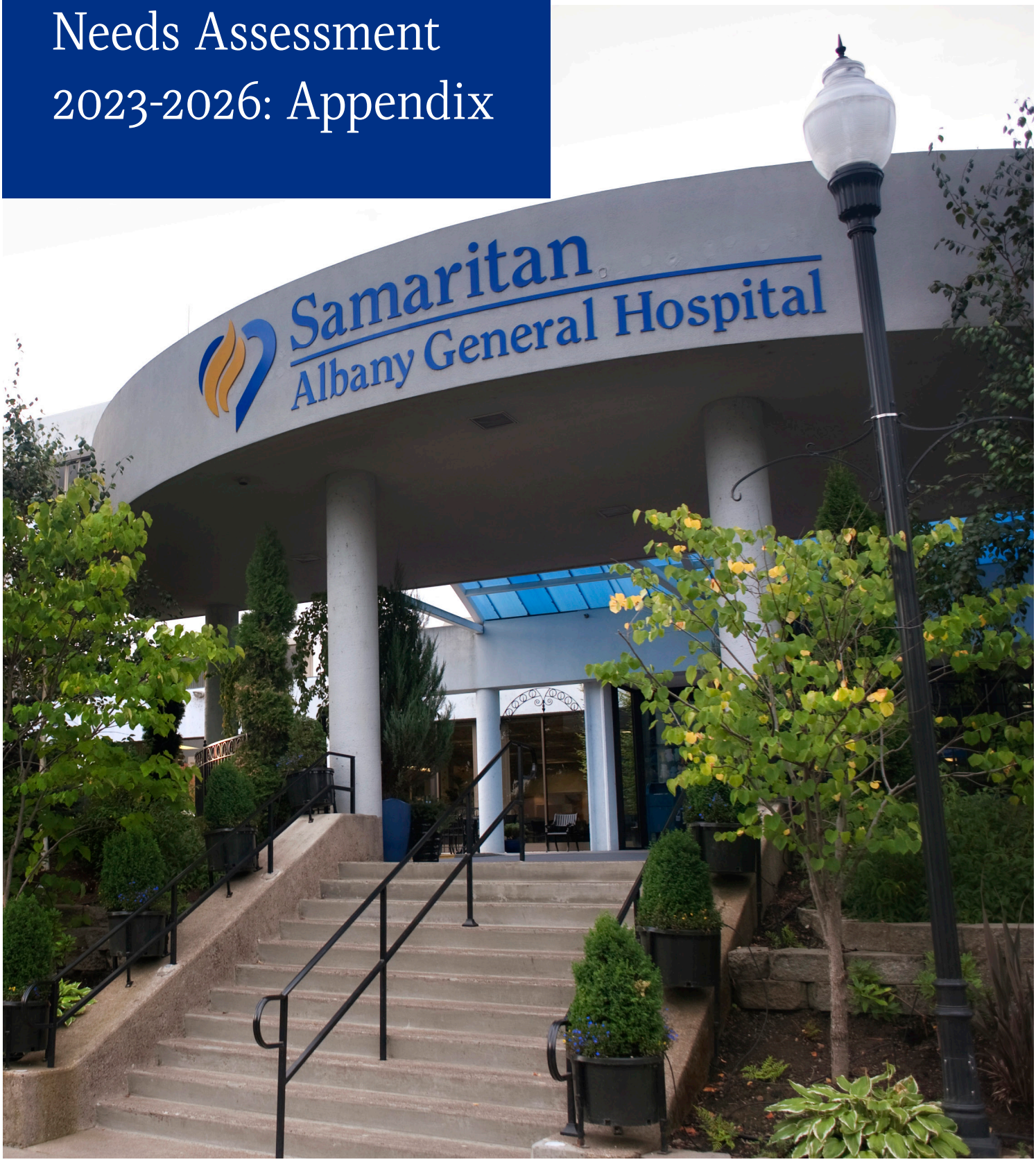
SAMARITAN ALBANY GENERAL HOSPITAL

Community Health Needs Assessment 2023-2026: Appendix

Samaritan Health Services



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APPENDIX A

COMMUNITY PERCEPTIONS OF HEALTH

Overview

> *I think quality of life is kind of teetering. Before the pandemic, there was—especially with the kids and stuff in school in the school district—talk of suicide, which was really pretty high in 2019. I think it has really been consistent in just like depression, anxiety, a lot of fear, uncertainty, hopelessness. And obviously, that impacts our health, because if you don't really see your future, what's the point of taking care of yourself?*

Respondents see a decline in health (77%) and quality of life (96%) for Albany-area residents over the last three to five years. The primary contributing factor (53%) was the COVID-19 pandemic, the most commonly cited effects of which were isolation and other mental health impacts (48%), delayed diagnosis/treatment and other physical health effects (32%), and economic and employment effects (13%).

Other contributing factors include inflation/cost of living and high levels of political and social conflict (including gun violence), as well as environmental and climate issues (especially in relation to wildfires and heat waves). Long-standing issues such as lack of affordable housing, lack of transportation, substance use disorder, and racism/discrimination also remain in force.

What are our biggest health problems?

MENTAL + BEHAVIORAL HEALTH. West Linn County continues to have a severe lack of acute and long-term mental and behavioral health services for children and youth, people with substance use disorder (SUD), marginalized and stigmatized communities, and veterans. These unmet needs have been exacerbated by the mental health effects of COVID-19 — especially social isolation — as well as by high housing costs, inflation, political strife, discrimination, bias and other issues.

> *We have a lot of kids who, just these last couple years, have been isolated. We don't necessarily know what everyone's home situation is, and what socializations they've been through or opportunities they've had. But we're seeing a lot of disciplinary issues ... a lot of instability, a lot of inconsistency. We're kind of having to start fresh with a lot of these kids. And right now, we're just seeing a lot of emotional instability and a lot of anger.*

BARRIERS TO ACCESS. COVID-19 has had far-reaching effects on regional health care capacity, resources and workforce, resulting in longer wait times, postponed care and related access issues. The lack of providers and difficulty of getting appointments was the most commonly cited barrier (50%). Other persistent barriers include fear and mistrust, lack of transportation, and the difficulty of navigating the health care system.

On the other hand, certain pandemic measures — such as telecommuting — greatly increased quality of life for some members of the disability community, who are now concerned that these gains may be lost as pandemic concerns wane.

> *COVID-19 is still the biggest threat to disability populations. Folks with autoimmune disorders or various disability types ... will continue to suffer from and die from COVID at much higher rates than the general population. We've more or less gone back to normal in so many ways that are going to isolate and continue to threaten the disabled population.*

UNHEALTHY LIFESTYLES. Poor nutrition and obesity are major concerns (80%), along with food insecurity and a lack of exercise and fitness options. These concerns were aggravated by COVID lockdowns, as children and adults lacked access to outdoor activities, healthy food and other opportunities for improved health and management of chronic disease.

> *We're having some very unfit kids coming back into our programs. We had basketball evaluation, and we had kids warm up and run the full length of the court one or two times. And maybe a handful of kids had to step away because they were already tired and couldn't run anymore. Kids that used to be really active got in the habit of sitting in front of a computer and watching TV and being at home, and that motivation to get outside and hang out with your friends goes away.*

HOUSELESSNESS + HOUSING INSECURITY. Lack of access to safe and affordable housing remains an urgent health problem, taking a toll not just on the mental and physical health of individuals and families —both housed and unhoused — but also on the ability of health care providers, public health agencies and community-based organizations to recruit and retain workers.

POVERTY + INCOME INEQUALITY. As housing, gas, food and other costs rise, fewer people are earning a living wage. This increases their mental and physical stress and limits their access to care, medication, counseling, educational opportunities, tests/screenings, nutritious foods and other health essentials.

Who has poor health + quality of life?

MARGINALIZED POPULATIONS. Migrants, refugees and undocumented residents are at a high risk for poor health and quality of life, and are indigenous people, communities of color, LGBTQIA+ people and people with disabilities. Marginalized people are also less likely to seek medical care due to mistrust,

trauma, cultural/linguistic barriers, and other issues. For those who do seek care, the lack of culturally competent providers can make that care less effective and more traumatic.

> *I'm tired of hearing "oh, there's only a few black people here." As if — since there's not a lot of us — the ones who are here don't deserve good service, or good health, or to be provided for. As a nurse, if I have one person on my unit or in a nursing home who has a Foley catheter, guess what: I have an obligation to know how to take care of a Foley catheter — just for that one person! There could be 100 people, but for that one person, I have to know that. I can't just be like, "Well, there's only one of you, so we don't need to do that. We're just gonna let you die, because it's just one of you." I don't get that narrative. I don't understand how you would ever say that to anyone. Because again, if there's 1%, 2%, 3%, they're still here; they still deserve all the things. It just sounds so heartless to me.*

People with limited English skills and few qualified interpreters, such as the Mam migrant community, face special legal and logistical barriers in receiving one-on-one care and in navigating the system, as do people with disabilities.

OTHER GROUPS. Seniors were a commonly cited high-risk group for poor health: "The challenges of not being able to access social groups and health care are even worse for elderly people." Many seniors are impacted by inflation, housing and other rising costs of living. They may also face worsening mental and physical health resulting from social isolation, lack of exercise, and avoidance or postponement of medical care due to COVID. Other groups high-risk groups include children, and people who lack access to healthy nutrition.

