# APPENDIX

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# Appendix A: HCWC CHNA Glossary of Terms

## Abbreviations

**ACA**: Affordable Care Act
**AI/AN**: American Indian/Alaska Native
**BIPOC**: Black, Indigenous, and People of Color
**BRFSS**: Behavioral Risk Factor Surveillance System
**CAT**: Community Action Team
**CBO**: Community-based organization
**CCOs**: Coordinated Care Organizations
**CHNA**: Community Health Assessment
**HCWC**: Healthy Columbia Willamette Collaborative
**HEDA**: Health Equity Data Analysis approach
**LGBTQ2I**: Lesbian, gay, bisexual, transgender, queer, two-spirit, and intersex
**OHEA**: Oregon Health Equity Alliance
**SDoH**: Social Determinants of Health
**STIs**: Sexually Transmitted Infections
**SNAP**: Supplemental Nutrition Assistance Program
**TANF**: Temporary Assistance for Needy Families

## Definitions

**Anti-Racism:** A critical awareness of race and racism; an active process against racism that seeks to understand how racial ideology is manufactured and how it impacts the lived experiences of people daily. Anti racism rejects the false notion of human difference, acknowledging the lived experiences shaped along racial lines, learning from diverse forms of knowledge and experiences and challenging systems of racial inequity. (Pollock, 2008).

**Built environment**: The human-made space in which people live and work on a daily basis. Built environment can include access to healthy foods, community gardens, mental and physical health services, walkability, and bike-ability (such as bike paths or bike lanes).[1]

**Community**: Group of people with diverse characteristics who are linked by social ties, common perspectives, and who may be engaged in joint action in geographical locations or

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[1] https://en.wikipedia.org/wiki/Built_environment

settings. This is but one definition. Community can be defined in multiple ways depending on the people asked and what groups have in common.[2]

**Culturally responsive practices[3]:** Practices using familiar cultural information and processes to scaffold learning and engagement. Culturally responsive practices emphasize a communal orientation that is focused on relationships, cognitive scaffolding, and critical social awareness.

Culturally relevant practices are strengths based approaches that use cultural knowledge, prior experiences, frames of reference, and performance styles of ethnically diverse persons to make encounters more relevant and effective for them.

- Seeing cultural differences as assets
- Creating caring service communities where culturally different individuals and heritages are valued
- Using cultural knowledge of ethnically diverse cultures, families, and communities to guide service development, interaction strategies, and relationships with children and families
- Challenging racial and cultural stereotypes, prejudices, racism, and other forms of intolerance, injustice, and oppression
- Being change agents for social justice and social equity
- Mediating power imbalances in services based on race, culture, ethnicity, ability, and class

**Discrimination**: Socially structured action that is unfair or unjustified and harms individuals or groups. Occurs on both structural and individual levels. For a robust explanation and definition, please see Healthy People 2020's definition.[4]

**Dominant Culture[5]:** Dominant culture of a society refers to the main culture in a society that is shared or accepted without any opposition by the majority of a population. The "dominant group" in the United States is white of European descent whose unquestioned

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[2] MacQueen KM, McLellan E, Metzger DS, et al. What is community? An evidence-based definition for participatory public health. Am J Public Health.

[3] Source: Culturally Responsive Teaching & the Brain, Z. Hammond 2015, Teel and Obidah (2008) (2) Hammond (2015).

[4] Dec;91(12):1929-38. https://www.ncbi.nlm.nih.gov/pubmed/11726368 iii Healthy People 2020. Office of Disease Prevention and Health Promotion. Social Determinants of Health topics: Discrimination: https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/discrimination

[5] 1. Sociologytwynham.com, 3. Racial Equity Tools.org, 2. Paying Attention to White Culture and Privilege: A Missing Link to Advancing Racial Equity, Gulati-Partee, G., OpenSource Leadership Strategies, and Potapchuk, M., The Foundation Review 2014 Vol 6:1

norms, traditions, beliefs, and historical and present systems of functioning are recognized by the vast majority of institutions in the country. Dominant culture is so normalized that it is difficult to see at the conscious level for those who are members of the dominant culture, which adds to its power. In many ways, the dominant culture in this country and its norms are not distinguishable from what people refer to as "American culture". Also known as "white culture", the dominant culture defines standards and norms in the U.S for what is considered normal, professional, of quality, good, and effective as well as what is abnormal, unprofessional, of poor quality, bad, and ineffective.

**Food insecurity**: Limited or uncertain access to adequate food because of lack of money and other resources.[6, 7]

**Gentrification**: Influx of new residents to an area, usually middle class or wealthier, that causes an increase in rent and housing costs and displaces the original or long-time residents of that area. Gentrification can have adverse effects on health for those being displaced.[8]

**Health equity**: Means everyone has a fair and just opportunity to be as healthy as possible.[9] HCWC, using an adapted definition from the World Health Organization,[10] defines health equity as when all people can reach their full potential and are not disadvantaged by social or economic class, race, ethnicity, religion, age, disability, gender identity, sexual orientation or socially determined circumstance. Optimal health depends on mitigating or eliminating avoidable inequities in the access to and utilization of resources and opportunities. Health equity demands intentionally and systematically addressing poor health outcomes by purposefully engaging the root and intersectional causes of adverse health status such as racism, structural disadvantage, and differential privilege.

**Implicit Bias[11]:** Refers to the attitudes, beliefs, and stereotypes developed over one's lifetime that impact one's understanding, actions, social behaviors towards others based on

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[6] U.S. Department of Agriculture. Definitions of Food Security: https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-us/definitions-of-food-security.aspx

[7] Healthy People 2020. Office of Disease Prevention and Health Promotion. Food Insecurity: https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/food-insecurity#1

[8] Centers for Disease Control and Prevention. Health Effects of Gentrification: https://www.cdc.gov/healthyplaces/healthtopics/gentrification.htm

[9] Robert Wood Johnson Foundation. "What Is Health Equity?" 2017. https://www.rwjf.org/en/library/research/2017/05/what-is-health-equity-.html

[10] World Health Organization. Equity. https://www.who.int/healthsystems/topics/equity/en/

[11] 1. The Kirwan institute For the Study of Race and Ethnicity, Ohio State University, 2. Stanford Encyclopedia of Psychology, Stanford University, 3. *Culturally Responsive Teaching & The Brain*, Hammond, Z. 2015

components of another’s identity, (such as racial identity, ethnic identity, socio-economic status, physical mobility, disability, language, gender, gender identity, religious identity, sexual orientation, etc.). Both positive and negative biases live deep within one’s subconscious and do not necessarily align with one’s outwardly communicated beliefs. They are often automatic or involuntary and activated without intention. Implicit bias is malleable and can be unlearned over time through intentional identification deconstruction.

**Inclusion[12]:** Authentic invitation to and participation of traditionally excluded groups or individuals into a process, activity, decision-making, etc. Inclusion involves authentic and empowered interaction and participation by all stakeholders who then share a sense of belonging.

**Intersectionality[13]:** Components of one’s identity have overlapping influences and cannot be examined in isolation from each other. They interact and impact a person’s lived experience in society, social systems and institutions. Also known as identity contingencies.

**Isolation**: Isolation is a key determinant of health. It is different from loneliness, though they are often discussed together. In this report, isolation means either geographic, physical, and/or social isolation. It pertains to social contacts or network that can include family and friends, but also the broader environment through social activities. Isolation also means being geographically isolated (where you live is a long way from other people, services).[14]

**Primary data**: Data collected first-hand through CAT engagement, surveys and focus groups.

**Qualitative data**: Non-numerical data based on traits or characteristics (for example, types of chronic health conditions someone may have).

**Quantitative data**: Numerical data that is measurable, and expresses a certain quantity, amount, or range. It is used to quantify a problem, or determine “how many”, “how often”, or “how much”. It is data that is produced through a systematic process that is verifiable, replicable and in and of itself is not subject to interpretation.

**Secondary data**: Data collected by another entity or for another purpose.

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[12] Race Equity and Inclusion Guide, Annie E. Casey Foundation, 2. Crossroads Charlotte Individual Initiative Scorecard for Organizations Scorecard Overview

[13] WPC Handbook, 2013, 2. *Critical Race Theory*, Delgado, R. & Stephanic, J. 2012, 3. *Whistling Vivaldi*, Steele, C., 2010

[14] Menec VH, Newall NE, Mackenzie CS, et al. Examining individual and geographic factors associated with social isolation and loneliness using Canadian Longitudinal Study on Aging (CLSA) data. PLOS ONE. 2019. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6358157/

**Social determinants of health**: Are the conditions in which people are born, grow, live, work, and age. These circumstances are shaped by the distribution of money, power, and resources at global, national, and local levels.[15]

**Systems of oppression:** Conscious and unconscious, non-random, and organized harassment, discrimination, exploitation, discrimination, prejudice and other forms of unequal treatment that impact different historically marginalized groups while preserving privilege for others who have not been historically marginalized

**Transgender**: gender identity and/or gender expression different from what is typically associated with the sex assigned at birth [16]

**Trauma**: A deeply distressing or disturbing experience

**Two-spirit**: Traditionally, Native American two-spirit people were male, female, and sometimes intersexed individuals who combined activities of both men and women with traits unique to their status as two-spirit people. In most tribes, they were considered neither men nor women; they occupied a distinct, alternative gender status. In tribes where two-spirit males and females were referred to with the same term, this status amounted to a third gender. In other cases, two-spirit females were referred to with a distinct term and, therefore, constituted a fourth gender. [17]

**Racial Justice[18]:** The systematic fair treatment of people of all races, resulting in equitable opportunities and outcomes for all. Racial justice—or racial equity—goes beyond "anti-racism." It is not just the absence of discrimination and inequities, but also the presence of deliberate systems and supports to achieve and sustain racial equity through proactive and preventative measures.

Racial Justice [is defined] as the proactive reinforcement of policies, practices, attitudes and actions that produce equitable power, access, opportunities, treatment, impacts and outcomes for all.

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[15] World Health Organization. Social Determinants of Health: https://www.who.int/social_determinants/sdh_definition/en/

[16] GLAAD. Media Reference Guide: https://www.glaad.org/reference/transgender

[17] Indian Health Service. Two Spirit. https://www.ihs.gov/lgbt/health/twospirit/

[18] Source: Race Forward, "Race Reporting Guide" Catalytic Change: Lessons Learned from the Racial Justice Grantmaking Assessment Report, Philanthropic Initiative for Racial Equity and Applied Research Center, 2009.

# Appendix B: HCWC CHNA Governance structure

## Vision

- Assessing community needs, improving health.
- To develop a comprehensive, community-driven, equity-focused regional community health needs assessment which informs health improvement plans, and regional investments in community health, of the participating hospitals, Coordinated Care Organizations (CCOs), and local public health authorities.

## Values

- Sharing Power
- Leading with Sharing Power
- Leading with Transparency
- Practicing Active Accountability
- Centering humanity
- Accessible for all stakeholders
- Community-Centered
- Collaborative
- Strong community partnership
- Mutually beneficial
- Authenticity - Represents communities’ narratives
- Transparency
- Practicing Active Accountability
- Centering humanity
- Accessible for all stakeholders
- Community-Centered
- Collaborative
- Strong community partnership
- Mutually beneficial
- Sharing Resources
- Equity
- Respect
- Honoring lived experiences and journeys
- Action-oriented

## Purpose

The purpose of HCWC is to align efforts of hospitals, public health, CCOs, and the residents of the communities they serve to develop a shared community health needs assessment across the four-county region of Clackamas, Multnomah, and Washington Counties, Oregon and Clark County, Washington. This unified and comprehensive approach will assess the health needs of all community members, but also with a focus on marginalized and underserved communities, to inform the health improvement plans and community investments of the participating organizations. It aims to eliminate duplicative efforts, prioritize needs, leverage resources, and enable collaborative efforts in implementing and tracking improvement activities.

This collaborative approach enables the creation of an effective, sustainable process; stronger relationships between communities, CCOs, hospitals and public health; meaningful community health needs assessments; helps to advance health equity within our region; and informs health improvement plans and activities that leverage collective resources to improve the health and wellbeing of our communities.

In order to be intentional about our commitment to community-centered approaches and equity as a project value, we have completed a Racial Justice chartering process which has been integrated into this document:

## Values in Action

| Key Project Moment | Value in Action |
|---|---|
| **Governance and Infrastructure** | ‣ Identify Opportunities to share decision-making between HCWC Leadership Group and CAT<br>‣ Partnership (ownership) with HCWC Leadership Group and CAT in decision making (Community Accountability) |
| **Budget/ Resource Allocation** | ‣ Community partners and members project participation is supported through resources<br>‣ Share proposal decision with Community Action Team |
| **Data Framing** | ‣ Define the interpretive scope (Community Accountability)<br>‣ Data will focus on a strength-based approach -- balanced of both deficit/strength, placed based perspective.<br>‣ Reporting will not compare communities or utilize white as the norm<br>‣ Use a SDoH frame to gain and understand how community partners categorize health/where it lives<br>‣ Always consider how this data would be useful for the community, and design communications its utilization |
| **Quantitative Data Collection** | ‣ Sharing data in collaboration<br>‣ Transparency in acknowledging data sources have limitations w/ community partners |

| **Key Project Moment** | **Value in Action** |
|---|---|
| | ‣ CAT guides this process<br>‣ Request that CAT create questions for listening sessions that may differ somewhat between groups (does not need to be one size fits all interview script) |
| **Qualitative Data Collection** | Making it clear/ directly stating that we are not asking community members to speak for/ represent their entire community<br>Demonstrate authenticity valuing experience and wisdom<br>‣ Language spoken at home<br>‣ Engagement/participation<br>‣ Vet questions by invested communities for cultural responsiveness |
| **Data Interpretation** | ‣ Look to the CAT to help lead the analysis.<br>‣ Ensure we vet our interpretation with other groups (learn from other groups) |
| **Report Drafting** | ‣ Provide tables to review for personal interpretation<br>‣ CAT guides within existing framework<br>‣ Ensure report utility is strong for all audiences |
| **Communications** | ‣ HCWC Leadership Group (LG) <—> CAT communication is bi-directional<br>‣ Look to CAT + listening session participants on how this report should be shared out<br>‣ Alternative formats for final reports - e.g. One pager, graphic novel format, etc.<br>‣ Return to listening sessions at the end of process to re-engage<br>‣ Any other ways of presenting the data to the community / other systems that we can utilize<br>‣ Ensure report is simple, straightforward, and easy to interpret<br>‣ Do not overload w/ data<br>‣ One pager |

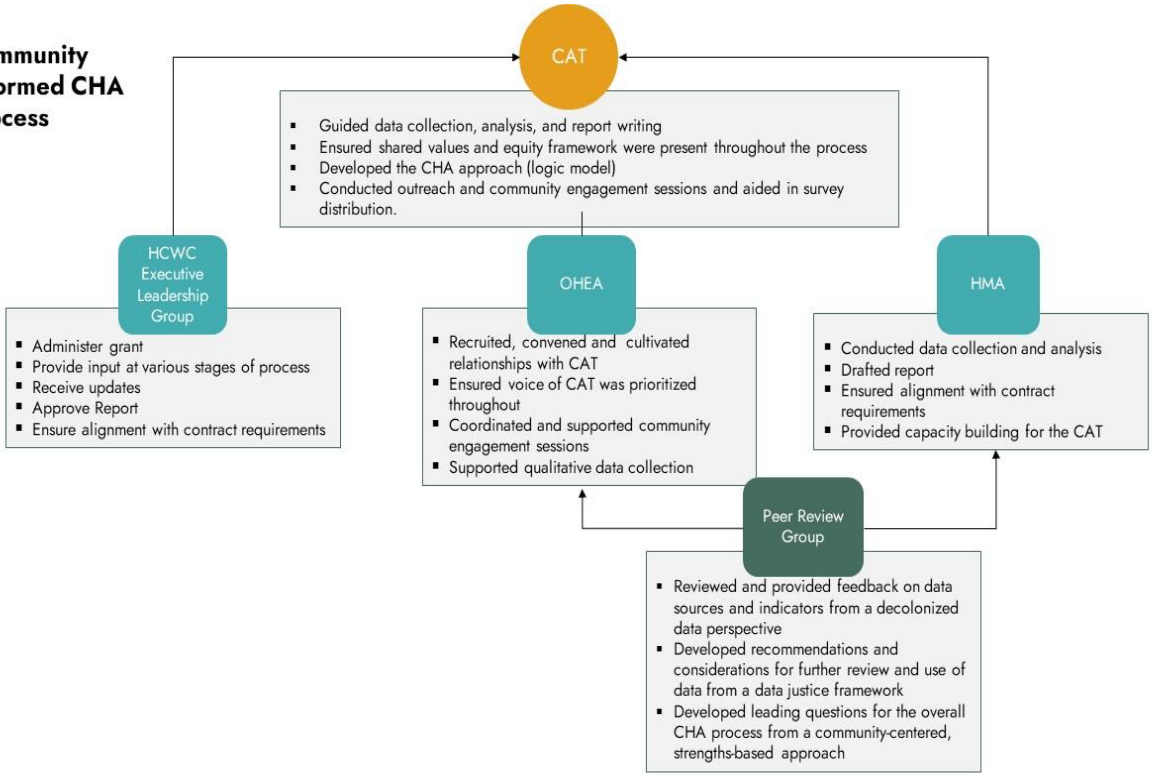
## Governance and Decision-Making

Five partners came together to ensure a community-centered CHA process.

| THE COMMUNITY ACTION TEAM (CAT) | THE PEER REVIEW GROUP | OREGON HEALTH EQUITY ALLIANCE (OHEA) | HEALTH MANAGEMENT ASSOCIATES (HMA) | THE HEALTHY COLUMBIA WILLAMETTE COLLABORATIVE (HCWC) |
|---|---|---|---|---|
| Comprised of leaders representing the diverse communities within the four-county region. The CAT met monthly to guide every step of the CHA, helping to ensure community voice, wisdom, and experience were central. | A collection of data professionals of color who have expertise in engaging in decolonized, community-centered, data approaches and/or are deeply connected to an anti-racist, Indigenous practice of doing health equity work. | A people of color-led collaborative, organized to center and uplift the wisdom of communities of color through racial justice informed health equity policies and practices. As one of six regional health equity coalitions across the Oregon, OHEA has deep roots in communities most impacted by health inequities, and experience in convening and engaging these communities. | Supports communities with tackling the problems that impact health outside the walls of hospital, provider, and payer offices, such as inadequate housing and food access, health equity and disparities, violence, discrimination, unemployment and underemployment. | A partnership comprised of health systems, public health partners, and Coordinated Care Organizations that jointly funded this CHA across the four-county region of Clackamas, Multnomah, and Washington Counties, Oregon and Clark County, Washington. |

The contributions of each partner are illustrated in the figure below.

## Community Informed CHA Process



**CAT**

- Guided data collection, analysis, and report writing
- Ensured shared values and equity framework were present throughout the process
- Developed the CHA approach (logic model)
- Conducted outreach and community engagement sessions and aided in survey distribution.

**HCWC Executive Leadership Group**

- Administer grant
- Provide input at various stages of process
- Receive updates
- Approve Report
- Ensure alignment with contract requirements

**OHEA**

- Recruited, convened and cultivated relationships with CAT
- Ensured voice of CAT was prioritized throughout
- Coordinated and supported community engagement sessions
- Supported qualitative data collection

**HMA**

- Conducted data collection and analysis
- Drafted report
- Ensured alignment with contract requirements
- Provided capacity building for the CAT

**Peer Review Group**

- Reviewed and provided feedback on data sources and indicators from a decolonized data perspective
- Developed recommendations and considerations for further review and use of data from a data justice framework
- Developed leading questions for the overall CHA process from a community-centered, strengths-based approach

# Appendix C: About the CHNA Data Approach

The data collection approach describes five overlapping phases involving eight steps in the community inclusive process for the Community Health Needs Assessment (CHNA) of the Healthy Columbia Willamette Collaborative (HCWC). This approach served as a guide for the development of the HCWC CHNA in partnership with the Community Advisory Team (CAT). Through this partnership, we developed a Health Equity Data Analysis (HEDA) plan to uncover:

- Not only overall health outcomes but also how health varies between population groups within the quad county region
- Not only individual behaviors but also the social and economic conditions that impact health and well-being
- The policies and systems that influence health through those social and economic conditions

The goals of this community inclusive CHNA were to:

- Deepen community partnerships
- Center community wisdom
- Tell a story that reflects lived experience
- Inform and influence key decision-making

This approach was used to guide the community engagement and data collection, analytic, and reporting process for the CHNA. This approach was informed and refined by the CAT. Specifically,

- Driving CHNA framework and data agreements
- Informing the qualitative data process
- Co-facilitating and advising community engagement
- Informing data analysis
- Informing communications and accountability

## IDEA PHASE

Alignment with Racial Justice Charter:

- Define the interpretive scope (Community Accountability)
- Data will focus on a strength-based approach -- balanced of both deficit/strengths, placed based perspective
- Reporting will not compare communities or use white as the norm
- Use a Social Determinant of Health frame to gain and understand how community partners categorize health/where it lives
- Always consider how this data will be useful for the community and design communications around its utility

## STEP 1: NEEDS ASSESSMENT PLANNING

From a review of past needs assessments, this step asked the following questions:

- Are there clear priority population(s)?
- What are the differences in health outcomes or health behaviors between population group(s)?
- What are the understood connections between specific social and economic conditions and health among priority population(s)?

## STEP 2: SETTING THE DIRECTION OF THE ASSESSMENT

- Developing and using a community vision (i.e., what should the community be like in five years). This step asked questions such as:
    - What things do you want to see improved in the community?
    - What are the living and working conditions (i.e. material circumstances such as education, work environment, unemployment, health care services or housing, and the social and community networks) that create health differences between population groups?
    - What are the causes of difference in living and working conditions between population groups?
    - What would it look like if there were improvements in living and working conditions?
    - What words best describe the improvements?
    - Which areas are most important?
- Deciding what stakeholders want to know and why (should align with the community vision). Asked questions such as:
    - Why is this information important currently?
    - Will this information help move communities closer to their vision, mission, or goals?
    - Where can this information be found?
    - Who knows this information?
    - Has the information already been collected?
    - By when is the information needed?
- Apply a focus on assets and concerns regarding community health and well-being. Asked questions such as:
    - As it relates to vision and the information that the group wants to know and why, what are the community strengths and challenges?
    - Where is there information available about assets?
    - Who knows this information?
    - Has the information already been collected?
    - By when is the information needed?

# DESIGN PHASE

## STEP 3: DEFINING THE INDICATORS

- Start with the vision, what the community wants to know, and the final assessment topics. For each topic, identify the different ways to *measure it;* these then become the "indicators".
- Reviewed indicators that have been traditionally and historically used in the HCWC CHNA process, and develop a protocol by which to assess each indicator (i.e., disparity by race/ethnicity; disparity by sex; trend over time, relative comparison to state estimate or other counties; magnitude, severity).
- Selected which indicators to prioritize for the assessment based on the criteria and assessment topics.

## STEP 4: CHOOSE THE DATA COLLECTION METHODS NEEDED FOR EACH INDICATOR

- Reviewed and synthesized strengths and challenges associated with various types of data collection methods
- Assessed resources available for data collection methods and prioritize data collection if resources are limited
- Asked questions such as:
    - What do you want to know?
    - What assessment topics do you want to cover and what indicators do you want to use?
    - Who would know this information (neighborhood residents, students, teachers, etc.)?
    - What resources (time, money, volunteers, etc.) are available for data collection?

# DATA COLLECTION PHASE

Alignment with Racial Justice Charter:

Quantitative Data Collection:

Sharing data in collaboration

- Transparency in acknowledging data sources have limitations w/ community partners
- Community Action Team guides this process

**Qualitative Data Collection:**

Making it clear/ directly stating that we are not asking community members to speak for/ represent their entire community and when reporting the findings, articulate the themes as such.

