

GOOD SAMARITAN REGIONAL MEDICAL CENTER



Samaritan  
Health Services

# Community Health Needs Assessment 2023-2026: Appendix



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# COMMUNITY PERCEPTIONS OF HEALTH

## Overview

*What I'm seeing is the mental health part — the emotional toll of a pandemic.*

Respondents see a decline in health (61%) and quality of life (87%) for Benton County residents over the last three to five years. The primary contributing factor (50%) was the COVID-19 pandemic, the most commonly cited effects of which were isolation and other mental health impacts (61%), delayed diagnosis/treatment and other physical health effects (22%), and economic and employment effects (17%).

Other contributing factors include inflation/cost of living and high levels of political and social strife (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, and racism/discrimination also remain in force.

## What are the biggest health problems in Benton County?

**MENTAL + BEHAVIORAL HEALTH.** Benton 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.

*Mental illness [since the pandemic] is ... really about loss of resilience and the impacts of isolation. We've seen a real reduction in social skills.*

**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 cost of care remains a commonly cited barrier (28%). Other persistent barriers include 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 (50%), 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.

**HOMELESSNESS + 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, 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.** 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. International students at OSU—and their family members or partners—may also be linguistically, culturally and/or legally blocked from accessing timely and appropriate care.

**LOWER SOCIO-ECONOMIC 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.

*People who are working and just can't make it — they're deferring care. They just are right on the edge, and any sort of catastrophic or major health event would just send them completely into a tailspin.*

The housing shortage affects health and quality of life across every age group and contributes to the county's mental health crisis. The rising cost of living — which sometimes includes higher utility charges at RV parks and related sites — is likely to increase the unhoused and unsheltered population along with the number of unsafe or unhealthy dwellings (in some communities, multiple families are already sharing a single apartment). Further, people experiencing poverty and housing instability often have multiple stigmatized identities that complicate their search for new housing.

#### **OTHER GROUPS**

- Many seniors in Benton County are 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.
- **Veterans** have unique health issues, including high rates of cancer, chronic illness and suicide. With no VA facilities nearby, transportation is a major barrier. Also, some female veterans report “horror stories” about VA service: “the care that they got wasn't really good.”
- Residents with mental and behavioral health issues—including SUD— face significant health challenges in addition to the costs, navigational difficulties and stigma associated with mental illness and substance use.

### **Which social determinants of health most affect our community?**

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

- Safe and affordable housing (17%)
- Transportation (17%)

- Access to health care (15%)
- Racism and discrimination (11%)

Other determinants cited include education, access to healthy food, economic conditions, employment, community engagement and resilience, cultural and linguistic competence, green spaces/walkability, 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, international students, 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. 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.

**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 frightening 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.*

**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, food deserts and food insecurity, and exposure to identity-based marginalization, discrimination and trauma.

### What are Benton County's main assets or strengths?

**COMMUNITY-BASED ORGANIZATIONS + ADVOCATES** are one of our main 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 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.*

**STRATEGIC ALLIANCES** between public health, social services, schools, the hospital system, local government, CSOs and CBOs are a strong asset. These partnerships allow the organizations with the most expertise and trust to treat their own communities, ideally with the financial and logistical support of partners.

*I love the coordinated care concept. You know, making sure all of the partners are at the table, where we get to focus on*

*the goals and outcomes we're looking for. And then how do you build those strategic alliances so that we've got the public, private, nonprofit partners working together? I think it's the most powerful model.*

**MEDICAL PROVIDERS + FACILITIES.** SHS is generally viewed as a major community asset and as an essential partner in health improvement efforts and innovations.

*The way that Samaritan worked with each of the county public health departments ... was amazing. I have not experienced anything like it within other health systems in Washington, Oregon, California or Nevada.*

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

*Corvallis is amazing in many ways. There are many individuals who volunteer or work in the healthy, sustainable community. Like supporting local businesses with donations to buy food from restaurants, and then serve it for free to people in need. That was a great example of something that happened during the pandemic — a caring community coming together to do something for an emergency. and this community is amazing in that way. So I think people are the strength here.*

### 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; 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, 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, gun violence, hate crimes, the need to rebuild a sense of community, and the ongoing evolution of addiction (including the increased prevalence of fentanyl).

### **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.

*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?*

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.*

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

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

**IMPROVE ACCESS.** This entails not just facilitating 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. Where possible, partners should aim to bring care to patients (e.g., through mobile services, pop-up clinics and alliances with schools, culturally specific organizations and other community-based partners).

