-identified as Latinx. Among the 26 Fellows from our later cohort, 37% self-identified as male, and 63% female. One hundred percent of our Fellows identified as Black, Indigenous, and people of color: Latinx (85%), Black (4%), and Asian (11%). 92% of Fellows were 18 and 24 years old in our later cohort. In selecting Fellows for the outreach campaign, we prioritized hiring young adults from

the communities most impacted by the pandemic. We did so under the assumption that this group of young adults could serve as the bridge between their families—and by extension, the community—and the public health and health care systems.

AltaMed's local COVID-19 vaccine initiative encompassed three implementation areas: outreach and education, direct service delivery, and community organizing. Activities under the first two areas ensured that vaccines were deployed equitably in the most impacted communities while also linking to and providing services to meet immediate needs rising from the pandemic, as a foundation for recovery from the impact of the COVID-19 pandemic. The last implementation area, community organizing and capacity building, is the driver of long-term community resilience. Table 1 presents activities conducted as part of each implementation area.

Data Collection

The case study design calls for data from multiple sources (Stake, 1995; Yin, 2014). This mixed-method approach allows for a more complete understanding (Greene et al., 1989) of AltaMed's model and implementation of COVID-19 vaccine outreach on (a) community recovery and (b) community resilience. For this study, we gathered quantitative data through community health worker surveys, outreach and service logs, and program participant surveys, using digital systems—Nationbuilder, Qualtrics, Google Sheets, and e-Canvasser—to capture and manage data specific to outreach and community health worker surveys. Qualitative data were gathered through Research Fellows reflection videos collected after every outreach and education activity, field photographs, notes from program planning and debrief roundtables, a free response questionnaire completed by community health workers, and observations. In addition, Research Fellows completed a pre-, mid-, and post-qualitative survey to assess the impact of their participation in the various components of the project.

Data Analysis Description

Outreach and service data are summarized in this article to reflect process outcomes of the work, in particular, to contribute to the analysis of the recovery aspect of this study's aim. Reflection videos and photographs were labeled and organized by themes. Greenfly, a digital content management platform, was used to organize and manage visual data. In addition, videos were transcribed using Otter.ai to produce 121 pages of text for analysis. Transcriptions, notes, observations, and the free-response questions

Table 1. Components of AltaMed's Los Angeles and Orange County COVID-19 Vaccine Initiative.

Intervention areas	Activities
Outreach and education	• Door-to-door canvassing • Community events • Neighborhood-based tabling • K-12 and college-based tabling • Outbound phone banks • Peer-to-peer texting • In-bound call center • Virtual town halls • Social media campaigns • Partner flyering program
Direct service delivery	• Vaccine appointment scheduling • Transportation coordination for vaccine appointments • Referrals and linkages to economic relief programs • Rapid COVID-19 test kit distribution • Safety kit distribution
Community organizing	• Continuous community needs assessment and asset mapping • Partnership mobilization and small business activation • Community and youth ambassadors programs • Street vendor outreach ambassador program • Community workforce development • Community volunteer program • College campus activation program • Digital community partners activation program

underwent content analysis guided by the theoretical framework (Mayring, 2002, 2014, 2019) to increase internal validity. Themes were organized in tables based on the study's two primary outcomes and under subcategories reflecting the different components of the theoretical framework. During in-person meetings, the authors discussed the themes generated from the content analysis and compared themes to photographs and video through data triangulation (Flick, 2002). Narratives and photographs were collectively selected to illustrate the themes.

Table 2. Summary of Direct Service Outcomes From July 1, 2021, to December 31, 2021.

Direct service type	Services	Outcomes
Testing services	Testing site referrals and appointments	17,353
	At-home testing kits distributed	775
Vaccine appointments	Campaign vaccine warm line	11,685
	Vaccines through partner events	19,100
	AltaMed vaccine pop-up events	2,198
Vaccine support services	Transportation for vaccines	1,181
Linkage to care	Telehealth appointments made	7,460
	COVID-19 safety kit distribution	1,950
Rental relief	Rental assistance referrals	8,356
	Organizational partners engaged	35
	Community members engaged	42
Other services	Referrals to legal services	176
	Social service referrals to partners	26,000
	Referrals to COVID-19 crisis line	8,578

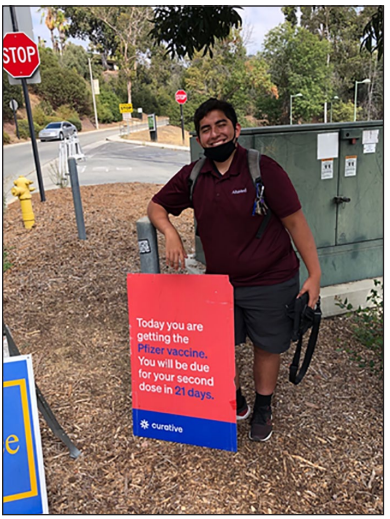
Results

Table 2 summarizes the direct service outcomes of AltaMed's COVID-19 vaccine initiative, as reported by CORE Fellows on outreach and service logs. These services are the first step toward community recovery, as they link individuals and families to resources that will reduce the immediate harm caused by the ongoing pandemic and address its social and economic impact.

Building the Foundation for Community Resilience

Although the section above provides a summary of the outreach, education, and service outcomes, this section provides findings from qualitative and visual data that provide insight into both the process and impact of integrating a community-centered organizing approach to AltaMed's COVID-19 vaccine initiative. This section is organized into the four components of community resilience highlighted in the conceptual framework.

Community Health and Well-Being. As a precursor to begin community healing from the additional trauma created by the COVID-19 pandemic and from the pandemic's health impact, it was necessary to engage in immediate harm-mitigation activities that connected individuals to vaccines and testing (see



Note: One barrier was that people had difficulty finding the vaccine pod and parking and needed direction.

Photograph by: Oscar Macias

Note: AltaMed Vaccine event at California State University Los Angeles. The entrance had a table, making it easy to get the vaccine.

Photograph by: Oscar Macias

Figure 2. COVID-19 Vaccine Community Events.