LOWER SOCIOECONOMIC STATUS. Low-income residents — including seniors, people in unsafe or unstable housing, the uninsured and the underinsured — tend to have poorer health and quality of life as well as less access to preventive and primary care and to the social determinants of health. Further, people experiencing poverty and housing instability often have multiple stigmatized identities that complicate their search for new housing.

PEOPLE WITH MENTAL + BEHAVIORAL HEALTH ISSUES. People living with mental illness and/or SUD often have poor health resulting from those conditions. In addition, they tend to be impacted by having fewer providers, higher barriers to navigating and accessing care, more difficulty in keeping appointments.

They also may face more shame and discrimination (e.g., in rural areas, conservative communities and/or cultures that traditionally stigmatize mental illness). At the same time, the loss of control and privilege for members of the white majority due to pandemic measures has also had a deleterious effect on their mental and emotional health.

Which social determinants of health most affect our community?

Preliminary analysis shows the following social determinants of health as the most significant ones for western Linn County.

- Safe and affordable housing (22%).
- Access to health care (19%).
- Transportation (16%).
- Access to healthy food (9%).

Other determinants cited include racism and discrimination, education, jobs and the economy, community engagement and resilience, access to green spaces, and disability rights.

What are the main barriers to improving health?

LACK OF ACCESS. The complexity of the health care system can be daunting, especially for lower-SES residents, newly insured patients, people with mental health issues, migrant workers and people with specific linguistic or cultural needs and expectations. Even affluent residents sometimes find it difficult to navigate the system and to gain insurance and health literacy. Although telehealth and other online options have gained in popularity since the pandemic, low-SES patients may lack internet access, while seniors may lack the skills they need to use newer tech-based options.

The cost of insurance, co-pays, medications and care remains prohibitively high even for many middle-class residents. This problem is intensified by the steep rise in housing costs, food prices, gas prices and other necessities. With inflation on the rise, many patients are electing to avoid or postpone routine tests and screenings as well as necessary treatments.

Lack of transportation remains a major barrier, especially at night or in bad weather.

> *Transportation really is a big barrier for a lot of folks. Whether the appointments are within the Valley or outside of the area, they don't have transportation. Or they have transportation, but they are not comfortable driving that distance.*

Already a problem, provider turnover/retirement rates increased in the wake of COVID, as did wait times for appointments.

> *Even if you have resources, you can't find a physician.*

For patients seeking care in the ED, staff shortages, pent-up medical demand and the ongoing pandemic can result in very long wait times; the resulting stresses and conflicts with patients may increase the risk of further workforce shortages due to staff and provider burnout. Fear, mistrust, shame and

stigma — especially among marginalized and/or historically traumatized populations — continue to be serious barriers.

> *Trust is big, obviously. Because there's always a reason why people don't trust you. Some of that deals with their lived experiences and what they've experienced in the past for other people that maybe nothing to do with you. And then there is the agency you work with — you know, they dealt with it and it wasn't trustworthy. And so now, you're expecting to be trusted. And it doesn't work like that.*

SOCIAL DETERMINANTS OF HEALTH. The housing crisis was cited as the primary obstacle to improving community health and quality of life and as a major obstacle to addressing workforce shortages. Other significant determinants include economic inequality, lack of funding for healthier communities, food deserts and food insecurity, and exposure to identity-based marginalization, discrimination and trauma.

STRUCTURAL EXCLUSION, MARGINALIZATION + BIAS. Community leaders who hold marginalized identities often see the health care system's interest in them as purely transactional; providers and public health agencies reach out because they need information, or for marketing purposes, but they do not form lasting relationships or make recommended policy changes. The exclusion of these community leaders from representation and decision-making within largely white institutions — combined with failure to address the region's lack of cultural and linguistic competence, equity and accessibility — is a persistent barrier to cooperating with culturally specific organizations to improve the health of marginalized and stigmatized communities. The problem is complicated by a highly vocal and visible — and in some cases, explicitly white supremacist — political movement opposing equity, diversity and inclusion efforts. Against this backdrop, continued institutional inertia and insularity may deepen the mistrust marginalized community members already feel.

> *If you're a nonwhite person, what has been done over history — and not just a long, long time ago — with our bodies, without permission and with different experiments, has impacted us today. So trust is huge. People saying "I'm here for you, Black people," but really, they're not — it's just talk or it's just performative — really, really hurts. It sets us back, because now you're confirming that they can't trust the health care system. ... I don't think people understand that when you lose trust like that, especially when you are untrustworthy ... you have to actually reach out and you actually have to earn people's trust. You have to also understand it's gonna be really hard. But you don't give up — you just keep coming, because you realize that there's been a lot of damage to repair.*

What are the area's main assets or strengths?

COMMUNITY ENGAGEMENT + RESILIENCE is one of our major assets, due to high levels of community connectedness, volunteerism and participation.

> *All of us trying to do all the same work, and people really partnering together to make change — that is something that our community does really, really well. ... We can really build on the people that are already doing the work in the community, both at the system level — the CCOs and the county — but then also on the provider and community-based organization level.*

The health care system — and the region as a whole — also has the potential to benefit from the largely untapped perspectives and abilities of migrant and other marginalized communities.

> *What we have to do, then, is to facilitate the recognition of the skills, knowledge, expertise that people have, especially people who are immigrants, who come from other countries ... Imagine the potential of finding a way of incorporating that knowledge or expertise into creating solutions that work for the community. There is a need for the system of services — for the system of providers — to modify their approach and move away from a purely needs-based approach to one that emphasizes assets. And the assets are people themselves and the community itself.*

COMMUNITY HEALTH RESOURCES + PROGRAMS tackle a wide range of issues and serve populations that may find it hard to get help anywhere else. Often rooted in the strengths, practices and resilience of specific communities, they are a crucial element of the region's social fabric and invaluable allies for partners who are prepared to defer to their expertise and to learn from their trusting relationships with the communities they serve.

> *These are people who are not waiting until someone else figures it out. They are like, "We are going to do something about it." And that's beautiful.*

PARTNERSHIPS between these organizations and public health, social services, schools, the hospital system, local government are an important asset that could be better utilized. A silver lining of the pandemic is that it often forced partners to work together; these connections should continue and increase going forward.

What issues will emerge in the next 3 to 5 years?

For most respondents, the major issue is the long-term impact of COVID. This encompasses the threat of current and future variants; the still-unknown health impacts of "Long COVID"; the delayed diagnosis and treatment of cancer, cardiovascular disease and other major illnesses; the effects of isolation, lockdown and bereavement, especially on children and youth; staffing and provider shortages, economic hardship and supply chain issues; the rapid growth of conspiracy theories, social turmoil and mistrust of institutions and experts; and the potential for a sharp increase in mental illness, SUDs and disability

over the coming decade.

> *We just lived through one of the most mass-disabling events in world history. We still don't understand the scale of that, and it's gonna continue to play out over time. So, where we would have had a population of, say, 16% of folks in the Linn-Benton area having some sort of disability, we might see that double or triple. And we have no idea what it really will look like. But we know it's going to be a lot more people with a lot of different disability types that are suddenly becoming disabled. And people don't individually become disabled: If you come up with a disability, the people around you also have to deal with a disability, right? They're suddenly having to figure out things like "how do I get you into this place if you can't walk right in? How do we engage in this activity if it's uncomfortable for you?" All of these things that suddenly happen where families and communities become disabled — not just individual people. That's the thing I'm trying to warn people about: The tsunami is coming.*

Other near-term concerns include racism, discrimination, lack of access to day care, the increase in suicidality among youth, and the ongoing toll of addiction on Oregonians of all ages.

What can local and regional partners do to improve health and quality of life?

A primary goal is for the hospital system, CCO, public health department, government agencies, and CBOs to improve their coordination, cooperation and communication.

> *I can't even tell you how many meetings I attend a month, just to try to stay connected. And I think that one of the things that would be really beneficial is finding a way to streamline that— all of the community-based organizations and the CCO and the county are all in the same meetings at the same time. ... So how do we do that where it's not taking so much time, so that way we can actually focus on doing the work?*

Better coordination and oversight could also help to avoid duplication of effort and improve the allocation of resources.

> *I think we need a system in place — whether it's run by a nonprofit or a local hospital board — that can funnel those resources to the right organization for the right thing. So like, one group does housing better than the other? Let's stop spreading that money out. Give it to that one, right? If one does mental health or health care better, let's get that money to that. Coordinated care can be really beneficial.*

Larger entities also need to recognize that their policies and requirements can be obstacles and overhead from the standpoint of smaller partners.

> *People that are in a system or health care setting are very used to having meetings throughout the day. It's not a big deal. But for community-based organizations, that literally takes people away from doing the work.*

A central part of increasing collaboration is acknowledging and overcoming the historical and current exclusion and/or exploitation of culturally specific partners and the ongoing failure of regional institutions to improve cultural competence.

