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Ideal Design for Emergence of Diversity, Equity, Inclusion, and Community Health Engagement Using Systems Thinking

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IDEAL DESIGN FOR EMERGENCE OF DIVERSITY, EQUITY, INCLUSION, AND COMMUNITY HEALTH ENGAGEMENT USING SYSTEMS THINKING

by

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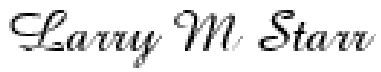

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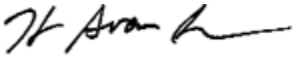

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2022

DEDICATION

This dissertation is dedicated to my Canadian parents, Gordon and Joan Jorgenson because without their love and care I would not be here at this moment. Second, this dissertation is dedicated to my wife Youn-Hyu Kim, and our son Simeon Paek for their constant love and support. Lastly, I would like to say “THANK YOU AND I LOVE YOU SO MUCH” to my parents, Heung-Suk Paek and San-Ok Kim who dedicated and sacrificed all things for their loving children, especially for my journey into the world. This dissertation is dedicated to my parents who have been waiting for over 30 years. I am sure they are happy now to see this dissertation and pray for their new life in Heaven in the name of the Lord Jesus Christ.

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Finally, I would like to acknowledge friends and family who supported me during my time here in the United States. First, I would like to say “Thank You” to Dr. Sang Joo Kim who has become my mentor and offered endless support. Second, I would like to acknowledge Dr. Dan Synnestvedt who was my college housemaster, professor, and colleague; he is now like a brother to me. Of course, first and foremost, I would like to thank my dissertation advisor Dr. Lawrence M. Starr for everything that he has been doing for me.

ABSTRACT

Diversity, equity, inclusion, and community health engagement (DEICHE) are complex contextual elements with interactions and interdependencies that make their emergence and sustainability in a community a significant challenge. This dissertation examines this argument by exploring the impact of Einstein Healthcare Network initiatives that sought to address social determinants of health in the Philadelphia Korean community. It applies systems thinking to understand these complex issues, and design thinking to generate an ideal concept for the emergence and sustainability of diversity, equity, inclusion, and community health engagement for the Philadelphia Korean community as a model for multicultural society in the greater Philadelphia region.

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CHAPTER 1

INTRODUCTION

Statement of the Problem

The interests and needs for diversity, equity, inclusion, and community health engagement (DEICHE) of Korean-Americans in the greater Philadelphia region are not being met adequately or sustainably. This dissertation will identify these interests, needs, use systems thinking, and methods informed by this approach to understand the existing problems and present a strategic plan, including an implementation design to meet these interests and needs.

While many Koreans who live in the Philadelphia region apply for and gain U.S. citizenship, others are visitors, including students and academics who have residency based on a family member who is a citizen. This dissertation uses the terms Korean and Korean-American interchangeably to reflect this broader community.

Primary Stakeholder and Problem History

The history of efforts to offer health engagement to Korean-Americans in Philadelphia began with Einstein Healthcare Network (EHN) (which in 2021 merged with the Jefferson Health System), the primary provider of health services in the northeast Philadelphia community. The Korean community of Philadelphia is a small subset of Koreans who immigrated and reside in the five contiguous counties of eastern Pennsylvania (Philadelphia, Montgomery, Delaware, Chester, and Bucks counties), and the United States.

Einstein Healthcare Network

Founded in 1866 as the Jewish Hospital in Philadelphia, Pennsylvania, the Einstein Healthcare Network (EHN) was a private and not-for-profit health system. It had several major hospitals, including one of Philadelphia's largest medical centers, many outpatient centers, and numerous primary care locations throughout the Philadelphia region. In 2006, EHN hired the author to be the Korean Coordinator. This position focused on implementing Korean Initiatives, a health-based strategy to work with Korean organizations in Philadelphia to provide programs to meet health community members' health needs.

In 2013, the job title was changed to Cultural Development Specialist to reflect the extended role and the revised and broadened services of Einstein's Korean Initiative. The expanded strategy identified five goals supporting EHN's mission "to improve the health status of the communities we serve." These were (1) Provide accurate and timely health information; (2) Provide an opportunity for dialogue around health issues; (3) Give support to callers by listening to them and guiding them to use Einstein Healthcare Network; (4) Provide health referral information, and (5) Identify trends in information requests from the patients.

In 2015, at a community health EXPO conference held at Arcadia University (October 2015), Ruth Lefton, C.O.O. of MossRehab/Einstein Medical Center Elkins Park, presented "What the Korean Community means to Einstein." In this address, she noted:

> I represent Einstein Healthcare Network this morning, including Einstein Medical Center Philadelphia, Elkins Park, Montgomery, and Belmont Behavioral Health. Yes, we have more facilities and offices such as the Germantown Community Health Services, Einstein Community Health Associates, and many other facilities and locations. Our mission is to improve the health status of the communities we serve.
>
> One crucial constituency in our community is the Korean population. I am so pleased with the success of the Korean Initiatives that we initiated in 2006. We have provided many programs and services, such as the annual flu shot, free breast cancer education

and screening, and prostate cancer education and screening. Yet, to truly serve the Korean community, we would like to create more strong partnerships with you. Our cultural development specialist, Reverend Sung Won Paek, will offer more health-related education and prevention programs with our Korean initiative team.

I am sure that this program, the Korean Community Health EXPO, will be a turning point for us, and I hope it can be the same for you and your families to get more health education and prevention programs to make your lives healthy. We also have been providing the Korean HOTLINE to serve the Korean community since 2013.

I hope it is easier for you to make appointments with Einstein physicians and offices. Einstein has been committed to providing the best medical and healthcare services for patients throughout the years. As a result, many people in the community see Einstein as "my hospital" or "my family's hospital." I am sure we will work with you and Reverend Sung Won Paek with our Einstein Korean Initiative team to assist you, your families, and the Korean organizations in providing more education and prevention programs. I hope our Korean initiatives are fulfilling your healthcare needs.

History of Korean Immigration to the United States

The first Korean immigrants to the United States were approximately fifty students, diplomats, merchants, and politicians who fled Korea after the failure of the Gap-Shin Coup between 1885-88. On December 22, 1902, the second group of 102 immigrants left Incheon Port on the American merchant ship S.S. Gaelic bound for the sugar cane fields in Hawaii. (Patterson, 1988). This marked the beginning of the first significant wave of Korean immigration to the U.S. However, immigration soon slowed after the conquest of Korea by Japan and was practically halted by the Immigration Act of 1924. Korean immigration would not resume in earnest until after the Immigration and Nationality Act of 1965, which allowed significantly increased quotas. (Min, 2011).

After the 1970s, Korean immigrants increased rapidly (Table 1), laying the groundwork for today's substantial Korean population. The peak period of immigration was between 1985 and 1987 when 35,000 Koreans a year entered the United States, the third-largest number of

immigrants to the United States after Mexico and the Philippines. (Min, 2011). Between 1991 and 1998, 136,651 Koreans immigrated to the United States, accounting for 1.8% of the total 7,605,068 immigrants from worldwide during the same period. However, the numbers started to decline after the peak of 35,849 in 1987, and in 1999, only 12,301 Koreans came, the lowest since 1972. (Min, 2006). In 2000, the number of Korean immigrants increased to 15,214 a year. Still, only about half of them were immigrants who intended to stay; the rest came to the United States for temporary purposes and later obtained permanent residency. U.S. Census Bureau data from 2019 indicate that there are 1.9 million Koreans in the U. S.

Table 1: Korean population in the U.S., 2000-2019

Year	Population
2000	1,228,000
2010	1,707,000
2015	1,822,000
2019	1,908,000

Note: Based on mixed-race and mixed-group populations, regardless of Hispanic origin. See methodology for more detail.
Source: 2000 and 2010 population estimates from U.S. Census Bureau, "The Asian Population: 2010" Census Brief, Table 6. 2015 and 2019 population estimates from 2015 and 2019 American Community Survey 1-year estimates (Census Data).
https://www.pewresearch.org/social-trends/fact-sheet/asian-americans-koreans-in-the-u-s/

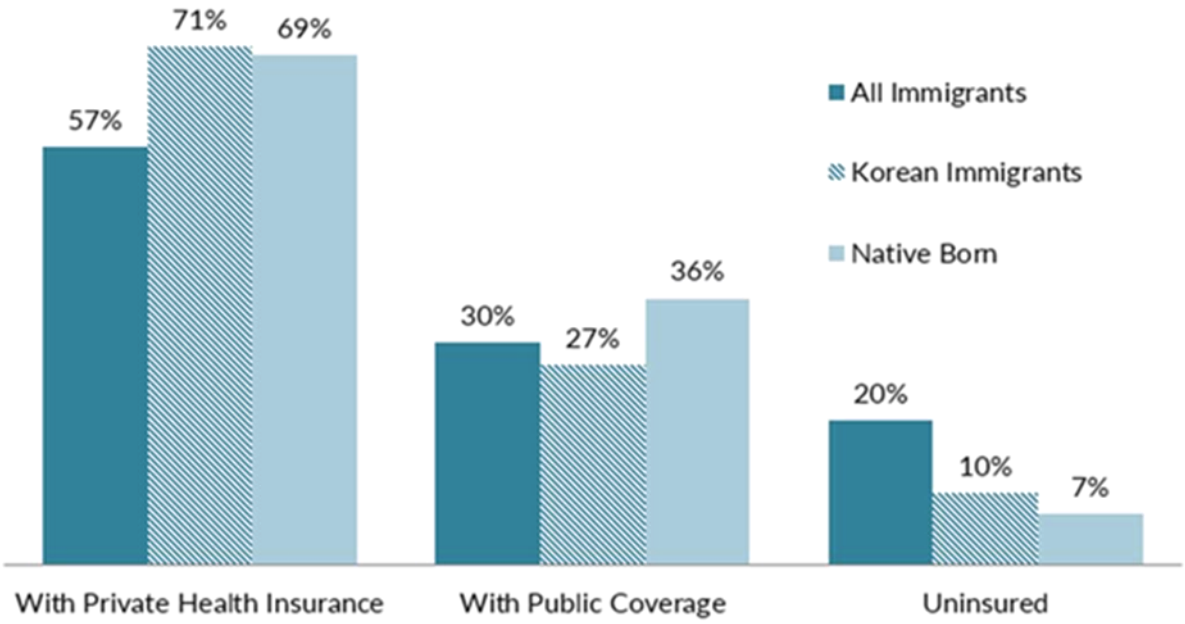
Korean Immigrants in American Society

Most Koreans who immigrated after 1965 engaged in arduous work quite different from their careers or jobs in Korea. Opportunities for Korean immigrants who started in the early 20th Century were minimal; many worked in the sugar cane fields in Hawaii. Most Koreans who came to the new country to live at the beginning of immigration were desperate to take root and thrive. (Min, 2011).

Except for medical staff who entered the country as international students, most Koreans operated groceries, laundries, and restaurants, and some successfully invested in large laundry shops and markets. A few immigrants and medical personnel with more education and resources could settle down more quickly. They overcame the loneliness of leaving their homeland for an unfamiliar land, enduring discrimination and crime, adapting to strange customs, making mistakes, and overcoming harsh trials from moment to moment.

As the number of immigrants increases, Koreans have branched out into other occupations requiring specialized knowledge, such as financial services and management. Still, many Korean-Americans do not have medical insurance. Korean immigrants were half as likely to be uninsured as the total immigrant population, but slightly more likely than the native-born population. In 2017, the majority (71 percent) of Korean immigrants held private health insurance, and they were more likely than both other groups to have private insurance. Conversely, they were slightly less likely than all immigrants and the U.S.-born to have public health coverage (see Figure 1).

Figure 1. Health Insurance Coverage by Origin, 2017



Note: The sum of shares by type of insurance is greater than 100 percent because people may have more than one type of insurance. Source: MPI tabulation of data from the U.S. Census Bureau 2017 ACS.

As the number of immigrants increases, Koreans have branched out into other occupations requiring specialized knowledge, such as financial services and management They have also moved into politics: examples include Harold Goh, former Assistant Secretary of State, current Korean Ambassador to Korea Sung Kim, present U.S. Representatives Andy Kim (D-N.J.), Young Kim, and Michelle Steel (both R-Ca.), Even first-generation immigrants have had political success, such as former U.S. Representative Jay Kim (Chang-Joon Kim), Seattle State Representative Shin Ho-Beom, and Oregon House and Senate member John Lim (Yong-Geun Lim). In Philadelphia, David Oh has served three consecutive terms as City Councilor.

Philadelphia Korean Community

In Philadelphia, Philip Jaisohn (a.k.a. Seo, Jae-Pil) was the first Korean to become naturalized as a U.S. citizen. He arrived in the U.S. in 1885 as a political exile. Dr. Jaisohn also became the first Korean-American physician and an influential political reformer in Korea when he returned to Korea in 1896. He established the first Korean modern newspaper, Tongnip Sinmun (The Independent), and organized a political organization called Tongnip Hyeop-hoe (Independent Club). In 1947, Dr. Jaisohn once again returned to Korea as the chief advisor to the commanding general of the U.S. Army in South Korea. He died in the U.S. in 1951. The Philip Jaisohn Memorial Foundation is the hub of Korean medical and social centers in greater Philadelphia; there is also a Philip Jaisohn Memorial House in Media, PA, a suburb of Philadelphia in Delaware County.

According to the U.S. Census in 2019-2020 there are over 40,000 Koreans live in the five-county Philadelphia region. The rapid growth of the Korean population suggests opportunities for building a solid Korean-American presence in the United States, the land of immigrants. However, Korean immigrants who establish communities in the United States desire and need to establish a new Korean-American identity and network. One resource explored in this dissertation is establishing a Korean-American Center which could offer services to the community to meet its interests and need for identity, networking, and more. At present, the Korean-American community in greater Philadelphia operates the dedicated facilities described in Table 2.

Table 2. Korean-American Community-Based Organizations

Specialties	Organization
Medical / Social / Senior Service / Home Care	Philip Jaisohn Memorial Foundation (A.K.A. Jaisohn Center)
Social Services	Korean Community Development Center
Social Services/ Senior Service/Home Care	Penn Asian Senior Service (A.K.A. PASSi)
Senior Day Care / Home Care	Albert Senior Care / Grace Senior Care
Home Care	Aurora Home Care

Korean Experiences

Bias Against Korean Immigrants

The first Korean immigrants to settle in Philadelphia started small commercial businesses in Center City, Germantown, Erie Avenue, 52nd Street, 53rd Street, Fifth Street, and Cheltenham Avenue. Many of the shops were founded and run by Jewish immigrants who moved to other locations. The Korean immigrants have been taking over many small businesses into the local community with hard work and kindness (McDonald, 1995).

Some Korean immigrants gathered children in the neighborhood in front of their corner stores and taught Taekwondo. The original purpose of teaching Taekwondo was to bring the local community together around the common interests of children and parents. However, Korean immigrants could not always avoid conflict with other community members, many of whom were African-American. Many African-Americans held negative stereotype views of Koreans, seeing them as selfish and earning money in the African-American community while living in suburban neighborhoods (Jennifer, 2018).