Figure 2). This included breaking away from the narrative of "vaccine hesitancy" as an inherent quality of Latinx communities and, instead, taking a community-engaged approach to identifying and co-developing solutions to the barriers that prevented community members from accessing vaccines. CORE Fellows tracked community barriers and needs at each outreach and/or vaccination event through taking photographs (e.g., Figure 2) and through reflections recorded after each event. After each event, program staff led a debrief session with CORE fellows in which they would assess these data. Through the ongoing process of data analysis and reflection, CORE Fellows and program staff outlined various categories of solutions to support community health and well-being.

Embedding Freirean principles into this work also called for addressing community health and well-being through a broader lens than the immediate urgency created by COVID-19. Table 3 illustrates how AltaMed's COVID-19 vaccine initiative operationalized this framework. Organizing work inherently works against established structures of exclusion, which adds

Table 3. Supporting Community Health and Well-Being Through AltaMed's COVID-19 Vaccine Initiative.

Adapted Freirean principles into COVID-19 vaccine initiative	Impact: recovery	Impact: community capacity and resilience building
Addressing barriers to COVID-19 vaccine access and testing (e.g., transportation, vaccine appointment support)	• Increased access to vaccines for communities instead of relying on "vaccine hesitancy" to explain lower vaccination rates in priority community	(1) Creating a process for continuous, community-informed, and community-led needs assessment during crisis (2) Implementing an intersectional way to address social needs during a crisis through creating solutions for barriers to service created by structural inequity (3) Integrating emotional wellness and mental health services as critical components of crisis response and supporting the workforce responding to crisis
Integrated information and service delivery that was non-COVID-19-specific	• Linked community members to services to meet unaddressed health concerns	
Contracted a counseling psychologist to conduct healing circles with workforce	• Supported well-being of workforce	
Implemented mental health *pláticas* with community members, facilitated by counseling psychologist who is representative of the community	• Provided one of the few culturally concordant spaces for community healing	

additional stressors for the team conducting this work. In addition, given that our workforce is composed of individuals from our community, they, too, were constantly impacted by the issues the initiative sought to address. Program staff leveraged debrief notes to better understand the needs of the workforce leading the initiative. The issue of mental health rose as one of the priorities of our community and the team. One of the initiatives Fellows, Sherry, recounts,

> One woman told me she was hospitalized for a couple of weeks as a single mother with two daughters. It was stressful for her not to be present and in good health for her underage children. It is hard to hear. Is there anything we can do to support people like that? I feel like there's leftover trauma and anxiety from that kind of situation, not having the support they need. That's something I want to try to do something about.

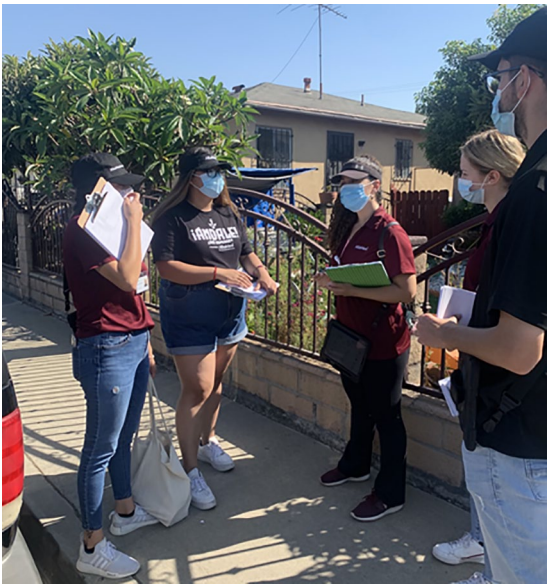


Figure 3. September 23, 2021—Door-to-Door Canvassing.
Photograph by: An Nguyen.

To respond to this need, AltaMed contracted with a counseling psychologist. In so doing, we intentionally embed mental health services as a core component of the support system for the workforce responding to the pandemic. We also prioritize mental health services in the communities most impacted by COVID-19 as a principal manner to enhance community health and well-being. However, sustaining health and community wellness in the face of future crises requires building infrastructure for crisis response.

Crisis Response Infrastructure. Introducing organizing strategies to AltaMed's COVID-19 vaccine outreach and education created opportunities to re-imagine FQHC's role in building a community-wide crisis response infrastructure that will outlive the COVID-19 pandemic. The initial pandemic response across the United States was dismal given the failure of the U.S. health care system to reach communities without existing infrastructure for crisis response. COVID-19 vaccine deployment required building the mechanisms through which health systems could reach communities, especially the health care safety net. One of these strategies was adapting political organizing strategies such as canvassing and phone banking to deliver public health

Table 4. Strengthening the Crisis Response Infrastructure.

Adapted Freirean principles into COVID-19 vaccine initiative	Impact: recovery	Impact: community capacity and resilience building
Trained and activated a community workforce through empathy-based power-building models for crisis response	• 7 Leads and 26 COVID-19 Community Organizing & Research Engagement Fellows conducted outreach and education in working-class communities of color in Los Angeles and Orange County (LA/OC)	(1) Development of a roadmap for activating community members as agents in crisis response (2) Creating a process for development and maintenance of partnership networks that can activate around community priorities (3) Building infrastructure to reach community members directly through trusted messengers (4) Increasing community stakeholders to remain engaged through the entire crisis management process (immediate response to recovery and preparedness)
Engaged workforce in participatory evaluation of messaging every 2 weeks	• Increased real-time relevance of messaging • Produced culturally and age-appropriate messaging	
Activated and expanded network of multi-sector outreach partners to disseminate community-informed messaging	• Increased cohesion in addressing misinformation/disinformation at the community-level	
Shared financial resources with partners to enhance service delivery capacity	• Increased capacity of smaller community-based organizations and businesses to engage in pandemic response	

messaging (See Figure 3) and using outreach data and field notes to identify gaps in infrastructure to reach community members, to understand the impact of messaging, and to learn about the processes that community uses to seek resources.