> *I want to emphasize the coming together part, so it doesn't feel like "we're over here and you need to come, you community member of color. Black folk, come over here to us and we'll let you play with us today because we need some information from you. But you ain't going to hear from us until the next time we need information from you." ... If you have a friend that does that, that's actually not a friendship. That's like, "I'm using you for what I need. But when you need something, I'm busy." Right?*

> *I want to stress that we can do better. Partnership's not talking down or making people feel like they're just only there to serve you. ... You don't come with expectations of like, "it's for me to get something from you." You're coming because you want to enjoy and learn and grow — because we have something to teach as well.*

More generally, there's an opportunity to be more engaged with and responsive to the communities throughout the region — particularly those who have historically been underserved.

> *I think giving more power and agency to the community itself. ... Maybe going back to cultural competency and tactfulness, and addressing some of these things that carry such a huge impact for the individual involved and therefore the community. Just having more compassion, more receptiveness. More awareness about how things are done and how things are said. It's almost like a hyper-recognition of the nuances of an interaction, and therefore being able to navigate them more adequately.*

These efforts should include providing help with navigation, patient advocacy and care coordination, and, when possible, reducing barriers that arise when patients need to move between agencies and providers.

> *If we can minimize the number of things that patients — especially disabled patients — are having to maintain and communicate over and over and over again, we open the door to better care and better quality of life.*

They should also include finding ways to improve access that do not necessarily depend on getting patients to a facility.

> *We have to continue to build a bridge between people in poverty in the community and the health care system, and think about nontraditional ways for people to be able to access care.*

What should our priorities be for the next 3 to 5 years?

MENTAL + BEHAVIORAL HEALTH SUPPORT. The region already lacks mental/behavioral health facilities, workforce and funding, and the need for these resources is likely to increase significantly in the wake of COVID-19, as youth and adults cope with the mental, physical and behavioral effects of the pandemic, including depression, anxiety, isolation, SUD and suicidality.

IMPROVE ACCESS. This entails not just facilitating and coordinating access to all aspects of care, but also providing necessary support ranging from child care, to transportation, to technology skills and access, to insurance literacy, health navigation, patient advocacy, cultural/linguistic competence, and accessibility.

> *We need to be more connected! I get calls from doctors' offices that have no idea what we do. And we've been here for 35 years, and we've got stuff everywhere, but they have no idea. And then what they do is, they refer people, but they don't pay attention that we can only serve the senior population that's 55 and over. ... If we could get better connected, it would be better for everyone.*

Where possible, partners should aim to bring care to patients (e.g., through telehealth, mobile services, pop-up clinics and alliances with schools, culturally specific organizations and other community-based partners).

> *It does not have to be a brick-and-mortar facility. The pop-up vaccination centers during the pandemic are a great example. Or using existing community facilities. Like, "we will have basic dental examinations and cleanings on the first Saturday of the month at the Senior Center" or something like that.*

Protecting and increasing access to women's health services, family planning services and reproductive rights should also be an ongoing focus.

SUPPORT COMMUNITY HEALTH + WELLNESS. Primary needs include nutrition and food security, addressing the housing crisis, and promoting exercise and fitness.

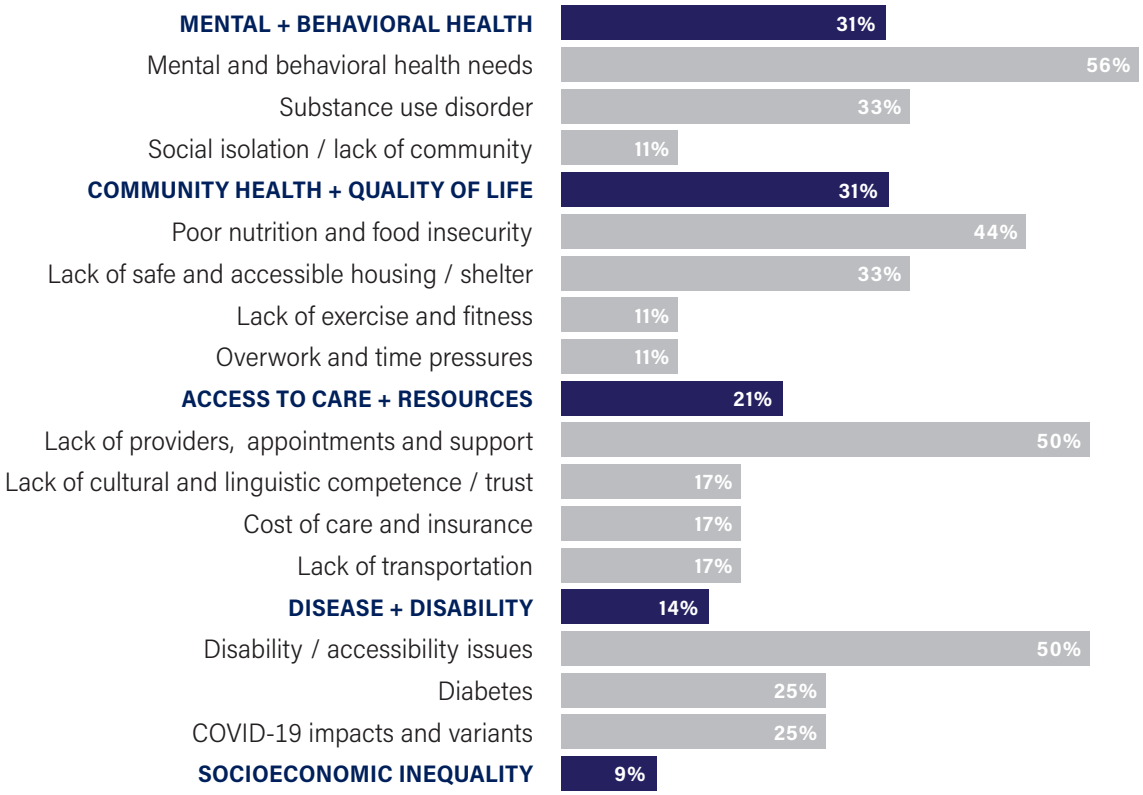
CULTURAL + LINGUISTIC COMPETENCE. Building cultural and linguistic competence, increasing workforce diversity, reducing institutional discrimination and bias, and partnering more closely and transparently with culturally specific organizations are long-standing needs that have taken on an even greater urgency since 2019.

> *Addressing racism and discrimination in our communities—especially our health care professionals and organizations. And not on a computer doing modules or whatever they do, but actual education. Like, training and next steps and strategic plans — all of that. So, not just having some equity team, but actually like, "What are we doing here? How are we addressing our implicit biases, and going through our hiring practices and stuff like that?" And actually having conversations about racism and discrimination: "What are the impacts to our patients and their families as we neglect populations that we are not serving? Whether that be LGBTQ, people of color, houseless people, poor people — what are the impacts of our bias, and sometimes racism and discrimination?"*

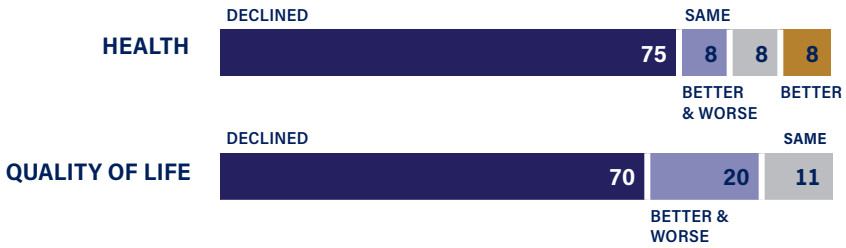
APPENDIX B

KEY INFORMANT INTERVIEW RESPONSES

What are the top health problems in your community?



How has health and quality of life changed in your community over the last 3 to 5 years?



NEGATIVE FACTORS

COVID-19 IMPACTS. Mental health effects; physical health effects; delayed diagnosis and treatment; economic and supply chain issues.

LESS ACCESS TO CARE + RESOURCES. Lack of providers and capacity; lack of cultural and linguistic competence; lack of trust; lack of transportation; lack of health literacy, awareness and education.

LOWER COMMUNITY HEALTH + QUALITY OF LIFE. Lack of housing and shelter; lack of exercise and fitness options; environmental and climate impacts.

INFLATION + HIGH COST OF LIVING.