Koreans sometimes were injured or lost their lives to gangsters or criminals in the neighborhood; many residents were robbed, bullied, and lived in fear. Nevertheless, they reached agreements with their neighbors, improved their relationships, and transformed the shopping streets, resolving the risk factors by working with community leaders and public offices one by one (Jennifer, 2018).

Stereotypes of Koreans

Some Korean immigrants realized their dream of becoming professionals or successful entrepreneurs; this did not happen overnight. Some worked hard for many years until they saved enough money to start a business (Park, 1990). Others started a business quickly with funds brought from Korea but had inadequate experience or skill and failed. However, most normal Koreans raised money through hard work, gathered Korean business comrades, and organized many groups to support each other (McDonald, 1995). They had one thing in common: they went to the United States for their children and sought a prosperous life, both politically and economically (McDonald, 1995). Some were looking for larger houses, but either they could not afford the monthly mortgage or borrowed too much money and went into default (Min, 2010). Many people started their pioneering lives in fields that required labor based on their health, but those who came later lived a more leisurely life in Korea (McDonald, 1995).

Most Korean immigrants cite their children's education as the primary reason for coming to the U. S. (McDonald, 1995); however, many parents were already busy with establishing themselves in a new country. Children of immigrant families who were new to the United States were reluctant to attend school because of language problems. Many immigrants also experienced difficulties in church due to language barriers and cultural differences; the barrier of English often divided second-generation immigrants into English-speaking and Korean-speaking

groups in these contexts (Park, 1990). The Korean churches tried to serve everyone and eventually split the services into English and Korean, but it was not easy. Fortunately, schools also created individualized English education programs for students who were not good at English and provided individual instruction (Jennifer, 2018).

Conceptual Frameworks

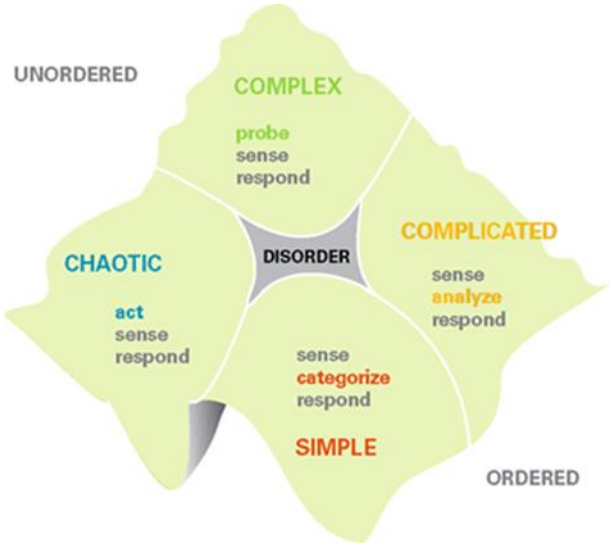
Using an epistemological conceptual framework (Starr, 2018) helps with sense-making, detecting the issues, and deciding how to deal with them. For example, rather than asking, "What should we do to solve the problem of diversity (or inclusion or equity, etc.)?" this kind of framework suggests by first assessing the nature and situational characteristics of the problem. This begins by asking, "What kind of problem is this? In addition, "In what kind of context is this problem located?" Problems in different contexts have different premises and assumptions and benefit from a range of methodologies and tools that are appropriate to these premises. To understand the current reality of the DEICHE problem and how to intervene and make effective decisions about these problems, the Cynefin framework (Snowdon & Boone, 2007) will be presented as the conceptual framework.

Cynefin Framework

The belief that our current health problems are exceedingly complex may have an inherently paralyzing effect. It may be helpful to consider the Cynefin framework as the problem-solving device (Figure 2, cf. Snowden, 2005; Van Beurden et al., 2013). The Cynefin framework is based on work by David Snowden and colleagues (Snowdon & Boone, 2007). Cynefin is a Welsh word for ecosystem or habitat, and its various elements recognize the dynamic evolutionary nature of complex systems. As noted in Figure 2, contexts may be

unordered and unstructured or ordered and well structured. Situations, problems, and systems are classified within one of four quadrants: simple or obvious, complicated, complex, and chaotic.

Figure 2. Cynefin Framework (Snowdon & Boone, 2007)



Ordered Simple Problems

Simple problems have clear cause and effect relationships; they present an ordered and known world that makes it easy to reach the desired result. Processes inside these systems are linear; if one determines ("senses") the facts and categorizes them, then there is a simple, appropriate, and “best” response to solving a problem. Simple techniques encourage following best practices, benchmarking, and other well-established solution pathways.

In "simple" or "obvious" contexts, the correct decision is often clear and repeatable, like a recipe. Easy delegation and information sharing are typically sufficient when the situation is well analyzed, and the management decision is straightforward. For example, changing operating hours or changing the appointment schedules with Korean patients requires essential

communication and schedule changes. The decision may be made by assessing requests and confirming availability with patients and the medical staff.

Ordered Complicated Problems

A structured complicated problem is a domain that requires expertise. To understand these problems fully, comparing and examining various causes and effects, application of “good practices,” analytic thinking, the application of the scientific method, and use of evidence-based research are preferred. In the "complicated" domain, there are multiple answers to a challenge, and the relationship between cause and effect may not be apparent to everyone. Healthcare leaders or managers need to "sense, analyze, and respond." For example, sensing that patient volume is dropping may be reflected in the revenue and financial reports, but the cause may not be clear. It requires deeper analysis to determine if the drop is related to healthcare organization budgets, new competition in the medical/social/ or business markets, programs no longer valued by patients or other reasons.

In the Philadelphia Korean community, there are many Korean senior daycare centers, which compete fiercely for business. Korean senior citizens, attracted by competitive benefits, move from one center to another, which produces complicated problems related to staffing and programs for the centers and the seniors. To solve these difficulties requires expertise not readily available within the centers because these leaders do not have the experience or methods to address this kind of problem. Complicated problems can cause challenges around the management table, but leadership in these moments is critical to the health and sustainability of organizations. Experts who offer alternative perspectives to those generated by current leaders should be evaluated.

Complicated decisions take time; there may be a trade-off between making a short-term decision, working with the immediate results versus waiting to find the “correct” answer and delaying the response. However, if the correct answer continues to elude analysis—if a solution to address reduced patient volume cannot be found, for instance—then the formulation of the problem may be in error; that is, the domain is unordered, not ordered, and the problem may be complex, not complicated. Mitroff and Silver (2009) referred to this as the Type 3 Error: solving the wrong problem.

Unordered Complex Problems

In the unordered and unstructured domain, the context of problems is non-linear and non-proportional; something that happened in the past and today may not occur tomorrow, and expending dedicated effort to a problem does not mean it will be effectively addressed. In this context, situations, variables, and results are volatile, uncertain, complex, and ambiguous, which means there is no consistently valid prediction method.

Complex problems are challenging because there are no experts or good or best practices; rather, solutions to problems must emerge from the interaction of several elements, some of which may have not been previously considered. One must probe the situation, which means engaging in small experiments several times to see what works, attempting to discover or sense a pathway that can lead to action. This problem context characterizes all organizational cultures and relationships, including diversity, equity, inclusion, and community health engagement. In challenges of this kind – where the situation is unordered and dynamic, which demands emergence over expertise – as noted by Jackson (2019), "systems thinking is the only appropriate response to complexity (p. xix)." As described by Paek and Starr (2020) regarding the global COVID-19 pandemic,

> COVID is … a dynamically complex problem (that) affects…many systems of society. We have never previously experienced this kind of situation, which helps to explain why everyone was unprepared and why errors were and continue to be made. For this kind of problem, there are no experts, for those who try it defies prediction although any are trying to understand its patterns of impact (p. 2).

In the complex domain, healthcare leaders who apply systems thinking will look for patterns and structures to emerge in their situation before they act. They must "probe first, then sense, and then respond." Healthcare organizations and broader cultural sectors operate in an increasingly complex domain; their problems and outcomes are not uniform or repeatable, nor do they have full impact measures.

When the Einstein Korean initiatives (described on page 4) were extended to Einstein Medical Center Montgomery (EMCM), the leaders assumed an ordered problem; they failed to appreciate the diverse and complex population in the Korean community. This was despite recommendations the author had made to the cultural development specialist that repeating the same projects at EMCM would not be effective because the context was different. The programs did not meet their predicted expectations and did not contribute to solving the issues of serving the Korean community.

In complex contexts, efforts to apply command-and-control management styles or to eliminate programs that are important to the institution's mission but do not bring in much revenue can have unintended and negative effects. Rather, these contexts should be seen as an opportunity to experiment in small ways, tolerate and learn from failures, and acknowledge that the disorder continues while searching for a new pattern to emerge. These situations are creative and innovative, but stressful for a leader unless one has the appropriate proficiencies.

Unordered Chaotic Problems

When the context is characterized by chaos, the only appropriate response is to identify how the situation can be made more stable and then converted first to a complex system, then into a complicated one. Shocks to the entire environment, like a novel coronavirus that shuts down most or all operations, create a situation that demands a novel solution. Complex systems are challenging enough, but chaotic contexts require leading through the "unknowable" and often the “un-understandable.” These are not times to be patient and seek patterns; it requires leaders to “stop the bleeding.” Searching for the right answer is pointless. Leaders must "first act to establish order, then sense where stability is present and from where it is absent, and then respond by working to transform the situation from chaos to complexity (Snowdon & Boone, 2007)." Rapid responses are required.

The current pandemic moves between contexts of chaos, complexity, and complication. Most educational, social, medical, and other organizational leaders have acted definitively by closing facilities, laying off employees, and seeking cash-flow stability. Communication is necessarily top-down; there is little time for consultation. Manufacture, distribution, delivery, and recording of sequential vaccines to millions has required logistics never previously addressed. During the chaos, there is very little control of any kind. It is more productive to find a way to convert chaos to complexity than complication.

Applying the Cynefin Framework

The Cynefin framework enables a decision-maker to categorize, better understand the type of problem encountered, and select appropriate methodologies and tools to address it. For example, if an issue or topic is complicated, one may apply analytic, evidence-based

thinking and practices. If a problem is complex, one may appropriately apply systems thinking and the methodologies informed by this approach. However, labeling a problem complex is only the start of this process because there are various kinds of complexity. These will be described and explained by referring to diversity, equity, inclusion, and community health engagement.

Purpose and Structure of this Dissertation

The purpose of this dissertation is to formulate the problem and to generate an ideal design for a viable, desirable, and sustainable organizational system that integrates the complex systems concepts of diversity, equity, inclusion, and community health engagement. The focus is on the Einstein Healthcare Network's efforts to engage the Philadelphia Korean community.

The dissertation is structured into chapters. Chapter 1: Introduction provides an introduction and overview of the thesis, including the background and context of the current challenges and the formulation of the research problem and research questions. Chapter 2: Literature Review describes diversity, equity, inclusion, and community health engagement, focusing on Korean and Asian communities and healthcare operation systems. It also describes the nature of complexity and systems thinking, an approach to improving problem formulations and interventions. Chapter 3: Methodology presents the research problem's methodology and tools to answer the research questions. Chapter 4 Results describes the outcomes of the surveys, interviews, and design methodology applied. Chapter 5 Discussion reviews the meanings of what was learned and the next steps.

Research Problem and Research Questions

Research Questions

1. When the Philadelphia Korean Community is formulated as a complex system, what are the challenges (problems and opportunities) of diversity, equity, inclusion, and community health engagement (DEICHE)? Responses to this question will be informed by the literature review presented in Chapter 2.
2. Informed by systems thinking, what is an ideal design for a hosting enterprise to promote, support, and sustain diversity, equity, inclusion, and community health engagement (DEICHE) in the Philadelphia Korean Community?

Responses to this question will be informed by the methodology and tools described in Chapter 3.

Significance of the Dissertation

Facing the harsh reality of the coronavirus pandemic, how can the Korean community work together with a mainstream health system to collaborate, cooperate, and promote diversity, equity, inclusion, and community engagement in American society? Social, political, medical, welfare, and education systems are volatile, uncertain, complex, and ambiguous, and will experience significant changes in the next ten years.

This dissertation will describe and explain the diversity, equity, inclusion, and engagement programs in one mainstream healthcare organization, Einstein Healthcare Network, based on the Cynefin framework. It will then propose a model system for an ideal design of diversity, equity, inclusion, and engagement programs, using design-thinking methodology and systems thinking theory.

CHAPTER 2

LITERATURE REVIEW

Introduction

I argue that diversity, equity, inclusion, and community health engagement (DEICHE) are central to organizational strategies for promoting health. Yet, attempts to systematically review the evidence on the impact of initiatives that evaluate these elements are rare. This chapter examines and summarizes the academic and practice literature and, where appropriate, narrows the focus to DEICHE in the Korean communities in the United States.

Andrulis et al. (2010) note that racial and ethnic disparities in health and health care in the United States are persistent. People in communities of color fare far worse than their white counterparts across various health indicators, such as life expectancy, infant mortality, the prevalence of chronic diseases, self-rated health status, insurance coverage, and many others. (Andrulis et al., 2010). High quality of services and clinical effectiveness are critical to healthcare organizations' success, but they must also control costs. Healthcare organizations must also include health equity as a strategic priority, broaden their scope, significantly invest in the structures and processes that improve health equity, and dismantle institutionalized racism within healthcare. (Schoonover, 2008). Zinzi et al. (2017) said that population health problems often do not identify discrimination as a root cause of racial health inequities. They found that structural racism refers to the totality of ways societies foster inequity through the interaction of discrimination in housing, education, employment, earnings, benefits, credit, media, health care, and criminal justice. Zinzi et al. (2017) also

warned that those patterns and practices reinforce discriminatory beliefs, values, and resource distribution.

Historical Context of DEICHE

President Lyndon Johnson made affirmative action a centerpiece of attempts to address racism in society at the time of the passage of the Civil Rights Act of 1964, although the ethos was first applied in 1961 when John F. Kennedy created the Equal Employment Opportunity Commission. Both presidents believed that inequality in society could be corrected only by giving certain benefits to those disadvantaged due to race, gender, religious disability, etc. The concept was portrayed in a speech made by Johnson in 1966:

> Imagine a 100-metre run in which one of the two runners has his legs shackled together. He has progressed ten yards, while the unshackled runner has gone fifty yards. At that point, the judges decide that race is unfair. How do they rectify the situation? Do they merely remove the shackles and allow the race to proceed? They could then say that "equal opportunity" now prevailed, but one of the runners would still be forty yards ahead of the other. Would it not be the better part of justice to allow the previously shackled runner to make up the forty-yard gap or start the race all over again? That would be affirmative action toward equality.

In addition, the 1960's was when the African-American civil rights movement was actively taking place. Some argued then and still do today that white people should compensate blacks for the unfair results caused by slavery and racial segregation.

Affirmative action had a significant impact on promoting the human rights of minorities and respect for diversity. The benefits of this system have produced President Barack Obama, former Secretary of State Condoleezza Rice, and former Defense Secretary Colin Powell. They admitted that racial allocations allowed them to go to prestigious universities and rise to the top ranks.

Diversity Before and in the 21st Century

Since the 1970s, diversity and inclusion in the United States have been topics of importance. Protests, legislation, and discussions have all come about because of the growing influence of these ideas, particularly given the multicultural makeup of the nation. Three significant areas of debate are education, healthcare, and government.