- Request that CAT create questions for listening sessions that may differ somewhat between groups (does not need to be one size fits all interview script)

Demonstrating authenticity that values experience and wisdom

- Consider language spoken at home
- Encourage engagement/participation
- Vet questions by invested communities for cultural responsiveness

## STEP 5: DRAFTING QUESTIONS AND RECRUITMENT METHODS FOR ANY DATA COLLECTION

In this step, we considered methods for drafting questions and recruiting participants for data collection methods, such as surveys or community forums.

- Reviewed and synthesized best practice approaches in data collection methods, including developing questions (i.e., survey and/or community forum) and engagement (i.e., participant recruitment, survey distribution)
- Data collection implementation

### Community Engagement Protocols

Visit: https://drive.google.com/file/d/1xfO1-0qYMIvePZq4q4vJ9ZI0xjdwr0_C/view?usp=sharing

### Community Survey

Visit: https://docs.google.com/document/d/1cxQBZylFcCMXux9ZDcGAgzDgkbV7-BQv/edit?usp=sharing&ouid=115656647515966616299&rtpof=true&sd=true

### Community Survey Communication Materials

Visit:
https://drive.google.com/drive/folders/1L1B1x5i2l5QVxGr65_QGBEAtkmYaiDaX?usp=sharing

## DATA ANALYSIS PHASE

Alignment with Racial Justice Charter:

**Data interpretation**

- Look to the CAT to help lead the analysis
- Ensure interpretations are vetted with other groups (learn from other groups)

### STEP 6: CONDUCT DATA ANALYSIS

A data analysis plan was created, including both opportunities for qualitative and quantitative data analysis. Regarding qualitative data analysis, more than one HMA person reviewed the qualitative data independently with the CAT offering resonance checks on the themes. For quantitative data analysis, the a step included revisiting original data analysis and assessing whether interpretation of data had changed, and if so, how and why.

Alignment with Racial Justice Charter:

**Report Drafting**

- Provide tables to review for personal interpretation
- CAT guides within existing framework
- Ensure report utility is strong for all audiences

**Communications**

- LG <-> CAT communication is bi-directional
- Look to CAT + listening session participants on how this report should be shared out
- Alternative formats for final reports - e.g. One pager, graphic novel format, etc.
- Return to listening sessions at the end of process to re-engage
- Any other ways of presenting the data to the community / other systems that we can utilize
- Ensure report is simple, straightforward, and easy to interpret
- Do not overload w/ data
- One pager

## DATA REPORTING / COMMUNICATIONS PHASE

### STEP 7: DISCUSSION ON COMMUNICATING THE ASSESSMENT FINDINGS

HMA and OHEA engaged the CAT in a communications work session to inform development of a communications plan for the CHNA. This exercise included exploration of questions around communicating assessment findings, including but not limited to:

- What data are most important to share, and why?
- What is the best way to present the results so they can be understood by diverse audiences, including those with limited English proficiency and low data literacy?

- How should the results be distributed?

## STEP 8: DEVELOP CHNA REPORT AND COMMUNICATION MATERIALS

The CAT-informed communications plan will outline a detailed process for developing the written CHNA report and other communications materials, such as individual county fact sheets, as well as proposed processes for future development of additional materials, like written documents trans-created in prevalent non-English languages, videos, or an interactive website.

# Appendix D: Forces of Change Methodology and Themes

## About the Forces of Change Assessment

Issues affecting the quad-county region are driven by both local, state and nationwide issues and policies. Changes that are often outside of the HCWC partner control
The Forces of Change Assessment seeks to summarize these issues, inquiring into:

- What is occurring or might occur that affects the health of our community or the local public health system?
- What specific threats or opportunities are generated by these occurrences?

The CHNA process was the beginning of a significant effort to fully understand the short- and long-term impacts of these influencers on community well-being and health, and if and how priorities need to be shifted. These forces bring about both opportunities and threats across multiple health and social determinant of health issues.

## Methodology

Step 1: Initially, HCWC Executive Group (EG) members were asked on January 28, 2021 to brainstorm Forces of Change and if and how they interact with pre-identified issue areas.  The areas were:

1. Housing and Homelessness
2. Education
3. Health Care
4. Transportation
5. Physical and Built Environment

1. Public Safety
2. Jobs/ Economy
3. Structural Racism
4. Social / Culture / Inclusion
5. Technology

Step 2: The CAT, with OHEA facilitation, were asked to brainstorm Forces of Change, add to/refine the list of forces by the EG.
Step 3: HMA, OHEA, and the CAT finalized list of forces and identified the threats and opportunities provided by each force.
Step 4: Forces of Change assessment and findings were used to 1) inform a root cause of the health issues and trends, 2) inform the areas of inquiry for the CHNA community survey and community engagement sessions, and 3) inform prioritization and recommendations for Community Health Improvement Plan(s).

## Summary of Executive Group (EG) Discussions

### WHAT KINDS OF FORCES EXIST?

The EG identified 6 overarching forces of change, including:

1. COVID-19 pandemic
2. Economy
3. Racial justice/uprising
4. Wild fires
5. Political unrest/divisive environment
6. New White House administration

These forces bring about both opportunities and threats across multiple health and social determinants of health issues. Issues discussed and/or raised by the EG include:

### HOUSING AND HOMELESSNESS

- Pandemic, economy, and wild fires had impacted access to housing and prevalence of homelessness.
- Potentially positive force of change was an upcoming Oregon state housing bond
- The seemed to be greater awareness of the increasing housing and homelessness in Portland, with counties calling on state leadership for more help and support; initiatives and research showing how neighborhoods could shelter individuals experiencing homelessness; growth of camps and concerns around increased trash.
- Concerns about the eviction moratorium ending or the “rental cliff”. The moratorium and other interventions (state unemployment insurance, CARES Act weekly $600 unemployment supplement) helped keep families afloat but did not resolve the larger issues with rent affordability. These interventions were scheduled to end in July 2021 and evictions would be legal again.

### ACCESS TO EDUCATION

- At the time of the assessment, everything was viewed through a COVID-19 lens. Education was challenging without in-person classes and there were concerns about school disenrollment and whether that would be sustained
- The issue of student loans was concerning, and there was a stated need to understand how best to alleviate that burden for students and families

- Education, as a force, was recognized as one that impacted other parts of the economy. COVID and the increase in remote learning impacted individuals' ability to remain in the work force, with greater impacts specifically on women.

## HEALTH EQUITY

- Related to racial justice/uprising, a positive impact was increased awareness of racism and the impact on health equity.
- Increased awareness of the need for cultural competence in the way health care was delivered, and how to infuse more cultural responsiveness and cultural healing in to health care.
- Resurgence of economic justice conversations, minimum wage increases, etc.
- Companies/businesses are working to understand how best to respond and for many, was prompting organizations (and systems) to do an internal assessment of their policies and procedures in regard to anti-racism first.
- One positive impact was that the new resources dedicated to health equity.

## SOCIAL ISOLATION

- In light of COVID-19, the issue of social isolation was exacerbated among older adults but had become an issue for all age groups.

## MENTAL HEALTH

- There was the perception that mental health issues, from mild to serious mental illness, continued to increase, and was exacerbated by COVID-19.
- School districts struggled to meet the demand of mental health concerns among students (i.e., Hillsborough school district has 6 week waiting lists for student to see a school psychologist or counselor)
- Mental health workforce issues persisted and the challenge of getting individuals the appropriate level of care
- It was still unknown the longer-term impacts COVID-19 as it related to mental health and concerns regarding increased deaths of despair and suicidality.

## PUBLIC SAFETY

- Violent crime, homicide, gun violence were perceived to be dramatically increasing.
- Perception among the community was that perhaps it's the lack of police response.
- Concerns with perceived (or real?) increase in child abuse and domestic violence.

### HEALTH CARE DELIVERY

- Telehealth was thought to be reaching more people in need of health care.

### CLIMATE CHANGE

- Climate emergency.
- Impact on utility costs for low-income people.

### TRANSPORTATION

- Recent state level metro transportation bond that would expand transportation access but believe it got voted down. In particular east county geography of Portland had disparity in transportation access.
- Rural areas and transportation was a challenge; non-emergency medical transportation benefit exists for CCO members, however the transportation can be slow.

# Appendix E: Demographic Profiles by County

## Clackamas County, Oregon

**Population (2019):** 410,463 individuals **Increase from 2016: 3.92%**

| Demographic Characteristic | % of Population *(2012-2016)* | % of Population *(2015-2019)* |
|---|---|---|
| **Gender** | | |
| Male | 49.2% | 49.3% |
| Female | 50.8% | 50.7% |
| **Age** | | |
| Median age (years) | 41.4 | 41.6 |
| Under 5 years | 5.5% | 5.4% |
| 5 to 19 years | 19.1% | 16.3% |
| 20 to 44 years | 30.3% | 26.5% |
| 45 to 64 years | 29.0% | 34.2% |
| 65 years and older | 16.1% | 17.6% |
| **Race/ethnicity** | | |
| American Indian and Alaska Native | 0.7% | 0.8% |
| Cherokee tribal grouping | 0.1% | 0.2% |
| Chippewa tribal grouping | 0.1% | 0.0% |
| Navajo tribal grouping | 0.0% | 0.0% |
| Sioux tribal grouping | 0.0% | 0.0% |
| Asian | 4.1% | 4.3% |
| Asian Indian | 0.4% | 0.4% |
| Chinese | 1.1% | 1.1% |
| Filipino | 0.5% | 0.5% |
| Japanese | 0.3% | 0.3% |
| Korean | 0.4% | 0.5% |
| Vietnamese | 0.5% | 0.6% |
| Other Asian | 0.9% | 1.0% |
| Black or African American | 0.9% | 0.9% |
| Hispanic or Latinx (of any race) | 8.2% | 8.7% |
| Native Hawaiian and Other pacific Islander | 0.3% | 0.3% |
| Native Hawaiian | 0.1% | 0.1% |
| Guamanian or Chamorro | 0.0% | 0.1% |
| Samoan | 0.1% | 0.0% |
| Other Pacific Islander | 0.1% | 0.2% |
| Two or more races | 3.4% | 4.1% |
| White | 89.0% | 87.5% |
| **With a disability** | 11.9% | 11.8% |
| **Foreign born** | 8.0% | 8.2% |
| **Percent of occupied households in which no member 14 years old and over speaks English "very well."** | | 1.6% |

## Clark County, Washington

**Population (2019):** 473,252 individuals **Increase from 2009: 4.96%**

| **Demographic Characteristic** | **% of Population *(2012-2016)*** | **% of Population *(2015-2019)*** |
|---|---|---|
| **Gender** | | |
| Male | 49.4% | 49.4% |
| Female | 50.6% | 50.6% |
| Age | | |
| Median age (years) | 37.8 | 38.4 |
| Under 5 years | 6.4% | 6.2% |
| 5 to 19 years | 21.1% | 20.4% |
| 20 to 44 years | 32.2% | 32.3% |
| 45 to 64 years | 26.6% | 26.1% |
| 65 years and older | 13.7% | 15.0% |
| Race/ethnicity | | |
| American Indian and Alaska Native | 0.6% | 0.6% |
| Cherokee tribal grouping | 0.0% | 0.1% |
| Chippewa tribal grouping | 0.0% | 0.0% |
| Navajo tribal grouping | 0.0% | 0.0% |
| Sioux tribal grouping | 0.0% | 0.0% |
| Asian | 4.3% | 4.6% |
| Asian Indian | 0.5% | 0.5% |
| Chinese | 0.8% | 1.0% |
| Filipino | 0.7% | 0.7% |
| Japanese | 0.4% | 0.4% |
| Korean | 0.5% | 0.5% |
| Vietnamese | 0.7% | 0.8% |
| Other Asian | 0.6% | 0.7% |
| Black or African American | 1.9% | 1.8% |
| Hispanic or Latino (of any race) | 8.7% | 9.6% |
| Native Hawaiian and Other pacific Islander | 0.8% | 0.8% |
| Native Hawaiian | 0.1% | 0.1% |
| Guamanian or Chamorro | 0.2% | 0.2% |
| Samoan | 0.1% | 0.1% |
| Other Pacific Islander | 0.3% | 0.5% |
| Two or more races | 4.6% | 5.1% |
| White | 84.6% | 84.6% |
| **With a disability** | 12.6% | 12.3% |
| **Foreign born** | 10.4% | 10.6% |
| **Percent of occupied households in which no member 14 years old and over speaks English "very well."** | | 2.8% |

## Multnomah County, Oregon

**Population (2019):** 804,606 individuals **Increase from 2016: 3.39%**

| Demographic Characteristic | % of Population *(2012-2016)* | % of Population *(2015-2019)* |
|---|---|---|
| **Gender** | | |
| Male | 49.5% | 49.5% |
| Female | 50.5% | 50.5% |
| Age | | |
| Median Age | 36.7 | 37.2 |
| Under 5 years | 5.9% | 5.5% |
| 5 to 19 years | 15.9% | 15.6% |
| 20 to 44 years | 41.1% | 41.2% |
| 45 to 64 years | 25.2% | 24.8% |
| 65 years and older | 11.9% | 13.0% |
| Race/ethnicity | | |
| American Indian and Alaska Native | 0.8% | 0.9% |
| Cherokee tribal grouping | 0.0% | 0.1% |
| Chippewa tribal grouping | 0.0% | 0.1% |
| Navajo tribal grouping | 0.0% | 0.0% |
| Sioux tribal grouping | 0.0% | 0.0% |
| Asian | 6.9% | 7.4% |
| Asian Indian | 0.3% | 0.4% |
| Chinese | 1.7% | 1.9% |
| Filipino | 0.6% | 0.6% |
| Japanese | 0.4% | 0.5% |
| Korean | 0.4% | 0.4% |
| Vietnamese | 2.0% | 2.2% |
| Other Asian | 1.5% | 1.4% |
| Black or African American | 5.4% | 5.5% |
| Hispanic or Latino (of any race) | 11.1% | 11.6% |
| Native Hawaiian and Other pacific Islander | 0.6% | 0.6% |
| Native Hawaiian | 0.1% | 0.1% |
| Guamanian or Chamorro | 0.0% | 0.1% |
| Samoan | 0.1% | 0.1% |
| Other Pacific Islander | 0.4% | 0.4% |
| Two or more races | 5.2% | 5.4% |
| White | 78.2% | 77.9% |
| **With a disability** | 13.3% | 12.5% |
| **Foreign born** | 13.9% | 13.8% |
| **Percent of occupied households in which no member 14 years old and over speaks English "very well."** | | 3.8% |

## Washington County, Oregon

**Population (2019):** 589,481 individuals **Increase from 2009: 4.50%**

| **Demographic Characteristic** | **% of Population *(2012-2016)*** | **% of Population *(2015-2019)*** |
|---|---:|---:|
| **Gender** | | |
| Male | 49.3% | 49.5% |
| Female | 50.7% | 50.5% |
| Age | | |
| Median Age | 36.2 | 36.7 |
| Under 5 years | 6.6% | 6.1% |
| 5 to 19 years | 19.9% | 19.3% |
| 20 to 44 years | 36.4% | 36.6% |
| 45 to 64 years | 25.2% | 24.9% |
| 65 years and older | 11.8% | 13.0% |
| Race/ethnicity | | |
| American Indian and Alaska Native | 0.6% | 0.6% |
| Cherokee tribal grouping | 0.0% | 0.0% |
| Chippewa tribal grouping | 0.0% | 0.0% |
| Navajo tribal grouping | 0.0% | 0.0% |
| Sioux tribal grouping | 0.0% | 0.0% |
| Asian | 9.5% | 10.6% |
| Asian Indian | 2.3% | 2.9% |
| Chinese | 1.8% | 1.9% |
| Filipino | 1.0% | 1.2% |
| Japanese | 0.6% | 0.8% |
| Korean | 1.1% | 1.1% |
| Vietnamese | 1.3% | 1.3% |
| Other Asian | 1.5% | 1.5% |
| Black or African American | 1.8% | 2.0% |
| Hispanic or Latino (of any race) | 0.4% | 16.7% |
| Native Hawaiian and Other pacific Islander | 0.2% | 0.4% |
| Native Hawaiian | 0.1% | 0.2% |
| Guamanian or Chamorro | 0.0% | 0.0% |
| Samoan | 0.1% | 0.0% |
| Other Pacific Islander | 16.2% | 0.2% |
| Two or more races | 4.9% | 5.4% |
| White | 77.6% | 75.9% |
| **With a disability** | 10.2% | 9.9% |
| **Foreign born** | 17.0% | 17.7% |
| **Percent of occupied households in which no member 14 years old and over speaks English "very well."** | | 3.9% |

## Appendix F: Community Engagement Sessions Methodology and Themes

Community members facilitated the Community Engagement (CE) Sessions which each lasted 2 hours and 15 minutes. The CAT identified community partner organizations and networks in all four counties. We offered partner organizations support and incentives for hosting the CE Sessions. Each partner organization recruited participants for the sessions. CE session participants received a $100 gift card for their time. The CAT, OHEA, and HMA designed the CE Session discussion protocol. OHEA delivered a "how to" facilitation guide and training to the CE Session facilitators, who were staff of partner organization. The CE Session agenda was as follows:

- Welcome and Grounding (15 min, discussion)
- What's a CHNA? Why are we here? (5 min, video)
- Interactive Storytelling (40 min)
- Break (10 min)
- Focus Group Questions (50 min)
- Closing and next steps (10 min)

A total of 37 CE Sessions were conducted, of which seven were in a language other than English or in a bilingual format. The sessions were recorded, transcribed into English, and uploaded to Dedoose, a web-based platform for analyzing qualitative and mixed methods data. Four HMA data analysts and the CAT analyzed CE Session transcripts. Using Dedoose, HMA analysts reviewed all transcripts and coded text into 8 (parent) codes and 69 sub (child) codes. The data were reviewed and organized by the codes to identify emergent themes as informed by CHNA data approach (See Appendix C)

For the CE Session analysis specifically, the DEPICT Model was adapted. The model is an approach to collaborative qualitative data analysis designed to involve individuals with varying levels of research proficiency[19] in this analysis process. This model incorporates opportunities for capacity building with involved community members, in addition to incorporating their perspectives into the interpretation of results, as is common in

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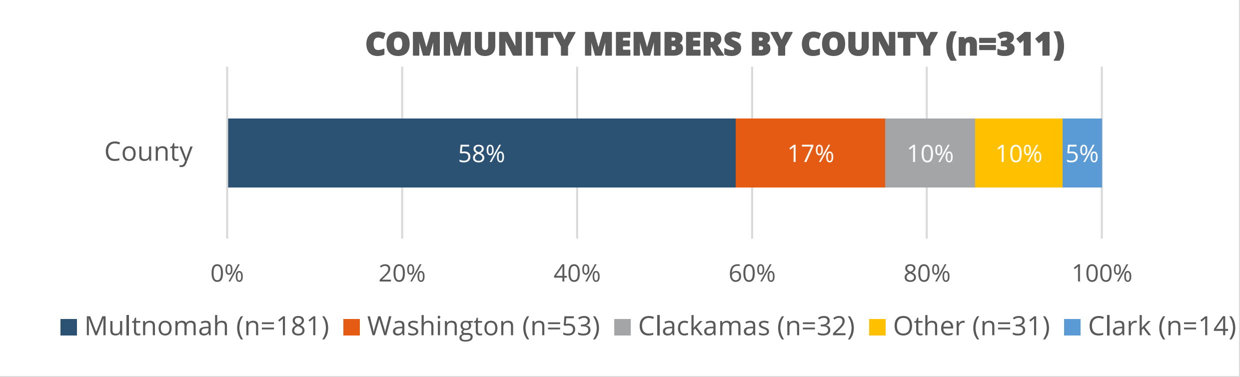
[19] Flicker, S. and Nixon, S. (2014). The DEPICT model for participatory qualitative health promotion research analysis piloted in Canada, Zambia and South Africa. Health Promotion International. Retrieved from https://www.academia.edu/5880861/The_DEPICT_model_for_participatory_qualitative_health_promotion_research_analysis_piloted_in_Canada_Zambia_and_South_Africa

participatory research.[20] The DEPICT Model has six steps in which community members participate: dynamic reading; engaged codebook development; participatory coding; inclusive reviewing and summarizing of categories/themes; collaborative analyzing; and translating. Due to time constraints of the project, as well as issues of CAT member time and capacity, CAT members were unable to participate in all aspects of the project as the team had envisioned. The CAT weighed in on the steps of qualitative analysis where they would prioritize their involvement and decided to prioritize involvement in analysis and interpretation. Therefore, HMA focused on building CAT capacity for analysis and interpretation through interactive meetings over a period of three months.

## Community Participant Demographics

Overall, 311 community members participated in the 37 CE Sessions across the Quad County region.

**FIGURE 1**



Seven of the CE Sessions were conducted in a language other than English, including Spanish (4), Arabic (2), and Chuukese, Marshallese, Samoa (1).

More than half (58%) of participants lived in Multnomah, followed by Washington (17%), Clackamas (10%), and Clark (5%). The top three race and ethnicity groups represented were Hispanic and Latino/a/x at 25%, followed by Black or African American (16%), and White (15%) community members. Specifically, participants identified as Mexican (20%), African American (16%), Western European (10%), Native American (9%), and Middle Eastern (9%). This allowed for a diverse representation of race and ethnicities in each county.

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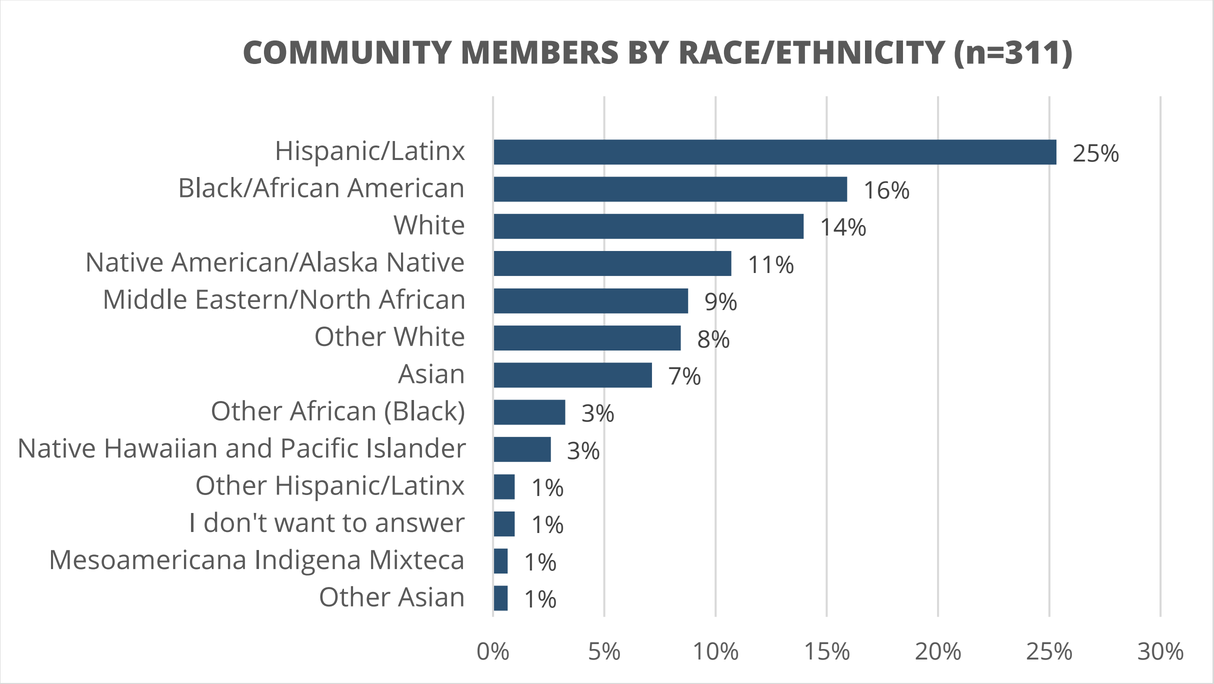
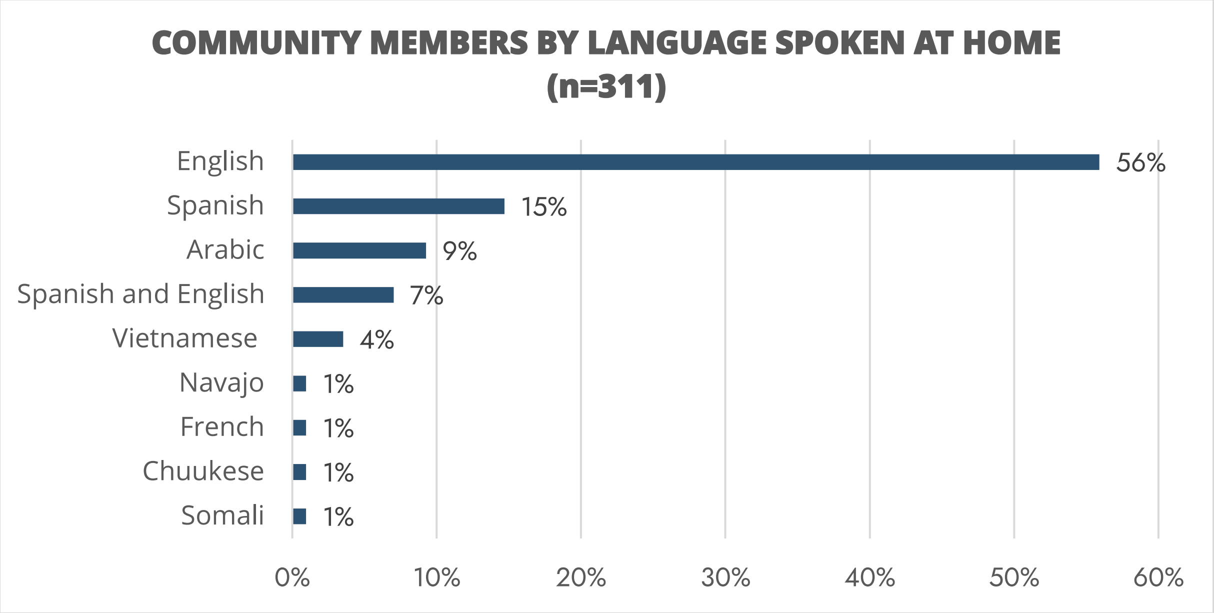
[20] Flicker, S., Savan, B., Kolenda, B. and Mildenberger, M.
(2008a). A snapshot of communitybased research in Canada: who? what? why? how? Health Education Research (**23):** 106–114.