*Think about how you get services to people instead of how you get people to services. ... Meeting people wherever they are. Talking to them about what they need, and getting that to them in some way, instead of expecting people to come to a regional medical facility for everything.*

Increasing services, supports and housing for people with mental and behavioral health issues — including those in the criminal justice system — is an immediate need.

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

**IMPROVE CARE QUALITY + CAPACITY.** Building cultural and linguistic competence, increasing workforce diversity, and reducing 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?"*

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. A stable, trained, trauma-informed workforce is required at every level of the health care and social services systems.

**SUPPORT COMMUNITY HEALTH + QUALITY OF LIFE.** Primary needs include 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.*

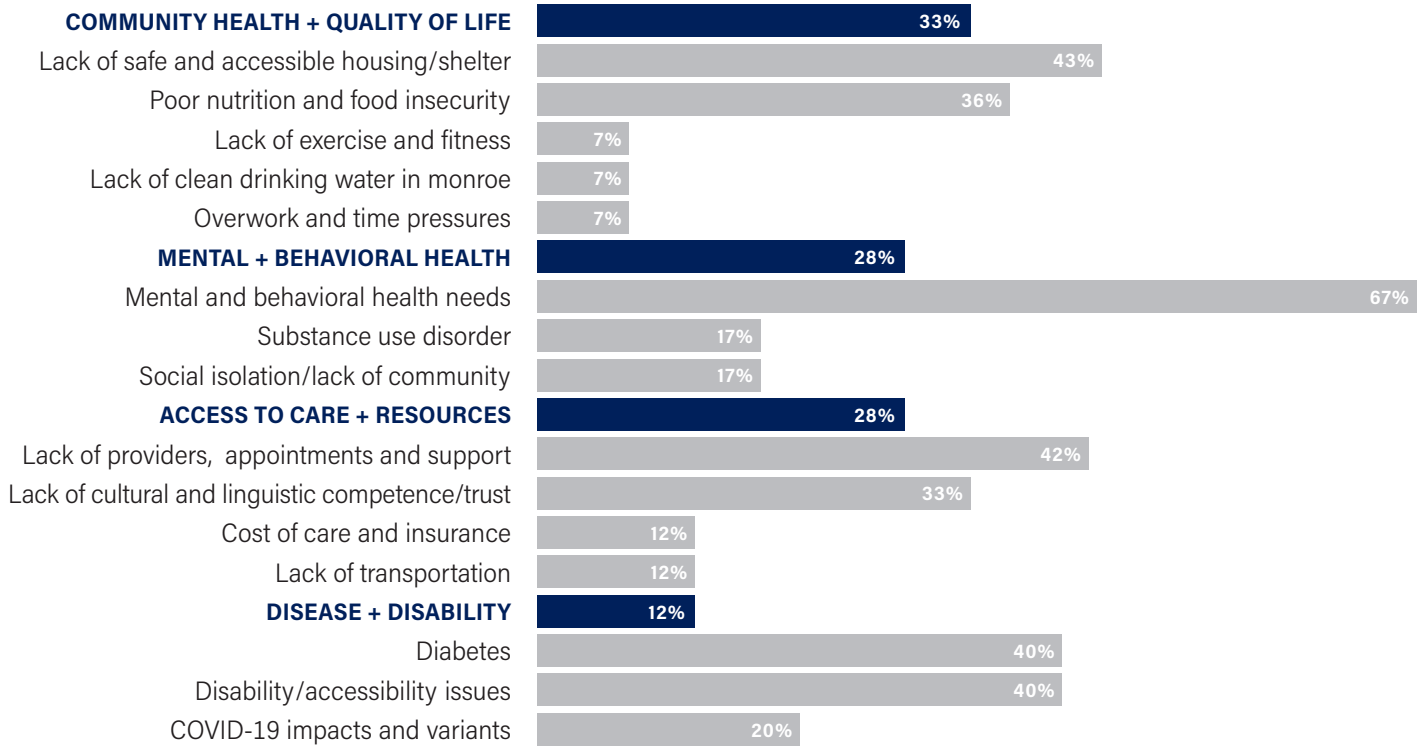
Other important needs include addressing the housing crisis, supporting children and families with resources like child care and parenting education, and strengthening partnerships and collaboration around social determinants of health.