AltaMed also partnered with the offices of local elected officials to build the capacity of their staff to organize these types of outreach events in their district. Through this capacity-building process, we initiated a process to activate existing infrastructure to reach community members in their community, rather than placing the burden on these communities to navigate ineffective systems and

limited infrastructure to reach services. Table 4 presents AltaMed's local vaccine implementation model's additional contributions to building crisis response infrastructure.

Establishing community relationships and trust is a critical pathway to sustaining infrastructure for crisis response beyond COVID-19. As such, the AltaMed COVID-19 vaccine initiative sought to increase its presence in neighborhoods within its service area through continuous, direct outreach and engagement. One of the Fellows, Gustavo, said,

> I think it's important we reach out, as we did during that phone bank. But, we could follow up, make sure the community knows that we care about them, and this can lead to good outcomes like scheduling their appointment for their second dose.

Gustavo's comment reflects the desire of the team to establish a continuous pipeline of communication and presence in the community to disrupt how working-class communities of color have been historically excluded from systems that can distribute information and services in a time of crisis.

Equitable Information and Delivery Ecosystems. Responding to the COVID-19 pandemic in working-class communities of color was difficult because it required the rapid development and dissemination of COVID-19 information against a backdrop of constant changes in scientific discoveries and public health recommendations. In addition, it required building inroads reaching these communities for the first time. In delivering outreach and services, we sought to build ecosystems that can outlive the pandemic and serve as an ongoing process for supporting community health. Table 5 outlines the processes that the AltaMed COVID-19 vaccine initiative undertook to build these equitable systems. These processes were captured through notes after debrief sessions, multi-media reflections from CORE Fellows, and to a smaller extent in reviewing outreach and service data to better understand the effectiveness of particular messages or influencers (e.g., assessing how many social media "re-shares" each message or particular messenger received). Combined, these sources of data helped to better evaluate the ways in which community-partnership increased the efficiency to deliver information for the team and provided greater likelihood that the information would be relevant to priority communities.

Engaged and Empowered Communities. One of the most important outcomes of AltaMed's COVID-19 vaccine initiative, thus far, has been developing a new model for leveraging a community health center workforce to organize

Table 5. Building Equitable Information and Service Delivery Ecosystems.

Adapted Freirean principles into COVID-19 vaccine initiative	Impact: recovery	Impact: community capacity and resilience building
Co-developed strategies, messaging, and materials with community workforce and community groups Re-defined social media "influencers" for grassroots social media organizing Implemented a three-tiered outreach strategy to: 1. Meet community where they are at to build trust; 2. Deploy COVID-19 vaccine and recovery information 3. Enhance critical consciousness and set priorities. Established network of value-aligned service delivery partners Created community-informed service inventories	- Increased effectiveness of messaging - Increased attendance at community vaccination events - Increased digital reach through activating partners that have historically been excluded despite having community trust and reach - Increased ability of FQHCs to reach priority community through multi-modal approaches - Improved efficiency of service referrals and linkages - Reduced information gap of available services	(1) Establishing a process for valuing community expertise through engaging them in strategy, material and messaging co-development (2) Centering and responding to community priorities in the deployment of services (3) Actively reaching community in the places where they naturally live, work, and gather instead rather than burdening community members to navigate through structurally inaccessible services (4) Aligning and building capacity of partners for a community-engaged approach to service delivery

FQHCs = Federally Qualified Health Centers.

for health. This model advances equity and social justice by building community capacity for long-term resilience and power-building. Andrew, one of the initiative's Fellows, reflects, "Outreach to me means becoming a voice, not one only informed by listening, but a voice to uplift other people, especially those who are not able to voice themselves." As part of the ongoing training and capacity-building of COVID-19 CORE Fellows, we engage in

Figure 4. Co-developing Outreach and Engagement Strategies With Community Organizing Fellows.
Photograph by: Gloria Itzel Montiel, Ph.D.

conversations about how structural racism and structural exclusion force powerlessness in working-class communities of color. At the same time, this initiative allows us to amplify the experiences and voices of others in the community that traditional systems have neglected. Second, this work reframes how outreach and engagement strategies are implemented at FQHCs through a participatory approach in which our community workforce co-developed the field strategies for the initiative rather than only implementing a work plan (see Figure 4). We outline the additional ways this work contributes to setting the foundation for engaged and empowered communities in Table 6.

Discussion

The COVID-19 pandemic created a unique moment for reconsidering the view of macro-level crises as static situations that can, through the right interventions, achieve a status of "managed." For Latinx and low-income communities in South East LA and Central Orange County, COVID was and is not a one-time crisis that needs to be managed but rather an ongoing source of devastation exacerbated by pre-existing social inequities (Enriquez et al., 2021; Sáenz & Garcia, 2021). Emergency management models (see: theoretical frameworks in Kapucu, 2008) define four elements (preparedness, mitigation, response, and recovery) for static crisis management and provide a framework to consider how our efforts contribute to COVID-19 response and recovery.

Table 6. Sustaining Engaged and Empowered Communities.

Adapted Freirean principles into COVID-19 vaccine initiative	Impact: recovery	Impact: community capacity and resilience building
Expanded role of FQHC-based community outreach workers to include community organizing	• Increased FQHC outreach and engagement capacity	(1) Building a process for FQHCs to engage with communities as co-learners and central agents of change
Developed community training curriculum with organizing and building community power as central strategy for outreach	• Increased capacity of Fellows to identify and address the results of systemic inequity • Trained 252 volunteers to join in COVID-19 outreach and education	(2) Strengthening existing community infrastructure to engage in organizing
Implemented community *pláticas* as a culturally-rooted method for dialogue with community members	• 12 *pláticas* held on various COVID-19-related topics • Provided forum for community members to voice concerns, questions, and ideas for solutions	(3) Enhancing connection between community members, service providers, the health care system, and other institutions
Created three community ambassador programs for general community members, youth, street vendors, and community-based organizations	• Increased number of trusted messengers to deliver vaccine information	(4) Building community critical consciousness and community capacity for collective action toward systems-level change
Initiated a multi-sectoral COVID-19 recovery workgroup that includes grassroots partners, community ambassadors, and institutional/ organizational partners	• Engaged new types of partners that are not traditionally engaged for public health messaging • Amplified unified COVID-19 vaccine messaging in community • 21 partners engaged	
Developed internal structures for more equitable partnerships with community stakeholders	• Increased efficacy of COVID-19 vaccine messaging through co-development strategies • Increased partner capacity to engage in COVID-19 vaccine education	

FQHC = Federally Qualified Health Centers.

