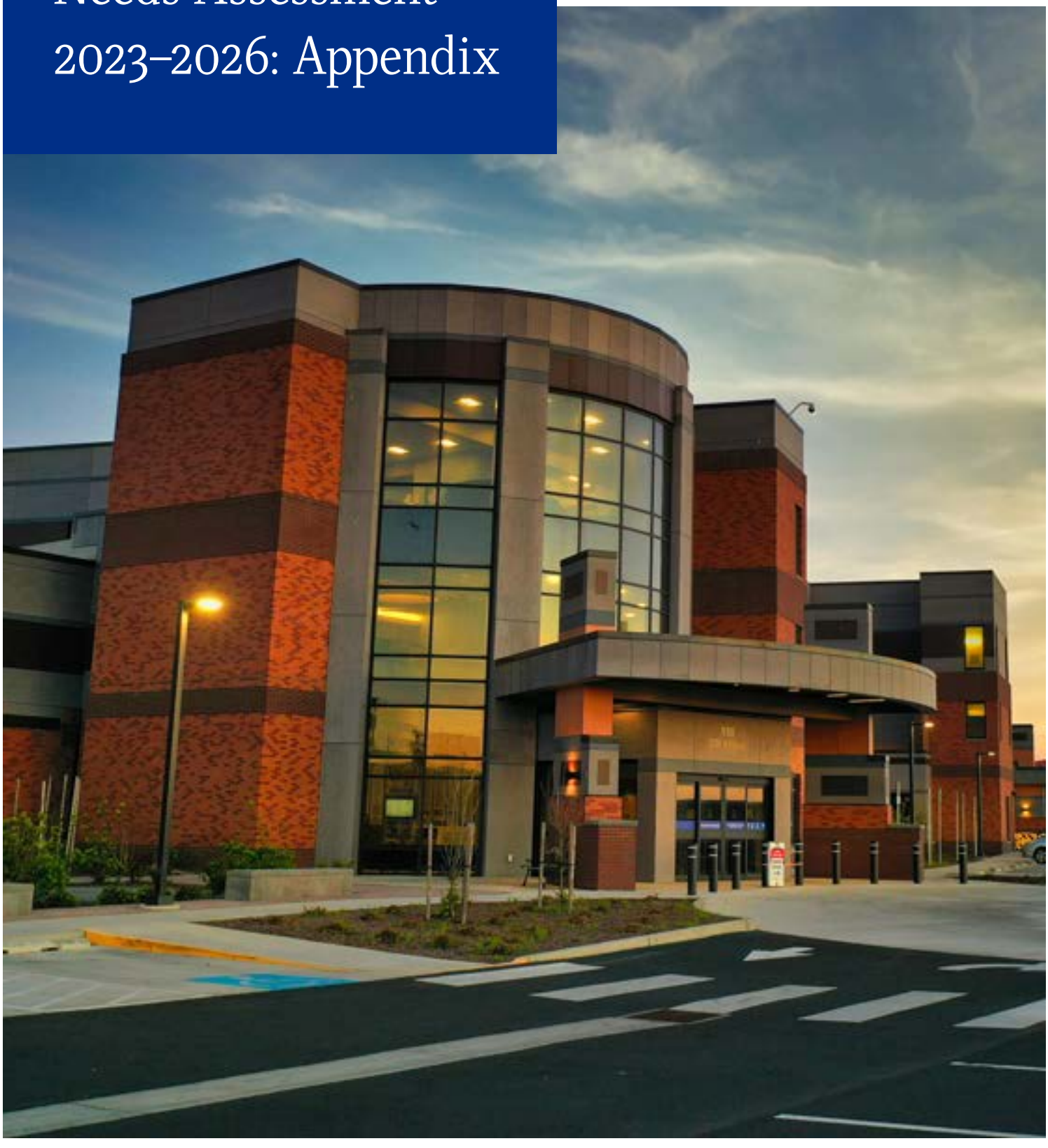
SAMARITAN PACIFIC COMMUNITIES HOSPITAL

Community Health Needs Assessment 2023–2026: Appendix

Samaritan Health Services



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COMMUNITY PERCEPTIONS OF HEALTH

Overview

Key informants see a decline in health (86%) and quality of life (80%) for Lincoln County residents over the last three to five years. The primary contributing factor (40%) was the COVID-19 pandemic, the most commonly cited effects of which were isolation and other mental health impacts (52%), delayed diagnosis/treatment and other physical health effects (19%), economic and supply chain effects (19%), and effects on the disability community (5%).

> *If you don't have something that changes the situation, the situation is going to continue to degrade. … It takes more than we have been able to allocate in resources to really change that trajectory. We see worsening childhood poverty, we see worsening teen pregnancies, we see more smokers in Lincoln County. You know, there's just worsening of those health factors — higher STD rates.*

Other contributing factors include inflation and the high cost of living, lack of access to providers, care and resources; environmental and climate issues (especially in relation to wildfires and heat waves); lack of child care and family supports; and high levels of political and social conflict (including gun violence). Long-standing problems such as lack of safe and affordable housing, lack of transportation, cost of care, and lack of resource awareness and navigation skills also remain in force.

What are the biggest health problems in Lincoln County?

MENTAL + BEHAVIORAL HEALTH. Lincoln 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 disorders (SUDs), 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.

> *At a baseline, a lot of kids and teens experience anxiety and depression just as part of growing up. But certainly with the pandemic — and other pressures and other issues — we're seeing a huge increase in diagnosed major depression and major anxiety issues, to a point where suicidality in kids has increased, and we're seeing more kids and adolescents in our emergency rooms and our crisis centers and at the schools.*

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. Lack of access to providers, appointments and support was the most commonly cited barrier. Other persistent barriers include the lack of transportation and the lack of cultural and linguistic competence.

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.

> *The investment in technology and telecommunication and telecommuting — all of that has really improved quality of life for a lot of folks. ... We have the opportunity to remake what was day-to-day life in a more accessible way. I'm not gonna lie to you: pre-pandemic life wasn't perfect. But comparatively ... some folks were so much happier and healthier because suddenly, things were available online that were never available before.*

COMMUNITY HEALTH + QUALITY OF LIFE. Lack of access to safe, stable 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. Poor nutrition and obesity are major concerns, 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.

DISEASE + DISABILITY. COVID remains a significant problem, especially for people with disabilities and other preexisting conditions.

> *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.*

Ongoing concerns include declining senior health and chronic health conditions such as diabetes and cardiovascular disease, all of which are complicated by the ongoing spread and evolution of COVID.

Who has poor health + quality of life?

LOWER SOCIOECONOMIC STATUS. Low-income residents — including seniors, people in unsafe or unstable housing, the uninsured

and the underinsured, and people who work in the tourist-service industry — 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.

> *Those who are doing any type of customer service for tourists that come through our community. Those jobs have been very difficult —especially the last couple years — with many places closing down and income not being as certain as it used to be. And then the high cost of living has impacted their ability to maintain stable and safe housing.*

The county's limited housing supply has been further depleted by the conversion of many properties to vacation rental dwellings. The housing shortage was also worsened by the loss of nearly 300 homes — and an unknown number of microshelters and encampments — in the Echo Mountain Complex fire. The rising cost of living is likely to increase the unhoused and unsheltered population along with the number of unsafe or unhealthy dwellings. Further, people experiencing poverty and housing instability often have multiple stigmatized identities that complicate their search for new housing.

MARGINALIZED POPULATIONS. Indigenous people, communities of color, LGBTQIA+ people, migrants, refugees, people with disabilities, people with SUD, and "basically anybody who's different from the white majority" is at risk for poor health and quality of life. They 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 barriers in receiving one-on-one care and in navigating the system.

> *Some of our undocumented folks in our racial and ethnic minorities, again in terms of access to care — access to culturally relevant care There are great efforts that are being done in the community and other places, but we have a long way to go.*

OTHER GROUPS

- **Seniors** in Lincoln County are often challenged by inflation, especially those who are on a fixed income and already struggling with housing costs. They may also have worsening mental and physical health due to social isolation, lack of exercise, and avoidance or postponement of medical care due to the pandemic. Because of staff shortages at nursing facilities, those who do receive acute care often have no place to go upon discharge and must stay indefinitely in an acute care bed.
- **Residents with mental and behavioral health issues** — including SUDs — face significant health challenges in addition to the costs, navigational difficulties and stigma associated with mental illness and substance use.