Diversity is important in education because, in the American education system, demographics vary across the country. Unlike other countries where the population is mostly one race, the United States has many different racial and ethnic groups. On top of that, according to Hyde (2009), diversity is not just about race, but many other kinds of differences, such as religion, ability, etc. Increased diversity in education is crucial because it adds more perspectives that everyone can listen to and benefit from. Diversity has always been an element of American history; many kinds of people worked together to create the country.

Diversity is also essential in healthcare; much like the education system, healthcare in America is already diverse in its population. Salisbury and Byrd (2006) discuss diversity in healthcare extensively. They make a good point when they state that diversity in healthcare can cause issues amongst the staff at first. However, they also say that increased diversity improves efficiency amongst workers and may benefit the patients. If more perspectives go into the healthcare system, more approaches are available to treat patients; having all sorts of people participate and make decisions increases the entire system's brainpower.

There are also many ways to increase diversity and effectively implement it in healthcare. Galambos (2003) explains how healthcare can develop cultural competence. This cultural competence comes from diversity and effective interventions that build the strength of healthcare networks. Crews et al. share this idea of cultural competence and elaborate it further. Both Crews et al. (2018) and Galambos use cultural competence to emphasize the critical need for diversity in healthcare.

According to Van de Ven et al. (2008), increased communication between diverse people allows for better productivity. According to Crews et al. (2018), the typical hiring process has people in higher positions get recommendations on who to hire. Because of that, there is implicit bias by those in leadership positions. What is especially important about diversity in healthcare is that if the people are diverse and have many different views, healthcare must too.

Cultural Competence

Alegria et al. (2010) argue that cultural competence may be necessary to understand equity and inclusion better. Cultural competence is the idea that people can learn to perceive and then understand different cultures and relate successfully to those cultures. Culture, however, does not just come from race or ethnicity. Alegria et al. (2010) stated that culture refers to individuals, families, and communities, all of which have unique cultures.

Since cultural competence is the ability to adapt to new cultures and how they do things, understanding is vital. Much like community engagement, understanding is key to cultural competence, as one must understand the cultures with which one is interacting. The cultural competence is also something that those in power should learn, as it is their

responsibility. Sukhera et al. (2017) state that the focus of community engagement should not be on guilt, but on requiring a commitment by those in power to give equal treatment to everyone they serve, so that understanding the people who have been discriminated against in the past is a responsibility and a proactive action rather than a reaction to circumstances.

Cultural competence and diversity can build a foundation for enormous positive changes. According to Pourdehnad and Bharathy (2004), an organizational shift can only be achieved if the design and leadership are prepared to change. Governments and general society are resistant to change in the short run, but healthcare and education can change more quickly. Newer methods can be implemented in both healthcare and education, which would increase cultural competence and community engagement. Organizers could use systems thinking to implement change, since organizations are massive systems. These changes will be brought into society as more people demand their rights and create more equality. Response from the community must also balance short and long-term goals. Short-term goals must address immediate issues and cannot just be surface-level changes. Long-term goals will tackle the actual problems and take a while for effects to show. Examples of long-term change could be influencing education to teach more about diversity and its impact. Short-term changes could include more resources for those in need and training for existing people.

Legitimacy of Diversity, Equity, and Inclusion

Society increasingly considers diversity an essential topic, particularly during political democratization. Diversity is also increasingly valued as our society changes from the beginning, but no one paid attention on how the diversity, equity, and inclusion are important with community engagement. Academic interest in diversity has increased in

many different fields (Eckel & King, 2004) which has contributed to its recognition as an essential topic.

Systems thinking is supported when diverse thinking, resources, and fields coexist and interact, i.e., interdisciplinary integration occurs. The example of the global communication network represented by the Internet suggests that the exchange of ideas is already transcending traditional time and space. Schwab (2016) refers to this as the Fourth Industrial Revolution (4IR) and describes it as a distinct transition in which:

> velocity, scope, and systems impact. The speed of current breakthroughs has no historical precedent. When compared with previous industrial revolutions, the Fourth is evolving at an exponential rather than a linear pace. Moreover, it is disrupting almost every industry in every country. And the breadth and depth of these changes herald the transformation of entire systems of production, management, and governance.

In addition, the development of gender equality in a male-centered, patriarchal industrial society is promoted by policy, and balanced national development is discussed to avoid the concentration of infrastructure centered on large cities. Wood (2004), an American historian argued that at the root of all these changes is the idea that "diversity is a beautiful thing" and "diversity is the essence of nature."

Diversity, Equity, and Inclusion as Social Constructs

Wood (2004) does not glorify diversity. Wood's main analysis target is social diversity, not natural diversity. His goal is a critique of the ideology of diversity, not the diversity of reality. It is said that diversity exists only in propaganda advertisements used by American commercial capitalism. Diversity has been reduced to a brand to respond to people's common-sense emotions and a product to be consumed. Diversity as a natural state, not essential diversity, is merely a 'discourse' of diversity and operates as an ideology that

dominates society. The author in no way denies diversity itself or declares that there is no diversity. True diversity is a beautiful and powerful wild force of nature that humans cannot control or use at will; it causes sudden and colossal changes that are indeterminate and contain uncertainty.

America's Diversity and Equity Debate

To distinguish true from ideological diversity, Wood (2004) divides diversity into two types: diversity I and diversity II. The former refers to the existing variety, and the latter refers to the fictional diversity conceptualized by humans, that is, the ideology created by the discourse surrounding diversity. The author focuses on diversity II, analyzes it, and criticizes the folly of this phenomenon. He also warns that misrecognition and application of diversity may be contrary to the idea of equality, which has long been regarded as a universal value in human history. This error has been around for quite some time in American society.

Reverse Discrimination Created by Guaranteed Policies

A system that guarantees diversity may unintentionally lead to reverse discrimination. The "Bakke Trial" in 1978 is a case in point. Alan Bakke was rejected from the University of California Davis's School of Medicine, even though he scored higher than other first-year students did at the time. He sued, saying it was unfair to admit applicants from a minority background who were less qualified than he was. While the university acknowledged that Bakke scored higher than the minority students did, it insisted that it had the right to deny his admission because of the legal doctrine of affirmative action. The Supreme Court ruled in favor of Bakke by a narrow margin of five to four; however, six of

the nine judges had different views. Judge Lewis Powell, who wrote the main opinion, walked a tightrope between Bakke's and the university's sides; by doing so, he saved "affirmative action. By one vote – or perhaps only half a vote – he allowed the continued integration of elite institutions of her education, despite persistent deficits in the academic qualifications of many minority applicants," (Jeffries, 2003) . Judge Powell's ambiguous remarks were quoted in every similar ruling, sparking a debate about whether "racial quota policy is conducive to diversity or vice versa." Bakke was admitted to medical school, but the Court held that affirmative action was still acceptable, if it did not create rigid racial quotas. From this, the seeds of a long debate about diversity in American society germinated. The decision weakened the position of supporters of the active policy.

Controversy over Inequality

Rawls (1971) wrote that accidental circumstances cause inequality, which must be corrected. Affirmative action was also started to correct this inequality. However, most importantly, the scope of inequality was vague; there is even controversy over how to correct disparities. It is controversial whether justice can be realized solely with "equality of opportunity" or whether "equality of results" should be pursued because equality of opportunity is not enough. Those who advocate "equality of results" believe that putting the socially weak on the same starting line as the strong would not be enough to correct the inequality by itself. To correct past discrimination and raise the status of the underprivileged tangibly, it is necessary to take more active measures that tilt the playing field towards those disadvantaged in the past.

The protection system for the socially disadvantaged reflected the will to realize this equality of results. However, there is a controversy over whom it would benefit and for how

long. That is why the argument that "it may guarantee diversity, but it is reverse discrimination against white people" followed.

Even though members of minority groups seemed to benefit from preferential treatment, some still opposed it. Clarence Thomas, the second African-American Supreme Court justice in American history, wrote in his autobiography in 2006 that he keeps his Yale Law degree in his basement with a 15-cent sticker from a cigar package on the frame. Thomas loaded up on challenging courses to prove he was not inferior to his white classmates but considered the effort futile. He also said that he turned down job interviews at law firms after he graduated. "I learned the hard way that a law degree from Yale meant one thing for white graduates and another for blacks, no matter how much anyone denied it," Thomas wrote. "I'd graduated from one of America's top law schools, but racial preference had robbed my achievement of its true value." The preferential treatment policy for minorities caused prejudice towards the elite of minority groups, undermining legitimate performance and self-esteem.

Community Engagement

According to McCloskey, McDonald, Cook, et al. (2011), community engagement is "the process of working collaboratively with and through groups of people affiliated by geographic proximity, special interest, or similar situations to address issues affecting the wellbeing of those people" (in Centers for Disease Control and Prevention [CDC], 1997, p. 9). In general, community engagement goals are to build trust, enlist untapped resources and allies, create better communication, and improve overall health outcomes as successful projects evolve into lasting collaborations (CDC, 1997; Shore, 2006; Wallerstein, 2002). According to Brunton et al. (2017), some examples of community engagement in healthcare

are service user networks, healthcare forums, volunteering, and courses delivered by trained peers. Community engagement allows for input from the community to be heard and uses the structure of communities to achieve a goal.

Community engagement allows for many benefits and is needed in the modern world. The world continues to become more democratic, and the idea of absolute rule over others has become weaker. More than ever before, humans cooperate and work together to improve the quality of life on a larger scale. When viewed from Brunton's practical social justice school (Brunton et al., 2017), community engagement aligns with democratic evolution. With cooperation, people can focus more on betterment by association due to innovative technology and ideas. These are the broader, more abstract concepts that community engagement can bring. On the other hand, the unitarian school measures the benefits of community engagement by statistical means. As shown by Sarrami-Foroushani et al. (2014), community engagement can improve the efficiency of projects focused on bettering communities. Community engagement allows for organizations and communities to benefit. For example, in Stansbury et al.'s (year) paper, the authors used community engagement to help older people with cognitive disorders. This article showed that community engagement could more effectively spread messages and use structured models to achieve higher profits, goals, charity work, etc.

There are many ways to implement community engagement. Sarrami-Foroushani et al. (2014) show the first step of implementing community engagement: knowing if you are prepared or not. By using the model Sarrami-Foroushani et al. show for preparedness, organizers can self-evaluate whether they will succeed in an intervention or not. Preparation makes it easy for organizers to make appropriate adjustments during interventions and know

what to expect. When implementing community engagement, it is also essential to develop context, trust, and communication with those served. Building these bonds allows organizers to better understand and engage with the community as a whole. For example, knowing the relationships between those members of the hierarchy of a group can influence how interventions are carried out. If leaders are deeply respected, they can be targeted and impact the community. There are many ways for interventions to be carried out, and each scenario is different; that is why context is essential. We can also implement community engagement in organizations such as schools or governments.

The main idea of community engagement is a collaboration between the stakeholders for the community. Within community engagement, elements of importance include trust, effective communication, and mutual understanding. Each part cannot exist independently, and they must all coexist for the entire system to work. To build trust, people must communicate, and to do that, they must understand each other, on a fundamental level.

The Korean-American Community in a Diverse Society.

This dissertation argues that when positive diversity, equity, inclusion, and community health engagement are established (as a central ideology), positive outcomes for stakeholders can emerge. The Korean-American community has a unique history of balancing diversity with the desire for cultural, social, or political integration and assimilation into American society.

Systems Thinking Applied to DEICHE

Diversity, equity, and inclusion are extremely complex and incorporate almost every aspect of our lives. In a human relationship, the first step is to simply be respectful and

understanding of differences from others. Viewing everyone's differences as a learning opportunity or a way to get to know others better will create a more inclusive relationship or environment. A complex system consists of interacting adaptive entities that produce dynamic patterns and structures. Diversity, equity, and inclusion play a different role in a complex system than they do in an equilibrium system, where it produces harmony and collaboration. Scott Page gave a concise primer on how diversity happens, how it is maintained, and how it affects complex systems. (2011). Page explained how diversity underpins system-level robustness, allowing for multiple responses to external shocks and internal adaptations; how it provides the seeds for large events by creating outliers that fuel tipping points; and how it drives novelty and innovation. (Page, 2011). Jackson also said that "systems thinking eschews simple solutions to complex problems. It embraces holism and creativity to handle complexity, change, and diversity. (Jackon, 2003)

Health is a multidimensional concept that includes physical, mental, social, economic, and social wellbeing. However, many of the current efforts to achieve health equity rely on linear thinking, which promotes responding to isolated aspects. Recent efforts by the Einstein Health Network did not achieve health equity and may have had only minor impact on wellbeing and self-determination. However, I argue that a systems view of health provides a more appropriate framework for improving health, wellbeing, and equity.

Russell Ackoff (1974), the leading systems thinker in the 1970s, offered two critical ideas of relevance on health equity. The first was a distinction between mechanical thinking and systems thinking. Mechanical thinking – which applies analysis, breaks the problems into parts, attempts to fix "broken parts," then reassembles the pieces, assuming the whole problem is solved. Systems thinking tries to understand the complex interrelationships

between a problem and the various aspects of its environment and context, and to design a system which dissolves the problem, i.e., creates conditions where the problem cannot exist.

Systems thinking is a mode of cognition, of thinking, an awareness or approach to problem formulation, and a cognitive skill that focuses on the interactions, relationships, and patterns among variables rather than on the individual variables themselves. Many prevailing diversity and inclusion initiatives heavily focus on changing individual awareness and individual behaviors. For example, diversity training often centers on helping individuals understand and manage their own biases. Along with these efforts, it is common to have special programs aimed at advancing marginalized populations by assisting them in understanding how to perform in line with the dominant culture. However, this reliance on individual awareness, competence, and motivation ignores the role of the more extensive systems in which individuals and communities operate. This is among the key reasons why current DEICHE results are not as meaningful, significant, sustainable, or timely as they need to be. Indeed, Wenger (2010) noted that a "complex social system can be viewed as constituted by interrelated communities of practice" because everything can be viewed as a system.

Senge (1994) described the importance of this holistic approach in decision making and problem-solving. Senge (2010) wrote, "we tend to focus on snapshots of isolated parts of the system and wonder why our deepest problems never seem to get solved." System thinking is a conceptual framework that underlines an extremely intuitive worldview. When individuals are expected to overcome habits within systems that do not enable and reinforce their efforts, we can scarcely expect even the most willing and most capable to succeed. Therefore, applying systems thinking to DEICHE means integrating diversity, equity,

inclusion, and community engagement in the organization as a whole and the relationships between the organization's parts to sustainably blend DEICHE into the company's underlying structures, processes, and ways of working. All core concepts and practical tools can be applied to understand each organization's complexity better through systems thinking.

Diversity has been prevalent for the past few decades in America due to the complex evolving circumstances of the American population and developments in the world. Not only has America always been full of diverse people due to the way it was founded, but modern technologies have allowed different groups to migrate to places far from their homelands. Most diversity research focuses on ethnic or racial identities but ignores other differences between people. Communities create diversity, and there are more communities than just race or ethnicity. In addition, any given person belongs to more than one community (Reynolds & Sariola, 2018). Communities should include different abilities, interests, socioeconomic groups, etc. Diversity recognizes that everyone is a unique combination of backgrounds and influences; it is the first essential step in understanding America and future change within the country's systems.