Literature has well documented the negative consequences and implications of not involving the community in crisis management and recovery discussions and decisions (Choi, 2004; Fordham, 1999; Kapucu, 2008; Ketteridge & Fordham, 1998; Mileti, 1999; Wood, Boruff & Smith, 2013). This means that crisis management and response must include measures to (a) provide ongoing and rapidly iterating crisis mitigation activities, (b) co-develop community-informed and adaptable response strategies, and (c) implement recovery initiatives that address the underlying reasons for disparities and build sustainable infrastructure for community preparedness. The present study expands what is known about how crisis response interventions to COVID-19 can be leveraged to increase individual community capacity to cope with a crisis while enhancing their participation in long-term community resilience building.

AltaMed's COVID Vaccine initiative advanced crisis mitigation and response efforts in Central Orange County and the Greater Los Angeles metropolitan area through outreach and service delivery initiatives (Baral, 2021; Dzigbede et al., 2020). Aligned with Freirean Principles for liberation education (Freire, 1970), we leveraged our initiatives as an opportunity to advance community engagement strategies to (a) increase community connectivity to facilitate spaces to create a collective understanding of the pandemic, (b) create spaces and connections that can increase community critical consciousness and lead to community defining priorities, and (c) build capacity, mobilize partners and stakeholders and provide avenues for collective action around community priorities.

Integrating Community Empowerment in Mitigation, Response, and Recovery Efforts

Mitigation and response efforts have the ability to protect communities and save lives at the onset, during, and after a disaster (Castro & Sloane, 2022; Strully et al., 2021). This also means that mitigation and response efforts that do not address the most pressing issues, fail to actually reach impacted communities, or address only surface-level impacts, can further contribute to disparities (Alexander et al., 2022; Grey et al., 2021). The pandemic's rapidly changing nature meant that to support mitigation structures, partnering with community members was a necessary precursor to equitable response efforts. Strategies to accomplish community partnership include leveraging canvassing activities, family interviews, co-planning sessions, and general community interactions to engage the community in setting priorities for the initiative. By engaging community members, the initiative enhanced its

effectiveness in identifying community needs and resource gaps and analyzing existing organizing, crisis response, and information infrastructures.

In the short term, the infrastructure that was created for co-learning, continuous multi-modal needs assessments, community ambassador programs (community, youth, and street vendors), small business activation, community volunteer programs, and partner community activation engage communities in COVID response and ensure that initiative supports community-centered crisis response. In the long term, capacity-building programs, community critical consciousness building pláticas, and avenues for community stakeholders to directly exert agency crisis response provide us with infrastructure to holistically engage communities in community power and resilience building (García, 2022; Gilmer et al., 2021, Jewett et al., 2021).

Our efforts provide evidence that employing community empowerment and participation strategies leads to increased community participation in recovery processes. Crisis response literature has established that community participation before (preparedness), during (mitigation and response), and after (recovery) any macro-level disaster can improve the ability of a community to "manage" it (Kapucu, 2008). Beyond that, literature across public health, community organizing, and community resilience literature shows that increased community participation leads to better long-term community outcomes, in this case, the ability for our communities not just to be "prepared" for the next crisis but rather recover equitably and build resilience (Chokshi, 2021; Daskalaki, 2018; Douglas et al., 2016; Grey et al., 2021; Halperin, 2020; Shepherd & Williams, 2014). Our model shows preparedness cannot be measured through institutions (Dzigbede et al., 2020; Kapucu, 2008) that respond to crises; preparedness must be measured through the community resilience indicators. We posit that preparedness is not a "state" nor a stage in the response process but rather an outcome of community-centered, empowerment-focused mitigation, response, and recovery efforts. Preparedness is an outcome that depends on investing in individual community members to cope with crises that create or exacerbate trauma, and to build their collective capacity to lead community resilience.

Conclusion

Historical exclusion and disinvestment have created forced powerlessness in working-class communities of color, contributing to SDoH and the health disparities they produce. FQHCs serve as the health care safety net in these communities and have responded to the pandemic through testing and vaccination programs in these same communities (Shapiro et al., 2021). However, to address the long-term trauma and impact of the pandemic, response efforts

need to do more than mobilize direct services. The case study presented in this article presents one model of how leveraging community empowerment models increases COVID-19 vaccine outreach and education effectiveness while building mechanisms and processes for community resilience.

A limitation of this study is the focus on a single clinical practice with FQHC designation, which limits the generalizability of the findings to other health care contexts. Furthermore, program implementation primarily reached Latinx communities, as this is the primary population AltaMed serves, limiting the understanding of how this model reached or impacted other historically marginalized communities. However, this study presents a valuable starting point to examine further how a community-engaged approach that is tailored and centered around local communities can contribute to building resilient communities. One strength of the study is that its multiple data sources allow for examining the nuanced ways in which processes and mechanisms are built within implementation to support recovery and the various components of resilient communities. In particular, the case study approach provides the mechanism for data triangulation and in-depth analysis of this phenomenon (Stake, 1995).

Furthermore, as one of the largest FQHCs in the United States, AltaMed provides the context by which to begin testing the conceptual model and disseminating learnings to other FQHCs that may not have the capacity or the resources to scale a community-led COVID-19 outreach and education initiative. This study can provide lessons that can be tailored across other sites. When crisis response organizations define their role as facilitators for community-driven crisis response, build structures to center communities, and leverage crisis response activities to increase community participation, they create the processes and infrastructure necessary for upstream approaches to crisis management. This approach improves the impact of crisis management activities, creates community contexts for community-driven equitable recovery, and lays the foundation for long-term community resilience building. FQHCs can utilize these learnings, as major actors in COVID-19 response, to redefine their role as facilitators that should (a) engage with communities as partners and co-learners, (b) create opportunities for them to identify and enact agency to advance their collective priorities, and (c) leverage their positionality to activate their networks and partners around community priorities.