> *Some of our undocumented folks in our racial and ethnic minorities, again in terms of access to care — access to culturally relevant care There are great efforts that are being done in the community and other places, but we have a long way to go.*

Which social determinants of health most affect our community?

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

- Access to health and behavioral care (21%).
- Access to housing and shelter (21%).
- Transportation (15%).
- Access to healthy food (13%).

Other determinants cited include racism and discrimination, education, employment, access to education, community engagement and resilience, access to green spaces, and accessibility/disability rights.

What are the main barriers to improving health?

BARRIERS TO 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.

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

appointments. 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.

> *It's difficult to keep people here when there's not adequate housing for them to live as a working professional — not a lot of options. And then the fallout of that is that they don't stay for very long, and our families are faced with yet another change in provider and stability for their own housing as well.*

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.

LACK OF SAFE + AFFORDABLE HOUSING. The housing crisis was cited as a primary obstacle to improving community health and quality of life and as a major obstacle to addressing workforce shortages.

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.

> *Who are the people in power that are implementing the direction for initiatives? If you're talking about policy change, or implementing a new strategic plan to tackle X, Y and Z, I think you need to have voices from the communities that you're serving at the table where decision-making is happening.*

The problem is complicated by a highly vocal and visible — and in some cases, explicitly white supremacist — political movement opposing equity, diversity and inclusion. Against this backdrop, continued institutional inertia and insularity may deepen the mistrust and trauma 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.*

POLITICAL + FUNDING ISSUES. Inequitable allocation of funding and resources is a barrier to improving health, especially given the many differences between county communities, underserved and marginalized populations, and so forth.

> *Resources are always limited in some way. There's much more attention now on making that allocation more equitable. But for all these needs — all these communities where we put our time and money — should it be on the sports team? Or should it be on an additional counselor in school?*

What are Lincoln County's main assets or strengths for improving health?

COMMUNITY NETWORKS are some of our greatest assets, tackling a wide range of issues and serving populations that may find it hard to get help anywhere else. Often rooted in the strengths, practices and resilience of specific cultures, community-based organizations and community health workers and navigators 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.

> *This might be a word that gets thrown often, but I would say that resiliency is key. The communities we serve are so strong and have such connections to their heritage and their roots for perseverance and, for lack of a better word, almost like trust or hope. And I think that comes from ensuring something better for generations to come. So paving the way for children, for grandkids coming in the future. That is a strength for sure.*

Strong partnerships between public health, social services, schools, hospitals, local government, CSOs and CBOs expand access to care, coordinate activities, and allow the organizations with the most expertise and trust to serve their own communities, ideally with the financial and logistical support of partners.

> *I think it's always great when you embed people in places where they already are. I've seen a lot more done with the school districts, and I think in a post-COVID era ... anytime we can meet meet a family where they already are, I think it's helpful. So just continuing to do more work within the schools if we can, with some of those community health navigators through the health department embedded in nonprofits.*

CARE PROVIDERS + RESOURCES. The county's public health agencies are a vital asset, and SHS remains an essential and forward-looking partner in health improvement efforts, including through telehealth.

> *We have the critical access hospitals that really do a lot to try to improve health in terms of education and nice new facilities. They offer free education to people in the community.*

The county's services for people with developmental disabilities was also cited as a major strength.

> *The developmental disability system in itself a huge safety net for people with developmental disabilities. The homelessness issue would be so much more within our communit if our system didn't exist. For those people that do qualify for our services, there's a lot of planning, coordination, support monitoring, specifically around health and safety — we are accountable for all of our clients. So the system itself, despite the lack of capacity, is definitely a positive.*

COMMUNITY ENGAGEMENT + ADVOCACY. Respondents emphasized the caring, commitment and resilience of Lincoln County communities, especially in the face of disaster, hardship and loss.

> *My experience here in Lincoln County is that the folks who live here are really committed to this community. I mean, the people that I know — from the seniors who have decided to retire here, to the folks who were born and raised in Lincoln County — everybody, I think, is very committed to this county. They appreciate the beauty of it; they appreciate, obviously, the ocean. ... As I like to say, people are pretty tribal here in Lincoln County. And so there's definitely a sense of commitment to addressing some of these really tough issues that we're facing.*

What do you see as emerging issues in the next 3 to 5 years?

For many 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; the still-unknown extent of unreported child abuse and domestic violence during pandemic lockdowns; 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, suicidality, disability, and gun violence 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, gun violence, hate crimes, the need to rebuild a sense of community, and the ongoing evolution of addiction (including the increased prevalence of fentanyl).

> *I think we're gonna see more and more fentanyl deaths. I think we need a a task force in Lincoln County. We're going to continue to have the fentanyl epidemic continuing to get worse if we don't stand up as a community and say, "We're not going to allow this in the community, and we're gonna actually focus on this happening."*

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

By far, the primary preferred goal for the hospital system, CCO, public health department, government agencies, and CBOs was to improve their coordination, cooperation and communication, both with each other and with the communities they serve.

> *Our community-based organizations just need our support — meaning public health, CCO, hospitals. Everybody needs to partner together and just work together on different initiatives. Have a better alignment on what needs to get done and how to do it. The true tragedy is, we just don't have enough community-based organizations to get done what needs to get done. Part of that is being in a rural area. But I'm just so jealous when I hear about Benton County and how they address homelessness ... they have multiple resources, and we don't even have one. ... But I do know that nobody at these community-based organizations is slacking off. I mean, everybody's trying to do their best.*

Larger entities also need to recognize that their policies and requirements can represent 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 — particularly from leadership and decision-making roles — and the ongoing failure of regional institutions to improve cultural competence.

> *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.*

Partners can also work individually and collectively to provide a healthier, safer and more stable environment for their workforce.

> *I think it starts with treating our employees a certain way: letting them know that their needs are going to be taken care of and that they have the support they need to perform their jobs at the highest level they can. Because that trickles down to the community we serve. If we are in good health and standing, and we feel like we're stable and supportive, we're able to provide that to our clients, which is our community. We live here and we work here, so we're all connected in that way.*

More generally, these partnerships have an important role to play in recovering from COVID-19 and restoring a sense of community.

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

HEALTH CARE SERVICES + ACCESS. Increasing services, supports and housing for people with mental and behavioral health issues is an immediate need. Access to medical, mental/behavioral and dental care needs to increase and improve, along with necessary supports like transportation, technology skills and access, insurance literacy, health navigation, patient advocacy, cultural/linguistic competence, and accessibility. Where possible, partners should aim to bring care to patients offsite (e.g., through mobile services, pop-up clinics and alliances with schools, culturally specific organizations and other community-based partners).

> *Why don't you get rid of these buildings — these massive buildings for the health department? Make a central office. Get a bunch of vans, like little mini motor homes. Go all over the place — schedule appointments in people's homes.*

Another recommendation is to increase peer support services beyond the ED, so that they can meet people before they're in an acute crisis, and hopefully avoid overdoses

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

COMMUNITY HEALTH + QUALITY OF LIFE. Priorities include the housing crisis; supporting children and families with resources like child care and parenting education; nutrition and food security; access to education and jobs; and fostering community resilience and engagement in the wake of the pandemic, gun violence, and intense political and cultural divisions.

> *We need to get really serious about this whole kind of resiliency back. A lot of folks are feeling very isolated and distanced, which has long-term impacts on your emotional health and your physical health. But again, you've got to get people to* want *to come out. And that's the struggle that we're having: How do we get the kids to re-engage? We spent two years teaching people to stay home. Now, we've got to spend two years teaching people how to get back and how to re-engage. And I don't know if we've ever developed energies like this in public health.*

CAPACITY, COORDINATION + QUALITY OF CARE. Building cultural and linguistic competence, increasing workforce diversity, recognizing and supporting disability rights, and reducing institutional discrimination and bias are immediate needs.