*Given the complexity, it is essential that we always work in collaboration. So this holistic, this 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.*

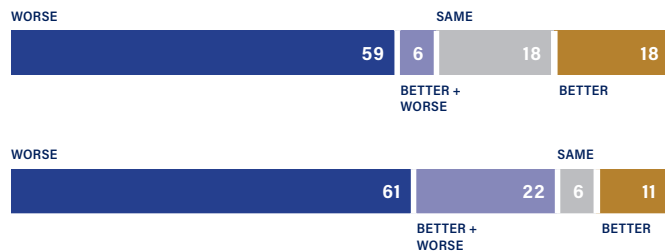


# KEY INFORMANT INTERVIEW RESPONSES

## 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; lack of digital skills and/or technology.

### POSITIVE FACTORS

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

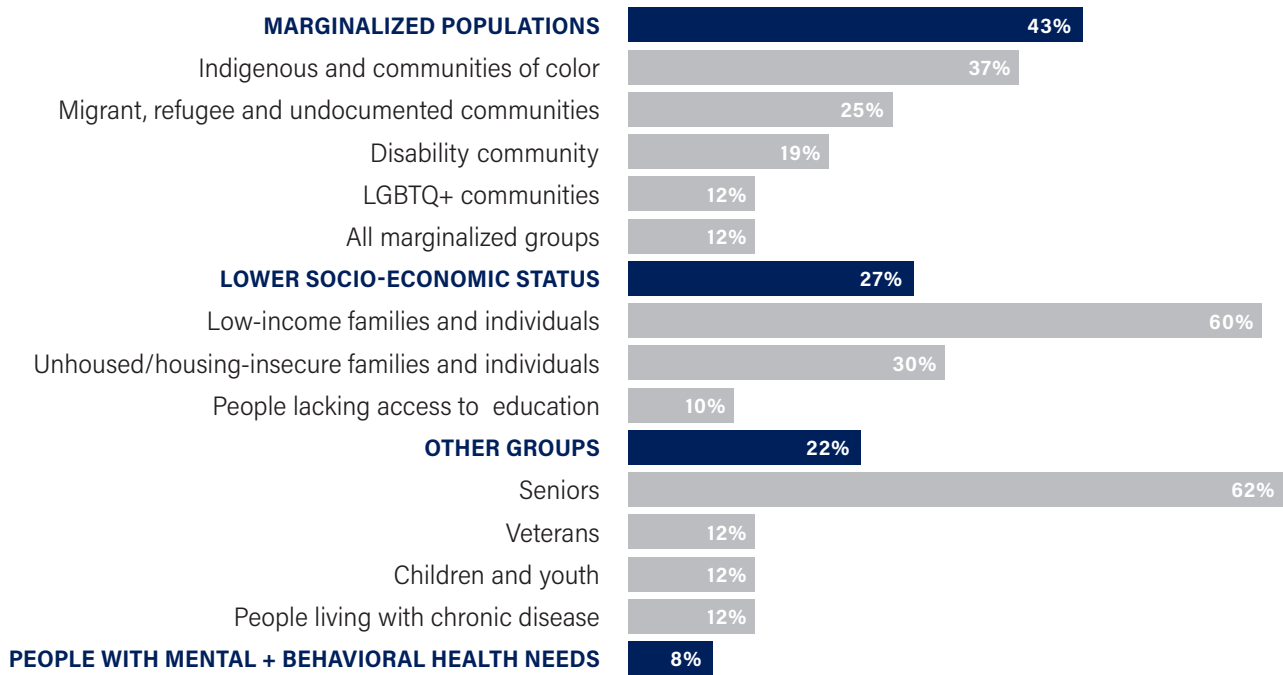
**IMPROVED COMMUNITY HEALTH + QUALITY OF LIFE.** New housing developments; new business and jobs in Monroe; food banks.

**BETTER COORDINATION OF COMMUNITY PARTNERS.**

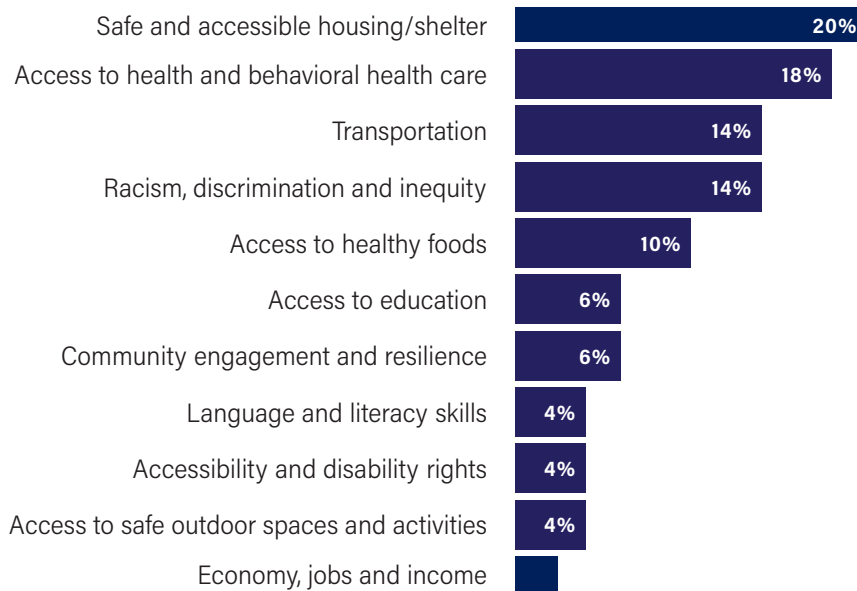
**MORE HEALTH LITERACY, AWARENESS + EDUCATION.** Nutrition education and healthy cooking classes.