Overall, our study contributes to the body of evidence (Swainston & Summerbell, 2008; Tai-Seale et al., 2016; Wallerstein & Duran, 2006) that highlights the effectiveness of equity models that integrate a human-centered lens to build community resilience. It also highlights the role of safety-net

clinics in advancing models that center and prioritize community leadership. As planning and resource allocation for COVID-19 recovery continues, it is imperative that the goal shifts away from returning to a pre-pandemic status quo. To ensure the long-term resilience of working-class communities of color, these same communities need to be actively and equitably engaged in setting priorities and co-creating solutions.

Acknowledgments and Credits

The authors thank Nena Davis and the Grants Development and Grants Management teams at the AltaMed Institute for Health Equity, Liselda Fabian and the AltaMed Workforce Development team, and Gabriela Tovar, Rocio Hernandez, and the Grants Management Team. The aforementioned teams assisted in securing funding for this initiative, managing grant funds, and/or helping to onboard our project team. We would also like to acknowledge Diana Rodriguez and Paulina Le for their support on graphic design and video transcription, respectively. Likewise, we would like to extend our gratitude to our partners at the University of California, Los Angeles, Dr. Moira Inkelas, Dr. Jennifer Peralta, and Dr. Vladimir Manuel, and our partners at Greenfly Kendall Perrin, Elaine Oliver, and Nicole Allen for helping us to create the infrastructure for collection and management of our qualitative data. Most importantly, we wish to extend special thanks to the AltaMed COVID-19 Community Organizing and Research Engagement Fellows and Administrative Support, Adaku Anusiem, Adelin Tiburcio, Adriana Aranda, Alexandra Garcia, Alexandra Mencias, Alexandra Perez, Allia Ochoa, Andrew Truong, Benjamin Amaya, Brianna Bustamante, Brittany Reynoso, Brittney Ultreras, Byanca Zavaleta, Christian Bustamante, Claudia Nguyen, Cristina Mares, Destinee Rodriguez, Edwin Diaz, Elena Chavez, Elizabeth Manuel, Eulises Cibrian, Eva Gomez, Felipe Ramirez, Fernando Barrientos, Gustavo Valle, Jacqueline Macias-Sandoval, Jasmin Navarrete, Joselin Amado, Khoa Le, Mariana Amarillas, Monica Gonzalez, Oscar Macias, Sherry Dorosk, Sophia Gonzalez, and Usiel Angeles, without whom this work would not have been possible.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: Funding for the various components of the AltaMed Institute for Health Equity's Los Angeles & Orange County COVID-19 vaccine outreach and engagement initiative was made possible through HRSA award number U3SHS42190-01-02, HRSA award number G32HS42575-01-01, UnidosUS award number 083906024, DirectRelief, CCLAC, a subgrant from the SELA Collaborative, RADx-UP 4U24MD016258-02, Subaward: A03-5097, and the American College of Preventive Medicine, award number 6 NU38OT000289-03-08.

ORCID iD

Gloria Itzel Montiel https://orcid.org/0000-0003-2540-1487

References

Alexander, M., Unruh, L., Koval, A., & Belanger, W. (2022). United States response to the COVID-19 pandemic, January–November 2020. *Health Economics, Policy and Law*, *17*(1), 62–75. https://doi.org/10.1017/S1744133121000116

Artiga, S., Tolbert, J., & Orgera, K. (2020, November 06). Hispanic people are facing widening gaps in health coverage. *KFF*. https://www.kff.org/policy-watch/hispanic-people-facing-widening-gaps-health-coverage/

Baral, P. (2021). Health systems and services during COVID-19: Lessons and evidence from previous crises: A rapid scoping review to inform the United Nations research roadmap for the COVID-19 recovery. *International Journal of Health Services*, *51*(4), 474–493. https://doi.org/10.1177/0020731421997088

Bertsimas, D., Boussioux, L., Cory-Wright, R., Delarue, A., Digalakis, V., Jacquillat, A., Kitane, D.L., Lukin, G., Li, M., Mingardi, L., Nohadani, O., Orfanoudaki, A., Papalexopoulos, T., Paskov, I., Pauphilet, J., Lami., O.,S., Stellato, B., Bourardi, H.T., Villalobos Carballo, K., Wiberg, H., & Zeng, C. (2021). From predictions to prescriptions: A data-driven response to COVID-19. *Health Care Management Science*, *24*, 253–272. https://doi.org/10.1007/s10729-020-09542-0

Burström, B., & Tao, W. (2020). Social determinants of health and inequalities in COVID-19. *European Journal of Public Health*, *30*(4), 617–618.

Camacho, K. G., Gomes Junior, S., Reis, A. T., Junqueira-Marinho, M. F., França, L., Abramov, D. M., de Azevedo, Z., Moreira, M., de Vasconcelos, Z., Salú, M., da Silva, M. L., Castro, B., Rodrigues, J. M., Pereira, C. D., Werner Junior, J., Bastos Junior, R. M., Caixeta, D., & Moore, D. (2022). Repercussions of the COVID-19 pandemic on health professionals in the state of Rio de Janeiro / Brazil. *PLOS ONE*, *17*(1), Article e0261814. https://doi.org/10.1371/journal.pone.0261814

Cardoso, M. R. A., Cousens, S. N., de Góes Siqueira, L. F., Alves, F. M., & D'Angelo, L. A. V. (2004). Crowding: Risk factor or protective factor for lower respiratory disease in young children? *BMC Public Health*, *4*(1), 1–8.