> *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?"*

Strengthening partnerships and collaboration around regional health issues, community needs and social determinants of health is equally important:

> *Given the complexity, it is essential that we always work in collaboration. So this holistic, integrated approach, we need to emphasize it; sometimes we have too many meetings. So I would say, increase and improve the efficacy and efficiency of collaborative work.*

A stable, trained, trauma-informed workforce is required at every level of the health care and social services systems. Workforce recruitment, training and retention has taken on new urgency in the wake of COVID-19, the housing crisis, the

wildfires, and the high rate of provider turnover and retirement.

> *Increase in providers and staff members; incentives to keep those staff here. I would say flexibility is what people are looking for right now: just the ability to have a better work and life balance—trusting employees to manage their own workload and their own schedule in a way that works for them and their family while meeting the needs of their clients. Not so much micromanaging or having set schedules, but being able to work a few hours here and a few hours there, as long as we're meeting client needs within that. Right now, people just want that flexibility: the ability to say when and where and who. And I think we would keep a lot more staff.*

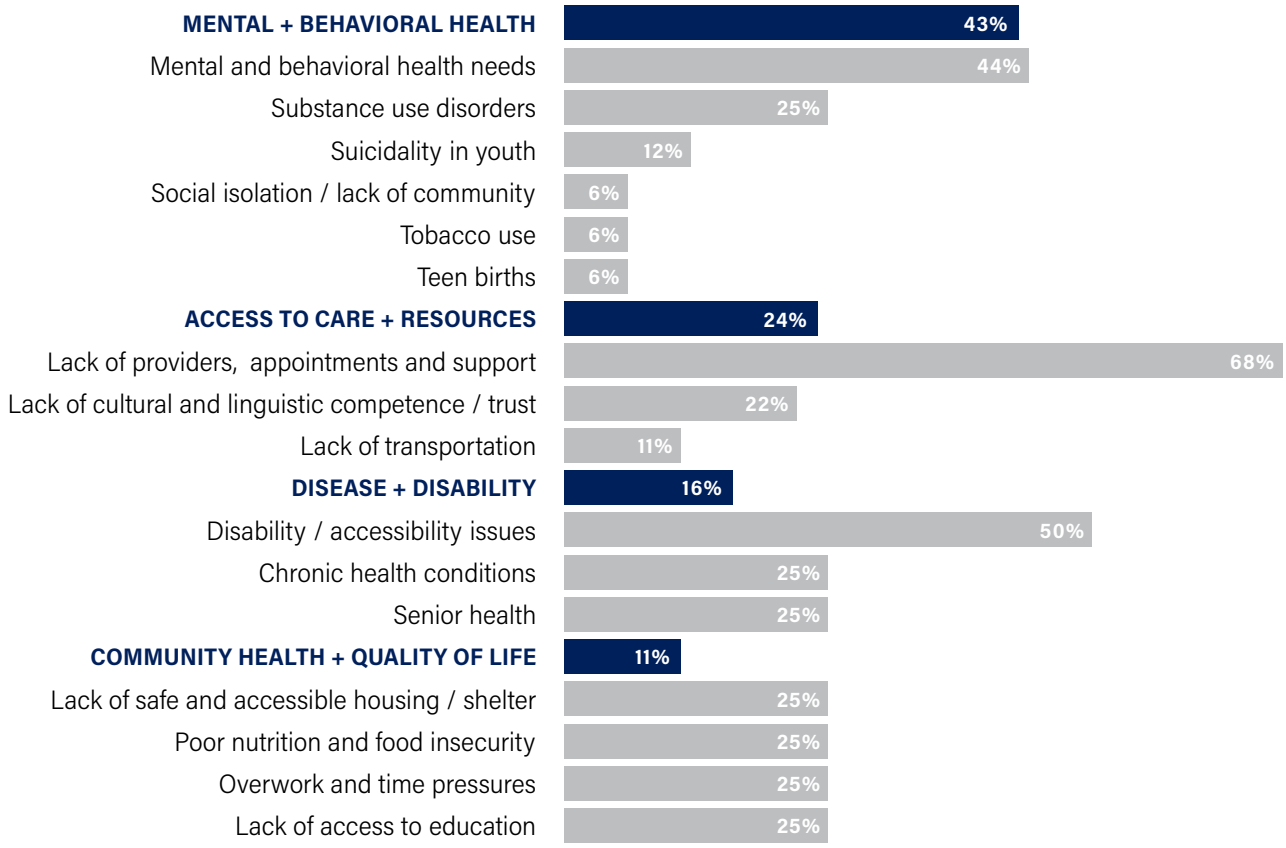
EDUCATION + OUTREACH. Priorities include promoting health literacy and disease prevention, and — where possible — identifying and addressing the upstream causes of persistent public health problems.

> *Community education, prevention and education about what health is, and increasing the awareness of social determinants of health and ACES — just bringing those to light so people really understand them.*

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; political conflict.

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. ADD

POSITIVE FACTORS

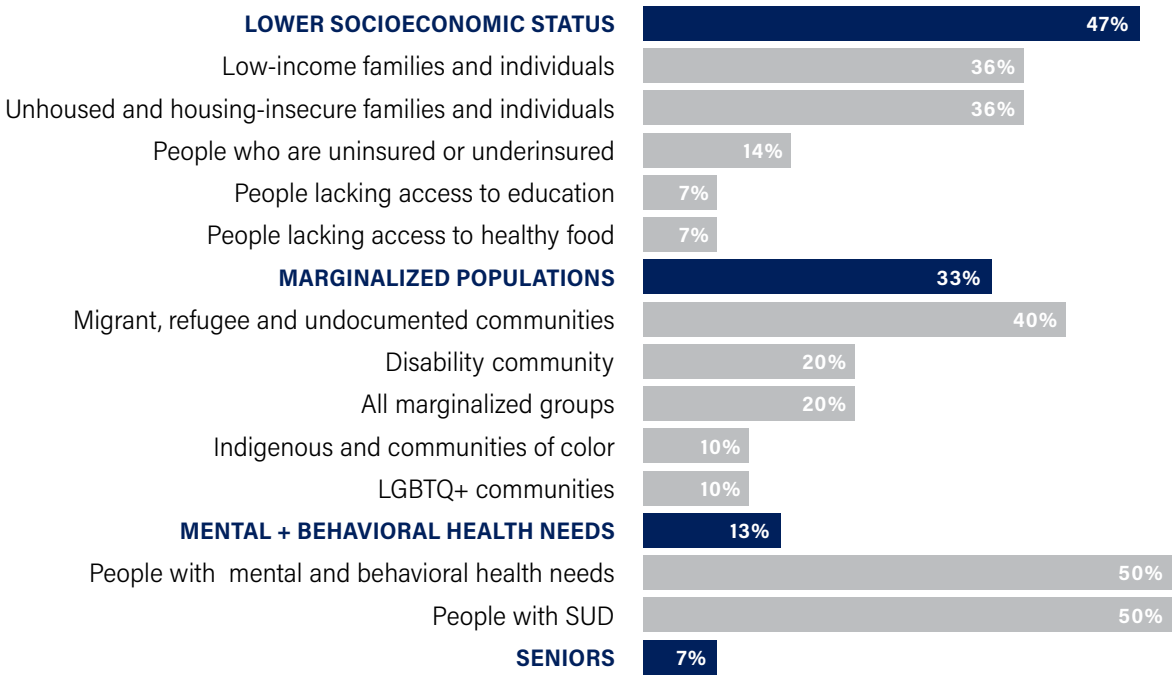
COVID-19 IMPACTS. Increased access and options for the disability community.