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

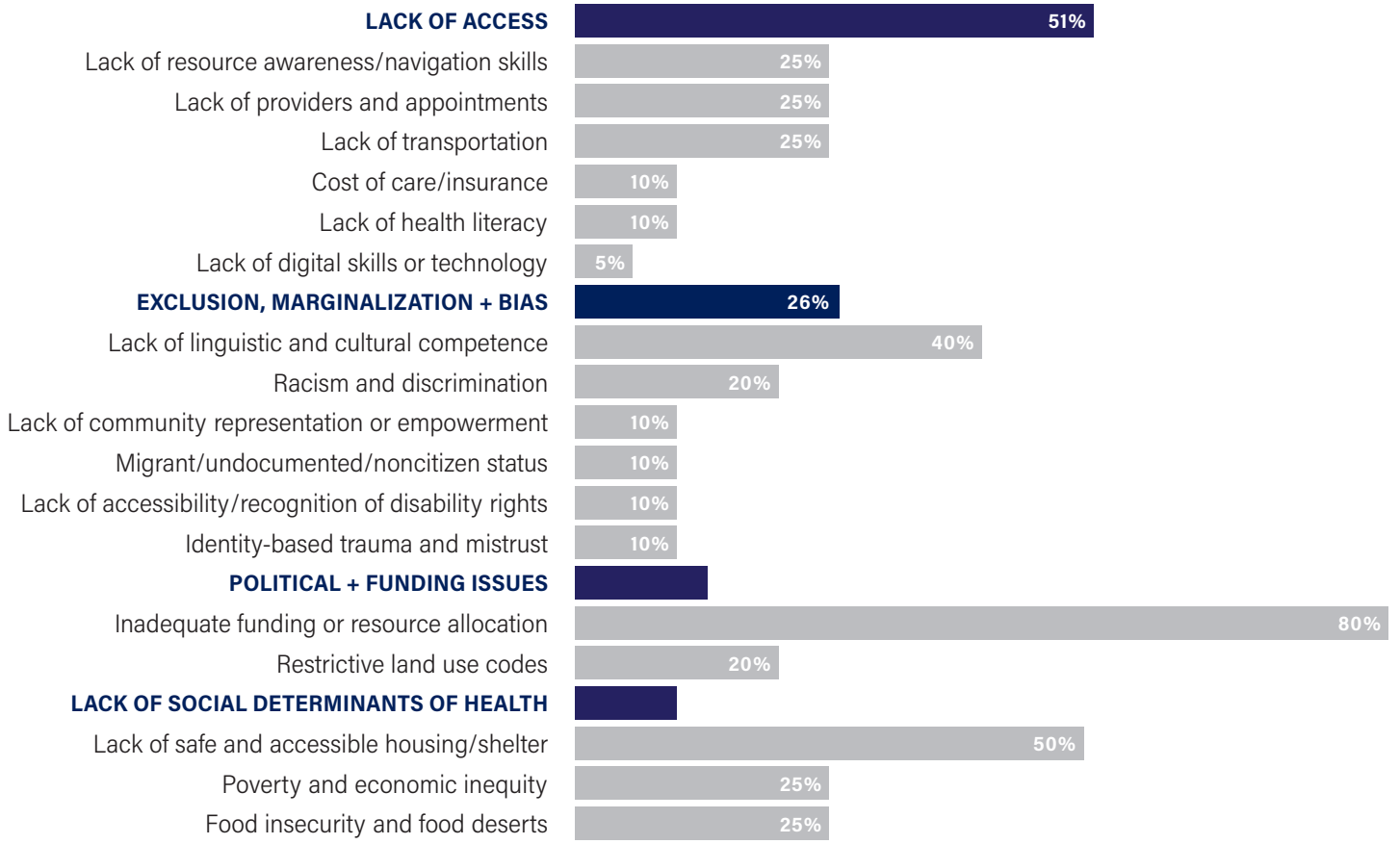
## What people or groups of people in your community do you view as having poor health and quality of life?