Castro, M. G., & Sloane, P. D. (2022). The role of a federally qualified health center in identification and management of an occupational COVID-19 outbreak: Lessons for future infection surveillance and response. *The Journal of Ambulatory Care Management*, *45*(1), 13–21. https://doi.org/10.1097/JAC.0000000000000397

Centers for Disease Control and Prevention. (2022). *COVID data tracker*. US Department of Health and Human Services. https://covid.cdc.gov/covid-data-tracker

Chokshi, D. A. (2021). From economic recovery to health resilience. *JAMA: The Journal of the American Medical Association*, *325*(8), 710–711. https://doi.org/10.1001/jama.2020.24936

Choi, S. O. (2008). Emergency management: Implications from a strategic management perspective. *Journal of Homeland Security and Emergency Management*, 5(1).

Cole, M. B., Raifman, J. R., Assoumou, S. A., & Kim, J. H. (2022). Assessment of administration and receipt of COVID-19 vaccines by race and ethnicity in US federally qualified health centers. *JAMA Network Open*, *5*(1), e2142698. https://doi.org/10.1001/jamanetworkopen.2021.42698

Daskalaki, M. (2018). Alternative organizing in times of crisis: Resistance assemblages and socio-spatial solidarity. *European Urban and Regional Studies*, *25*(2), 155–170. https://doi.org/10.1177/0969776416683001

Douglas, J. A., Grills, C. T., Villanueva, S., & Subica, A. M. (2016). Empowerment praxis: Community organizing to redress systemic health disparities. *American Journal of Community Psychology*, *58*(3–4), 488–498. https://doi.org/10.1002/ajcp.12101

Dzigbede, K. D., Gehl, S. B., & Willoughby, K. (2020). Disaster resiliency of U.S. local governments: Insights to strengthen local response and recovery from the COVID-19 pandemic. *Public Administration Review*, *80*, 634–643. https://doi.org/10.1111/puar.13249

Egede, L. E., & Walker, R. J. (2020). Structural racism, social risk factors, and Covid-19—A dangerous convergence for Black Americans. *New England Journal of Medicine*, *383*(12), e77.

Enriquez, L. E., Rosales, W. E., Chavarria, K., Morales Hernandez, M., & Valadez, M. (2021). COVID on campus: Assessing the impact of the pandemic on undocumented college students. *AERA Open*, 7(1), 1–19. https://doi.org/10.1177/23328584211033576

Flagg, L. D., & Campbell, L. A. (2021). COVID-19 in communities of color: Structural racism and social determinants of health. *Online Journal of Issues in Nursing*, *26*(2), Article 6.

Flick, U. (2002). *An introduction to qualitative research* (2nd ed.). SAGE.

Fordham, M. (1999). Balancing resilience and vulnerability. *International Journal of Mass Emergencies and Disasters*, *17*(1), 15–36.

Freire, P. (1970). *Pedagogy of the oppressed* (M. B. Ramos, Trans.). Continuum.

Galdamez, M., Keseven, C., & Melaas, A. (2020). *In a vulnerable state: Hispanic essential workers in California*. Milken Institute. https://milkeninstitute.org/sites/default/files/reports-pdf/InaVulnerableState_0.pdf

Godoy, M. Meet Maryland's secret weapon in the battle to close the Latino vaccination gap. *National Public Radio*, July 7, 2021. https://www.npr.org/sections/health-shots/2021/07/07/1012502246/meet-marylands-secret-weapon-in-the-battle-to-close-the-latino-vaccination-gap (accessed 13 September 2021).

García, A. A., Jacobs, E. A., Mundhenk, R., Rodriguez, L., Pulido, C. L., Hall, T., Allport-Altillo, B., & Tierney, W. (2022). The neighborhood health initiative: An academic–clinic–community partnership to address the social determinants of health. *Progress in Community Health Partnerships: Research, Education, and Action*, *16*(3), 331–338.

Gharouni, K., Ardalan, A., Araban, M., Ebrahimzadeh, F., Bakhtiar, K., Almasian, M., & Bastami, F. (2020). Application of Freire's adult education model in modifying the psychological constructs of health belief model in self-medication

behaviors of older adults: A randomized controlled trial. *BMC Public Health*, *20*(1), Article 1350. https://doi.org/10.1186/s12889-020-09425-7

Ghosh, A. K., Venkatraman, S., Soroka, O., Reshetnyak, E., Rajan, M., An, A., & Hupert, N. (2021). Association between overcrowded households, multigenerational households, and COVID-19: A cohort study. *Public Health*, *198*, 273–279.

Gibson, B., Schneider, J., Talamonti, D., & Forshaw, M. (2021). The impact of inequality on mental health outcomes during the COVID-19 pandemic: A systematic review. *Canadian Psychology/Psychologie Canadienne*, *62*(1), 101–126.

Gilmer, T. P., Center, K., Casteel, D., Choi, K., Innes-Gomberg, D., & Lansing, A. E. (2021). Developing trauma resilient communities through community capacity-building. *BMC Public Health*, *21*(1), 1681–1681. https://doi.org/10.1186/s12889-021-11723-7

Girard, J. M., Sprunger, J. G., & Chard, K. M. (2022). Reading between the lines: Exploring lexical and emotional content in baseline trauma impact statements. https://doi.org/10.31234/osf.io/aqtdm

Greene, J. C., Caracelli, V. J., & Graham, W. F. (1989). Toward a conceptual framework for mixed-method evaluation designs. *Educational Evaluation and Policy Analysis*, *11*, 255–274.

Grey, C. N. B., Homolova, L., & Davies, A. (2021). Community-led action in response to the COVID-19 pandemic in Wales: A national, cross-sectional survey. *The Lancet (British Edition)*, *398*, S51–S51. https://doi.org/10.1016/S0140-6736(21)02594-0

Griffin, G. (2020). Defining trauma and a trauma-informed COVID-19 response. *Psychological Trauma: Theory, Research, Practice, and Policy*, *12*(S1), S279–S280. https://doi.org/10.1037/tra0000828

Grills, C., Carlos Chavez, F. L., Saw, A., Walters, K. L., Burlew, K., Randolph Cunningham, S. M., Rosario, C.C., Samoa, R., & Jackson‐Lowman, H. (2022). Applying culturalist methodologies to discern COVID‐19's impact on communities of color. *Journal of Community Psychology*. https://doi.org/10.1002/jcop.22802

Guetterman, T. C., & Fetters, M. D. (2018). Two methodological approaches to the integration of mixed methods and case study designs: A systematic review. *American Behavioral Scientist*, *62*(7), 900–918.