**FIGURE 2**



English was the most common language spoken at home (56%), followed by Spanish (22%), Arabic (9%), and Vietnamese (4%).

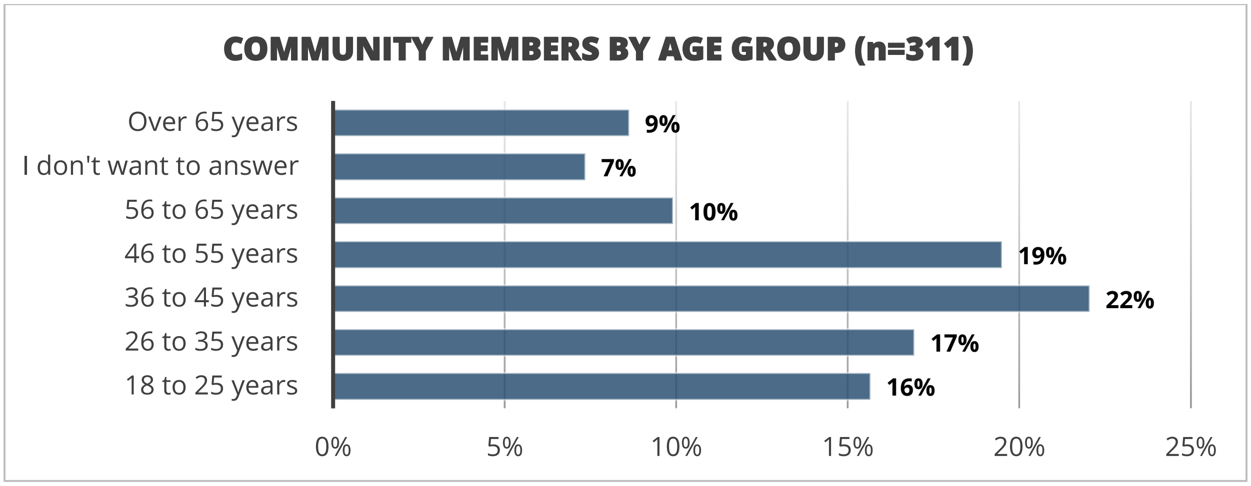
**FIGURE 3**



Note: Top 9 languages with 3 or more community members.

The most common age group was 36 to 45 years (22%), followed by 46-55 years (19%), and 26-45 years (17%).

**FIGURE 4**



Nearly 25% of participants identified as a non-heteronormative in sexual orientation. Twenty two percent of participants report some type of disability. The following tables offer additional participant demographics, including the number and percent of participants by the priority populations.

**FIGURE 5 NUMBER AND PERCENT OF PARTICIPANTS BY PRIORITY POPULATION**

| Priority Population | Number of People | Percent of People |
|---|---|---|
| Latinx Communities - CHWs | 24 | 8% |
| People who use drugs and insecurely housed | 22 | 7% |
| Justice Involved | 22 | 7% |
| Muslim Communities | 21 | 7% |
| People living with Disabilities | 18 | 6% |
| Latinx Communities | 18 | 6% |
| Immigrant youth or BIPOC youth | 17 | 5% |
| Native American and Alaska Native | 16 | 5% |
| BIPOC | 15 | 5% |
| Justice involved youth | 13 | 4% |
| Vietnamese folks | 11 | 4% |
| Intergenerational (youth and adults) | 11 | 4% |
| API Communities | 11 | 4% |
| Rural | 10 | 3% |
| Arabic speaking community members | 10 | 3% |
| Men’s recovery group | 10 | 3% |
| Insecurely Housed | 9 | 3% |
| BIPOC and Insecurely Housed | 9 | 3% |
| Older LGBTQ Adults | 9 | 3% |

| Priority Population | Number of People | Percent of People |
|---|---|---|
| Pacific Islander communities | 8 | 3% |
| Black and African American older adults, veterans, people with disabilities | 7 | 2% |
| Black / African American | 7 | 2% |
| Black and LGBT Populations | 6 | 2% |
| Black/African American | 6 | 2% |
| BIPOC youth | 1 | 0% |
| Total | **311** | **100%** |

**Figure 6 Number and Percent of Participants by County of Residence and Priority Population**

*Note: Use this table to understand representation of the priority populations within a county.*

| Priority Population and County of Residence | Number of People | Percent of People |
|---|---|---|
| **Clackamas** | **32** | **10%** |
| Rural | 9 | 3% |
| Justice Involved | 4 | 1% |
| Men's recovery group | 4 | 1% |
| People living with Disabilities | 4 | 1% |
| API Communities | 3 | 1% |
| Arabic speaking community members | 2 | 1% |
| Latinx Communities - CHWs | 2 | 1% |
| Native American and Alaska Native | 2 | 1% |
| Black / African American | 1 | 0% |
| Older LGBTQ Adults | 1 | 0% |
| **Clark** | **14** | **5%** |
| Justice Involved | 3 | 1% |
| Pacific Islander communities | 3 | 1% |
| Latinx Communities - CHWs | 2 | 1% |
| People living with Disabilities | 2 | 1% |
| API Communities | 1 | 0% |
| Black/African American | 1 | 0% |
| Latinx Communities | 1 | 0% |
| Muslim Communities | 1 | 0% |
| **Multnomah** | **181** | **58%** |
| People who use drugs and insecurely housed | 21 | 7% |
| Justice Involved | 14 | 5% |
| Latinx Communities | 14 | 5% |
| Muslim Communities | 13 | 4% |
| Intergenerational (youth and adults) | 11 | 4% |
| Native American and Alaska Native | 11 | 4% |
| Immigrant youth or BIPOC youth | 10 | 3% |
| Latinx Communities - CHWs | 10 | 3% |
| BIPOC | 9 | 3% |
| BIPOC and Insecurely Housed | 9 | 3% |
| People living with Disabilities | 9 | 3% |

| Priority Population and County of Residence | Number of People | Percent of People |
|---|---|---|
| Insecurely Housed | 8 | 3% |
| Older LGBTQ | 7 | 2% |
| Black / African American | 6 | 2% |
| Arabic speaking community members | 5 | 2% |
| Black and LGBT Populations | 5 | 2% |
| Men’s recovery group | 5 | 2% |
| Black/African American | 4 | 1% |
| API Communities | 3 | 1% |
| Justice involved youth | 2 | 1% |
| Black and African American older adults, veterans, people with disabilities | 1 | 0% |
| BIPOC youth | 1 | 0% |
| Pacific Islander communities | 1 | 0% |
| Rural | 1 | 0% |
| Vietnamese folks | 1 | 0% |
| Other | **31** | **10%** |
| Justice involved youth | 10 | 3% |
| Latinx Communities - CHWs | 8 | 3% |
| Pacific Islander communities | 4 | 1% |
| Native American and Alaska Native | 3 | 1% |
| Black and LGBT Populations | 1 | 0% |
| Insecurely Housed | 1 | 0% |
| Justice Involved | 1 | 0% |
| Latinx Communities | 1 | 0% |
| People living with Disabilities | 1 | 0% |
| People who use drugs and insecurely housed | 1 | 0% |
| **Washington** | **53** | **17%** |
| Vietnamese folks | 10 | 3% |
| Immigrant youth or BIPOC youth | 7 | 2% |
| Muslim Communities | 7 | 2% |
| Black and African American older adults, veterans, people with disabilities | 6 | 2% |
| BIPOC | 6 | 2% |
| API Communities | 4 | 1% |
| Arabic speaking community members | 3 | 1% |
| Latinx Communities | 2 | 1% |
| Latinx Communities - CHWs | 2 | 1% |
| People living with Disabilities | 2 | 1% |
| Black/African American | 1 | 0% |
| Justice involved youth | 1 | 0% |
| Men’s recovery group | 1 | 0% |
| Older LGBTQ | 1 | 0% |
| African American African seniors, vets, people with disabilities |  | 0% |
| **Total** | **311** | **100%** |

**FIGURE 7 NUMBER AND PERCENT OF PARTICIPANTS BY PRIORITY POPULATION AND COUNTY**

*Note: Use this table to understand which counties included representation by a priority population. Multnomah and Washington Counties included representation of Black and African American older adults, veterans, people with disabilities.*

| Priority Population and County of Residence | Number of Participants | Percent of Participants |
|---|---|---|
| Black and African American older adults, veterans, people with disabilities | **7** | **2%** |
| Washington | 6 | 2% |
| Multnomah | 1 | 0% |
| API Communities | **11** | **4%** |
| Washington | 4 | 1% |
| Clackamas | 3 | 1% |
| Multnomah | 3 | 1% |
| Clark | 1 | 0% |
| Arabic speaking community members | **10** | **3%** |
| Multnomah | 5 | 2% |
| Washington | 3 | 1% |
| Clackamas | 2 | 1% |
| BIPOC | **15** | **5%** |
| Multnomah | 9 | 3% |
| Washington | 6 | 2% |
| BIPOC and Insecurely Housed | **9** | **3%** |
| Multnomah | 9 | 3% |
| BIPOC youth | **1** | **0%** |
| Multnomah | 1 | 0% |
| Black / African American | **7** | **2%** |
| Multnomah | 6 | 2% |
| Clackamas | 1 | 0% |
| Black and LGBT Populations | **6** | **2%** |
| Multnomah | 5 | 2% |
| Other | 1 | 0% |
| Black/African American | **6** | **2%** |
| Multnomah | 4 | 1% |
| Clark | 1 | 0% |
| Washington | 1 | 0% |
| Immigrant youth or BIPOC youth | **17** | **5%** |
| Multnomah | 10 | 3% |
| Washington | 7 | 2% |
| Insecurely Housed | **9** | **3%** |
| Multnomah | 8 | 3% |
| Other | 1 | 0% |
| Intergenerational (youth and adults) | **11** | **4%** |
| Multnomah | 11 | 4% |
| Justice Involved | **22** | **7%** |
| Multnomah | 14 | 5% |

| Priority Population and County of Residence | Number of Participants | Percent of Participants |
|---|---|---|
| Clackamas | 4 | 1% |
| Clark | 3 | 1% |
| Other | 1 | 0% |
| Justice involved youth | **13** | **4%** |
| Other | 10 | 3% |
| Multnomah | 2 | 1% |
| Washington | 1 | 0% |
| Latinx Communities | **18** | **6%** |
| Multnomah | 14 | 5% |
| Washington | 2 | 1% |
| Clark | 1 | 0% |
| Other | 1 | 0% |
| Latinx Communities - CHWs | **24** | **8%** |
| Multnomah | 10 | 3% |
| Other | 8 | 3% |
| Clackamas | 2 | 1% |
| Clark | 2 | 1% |
| Washington | 2 | 1% |
| Men's recovery group | **10** | **3%** |
| Multnomah | 5 | 2% |
| Clackamas | 4 | 1% |
| Washington | 1 | 0% |
| Muslim Communities | **21** | **7%** |
| Multnomah | 13 | 4% |
| Washington | 7 | 2% |
| Clark | 1 | 0% |
| Native American and Alaska Native | **16** | **5%** |
| Multnomah | 11 | 4% |
| Other | 3 | 1% |
| Clackamas | 2 | 1% |
| Older LGBTQ | **9** | **3%** |
| Multnomah | 7 | 2% |
| Clackamas | 1 | 0% |
| Washington | 1 | 0% |
| Pacific Islander communities | **8** | **3%** |
| Other | 4 | 1% |
| Clark | 3 | 1% |
| Multnomah | 1 | 0% |
| People living with Disabilities | **18** | **6%** |
| Multnomah | 9 | 3% |
| Clackamas | 4 | 1% |
| Clark | 2 | 1% |
| Washington | 2 | 1% |
| Other | 1 | 0% |

| Priority Population and County of Residence | Number of Participants | Percent of Participants |
|---|---|---|
| People who use drugs and insecurely housed | **22** | **7%** |
| Multnomah | 21 | 7% |
| Other | 1 | 0% |
| Rural | **10** | **3%** |
| Clackamas | 9 | 3% |
| Multnomah | 1 | 0% |
| Vietnamese folks | **11** | **4%** |
| Washington | 10 | 3% |
| Multnomah | 1 | 0% |
| **Total** | **311** | **100%** |

## CE Session Thematic Analysis and Findings

The word cloud presents the 876 excerpts identified and coded, illustrating the topics that community members spoke about and which HMA analysts coded. Community members most frequently discussed access to culturally and linguistically responsive health care and this code/theme appears across all parent codes.

The following page provides a high-level summary of findings by parent code.

1. Racism, Oppression, and Discrimination
2. Meaning of Health
3. Community Strengths
4. Essential Community Resources and Services
5. Access to Cultural and Linguistic Responsive Health Care
6. Civic Health
7. Support Family and Community Ways
8. Neighborhood for All

## Racism, Oppression, and Discrimination

As recommended by the peer review group, we focused on ensuring that any description of community health highlighted resiliency and avoided “blaming the victim” for poor group outcomes.[21] With this context, we can ensure that the CHNA will result in further understanding of the ways in which the cumulative effects of institutional and structural racism – rather than individual choices or behaviors – are responsible for poor group health outcomes.

Through the CE Sessions, we have begun to expand our understanding of the story. The community members discussed the multiple ways that racism, oppression, and discrimination influenced their individual health and well-being and that of their community. Community members discussed the **deep history of racism in their communities** and the impact it has had on their health, wellbeing, and quality of life. They identified racism and oppression as a root cause of health inequities and disparities and recognized that it is disproportionally experienced by racial and ethnic minorities. Many community members shared powerful stories about the impact of racism and oppression on health outcomes.

- *“A lot of the answers allude to finding refuge from white supremacy and whiteness here. It's literally getting away, which is how we find health. Being away from the system is how we find health.”*

**Overall, community members noted that opportunities to meaningfully engage community members and build shared power within communities would be key to engaging the community, ensuring better access to care, and improving experience with the health care system.**

Community members spoke about ways in which government-sponsored **displacement, exclusion, and segregation** have exacerbated racial disparities in their respective regions and communities, removing them from their land and homes. Members expressed a great, “*distrust of government who has the power to create policies and change; however, these policies do not benefit the people and communities who need them most.”* Several community members spoke about the issue of not being able to own land. Others spoke specifically to geographic displacement and issues of

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[21] https://drive.google.com/file/d/1KNn_iuGDGi5Nn2tSneBRuJ7ExGBIrlcP/view

gentrification. In addition, issues of persecution, conflict and human rights violations also emerged as themes.

- *"I think the biggest thing for me, thinking about the native community, is that our treaty rights need to start being honored and respected. [This is the] cause that's the root of everything. Like I want our land back. I want the American government to understand the word sovereign nations and we have a right to our land. We have a right to our culture. We have a right to so many things that we continue to be denied. It's like if our treaty rights were honored, they wouldn't be picking up supplies. They wouldn't have to deal with [issues like] food access and all these different things. And it's because the American government is actively trying to kill us. It's frustrating because that's like the root of it, of it all is that like we're actively, you know, fighting against genocide."*
- *"You have talk about colonization and stealing land and then having to come back to your own land and not being able to access your land, or even have the opportunity to be healthy on it. It is absolutely beyond me. You're from your land and told to get the hell out. And then on top of that, just to make matters worse, you can't even be healthy on your own land, which is like ridiculous. And I don't, it we've now become another commodity for capitalism and [the] health system. And it's like, what body parts do you need help with so that we can make it expensive for you to like get help to heal yourself. It's almost like intention, the sicker that they make you, the more you're going to need the health system, the more money you're going to have to spend for yourself. So, it's, it's like almost like, is this intentional? Like, you're trying to kill us so that we can just spend more money in this health system and then make it hard for us to access it? So, it's just infuriating and just, it angers me so much."*

A few community members spoke about ways in which **generational poverty** has disproportionately impacted communities of color and the persistent barriers toward financial well-being and building wealth. Specifically, a great deal of turmoil has been experienced by Native Americans and tribal communities, and there has been a lasting effect of past public policies that have resulted in housing instability and economic hardship.

- *"...but with our native culture and with our communities, our poor communities, you know, there's, there's nothing to really, for them to gain from it. So, it's almost like they don't care, you know, and we'd have to make them care."*

In addition, community members expressed concerns with **underrepresentation in data** and not having their ethnicities and cultures represented. They discussed how research often lumps together racial and ethnic groups, which can eliminate experiences of certain communities of people. It is important for people to have representation in data and there is a lot of ambiguity that should be avoided, since data is used to look at where to focus efforts, resources, funding for programs and initiatives, etc.

- *"As Alaska Native, a lot of folks don't know that 227 of the 576 tribes are in Alaska. They're all very different. We're just a part of the acronym, AI/NA. Sometimes we get left out of data actually or in policy language. There have been a couple of times where I had the opportunity to read a house bill or something else and we were completely left out. I went recently to Epic imaging for a mammogram and the demographics options they had were*

*American Indian and Eskimo. They need to start having dropdowns for tribes and then also Alaska Natives to be included in that drop down. There's a lot, I mean, there's a good many Alaska Natives living down here."*

Lastly, many community members described the history of racism and discrimination as it pertains to access to health care. There has not been a great **acknowledgement of racism as a major health care and public health issue**, and community members desire a system that cares for them, works to combat systemic racism, and begins to identify changes that can make health care more inclusive and equitable.

- *"And yet I think so much of us experience oppression and discrimination from the medical system."*
- *"I think a lot of the stresses that our bodies face come from everyday discriminations and oppressions that we face. So, I think it would be super important to have a health care system that cares about us."*
- *"Sometimes when I go, it just makes me feel uncomfortable when they say, Oh, you have an accent, where are you from? And then it puts me back. I don't know if I want to say I'm from Egypt, they judge... we don't know how they're going to take it all. You just worry about saying where we are from. So, its fear, the fear of discrimination by the medical field."*
- *"We have this huge plethora of some of the greatest brains, but yet they don't know how to deal with non-white clients. There are stereotypes and tropes and, and there's microaggressions. The hidden biases. And sometimes they don't even care because they're arrogant. I'm the white man, I'm the male, and this is my job. And you're going to listen to me."*
- *"I think of health a lot more broadly holistically, not just am I able to function in this society to that extent that I need to function to just be productive, but safe, feeling welcome, feeling in community, feeling healthy in those ways. And that is extremely hard to navigate here. As folks have mentioned. It is so hard to get a therapist of color. I have one and I had to jump through some hoops. I have excellent insurance that I'm going to lose soon because we are separating, I had to jump through a lot of hoops to be able to get this person cause they're out of service. I literally had to have a conversation with a white person and explain to them how I have PTSD from white supremacist systems."*

## The Meaning of Health

When asked to describe the meaning of health, community members overwhelmingly aligned the meaning of health with a **holistic view of human functioning**. This holistic view holds physical, emotional, mental, spiritual, and community well-being as core and interrelated components of health. Several community member definitions stood out:

- *"Health is not just like the absence of illness, but also the proactive steps that people take to ensure overall wellness."*
- *"Health is about people being able to live out their values and live their life with meaning."*

- *"Health is all about understanding the needs of not only yourself, but those close to you and your community. And when you understand your needs and your community needs, then that's when things can start to change."*

***Storytelling:***
*We put an outdoor fire pit and I could tell you that that smoke therapy and our family, just all sitting around it, telling stories, telling traditional stories, coming to sing, you know...just laughing has been so healing for us.*

Many community members noted the **disconnect between holistic health and the narrower view of health care**, citing aspects of health care (e.g., yoga classes, meditation, consistent access to food) that are not paid for by insurance. Participants noted misalignment between the health care system and their values around health.

Participants highlighted **institutional racism and white supremacist systems as interfering with health**, noting that sometimes health can only be found outside of those systems. Many described **safety, belonging, and consistent access to resources as core to health** and identified ways that the current and predominant medical model does not address these needs and/or actively works against these needs.

Several community members highlighted the **essential role of community and spiritual traditions in health and healing**. One noted: *"One of the things that I really value from my culture is that health and wellness is looked at as like a community thing to participate in. [For instance, if] someone is sick, then it becomes like the community's job to support that person."* Overwhelmingly, community members shared the view that health is about the whole person, and highlighted ways that that conceptualization needs to be incorporated throughout the health care system, from prevention to diagnosis to treatment.