POSITIVE FACTORS

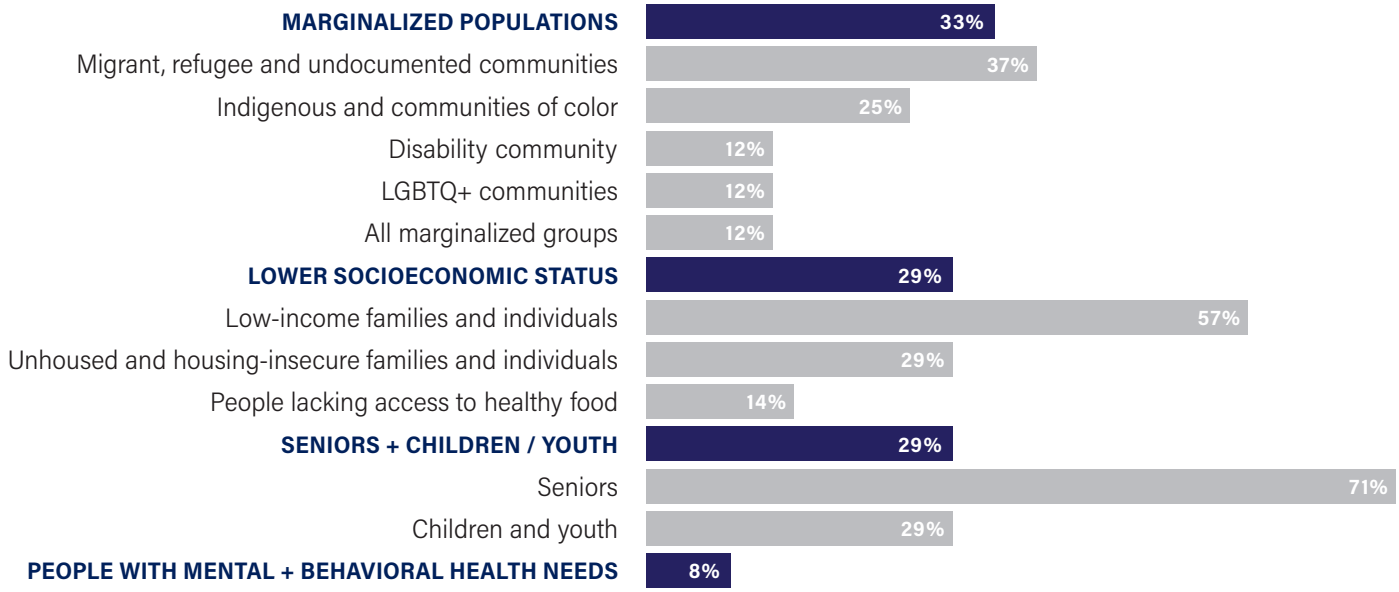
COVID-19 IMPACTS. Increased access and options for the disability community.

IMPROVED COMMUNITY HEALTH + QUALITY OF LIFE. New housing developments.

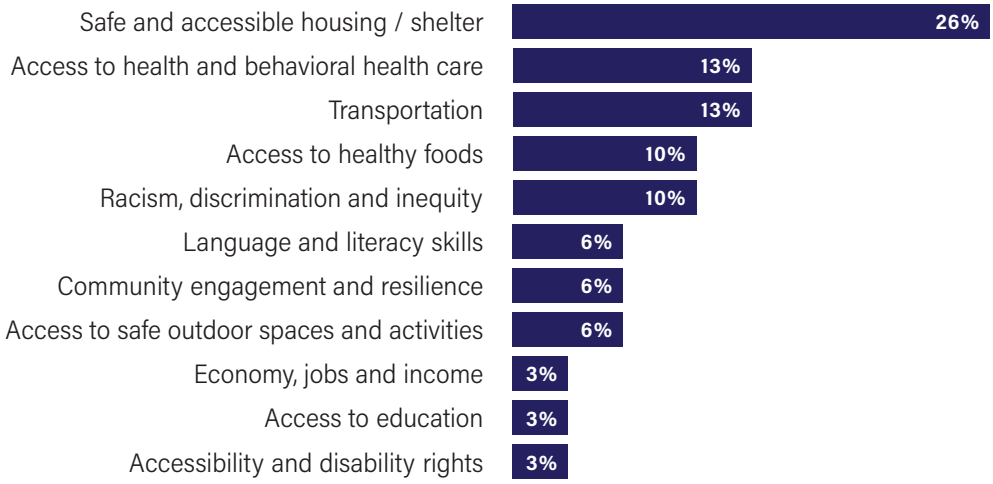
BETTER COORDINATION OF COMMUNITY PARTNERS.

POLITICAL + CULTURAL FACTORS. Benefits of strong family connections and emotional support.

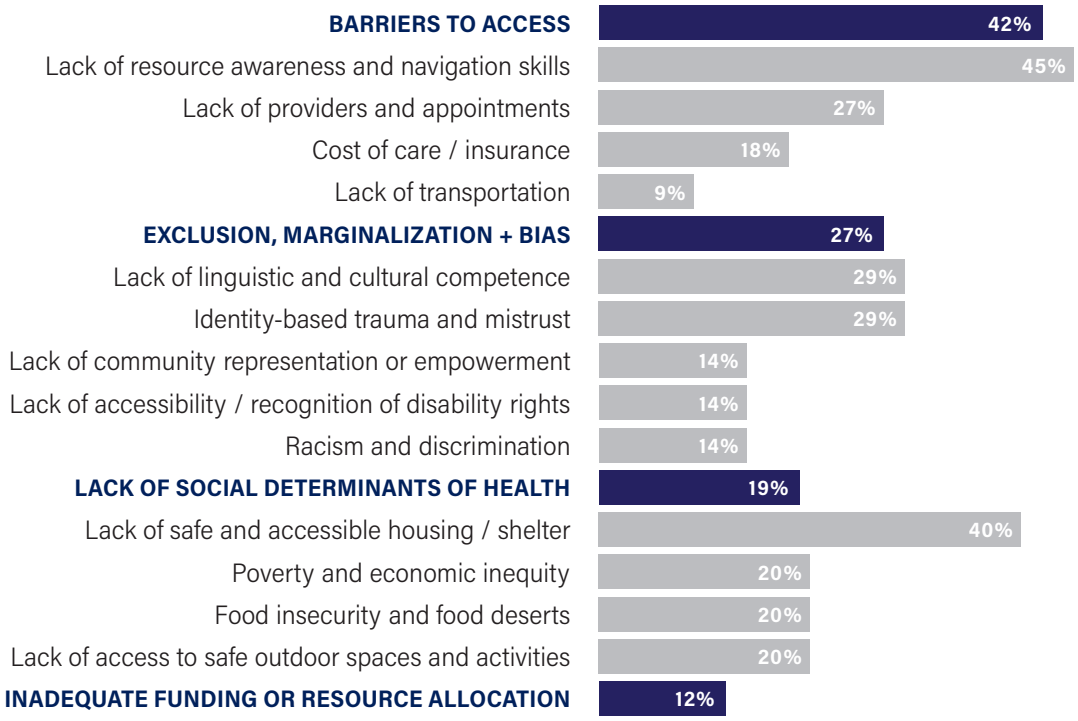
What people or groups of people in your community do you view as having poor health and quality of life?



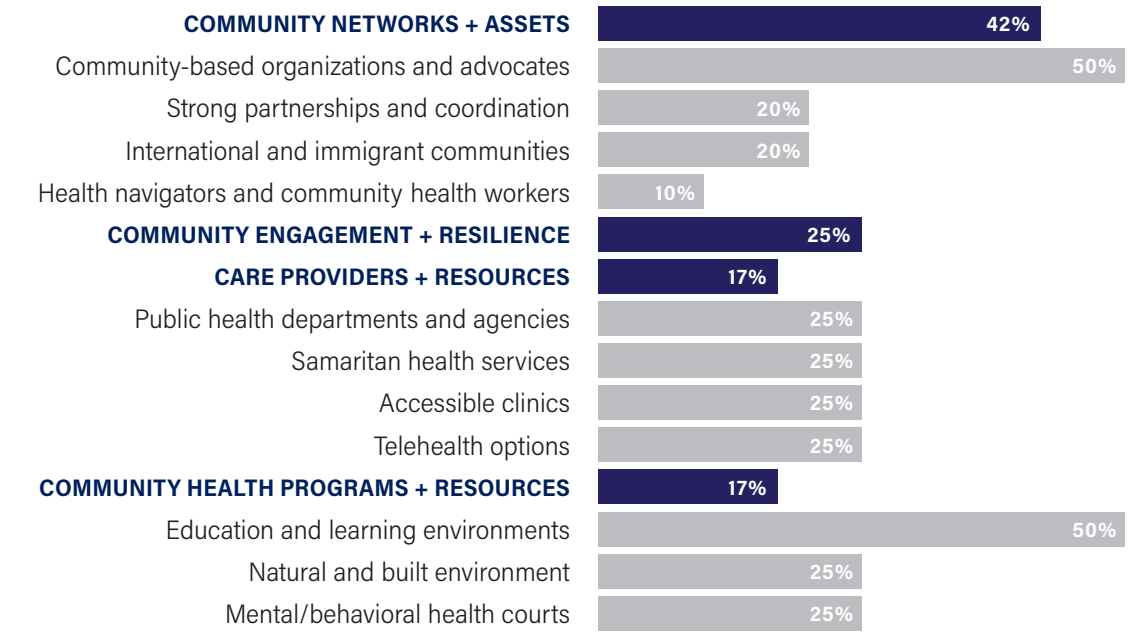
Which social determinants of health most affect your community?