Halperin, D. T. (2020). Coping with COVID-19: Learning from past pandemics to avoid pitfalls and panic. *Global Health, Science and Practice*, *8*(2), 155–165. https://doi.org/10.9745/GHSP-D-20-00189

Halperin, J., Conner, K., Telleria, C., Agins, B., & Butler, I. (2021). The vital role of a federally qualified community health center in New Orleans, Louisiana, during the COVID-19 pandemic. *The Journal of Ambulatory Care Management*, *44*(1), 2.

Hill, L., & Artiga, S. (2022, August 22). COVID-19 cases and deaths by race/ethnicity: Current data and changes over time. *KFF*. https://www.kff.org/coronavirus-covid-19/issue-brief/covid-19-cases-and-deaths-by-race-ethnicity-current-data-and-changes-over-time/

Jewett, R. L., Mah, S. M., Howell, N., & Larsen, M. M. (2021). Social cohesion and community resilience during COVID-19 and pandemics: A rapid scoping

review to inform the United Nations Research Roadmap for COVID-19 recovery. *International Journal of Health Services*, *513*(3), 325–336. https://doi.org/10.1177/0020731421997092

Johnson-Mann, C., Hassan, M., & Johnson, S. (2020). COVID-19 pandemic highlights racial health inequities. *The Lancet Diabetes & Endocrinology*, *8*(8), 663–664.

Kapucu, N. (2008). Collaborative emergency management: Better community organising, better public preparedness and response. *Disasters*, *32*, 239–262. https://doi.org/10.1111/j.1467-7717.2008.01037.x

Kim, S. J., Watson, K., Khare, N., Shastri, S., Pinto, C. L. D. G., & Nazir, N. T. (2021). Addressing racial/ethnic equity in access to COVID-19 testing through drive-thru and walk-in testing sites in chicago. *Medical Research Archives*, *9*(5).

Ketteridge, A. M., & Fordham, M. (1998). Flood evacuation in two communities in Scotland: lessons from European research. *International Journal of Mass Emergencies and Disasters*, *16*(2), 119–143.

Kearney, A., Lopes, L., & Brodie, M. (2021, January 14). Vaccine hesitancy among Hispanic adults. *KFF*. https://www.kff.org/coronavirus-covid-19/poll-finding/vaccine-hesitancy-among-hispanic-adults/

Koliou, M., van de Lindt, J. W., McAllister, T. P., Ellingwood, B. R., Dillard, M., & Cutler, H. (2018). State of the research in community resilience: Progress and challenges. *Sustainable and Resilient Infrastructure*, *5*(3), 131–151. https://doi.org/10.1080/23789689.2017.1418547

Liu, S. R., & Modir, S. (2020). The outbreak that was always here: Racial trauma in the context of COVID-19 and implications for mental health providers. *Psychological Trauma*, *12*(5), 439–442.

Mileti, D. (1999). *Disasters by design: A reassessment of natural hazards in the United States*. Joseph Henry Press.

Macias Gil, R., Marcelin, J. R., Zuniga-Blanco, B., Marquez, C., Mathew, T., & Piggott, D. A. (2020). COVID-19 pandemic: Disparate health impact on the Hispanic/Latinx population in the United States. *The Journal of Infectious Diseases*, *222*(10), 1592–1595.

Mayring, P. (2002). Qualitative content analysis: Research instrument or mode of interpretation? In M. Kiegelmann (Ed.), *The role of the researcher in qualitative psychology* (pp. 139–148). Ingeborg Huber.

Mayring, P. (2014). *Qualitative content analysis: Theoretical foundation, basic procedures, and software solution*. https://www.ssoar.info/ssoar/handle/document/39517

Mayring, P. (2019). Qualitative content analysis: Demarcation, varieties, developments. *Forum: Qualitative Social Research*, *20*(3), 1–26.

Merriam, S. B. (1998). *Qualitative research and case study applications in education* [Revised and expanded from "Case Study Research in Education"]. Jossey-Bass Publishers.

Montiel, G., Moon, K. J., Cantero, P. J., Pantoja, L., Ortiz, H. M., Arpero, S., Montanez, A., & Nawaz, S. (2021). Queremos transformar comunidades: Incorporating civic

engagement as an equity strategy in promotor-led COVID-19 response efforts in Latinx communities. *Harvard Journal of Hispanic Policy*, *33*, 79–101.

Ndumbe-Eyoh, S., Muzumdar, P., Betker, C., & Oickle, D. (2021). 'Back to better': Amplifying health equity, and determinants of health perspectives during the COVID-19 pandemic. *Global Health Promotion*, *28*(2), 7–16. https://doi.org/10.1177/17579759211000975

Nolas, S. M. (2014). Towards a new theory of practice for community health psychology. *Journal of Health Psychology*, *19*(1), 126–136.

Pinderhughes, H., Davis, R., & Williams, M. (2015). *Adverse community experiences and resilience: A framework for addressing and preventing community trauma*. Prevention Institute.

Purtle, J. (2020). COVID-19 and mental health equity in the United States. *Social Psychiatry and Psychiatric Epidemiology*, *55*(8), 969–971.

Reyes-Velarde, A. (2021, May 19). Many Latino men haven't gotten vaccinated. Misinformation, fear and busy lives are factors. *Los Angeles Times*. https://www.latimes.com/california/story/2021-05-19/why-many-latino-men-havent-gotten-vaccinated-yet

Roberts, J. D., Dickinson, K. L., Koebele, E., Neuberger, L., Banacos, N., Blanch-Hartigan, D., Welton-Mitchell, C., & Birkland, T. A. (2020). Clinicians, cooks, and cashiers: Examining health equity and the COVID-19 risks to essential workers. *Toxicology and Industrial Health*, *36*(9), 689–702. https://doi.org/10.1177/0748233720970439

Rollston, R., & Galea, S. (2020). COVID-19 and the social determinants of health. *American Journal of Health Promotion*, *34*(6), 687–689.