## Community Strengths

In responding to the question about **what strengths, values, knowledge, or skills do you or your community share about health, healing and wellness**, community members mainly spoke about the idea of connectedness between these. Their ideas about the **connectedness of health, healing, and wellness** were not narrowly confined as such, but were expansive and inclusive of culture, history, and the environment. In sum, these are the strengths that exist within community to support, sustain, and advance health, healing, and wellness. Many community members shared that they relied on community strengths when they did not want to or could not access or utilize the health care system.  Exemplary quotes include:

- *"Just telling our stories to each other, relating to each other, that's part of how we connect and how we heal from our traumas."*
- *"One of the strengths that we have within our community is relationships and word of mouth."*

A strength of connectedness is the willingness and ability to, as one community member noted, *"show up and support each other."* Community members agreed that cultural practices are vital to overall wellness and the ability to heal; one said, *"It's like the things that our culture does and the way that we take care of one another."*

**_Storytelling:_**
*"I'll share a story on getting the COVID vaccine. When somebody that looks like me can communicate to me about the importance of getting the vaccine, then I might hear that. I was one of the first ones working on the front lines, seeing the pandemic, and walking folks through infections, and still, the vaccine hesitancy was right here in front of my face. I had to look to health care professionals that looked like me that were doing the research on the vaccine to trust, not my counterparts that are white or represent the dominant culture."*

Community members, particularly younger CE Session participants, noted that connecting to share information, and awareness building on certain health topics was critical to health and well-being. For example, one youth noted that *"within my high school community and alongside my peers, I think inclusivity and accessibility is definitely something that I'm seeing a lot more of and helping to spreading awareness on health issues that affect marginalized communities."*
Community members identified a challenge to achieving desired levels of health and well-being within the existing health care system is that all too often the relationship or the connection does not exist. One said, *"(Health) also very relational. I think that like so many parts of like the health care system and the way that it exists, you are grasping for someone's time."*

**Culture** was also noted as a community strength among participants. Culture is the patterns of ideas, customs and behaviors shared by a particular people or society. These patterns identify members as part of a group and distinguish members from other groups. Culture may include all or a subset of the following characteristics. Studies show that the influence of culture on health is significant, affecting perceptions of health, illness and death, beliefs about causes of disease, approaches to health promotion, how illness and pain are experienced and expressed, where patients seek help, and the types of treatment patients prefer.[22] Aspects of culture that were noted among community members include:

- **Songs and Story Telling:** "*I've learned that different songs, what the words mean and why we sing them each year that they've practiced them and learn the medicine they carry. They have helped me, the songs come to me now when I need them or when others do. And I see how the songs help the people. I love seeing when the elders get happy from singing."*
- **Cultural Ceremonies**: *"I think that our cultural ceremonies that we have across this land, no matter where it might be, the traditional ceremonies our people have carried on for a long, long*

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[22] University of Minnesota, Center for Advanced Research on Language Acquisition. What is culture?

> *time are a big part of our healing. I feel the more we believe in that healing, and the power of that healing from that ceremony, the better it will be for us in the long run."*

Community members often invoked the importance of having a **connection to the environment** as a community strength. Environment, not only as a source of healing and health, but also the ways in which environment impacts health. One participant noted *"health, healing, and wellness are related to our connection to land's capacity to grow, harvest, hunt our traditional foods and utilize the medicine available to us."* Additionally, physical being or presence in the environment or in nature impacts health, as one community member noted, *"I think about getting outside and the sunshine, fresh air, and water, and similar to a ceremony. This [activity] is healing".*

Many community members noted **connectedness among community members with a shared history of trauma** as a community strength. One stated, *"a strength [is] that we all have similar experiences together."*

In addition to the concept of connectedness, **another common theme of community strength was community capacity for resilience, despite adversity.** One aspect of resiliency expressed by community members was the idea of "problem solving" or "being good problem solvers." For example, community members said:

- *"One strength of the community is that we're really good problem solvers because we have to be. I think because we aren't often served well and we're often overlooked, we've gotten very good at adapting and problem solving and finding work arounds."*
- *"We need to change it ourselves and show them [government] what we can do. And then there would be a way to show them how to go about making that change."*

Lastly, a community strength commonly noted among participants was **intergenerational knowledge and compassion**. Adult community members' discussions reflected a deep respect and awareness of the need to support youth and children and to find space for youth to understand the ways in which their cultural practices can support health and healing. One community member noted their role or responsibility "*as a native woman to reach out to younger people who are struggling and offer [ceremony, practices, etc.] as opportunity for healing."* Another noted, *"we've had elders in our community that have been organizing for over 25 years to create spaces for our young ones to be able to come in."* Several community members specifically reported an increase in awareness and attention to mental health issues among youth and adults and an effort to reduce the stigma of discussing and addressing poor mental health. Some specific resources noted are peer supports and recovery as well as community partnerships. For example, one participant noted, *"we've done well at making connections with other native serving organizations to build those partnerships, to really bring in the healing and wellness."*

## ESSENTIAL COMMUNITY RESOURCES AND SERVICES

Across the CE Sessions, community members identified a diverse set of non-clinical resources that were supportive to social drivers of health as being critical to improving the health of their communities. These resources ranged from supports to meet basic needs such as **access to healthy and culturally relevant foods** and **employment opportunities** to components of the physical and community environment that impact **access to needed resources**. Importantly, community members highlighted vital mechanisms of **community support** that they believed were key to their health and well-being.

***Essential Community Resources and Services*** *includes a focus on:*
Education
Employment opportunities
Unlivable wages
Food Access
Access to technology
Language accessibility
Supports for physical and visual accessibility
Access to pro-bono or low-cost legal services
Access to reliable transportation

### Access to Healthy and Culturally Relevant Foods

Access to healthy and diverse foods was a core theme when community members identified essential community resources. Community members noted the presence of food deserts and highlighted that, even when grocery stores open in neighborhoods where they are most needed, stores are less likely to offer high quality fresh foods, and sometimes healthy options are out of reach financially. Community members also highlighted the importance of access to culturally relevant foods, which many found lacking amongst current resources.

- "*People don't realize that it's not just the cost of health care. It's the cost of maintaining health and how expensive that is. There's a lack of understanding that to have good health, it's pointless to go to the doctor and take whatever pills they give you, whether it's antidepressants or whatever, if you can't eat properly - because those pills are basically a band-aid that will eventually stop working.”*
- *“When you're not able to get fresh produce, you're not going to be as healthy as you can be…And I know for a lot of people…in my community, we have to rely on a lot of pre-made really unhealthy foods like cereal and a lot of other stuff like that.”*
- *“The food is very important. Yes. And that food, you know, those sacred foods, those traditional foods, you know, that is what keeps us healthy. If we go back to that traditional diet, we reverse our diabetes and high blood pressure and heart disease.”*
- *“Thinking about where all those farmer's markets and Whole Foods and Trader Joe's are in the city and where they're concentrated, it's the areas that are gentrified versus like where a lot of immigrant and refugee communities may still live and all that. So, you know, just more access to fresh foods, cultural foods, not just an aisle. There are plenty of us here. We deserve more than an aisle.”*

### Employment and Career Development Opportunities

Community members described the value of career development training and employment pipeline opportunities that bring more individuals into the formal workforce and provide them with opportunities for a living wage and professional development and advancement. Notable quotes included:

- *"We need to create new enterprise and we need to get our own people in health care. And if they start out as a [community health worker], then, you know, maybe they're going to get interested in nursing. We need nurses. We need doctors."*
- *"One thing is a pipeline for training into work that pays well. A lot of times, if there are trainings of this kind of nature, they're pretty sparse grants that actually don't connect folks to actual work.... Folks don't even know how they can tap into resources to be connected...into a network."*

In addition, community members noted a few barriers related to employment, including loss of benefits, challenges with background checks due to prior criminal justice involvement, and the accessibility of training in trades in addition to education received at a two- and four-year college.

- *"I can get a job, you know, and I have a master's degree. The problem is being able to figure out how to make enough money to balance out losing those benefits while being able to work. And quite frankly, you know, I would need at least like 50 grand a year starting out to be able to provide for my medical and health needs, as well as my financial needs."*
- *"The background checks keep us from serving our communities. So that's a problem that really, I think, needs to be addressed because otherwise it's a whole vicious circle."*
- *"Well, in terms of jobs...I really think that we need to be more supportive of...training in the trades because not everybody wants to go to community college or to university. And it's a really difficult place to be as a native person or as a person of color or culture."*

### Access to Needed Resources

Community members identified a variety of challenges to their being able to access essential resources and support services. They reported being concerned about the lack of access to adequate transportation and they acknowledged both the benefits and challenges to increased use of telehealth. In addition, several community members described medical facilities, community spaces (e.g., parks), and equipment where lack of accessibility for people with physical and/or intellectual disabilities limit their capacity to utilize needed resources, even when the resources or services are theoretically "available." One community member mentioned how education and a broader understanding of accessibility could help advance and improve access to care for community members experiencing those challenges:

- *"We need education both of the public and the community and the chronic illness committee and of health care professionals about even just basic things, such as what disability means and what accessibility means. Accessibility is not a one size fits all, and we need to stop pretending that for example, a public toilet is accessible if it has scented hand soap. Disability is anything that impairs a person's bodily functions or life functions, including ability to perform, self-care, get an education, perform a job."*

Community members described that some services and supports they utilize are designed to be inclusive, while others are not:

- *"I'm really surprised to go into any medical facility at this time. I mean, 2020, 2021 and still find their intake forms do not use inclusive language. They're totally male or female. Those are your only options. And even in big organizations, you know, that in my opinion should know better."*
- *"She took a picture of a sign outside of her hospital door, a laminated checklist of triggers for symptoms, including light, sound, and scent, so that the provider could indicate that scent or light or sound would trigger symptoms in the patient inside. And everybody could be mindful of not making the patient feel worse while they were recovering from spine surgery. It was one of the most humane interventions I've seen in the medical setting. I know people who avoid going to the doctor, not because they don't need care, but because they can't be upright enough to go in, or there will be so many triggers that make them feel worse and little chance of a positive outcome from an ignorant doctor."*

**Community members reported that access to transportation** presents a day-to-day challenge for many, both because of limitations to the medical transportation system, as well as limitations in public transportation. Community members provided several examples in which a lack of access to transportation impacted their capacity to receive adequate care:

- *"For example, I know that some people will have a hard cutoff at 30 visits a year for transportation difficulties. I just heard from a community member tonight actually that she is scheduled for an MRI, but Ride to Care canceled all rides that were not life-threatening because they're slammed. So, she's unable to get the care that she needs in a timely fashion."*
- *"Access to medical transportation has been a real difficult problem lately with Ride to Care…When COVID first happened, any of the transportation options were so easy because nobody was using it. So, they didn't overbook like they're doing now."*
- *"Some days my doctors will call me and say, we need you to go and get this done or that done. And I don't have a way there and transportation, I have ride connection, but you must make it so far in advance that when the doctor calls and says do it, or if people call and say do it, I can't."*

**Technology** was the focus of several CE Sessions and community members highlighted the opportunities that have been created by providing more virtual care (easier access to a broad range of providers). Community members also shared concerns about accessibility for those who might have less comfort with navigating virtual spaces and/or don't have reliable access to broadband internet and Wi-Fi connections:

- *"…there's a lot of resources and a lot of services that have gone online, especially because of COVID…I worry about people like seniors, who may not even have computers or the literacy or ability to access them. I worry about communities who, you know, there are language barriers. How are you going to even navigate a website that's not in your language? And then also people who don't even have electricity, how are they going to access this information and these amazing resources that are there for them, but they don't even know about it."*

## ACCESS TO CULTURAL AND LINGUISTIC RESPONSIVE CARE

***Access to Cultural and Linguistic Responsive Care** includes a focus on:*

- Mental health services and support
- Access to culturally specific clinics and/or community centers
- Access to health care workers that reflect and represent our communities
- Access to health workers that speak and understand our communities' languages
- Access to disaggregated data from health systems

Overarchingly, community members' input illuminated the fact that access to health care should not solely focus on meeting communities' clinical needs, but should consider holistic, person-centered, and community-centered needs that are much broader and often dependent upon social and cultural factors that influence the ways people seek to take care of themselves and their loved ones. Further, community members' feedback suggests that communities within the Quad Counties clearly offer culturally and linguistically specific strengths and values that can and should be recognized and supported by the health care system at large. In doing so, this could result in shifting the "access to care" paradigm from focusing only on clinical and physical health needs, to addressing other aspects of a person's life—the behavioral health (mental health and substance use disorder) and social factors (social drivers of health). This could support them in addressing and improving their general well-being and health and, in turn, may increase their access to care.

Throughout the CE Sessions**, community members' feedback shed light on the multiple, complex, and often interrelated challenges they have had and still experience in accessing the clinical care that they feel they need and want.** Community members across all priority populations echoed each other in describing their desire for clinical care that attends to the whole-person and their communities at large. They argued that clinical care treating symptoms and diseases was insufficient, even when they could get it. **Instead, community members reported wanting health care that is attentive to healing marginalized communities' experiences, past traumas, and historical inequities**.

- *"[I]t would be super important to have not just like a health care system that cares about…the surface level things, but also below that…with healing…communities and allowing a safe… and welcoming space for that."*
- *"[S]eeing your elders not really get the support that they need is really difficult to see, you know? And it like makes you kind of sometimes lose faith in the system when…you know how much they've gone through to come to this country and then seeing them not really get the support when it comes to…interpretation, like…having an interpreter there to kind of translate or just…then sometimes just no compassion…"*

**Past experiences and trauma with care that is not culturally, and linguistically responsive poses continued challenges to community members' willingness and ability to access care.** Some community members referred to their own experience, and that of their ancestors and family members, of not receiving clinical care that considered their personal and/or culturally informed ways of being. This resulted in being traumatized by the care they did receive, which they referenced as a reason they were wary of the existing health care system, places of care, and providers. Community members recalled experiences when they did seek care from the health care system, they often felt **traumatized, dismissed, and discriminated against**.

- *"Like when we do take that chance and go to the doctor, we're not heard. So, if we are told to value our health and listen to our bodies and all those things, and then when we do that, we're then dismissed or brushed off or invalidated. Then that makes you not want to do that [go to the doctor]. And then you end up negatively affecting your health."*
- *"What I do know about health care for Micronesian Islanders especially, well, at least when we come from a Western medicine sense is that there's no access. And when you do have access, the physicians who are mostly white, don't think you know what you're talking about with your own health care. They don't listen to patients."*
- *"I'm not confident that health care providers listen to immigrants."*
- *"I've had a really hard time in this last, probably two years just trying to find a doctor or anything that could really understand where I'm coming from and respect…what I want for myself and my body. It's really turned me off from going to the doctor."*
- *"It can be really hard to get the right kind of care from a doctor who doesn't quite understand you. Elaborating on that more, a huge issue with black women or black people who are assigned female at birth, is our health being undermined, I guess. And we're pretty much always passed off as being overdramatic and a lot of the time our health concerns aren't taken seriously. To me that seems like a farfetched, impossible thing until I experienced it."*
- *"I feel like the power dynamic in that room is not really equal. And it's hard to tell the doctor what you want and have them listen. And if for some reason they don't listen or they don't treat you with the respect that you wanted or think you deserve, there's not really anyone else there to step in and defend you. And so, you're kind of just left. I've had good doctor appointments too but sometimes, I'm just like, [they] leave you with this bad feeling and you don't really know who to talk to about it or anything like that. So, you just avoid going to the doctor then unless you really need to."*

Many community members reported wanting to be cared for by health care providers **with shared experiences, cultures and language, i.e., providers who are representative of the community members they cared for**. Some community members mentioned that just training providers in cultural competency is not enough, nor is having interpreters because they may or may not share the same linguistic dialect or experience or are not competent in medical translation. For one community member, shared experience could be valued by health care systems enough to take precedence over historically valued educational background and would result in hiring more providers who are represent the communities they care for. This person said, *"We also need our coordinated care organizations to look like us, to hire people who are from the community to hire people who have these, you know, educational background that are not education and background here [i.e., the person's home country where they received education], but it gives you a background out of there. So basically, respecting and valuing the past experiences and best degrees of* *our own community, that has not been happening because of the hiring process of the bureaucracies, like, you must have a high school degree and things like that. We need to get beyond that and actually…value the cultural and lived experiences."*

Other community member comments reflected this as well.

- *"I think that if we had more Arab American doctors who truly understand our community, understand the background, that is something that can help."*
- *"…[W]e've all talked about needing therapists of color, needing therapists that have similar backgrounds to us, and that aren't white, that aren't men, whatever it may be."*
- *"We don't have providers who speak our language, who share our own experiences, who have our lived experiences. And at the end of the day, when we go to the doctor and, and we have an interpreter there, the interpreter does everything they can in their hand and in their power to translate, to interpret what we are feeling, but it's not, it's never like having a provider who speaks your own language and can deliver that."*
- *"Interpretation is not just around language, you know, but around differences in the English language between the medical community and the native community."*
- *"It's important to actually make the doctor understand that the interpretation is not a literal interpretation. You must make both sides, understand each other, and become comfortable with each other. So, they interact in a better way and that would save his time as a doctor and make the patient really take the medication and understand how this medication benefits him."*

Some community members described being **burdened by having to explain their experience and the shared experience they had being part of a historically marginalized community.** While they felt it is critical to being cared for, some described it as a challenge to their being able to get appropriate care they needed.

- *"So, it's like finding a therapist that can understand you, where you don't have to explain your entire existence and systems of oppression to…so you don't have to explain your whole existence to them."*
- *"It can be really hard to get the right kind of care from a doctor who doesn't quite understand you. Elaborating on that more, a huge issue with black women or black people who are assigned female at birth is our health being undermined, I guess. And we're pretty much always passed off as being overdramatic and, a lot of the time, our health concerns aren't taken seriously. And to me that seemed like a farfetched, impossible thing until I experienced it."*
- *"I think the notion of cultural competency, was a really great start, but [it] really screwed some folks up because you can't know black people…If you're willing to sit for long enough to hear it, you can know their pains, their successes, or accomplishments, all the stuff that that is concerning that person… even though there are some similarities across our community, even though there are symptoms that impact across community, it really is about health care provider [and an] awareness of the individual."*

Some community members noted that the health care system and providers should have **different expectations and approaches when caring for communities most impacted by systemic oppression**. One member, who identified as Black, pointed out that even the treatment model for mental health was not responsive and did not resonate with her or Black community in general.

- *"What I would say is there has to be an understanding that if you really want to do work with marginalized communities, specifically the black community, you have to understand that the work is not going to look the same. You must understand that there needs to be more, there's going to have to be more resources put towards it. And the expectations, the blanket expectations that are typically put on community to perform in a certain way to get funding or to get the service has to be addressed as well."*
- *"[The] therapy model two is just a little bit… and I feel like this way for me, it is a little impersonal just because you're going to be like in a room with someone else who is not going to be sharing with you. I've heard that for some people it's beneficial for them and that's great…but I feel like for a lot of black folks, we're a very connected people. We like to share things, and I think that like just being in a circle and communicating that way is…better. I think that if we're going to be creating or rolling out programming, that we should use models that we know work or are more culturally geared."*
- *"I know that when the doctor asks me at the beginning of the appointment, "how are you doing today?" and you have struggled to shower and put on your best clothes and comb your hair, and people have helped you get there. And when they [the doctors] document the fact that you are well-groomed, that you said you are feeling good, that those things hurt me in getting specialty care and hurt me and getting social security disability, because the doctor's note said that I was doing good and that I was able to care for myself because I showed up well-groomed and I showed up on time."*
- *"I see a lot of people with disabilities that need help, like in support. We have a lot of people that are falling through the cracks that aren't necessarily getting help."*
- *"So, if you are blind and need health care information or needing to fill a form before you go to an MRI, or before you go to the next room and you need to fill a form that literally the answers that you put in this form is going to affect your life in the next minute, you don't have that form interpreted in your own language…. So, in addition to the language [translation], we [need] also like an…accessibility aware system that literally engages everybody and [attends to] everybody's needs."*

Community members noted challenges related to **insurance and affordability of health care** were constants in their lives and had a real impact on the understanding of what should be considered whole-person care. Even community members with insurance reported the numerous obstacles they face daily in getting the care they wanted. For some, the increase of telemedicine, which is typically considered by the dominant health care system as an affordable method of increasing access to care, was not a viable solution to accessing care because many of them and their community members did not have access to reliable internet services or, as they noted, their senior populations did not know how to use online services.

- *"I have insurance, but because I'm a grad TA, it's like a step up. But even so, navigating the insurance, I had a huge problem with the eyeglass place. I spent an hour and a half on the phone with the insurance company to make, to figure out exactly what they cover. And then I called the, you know, around not everybody takes that insurance. So, I found a place. I had four*

*conversations before my appointment to make sure they were going to call and make sure [they would accept my insurance]."*
- *"Even though they give you an advocate, that's the insurance advocate, whose side do you think they are on? They're not advocating for me in the most part."*
- *"[I]t would be nice to be able to have a referral, you know... To have possibly other doctors besides just a few. So that kind of gets frustrating, when you're referred to see another doctor, but then...there's only limited ones that will see you or won't accept your insurance."*
- *"A lot of our elders don't have that capability to get online or, if you're looking at [that] community that might be remote, [they] might not even have internet access."*
- *"How has technology been a barrier? No Wi-Fi. To rely on Wi-Fi and not have it has been really stressful; To make appointments you have to use one or four computers."*

Community members' access to care is challenged by **lack of linguistically responsive health care services and supports**, including the lack of translation of written materials in needed languages or provision of materials for persons with visual or audio support needs. This also includes lack of an assurance of confidential interpretation services, lack of interpretation services in dialects or from persons with lived experiences, like the community members.

- *"Look, there's no written materials that are allowing the person to be independent and pursuing their own health. The other thing is, and this is a problem for English speakers and it's like bigger for like non-English speakers. And our community is part of it is if you are a visually impaired or hearing impaired or disabled in any way, this scarcity of materials and ability to get access to the health needs that you need is becoming non-existent."*
- *"At the end of the day, when we go to the doctor and we have an interpreter there, the interpreter does everything they can in their hand and in their power to translate, to interpret what we are feeling, but it's not, it's never like having a provider who speaks your own language and can deliver that."*
- *"I want the doctors to speak more simply, [to make it] easier to understand for people who aren't in that field. We need more that are bilingual but also know more languages."*
- *"[L]istening to my elders as I was growing up, my grandparents, my uncles, my aunts, my parents, they instructed me, I guess you could say, in the traditional way of my people. And a lot of it was taught to me in my language. I understand my language. Sometimes it's hard to translate my language, the English and English into my language. Basically, they put it in simple terms. The English language is basically backwards compared to our traditional language."*

Community members relayed that their distrust of the health care system, particularly because it is not culturally or linguistically responsive, has often resulted in **delaying or avoiding seeking out health care** altogether. While access to care may not have been an obstacle, their past experiences or understanding of the system resulted in them making decisions about whether to utilize the system.

- *"I try not to go in for any little thing. And so, I will wait and wait and wait. And it'd been like three weeks since my back had been hurting. And, uh, I finally called NARA about it. I thought about going into urgent care, cause they're easy going at Emmanuel or whatever. But, um, I don't like* *the bias of health care providers when you go in and you know, you might be red flagged because you're an addict or whatever it is."*

- *"I've had a really hard time in this last, probably two years just trying to find a doctor or anything that could really understand where I'm coming from and respect what I want for myself and my body."*
- *"I just haven't found anybody that is willing to listen to what I really have to say, you know? And so, I think that's been the hardest for me is just trying to communicate that. And I really feel like I can advocate for myself and communicate for myself, but there's a lot of people out there my age, or there's a lot of native people out there that cannot do that. And so, you know, then they don't get the health care that they need."*
- *"A lot of the services that are available are just too difficult to navigate. So, um, I just, I try not to mess with Western doctors as much as possible. I've been seeing a naturopath for years and they do everything in house. Like I can do my lab work and my therapy, like everything just there."*

## CIVIC HEALTH

**Civic Health focused on building political awareness, power, and infrastructure to shape and improve community health, and includes a focus on:**

- Civic representation
- Civic education
- Civic engagement
- Racial justice and equity education

One of the core themes that emerged from the CE Sessions regarding civic health was community members' reporting of their **need for additional education focused on health care rights and pathways for advocacy**. For example, many community members noted a need for education and outreach to recent immigrants and refugees about civic engagement and resources for understanding systems of care. For example, one community member noted, *"They don't know to whom they can reach out to help them with an application for a green card or application for health insurance and, or like if they want rent assistance."*

In addition to educational needs, several community members described larger **systems and policy issues, including historical trauma and oppression, that impact civic health**. These needs included honoring the treaty rights of indigenous communities, as well as a greater response to missing and murdered women and children in these communities. Participants described opportunities to advocate for their needs in a variety of governmental forums, primarily around issues of race and racism. One policy change identified was the need for improved data collection with respect to race and ethnicity to guide policy making and allocation of resources (for example, distinguishing between Alaska natives and other indigenous communities in the Pacific Northwest).