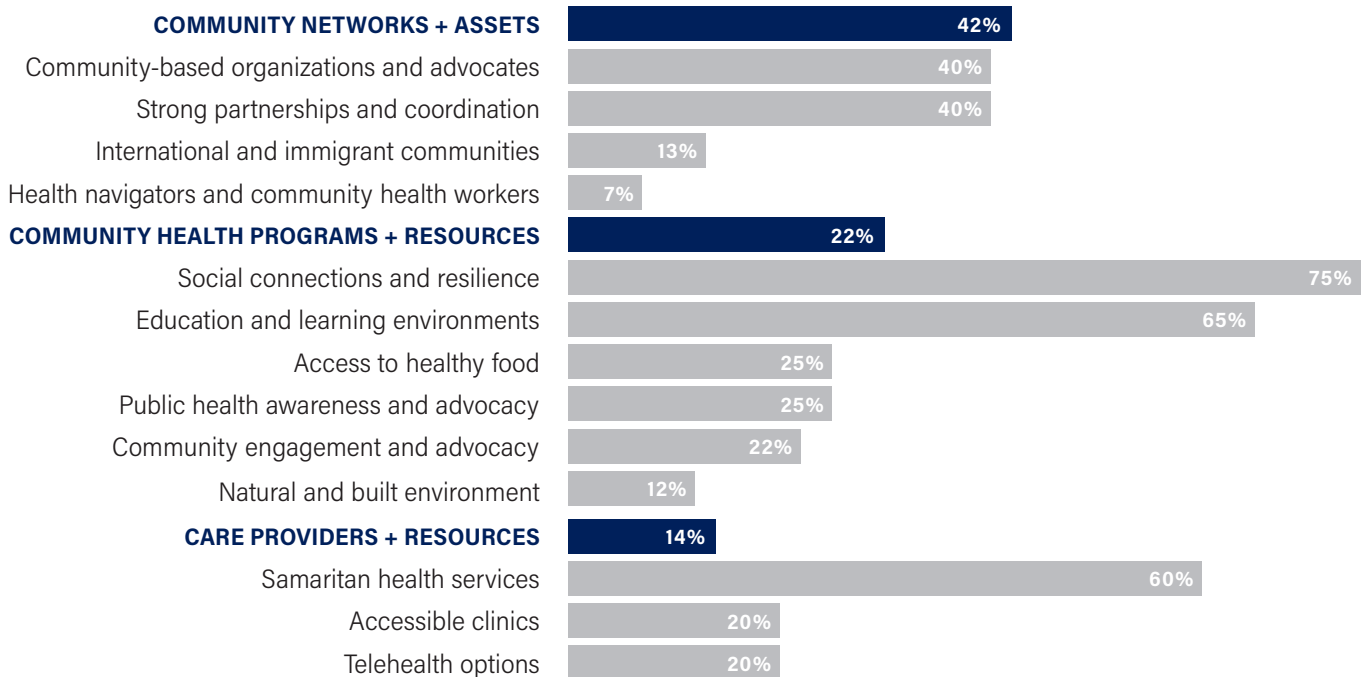
## Which social determinants of health most affect your community?