In addition to diversity, equity and inclusion are other ideas that have spread worldwide. Community engagement is the idea that people work with communities and involve them in decisions or actions. According to Santana et al., a component of person-centered care, a more individualized version of community engagement, is to work with the person, not for them (Santana et al., 2017). Newer methods can be implemented in both healthcare and education, which would increase cultural competence and community

engagement. By seeing the connections between the elements, organizers can fine-tune solutions to individual needs and adapt to new issues.

While we are still in the COVID-19 pandemic, we do not know what deadly pathogen will come next, but we do know that the fee-for-service model that we practice does not work anymore. It is already proven that our current health systems were not ready for COVID-19, and we must think what the next step is or what kind of healthcare models should be created.

Kim Barnas and John Toussaint make that ominous observation at the start of "Reinvention," the last chapter in their recent book "Becoming the Change." In the final chapter, they examine what it will take to reinvent healthcare models through innovation. (Barnas & Toussaint, 2020) Even though they do not claim to have answers, they do propose a new process for finding them. At this time, we can revisit what Jackson said which is that "the only appropriate approach to a complex problem is systems thinking" (Jackson, 2019).

CHAPTER 3

METHODOLOGY

I argue that as a systems concept DEICHE should be applied to the Philadelphia Korean American community as an integrated whole, with each of its interdependent elements forming a complex problem within an unstructured and unordered context. Complex problems also referred to as wicked (Churchman, 1967; Rittel & Webber, 1973) or messes (Ackoff, 1974; 1981) are qualitatively different from those that are complicated within a structured and ordered environment. As explained by Goldstein, Hazy & Lichtenstein (2010: 3-71).

> Until recently the differences between complicated and complex were not well understood; as a result, they have often been treated in the same way, as if the same process should be used to "deal with" situations (or concepts) that are complicated or complex. Business schools justified this by treating organizations as if they were machines that could be analyzed, dissected, and broken down into parts. According to that myth, if you fix the parts, then reassemble and lubricate, you'll get the whole system up and running. But this is exactly the wrong way to approach a complex problem.

Snyder (2013) and Glouberman and Zimmerman (2002) noted that many social challenges are complex and as an example described "how to raise a child" (see Starr, 2020, p. 16). These can be applied to DEICHE within the Philadelphia Korean community (Table 3).

Table 3. Extending Glouberman and Zimmerman's (2002) complex problem definition

How to Raise a Child	How to Implement DEICHE
Formulae have limited application	Formulae or best practice strategies have limited application
Raising one child provides experience but no assurance of success with the next	DEICHE in one community provides experience but no assurance of success in another community
Expertise can contribute but is neither necessary nor sufficient to assure success	Expertise in DEICHE can contribute but is neither necessary nor sufficient to assure success
Every child is unique and must be understood as an individual	Every DEICHE problem is unique and must be understood as individual
Uncertainty of outcome remains	Uncertainty of outcome remains
An optimistic approach to problem-solving is possible	An optimistic approach to problem-solving is possible

This chapter provides the process by which the two research questions will be addressed.

Research Questions

Research Question 1: When formulated as a complex system, what are the challenges (problems and opportunities) of diversity, equity, inclusion, and community health engagement (DEICHE) in the Philadelphia Korean community? Chapter 2 provided a significant part of the response to Research Question 1 by describing frameworks for understanding DEI and its community challenges. The Cynefin framework (Snowdon & Boone, 2007) provided an approach to formulate these challenges. The applications of this framework and the broader historical background of the Korean-American experience nationally and in Philadelphia offered additional insight. Formulated as a complex system problem, a stakeholder approach to the methodology is an informed example from this approach that can also help express the challenges of DEICHE in the Philadelphia Korean

Community. This chapter expands the response to this question by providing attitudes, opinions and beliefs by stakeholders. A methodology and set of tools are described beginning with the report of a pilot study that helped to gather understanding of the current reality and context of the Philadelphia Korean Community.

Research Question 2: Informed by systems thinking, what is an ideal design for a hosting enterprise to promote, support, and sustain DEICHE in the Philadelphia Korean Community? To respond to this question, a design team was created which followed a methodology to generate a prototypical design for a DEICHE program that would address and overcome the challenges in the current reality.

Pilot Study Design

To improve understanding of the current reality of DEICHE in the Philadelphia Korean Community, a pilot study was conducted in 2021. A random selection of Einstein Healthcare Network employees (n=12) and (community-based) Einstein Korean Advisory Board Members (n=24) were interviewed. Questions were posed (Table 4) to collect perceived problems, obstructions, and conflicts as well as the opportunities that would improve relationships.

Table 4. Questions to the stakeholders: Einstein Employees and Einstein Korean Advisory Board

Einstein Employee (n=12)	Einstein Korean Advisory Board Members (n=24)
1. Do our community initiatives recognize and redistribute power in meaningful ways? 2. How does our organization support marginalized and disadvantaged groups? 3. How can our community engagement promote	1. Are EHN initiatives helping our multicultural community patients persist in and complete their medical services at normative rates? If not, what is missing? 2. Are EHN initiatives creating opportunities and providing resources for multicultural community people

behaviors and norms that make our stakeholders feel a part of our community? 4. How do we ensure the inclusion of diverse perspectives as we develop Einstein's mission?	looking for careers in the EHN system? If not, what is missing? 3. Do EHN initiatives offer our multicultural community the ability to access equitably all opportunities provided by EHN? Does engagement come through positively and inclusively?

The responses to the questions (Table 5) indicated that just developing strategies do not solve the problems. When external stakeholders (Korean community leaders) were interviewed, they all mentioned three significant concerns or needs: 1) create a welcoming atmosphere; 2) remove barriers – language, food, taboos, wheelchair access, time, transportation, and childcare; 3) involve the community more directly.

Table 5. Findings from the Pilot Study

Problems	More
Systemic Problems	Difficulties in making appointments Complex medication regimes Lack of care transition
Lack of reconciliation	Insufficient explanation of post-discharge procedures Confused or angry patients/family Caused readmission
Lack of communication	No communication

Perceived Needs of Internal Stakeholders

The internal stakeholders suggested that EHN should develop and communicate a shared understanding of how diversity and inclusion are essential drivers in the pursuit of excellence and growth. They also insisted that competitive and successful marketing and public relations campaigns would enhance EHN's position. Finally, they suggested that EHN

should review and enhance internal and external community-based programs and activities in a systematic perspective, including advancing safety in the working environment; providing more effective community services in the local community; reinforcing a hate-free campus; creating a welcoming climate for all; recruiting and training a diverse staff; and changing the culture in the EHN system.

Overall, this sample of stakeholders emphasized that diversifying leadership and management were essential to improved performance, in order to increase the number of employees prepared and competing for mid-level and higher management positions. The most important thing from the internal stakeholder view was identifying and reducing health disparities. They insisted that EHN implement culturally and linguistically appropriate services, train within the system, and work with Korean community organizations or centers.

Implications of the Pilot Study

Diversity, equity, inclusion, and community engagement were important factors in improving EHN's outreach to multicultural groups. The premise was that if EHN worked with the Korean community more closely through the Korean community center, offering DEICHE services, the outcome would be more efficient and effective from the providers' and the stakeholders' perspective.

A community engagement approach involves a series of steps to actively involve the community in addressing one of the significant issues described by Swainston and Summerbell (2008), such as forming a coalition or facilitating community workshops. The community leaders and former employees strongly emphasized a collaborative method

involving the community in conversation and community engagement programs during in-person interviews.

Most of the sample of external stakeholders, including the former Einstein Korean advisory board members interviewed, said that their EHN service experiences had been good ones. They said they had been watching how the Einstein Korean initiatives started and changed the relationship with the Korean community. They also recommended building close relationships with community organizations as essential for a successful healthcare organization.

Specifically, five components were noted when considering the DEICHE community center with the Korean community. These were (1) New approaches to promotions and development; (2) Share EHN DEICHE programs with the local community; (3) Training to encourage existing employees to consider transferring to the DEICHE department; (4) Forming an employee resource group for DEICHE initiatives; and (5) Providing DEICHE training for the entire staff.

Dissertation Participants, Materials and Methods

The network of contacts and interviewees developed for this dissertation arose in the following manner. Initial lists of organizations and associated individuals in the Korean community were generated. These lists included: residents at Korean senior centers. The leadership of the centers approved the project; Philadelphia Korean community-related business organizations. The president of each business association approved the project; former and current presidents and board members of the Korean-American Association of

Greater Philadelphia; clergy associated with Church organizations identified by the President of the (Philadelphia) Korean religious association.

Following approval to carry out the research by the Thomas Jefferson University Institutional Review Board, the identified participants voluntarily responded to surveys and interviews. Design session members were drawn from those who completed the survey and were interviewed. Design team members were stakeholders and leaders in education, health, social service, senior service, and community activities.

Early participants were asked to suggest other individuals who were familiar with and knowledgeable about the Einstein Korean Initiatives, who would be interested in taking the survey, and would be willing to talk about the survey questions in more depth. The researcher felt that this was more efficient and productive in developing a diverse and nuanced look at the Korean community than simply "you know me, so you can help me." Additionally, several Korean interviewees were recruited who helped with some of the initial survey processes and assisted with the explanation of some questions.

Participants in the Korean community were recruited purposively from stakeholders involved in Korean community education, health, business, and senior services in the greater Philadelphia area. Selection criteria for Korean community business owners and leaders would include working areas and years of work experience. Snowball sampling was employed. Informed consent was obtained from all participants to participate in interviews and surveys. Anonymity and confidentiality were maintained in all study reporting; participants were assured that they can refuse to answer questions and can end the interview at any time.

Community Senior Day Care Contacts

Telephone calls were made to the directors of Senior Day Care Centers utilizing three approaches: arranging a one-hour session with the researcher and voluntarily participating Korean senior citizens; surveys conducted by a native speaker (the researcher) to set the stage, and finally conducting the survey with the staff who assist the survey process. All participants in these surveys were volunteers and were informed that they could stop participating in the project at any time.

Key Korean community leaders (representative of business associations and Korean-American associations of Greater Philadelphia) were sent the survey by email. This group consisted of 76 business owners, the former president and board members of KAAGP, and employees at Korean community health, education, social service, and community-based organizations.

Surveys were administered to 130 people on April 18 and 21, 2022. The survey planned for the Grace Senior Day Care Center was canceled due to COVID protocols. The survey is in Appendix A.

Interviewing Key Contacts

Based on the need and convenience of each interviewee, a time and location were arranged for the interview. The interviews were held in a variety of community locations, including several senior service centers, Korean churches and temples, university campuses, Korean social service agencies, Jaisohn Medical Center, Primary Care Doctor's office, places of business, and Starbucks. A total of 10 interviews were conducted. All individuals were interviewed face-to-face, except two who were interviewed by telephone and one via

Zoom due to schedule constraints. In situations in which additional clarification of some issue was needed, a brief follow-up telephone call was made, or an email was sent. Ten (10) people participated in the interviews.

Interviews were conducted using the core questions on the survey, and expanded to increase clarity. The interview questions and extended topics are in Appendix B. The interview was conversational and informal. The initial phase of the interview process included an explanation of how the researcher became interested in diversity, equity, inclusion, and community engagement, the purpose of the dissertation, and the need for ongoing contact and collaboration with the Korean community and healthcare organizations in the greater Philadelphia area. Each individual was asked about the situation in their area of expertise, and about what needs and problems they saw as the greatest priorities in the Korean community, along with the survey questions. During the conversation, the interviewer asked additional questions, such as what additional problems and needs were they aware of relative to the Korean community? Most respondents spoke freely on the basic open-ended questions.

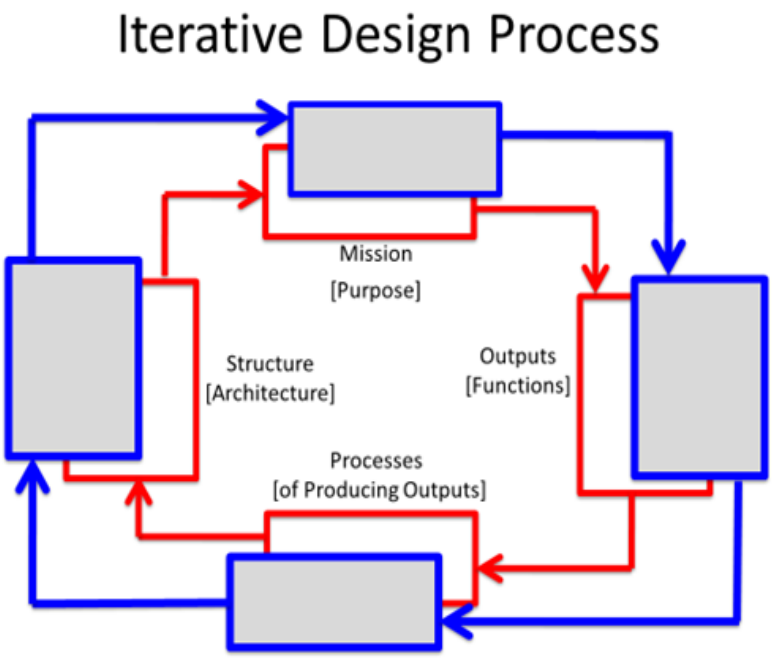
The interviewer drew questions from the course of the conversation, from information gained from previous interviews, and from a review of the literature, probing at times when information was not volunteered in response to open-ended questions. Interviewees were free to answer questions or not and were encouraged to expand their initial response if they chose. Each interviewee was asked to provide their recommendations for members of the ideal design team and was asked if their name could be used as an introduction. They were also asked if they knew anyone interested in volunteering with a

social service agency, and whether they were interested in finding out more about the results of the project when it was completed.

Design Team Methodology

From the sample of stakeholders who participated in the survey and the interviews, a design team of 10 people was created. This group facilitated by the researcher discussed and generated possible solutions and new designs to meet the challenges of DEICHE by addressing purposes, functions, processes, governance, timeframe, and milestones for an ideal organizational system. From the design that emerged from their activities, a strategic plan was created. The activities of the design team are presented in Figure 3.

Figure 3. Design Team Activities



Presentation of Findings

The systems thinking approach enables understanding inter-relationships, interactions, and various perspectives of a system, including reflecting on the system's boundaries. Systems reflect dynamic, often unpredictable interactions amongst diverse, constantly adapting parts that continually change about each other and the collaborative environment (Rusoja, Haynie, Sievers, et al, 2018). These relationships can be represented via causal loop diagrams, which use reinforcing loops (representing feedback loops that accelerate change) and balancing loops (representing feedback). The systems diagrams presented in this study draw on Korean-American data, modified for the ideal design of diversity, equity, inclusion, and community health engagement programs.

CHAPTER 4

RESULTS

This chapter presents the results of the surveys, interviews, and design sessions from which emerged the ideal design for a viable, desirable, and sustainable organizational system that integrates the complex systems concepts of diversity, equity, inclusion, and community health engagement.