## SUPPORT FAMILY AND COMMUNITY WAYS

**Support Family and Community Ways includes a focus on:**

- Access to peer education services
- Non-academic youth development programs
- Provision/funding for peer mentorship programs
- Language accessibility

During the community engagement sessions, some community members noted a **specific desire to have more peer support and a desire for agencies to employ more people who have lived experience** as peers, counselors, and providers, expressing that this would be an excellent way to support both family and communities. Community members desired agencies that were run and managed by people with lived experience. Several community members expressed the lack of sufficient access to peer education services as a barrier, including lack of sufficient numbers of peers employed by agencies to assist with this effort. In addition, members of the community mentioned the need for a **way to exchange information and educational resources** among community members.

- *"I have not been seeing that much Arabic specific [resources]. Most of the time it's other cultures and yes, other cultures also need it, but our Arabic community does not have these services..."*
- *"My vision was that our people would be on the other end of that line, you know, like there would be native person talking to a native person and saying, 'Hey, here's a resource, a viable resource that I think might work for you. Or maybe you could look at, or maybe I could help you call them, or maybe I could help you fill out the form. But, you know, we're talking to our own people about these things, not just that there's a phone number of a resource, here or call them. I really am envisioning our community coming together to help each other and create or develop these resources for our people, for our communities."*

In addition to formal methods of supporting families and communities, community members acknowledged **informal methods which included spiritual gatherings, sharing ceremonies, conferences, and cultural events** to discuss past traumas as a community and to work toward healing together. Across the sessions, community members spoke to the importance of holistic care and various methods of self-care as well as the meaning of community wellness and the specific supports needed to achieve this. One community member described the need for a **shared physical space in the community**, where people can meet to discuss recipes, harvest, and cook traditional foods together and educate each other on traditional medicine. Other members spoke to the importance of spreading awareness on health issues that affect marginalized communities such as Lesbian, Gay, Bisexual, Transgender, Queer, Intersectional, and more (LGBTQIA+) and Black and Indigenous people of color (BIPOC) youth. Younger members of the community reported needing **peer education** in their high school community about these topics and shared that inclusivity has been a great barrier to accessing these services. They expressed the desire for specific health committees or creation of community youth groups to support family and community ways.

- *"I know that there is a church. I'm not sure which specific one, but they put on a young life youth group. And I am aware of probably over a dozen Sandy high school students who do attend that. Other than that, there's not many options for community."*
- *"...a coffee shop does have a youth program and my stepbrother was involved in it a few years back. And I'm not sure exactly what they do. I've been trying to keep up with their activities, but I know they work on a community garden and do a lot of community service acts and it was a very inclusive environment. I have talked with and worked with a lot of the administrators of that program over the years."*

**Neighborhood for All includes a focus on:**

- Housing Access
- Forced Displacement/Gentrification
- Community Safety including police profiling

## NEIGHBORHOOD FOR ALL

Across the CE Sessions, community members expressed great concern regarding the safety of environments in their neighborhoods, access to safe and affordable housing, as well as community safety concerns.

### Healthy Environments

Many community members discussed the need for a healthier environment and living spaces, which directly and indirectly impact their health and wellbeing. Community members wanted **safe, healthy, and supportive environments** which, for them, included access to clean air, safe drinking water, nutritious foods, and safe places to live. Several people reported environmental hazards that have increased their risk to certain diseases including cancer, heart disease and asthma.

- *"You're just surrounded by trash and, um, the air quality is terrible and you usually find that for low-income and I don't think that's fair because if they can't afford it, that takes a major toll on their health and that's going to lead to greater problems in the future"*
- *"Design of the neighborhoods in my experience, there is no sidewalks. So, we need to walk on the roads, to just walk to the nearest park, which can be discouraging to go and walk outside."*

### Housing Access

As an important determinant of health, community members recognized the range of ways in which **lack of housing negatively affected their health and wellbeing**. Many living in poverty spoke about the community need for more affordable housing options, while others spoke about their concerns related to housing accessibility in their communities. Community members described home ownership as a privilege and many alluded to the meaning and benefits of "home," including feeling a sense of control over their own lives, autonomy, empowerment, and security related to having a home. Several community members shared stories and recollection of past hardships as well as current experiences with affordable and accessible housing options. Another shared theme was the need for more awareness among community about housing and shelter options.

- *“The supports that would probably be the most helpful for my community's health and wellness would be housing assistance, utility assistance, and paid work that meets Portland's more expensive standards of living.”*
- *“I would definitely say affordable housing. [It] is very expensive to live, in Portland or find something that you can afford, especially if they're going to school and trying to work.”*
- *“I think housing that is not stable, there is not a lot of affordable housing in Portland. There's a lot of housing, but the question is, is it affordable? And oftentimes it is not affordable.”*
- *“I think there's a need for like more affordable housing. What I have noticed is that it seems that Black people from Portland [are] getting pushed out more and more like to Gresham and further and further.”*
- *“I have enough money to pay rent, but then I got to go way far out of my way to get to somewhere that is good quality.”*
- *“There are many, many programs for housing here, but nobody knows about it. We need to educate people or make a workshop for them… They have like many, many programs for housing, but nobody knows this is a bigger problem.”*
- *“I know I lost the ability to live in my own home when I became wheelchair bound and I couldn't believe how difficult it was to find accessible housing. I can't walk up and down stairs and it has really limited where I'm able to live and what communities I'm able to participate in. It feels really difficult applying to rent somewhere and then not being sure about whether or how I'll be able to get support for modifications. [It] is really anxiety inducing, and I've called around for legal aid…”*

### Community Safety

Community members reflected on the importance of community safety as it related to their health. For most, **safety included being protected from violent acts in their neighborhoods and homes, as well as safety from injuries.** Several community members discussed ways in which they felt unsafe and the negative impact this has had on their well-being, such as the chronic stress associated with living in an unsafe neighborhood. A few community members spoke about their fear of violence and how it has kept them indoors. For example, for those who felt the need to stay inside to keep safe, there were many issues with accessing services (such as going to get groceries), enjoying the neighborhood by taking walks and participating in outdoor activities, or getting the care they need. Community members reported wanting policies and programs to be implemented that would protect residents from accidents and violence in their neighborhoods.

- *“I think security and safety is a big issue… I've lived in Oregon for 30 years and I've never quite been comfortable here. And what that does is it causes mental stress, which causes physical stress.”*
- *“I can name at least three times in the past couple of years that there has been caution tape taping off that intersection. And you must do a detour because someone got shot in broad daylight. I know there's a shooting down on Halsy like a month or so ago in broad daylight. I don't know what we need to fix that, but I think it's an area thing, honestly. Like I feel like there's more areas that shootings happen more than others.”*

- *"I think that a lot of black men grow up with PTSD, you know, based upon the fact that you walk around in fear from the time you're able to realize that it's not safe out there for you, for that reason, not because of your own, but because of uncontrollable circumstances like the police."*

# Appendix G: HCWC Community Survey Demographics and Results

This appendix includes three sections reporting the community survey demographics and results:

Section 1: Survey Respondent Demographics
Section 2: Regional Analysis
Section 3: Equity Analysis

## Section 1: Survey Respondent Demographics

**FIGURE 8 PERCENT RESPONDENTS BY COUNTY OF RESIDENCE**

| County | Number | Percent |
|---|---|---|
| Clark | 72 | 14% |
| Multnomah | 87 | 17% |
| Washington | 87 | 17% |
| **Clackamas** | **259** | **51%** |
| Other | 5 | 1% |

**FIGURE 9 PERCENT RESPONDENTS FOR HOW OFTEN IS WHERE YOU LIVE ALSO WHERE YOU GET SERVICES AND RESOURCES**

| How often is where you live also where you get services and resources? | Number | Percent |
|---|---|---|
| Always | 138 | 27% |
| **Usually** | **233** | **46%** |
| About half the time that I need something | 83 | 16% |
| Seldom | 38 | 7% |
| Never | 15 | 3% |
| Don't know | 2 | 0% |
| I don't know what this question is asking | 2 | 0% |
| I don't want to answer | 1 | 0% |

**FIGURE 10 PERCENT RESPONDENTS BY "SATISFACTION WITH QUALITY LIFE"**

| Selection | Number | Percent |
|---|---|---|
| Very Satisfied | 90 | 18% |
| **Satisfied** | **229** | **47%** |
| Neutral | 101 | 21% |
| Unsatisfied | 48 | 10% |
| Very Unsatisfied | 22 | 4% |
| Not applicable | 1 | 0% |

**FIGURE 11 PERCENT RESPONDENTS BY AGE**

| Selection | Number | Percent |
|---|---|---|
| 18 to 25 years | 11 | 2% |
| 26 to 35 years | 53 | 11% |
| 36 to 45 years | 78 | 15% |
| 46 to 55 years | 109 | 22% |
| 56 to 65 years | 95 | 19% |
| **Over 65 years** | **149** | **30%** |
| I don't want to answer | 9 | 2% |

### FIGURE 12 PERCENT RESPONDENTS BY RACE/ETHNICITY

| Selection | Number | Percent |
|---|---|---|
| Asian *(includes: Cambodian, Chinese, Filipino/a, Japanese, Korean, Laotian, South Asian, Vietnamese, and other Asian)* | 30 | 6% |
| Biracial/Multiracial | 12 | 2% |
| Black and African American: African-American | 13 | 2% |
| Don't know/Unknown | 1 | <1% |
| Don't want to answer/Decline | 20 | 3% |
| Hispanic and Latino/a/x *(includes: Central American, South American, and other Hispanic and Latino/a/x)* | 19 | 3% |
| Mexican | 40 | 6% |
| Middle Eastern/North African: Middle Eastern | 2 | <1% |
| Native American and Alaska Native: Indigenous Mexican, Central American, or South American | 8 | 1% |
| Native American and Alaska Native: Native American | 10 | 1% |
| Native Hawaiian and Pacific Islander *(includes: Chamoru (Chamorro), Marshallese, Native Hawaiian, and other Pacific Islanders)* | 11 | 2% |
| Other | 2 | <1% |
| Other White | 15 | 2% |
| Samoan | 10 | 1% |
| **White** | **387** | **54%** |
| White: Eastern European | 23 | 5% |
| White: Slavic | 6 | 1% |
| White: Western European | 74 | 10% |

### FIGURE 13 PERCENT RESPONDENTS BY LANGUAGE USED MOST OFTEN AT HOME

| Selection | | Number | Percent excluding blanks |
|---|---|---|---|
| **English** | | **416** | **89%** |
| Spanish | | 32 | 7% |
| Samoan | | 8 | 2% |
| **Aggregated Results:**<br>Arabic (1)<br>Thai (1)<br>Hawaiian (1)<br>Lao (1)<br>Haitian Creole (1)<br>Marshallese (1) | Romanian (1)<br>Russian (2)<br>French (1)<br>Portuguese (1)<br>Cantonese (1)<br>German (1)<br>Chinese (1) | 14 | 3% |

### FIGURE 14 PERCENT RESPONDENTS BY LANGUAGE WOULD YOU PREFER TO USE WHEN COMMUNICATING (IN PERSON, PHONE, VIRTUALLY) WITH SOMEONE OUTSIDE THE HOME

| Selection | Number | Percent |
|---|---|---|

| | | |
|---|---:|---:|
| **English** | **415** | **78%** |
| Spanish | 24 | 5% |
| **Aggregated Results:** | **12** | 3% |
| Samoan | 3 | |
| Hawaiian | 1 | |
| Lao | 1 | |
| Russian | 1 | |
| German | 1 | |
| Same, see above, primary language | 4 | |
| In person | 1 | |

**Figure 15 Percent respondents by Language would you prefer to use to read important written information such as medical, legal, or health information**

| Selection | Number | Percent |
|---|---:|---:|
| **English** | **408** | **76%** |
| Spanish | 26 | 5% |
| **Aggregated Results:** | **11** | 2% |
| Samoan | 2 | |
| Hawaiian | 1 | |
| Lao | 1 | |
| Russian | 1 | |
| German | 1 | |
| Same, see above, primary language | 5 | |

**Figure 16 Percent respondents by housing status**

| Selection | Number | Percent |
|---|---:|---:|
| **Owns or shares own home, condominium, or apartment** | **362** | **72%** |
| Rents or shares own home or apartment | 95 | 19% |
| Lives with parent or family member | 17 | 3% |
| Some other arrangement, please describe. See responses below | 16 | 3% |
| Lives in public housing | 6 | 1% |
| I don't want to answer | 3 | 1% |
| Homeless and sharing housing | 0 | 0% |
| Homeless and living in emergency shelter or transitional housing | 0 | 0% |
| Don’t know | 1 | 0% |
| I don't know what this question is asking | 1 | 0% |

**Figure 17 Percent respondents by household income and number of people income support**

| Selection – Income | Number | Percent |
|---|---:|---:|
| Less than $15,000 | 18 | 4% |
| $15,000 to $24,999 | 33 | 7% |
| $25,000 to 49,999 | 58 | 12% |

| | | |
|---|---:|---:|
| **$50,000 to $74,999** | **86** | **17%** |
| $75,000 to $99,999 | 72 | 14% |
| $100,000 to $124,999 | 53 | 11% |
| $125,000 or greater | 80 | 16% |
| Not employed, student, retired, homemaker | 21 | 4% |
| Don't know | 4 | 1% |
| I don't know what this question is asking | 1 | 0% |
| I don't want to answer | 74 | 15% |

**Figure 18 Average Number of People Supported Per Household Income**

| Selection – Income | Number | Percent | Average Number of People this Income Supports |
|---|---:|---:|---:|
| Less than $15,000 | 18 | 4% | 1.2 |
| $15,000 to $24,999 | 33 | 7% | 1.8 |
| $25,000 to 49,999 | 58 | 12% | 2.2 |
| $50,000 to $74,999 | 86 | 17% | 2.2 |
| $75,000 to $99,999 | 72 | 14% | 2.6 |
| $100,000 to $124,999 | 53 | 11% | 2.7 |
| $125,000 or greater | 80 | 16% | 2.9 |
| Not employed, student, retired, homemaker | 21 | 4% | 1.0 |
| Don't know | 4 | 1% | 0.8 |
| I don't know what this question is asking | 1 | 0% | 0.0 |
| I don't want to answer | 74 | 15% | 1.5 |

**Figure 19 Percent respondents by primary source of health insurance**

| Health Insurance Type | Number | Percent |
|---|---:|---:|
| Private | **296** | **56%** |
| Public | 160 | 30% |
| No insurance | 12 | 2% |
| Other | 34 | 6% |
| Blank/No response | 28 | 5% |

**Figure 20 Percent respondents by primary source of health insurance type**

| Selection | Number | Percent |
|---|---:|---:|
| **A plan purchased through an employer or union (includes plans purchased through another person's employer)** | **268** | **53%** |
| Medicare | 119 | 24% |

| | | |
|---|---:|---:|
| Medicaid (Health Share of Oregon, Trillium Community Care, or Apple Health) or other state program | 37 | 7% |
| Other | 34 | 7% |
| A plan that you or another family member buys on your own | 28 | 6% |
| I have no health care insurance | 9 | 2% |
| Veterans' Administration | 4 | 1% |
| I have no health care insurance and pay cash for health care | 3 | 1% |
| I don't want to answer | 2 | 0% |
| Don't know | 1 | 0% |
| Alaska Native, Indian Health Service, Tribal Health Services | 0 | 0% |
| I don't know what this question is asking | 0 | 0% |

**FIGURE 21 PERCENT RESPONDENTS BY GENDER PRONOUNS**

| Selection | Number | Percent |
|---|---:|---:|
| **She/Her** | **326** | **59%** |
| He/Him | 77 | 14% |
| No pronouns, use my name | 59 | 11% |
| They/Them | 30 | 5% |
| I don't want to answer | 21 | 4% |
| Not listed, Please Specify | 16 | 3% |
| Don't know | 10 | 2% |
| I don't know what this question is asking | 9 | 2% |

## Section 2: Regional Analysis

**FIGURE 22 HOW OFTEN IS WHERE YOU LIVE ALSO WHERE YOU GET SERVICES AND RESOURCES?**

| | Always/Usually | 50% or less of the time | Don't know/ No response |
|---|---:|---:|---:|
| Region | 73% | 26% | 1% |
| Clackamas (n=259) | 66% | 33% | 1% |
| Clark (n=72) | 82% | 18% | 0% |
| Multnomah (87) | 75% | 23% | 2% |
| Washington (n=87) | 84% | 15% | 1% |

**FIGURE 23 PERCENT RESPONDENTS WHO ARE VERY SATISFIED/SATISFIED WITH...**

| | All Respondents (n=530) | Clackamas County (n=259) | Clark County (n=72) | Multnomah County (n=87) | Washington County (n=87) |
|---|---:|---:|---:|---:|---:|
| Your own health | 65% | 71% | 68% | 53% | 72% |
| The quality of life in your community | 60% | 66% | 67% | 39% | 70% |
| The safety in your community | 53% | 59% | 58% | 32% | 63% |

| | | | | | |
|---|---|---|---|---|---|
| Getting the medical care you need | 66% | 73% | 75% | 47% | 69% |
| Getting the mental health or substance use care you need | 39% | 38% | 51% | 37% | 40% |
| Getting help during stressful times | 40% | 38% | 51% | 40% | 44% |

## COMMUNITY STRENGTHS AND GAPS

**FIGURE 24 NUMBER AND PERCENT OF SOCIAL DETERMINANT OF HEALTH CATEGORY SELECTED AS A COMMUNITY STRENGTH AND GAP AMONG ALL RESPONDENTS**

**Q: Think about the times over the past year that you needed support to improve and/or maintain your health and wellness and received the support you needed. What support did you get? *<u>Please select the one that was most impactful</u>*.**

| Rank | Strength | Number of times selected |
|---|---|---|
| 1 | Health care supports (i.e., specialty health care, mental health care, doctors, clinics, hospitals) | 361 |
| 2 | Economic supports (i.e., safe workplace, job stability, good paying job) | 233 |
| 3 | Supports to feel safe or well in my neighborhood (i.e., community safety, housing, grocery stores, parks, transportation, internet, etc.) | 195 |
| 4 | Social and community connection supports (i.e., opportunities for involvement in public decision-making, arts and cultural centers and events, faith-based centers and/or organizations, summer youth programs) | 156 |
| 5 | Education supports (i.e., childcare, good schools, school-based resources) | 83 |

**FIGURE 25 Q: THINK ABOUT THE TIMES OVER THE PAST YEAR YOU NEEDED SUPPORT TO IMPROVE AND MAINTAIN YOUR HEALTH AND WELLNESS AND DID NOT RECEIVE THE SUPPORT YOU NEEDED. WHAT DID YOU NOT GET? PLEASE SELECT THE ONE THAT WAS THE MOST IMPACTFUL.**

| Rank | Gap | Number of times selected |
|---|---|---|
| 1 | Health care supports | 188 |
| 2 | Supports to feel safe or well in my neighborhood | 177 |
| 3 | Social and community connection supports | 129 |
| 4 | Economic supports | 83 |
| 5 | Education supports | 74 |

**FIGURE 26 BY SOCIAL DETERMINANT OF HEALTH CATEGORY, THE PERCENT OF RESPONSES WHO FELT THE HELP/ SUPPORT/ SERVICE RECEIVED WAS … (SELECT ALL THAT APPLY)**

| | # of people who chose this | In my opinion, the help/ support/ service I received was (please select all that apply): |
|---|---|---|
| Health care supports | 361 | 22% Affirming<br>40% Affordable<br>**54% Easy to Access**<br>51% High Quality |
| Economic Support | 233 | 23% Affirming<br>16% Affordable<br>**33% Easy to Access** |

| | | |
|---|---|---|
| | | 31% High Quality |
| Supports to feel safe | 195 | 25% Affirming<br>27% Affordable<br>**53% Easy to Access**<br>41% High Quality |
| Social and Community connection | 156 | 48% Affirming<br>35% Affordable<br>**55% Easy to Access**<br>42% High Quality |
| Education Supports | 83 | 19% Affirming<br>27% Affordable<br>**46% Easy to Access**<br>39% High Quality |

**FIGURE 27 BY SOCIAL DETERMINANT OF HEALTH CATEGORY, THE PERCENT OF RESPONSES WHO DID NOT RECEIVE THE HELP/ SUPPORT/ SERVICES NEEDED BECAUSE ... (SELECT ALL THAT APPLY)**

| | # of people who chose this | In my opinion, I DID NOT receive the help/ support/ services I needed because they were (please select all that apply): |
|---|---|---|
| Health care supports | 188 | **11% Not Affirming**<br>28% Not Affordable<br>**59% Not Easy to Access**<br>16% Not High Quality |
| Supports to feel safe | 177 | 20% Not Affirming<br>18% Not Affordable<br>**41% Not Easy to Access**<br>**12% Not High Quality** |
| Social and Community connection | 129 | 25% Not Affirming<br>**7% Not Affordable**<br>**47% Not Easy to Access**<br>8% Not High Quality |
| Economic Support | 83 | 14% Not Affirming<br>22% Not Affordable<br>**43% Not Easy to Access**<br>**11% Not High Quality** |
| Education Supports | 74 | **14% Not Affirming**<br>38% Not Affordable<br>**46% Not Easy to Access**<br>39% Not High Quality |

Key themes from an analysis of “In your own words” responses, which was an opportunity for respondents to write in their own response, for avoiding getting health care, for which illustrative quotes are included:

### COVID-related

- Concerns about getting a COVID vaccine.
- I delayed because I was worried about COVID.
- Hospitals and clinic very busy during COVID & wild fire season in PDX.

- Didn't schedule dentist or doctor wellness visits due to avoiding covid exposure. There is a lack of available vaccine and covid testing sites with available appointments in the Gresham, Sandy area.

### Gender

- Gender (as a woman, I feel I am sometimes dismissed).
- My health problems are often dismissed and I think this is because I am female and have pain. Doctors are programmed not to care if someone is in pain anymore because they thing the person is seeking pain medications. This blanket approach is leaving people who do not have addiction issues in pain and without treatment.
- In the past, I've found that some male doctors did not listen to me and also tried to prescribe antidepressants for fatigue. I prefer female doctors for this reason.
- I am often dismissed due to my gender being female by providers and community members of both sexes.
- I do not give personal answers to a male doctor.

### Cultural Competency and Sensitivity

- My health beliefs (about diet, alternative medicine, etc..) do not always align with mainstream medical thinking; some providers can be dismissive of these ideas. Also, I have found the being a post-menopausal woman seems to lead to assumptions about me that may or may not be accurate.
- I have avoided or delayed heath care because I was worried that my concerns would not be taken seriously, or I would not be treated fairly because of the lack of awareness & understanding of how brain injury impacts a person's life.
- My beliefs do not align with the "dominant" culture. Many of my peers are avoiding going to the doctor for this reason.
- Because the provider had a language barrier and would not listen to me.

### Lack of Whole Person Care

- Going to a health care provider is getting more difficult all the time. They will only treat 1 problem at a time and then want you to reschedule to talk about something else. Then you must wait for another appointment.
- My desire to find a root cause and treat that rather then just take meds to control the symptoms is not welcomed. My use of natural treatments and birthing has been judged. I once had a very public argument with an OB Doc where I was being yelled at and told I was putting my child in danger. I left and did not return. When I did need to come back on another birth where I tore I was stitched up without any local anesthesia or any pain killers. These may have happened years ago but they impact my level of trust with western health care. I often wait to be seen until I must.
- I value an approach that supports healthy aging and proactive practices. Most health care is focused on treatment once a condition exists. Would like to see more ability to use Medicare for alternative medicine (e.g., massage and acupuncture).

### Judgement from doctor

- My weight is often seen as the problem
- Not getting help sooner

### Not enough time or attention from health care providers

- A huge concern for me in this area is simply laziness on the part of health care providers. Many health care professionals are stressed and overworked, and this creates a cookie cutter approach to care that I do not trust to properly identify and address my individual issues and health concerns.