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

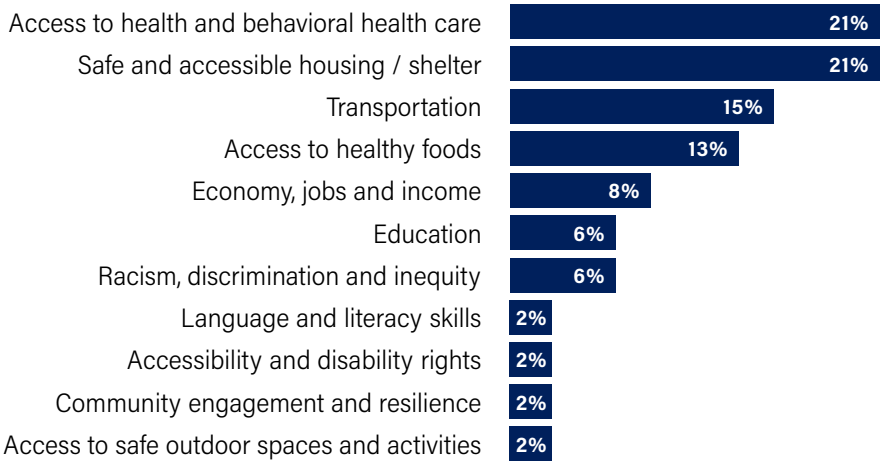
BETTER COORDINATION OF COMMUNITY PARTNERS.

MORE ACCESS TO CARE + RESOURCES. New and improved hospitals; more access to insurance through Samaritan Health Plans.

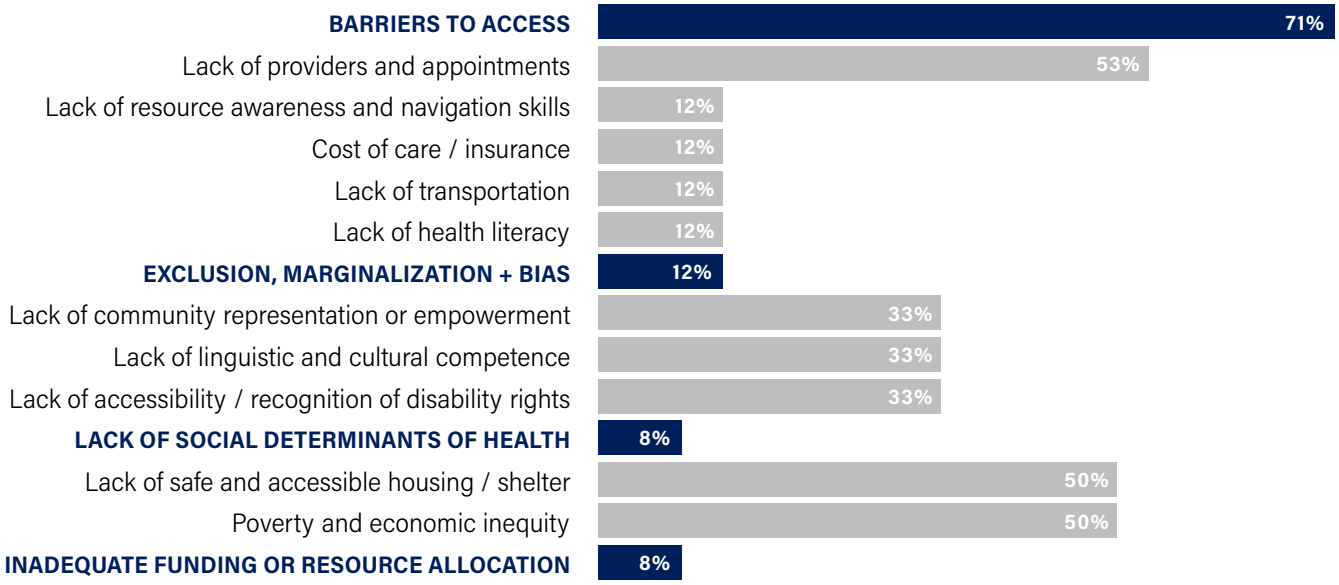
What people or groups of people in your community do you view as having poor health and quality of life?



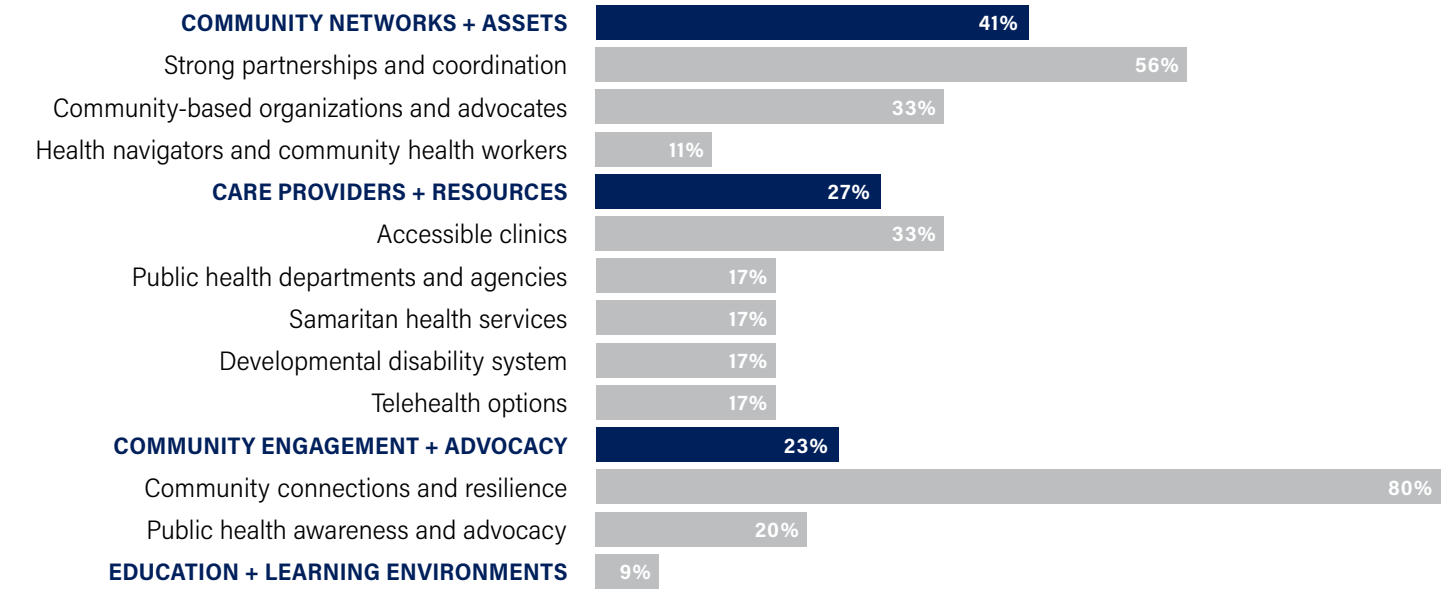
Which social determinants of health most affect your community?



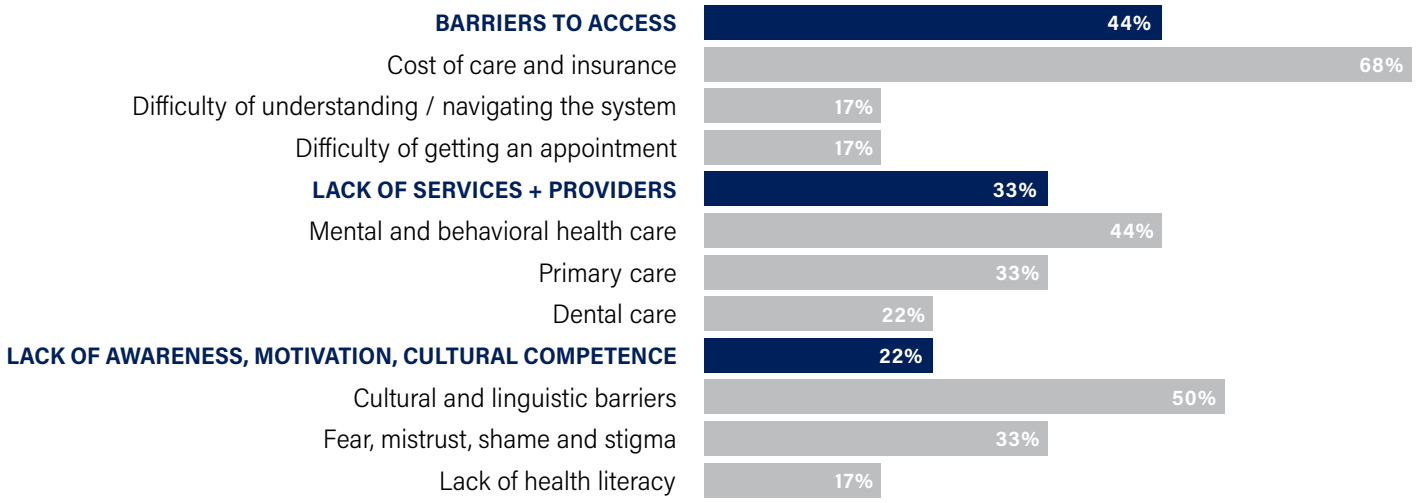
What are the most significant barriers to improving health in your community?