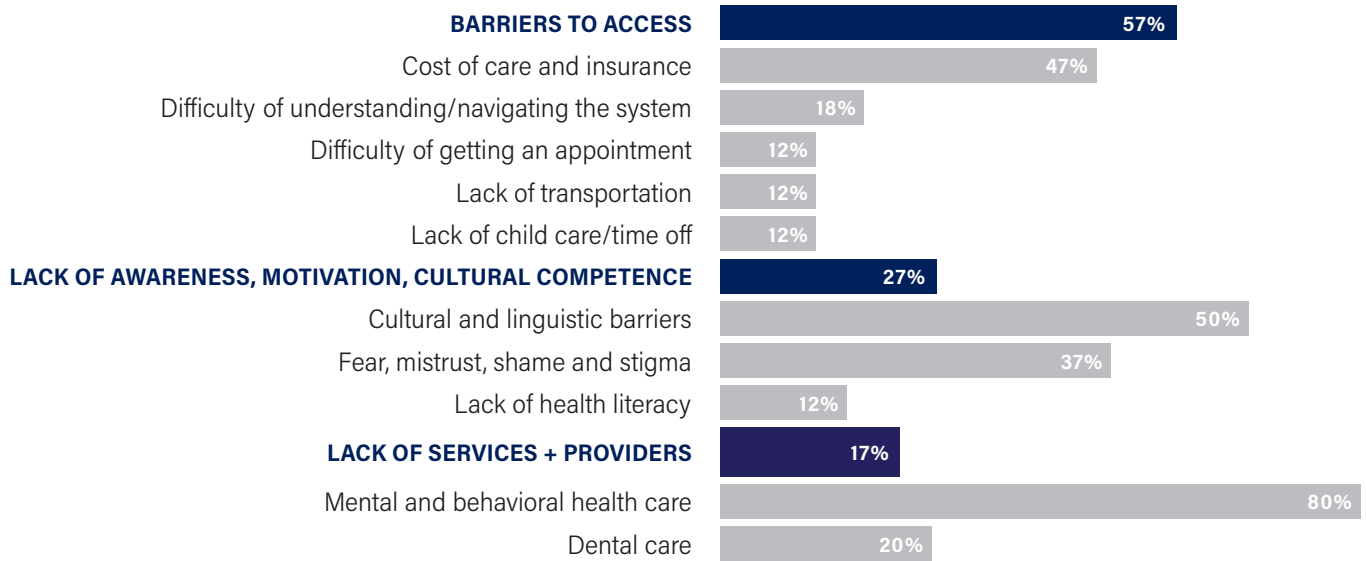
## What are the most significant barriers to improving health in your community?



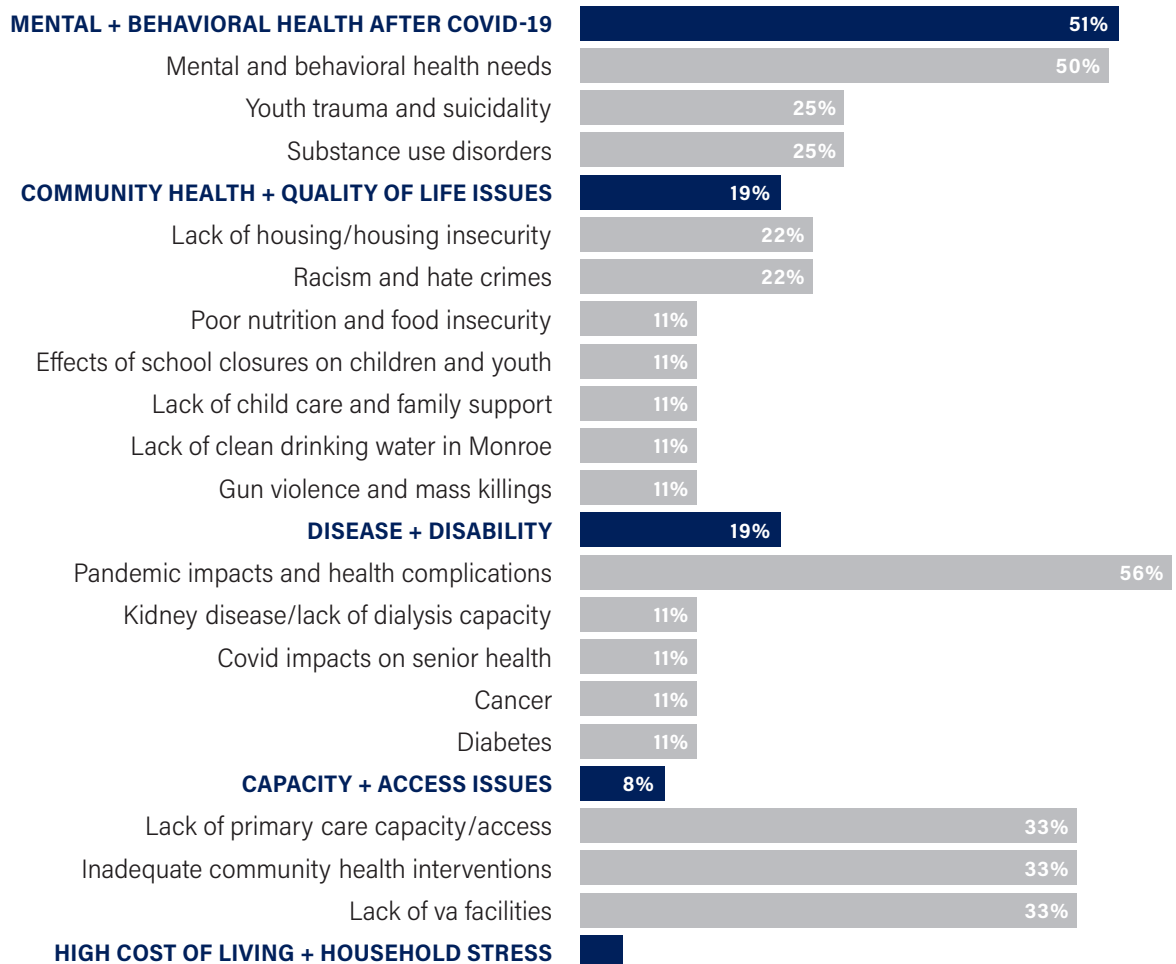
## What are the most important strengths or assets for improving community health?