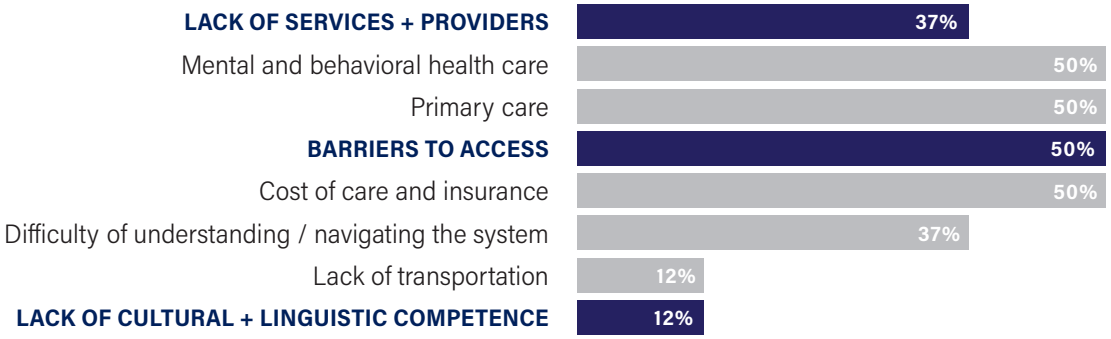
What are the most significant barriers to improving health in your community?



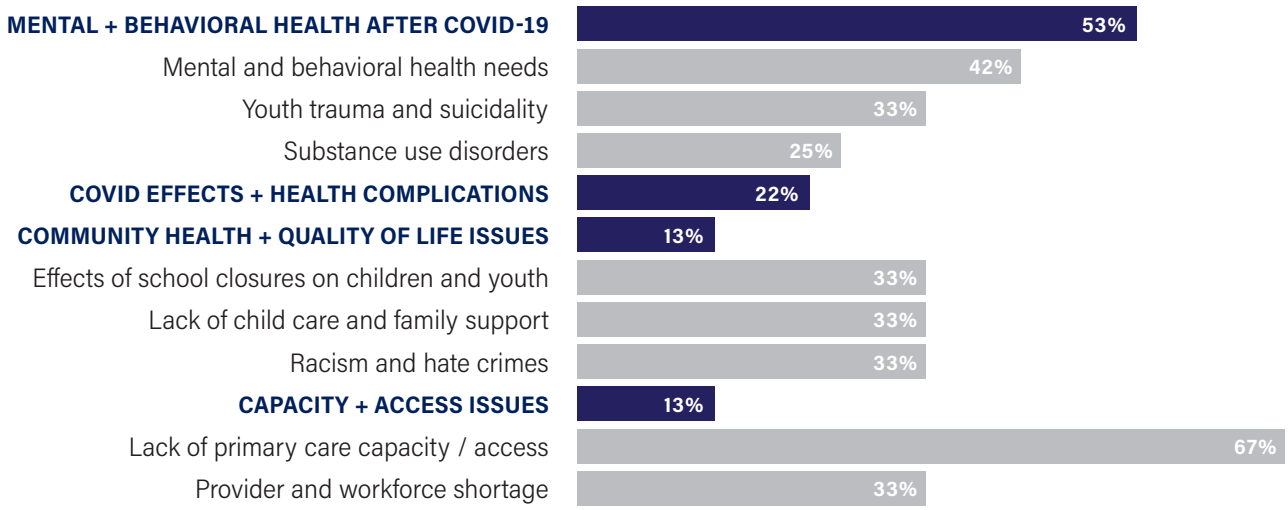
What are the most important strengths or assets for improving health in your community?



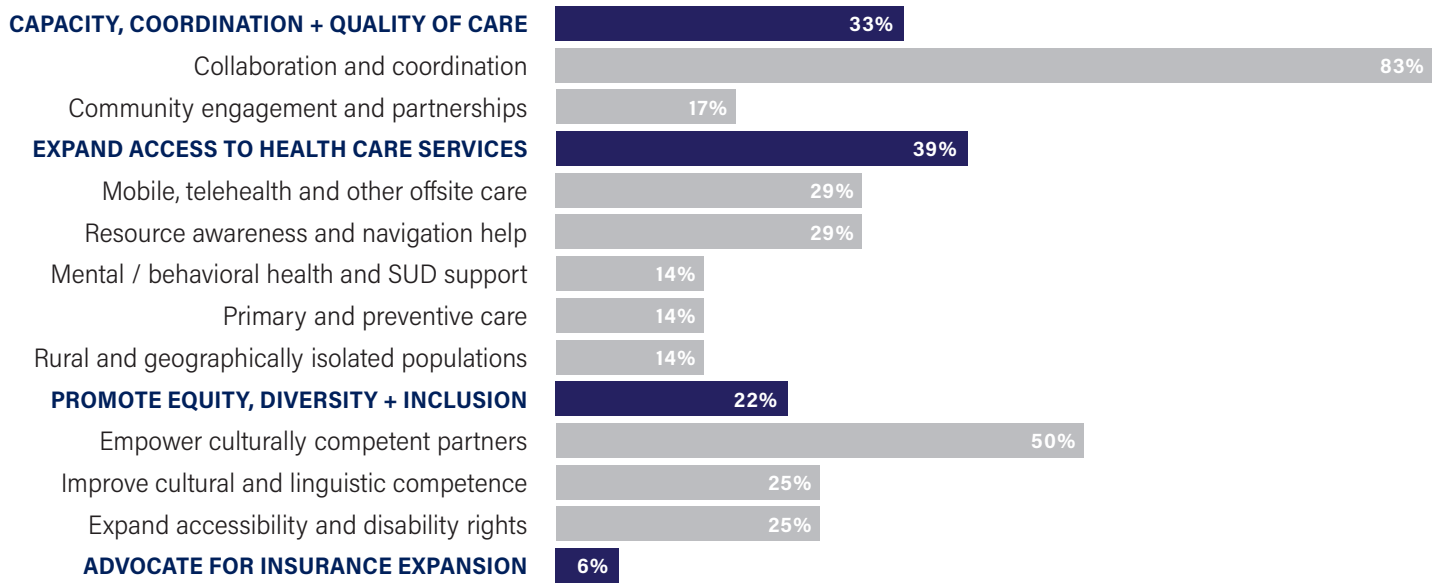
Describe your community's issues with accessing health care.



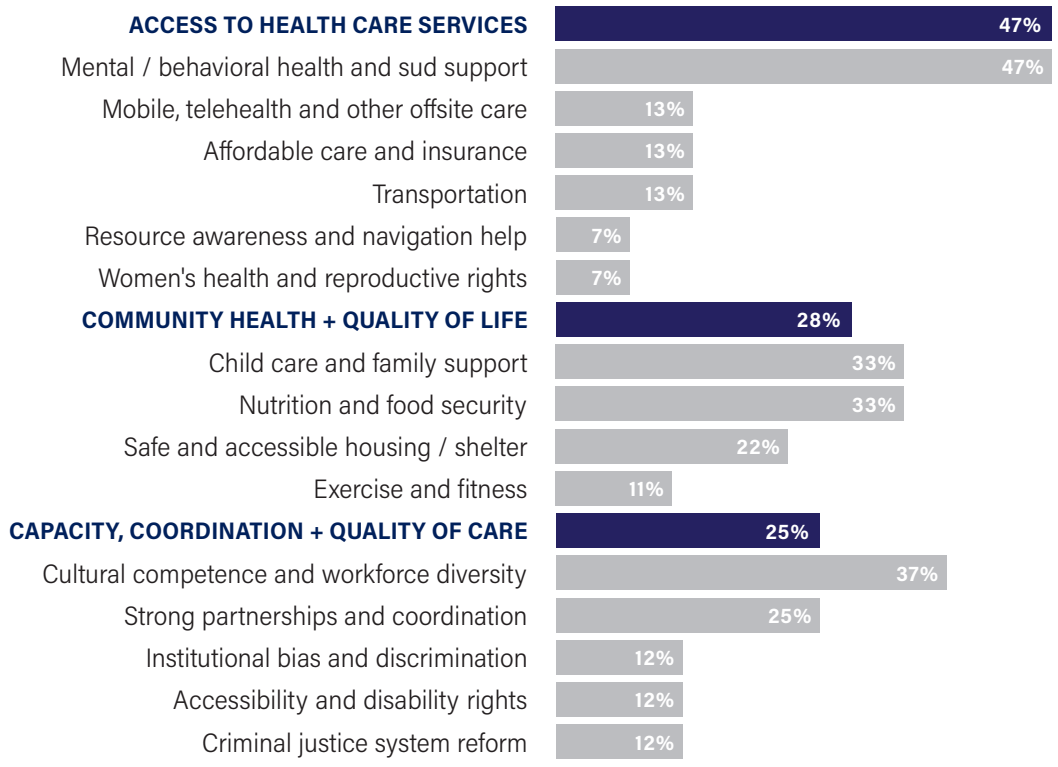
What do you see as emerging health issues for your community in the next 3 to 5 years?



What could local and regional partners do to improve health and quality of life in your community?