The purpose of the surveys and interviews was to provide a broad description of the current reality of the people and context of the Philadelphia Korean community. In the systems-informed methodology of idealized design and interactive planning, an analysis of the current reality is presented to demonstrate the complexity of the current problematic situation. This analysis highlights conflicts and obstructions between stakeholders and increases motivation by the community to redesign their reality to create an organizational and social system they prefer.

Survey Responses

Survey responses were analyzed to obtain basic descriptive statistics. Open-ended data were coded for themes. Interviews were transcribed and analyzed in Korean and English. Audio files and electronic transcripts were stored on secure servers, and transcripts were stored securely in locked cupboards in the researcher's office and secured computer. Relevant official documents, including circulars, memos, guidelines, and regulations were collected to contextualize interview findings. Throughout the research process, a thematic analysis of interview transcripts was conducted in Microsoft Excel.

For this project, the 13-item survey was administered to 147 Korean American senior citizens, 24 Korean American small business owners, 24 Korean community organization representatives, 12 former administrators and board members of Korean American Association of Greater Philadelphia, and 24 Korean American religious leaders. A total of 206 people returned completed forms. These were considered representative stakeholders.

The survey contained two sections: The demographic items (Questions 1-3) were four forced-choice and open-ended questions regarding participants' gender, age, and years lived in the USA. The English proficiency and perceptions section (Questions 4-9) was concerned with Einstein Korean Initiatives. These items used an interval scale response format ranging from 0 = none, 1 = low to 7 = high. Each item from 6 to 9 was followed by a request for a recommendation of "what would you want if you could have anything" response format. This framing integrated with the design sessions, which asked stakeholders to design a system they would have "if you could have anything."

Demographics

Responses to the three demographic questions are presented below. Responses are presented separately for the seniors and community participants.

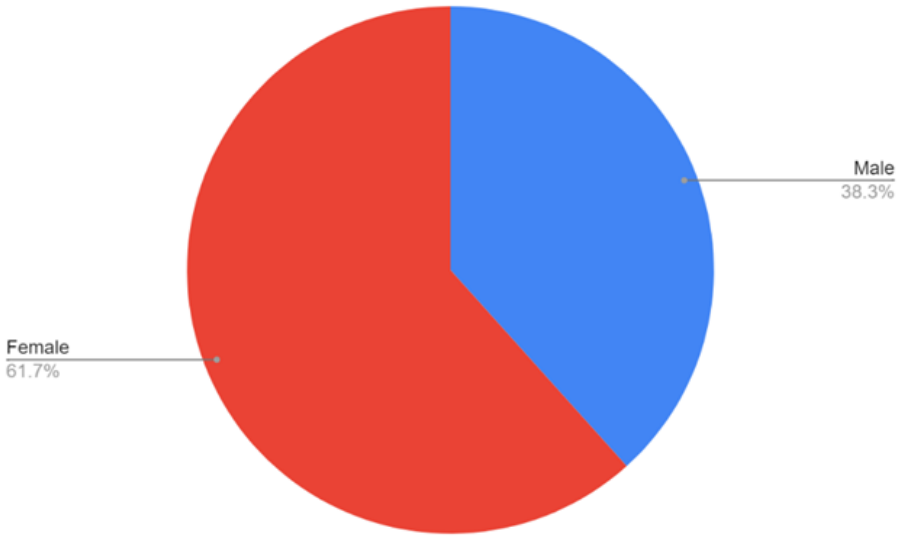
Q 1. What is your gender identity?

Gender identity response categories were Male, Female, and Prefer Not to Say. The results (Table 6) indicated that of the 206 respondents, 79 people (38.34%) self-identified as male, and 127 people (61.65%) self-identified as female. Among the seniors, 85 (65.38 %) were female and 45 (34.61%) were male; among the community members, 42 (55.26 %) were female and 34 (44.73%) were male.

Table 6: Q1. What is your gender identity?

What is your gender identity?	Senior Responses	Community Responses	Total Responses
Male	45 (34.61%)	34 (44.73%)	79 (38.34%)
Female	85 (65.38%)	42 (55.26%)	127 (61.65%)
Total	130 (100%)	76 (100%)	206 (100%)

Figure 4. What is your gender identity (all participants)?



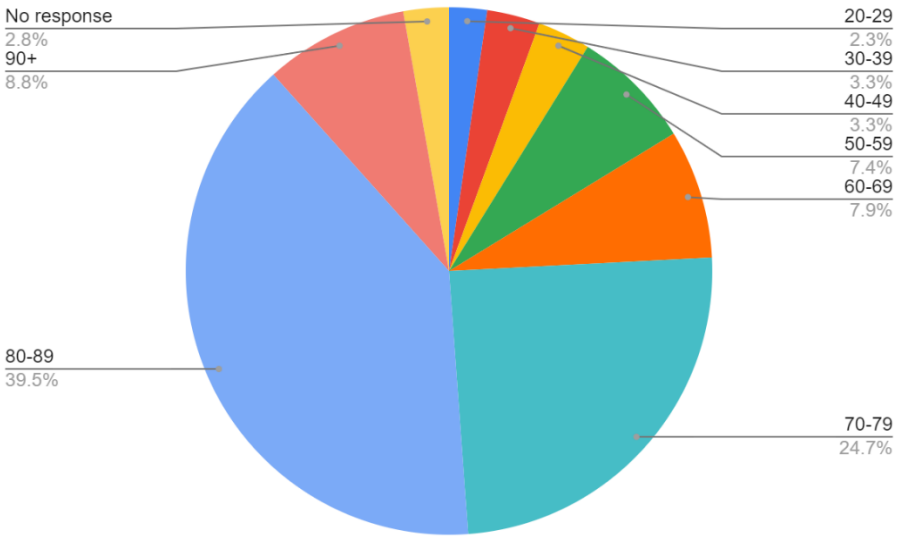
Q 2. What is your age?

Participants were selected from among ten adult age groupings that ranged from 20-29 years to 90+ years. Results (Table 7) showed that ten participants were 90+ years or older, 85 were 80-89 years, 53 were 70-79 years, 17 were 60-69 years, 16 were 50-59 years, 7 were 40-49 years, and 7 were 30-39 years. Five participants were 20-29 years.

Table 7: Q2. What is your age?

Q2. What is your age?	Senior Responses	Community Responses	Total Responses
20-29	5 (3.84%)	5 (6.57%)	5(2.4%)
30-39	7 (5.38%)	7 (9.21%)	7(3.39%)
40-49	7 (5.38%)	7 (9.21%)	7(3.39%)
50-59	7 (5.38%)	9 (11.84%)	16(7.76%)
60-69	5 (3.84%)	12 (15.78%)	17(8.25%)
70-79	38 (29.23%)	15 (19.73%)	53(25.72%)
80-89	66 (50.76%)	19 (25%)	85(41.26%)
90+	8 (6.15%)	2 (2.63%)	19(9.22%)
No Response	6 (4.61%)	0 (0%)	6(2.91%)
Total	130 (100%)	76 (100%)	206 (100%)

Figure 5. Q2: What is your age (all participants)?



Q 3. How long have you lived in Philadelphia (or the United States)?

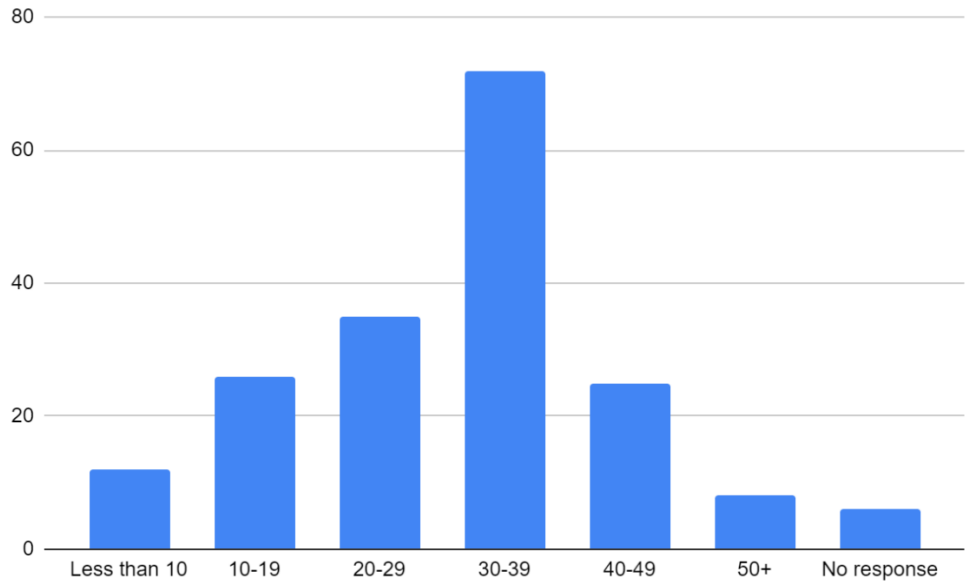
Participants were selected from among six groupings that ranged from less than 10 years to 50+ years of living in Philadelphia (or the United States). Results (Table 8) showed that eight participants had lived for 50+ years in the United States, 45 for 40-49 years, 72 for

30-39 years, 25 for 20-29 years, and 26 for 10-19 years. Only 12 (twelve) participants had lived under 10 years in the U.S.

Table 8: Q3. How long have you lived in Philadelphia (or the United States)?

Q3. For how long have you lived in Philadelphia (or the United States)?	Senior Responses	Community Responses	Total Responses
Less than 10	6 (4.61%)	6 (7.89%)	12 (5.82%)
10-19	14 (10.76%)	12 (15.78%)	26 (12.62%)
20-29	26 (20%)	9 (11.84%)	35 (16.99%)
30-39	53 (40.76%)	19 (25%)	72 (34.95%)
40-49	24 (18.46%)	21 (27.63%)	25 (12.13%)
50+	5 (3.84%)	3 (3.94%)	8 (3.88%)
No Response	3 (2.30%)	6 (7.89%)	6 (2.91%)
Total	130 (100%)	76 (100%)	206 (100%)

Figure 6. How long have you lived in Philadelphia or the United States (all participants)?



Survey Attitudes and Beliefs

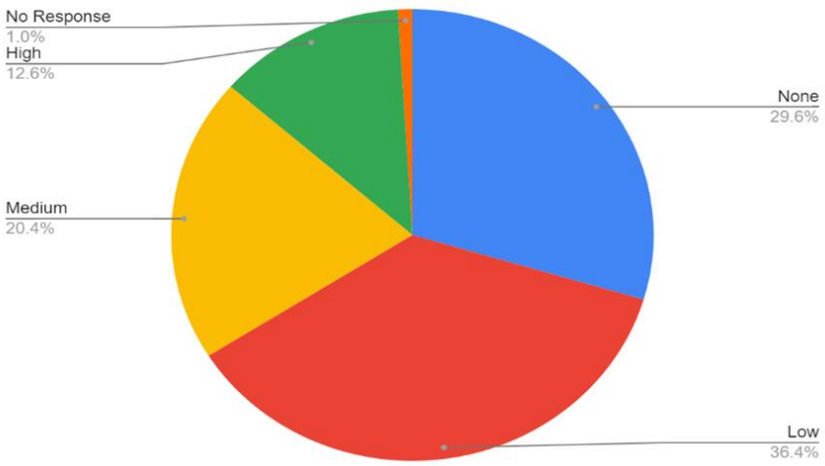
Q 4. What is your ability to speak English when having a conversation with health professionals?

This question used an interval scale response format ranging from 0 = none, 1-3 = low to 7 = high. Sixty-one people (29.61 %) responded "none," 75 people (36.40 %) responded "low," 42 people (20.38 %) responded "medium," 26 people (12.62 %) responded "high," and two people (0.97 %) did not respond. Sixty-seven senior citizens responded "low," but eight community stakeholders responded "low." 54 community stakeholders responded "medium" or "high," but only eleven senior citizens responded "medium" or "high." (See Table 9 and Figure 7).

Table 9: Q 4. What is your ability to speak English when having a conversation with health professionals?

Q. 4: English proficiency when speaking with health Professionals	Senior Responses	Community Responses	Total Responses
0 None	58 (44.71%)	3 (3.94%)	61 (29.61%)
1 – 3 Low	67 (51.53%)	8 (10.52%)	75 (36.89%)
4 – 5 Medium	8 (6.15%)	31 (40.78%)	42 (20.38%)
6 – 7 High	3 (2.30%)	23 (30.26%)	26 (12.62%)
No Response	2 (1.53%)	0 (0%)	2 (0.97%)
Total	130 (100%)	76 (100%)	206 (100%)

Figure 7: What is your ability to speak English when having a conversation with health professionals? (all participants).



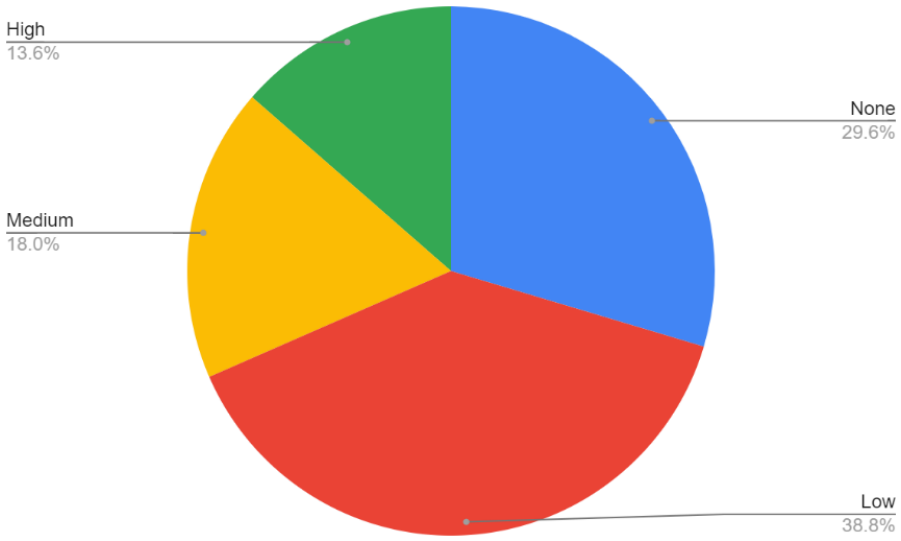
Q 5. What is your ability to understand English when having a conversation with health professionals?

This question used an interval scale response format ranging from 0 = none, 1-3 = low to 7 = high. Sixty-one people (29.61 %) responded “none,” 80 people (38.83 %) responded “low,” 37 people (17.96 %) responded “medium,” 28 people (13.59 %) responded “high,” and zero people (0 %) did not respond.” When the responses of the participants are separated into senior citizens (Senior Responses) and the other Korean stakeholders (Community Responses), some differences were noted. Fifty-nine seniors responded that they had no ability to speak English and 70 responded their proficiency was low, but only two community stakeholders responded that they had no English ability and 10ten indicated their proficiency was low. (See Table 10 and Figure 8)

Table 10: Q 5. What is your ability to understand English when having a conversation with health professionals?