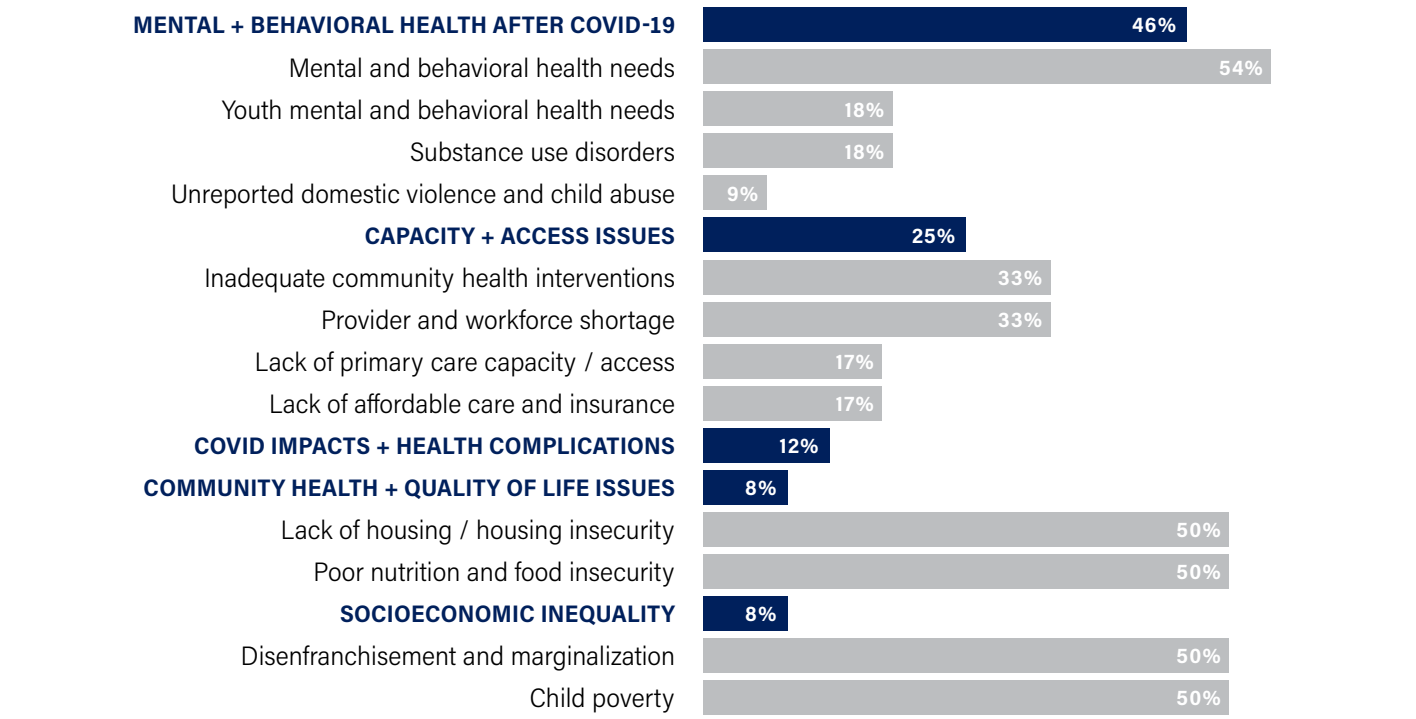
What are the most important strengths or assets for improving community health?



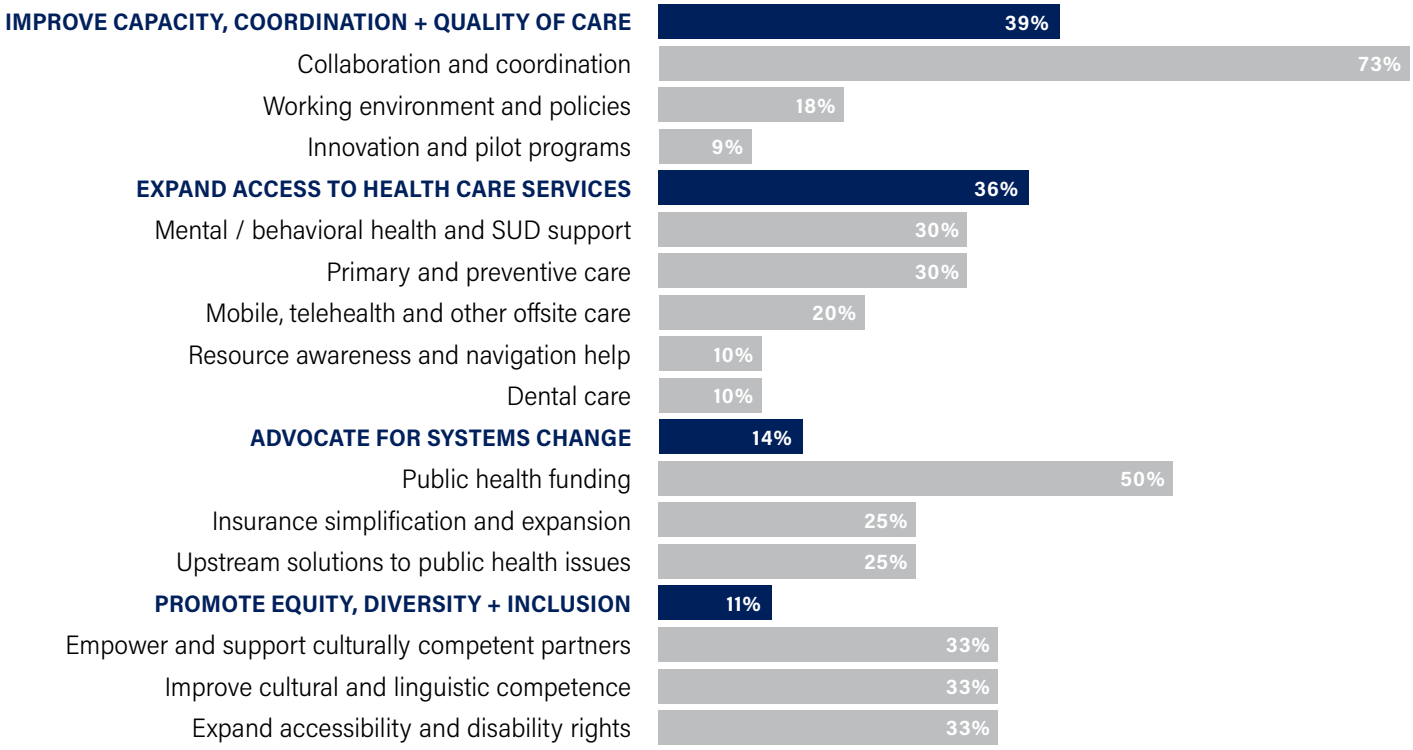
Describe your community's issues with accessing health care.