- Too many patients for one doctor to concentrate on. In 15-20 min the doctor can't understand the whole picture of the problem.
- In the last year, my health system "forgot" or "lost" critical appointments (Breast Cancer detection). I felt numerous times the displeasure of some of the staff towards my care
- Health care providers don't seem to have the time to listen nor read your chart before you see them

## Section 3: Equity Analysis

FIGURE 28 PERCENT RESPONDENTS WHO ARE VERY SATISFIED/SATISFIED WITH…

| | All Respondents (n=530) | BIPOC (n=97) | LGBTQ2I (n=93) | Respondents with a Disability (n=141) | Older Adults (65+ years) |
|---|---|---|---|---|---|
| Your own health | 65% | 59% | 55% | 45% | 81% |
| The quality of life in your community | 60% | 40% | 47% | 47% | 77% |
| The safety in your community | 53% | 35% | 44% | 42% | 64% |
| Getting the medical care you need | 66% | 46% | 49% | 51% | 85% |
| Getting the mental health or substance use care you need | 39% | 31% | 31% | 34% | 43% |
| Getting help during stressful times | 40% | 33% | 33% | 38% | 51% |

FIGURE 29 PERCENT OF RESPONDENTS WHO LIVE WHERE THEY GET SERVICES AND RESOURCES 50% OR LESS OF THE TIME

**BIPOC**

| Race/Ethnicity Status | Overall number of respondents who live where they get services and resources 50% or less of the time | Percent | % of this demographic that responded |
|---|---|---|---|
| White | 97 | 71% | 25% |
| BIPOC | 30 | 22% | 31% |
| Unknown | 9 | 7% | 20% |
| | 136 | 100% | |

### LGBTQ2IA

FIGURE 30 NUMBER AND PERCENT OF RESPONDENTS WHO LIVE WHERE THEY GET SERVICES AND RESOURCES 50% OR LESS OF THE TIME

| Sexual Orientation | Overall number of respondents who live where they get services and resources 50% or less of the time | Percent | % of this demographic that responded |
|---|---|---|---|
| Non-LGBTQ2IA | 84 | 62% | 24% |
| LGBTQ2IA | 31 | 23% | 33% |
| Unknown | 21 | 15% | 24% |
| | 136 | 100% | |

## Respondents with a Disability

**FIGURE 31**

| Race/Ethnicity Status | Overall number of respondents who live where they get services and resources 50% or less of the time | Percent | % of this demographic that responded |
|---|---|---|---|
| Disabled | 39 | 29% | 28% |
| Not Disabled | 97 | 71% | 25% |
| | 136 | 100% | |

**FIGURE 32 WHAT HAVE BEEN SOME OF THE CHALLENGES FACED IN GETTING THE CARE YOU NEEDED OR WANTED?**

| Percent of Respondents by Group Who Selected The Challenge | All Respondents (n=530) | BIPOC (n=97) | Non LGBTQ2IA Sexual Orientation (n=93) | Respondents with a Disability (n=141) | Older Adults (65+ Years) |
|---|---|---|---|---|---|
| I have not experienced any barriers | 36% | 25% | 23% | 26% | 37% |
| Poor physical access (i.e., handicap accessibility) | 4% | 6% | 10% | 10% | 3% |
| Do not know what services and resources were available | 15% | 28% | 25% | 23% | 6% |
| Language barriers | 4% | 14% | 4% | 5% | 1% |
| Needed evening and/or weekend hours of service | 16% | 23% | 29% | 21% | 7% |
| Needed services not offered in my area | 12% | 12% | 20% | 22% | 5% |
| Not easy to travel to/lacked transportation | 11% | 14% | 18% | 23% | 8% |
| Not eligible for services | 12% | 24% | 20% | 23% | 5% |
| Application forms were too complicated | 6% | 10% | 9% | 9% | 3% |
| Did not feel safe | 6% | 9% | 5% | 7% | 2% |
| Could not find services that understood, valued, and respected my culture | 5% | 14% | 9% | 7% | 2% |
| Could not find providers that looked like me | 0% | 0% | 5% | 6% | 1% |
| No health insurance | 4% | 10% | 4% | 4% | 1% |
| High out-of-pocket costs | 15% | 21% | 28% | 20% | 8% |
| Felt embarrassed about getting services | 5% | 5% | 9% | 10% | 2% |
| Don't know | 2% | 6% | 4% | 1% | 2% |
| I don't know what this question is asking | 0% | 1% | 0% | 1% | 0% |
| I don't want to answer | 1% | 1% | 0% | 1% | 1% |
| In your own words: | 17% | 16% | 20% | 21% | 11% |
| Blanks | 8% | 4% | 2% | 5% | 37% |

## Challenges faced in getting care

Key themes from an analysis of "In your own words", which was an opportunity for survey respondents to write in their own response, indicated challenges faced in getting care, for which illustrative quotes are included:

### COVID-related

- Need to "justify" needing a COVID test
- In-person services were canceled by COVID restrictions
- Was denied access due to covid mandated restrictions. Covid fear porn usurped all access but government approved means
- I need to get a Covid test prior to a medical procedure. The closest location is Providence on NE 42nd (too scary). Next closest is in Tigard (too far).
- Services were delayed due to covid restrictions
- fear of going to any health care center due to covid
- Not able to access because of mask mandates
- Standing in line is very hard on my back, my daughter got me a wheelchair for the Covid shots lines
- Government lock downs were the biggest obstacle with the vaccine mandates
- Should have had much better vaccine clinics right away in our County - had to wait in line in airport in PDX for hours to get vaccinated when vaccines were available. Should have had better access in our county.
- Services not available due to high volume of covid patients - clinics for non-emergency care shut down

### Cost

- Life supporting drug prices are too high. Health care costs are too high
- Again, after paying the premiums for ACA, no money left to actually use the services
- Because I support myself financially I am ineligible for many services. My out-of-pocket costs are very high and a barrier to quality of life. I would be screwed if I lost my job. Finding helpful providers is difficult and travel is often required which is a barrier to getting some treatments
- Shingle shots need to be free to seniors, not $180 each, even with Medicare
- Perdí mi trabajo ya hace más de dos meses y me quede sin aseguranza medica y hace dos semanas tuve que pagar de mi bolsa la consulta y el medicamento muy caro por cierto un botecito de 5ml a 160 dólares. *lost my job more than two months ago and I was left without medical insurance and two weeks ago I had to pay out of pocket for the consultation and the very expensive medicine, by the way, a 5ml bottle at 160 dollars.*

### Cultural and Linguistic Competency

- The language used to access certain things are too complicated which allows people to feel not capable of filling out paperwork not capable of understanding what they're feeling out.
- I have been flat out refused services by more than one medical provider/clinic because I'm HIV+
- Could not get providers that looked like me
- Providers did not understand LGBTQ health and had stigma against my identities
- Sent in circles to find the resources I needed. Online has inaccessible language to English speakers.

- In the past, it's been hard to find medical providers that I have felt trust with. Some of that is based on my identity, and some of it is having trusted medical providers before but then not being taken seriously or getting the care I need. This history makes it hard for me to reach out, and I often wait to reach out until I'm really sure I need help.

### Insurance

- Providers in my area do not take my health insurance plan
- My insurance is through Kaiser - Added Choice, which means that I can use my own PCP. However, Vancouver Clinic and Kaiser do not communicate well for scheduling medical procedures.
- No vision insurance
- I do not experience this now but I lacked health insurance for most of my 20s and I still have long term health conditions that were harmed by this lack. This is one of many reasons poor people in America have a lower life expectancy than the general public.
- Change in insurance resulting in different practices/providers
- I would say that the difficulties we've experienced were in finding services for family members including health insurance and high out-of-pocket costs. I fully support and advocate for Universal Health care.
- Insufficient providers, especially in mental health
- Had to stop seeing my therapist after I changed insurance plan and her out of pocket is $150/apt. It’s hard to know who covers what these days

### Service or doctor needed not available

- Long wait times to see the provider of my choice.
- Provider availability. We must wait a long time for the next available appointment
- Health care overloaded/understaffed
- Hospital accessibility for surgery
- I have had to wait a long time for specialists appointments. Mental-health concerns still seem to have some stigma attached, even among health-care workers
- No in-home services
- Mental health care providers who were not seeing new patients. An extreme backlog of patients needing services, waitlists for appointments. Providers refusing to see children
- Availability of services
- Long wait list for services
- Providers were inaccessible due to over booking and lack of employees
- Access has been seriously impacted. It is impossible/very difficult to get some specialty services. I had to force pediatrics to provide appointments for both my young children on the same day/same hours. They wanted to only see the child where a CCO incentive was being met and not the child who actually needed to be seen for a condition. Other parents who are not as savvy or have the tenacity of myself would have had to come back twice and miss additional work, which means the child that needed to be seen would have been greatly impacted because the likelihood of a busy parent who may not have the resources to return would not have come back for quite some time.
- Doctor office is booked way out, hard to get appointment
- I work odd hours, so I guess hours of operation is a factor for me
- Unless you're an emergency, you usually cannot see someone today
- Health care organizations should not be able to reduce services to telehealth when the patient is asking for in person care with good reason. I had an injury continue a year longer than it

should have because Kaiser would not allow me to access in person physical therapy when remote physical therapy was failing

- PT and OT should always be in-person appointments

### Transportation / Distance

- Better transportation for all and better health care as well that insurance doesn't needing to be one particular health insurance
- When my husband was very sick we had to travel to Vancouver frequently for treatments. We didn't qualify for things such as handicap housing or for assistance getting in home caregiving because we were "over income".
- No bus service in our rural areas
- Heavy traffic especially trying to go to West from the eastside, makes it very difficult
- I have had to drive 3 1/2 hours to go to a specialist in another town because none were available in my city. I have also had to have a consult with a specialist in another state because none were available in my state.
- Long distances to travel for health care - worry about wear on old car
- I get mental health care and am appreciative of it, but the provider is 15 miles away. If I had no car, I would be totally unable to get there
- Health care provider is 35 minutes away, rough to take that much time out of your day when need an appointment

### Other

- I have had negative experiences with medical professionals in the past.
- Everyone should have coverage and easy access. I feel for those that do not, as I have experienced this myself
- Such as kids received 4 month delay in getting needed dental care
- Health system is a very interesting topic to talk about. I have a lot to say but I am grateful for what I receive.
- There are times that I feel some age discrimination in a couple of local doctors offices.
- I have pulled back from some medical services in the Portland City vicinity due to the obvious (transients camping on public walkways, feces, usual panhandling related issues, lack of faith in police support if something should arise.
- In this last year, people, even in institutions have felt that they have permission to be blatantly disrespectful and negate services (like emergency transportation) because of race, gender
- All I wanted was to be able to choose between a few female PCPs in Kaiser at Sunnyside. In the search results I got loads of specialists including pediatricians but not just general practitioners at Sunnyside. It took me a few months of checking intermittently ("Find a Doctor" on the KP app) before I selected someone; then a few weeks later when I was ready to book I had to end up going to North Portland to see her
- My doctor chooses not to be all she can be so that's on her.
- Too busy with more pressing needs

**FIGURE 33 I HAVE AVOIDED OR DELAYED HEALTH CARE BECAUSE I WAS WORRIED THAT MY CONCERNS WOULD NOT BE TAKEN SERIOUSLY, OR I WOULD NOT BE TREATED FAIRLY DUE TO MY:**

| | All Respondents (n=141) | BIPOC (n=42) | LGBTQ2I (n=46) | Respondents with a Disability (n=68) | Older Adults (n=21) |
|---|---|---|---|---|---|
| Age | 30% | 26% | 33% | 44% | 43% |
| In your own words: | 30% | 19% | 33% | 28% | 57% |
| Specific health condition (i.e., HIV/AIDS or excess weight, etc.) | 29% | 24% | 26% | 34% | 14% |
| Disability (physical, mental, behavioral) | 26% | 19% | 48% | 43% | 10% |
| Insurance status | 23% | 29% | 28% | 19% | 19% |
| Gender identity | 18% | 12% | 28% | 24% | 0% |
| Income | 17% | 19% | 22% | 24%* | 14% |
| Race (discrimination based on physical characteristics or qualities attributed to one's race, including Black, American Indian, Pacific Islander, Asian, etc.) | 16% | 40% | 4% | 15% | 0% |
| Ethnicity (discrimination based on cultural identity of a person, including culture, religion, nationality, ancestry, dress, and customs such as Hispanic, Latino/a, Spanish) | 14% | 36% | 7% | 13% | 0% |
| Substance use | 11% | 10% | 15% | 10% | 0% |
| Sexual orientation | 11% | 10% | 28% | 19% | 5% |
| Religion or Spiritual beliefs | 9% | 10% | 11% | 9% | 0% |
| Preferred language (i.e., I'm worried the doctor won't understand me) | 6% | 14% | 4% | 7% | 10% |
| Immigration status | 4% | 10% | 0% | 4% | 5% |
| Don't know | 4% | 2% | 2% | 1% | 0% |
| I don't know what this question is asking | 1% | 0% | 0% | 0% | 0% |
| I don't want to answer | 1% | 0% | 4% | 0% | 0% |

**FIGURE 34 IN YOUR OPINION, WHAT ARE THE THREE MOST IMPORTANT HEALTH DISEASES AND CONDITIONS IN YOUR COMMUNITY?**

| | All Respondents (n=530) | BIPOC (n=97) | LGBTQ2I (n=93) | Respondents with a Disability (n=141) | Older Adults (n=149) |
|---|---|---|---|---|---|
| Mental health (i.e., stress, anxiety, depression, grieving, etc.) | 71% | 70% | 78% | 72% | 57% |
| Chronic disease (i.e., diabetes, heart disease and stroke, high blood pressure) | 60% | 69% | 53% | 59% | 63% |
| Vaccine preventable diseases (i.e., COVID-19, measles, influenza, mumps, pertussis, etc.) | 41% | 33% | 42% | 48% | 52% |
| Substance use (i.e., alcohol, marijuana, heroin, cocaine, etc.) | 38% | 28% | 39% | 35% | 38% |
| Dental/oral health | 24% | 32% | 30% | 30% | 19% |
| Cancer | 19% | 31% | 14% | 14% | 21% |

|  | All Respondents (n=530) | BIPOC (n=97) | LGBTQ2I (n=93) | Respondents with a Disability (n=141) | Older Adults (n=149) |
|---|---|---|---|---|---|
| In your own words | 10% | 10% | 14% | 16% | 13% |
| Unintentional injuries (i.e., motor vehicle accidents, drowning) | 7% | 10% | 6% | 9% | 6% |
| Rape/sexual assault/sex trafficking | 5% | 5% | 12% | 6% | 2% |
| Sexually Transmitted Infections (STIs), HIV/AIDS, and other infectious diseases | 4% | 13% | 9% | 4% | 1% |
| Don't know | 4% | 3% | 3% | 4% | 8% |
| Blanks | 4% | 1% | 1% | 0% | 0% |
| Respiratory/lung disease (i.e., asthma) | 4% | 9% | 3% | 2% | 3% |
| I don't know what this question is asking | 0% | 0% | 0% | 0% | 0% |
| I don't want to answer | 0% | 0% | 0% | 0% | 0% |

Key themes from an analysis of “in your own words” responses, which were opportunities for respondents to write in their own response, concerned the following health issues or topics, for which illustrative quotes are include:

### Mental health and substance use:

- Walking through pdx - we need better support for substance use. where are the safe consumption sites? where are the street outreach workers? where are the crisis response teams?
- The mental health needs of people living in Oregon are not being adequately addressed. People living on the street need more medical services.

### Violence and Injury

- Workplace injuries that are ‘chronic’.
- Brain Injury, #1 disability in our country.
- Domestic Violence.
- Rape/sexual assault/sex trafficking are also important, but I figure they actually fall under the mental health category.
- I would add that BIPOC people are being killed by police here and this is not properly known and addressed.
- Gun violence
- Public violence and lack of law enforcement

### Social Determinants of Health

- Many people do not have access to social determinants of health such as affordable housing, jobs, parks, and transportation.
- Social determinants of good health and education.
- Lack of housing, poverty.

### General public health:

- Living here is chaotic and deserves better humane, public health response to the issues plaguing our homeless, neighborhoods, and downtown.
- Help people take care of themselves so they stay healthy instead of spending more money and time after they become unhealthy

### Access to care

- There are not enough treatment facilities. There are virtually no treatment facilities that address mental health and addiction together - for youth - there are also no treatment facilities for male youth with eating disorders.
- I use my own money to get the alternative care I need.

### Chronic diseases and risk behaviors

- Diabetes
- Obesity.
- People with the same or similar chronic illness have poor quality of life, inability to access knowledgeable doctors, and thus often have stress/anxiety and depression.
- Being 71 little injuries (knees and hand pain) that may be chronic and slows down my active lifestyle.
- Rare, genetic, abnormally presenting and complex conditions needing to be treated by a care team of doctors. Treat the pain/comorbidities FIRST and the mental health will improve. Take it from a patient in over 70 support groups.
- Connective tissue disorders and how they are comorbid with often poorly understood and often stigmatized disorders such as: ME/CFS, migraine, autoimmune disease, spinal instability where there are only specialists on the east coast that have expertise in spinal instability as related to connective tissue disease, anaphylaxis from mast cell disease, even parents of kids with connective tissue disorders who are accused of child abuse. Critically ill patients with mobility issues are not able to access appropriate wheelchairs.

### Environmental Quality

- Air quality in parts of Hillsboro could be better, sometimes the sewage treatment plants stink, they say to report it when it occurs, but still they do nothing.
- Chronic genetic diseases are the biggest and chronic disease due to environmental toxin exposure.

### Dental Care

- People can't afford dental care. Everyone I know is constantly in a state of extreme emotional stress. Many people I know have issues with overuse of alcohol/other drugs due to mental health and stress of poverty.
- Dental care is exceptionally expensive even with insurance. Not universally available despite lots of providers.
- I'm on Medicare and must finance my own dental care.
- My Medicare supplement does not adequately cover dental care. COVID-19 is a horror story and not being adequately addressed. I do not need mental health care but many others do and can't find it.

### Other Comments:

- En mi cultura lo consideran tabú. No es fácil hablar de estos temas. *In my culture they consider it taboo. It is not easy to talk about these issues.*
- Marijuana is not a substance in the ways that others are listed. Please stop incorporating this medicine in this description. It is a form of coopting patriarchal approaches to research, benefits and more. And who is doing the research, for how long and what are the measured outcomes and what do the measurement questions include?

**FIGURE 35 PERCENT OF RESPONDENTS BY INSURANCE TYPE WHO ARE VERY SATISFIED OR SATISFIED WITH HEALTH CARE RECEIVED AND HEALTH, BY INSURANCE STATUS**

| Percent of respondents by insurance type who are very satisfied or satisfied with… | Private Insurance (n=296) | Public Insurance (n=160) | No Insurance (n=12) |
|---|---|---|---|
| Your own health | 70% | 70% | 33% |
| Getting the medical care you need | 71% | 71% | 17% |
| Getting the mental health or substance care you need | 45% | 38% | 25% |

# Appendix H: Health Priority Area Supporting Data

## A Neighborhood for All

**FIGURE 36 PEOPLE EXPERIENCING HOMELESSNESS OR HOUSELESSNESS**

| | Washington State | Oregon State | Region | Clackamas | Clark | Washington | Multnomah |
|---|---|---|---|---|---|---|---|
| Rate per 10,000 people | 30.1 | 35.0 | 22.2 | 8.4 | 18.8 | 10.3 | 51.3 |
| # on One Night | 22,923 | 14,476 | 6,059 | 352 | 916 | 618 | 4,173 |

Source: State of Homelessness Report, January 2020.

### Housing Cost Burden

**FIGURE 37 PERCENT OF HOUSEHOLDS PAYING 35% OR MORE OF THEIR HOUSEHOLD**

| | Region | Clackamas | Clark | Multnomah | Washington |
|---|---|---|---|---|---|

| | | | | | |
|---|---|---|---|---|---|
| 2010-2014 | 38.6 | 37.2 | 36.2 | 41.9 | 36.6 |
| 2011-2015 | 37.3 | 35.6 | 34.7 | 40.9 | 35.2 |
| 2012-2016 | 35.9 | 33.7 | 33.3 | 39.5 | 33.9 |
| 2013-2017 | 35.1 | 32.6 | 31.9 | 39.2 | 33.0 |
| 2014-2018 | 34.2 | 31.8 | 31.1 | 38.2 | 32.4 |
| 2015-2019 | 33.4* | 31.6* | 30.9* | 36.8* | 31.6* |

*Statistically different compared to 2010-2014. Source: American Community Survey, Table B25070.

**Figure 38 Households spending more than 50% of income on rent are considered severely rent-burdened. Rent costs do not include utilities, insurance, or building fees.**

| | Region | Clackamas | Clark | Multnomah | Washington |
|---|---|---|---|---|---|
| 2010-2014 | 24.6 | 23.0 | 21.7 | 28.0 | 23.2 |
| 2011-2015 | 24.4 | 22.4 | 21.3 | 23.6 | 27.6 |
| 2012-2016 | 24.1 | 22.4 | 21.0 | 22.8 | 27.3 |
| 2013-2017 | 24.1 | 22.2 | 21.0 | 22.5 | 27.6 |
| 2014-2018 | 23.7 | 23.1 | 20.9 | 22.4 | 26.4 |
| 2015-2019 | 23.4* | 25.3 | 20.9 | 21.1* | 25.3 |

*Statistically different compared to 2010-2014. Source: American Community Survey, Table B25070.

**Figure 39 Percent of Households Paying more than 50% of income on housing are considered severely housing cost-burdened.**

| | Region | Clackamas | Clark | Multnomah | Washington |
|---|---|---|---|---|---|
| 2010-2014 | 16.9 | 15.8 | 14.3 | 19.6 | 15.5 |
| 2011-2015 | 16.4 | 15.0 | 13.8 | 19.3 | 15.2 |
| 2012-2016 | 15.8 | 14.1 | 13.2 | 18.7 | 14.5 |
| 2013-2017 | 15.5 | 13.8 | 12.8 | 18.7 | 14.2 |
| 2014-2018 | 15.1 | 13.7 | 12.5 | 18.0 | 13.9 |
| 2015-2019 | 14.6* | 14.1* | 12.2* | 17.0* | 13.4* |

*Statistically different compared to 2010-2014. Source: American Community Survey, Table B25070.

**Figure 40 Median household income, Income in the past 12 months, in inflation-adjusted 2017 dollars.**

| | Region | Clackamas | Clark | Multnomah | Washington |
|---|---|---|---|---|---|
| 2010-2014 | $ 67,916 | $ 73,754 | $ 67,884 | $ 60,240 | $ 74,406 |
| 2011-2015 | $ 69,318 | $ 75,103 | $ 69,172 | $ 61,596 | $ 76,001 |

| | | | | | |
|---|---|---|---|---|---|
| 2012-2016 | $ 71,937 | $ 77,686 | $ 70,882 | $ 64,761 | $ 78,620 |
| 2013-2017 | $ 74,993 | $ 80,312 | $ 75,237 | $ 66,959 | $ 82,115 |
| 2014-2018 | $ 77,187 | $ 82,587 | $ 77,238 | $ 69,369 | $ 84,111 |
| 2015-2019 | $ 80,467* | $ 85,371* | $ 79,822* | $ 73,376* | $ 87,207* |

*Statistically different compared to 2010-2014. Source: American Community Survey, Table B19013.

**FIGURE 41 MEDIAN HOUSEHOLD INCOME BY RACE AND ETHNICITY, INCOME IN THE PAST 12 MONTHS, IN INFLATION-ADJUSTED 2017 DOLLARS.**

| | Full population | Non-Hispanic White | Non-Hispanic Black | Asian or Pacific Islander | Hispanic or Latino |
|---|---|---|---|---|---|
| 2010-2014 | $ 67,916 | $ 71,157 | $ 51,690 | $ 77,852 | $46,987 |
| 2011-2015 | $ 69,318 | $ 72,919 | $ 49,797 | $ 78,689 | $ 48,624 |
| 2012-2016 | $ 71,937 | $ 75,499 | $ 49,144 | $ 82,477 | $ 51,607 |
| 2013-2017 | $ 74,993 | $ 78,536 | $ 54,324 | $ 88,603 | $ 54,446 |
| 2014-2018 | $ 77,187 | $ 80,703 | $ 51,304 | $ 90,620 | $ 58,134 |
| 2015-2019 | $ 80,467* | $ 83,918* | $ 52,171 | $ 92,038* | $ 61,526* |

*Statistically different compared to 2010-2014. NOTE: As reported by National Low Income Housing Coalition (Out of Reach 2020), fair market rent for two bedroom (HUD, 2020) is $1,1441 per month. Annual income needed to afford a two bedroom at fair market rent (2020) was $63,024. Source: American Community Survey, Table S1903.