What is your ability to understand English when having a conversation with health professionals?	Senior Responses	Community Responses	Total Responses
None (0)	59 (45.38%)	2 (2.63%)	61 (29.61%)
Low (1-3)	50 (53.84%)	30 (39.47%)	80 (38.83%)
Medium (4-5)	15 (19.23%)	22 (28.94%)	37 (17.96%)
High (6-7)	6 (4.61%)	22 (28.94%)	28 (13.59%)
No Responses	0 (0%)	0 (0%)	0 (0%)
Total	130 (100%)	76 (100%)	206 (100%)

Figure 8. Q.5: What is your ability to understand English when having a conversation with health professionals (all participants)?



Q 6. How much does Einstein-Jefferson help Korean patients with health problems?

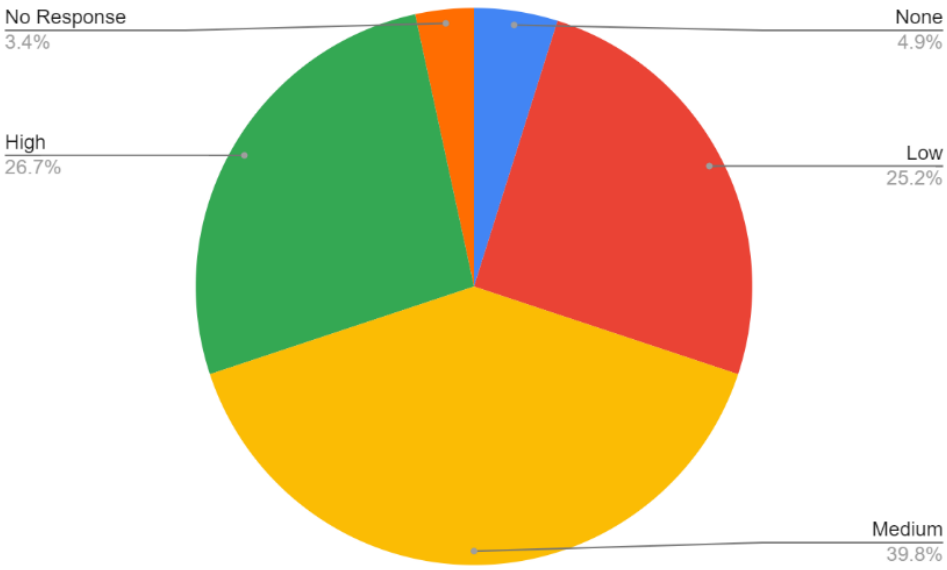
This question used an interval scale response format ranging from 0 = none, 1-3 = low to 7 = high. Ten people (4.85 %) responded “none,” 42 people (25.24 %) responded “low,” 82 people (39.80 %) responded “medium,” 55 people (26.69 %) responded “high,” and seven people (3.39 %) did not respond. The majority of most seniors (102 people) responded “medium” and or “high,” but only five community stakeholders responded

"high," while 36 community stakeholders responded "none" and or "low." Only eight community stakeholders responded, "High." This shows that most of the senior citizens have been vising the EHN and receiving health services. (See Table 11 and Figure 9)

Table 11: Q 6. How much does Einstein-Jefferson help Korean patients with health problems?

How much does Einstein-Jefferson help Korean patients with health problems?	Senior Responses	Community Responses	Total Responses
None (0)	2 (1.53%)	8 (10.52%)	10 (4.85%)
Low (1-3)	24 (18.46%)	28 (36.84%)	52 (20.38%)
Medium (4-5)	55 (42.30%)	27 (35.52%)	82 (39.80%)
High (6-7)	47 (36.15%)	8 (10.52%)	55 (26.69%)
No Responses	2 (1.53%)	5 (6.57%)	7 (3.39%)
Total	130 (100%)	76 (100%)	206 (100%)

Figure 9: Q 6. How much does Einstein-Jefferson help Korean patients with health problems (all participants)?



Q 7. How much does Einstein-Jefferson help Koreans looking for jobs?

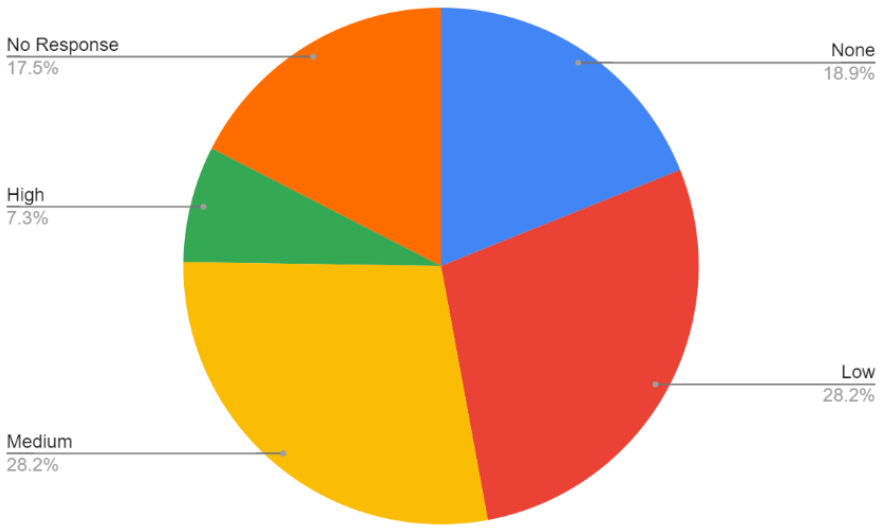
This question used an interval scale response format ranging from 0 = none, 1-3 = low to 7 = high. 39 people (18.93 %) responded "none," 58 people (28.15 %) responded

"low," 58 people (28.15 %) responded "medium," 15 people (7.28 %) responded "high," and 36 people (17.47 %) did not respond. . Over 100 seniors responded "none," "low," or "medium," but 42 community stakeholders responded "medium" or "high." This is likely because the Korean community stakeholders had experience with EHN Korean employment projects, and their children applied for and received many positions with the EHN system. (See Table 12 and Figure 10).

Table 12: Q 7. How much does Einstein-Jefferson help Koreans looking for jobs?

Q 7. How much does Einstein-Jefferson help Koreans looking for jobs?	Senior Response	Community Responses	Total Responses
None (0)	32 (24.61%)	7 (9.21%)	39 (18.93%)
Low (1-3)	44 (33.84%)	14 (18.42%)	58 (28.15%)
Medium (4-5)	32 (24.61%)	26 (34.21%)	58 (28.15%)
High (6-7)	9 (6.92%)	16 (21.05%)	15 (7.28%)
No Responses	33 (25.38%)	3 (3.94%)	36 (17.47%)
Total	130 (100%)	76 (100%)	206 (100%)

Figure 10: How much does Einstein-Jefferson help Koreans looking for jobs (all participants)?



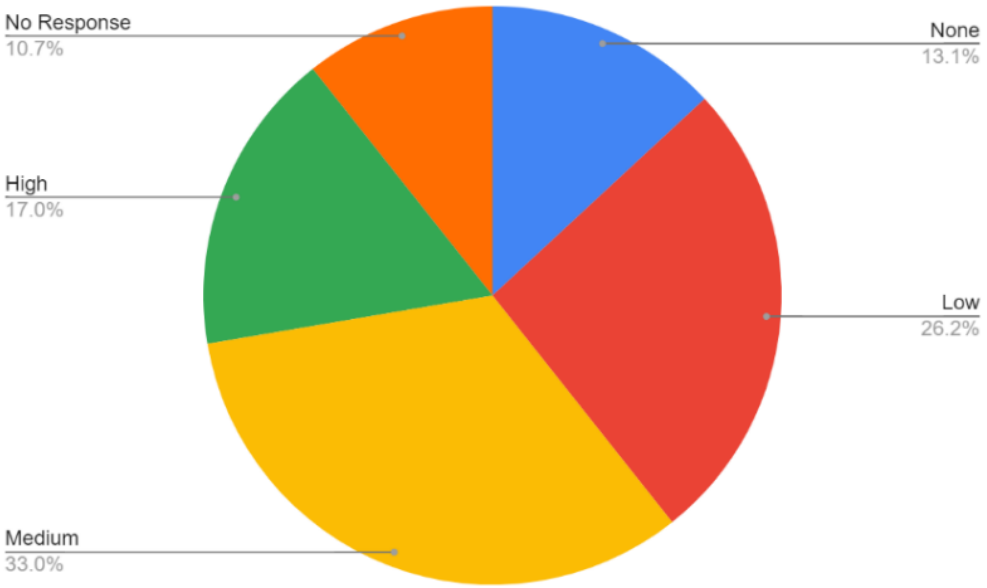
Q 8. How much does Einstein-Jefferson provide diversity, equity, and inclusion of Koreans?

This question used an interval scale response format ranging from 0 = none, 1-3 = low to 7 = high. 27 people (13.10 %) responded “none,” 54 people (26.21 %) responded “low,” 68 people (33 %) responded “medium,” 35,” 35 people (16.99 %) responded “high,” and 22 people (10.67 %) did not respond. (See Table 13 and Figure 11)

Table 13: Q 8. How much does Einstein-Jefferson provide diversity, equity, and inclusion for Koreans?

Q 8. How much does Einstein-Jefferson provide diversity, equity, and inclusion for Koreans?	Senior Responses	Community Responses	Total Responses
None (0)	17 (13.07%)	10 (13.15%)	27 (13.10%)
Low (1-3)	29 (22.30%)	25 (32.89%)	54 (26.21%)
Medium (4-5)	47 (36.15%)	21 (27.63%)	68 (33%)
High (6-7)	23 (17.69%)	12 (15.78%)	35 (16.99%)
No Response	14 (10.76%)	8 (10.52%)	22 (10.67%)
Total	130 (100%)	76 (100%)	206 (100%)

Figure 11: How much does Einstein-Jefferson provide diversity, equity, and inclusion of Koreans (all participants)?



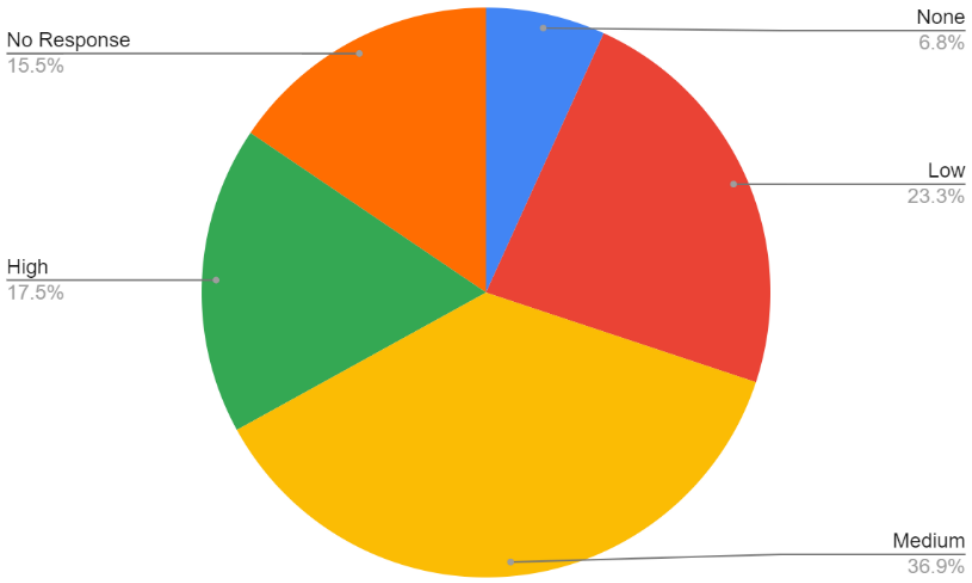
Q 9. How much does Einstein-Jefferson provide community engagement programs to Koreans?

This question used an interval scale response format ranging from 0 = none, 1-3 = low to 7 = high. 14 people (6.75 %) responded "none," 48 people (23.30 %) responded "low," 76 people (36.89 %) responded "medium," 36 people (17.47 %) responded "high," and 32 people (15.53 %) did not respond. The two groups' views on EHN community engagement in the Korean community also differed greatly. Fifty-seven seniors (43.85%) responded "medium" and "high," and 54 community stakeholders (71.04%) gave "medium" and "high" because the most community stakeholder has been participating in the EHN community events as vendors or supporters. (See Table 14 and Figure 12)

Table 14: Q 9. How much does Einstein-Jefferson provide community engagement programs to Koreans?

Q 9. How much does Einstein-Jefferson provide community engagement programs to Koreans?	Senior Responses	Community Responses	Total Responses
None (0)	12 (9.23%)	2 (2.63%)	14 (6.75%)
Low (1-3)	34 (26.15%)	14 (18.42%)	48 (23.30%)
Medium (4-5)	33 (25.38%)	42 (55.26%)	75 (36.40%)
High (6-7)	24 (18.46%)	12 (15.78%)	36 (17.47%)
No Responses	26 (20%)	6 (7.89%)	32 (15.53%)
Total	130 (100%)	76 (100%)	206 (100%)

Figure 12: How much does Einstein-Jefferson provide community engagement programs to Koreans (all participants)?



Analysis of Interviews

All responses from interviews were transcribed from handwritten notes. Transcribed interviews contained basic demographic and personal data, selected direct quotations, and salient paraphrased statements made by the informant during the interview. These transcriptions were used to identify the needs, problems, and challenges that each informant thought to be of sufficient importance to bring to the attention of the interviewer.

An analysis of the patterns of responses related to themes, needs, and problems was conducted. From the responses reviewed, patterns were extracted that indicated problems and needs. These were merged into a separate master list of all problems and needs identified. The master list was categorized into the problem and needs domains, which were joined into larger coherent conceptual units. For example, specific DEICE conditions such as discrimination, miscommunication, or unwelcoming feeling were joined together into the

general category of DEICE. Similarly, items typically linked and that often co-occur were joined into larger groups: health fairs, language service services education programs, free cancer screening programs, and youth internship programs were combined into one group, and all health disparities were joined into another group.

This process yielded a master list of five topics relevant to DEICE programs and unmet needs. These were discrimination, health and medical issues, lack of awareness of community services, language barriers, and intragroup conflict. To evaluate the number of participants concerned about each of these interests and needs, the interviewer made two subsequent reviews of the interview transcripts, noting when each informant mentioned each item. Counts of informants concerned about each within the Korean community were transformed into percentages of informants from the community, the results of which are shown as areas of significant concern in Table 15.

Table 15. Comments from Surveys and Interviews

Significant Topics of Concern	**Comments**
Discrimination	• There is a "lack of Korean speaking staff" in each department. • There are only a few medical staff members who speak Korean. • "Koreans are not treated with respect." • They feel that because "they look different, they are treated differently and do not get good service": in particular, the staff sometimes asks them to stop talking in Korean. • Some former employees said that they were "stuck in entry-level positions and were never promoted."
Health and Medical Issues	• Korean seniors have diseases such as hepatitis, cervical cancer, stroke, heart attacks, diabetes, ulcers, and osteoporosis. • Korean seniors are more likely to seek traditional healers (who treat them with herbs, acupuncture, and other traditional medicine) instead of going to a primary care physician or visiting the hospital.