## 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?

### IMPROVE CAPACITY, COORDINATION + QUALITY OF CARE

41%

Collaboration and coordination

67%

Community engagement and partnerships

33%

### EXPAND ACCESS TO HEALTH CARE SERVICES

41%

Resource awareness and navigation help

44%

Mobile, telehealth and other offsite care

33%

Mental/behavioral health and sud support

11%

Affordable care and insurance

11%

### PROMOTE EQUITY, DIVERSITY + INCLUSION

18%

Empower and support culturally competent partners

50%

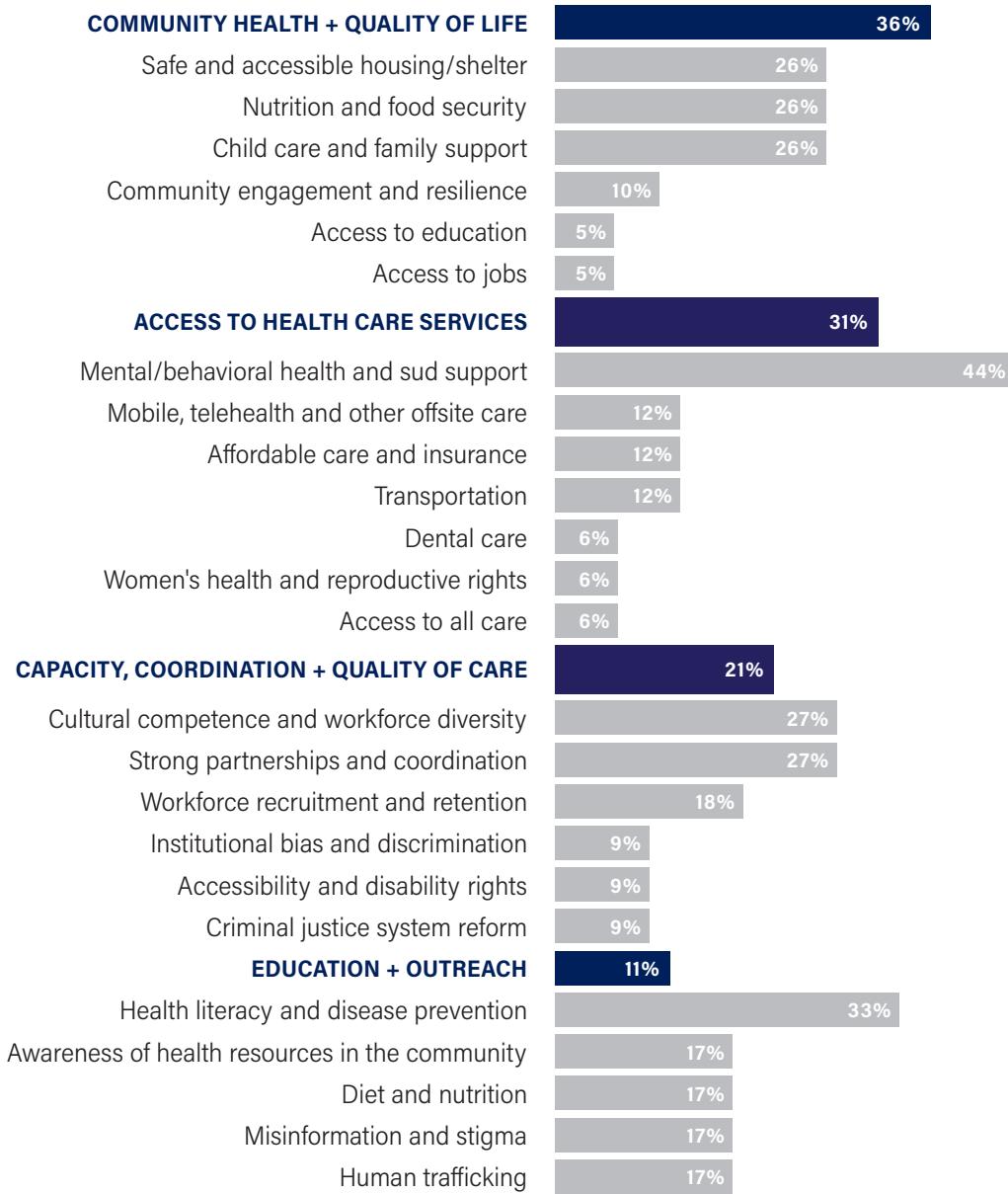
Improve cultural and linguistic competence