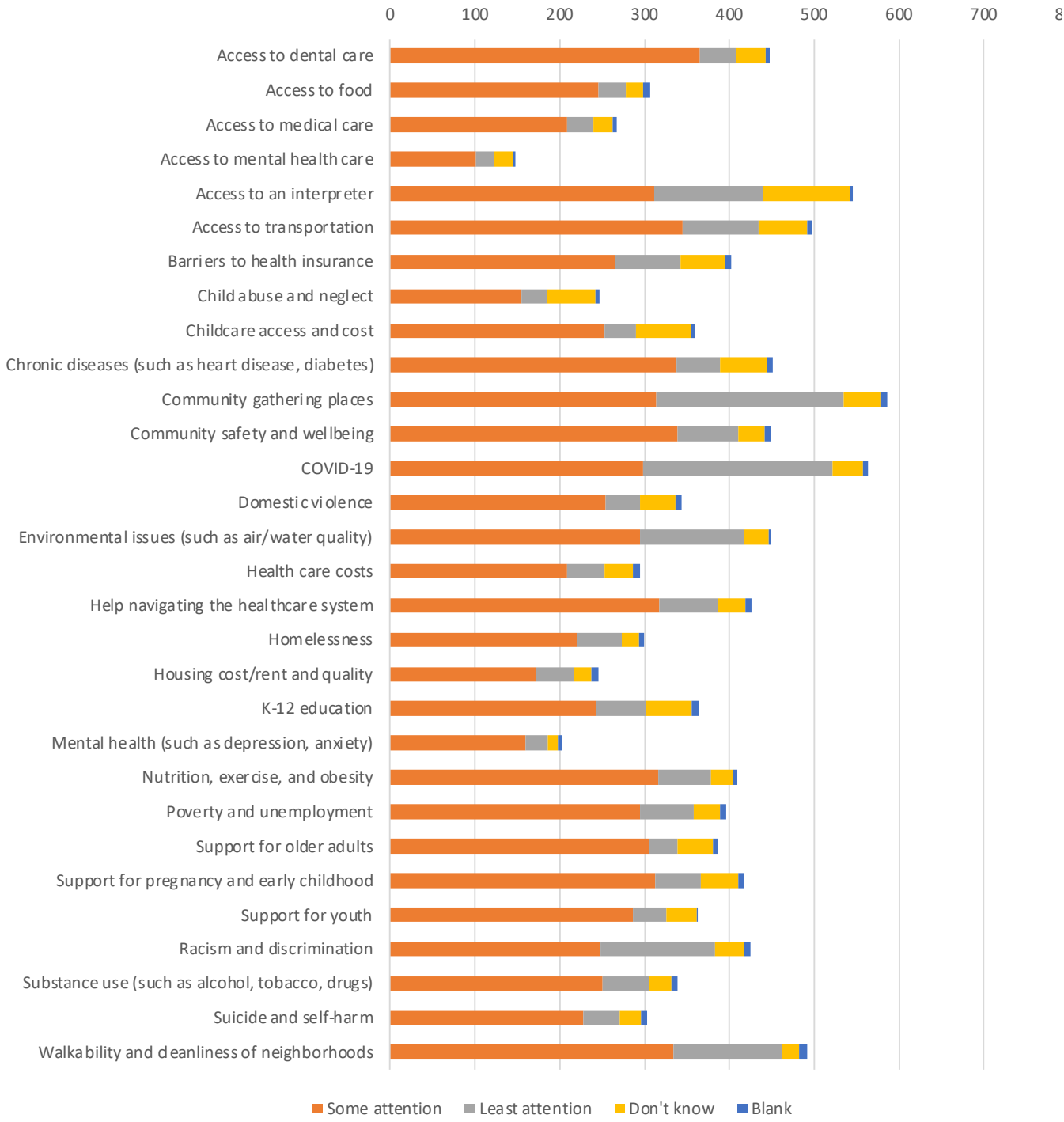
What do you think should be community health priorities over the next 3 to 5 years?



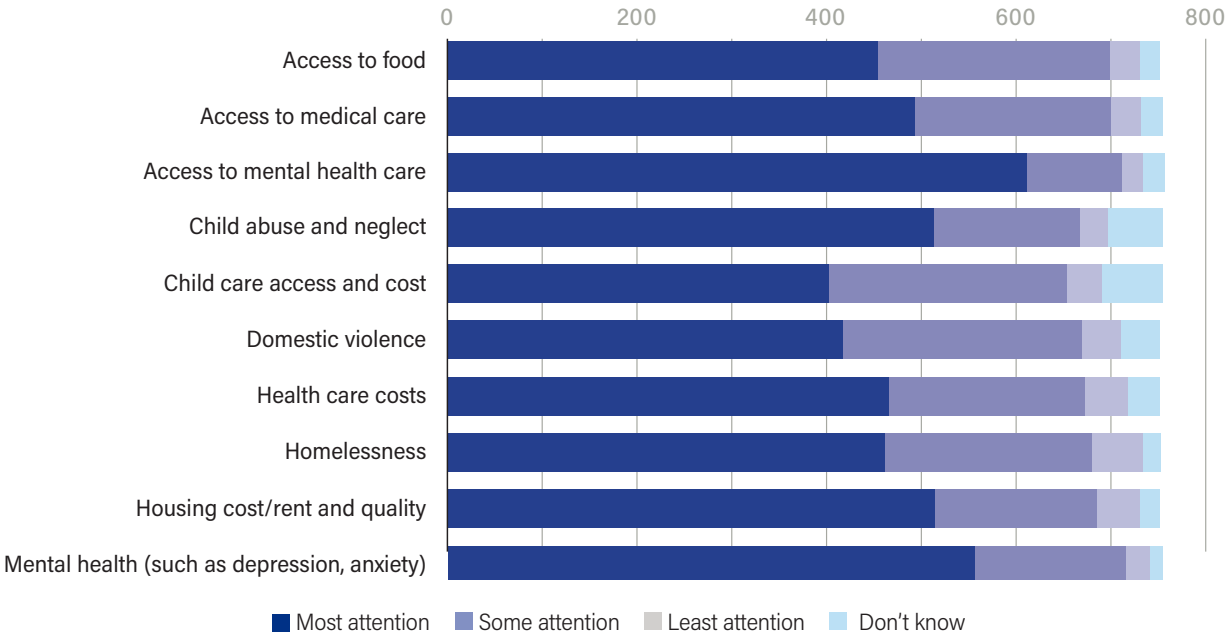
APPENDIX C

COMMUNITY SURVEY RESPONSES

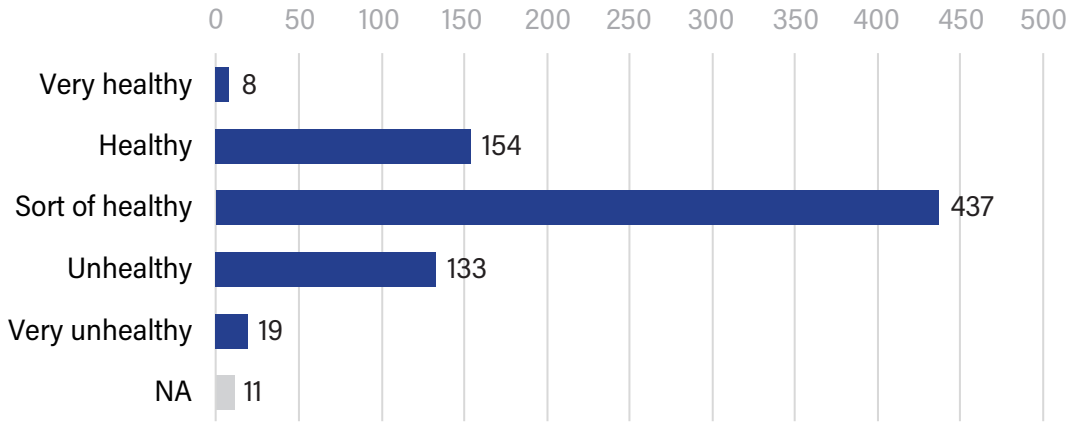
How much attention should be paid to the following issues?



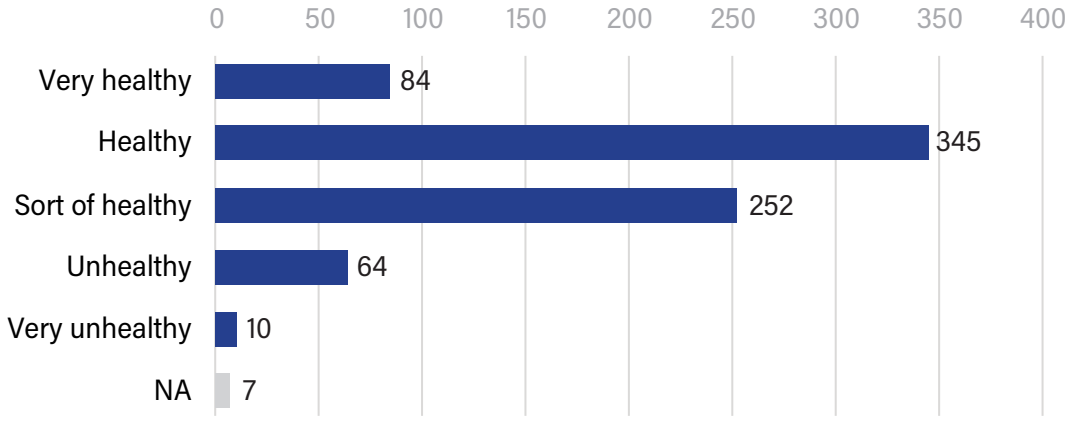
Highest priorities in Linn County according to the community survey.