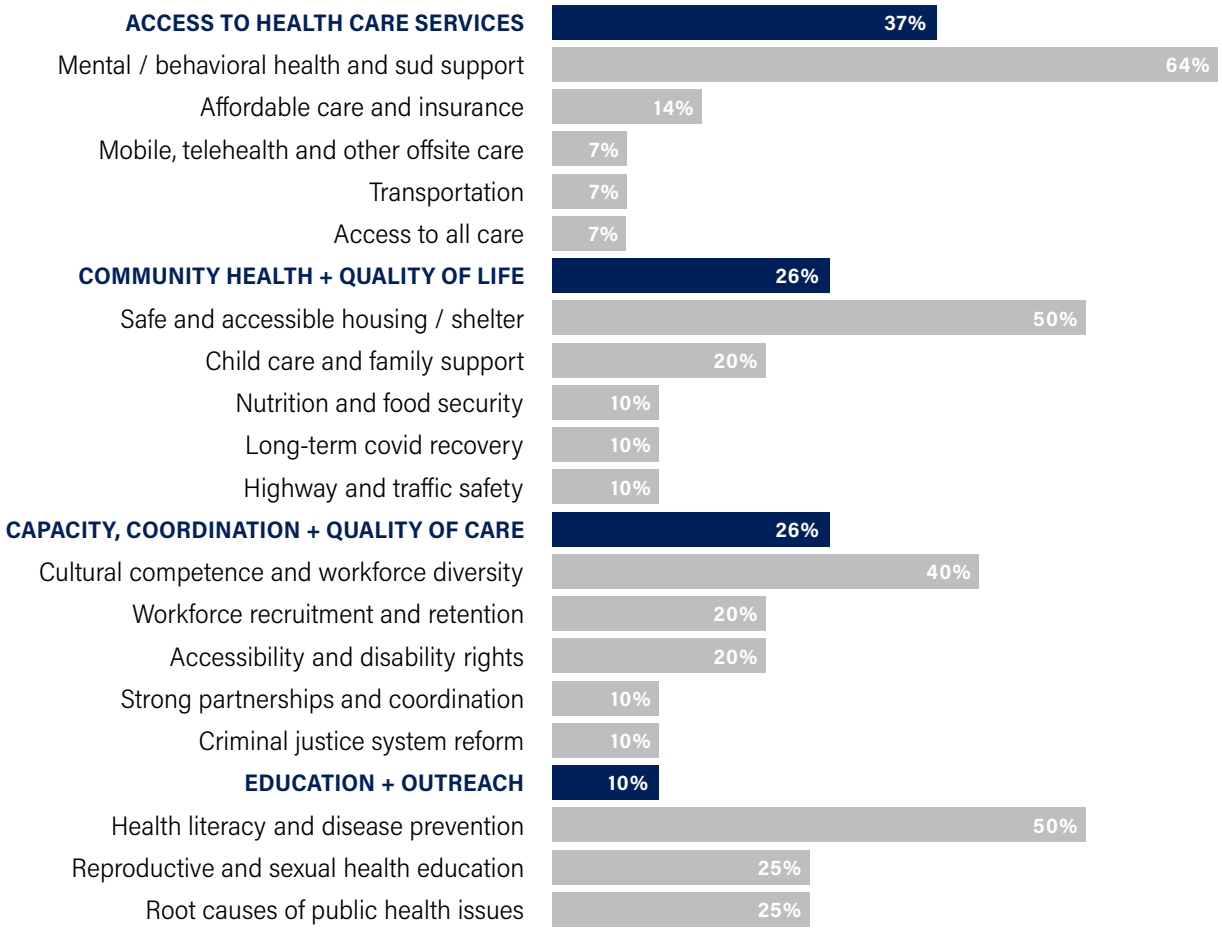
What do you see as emerging health issues for your community in the next 3 to 5 years?



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



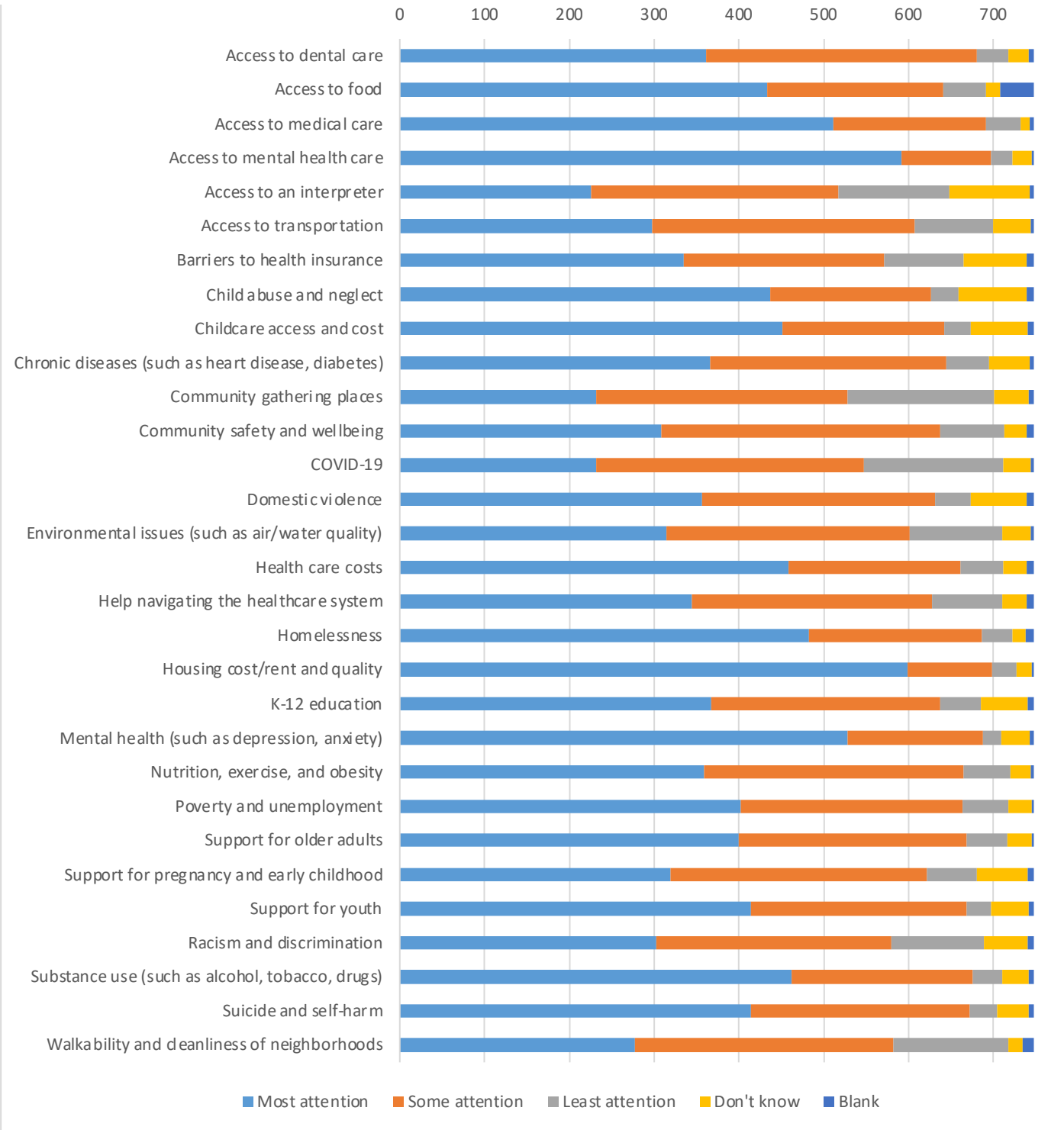
What do you think should be community health priorities over the next 3 to 5 years?