### Violent Crime

**FIGURE 42 VIOLENT CRIME RATE PER 100,000**

| | Region | Clackamas | Clark | Multnomah | Washington |
|---|---|---|---|---|---|
| 2010-2014 | 263.6 | 86.4 | 212.5 | 472.0 | 147.8 |
| 2011-2015 | 232.8 | 68.6 | 216.9 | 407.0 | 125.0 |
| 2012-2016 | 241.5 | 81.4 | 222.3 | 414.1 | 135.5 |
| 2013-2017 | 249.4 | 96.0 | 228.4 | 420.1 | 142.7 |
| 2014-2018 | 265.0 | 117.9 | 241.2 | 432.7 | 160.6 |
| 2015-2019 | 282.0 | 145.6 | 255.4 | 450.4 | 171.1 |
| 2016-2020 | 326.9 | 179.6 | 265.8 | 529.1 | 206.7 |

Source: FBI Crime Data Explorer

## Essential Resources and Services

### Economic Opportunity

**FIGURE 43 PERCENT OF RESIDENTS IN FAMILIES THAT ARE IN POVERTY (BELOW THE FEDERAL POVERTY LEVEL).**

| | Region | Multnomah | Washington | Clark | Clackamas |
|---|---|---|---|---|---|

| | | | | | |
|---|---|---|---|---|---|
| 2010-2014 | 9.6 | 9.8 | 8.8 | 10.1 | 9.6 |
| 2011-2015 | 13.5 | 18.1 | 11.8 | 11.2 | 9.5 |
| 2012-2016 | 12.7 | 17.1 | 11.1 | 10.2 | 9.2 |
| 2013-2017 | 12.2 | 16.4 | 10.3 | 10.3 | 9.0 |
| 2014-2018 | 11.3 | 15.1 | 9.6 | 9.3 | 8.5 |
| 2015-2019 | 10.5* | 13.8* | 8.9* | 9.3* | 8.0* |

*Statistically different compared to 2010-2014. Source: American Community Survey (Table B17001).

**FIGURE 44 DEEP POVERTY: INDIVIDUALS IN FAMILIES WHOSE INCOME IS LESS THAN HALF OF THE FEDERAL POVERTY LEVEL, IN PAST 12 MONTHS INCOME.**

| | Region | Multnomah | Washington | Clark | Clackamas |
|---|---|---|---|---|---|
| 2010-2014 | 6.1 | 8.5 | 4.9 | 4.9 | 4.3 |
| 2011-2015 | 5.9 | 8.3 | 4.8 | 4.6 | 4.4 |
| 2012-2016 | 5.7 | 8.1 | 4.6 | 4.3 | 4.1 |
| 2013-2017 | 5.4 | 7.7 | 4.2 | 4.6 | 3.8 |
| 2014-2018 | 5.1 | 7.0 | 4.0 | 4.2 | 3.8 |
| 2015-2019 | 4.8* | 6.3* | 4.0* | 4.2 | 3.6 |

*Statistically different compared to 2010-2014. Source: American Community Survey (Table C17002).

**FIGURE 45 PERCENT OF RESIDENTS IN FAMILIES THAT ARE IN POVERTY (BELOW THE FEDERAL POVERTY LEVEL), BY AGE GROUP**

| | Full population | Infants (0-4 years) | Juveniles (5-17 years) | Young Adults (18-39 years) | Middle-Aged Adults (40-64 years) | Seniors (65 and older) |
|---|---|---|---|---|---|---|
| 2010-2014 | 13.8 | 19.3 | 17.9 | 15.5 | 10.1 | 8.3 |
| 2011-2015 | 13.5 | 18.2 | 17.3 | 15.3 | 10.1 | 8.0 |
| 2012-2016 | 12.7 | 17.3 | 16.1 | 14.3 | 9.5 | 7.8 |
| 2013-2017 | 12.2 | 16.2 | 15.4 | 13.7 | 9.1 | 8.3 |
| 2014-2018 | 11.3 | 14.8 | 14.0 | 12.5 | 8.8 | 8.1 |
| 2015-2019 | 10.5* | 13.3* | 13.1* | 11.5* | 8.3* | 7.8 |

*Significantly different compared to 2010-2014. Source: American Community Survey (Table C17002).

**FIGURE 46 PERCENT OF CURRENTLY EMPLOYED RESIDENTS 16 AND OVER WHO ARE IN POVERTY.**

| | Region | Clackamas | Clark | Multnomah | Washington |
|---|---|---|---|---|---|
| 2010-2014 | 7.2 | 4.8 | 5.3 | 9.8 | 6.7 |
| 2011-2015 | 7.2 | 4.8 | 5.2 | 9.8 | 6.8 |
| 2012-2016 | 6.7 | 5.0 | 4.8 | 9.0 | 6.3 |

| | | | | | |
|---|---|---|---|---|---|
| 2013-2017 | 6.4 | 4.8 | 4.8 | 8.6 | 5.8 |
| 2014-2018 | 5.8 | 4.3 | 4.3 | 7.8 | 5.5 |
| 2015-2019 | 5.3* | 4.0* | 4.1* | 7.1* | 4.9* |

Source: American Community Survey (Table B17005)

**FIGURE 47 ECONOMIC CHARACTERISTICS AMONG PEOPLE WITH A DISABILITY, 2015-2019**

| | Region | Clackamas | Clark | Multnomah | Washington |
|---|---|---|---|---|---|
| Total Population Age 16 Over | 1,826,437 | 330,486 | 369,305 | 662,120 | 464,526 |
| Total Population with a Disability | 248,046 | 45,563 | 54,010 | 94,497 | 53,976 |
| % Population with a Disability | 13.6% | 13.8% | 14.6% | 14.3% | 11.6% |
| % Population Employed | 64.1% | 62.0% | 61.5% | 66.5% | 66.5% |
| % Population with Disability and Employed | 27.5% | 26.3% | 26.4% | 28.1% | 29.0% |
| % Total Population and Less than High School Graduate | 7.6% | 6.6% | 7.3% | 8.5% | 7.8% |
| % Population with Disability and Less than High School Graduate | 13.1% | 12.5% | 11.8% | 16.2% | 11.7% |
| Median Earnings in past month among Total Population | $40,126.50 | $41,647.00 | $40,093.00 | $37,658.00 | $41,108.00 |
| Median Earnings in past month among Population with a Disability | $27,595.50 | $29,771.00 | $30,036.00 | $23,235.00 | $27,340.00 |
| % Total Population At or above 150% of Poverty Level | 84.6% | 87.5% | 85.1% | 79.6% | 86.1% |
| % Total Population with Disability At or above 150% of Poverty Level | 72.3% | 75.9% | 73.7% | 63.2% | 76.2% |

Note: Regional estimates are unweighted averages. Source: American Community Survey (Table S1811)

**FIGURE 48 UNEMPLOYMENT RATE BY RACE AND ETHNICITY AND DISABILITY STATUS, 2015-2019**

| | Region | Clackamas | Clark | Washington | Multnomah |
|---|---|---|---|---|---|
| With any disability (of any race/ethnicity) | 10.8 | 10.0 | 11.1 | 11.3 | 10.9 |
| White alone | 4.3 | 4.5 | 4.2 | 4.2 | 4.4 |
| Some other race alone | 6.4 | 6.3 | 5.8 | 8.2 | 5.3 |
| Multiracial | 7.4 | 6.5 | 6.9 | 8.3 | 8.0 |
| Native Hawaiian/Other Pacific Islander alone | 4.6 | 6.7 | 1.4 | 6.4 | 3.7 |

| | | | | | |
|---|---|---|---|---|---|
| Hispanic or Latino origin (of any race) | 5.3 | 5.7 | 4.2 | 6.2 | 5.2 |
| Black/African American alone | 8.6 | 9.4 | 5.2 | 9.1 | 10.6 |
| Asian alone | 4.3 | 5.4 | 3.7 | 3.4 | 4.5 |
| American Indian/Alaska Native alone | 8.1 | 8.0 | 7.9 | 6.0 | 10.5 |
| Total Population Age 16 and over | 4.7 | 4.8 | 4.4 | 4.5 | 4.9 |

Note: Regional estimates are unweighted averages. Source: American Community Survey (Table S2301)

## Education Opportunity

**FIGURE 49 RESIDENTS 25 OR OLDER WITH AT LEAST A HIGH SCHOOL DEGREE: INCLUDING GED AND ANY HIGHER EDUCATION**

| | Region | Clackamas | Clark | Washington | Multnomah |
|---|---|---|---|---|---|
| 2010-2014 | 90.9 | 92.8 | 91.2 | 90.6 | 90.0 |
| 2011-2015 | 91.1 | 93.1 | 91.4 | 90.7 | 90.3 |
| 2012-2016 | 91.4 | 93.3 | 91.7 | 90.8 | 90.7 |
| 2013-2017 | 91.7 | 93.2 | 92.0 | 91.3 | 91.0 |
| 2014-2018 | 91.9 | 93.3 | 92.3 | 91.6 | 91.3 |
| 2015-2019 | 92.2* | 93.4 | 92.7 | 92.2 | 91.5 |

*Significantly different compared to 2010-2014. Source: American Community Survey (Table B15002)

**FIGURE 50 RESIDENTS 25 OR OLDER WITH AT LEAST A HIGH SCHOOL DEGREE: INCLUDING GED AND ANY HIGHER EDUCATION, BY RACE AND ETHNICITY**

| | Full population | Non-Hispanic White | Non-Hispanic Black | Asian or Pacific Islander | Hispanic or Latino |
|---|---|---|---|---|---|
| 2010-2014 | 90.9 | 94.5 | 88.4 | 84.6 | 63.9 |
| 2011-2015 | 91.1 | 94.6 | 89.1 | 84.9 | 65.5 |
| 2012-2016 | 91.4 | 94.9 | 89.3 | 85.0 | 66.4 |
| 2013-2017 | 91.7 | 95.0 | 89.7 | 86.1 | 68.2 |
| 2014-2018 | 91.9 | 95.3 | 89.4 | 86.6 | 69.2 |
| 2015-2019 | 92.2* | 95.6* | 89.3 | 86.5 | 69.9 |

*Significantly different compared to 2010-2014. Source: American Community Survey (Table B15002).

**FIGURE 51 PERCENTAGE OF 3- AND 4-YEAR-OLDS ENROLLED IN SCHOOL**

| | Region | Clackamas | Clark | Washington | Multnomah |
|---|---|---|---|---|---|
| 2010-2014 | 45.5 | 44.9 | 39.1 | 45.7 | 49.5 |
| 2011-2015 | 47.1 | 47.7 | 39.1 | 48.0 | 50.7 |
| 2012-2016 | 47.4 | 48.1 | 37.8 | 47.5 | 52.5 |

| | | | | | |
|---|---|---|---|---|---|
| 2013-2017 | 47.9 | 48.2 | 38.5 | 47.6 | 53.4 |
| 2014-2018 | 48.5 | 48.0 | 39.8 | 47.1 | 55.0 |
| 2015-2019 | 49.4* | 49.0 | 39.2 | 48.4 | 56.4* |

*Significantly different compared to 2010-2014. Source: American Community Survey (Table C17002).

## Access to Culturally Specific and Healthy Foods

**FIGURE 52 ADDITIONAL MONEY THAT WOULD BE NEEDED FOR RESIDENTS THAT ARE FOOD-INSECURE TO BUY ENOUGH FOOD FOR THEIR HOUSEHOLD.**

| | Annual food budget shortfall |
|---|---|
| Region | $ 140,638,164.29 |
| Clackamas | $ 22,305,789.04 |
| Multnomah | $ 59,185,810.87 |
| Washington | $ 30,296,159.90 |
| Clark | $ 28,850,404.49 |

Note: Calculated using the weekly food budget shortfall of people reporting food insecurity, weighted by the time spent food-insecure. This number can be interpreted as the amount of food benefits that would be needed to ensure nobody goes to bed hungry.
Source: Feeding America (Map the Meal Gap 2020)

**FIGURE 53 PERCENT RESIDENTS WHO HAVE LOW TO VERY LOW FOOD ACCESS**

| | Very low food access | Low food access |
|---|---|---|
| Region | 14.1 | 35.0 |
| Clackamas | 17.6 | 34.4 |
| Multnomah | 7.5 | 33.8 |
| Washington | 14.2 | 40.1 |
| Clark | 22.0 | 31.4 |

Note: Percent of residents who have low access to food, defined solely by distance: further than 1/2 mile (low) or 1 mile (very low) from the nearest supermarket in an urban area, or further than 10 miles in a rural area. Source: USDA (Food Access Research Atlas).

## Access to Virtual Resources

**FIGURE 54 NUMBER AND PERCENT OF HOUSEHOLDS WITH NO ACCESS TO THE INTERNET THROUGH SUBSCRIPTION BROADBAND, DIAL-UP, SATELLITE, CELLULAR DATA, OR ANY OTHER SERVICE**

| Year | Region | Clackamas | Clark | Washington | Multnomah |
|---|---|---|---|---|---|
| 2013-2017 | 10.4% | 10.7% | 9.8% | 8.4% | 12.0% |
| 2014-2018 | 9.0% | 9.2% | 8.4% | 7.0% | 10.6% |
| 2015-2019 | 7.8% | 8.6%* | 7.2% | 6.0%* | 9.2%* |
| Total Households (2015-2019) | 902,937 | 161,295 | 180,862 | 222,877 | 337,903 |

| | | | | | |
|---|---|---|---|---|---|
| % of Households (2015-2019) | 70,429 | 13,871 | 13,022 | 13,373 | 31,087 |

*Significantly different compared to the region. Note: Regional estimates are unweighted averages. Source: American Community Survey (Table B28002).

# Access to Culturally and Linguistically Responsive health Care

## Affordable Health Care For All

**FIGURE 55 PERCENT OF RESIDENTS WITHOUT HEALTH INSURANCE**

| | Region | Washington | Multnomah | Clackamas | Clark |
|---|---|---|---|---|---|
| 2010-2014 | 13.1 | 13.0 | 14.6 | 11.1 | 12.4 |
| 2011-2015 | 11.3 | 11.3 | 12.4 | 9.6 | 11.0 |
| 2012-2016 | 9.5 | 9.5 | 10.4 | 8.1 | 9.3 |
| 2013-2017 | 8.1 | 8.1 | 8.9 | 6.8 | 7.7 |
| 2014-2018 | 6.6 | 6.8 | 7.1 | 5.6 | 6.3 |
| 2015-2019 | 6.0* | 5.9* | 6.7* | 5.3* | 5.8* |

*Significantly different compared to 2010-2014. American Community Survey, Tables B27001/C27001.

**FIGURE 56 PERCENT OF RESIDENTS WITHOUT HEALTH INSURANCE BY AGE, 2015-2019**

| | Region | Clackamas | Clark | Washington | Multnomah |
|---|---|---|---|---|---|
| Full population | 6.0 | 5.3* | 5.8 | 5.9 | 6.7* |
| Infants (0-4 years) | 2.5* | 2.9 | 2.3 | 3.3 | 2.0 |
| Juveniles (5-17 years) | 3.0* | 3.2 | 2.7 | 3.1 | 3.0 |
| Young Adults (18-39 years) | 10.0* | 9.0* | 10.8 | 9.3 | 10.5 |
| Middle-Aged Adults (40-64 years) | 6.0 | 5.8 | 5.5 | 6.2 | 6.3 |
| Seniors (65 and older) | 0.8* | 0.6 | 0.7 | 0.6 | 1.0 |

*Significantly different from the region for that age group. Source: American Community Survey, Tables B27001/C27001.

**FIGURE 57 PERCENT OF RESIDENTS WITHOUT HEALTH INSURANCE BY SEX, 2015-2019**

| Sex | Region | Clackamas | Multnomah | Washington | Clark |
|---|---|---|---|---|---|
| Full population | 6.0 | 5.3 | 6.7 | 5.9 | 5.8 |
| Females | 5.3* | 4.5 | 5.8 | 5.2 | 5.2 |
| Males | 6.8* | 6.2 | 7.5 | 6.6 | 6.4 |

*Significantly different from the region for that age group. Source: American Community Survey, Tables B27001/C27001.

FIGURE 58 ACCESS TO PREVENTATIVE CARE

| | Visited doctor for routine checkup (2019)[1] | Visited dentist (2018)[2] | Taking medicine for high blood pressure control among adults aged >=18 years with high blood pressure (2019) | Cholesterol screening among adults aged >=18 years (2019) |
|---|---|---|---|---|
| Region (unweighted average) | 69.6 | 68.8 | 50.3 | 85.5 |
| Clackamas | 69.1 | 70.1 | 49.1 | 86.0 |
| Multnomah | 71.9* | 67.5 | 49.1 | 86.6 |
| Washington | 71.0 | 66.5 | 51.8 | 87.8 |
| Clark | 66.3* | 71.6 | 51.3 | 81.7* |

*Significantly different compared to the region 1. Percent of resident adults aged 18 and older who report having been to a doctor for a routine checkup (e.g., a general physical exam, not an exam for a specific injury, illness, condition) in the previous year (Age-adjusted prevalence). 2. Percent of resident adults aged 18 and older who report having been to the dentist or dental clinic in the previous year (Age-adjusted prevalence). Source: PLACES, Behavioral Risk Factor Surveillance System (BRFSS).

FIGURE 59 ACCESS TO PREVENTATIVE CARE (CONTINUED)

| | Mammography use among women aged 50–74 years (2018) | Cervical cancer screening among adult women aged 21-65 years (2018) | Older adult men aged >=65 years who are up to date on a core set of clinical preventive services: Flu shot past year, PPV shot ever, Colorectal cancer screening (2018) | Older adult women aged >=65 years who are up to date on a core set of clinical preventive services: Flu shot past year, PPV shot ever, Colorectal cancer screening, and Mammogram past 2 years (2018) |
|---|---|---|---|---|
| Region (unweighted average) | 74.0 | 86.3 | 23.6 | 26.2 |
| Clackamas | 72.7 | 87.7 | 23.0 | 23.6 |
| Multnomah | 75.5 | 86.4 | 23.3 | 26.3 |
| Washington | 78.6 | 85.3 | 22.0 | 27.9 |
| Clark | 69.1 | 85.7 | 25.9 | 27.0 |

Source: PLACES, Behavioral Risk Factor Surveillance System (BRFSS).

## Support Family And Community Ways

### Social support and connection

**FIGURE 60 DISCONNECTED YOUTH: PERCENT OF RESIDENTS AGES 16-19 YEARS WHO ARE NEITHER WORKING NOR ENROLLED IN SCHOOL, 2015-2019**

| | Region | Clackamas | Clark | Multnomah | Washington |
|---|---|---|---|---|---|
| 2010-2014 | 8.8 | 8.1 | 9.5 | 9.5 | 7.9 |
| 2011-2015 | 7.9 | 8.0 | 7.6 | 8.8 | 6.8 |
| 2012-2016 | 7.1 | 6.9 | 7.1 | 7.9 | 6.3 |
| 2013-2017 | 6.4 | 6.5 | 6.2 | 7.1 | 5.4 |
| 2014-2018 | 6.2 | 6.3 | 6.5 | 6.4 | 5.6 |
| 2015-2019 | 6.0* | 6.1* | 6.7 | 6.0* | 5.1* |

*Significantly different compared to 2010-2014. Source: American Community Survey (Table B14005

**FIGURE 61 SENIORS LIVING ALONE: PERCENT OF RESIDENTS AGE 65 AND OLDER WHO LIVE ALONE.**

| | Region | Clackamas | Multnomah | Washington | Clark |
|---|---|---|---|---|---|
| 2010-2014 | 28.4 | 25.0 | 31.6 | 28.8 | 25.5 |
| 2011-2015 | 27.9 | 24.7 | 31.7 | 27.4 | 25.2 |
| 2012-2016 | 27.6 | 24.5 | 31.5 | 27.1 | 24.4 |
| 2013-2017 | 27.6 | 24.5 | 31.4 | 26.7 | 24.8 |
| 2014-2018 | 27.7 | 24.6 | 31.8 | 26.6 | 25.1 |
| 2015-2019 | 27.4 | 25.0 | 31.1 | 26.5* | 24.4 |

Note: Does not include those living in group homes such as nursing homes. *Significantly different compared to 2010-2014. Source: American Community Survey (Table B09020)

# Appendix I: Health Behaviors and Outcomes Supporting Data

Visit https://docs.google.com/spreadsheets/d/1ziGYOfw3eNoReJieqN9pnXpg3O02pmQI/edit?usp=sharing&ouid=115656647515966616299&rtpof=true&sd=true

# Appendix J: CHNA Data Limitations

Qualitative data is ideal for capturing rich descriptions of lived experiences. Despite efforts to speak to a broad range of community members, limitations to the qualitative data remain:

- Community-based organizations (CBOs) helped to recruit community members for focus groups. Communication materials, including electronic and paper flyers, social media posts, and newsletters were used to recruit participants. CBOs leverage their existing networks and communication channels. This strategy is necessary for contacting community members and for securing spaces where participants feel safe. However, it inherently excludes disconnected individuals (i.e., those not engaged in services).
- CBOs limited capacity and the ability to prioritize these sessions given the additional services and supports they are offering due to the needs exacerbated by COVID-19 and Oregon's wildfires.
- Many of the CE sessions were conducted via Zoom in a virtual setting. The virtual sessions required technology to work and for participants to have access to and to be comfortable with that technology.

**Limits to the quantitative data included a lack of sufficiently granular data**. Many of the health indicators and outcomes do not allow for analysis by subgroup such as race, ethnicity, or county. For some indicators, the data collection process does not encompass these and other subgroups. For example, it is difficult to capture health information about migrant workers or incarcerated populations. Without this individual and community representation in the data, the ability to understand the nuances of the health issues and socioeconomic factors is challenged. One example of this is the 2020 Census. The 2020 Census was an important opportunity to achieve a fair and equitable count so that all community members are represented in population data. This is vital because:

- It determines how resources are allocated.
- It informs representation in government.