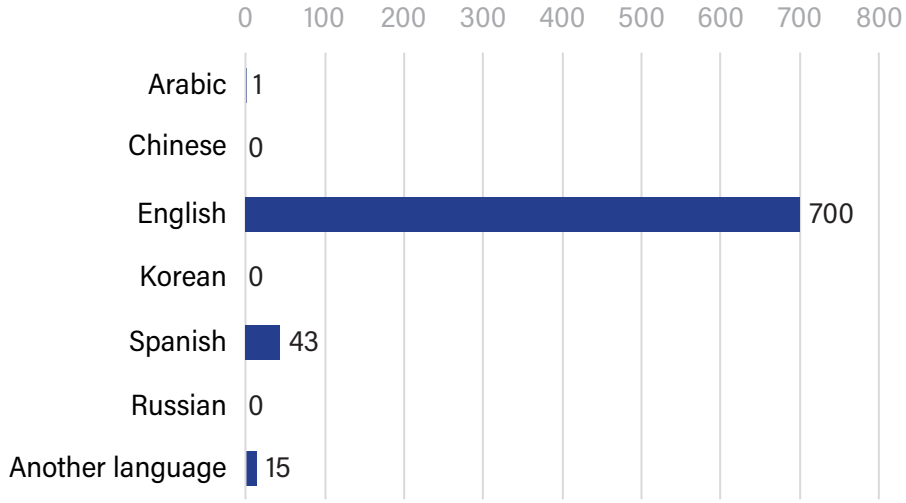
How healthy is your community?



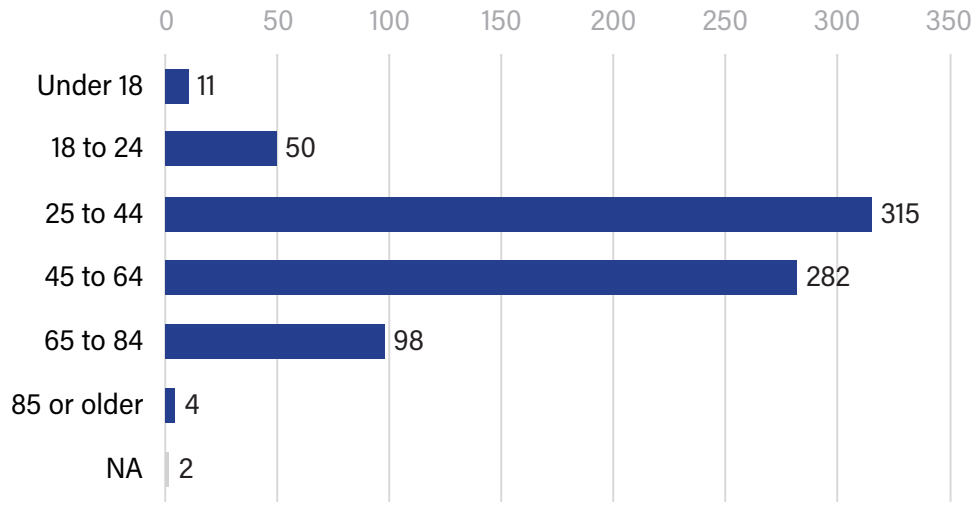
How healthy are you?



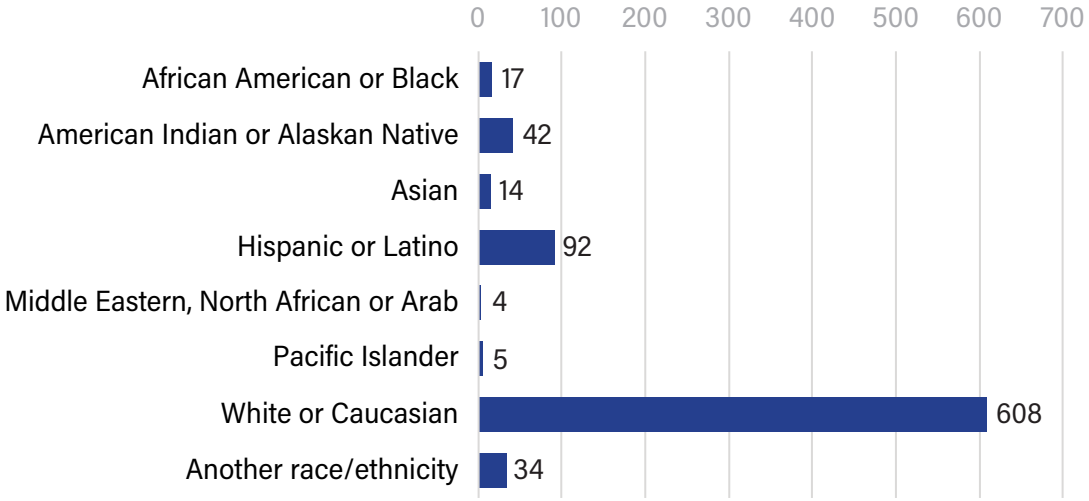
What language do you usually speak at home?



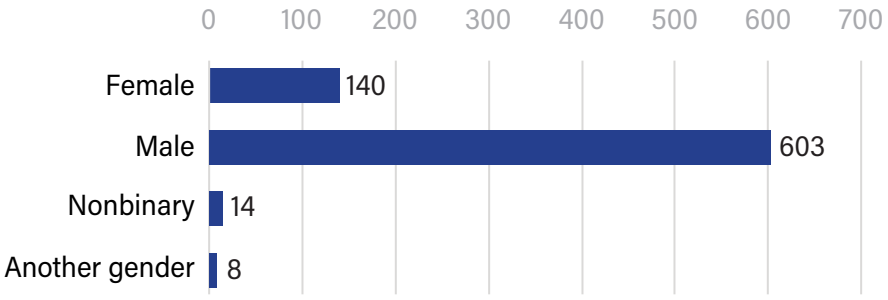
How old are you?



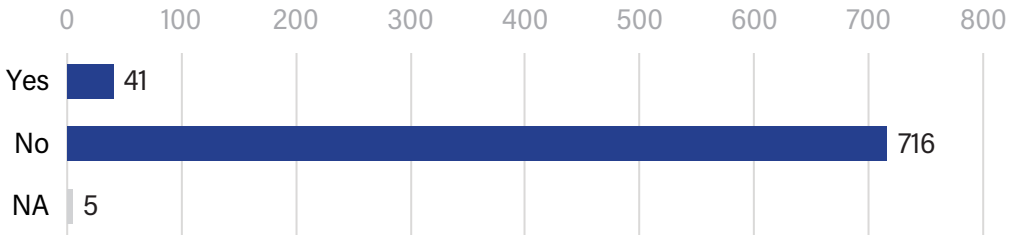
What race or ethnicity do you identify as?



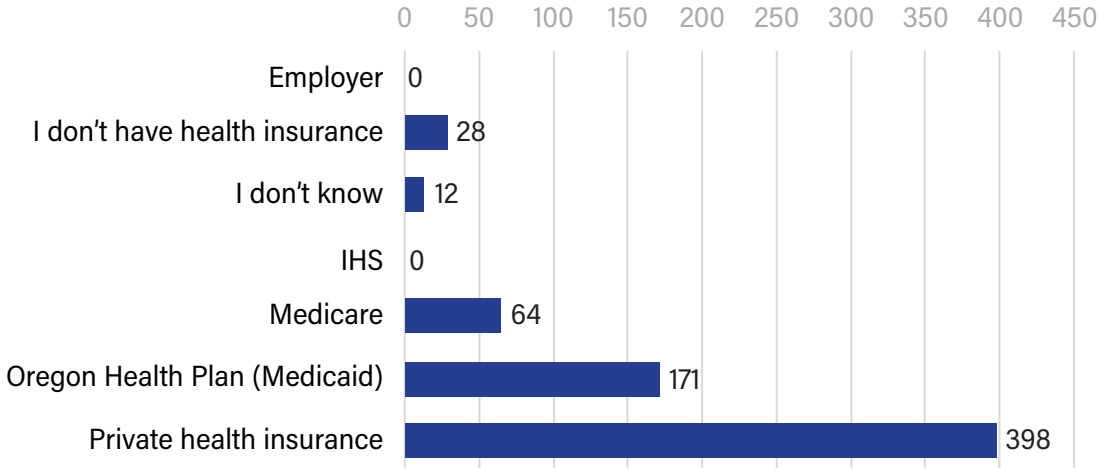
What is your gender identity?



Are you a veteran?



Where do you get your health insurance?



APPENDIX D

FOCUS GROUPS

Qualitative information from focus groups is used primarily to inform and confirm the overarching CHNA narrative and to provide quotes that illuminate common health concerns, individual experiences relating to understanding and accessing care, and the impacts of social determinants of health on specific communities.

Focus groups conducted in or relating to Linn County included representatives of Spanish-speaking and bilingual communities, the African American community, isolated rural communities, people with behavioral health issues such as SUD, the unhoused or unstably housed population, and health or social service providers.

Focus groups were conducted through an interpreter when necessary, and English translations were supplied either during the group or during transcription. The following section identifies major themes of these discussions and includes representative quotes from various focus group members.

In general, participants had the same concerns as other groups. **MENTAL AND BEHAVIORAL HEALTH ISSUES** (such as depression, anxiety, substance use disorder, domestic violence and sexual abuse) and **LACK OF ACCESS TO CARE** were cited as top priorities.