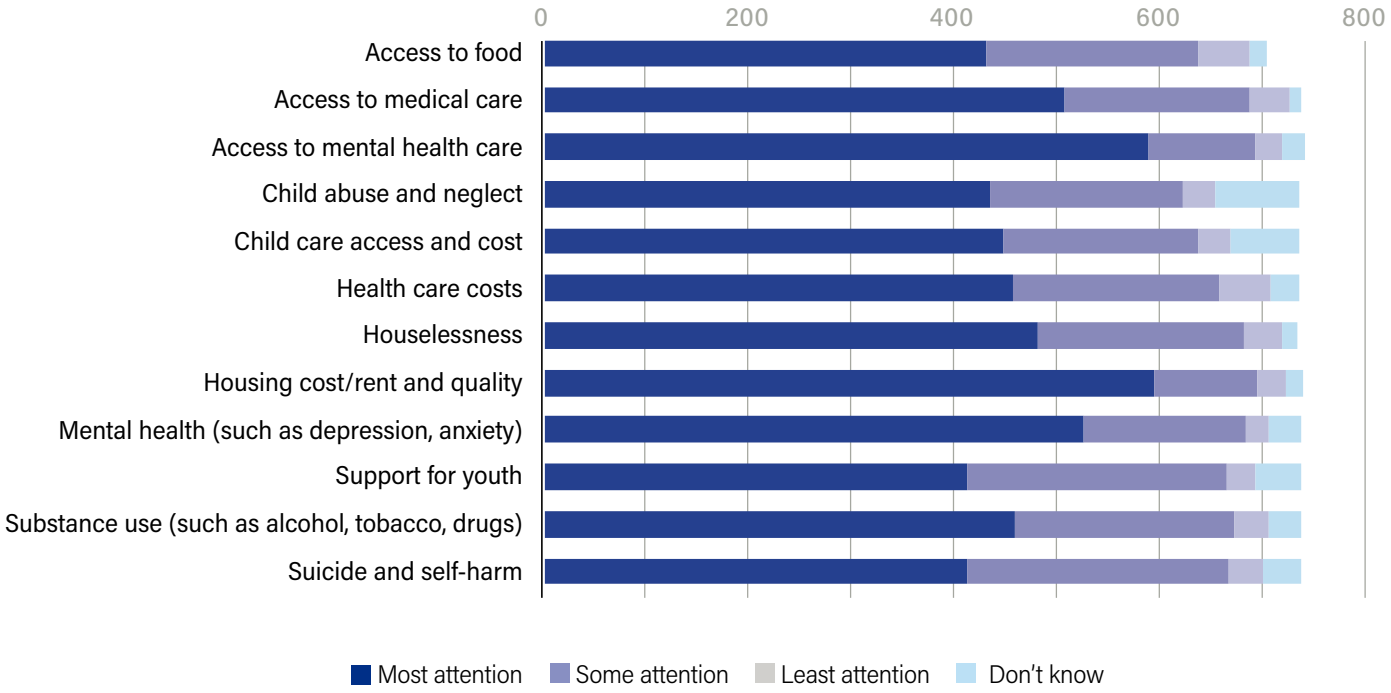
APPENDIX C

COMMUNITY SURVEY RESPONSES

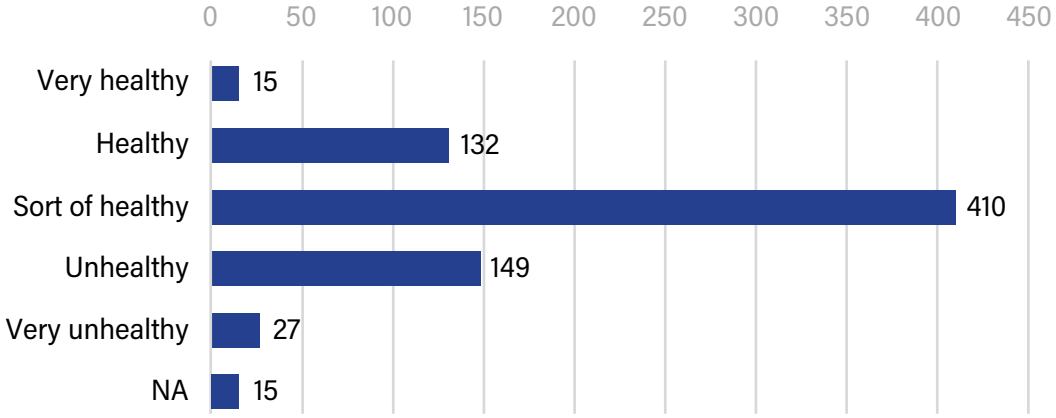
How much attention should be paid to the following issues?



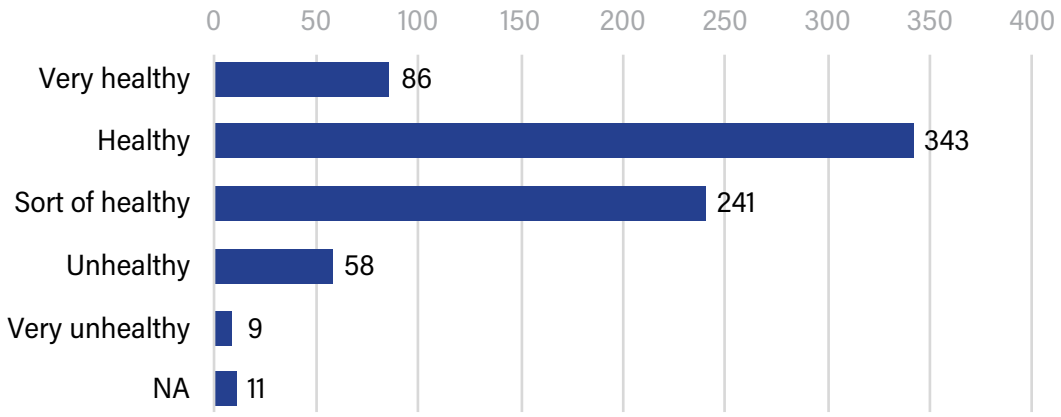
Highest priorities in Lincoln County according to the community survey.



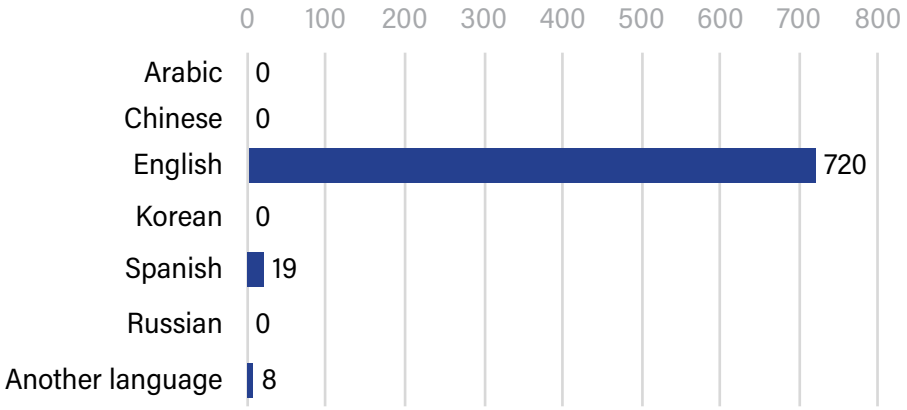
How healthy is your community?



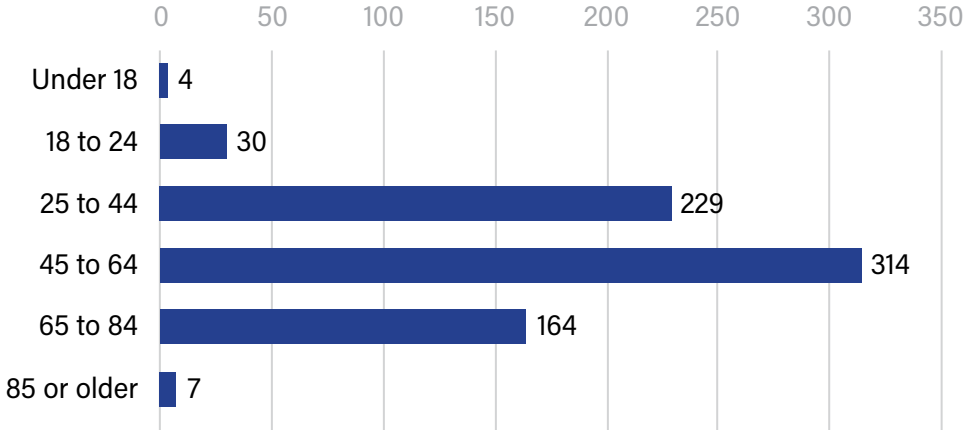
How healthy are you?