Reitsma, M. B., Claypool, A. L., Vargo, J., Shete, P. B., McCorvie, R., Wheeler, W. H., Rocha, D.A., Myers, J.F., Murray, E.L., Bregman, B., Dominguez, D.M., Nguyen, A.D., Porse, C., Fritz, L.F., Jain, S., Watts, J.P., Salomon, J.A., & Goldhaber-Fiebert, J. D. (2021). Racial/ethnic disparities In COVID-19 exposure risk, testing, and cases at the subcounty level in California: Study examines racial/ethnic disparities in COVID-19 risk, testing, and cases. *Health Affairs*, *40*(6), 870–878.

Sáenz, R., & Garcia, M. A. (2021). The disproportionate impact of COVID-19 on older Latino mortality: The rapidly diminishing Latino paradox. *The Journals of Gerontology, Series B*, *76*(3), e81–e87. https://doi.org/10.1093/geronb/gbaa158

Shapiro, A., Hackley, B., Hargarten, L., Kavanaugh, M., Tercero, F. S., Herszenson, D., & Kopa, J. (2021). The role of a federally qualified health center during a pandemic. *Pediatrics*, *147*(3_MeetingAbstract), 60–61.

Shepherd, D. A., & Williams, T. A. (2014). Local venturing as compassion organizing in the aftermath of a natural disaster: The role of localness and community in reducing suffering. *Journal of Management Studies*, *51*(6), 952–994. https://doi.org/10.1111/joms.12084

Smith, K., Bhui, K., & Cipriani, A. (2020). COVID-19, mental health and ethnic minorities. *Evidence-Based Mental Health*, *23*(3), 89–90.

Stake, R. E. (1995). *The art of case study research*. SAGE.

Swainston, K., & Summerbell, C. (2008). *The effectiveness of community engagement approaches and methods for health promotion interventions. Rapid Review. Phase 3* (including consideration of additional evidence from stakeholders). NICE National Collaborating Centre University of Teesside.

Strully, K. W., Harrison, T. M., Pardo, T. A., & Carleo-Evangelist, J. (2021). Strategies to address COVID-19 vaccine hesitancy and mitigate health disparities in minority populations. *Frontiers Public Health*, *9*, 645268. https://doi.org/10.3389/fpubh.2021.645268

Tai-Seale, M., Sullivan, G., Cheney, A., Thomas, K., & Frosch, D. (2016). The language of engagement: "Aha!" moments from engaging patients and community partners in two pilot projects of the patient-centered outcomes Research Institute. *Permanente Journal*, *20*(2), 89–92. https://doi.org/10.7812/TPP/15-123

Tinson, A., & Clair, A. (2020). *Better housing is crucial for our health and the COVID-19 recovery* (pp. 1–25). The Health Foundation.

Wallerstein, N., & Bernstein, E. (1988). Empowerment education: Freire's ideas adapted to health education. *Health Education Quarterly*, *15*(4), 379–394. https://doi.org/10.1177/109019818801500402

Wallerstein, N., & Duran, B. (2006). Using community-based participatory research to address health disparities. *Health Promotion Practice*, *7*(3), 312–323. https://doi.org/10.1177/1524839906289376

Webb Hooper, M., Nápoles, A. M., & Pérez-Stable, E. J. (2020). COVID-19 and racial/ethnic disparities. *JAMA: The Journal of the American Medical Association*, *323*(24), 2466–2467. https://doi.org/10.1001/jama.2020.8598

Wood, L. J., Boruff, B. J., & Smith, H. M. (2013). When disaster strikes… how communities cope and adapt: A social capital perspective. *Change*, *11*, 12.

Wolfe, R., Harknett, K., & Schneider, D. (2021). Inequalities at work and the toll of COVID-19. *Health Affairs Health Policy Brief*, *4*.

Yearby, R. (2020). Structural racism and health disparities: Reconfiguring the social determinants of health framework to include the root cause. *The Journal of Law, Medicine & Ethics*, *48*(3), 518–526.

Yin, R. K. (2014). *Case study research: Design and methods* (5th ed.). SAGE.

Author Biographies

Rosa Vazquez (she/her/ellas) leads the local implementation of AltaMed Health Services' COVID-19 outreach initiative. Rosa is a first-generation graduate from Harvard College with a concentration in Government, a minor in Ethnicity, Migration, and Rights, and a citation in Spanish. Rosa is the Consulting Manager on multiple grants focused on centering community voices, leadership, and experiences in COVID-19 response and recovery. Grounded in her lived experiences, Rosa partners with community members to build structures for community members to lead health interventions and policy and systems change. Her past experiences include electoral and issue campaigns and immigration organizing initiatives.

Aileen Navarrete (she/her/ella) has a Masters of Public Health from Boston University and a bachelor's degree in neuroscience from Harvard College. She served as the Data, Tracking, and Evaluation Coordinator for Phase I of AltaMed's local Andale Que Esperas vaccination campaign and subsequently as a Project Coordinator with AltaMed's Community Organizing & Research Engagement team. Currently, Aileen is a first-year medical student at the University of California, Irvine School of Medicine.

An Thien Nguyen (they/them) was raised in Riverside, California. An is the Dissemination & Research Coordinator for AltaMed's COVID-19 Recovery Campaign. An is a cum laude graduate in Political Science from the University of California, Irvine (UCI) with past experiences as a scholarship advisor and political organizing director. An echoes positivity and healing through actively engaging in community-centered and restorative justice organizing.

Gloria Itzel Montiel, PhD (she/her/ella), is a health equity leader, researcher, and faculty fellow. Over the last 10 years, she has partnered with community residents, promotoras, and cross-sectoral partners to design grant-funded multi-systemic programs in the areas of chronic disease prevention and management, mental health, housing and financial stability, education, youth development and leadership, and civic and community engagement. Her professional and academic work is informed by her lived experience of growing up and navigating educational and health care systems as an undocumented individual. Montiel has been a DACA recipient since 2013.