Access issues included lack of providers, appointments and staff; lack of transportation; cost of care; lack of care coordination; lack of senior care; lack of veterans care; and lack of resource awareness and navigation help.

- Everything that happens in our home is then reflected in our mental health. My child would ask me why I cry when I am having a bad day due to my health, and although I try to keep that situation from him, he is very aware of what's going on and the pain and stress associated with that. I have noticed that this too affects our relationship; he does not understand why sometimes I do not play with him and gets irritable because he is bored.

- Maybe there are resources and services specific for mental health, but if they exist in our community, they are very expensive and inaccessible.

- A lot of the kids that I've worked with, they're not willing to re-engage because of the provider turnover. They feel like they're constantly having to ... be retraumatized because this counselor doesn't know what they've already disclosed to the other counselor, obviously. So some of them are just like, "I don't even want to try, because I've already tried and that person just left."

- I think that our culture is not used to going to the doctor once a year to see if we are well or in good health. We only consider going when we feel bad.

- If you are asked about your health insurance, your citizenship status or your income, that creates a big barrier, and you decide you do not want to go through that because it is depressing and invasive.

- Sometimes people do not have enough money to go to the emergency room, so they wait to see if the illness passes because they think "I prefer to put up with it than to have another expense."

- Another thing related to culture in our home country: We didn't struggle financially that way, so we didn't ask for help. So it's hard to ask for help here. And besides asking for help, waiting.

Focus group participants were more likely to cite specific **DISEASES** as a top health problem. For example, Latinx respondents tended to cite air quality/allergies and diabetes as major issues in their community. Black participants cited the high rate of pregnancy-related deaths among Black women as well as issues relating to hypertension, heart disease, prostate cancer screening that disproportionately affect the Black community.

LACK OF CULTURAL COMPETENCE. Institutional bias and inequity, lack of workforce diversity, identity-based trauma shame and stigma, and lack of culturally and linguistically appropriate care.

Participants who hold marginalized and stigmatized identities tended to report more health issues, poorer mental and behavioral health, less access to social determinants of health (including housing and health care), and more experience of bias, discrimination, racism and inappropriate and/or inadequate care.

- When I'm experiencing a depressive episode and I can't get out of bed, I want to go to a therapist who looks like me. Because it's likely some of my depression is around something of a shared experience, because we're both people of color. And that just doesn't exist.

Participants from specific marginalized communities emphasized that experiences of trauma and bias will be difficult to undo, but that addressing institutional bias, workforce diversity and providing culturally responsive care and patient advocates are the minimum steps it will require.

It's important to note that institutional stigma and bias don't only affect marginalized groups. Multiple focus group participants—particularly those with dyed hair, piercings, tattoos and or "unconventional" clothing—reported that SHS staff had interpreted their ED encounters as drug-seeking behavior and left painful and/or life-threatening conditions undiagnosed and untreated.

Further, witnessing this type of mistreatment in an ED may distress fellow patients from many different backgrounds, lowering the perception of SHS and its quality of care for the broader community.

COMMUNITY HEALTH AND QUALITY OF LIFE issues include poor nutrition, food insecurity, lack of safe and accessible housing and shelter, and socioeconomic inequality.

- If everything we have is derived from our food intake then we are not taking good care of our own nutrition. We have relatives who have died of cancer, so if we don't have a good diet we will go through the same thing.

Selected answers to focus group questions

What people in your community do you view as having poor health and quality of life?

- Mothers, because we hide the pain to be well for the children.
- Hispanics because there is no confidence or trust to talk about what is happening.
- Farm workers, because they have to work in extreme climates.
- Black people that have an added layer of oppression on top of being Black: so, those that fall in the intersection of being Black and being trans or LGBTQ+.
- People struggle with access to healthy food in some areas. ... They might only live next to places that are more like fast food or convenience store-type food.
- Folks who have engaged in drug use or misuse, and even though they probably are in recovery now—those folks' bodies have been through hell.
- People who are living unsheltered and don't have an option of shelter and can't make all those different appointments in the gaps and services.
- Stress is the silent killer that will kill you. And it manifests in so many different ways that you don't even know it.
- Undocumented, because they do not know their health rights and are afraid to ask for help.
- Seniors affected a lot by the confinement during COVID.
- Children sometimes because they are playing do not eat a proper diet. They give priority to play than to eat, or sometimes in schools they grab food that is not so healthy.

Which social determinants of health most affect your community?

- I think discrimination plays a big role in the lack of reliable health care services. I have had traumas caused by what seems like medical neglect due to discrimination.
- Parents are so focused on just surviving and making sure they can pay the rent, or the mortgage, or whatever — you know, put milk on the table — that the value of education is no longer in the picture.
- There are a lot of people who are working for the minimum wage; it's not really a livable wage. And then on top of that, the prices of rents in the area are not compatible with somebody who is making minimum wage. And it just seems like that disparity gets bigger and bigger — rent keeps going up.
- Lack of education about drugs and harm reduction.
- Lack of birth control/sex education and reproductive health education.
- Shortage of baby formula. You know, they're feeding their babies with things that aren't fortified with all the Brain Stuff. And so we're gonna see the effects of this in three or four years when these kids have delays because they didn't get the nutrients they needed.

What are the most significant barriers to improving health in your community?

- I've had people with maggots in wounds on the street refusing to go to the hospital because they were treated so badly.
- It's scary to go to the doctor. You don't know what your bill's gonna be! I went to the ER and it was thousands of dollars. No one can really afford that. So then you almost want to not go.
- Not being well informed. Let's say in my case that I am going to Corvallis. If a friend has dental problems and she asks me, "Well, where are you going?" I tell her where to go, or sometimes there is information posted on Facebook for people to learn where to go because sometimes people don't know where to go to receive dental services.
- Most of us go when it is already too late. We already have this big problem of illness, or a very serious family problem, so then is when we go to the doctor or to a counselor.

- I never asked for any services my U.S.-born children qualified for because I was scared of all the questions they were going to ask about me and my husband.
- Feeling like you're treated differently because you have state insurance or you have OHP. Like, I had to swallow my pride because my kids matter ... But I could see how some people would be like, "This wasn't worth it. The shame was not worth it."

What do you see as emerging health issues for your community in the next 3 to 5 years?

- When the pandemic ends, people's mental health is predicted to get worse. I feel like I'm already seeing some of that with folks, and that's for people housed and unhoused alike.
- The younger generation, very reasonably, doesn't have confidence in the large systems. It would actually be insane if they did, given their experiences — that would be the definition of insanity, if they had confidence in those systems. At the same time, that's the direction we need to move because it's way more easy to destroy it than create. It's way easier to divide than bringing people together.
- If schools continue offering the same meals, another big problem would be diabetes in children and teenagers.
- There was a lot of division in our country. And the fact that we were all isolated and online just created more division. And so people are coming out of this pandemic and they're still isolated socially.
- Agitation, frustration can manifest itself in forms of violence, prejudices. And that fuels fear, which fuels more violence. And that's a little bit scary. I think that is inevitable unless our communities are able to come together and change things.
- I keep insisting on child care, because even though they want to go to work they can't, so they don't help their own family finances and they can't give themselves a better kind of life or have better opportunities.
- The biggest problem that we're experiencing now — and we'll continue to — is the workforce. We've got to get a larger workforce in the health care field and in the prevention, treatment and recovery field.
- One of my daughters was threatened. One of the kids said they're gonna get their grandpa's gun and bring it to school, and it was not addressed properly at all. And I felt unsafe at that time. ... Safety in our schools is a huge issue.

If you could do just one thing to improve health and quality of life in your community, what would it be?

- Nutritionists that work with low-income families ... I have wanted to go to a nutritionist, but they are expensive.
- Build groups that inform the community of their rights and resources available in their community.
- If I was going to do one thing, it would be a community center for Black people that can be welcoming to the rest of the community. It would be something like the Black Cultural Center on campus, but for the area at large.
- Culturally appropriate community resources; no one would ask about your citizenship status.

What can the hospitals, health departments, OHP providers and community organizations do to improve quality of life in your community?

- We need an emergency mental health department where people can get ... actual services instead of being pushed out the door by a social worker to make an empty bed.
- Have health navigators to help the community.
- Access to interpreters in multiple languages.
- Build groups that inform the community of their rights and resources available in their community.
- These organizations [should have] nonbiased advocates that are able to check in with the families and be like, "OK, let's fill out this form together."
- In addition to fixing the systems in their own facilities, I think also putting money in the hands of Black-led organizations that know how to exactly what their people need.
- We need a needle exchange in Linn County.
- Our CBO is putting in micro shelters on a piece of land with a navigation center. They can be there 24/7 and have a safe place to sleep. And it's managed 24/7, so they always have someone to go to. And we have services arranged to come in to meet them in our navigation center, so they don't have to go out and try to make all these appointments.
- I think we need more trainings with providers to address the way they treat people that use drugs. Are people experiencing homelessness? Are people engaging in sex work? You know, just marginalized communities in general. I think we could just be so much more effective—even if we still have long wait times—if people were treated like they mattered and like they were important when they came in for care. I think that would make a big difference.

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