	• Koreans are also often biased against small hospitals or clinics in the suburbs. They have more trust in large hospitals such as Penn Medicine or Jefferson Health, even though these facilities do not provide face-to-face Korean interpreters. • Korean seniors said that they "could not ask the medical staff questions because cannot speak English." • Koreans avoid preventative care. They know Einstein "offers free mammograms and prostate screening," but they do not want to go because they are not familiar with these procedures and their benefits.
Lack of Awareness of Community Service	• Do not know where they can go for community services except the Jaisohn Center. • Four Korean community social services centers are available, but this is still not well known in the community. • Some Korean service centers "charge a fee" that seniors "do not want to pay," so they ask their children to take them to Philadelphia. • EHN had a Korean hotline, which "helped a lot, but it no longer exists." Korean seniors feel that they still need this kind of service, with someone who answers in Korean to point them in the right direction. • Senior and community stakeholders said that they need "Korean case managers or navigators." • Many female stakeholders said that some "women need help with domestic violence" and are unable to find it.
Language Barrier	• Limited English skills make it "too difficult to deal with medical issues and social services concerns." • When there are no Korean-speaking doctors, "[it] makes every other problem worse." • The language issue is the most serious source of "stress" for Korean seniors. • Some Koreans hesitate to attend programs and services because they feel they "cannot speak English and cannot understand." • Language is not a major issue for some stakeholders from the Korean community, but their parents need more support when their parents visit the social services, health care, education, or legal systems. • Many seniors stay in their apartments or homes all day and rarely go outside because of the language issue. • Language issues create "extra stress" for the children because they learn English faster and are more fluent than their parents • Korean service centers offer English as a Second Language (ESL) classes, but few seniors participate.

	• Few hospital clinics have brochures, flyers, and forms in Korean, and they do not provide any face-to-face interpretation service to help when Korean people arrive for services.
Intragroup Conflicts	• In the Korean community, there are still conflicts between different belief systems (e.g.; Christian vs Buddhist, different Christian denominations, Christian vs Muslim, etc.), where they come from the regional background. • Generation gaps within and among the community organizations, churches, and institutes. • In addition, power struggles often erupt in many churches as members jockey for a limited number of church positions and roles of authority within a church (deacons, committee chairs).

Application of the Cynefin Framework

The interview comments were examined and aligned with the four contextual categories described by Snowdon and Boone (2007) in the Cynefin Framework. This provided additional understanding that DEICHE consisted of situations and challenges with varying contexts including those that are unstructured and complex.

Ordered Simple Problems

From the survey and interviews, five concerns were identified as ordered simple problems: Lack of interpretation services – "I do not see any Korean interpreters," "no interpreter," "I do not like to use the computer," lack of health education – "why do not provide the education program what you did mover than 10 years," lack of preventative health care and screening – "I do not see any screening programs. You offered almost every month before," failure to access treatment earlier rather than waiting for the status before problems became acute – "my husband just diagnosed prostate cancer last month," "you provided prostate cancer screening every month, why not now," and addressing mental

health concerns and illness – “can you recommend any mental health doctor, as Korean please.”

Ordered Complicated Problems

In the Philadelphia Korean community, there are six Korean senior daycare centers, which compete fiercely for business by offering various benefits and amenities, such as lunches, transportation services, and food stamps. Three directors of the Korean senior daycare centers said that “at least fifteen percent of our residents move from one center to another annually,” because they want to take advantage of different offers, which produces complicated problems related to staffing and programs for the centers and the seniors.

Unordered Complex Problems

During the COVID-19 pandemic, over 75 Korean senior citizens passed away; Korean community organizations were unable to help the families effectively. In the Korean Community survey, ten senior citizens and seven business owners expressed racial discrimination, which comes from a lack of trust and perceived lack of powerlessness in the Korean Community: “we need more Korean politicians; we have two in the City of Philadelphia but we need more in local communities; Korean community organizations should work with the main-stream organizations; sometimes I heard that the Korean community is like a ghetto.”

Unordered Chaotic Problems

There was a tragedy in Philadelphia in 2020. According to statistics compiled by Stop AAPI Hate (Briggs, 2021), 3,800 anti-Asian hate incidents were reported nationwide in 2020, including ninety-seven in Pennsylvania. A representative of the City of Philadelphia

said anti-Asian American hate incidents tripled between 2019 and 2020 and that twenty-eight such complaints have already been received in 2021.

Senior citizen participants said that the Philadelphia Riot was the first time when they felt that they might die or be killed by someone on the street. They said that they could not go outside and stayed home for almost one month: “I did not go outside of my apartment; I was scared to see my next door neighbors who are black; I called to my son whenever I wanted to go outside; I did not go to Sunday services for two months because I did not have transportation.” All the senior citizen participants said that the Philadelphia riots were the first time when they felt that they might die or be killed by someone on the street. One of the interviewees said that “I lost three businesses within two weeks; I have been supporting supported my neighbors for the last 15 years, offering so many gifts, turkeys, children’s clothes, and foods, but they came to my business and took everything; I do not know what I can do; I was really angry and wanted to buy a gun.”

What Kind of Challenge is DEICHE?

I have argued that DEICHE is a complex problem which benefits from systems approaches for problem formulation and for problem intervention. Specifically, I have argued that the appropriate approach includes a design-based methodology for problem solving.

To address the nature of the problem, I have linked responses from the stakeholders to the Cynefin Framework (Snowdon & Boone, 2007) focusing on ordered (structured) vs unordered (unstructured) problems.

Ordered (Structured) Problems

Ordered problems may be simple or complicated. Simple problems have clear cause and effect relationships; they present an ordered and known world that makes it easy to reach the desired result. Processes inside these systems are linear; if one determines ("senses") the facts and categorizes them, then there is a simple, appropriate, and “best” response to solving a problem. Simple techniques encourage following best practices, benchmarking, and other well-established solution pathways.

From the survey and interviews, several concerns were identified as ordered simple problems. For example, “I do not see any Korean interpreters,” “why do not provide the education program what you did mover than 10 years,” “you provided prostate cancer screening every month, why not now,” and addressing mental health concerns and illness – “can you recommend any mental health doctor, as Korean please.”

A structured complicated problem is a domain that requires expertise. To understand these problems fully, comparing and examining various causes and effects, application of “good practices,” analytic thinking, the application of the scientific method, and use of evidence-based research are preferred.

In the Philadelphia Korean community, there are six Korean senior daycare centers, which compete fiercely for business by offering various benefits and amenities, such as lunches, transportation services, and food stamps. Three directors of the Korean senior daycare centers said that “at least fifteen percent of our residents move from one center to another annually,” because they want to take advantage of different offers, which produces complicated problems related to staffing and programs for the centers and the seniors.

Unordered (Unstructured) Problems

In the unordered and unstructured domain, the context of problems is non-linear and non-proportional; something that happened in the past and today may not occur tomorrow, and expending dedicated effort to a problem does not mean that it will be effectively addressed. In this context, situations, variables, and results are volatile, uncertain, complex, and ambiguous, which means there is no consistently valid prediction method.

In the Korean community survey, some senior citizens and business owners said they had experienced racial discrimination, stemming from which produced a lack of trust among the Korean community towards healthcare providers and a lack of power in the Korean community, such as "when I visit the hospital the front desk people ignored me; I do not speak English and do not know how I can ask questions; I just show them the doctor's notes; sometimes the front desk people did not say anything and just pointed their fingers and showed towards the chairs."

During the COVID-19 pandemic, over 75 Korean senior citizens passed away; Korean community organizations were unable to help the families effectively.

In the Korean Community survey, ten senior citizens and seven business owners expressed racial discrimination, which comes from a lack of trust and perceived lack of powerlessness in the Korean Community: "we need more Korean politicians; we have two in the City of Philadelphia but we need more in local communities; Korean community organizations should work with the main-stream organizations; sometimes I heard that the Korean community is like a ghetto."

When the context is characterized by chaos, the only appropriate response is to identify how to stabilize the situation, and then convert it first to a complex system, then into a complicated one. Shocks to the entire environment, like a novel coronavirus that shuts down most or all operations, create a situation that demands a novel solution.

According to the president of Korean American Association of Greater Philadelphia (KAAGP), riots in Philadelphia led to 56 Korean stores being looted, mainly in downtown Philadelphia. The most intensively looted were beauty supply stores, with at least thirty-one stores attacked. Cell phone stores, pharmacies, and laundries were also heavily affected. The Ministry of Foreign Affairs in Korea also reported 14 Korean businesses looted in Chicago, Illinois, ten in Minneapolis, Minnesota, ten in St. Louis, Missouri, five in Los Angeles, California, and four in Washington, D.C., among other major American cities. *The Chosun Ilbo* reported that the damage to Korean-American stores in Philadelphia alone reached fifteen million dollars (about 18.3 billion won).

The Philadelphia riot did not stop at Center City but reached all the way to Koreatown, located along North 5th Avenue more than five miles away. Pharmacies and accessory stores were looted. The National Guard was not deployed in Koreatown, so shop owners were worried that they could be looted again at any time. Friends of the author had two business locations in Center City, both of which were looted. Another friend's footwear store on Germantown Avenue also was looted, and the owner was beaten seriously, requiring three weeks' hospitalization. Owners were helpless before the mob, who broke locks and cut through steel doors with chainsaws, and smashed windows.

The current pandemic moves between contexts of unordered chaos, complexity, and ordered complication and simple. Most educational, social, medical, and other

organizational leaders have acted by closing facilities, laying off employees, and seeking professional and personal cash-flow stability. Communication is top-down; there is little time for consultation.

Confusing Problem Domains

The Korean community consisting of senior citizens and the community stakeholders are experiencing simple, complicated, complex and chaotic challenges. These are longstanding problems; during the author's time at EHN, it was clear that many services and programs were ineffective. Many of these efforts failed because EHN focused on simple and complicated problems – trying to fix or improve a situation - rather than complex and chaotic problems where a systemic redesign would be appropriate.

When the Korean-American Association of the Greater Philadelphia asked the author to provide more programs, it was suggested that a systems approach be applied. This meant that rather than limiting initiatives to the Korean community, they should be expanded to the broader community. Perhaps discussion with Asian-American, Latino-American, or African-American organizations could generate and develop useful collaborations. This would shift the approach from reductionist to systemic and would help in networking with local community leaders and politicians.

Idealized Design Team

The idealized design team consisted of ten interviewees who have been working with the researcher for at least 10 years in the Korean community. The team was introduced to the topic with a brief lecture on the methodology of Interactive Planning (IAP) created by Russell L. Ackoff who emphasized creating the future by designing a desirable present. The

first part of the topic was an idealization, which entails a description of the current reality – the context – as collected from the surveys and interviews. The design team worked on a schematic using five major concerns: discrimination, health and medical issues, lack of awareness of community service, language barrier, and intragroup conflicts. The second part of the process involved having the team design an ideal system in which the concerns were dissolved.

The team was challenged to design an ideal DEICHE system for the Korean community that could be implemented within a healthcare organization in greater Philadelphia. Tables 16 and 17 describe the topics and prompt questions used to generate an ideal DEICHE design.

Table 16. Design Topics

	Design Topics
1st Step	Mission for the Ideal DEICHE program
2nd Step	Value proposition for the Ideal DEICHE program.
3rd Step	Functions (Outputs) for the Ideal DEICHE program
4th Step	Processes for the Ideal DEICHE program.
5th Step	Structure (Specification/design) for the Ideal DEICHE program.
6th Step	Revenue model for the Ideal DEICE program.

Table 17. Design Prompt Questions

	Design Prompt Questions
1	What is the reason for being? / What is the mission of an ideal DEICHE program? What is the "value proposition?"
2	What does an ideal DEICHE program provide? /What services should an ideal DEICHE program provide/deliver to customers?

3	What are the primary functions (outputs) of an ideal DEICHE program? /What functions must the organization perform to produce the outputs or achieve the mission?
4	Who are the customers (consumers)?
5	How should the ideal DEICHE organization differentiate itself from its competitors?

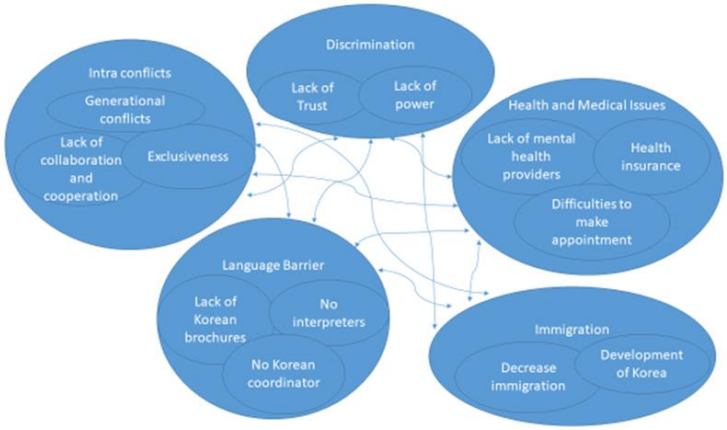
Idealized Design Team Results

Current Reality Map: System Influence Diagram

Figure 13 represents an influence diagram or map of the five concepts that emerged from the interviews as central characteristics of the current reality of DEICHE within the Korean Community of Philadelphia. As presented, each of the concepts may be understood as a subsystem containing important elements that are interdependent such as immigration's elements of perceived lack of trust and lack of power.

The map also presents the interrelationships among the five subsystems. This important characterization supports the complex systems nature of DEICHE. This kind of problem loses its meaning if deconstructed into any single cause; only by considering the whole can understanding and effective navigation be enabled.

Figure 13. Current Reality Map – System Influence Diagram



Five Major Concerns in Current Reality

The five major concerns that emerged (Table 15) were offered to the design team as ideal considerations and to frame the suggestions for an ideal DEICHE. The first concept was discrimination, which referred to a lack of trust among members of the Korean community and a lack of power felt by the Korean Community. This consideration was to encourage Korean community leaders, government agencies, and other institutions to be more welcoming, accepting, and persistent in their outreach to Korean individuals. There was also the suggestion to sponsor a workshop or training on the subtle discrimination faced by Korean employees and students.

The second concept was health and medical issues; the survey responses and interviewees said that these concerns are based on having too few mental health providers, lack of health insurance, and difficulties making an appointment with the hospital. The design team suggested encouraging the Korean community to design and provide culturally and linguistically appropriate cancer testing, prevention, and treatment strategies. Hepatitis is a major disease in the Korean community, so a good place for the hospital to start would be to offer hepatitis prevention and treatment strategies. The design team strongly suggested that providing a forum or seminar on the issues is crucial. The Korean community-based organizations could provide this by offering an ongoing series of health fairs dealing with a variety of medical issues for their members.

The third concern was a lack of awareness of community services. Three Korean community organizations offer community services, but are not effective, according to the design team. The design teams suggested that the community organizations should communicate with the city, townships, or counties, and provide the services not just what

they have been doing, but participate in new initiatives by the township, county, or state governments. The Korean community-based organizations can also invite social service representatives to talk about their missions and explain how to apply for and receive services. Finally, the design team suggested encouraging Koreans to be volunteers at local social service agencies.