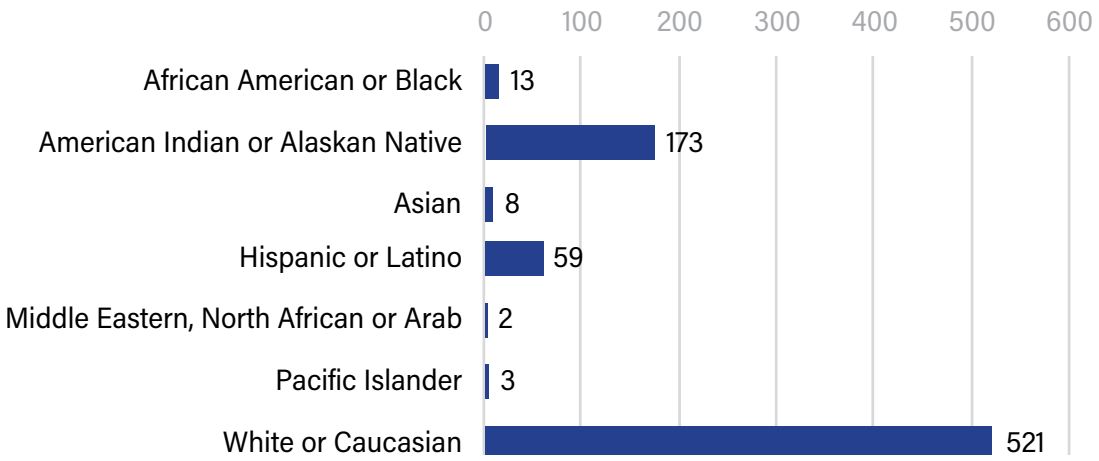
What language do you usually speak at home?



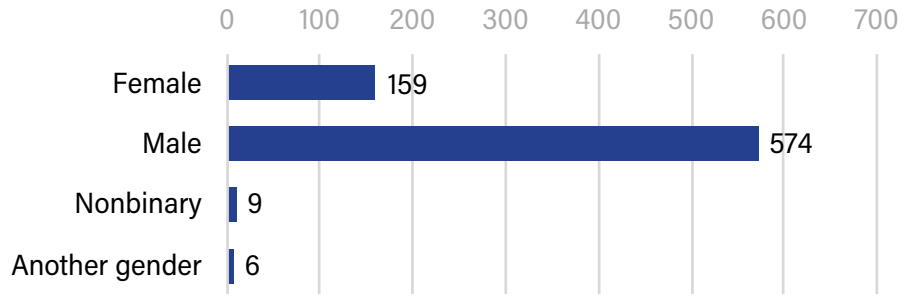
How old are you?



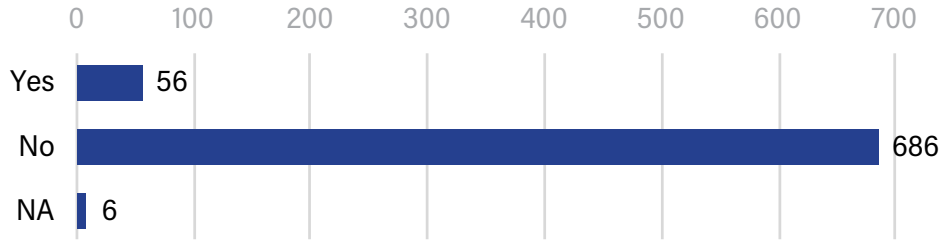
What race or ethnicity do you identify as?



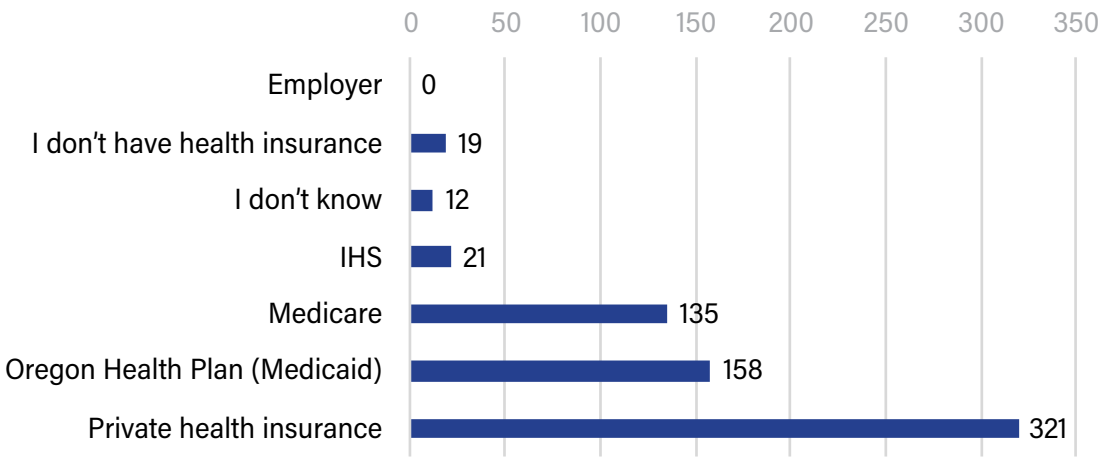
What is your gender identity?



Are you a veteran?



Where do you get your health insurance?



APPENDIX D

FOCUS GROUP RESULTS

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 Lincoln County included representatives of Spanish-speaking and bilingual communities, Mam-speaking immigrants from Guatemala, 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.

- You can push yourself hard enough to get off some hard drugs. And when your insurance stops, the health care stops, and then you're pushed back on the streets to be put in that vulnerable position. That's not right.
- There's people who know they need help, but they don't know how to ask for that help. There needs to be people involved in the system who are looking and listening for those people to say ... let me help you.
- Nobody talks to each other. They call it a care team, but they don't communicate.
- I've had a lot of difficulty making appointments ever since I got here. ... And there is another problem: If you are 15 minutes late for an appointment, they cancel it and give you another appointment for the following month.

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. COVID-19 and cancer were also cited as concerns.

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

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.

- A lot of people have a stigma of going to a facility, and so they would rather the facility come to them or their case manager come to them. And so they're refusing care because they don't feel comfortable going to the facility.

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.

- We don't have a lot of LGBTQ-friendly providers and options here on the Coast. I feel like that presents a large barrier to accessing affirming and safe health care for our LGBTQ community members here in Lincoln County.

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.

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.
- 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.
- Black people suffering the effects of lifelong stress.

Which social determinants of health most affect your community?

- Just the coastal environment — when can you get a bus to go across the hill? If you have to go to Corvallis? That's an added system barrier.
- There's such a measure of shame that comes from asking or seeking help.
- 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.
- 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.
- 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.

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

- By the time you actually get in, chances are the doctor you signed up for is gone, because ... they get here and figure out that they can't find housing.
- Once I took the bus to get to my appointment that was at 8 a.m. I arrived at 8:05 and they canceled my appointment. They rescheduled my appointment for two months later. That made me waste my day.
- A lot of googling it and going, "OK, this is what I think I have. You know, if I drink cranberry juice, it'll go away." ... Some of that might be just a normal way of self-preservation and saving money.
- I've had people with maggots in wounds on the street refusing to go to the hospital because they were treated so badly.
- 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.

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.
- These kids, whether we think it or not, they are being traumatized by [gun violence]. And how it's going to play out is a little scary, because we have a tendency to be more reactive than proactive.
- 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.
- 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, because there's things that were said, you know, and opinions that differ.

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

- More encompassing insurance and availability for people to actually be able to afford to go to the doctor. People live out here because it's cheaper. They don't have the money to live, basically. So how are they going to have the money to go to the doctor?
- I think that nutritionists that work with low-income families would also be needed. 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.
- I'd just like to see more ways to stabilize people who are unhoused, whether that's sanctioned camping, or tiny

homes, or whatever that looks like. If people keep getting pushed around as they have cleanups and sweeps, it just really makes it so much harder for them to try to remember what day it is where they have a medical appointment, do they feel comfortable and safe leaving all of gear behind so they can go speak to a doctor. Just stabilizing, in the most basic of terms, and just letting people have a place to sleep would really make a big difference for folks.

- I would love to see more postpartum care — affordable care. Child care leave.
- It should be like this: "OK, are you alive or dead?" "I'm alive." "Well, guess what? We're going to help you no matter what." That's what I want to see in three to five years. I want to hear the word *yes*.

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