Each county in the region was above the national census return rate (the number of people who return a completed census survey). This means the rate at which people responded to the census in each county in the region was higher than the rate of return in United States.[23] However, this was not true for all populations within each county.  Figures 1 and 2

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[23] A county's census self-response rate is one of 84 metrics used to assess community health and well-being in the 2020 Healthiest Communities rankings. The metrics fall into 10 broad health and health-related categories,

below reveal that this is true for the region too. **Figure 1 shows the percent of communities within the region by the percent of the population who are BIPOC and census return rates.**

**FIGURE 62**

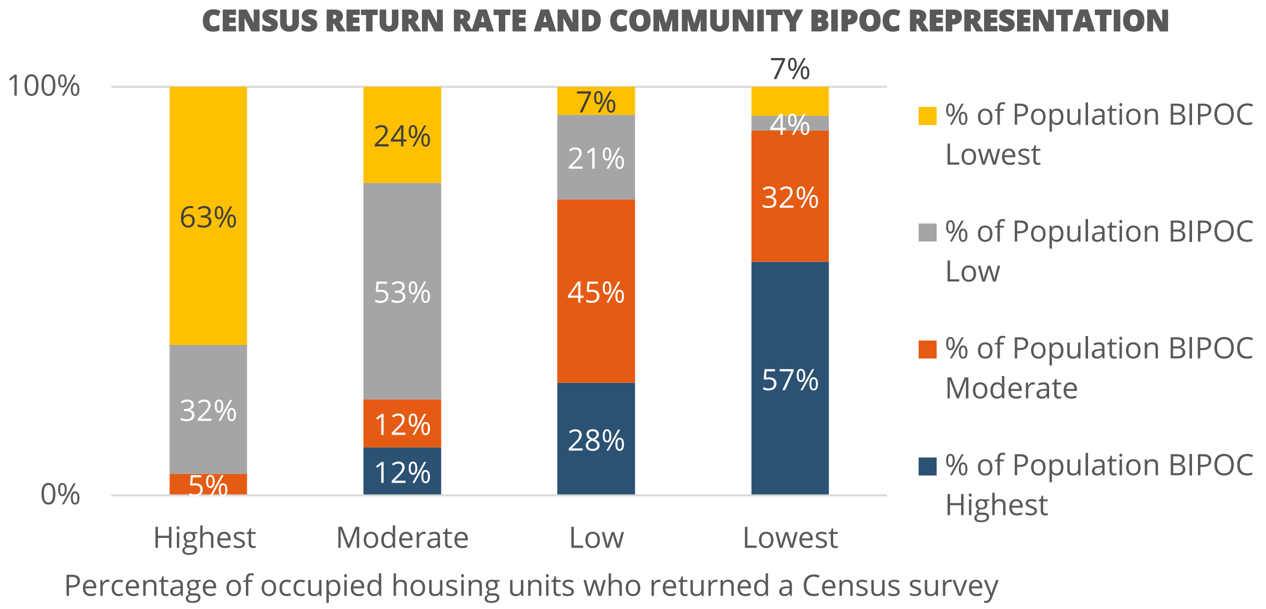

Figure 63 provides a geographic illustration. Dark blue areas in the map reflect areas with higher BIPOC populations. Red circles indicate areas with the lowest Census return rate. Together, dark blue areas and red circles were areas with low census return rates within large BIPOC resident communities.

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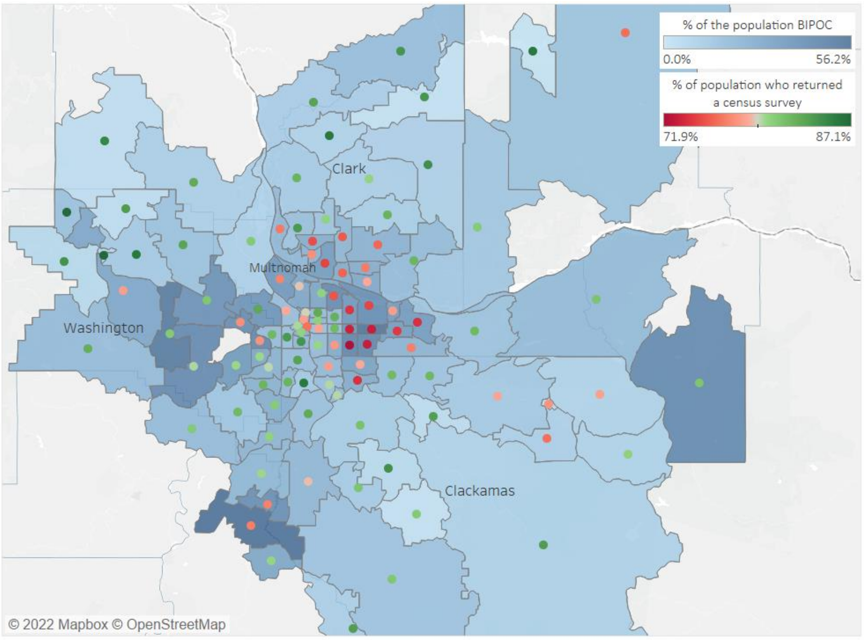
from equity and housing to public safety and population health. The rate is part of the community vitality category, which also includes measures of voter participation and the share of nonprofits per capita within a community.

**FIGURE 63**



Percentage of occupied housing units that complete and return the decennial Census form. Source: Decennial Census, 2010.

**All data sets used in the CHNA have limitations. There are both technical and political issues to consider:**

- The raw data that is collected, in addition to the stories that the data tells, generally reflects the values of the entity that is collecting the data.
- Databases reflect individual, legal, and societal decisions about what information are open to making public.
- Data are often categorized in ways that reflect dominant cultural norms and practices. And, even when these norms are changing (as in the case of acknowledging multi-racial identities or a spectrum of gender identities), public databases may lag years behind how researchers and activists are reconfiguring identity groups and other classifications.
- Data has and continues to “erase” various communities in its collection, analysis and reporting processes which are often rooted in dominant structure frameworks. Identifying health disparities requires data on health status and individual determinants of health for subgroups of the population, at the national, state, and community levels—

Peer Review Group Members

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- Alesha Casayuran, MPH
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- Kelly Gonzales, PhD, MPH
- Carla Edith Jimena

> data that are frequently difficult to obtain. Problems include small sample sizes, missing data, and measurement errors.[24]

Recognizing that anti-racist data approach is still an emerging practice, the CHNA partners recognized the limitations of our own experience in this space and the tension between dominant culture data practices and community-centered approaches. Local experts were from these communities who have dedicated their field of practice and study to these topics.

The Peer Review Group reviewed the proposed CHNA process, indicators, and data sources to make recommendations for how to elevate anti-racist, Indigenous practices of data collection, analysis, and reporting. These materials were reviewed by the CAT members over several in-depth discussions from March 2021 to July 2021 with a framework and the list of recommendations were developed in July 2021. These recommendations were used to shape subsequent data analysis and reporting processes as well as serve as an accountability tool for the partners of this project.

Through this process, this CHNA seeks to name the continued challenges with data that perpetuates racism and white supremacy culture. More data in the future is needed to emphasize community strengths and center racial justice – as this CHNA strives to do. Lastly, future CHNA and data efforts should be done in relationship with community members, be intentional about power-sharing, and center community member stories and wisdom.

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[24] Bilheimer, L. T., & Klein, R. J. (2010). Data and measurement issues in the analysis of health disparities. Health services research, 45(5 Pt 2), 1489–1507. https://doi.org/10.1111/j.1475-6773.2010.01143.x

# Appendix K: Reflections for Future CHNAs

Developing a community-informed and equity-centered community health assessment is a complex and daunting task that takes considerable time and resources. Developing one amid a pandemic, unprecedented environmental events (wildfires and extreme heatwaves), and extreme political and civil unrests is even more challenging. Here are some reflections on this CHNA that are intended to help inform futures efforts.

## DATA SOURCES AND ASSESSMENTS

Data sources and assessments that are grounded in anti-racist data practices, uplift community wisdom and experience, and allow data stratification by race, ethnicity, language, disability, and more are few and far between. Having comparable data sources between regions is another limitation. These pose challenges to developing regional comparisons, understanding disparities by populations, and understanding and addressing the challenges faced by the region's communities. Efforts and investments to support data collection and assessments that leverage emerging anti-racist data collection practices and are community-driven are needed in the region.

## ROLE OF THE CAT AND COMMUNITY

This cycle of the HCWC CHNA pushed the role of community further into the forefront than previous cycles. The CAT was a critical piece of this project. The CAT identified the priority areas, priority populations, community engagement efforts, and made meaning out of the data. Their knowledge of what is going on in the community and the relationships they bring were vital. However, time and budget constraints posed challenges to advancing this community-led effort, meaning that the bulk of the work conducting this CHNA, collecting and analyzing the data, and writing this report fell to the paid staff doing this assessment. Additionally, and perhaps the most significant barrier to community engagement this past cycle, was the time constraint created by the timeline. Conducting a community-driven and equity-centered CHNA takes significant resources and the two-year period created challenges in allowing the CAT the time necessary to meaningfully engage in all aspects of the CHNA. Many significant events over the last two years not only impacted the health of communities, but also their availability to participate in this CHNA. The impact of the pandemic as many CAT members expressed mental and emotional exhaustion due to the realities of living in a pandemic and managing rising racism and race-based hate crimes. Many of the community-based organizations and community members engaged reported similar concerns.

Future CHNAs could continue to advance community-driven efforts by funding organizations closer to communities to conduct the assessments themselves. These assessments could then become the data sources for the HCWC CHNA, rather than HCWC CHNA doing their own data collection. Additionally, we'd recommend going back to a three-year cycle and leveraging the CAT relationships and capacity by engaging members interested in the next cycle.

## DATA ANALYSIS AND DEPICT MODEL

To pursue a more community-led and anti-racist data approach, various collaborative data analysis models were researched and shared with the CAT. The DEPICT model was selected which would allow the CAT to engage in every aspect of the assessment methods, including data analysis and reporting.[25] While the DEPICT model aligned with the desires of the CAT, ultimately, the process lacked the budget or time necessary to implement it fully. The CHNA adopted a modified DEPICT approach. Future cycles should consider the necessary resources and time to use the full DEPICT.

## TRANSLATION AND INTERPRETATION

One of the barriers in this cycle was the costs associated with translating materials into other languages and for interpretation to ensure full participation and access to community engagement opportunities. This includes serving on the CAT. Additionally, with centering equity and engaging more diverse communities – it is imperative that efforts are taken to ensure the final product is accessible to those very communities being represented. This means having a more robust budget for translation and interpretation including making the completed CHNA available in multiple languages.

## PEER REVIEW GROUP RECOMMENDATIONS

Upon review of the data available and the start of analysis, it became clear that a better understanding of the emerging decolonized data and community-centered research and data practices was needed. This led to the convening of the Peer Review Group. The group's recommendations should continue to inform future HCWC cycles as the collaborative continues to move closer to a community-led and equity-centered CHNA and process.

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[25] https://www.semanticscholar.org/paper/The-DEPICT-model-for-participatory-qualitative-in-Flicker-Nixon/c25d631d54ee6f70a2e5ace24dcdd5b25c7884d4

# Appendix L: Peer Review Group Recommendations and Action Steps.

The following are considerations recommended by the Peer Review Group. Upon final review, OHEA sorted these considerations by partners within the HCWC CHNA project (CAT, HMA, OHEA). For each consideration we have provided a suggested next step and action.

**Summary of Consideration/Implications:** Documents offer good language for drafting the CHNA, including how to describe our approach. For example, the CHNA should:

- Include introductory language framing our approach to the CHNA, and how it is similar and different from previous processes, including a section on how we centered community/communities in our CHNA
- Make sure the CHNA is developed and written from a strengths-based approach/perspective
- Reflect the story and narrative the CAT is trying to build
- Include context for the CHNA that names historical and contemporary injustices, oppressions, etc, and acknowledges the impacts on community outcomes
- Explicitly name racism, colonialism, white supremacy culture, and white superiority as determinants of health that must be acknowledge and addressed - these are the drivers of the outcomes we see
- Describe who this CHNA is for, how we hope it is used, and explicitly state how we don't want it used (as weapons against our communities)
- Offer an expansive definition of "data" that we used in this CHNA, and the limitations of different data sources used
- Be explicit and clear on how we stratified data and what the categories mean/how they are defined.

### Considerations/Next Steps for the CAT

| Consideration/Recommendation | OHEA Response | HMA Response |
|---|---|---|
| **1.** Focus on what power and strengths the community has versus what they need; demonstrate appreciation and value(ing) of those contributions to the | We recommend that this consideration be used as a guide during upcoming data analysis and communication planning. It should be revisited as a guiding framework for both sections. | Agree – CE sessions, survey, and CAT activities are structured to gather data to this end, HMA will have this front of mind as overarching goal of analysis and CHNA overall all.<br>Outline for CHNA included this in |

| Consideration/Recommendation | OHEA Response | HMA Response |
|---|---|---|
| greater good and also to the very community they emerge from | | framework. |
| 2. The indicators are heavily focused on deficits instead of strengths, and tell a narrative of challenges and deficits of a community "at risk" and lacks self-determination.<br>a. Does the community want to tell a story of deficits? Or do they want to tell a story of strengths and resistance and of thriving futures? Were they given a choice?<br>b. How are community members disrupting the structural inequities, historical violence, and trauma underlying the outcomes represented by the indicators? This data is critical to the assessment<br>c. How is power being exercised and manifested in this community? Who has agency? | We recommend the CAT play a role in assessing if the final indicator list developed by HMA exhibits what is said to the left.<br>We recommend that this consideration be used as a guide during upcoming data analysis and communication planning. It should be revisited as a guiding framework for both sections.<br>Ensure the initial framing (logic model) of indicators is revisited throughout the process. | Agree – Most indicators pulled from previous HCWC CHNAs. Intend to conduct an assessment of each indicator, example questions to assess each indicator include:<br>• Is it strengths-based or deficit based<br>• How was community engagement in the data source<br>• Is it a trusted source by BIPOC communities<br>• How has the data been used - historical impacts of that data?<br>HMA recognizes that indicators/outcomes just part of story, all indicators are driven by structural / systemic factors. HMA can 1) look at different ways to link data indicators (risk/protective factors versus how is connected to structures, 2) code for mentions of structural inequities, historical violence, and trauma in CE session and survey data<br>E.g. Have data about youth suicide, put side by side with data about protective factors related to youth suicide. Put deficit up with community capacity to address (school connectedness? Others?). Present |

| Consideration/Recommendation | OHEA Response | HMA Response |
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| | | structural solutions to problem, not community deficits, problem lies in structures not individual/community behaviors.<br>Consider an approach such as the “5 Whys” – 3 issues we prioritize, can CHNA structured around 5 whys? |
| **3.** Begin with the vision of the future the group would like to see its community in; that will be the guide | We recommend this serve as a guiding framework for final report creation and communications plan. | Agree |
| 4. Focus on upstream processes and structural/institutional origins of the outcomes instead of focusing on the outcomes at the individual level - the outcomes represented by the indicators will not change unless the upstream causes shift | We recommend that this be used as a guide during data analysis and communication planning.<br>We recommend this be used as a guiding framework when coding and theming transcripts as well as capacity building with CAT that ties structural forces named in data to outcomes. These efforts should be noted in the final report as a part of this process.<br>We recommend ensuring transparency about the flaws of this process i.e. use of ACS data | Agree.<br>Clarification: HMA is not focusing on outcomes at the individual level, CHNA is community level. Understand concerns of breaking up community by categories. We will connect outcomes to structures/systems. |

| **Consideration/Recommendation** | **OHEA Response** | **HMA Response** |
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| **5.** Many of the indicators selected are from datasets that BIPOC communities do not trust due to colonial and imperialist methodologies. | We recommend including a note on datasets in the beginning of the CHNA that acknowledges specific issues with data sources and what efforts were made to adjust to this.<br><br>We recommend mentioning that PRG in the final report and why. | Agree.<br>Agree.<br><br>We need to think through what this mean for us in regards to 1) how to educate community the limitations of the data sources 2) if and how to use the indicators to tell the community story. |
| **6.** Public health data and CHNA methodologies are rooted in implicit and explicit colonization and white supremacy | We recommend defining elements of community-centered approach that were taken in this project in order to address problematic methodologies in final report.<br>We recommend highlighting our use of community facilitators as a way to demonstrate community-led processes. If possible, facilitators can be invited to note what it was like facilitating the focus groups.<br>If possible, we recommend including recommendations that have come from CAT conversations about how this can be mitigated for in future assessments. | Agree.<br>Agree.<br>Agree – can include lessons learned? We need to ensure CAT perspective and recommendations are being collected / captured.<br>HMA will be sure to recognize why we used Peer Review Group as part of process. |
| **7.** Adverse health outcomes are the result of historical and intergenerational trauma, and other structural and institutional factors - the unit of analysis should be community, not the individual (e.g. access might be | We recommend that we explicitly name an SDOH framework that includes naming racism, colonization, and colonialism as fundamental SDOH as part of the data analysis and the report.<br>We recommend using this as a guiding framework for the codebook development | Agree.<br>Consider frameworks such as the Political determinants of health or Sum of Us Heather McGhee<br>Framework for codebook is CAT-driven logic model – HMA will include codes to address structural/institutional factors, |

| **Consideration/Recommendation** | **OHEA Response** | **HMA Response** |
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| experienced individually but the origins of inequitable access are structural) | and development of themes. | racism, |
| **8.** Access is not enough - can have access but the experience engaging with institutions can be harmful; need to understand how institutions fail to serve community members. Need to understand why institutions refuse to take action to dismantle and abolish embedded institutional racism. Need to understand the models for taking such action | Looking to the next CHNA, we recommend using this as a core consideration when considering project timelines to challenge false parameters of the project (HMA as project management, for HCWC Exec Team to consider/reflect on). In what ways did we render parts of this process inaccessible due to timelines?<br>We recommend considering how the survey responses acknowledge this recommendation/framework (ex. Do folks select that something is physically accessible but that it is not culturally responsive?) | Debrief/lessons learned – not include in CHNA, but can conduct and report to OHEA, HCWC, other |
| 9. The focus on outcomes is not enough -- we must also examine the processes, context, and history of these outcomes<br>10. -AND-<br>11. The indicators are heavily focused on deficits instead of strengths, and tell a narrative of challenges and deficits of a community “at risk” and lacks self-determination. | We recommend considering this as a guiding framework for the codebook development and that final reporting is done with this framework in mind<br>● OHEA can support ensuring this is done | Agree – HMA goal is to always connect outcomes to processes, context, and history of these outcomes<br>An assessment should be done of the existing indicator list for 1) where we can “reverse” the indicators to be strengths based 2) identify the data that are needed to examine the underlying/root causes of the outcome that any one indicator suggests |

| Consideration/Recommendation | OHEA Response | HMA Response |
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| 12. Does the community want to tell a story of deficits? Or do they want to tell a story of strengths and resistance and of thriving futures? Were they given a choice?<br>13. How are community members disrupting the structural inequities, historical violence, and trauma underlying the outcomes represented by the indicators? This data is critical to the assessment<br>14. How is power being exercised and manifested in this community? Who has agency? | | |
| 15. Reject dominant hierarchies of knowledge; everything can be data, not just quantitative/numeric data | We recommend including stories (including from CAT members) as section leads, as a way to contextualize quant in qualitative setting. | Agree.<br>Any coding of CE sessions and survey data will include one for stories. Consider also to identify stories that highlight disruption, or programs being run in ways that have grown out of community |
| **16.** Data should be community centered and community collected/analyzed using principles of data justice | We recommend naming the PRG was a necessary partner in the data analysis portion of the work in the final report | Agree. |
| 17. The purpose of administrative data (Census, ACS, Vital Stats, Immunization, etc.) is surveillance, not the equitable | We recommend that folks analyzing the datasets mentioned gain understanding about the racist foundations of these data sources. This will require personal capacity | Agree.<br>Include in CHNA section on data source limitations<br>See below for a list of references HMA is |

| **Consideration/Recommendation** | **OHEA Response** | **HMA Response** |
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| distribution of resources or the assessment of needs. This kind of data continually erases communities. This data must be interpreted within this context. | building work. Limitations of this data should also be named to the CAT and in the final report. | using to inform approach to the CHNA |
| 18. More data is not necessarily better, and the use of multiple datasets that are collected by disparate institutions will lead to a lack of harmonization (especially with regard to definitions and categories of data collected) | We recommend this as a consideration for the HCWC Exec team, in support of future RFP's and CHNA/CHIP processes.<br>ZJ: Can we pull some of these HCWC Exec points and share as recs for the next process(es) for CHNA and CHIP? | Agree!<br>HMA is committed to a prioritization process to ensure data included is meaningful |
| 19. Use community stories and other qualitative data as a primary source for indicators; focus on knowledge, lessen reliance on quantitative data | **(REPEAT)** We recommend including stories (including from CAT members) as section leads, as a way to contextualize quant in a qualitative setting. | Agree. |
| 20. Make distinction between primary, secondary, tertiary data sources and make sure to thoroughly vet and critique primary sources, explicitly name primary sources | Recommendation as is: Make distinction between primary, secondary, tertiary data sources and make sure to thoroughly vet and critique primary sources, explicitly name primary sources | Agree.<br>CHNA should include a description of these types of data sources, and the prioritization/assessment process conducted to vet whether any data source is included in the CHNA. For example, some criteria might be:<br>• How was community engagement in the data source<br>• Is it a trusted source by BIPOC communities |

| Consideration/Recommendation | OHEA Response | HMA Response |
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| | | - How has the data been used - historical impacts of that data |
| 21. If data is stratified by demographics, need to be explicit as to how these are defined (racial categories, sexual orientation and gender identity categories) | Recommendation as is: We recommend including stories (including from CAT members) as section leads, as a way to contextualize quant in qualitative setting. | Agree |
| 22. Need to critically evaluate data quality and **make explicit** the limitations (e.g. Medicaid data is often missing race/ethnicity data) | We recommend limitations of this data should be named in the final report as we become aware of them. | Agree. Include in the data limitations section reference to how data often drives invisibility |
| 23. See detailed critique of data sources (link to matrix) | Recommendation as is: See detailed critique of data sources (link to matrix) | Agree.<br>Consider include matrix as an appendix to the CHNA, and referenced during the data limitations sections |

| Consideration/Recommendation | OHEA Response | HMA Response |
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| 24. Consider and identify the level of community engagement in the data - was it meaningful, was there transfer of power, or was it performative? | We plan to continue to review the data analysis processes and ensure capacity building and co-learning opportunities are integrated into each step of the process for the CAT<br>We plan to create a timeline of the project that reflects steps of community engagement for final report | |

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| | We plan to include a critique about our community engagement process via focus groups<br>○ What role we played in fostering harmful spaces via our questions<br>○ Focus group questions were high reading level | |

| Consideration/Recommendation | OHEA Response | HMA Response |
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| **25.** In addition to working in partnership with the CAT, it is critical to be in relationship with community members who are engaged in critiquing dominant forms of data collection and developing community-based, community-centered, and decolonizing data. They can be guides as to what data is trusted or invalid, and provide other sources of data or suggest decolonized methodologies | We recommend noting this to HCWC as a rec for next RFP and highlight what had to be done here re: PRG creation | Agree. This will be important to understand the scope better and have a realistic expectation of cost. |
| **26.** Important to consider how this data can be weaponized against the community, especially if it was collected without centering, engaging, and power sharing with community | We recommend this as a consideration and discussion point for the final report creation and communications planning<br>We recommend that folks analyzing the datasets mentioned gain understanding about the racist foundations of these data sources. This will require personal capacity building work. Limitations of this data | Agree |

| Consideration/Recommendation | OHEA Response | HMA Response |
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| | should also be named to the CAT and in the final report. | |
| **27.** Important to consider how communities are erased in the data | We recommend including the distribution of folks engaged in focus group and surveys, highlight gaps<br>We recommend including the distribution of folks engaged in on the CAT, highlight gaps | Agree.<br>HMA also views the recommendation as more than just who physically was included in the CAT, surveys, and community engagement sessions but rather ensuring we discuss the role that data plays in dehumanization/invisibilizing |
| **28.** Identify racism, colonialism, white supremacy culture and white superiority as the determinants of health that must be acknowledged and addressed. If BIPOC lives are shaped by these determinants, then they must be central to the determinants and indicators. | We recommend including a section in the CHNA report that defines racism, colonialism, white supremacy culture and white superiority as the determinants of health that must be acknowledged and addressed | Agree<br>Would we refer to Shared Definitions file Racial Equity Glossary of Terms – SP HCWC CHNA HERE |
| **29.** Focus on community strengths, how community expresses and wields agency and power, include this data | See related recommendations on community strength<br>We recommend highlighting efforts with question selection to do this work | Agree |
| 30. Cultivate partnerships and be in relationship with community members who are experts in and engaged in data work about their communities | ● Identify 1-2 CAT members (Waddah and Joannie) who can serve in additional advisory roles<br>● Consideration for next CHNA to not start again and learn from relationships and groups convened. | Agree. |

| Consideration/Recommendation | OHEA Response | HMA Response |
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| | - Cultivate relationship with groups like BIPOC data group in prep for next CHNA cycle | |
| 31. Identify the framework that will guide the health indicators; which ones center BIPOC and community strengths (e.g. data justice) and which ones are deficit based (dominant frameworks)? | We recommend reviewing initial CAT framework and editing to center community strengths with CAT. | Agree. |
| 32. Specific recommendations for Peer Review Group members (see comments on document) | Recommendation as is | |