The fourth concern was the language barrier. The language barrier is not new; it has been there ever since the first Korean immigrants arrived in the U.S. Still, there are few Korean brochures in the hospitals and no Korean interpreters. Korean community leaders should contact health care organizations and offer help with creating Korean brochures or supplying health information. Three design team members suggested that fundraising within the Korean community and collaborating with the healthcare organizations would work.

The last concern was intragroup conflicts. The Korean community is already a diverse community and has some internal problems, which cause a lack of collaboration and cooperation. There are over 30 Korean organizations in the Philadelphia area, but they do not work together. Two design team members suggested that the Korean American Association of Greater Philadelphia should have its own center and invite all Korean community-based organizations to use the center as the hub of community events and programs.

Suggestions for Prototype New System

These were the main elements of the new system: 1. promotes participation; supports an environment of empowerment; 3. Key stakeholders feel integral; 4. promotes creativity; 5. facilitates ease of implementation. Team members were also asked to consider their

design for internal and customer-facing projects, goal setting, project post-mortems, risk mitigation, and whatever else they could think of that a team is required to be done.

Ends Planning for New Reality

The design team suggested five components that would ideally address DEICHE for a community engagement program. The first was to address the challenges of human resource management by "Go Behind Hiring," which means that the HR (Human Resource) is not just hiring but leads in creating diversity within the organization. Therefore, human resource management is essential for the success of the DEICHE program. The organization should create a highly inclusive workplace and recruit staff that best fit this model.

The second component is the role of executive leadership. The executive leadership have to have diverse; not only racial diversity but the cultural and experiential diversity are important as well. Executive leadership should engage with the DEICHE programs from the beginning.

The third component is communication. The organization should keep channels of communication open constantly and listen to different voices both internally and externally.

The fourth component is the best workforce team and welcoming a multicultural workforce. The organization should have DEICE teams and give awards to those who do the best job promoting DEICE at least quarterly. The high-performance team in terms of DEICE will lead the organization into success.

CHAPTER 5

DISCUSSION

This chapter addresses the general and research questions described in Chapter 1 and discusses the implications of the results of the situation analysis / current reality of DEICHE, and the design and strategy of an ideal DEICHE generated by the design team.

The general research challenge posed in this dissertation is how and why the interests and needs for diversity, equity, inclusion, and community health engagement (DEICHE) of Korean-Americans in the greater Philadelphia region are not being met adequately or sustainably. From this, two research questions were formulated. First, when the Philadelphia Korean Community is formulated as a complex system, what are the challenges (problems and opportunities) of diversity, equity, inclusion, and community health engagement (DEICHE)? Second, informed by systems thinking, what is an ideal design for a hosting enterprise to promote, support, and sustain diversity, equity, inclusion, and community health engagement (DEICHE) in the Philadelphia Korean Community?

Current Reality of DEICHE

The pilot study conducted in 2019 revealed concerns or needs within the Einstein Korean Initiative based on opinions of leaders in Einstein Healthcare Network and former Einstein Korean Advisory Board members. Chapter 2 of this dissertation presents an extensive review of the relevant research and literature dealing with diversity, equity, inclusion, and community engagement, including the perceptions of DEICE in the Korean community. Chapter 3 described surveys and interviews directed to Korean community stakeholders, which added understanding of DEICHE by identifying five basic concerns of

stakeholders. One implication of these concerns is that DEICHE is a complex systems problem. There is no single root cause; rather, there are multiple interacting and codependent elements that influence emerging outcomes. The formulation of the influence diagram in Figure 13 (p.79) presents this.

Chapter 4 summarized the survey and interview results. It showed that ability to communicate (speaking and comprehension) in English is a much greater problem for Korean senior citizens than it is for other Korean community stakeholders who are business owners, community leaders, and professionals. Indeed, Korean senior citizens received health and medical services from EHN through the Einstein Korean Initiatives supported because EHN had hired over 45 Korean-speaking staff, including physicians, nurses, medical technicians, receptionists, and interpreters. Unlike the seniors, the community stakeholder did not report having difficulty speaking English which gave them the freedom to go to any healthcare organization, such as Penn Medicine, Jefferson, or Temple, that is convenient. Korean seniors, however, felt discrimination whenever they went to healthcare organizations other than EHS when support was present. Unfortunately, the Einstein Healthcare Network could not provide the same kinds of programs anymore, which I offered through the EHN system.

Previous efforts by individuals and enterprises within the EHN have tended to rely on experts and consultants who have developed a variety of approaches to address individual factors affecting diversity, equity, diversity and inclusion, and community engagement as if they are independent. These efforts have been unsuccessful in part because expertise may be relevant to well-structured complicated problems but are insufficient for unstructured complex problems (Snowdon & Boone, 2007). Indeed, an important characteristic of an

unstructured complex systems challenge is that there are no experts or best or good practices for this kind of problem because it is in the domain of emergence (Snowdon & Boone, 2007). For this reason, an important approach of this dissertation was for stakeholders to come together to co-design a new system that addressed the main challenges of the current reality of DEICHE. Furthermore, DEICHE literature has not previously identified the application of a systems and design approach to address the elements of this kind of challenge.

Design of an Ideal DEICHE Program

The second research question informed by systems thinking is, what is an ideal design for a hosting enterprise to promote, support, and sustain diversity, equity, inclusion, and community health engagement (DEICHE) in the Philadelphia Korean Community?

Discerning the context in which a problem or opportunity is located becomes essential for proper problem formulation and problem intervention. Snyder (2013) refers to a comparison between following a recipe, sending a rocket to the Moon, and raising a child (originally from Glouberman & Zimmerman, 2002). Following a formula or recipe is considered a simple but structured problem because there are proven and best practices. A complicated problem which is also ordered is sending a rocket to the moon. Ray (2017) wrote that "leadership like rocket science can be taught" because it required a high level of expertise in varying fields. A complex problem which is unstructured includes raising a child or addressing DEICHE because each child or DEICHE organizational system is unique, each has his/her/its own interests and purposes, so there are no experts or formulas to follow. Snyder (2013: 8) wrote,

> Educational initiatives, and in fact the social sciences more broadly, often attempt to dwell in the realm of the complicated when in fact they are operating in the realm of the complex … Experts devise a policy targeting a single or relatively small set of problems and launch it, believing (or at least hoping), that the solution they are advocating is whole, complete, widely replicable and easily actionable. All that is then left is to wait for the results and see if the metaphorical rocket reaches the moon. Iterative feedback is often limited in this approach, and flexibility is not often a high priority in the initiative's design. What these efforts miss, are that complex problems cannot be adequately captured via such linear formulaic approaches (p. 8).

To design a DEICHE program requires the presence of a set of integrated elements including organizational capacity, community partnership, workforce elements, and leadership. The fundamental premise of this dissertation is that the challenge of DEICHE is a complex systems problem, which means only applying research methodology is insufficient to understand and address this kind of problem. Complex social problems are better addressed with systems methods and tools, including interactive planning and idealized design.

Designing the Prototype

The Korean community leaders as the ideal design team identified and summarized the major challenges of DEICHE in the Korean community including discrimination, health, and medical issues, lack of awareness of community services, language barriers, and intergroup conflicts. The ideal design team also suggested five components for the prototype of a new system; namely, promoting participants, supporting an environment of empowerment; key stakeholders feel integral, promoting creativity, and facilitating ease of implementation. These are being developed with facilitation by the pastoral care department at Grand View Health (GVH).

Prototype Characteristics

Interconnectedness defines the relationships in the organizational system between people. A key tenet of systems thinking is that everyone has an impact on a system just by being in it. Identifying and promoting processes that allow each person to understand the interests and purposes of others is essential to for strategic agreement and to lay the groundwork for difficult conversations, which are likely to be necessary. By creating safe space for open conversations, communities are more likely to get closer to an accurate view of any situation.

Sponsorship concerns the relationship between senior leadership and the community. When the author proposed a design and projects for the pastoral care department, he asked the senior leader to allow him to implement the design contained in the dissertation. The senior leader approved immediately and promised to provide all needed support.

Communication and feedback are central elements in an effective social system. After the first pastoral care task force meeting, the author contacted the community pastors and chaplains who have worked with GVH over the past decades. Stakeholders were defined as everyone throughout the entire system who was interested and was invited to join the pastoral care task force. At present, the task force has eight members: three GVH employees, three pastors and chaplains from the local community, and two pastoral care professionals. A GVH pastoral care advisory board was also organized to act as a containing system.

Context mappings are systems tools that help describe the current situation and that can indicate where small changes can influence the whole system. Working together to create a map of the current situation can be an engaging and helpful method of getting a new perspective on what to do next and as well as revealing what might be missing. Working with the advisory

board, we have created maps of GVH pastoral care, its activities, and options for implementing DEICHE policies. The pastoral care team is defining and applying the following six components, adapted to fit with GVH policies:

1. Mission for the ideal pastoral care department
2. Value proposition for the ideal pastoral care department
3. Functions (outputs) for the ideal pastoral care department
4. Processes for the ideal pastoral care department
5. Structure (Specifications/design) for the ideal pastoral care department
6. Revenue model for the ideal pastoral care department

In this writing, the author is a member of the diversity committee that GVH is developing. I have been assigned to lead the diversity, equity, and inclusion committee and to develop the DEI department after completing the pastoral care department.

What I have learned

During the completion of this dissertation, I learned that there are many ways of how we define diversity, equity, and inclusion. Colon-Kolako (2022) suggests the following Key DEI definitions based on her association as Chief DEI Officer with the Tufts Medical System: *Diversity*: Any mixture characterized by differences, similarities, related tensions and complexity; *Inclusion*: Strives to create an environment where everyone feels value, respected and appreciated. *Equity*: Ability to achieve the highest level of success, and health possible regardless of who you are, economic status, and where you live. *Belonging*: (1) Seen for your unique contributions; (2) connected to your coworkers; (3) supported in your daily work and career development; and (4) proud of your organization's values and purpose.

I also learned that it became clear that the application of system thinking often requires significant time and financial support. Many healthcare organizations and institutes will not

have the resources to devote to this kind of approach. While working with Einstein Healthcare Network, the author's guiding principle was to set a good example of high-quality service to patients, families, and staff. For instance, he made a point of greeting everyone entering the hospital and passing by the reception desk was/ still is. The author's recommendation to colleagues who are interested in changing their organizations with systems thinking is to engage at "ground level," in other words, with those employees who are working with patients and families face to face, making sure that they are involved at the design stage of new interventions. This was an effort to change the mindset of the other employees who staffed the front desk into one that was more customer-friendly and service-oriented.

Changing organizations with systems thinking can take a long time to solve issues because the concept of systems thinking in itself is highly complex and difficult to turn into action. Most healthcare leaders are wrapped up in the demands of the present, and often don't take the time to look even one year ahead, much less plan five or ten years into the future. Since systems thinking is about the bigger picture, often the interventions developed or the tools designed turn out to be complex in themselves. They must align priorities, live up to the expectations of system stakeholders, and coordinate with and among the stakeholders. Once the "ground level employees are fully engaged, it is time to build capacity at the "middle level" of supervisors and managers. Eventually, change will be extended to "senior level," executives, and leaders. It is crucial to continually provide high-quality services throughout the systems internally and externally and to continue to build collaboration among departments, stakeholders, and communities.

Limitations of the Dissertation

Systems and design research, like traditional science research, is better served with a representative sample drawn from the relevant population. Whether referring to stakeholders or subjects or participants, those who provide responses based on attitudes, beliefs or opinions should be an unbiased set of representatives.

Gathering opinions from stakeholders of the Philadelphia Korean DEICHE community may have benefited from a larger number and more diverse group of participants for the surveys and interviews. There are at least 15,000 Korean citizens in the greater Philadelphia area, but only 206 of them were surveyed, and most came from senior daycare centers. There are at least 500 Korean-American professionals in education, healthcare, social service, and religious community developments in the region, but only ten people were interviewed. The selection of the design team could also have benefited from a more diverse community.

Designing a novel system, i.e., the activity of the design team, is a process referred to as third-generation design (Barabba, 2004). First generation design occurs when experts *design a new system for others*. This is the common approach where organizational leaders create processes or programs without including the users in the design process.

Second-generation design occurs with experts and stakeholders *co-designing a system with others*. This design process commonly involves participants and stakeholders who provide their attitudes, opinions and beliefs about a proposed program. But the experts or organizational leaders "listen to the voices" but make the final decisions,

Third-generation design occurs when experts and organizational leaders provide input and other information, but only the stakeholders create the final design which is

referred to as *design by users*. While there was effort to move toward third generation design, the author, who did the interviewing and facilitated the design sessions and who was fluent in the Korean language and the cultural nuances of the interview subjects, primarily followed second generation processes. This placed limitations on the autonomy of the stakeholders to design what they wanted, and when some subjects were unwilling to talk in detail, the author listened to their voices but made the final decisions about choices.

The ideal design prototype in this dissertation has only barely started, and will address only some of the Korean community problems and concerns about DEICHE. However, the Grandview Health System has committed to allow this project to go forward so there is optimism that a full first prototype will emerge that can be implemented and which can be developed by the stakeholders to dissolve many of the challenges of this complex challenge. It may be a good example of how a healthcare system in good faith tries to understand and may implement solutions using systems and design thinking and methods.

Appendix A: KOREANS IN PHILADELPHIA SURVEY

By participating in this survey, you are agreeing to provide honest answers. Your responses will be anonymous – which means no one on the research team or anyone else will be able to identify who completed these surveys. You may stop responding to this survey at any time.

Instructions: Please place an "X" or " √" to indicate your response.

By selecting "I consent/agree," you agree to participate in this survey based on the above conditions.

[ ] I consent/agree [ ] I do not consent/agree

1. What is your gender?

   [ ] Male [ ] Female [ ] No Response

2. What is your age?

   _____ years [ ] No Response

3. For how long have you lived in Philadelphia (or the United States)?

   _____ years [ ] No Response

(Please choose a number from 0 to 7)

4. What is your ability to speak English when having a conversation with health professionals?

0	1	2	3	4	5	6	7
None	Low		Medium				High

5. What is your ability to understand English when having a conversation with health professionals?

0	1	2	3	4	5	6	7
None	Low		Medium				High

6a. How much does Einstein-Jefferson help Korean patients with health problems?

0	1	2	3	4	5	6	7
None	Low		Medium				High

6b. What would you want if you could have anything?

7a. How much does Einstein-Jefferson help Koreans looking for jobs?

0	1	2	3	4	5	6	7

None	Low	Medium	High

7b. What would you want if you could have anything?

8a. How well does Einstein-Jefferson provide diversity, equity, and inclusion for Koreans?

0	1	2	3	4	5	6	7
None	Low			Medium			High

8b. What would you want if you could have anything?

9a. How well does Einstein-Jefferson provide community engagement programs to Koreans?

0	1	2	3	4	5	6	7
None	Low			Medium			High

9b. What would you want if you could have anything?

Appendix B: Interview extended questions and topics

Interview Extended Questions and Topics:

1. What are the needs and problems of seniors? Younger people?
2. Are there any special needs or problems regarding diversity, equity, and inclusion?
3. Is there discrimination towards the people of your community?
4. What doctors or hospitals do people use?
5. Are there particular health problems the Korean community needs to deal with?
6. Are you aware of issues related to domestic violence, mental health, depression, and poverty?

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