25%

Expand accessibility and disability rights

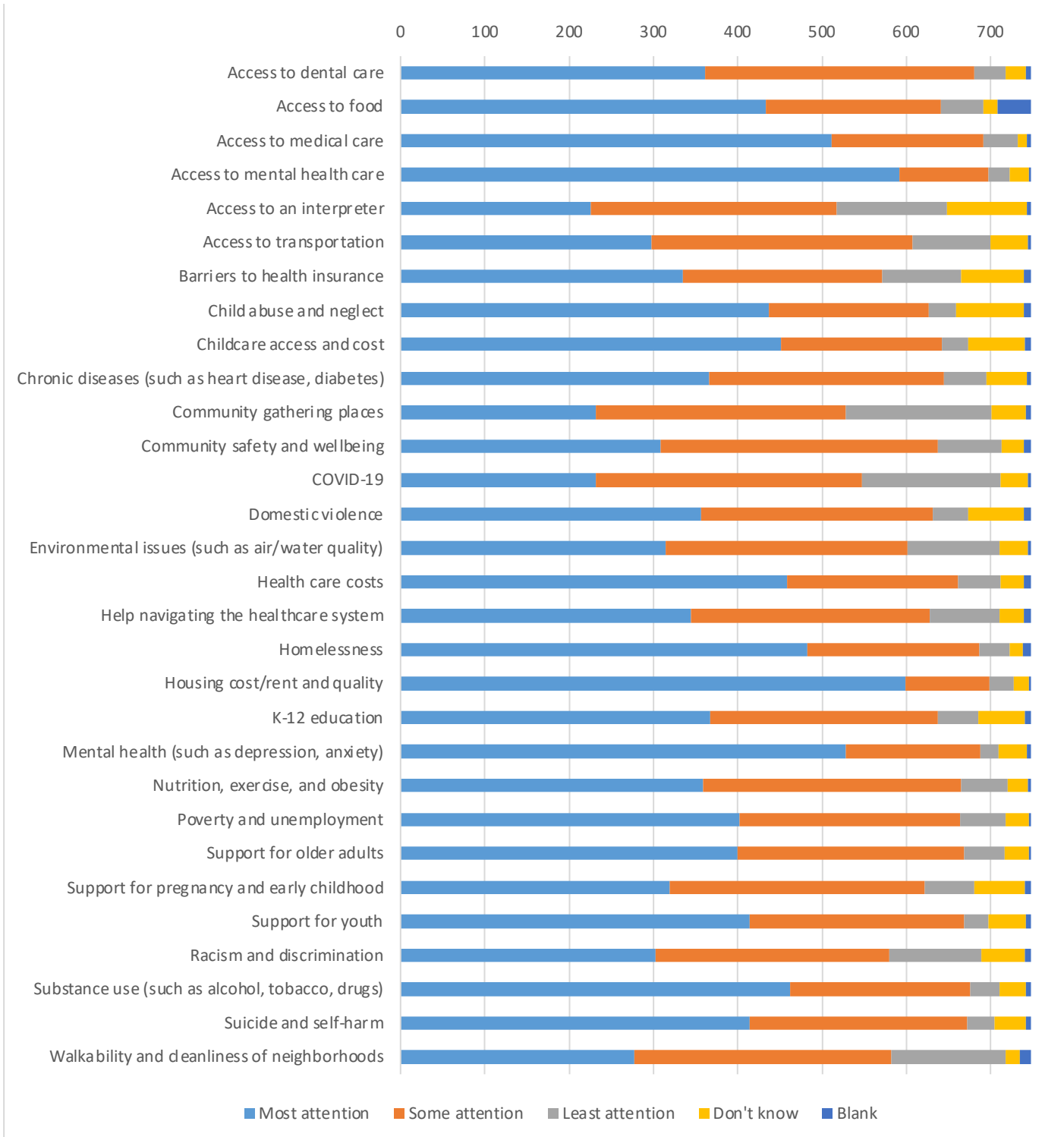
25%

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

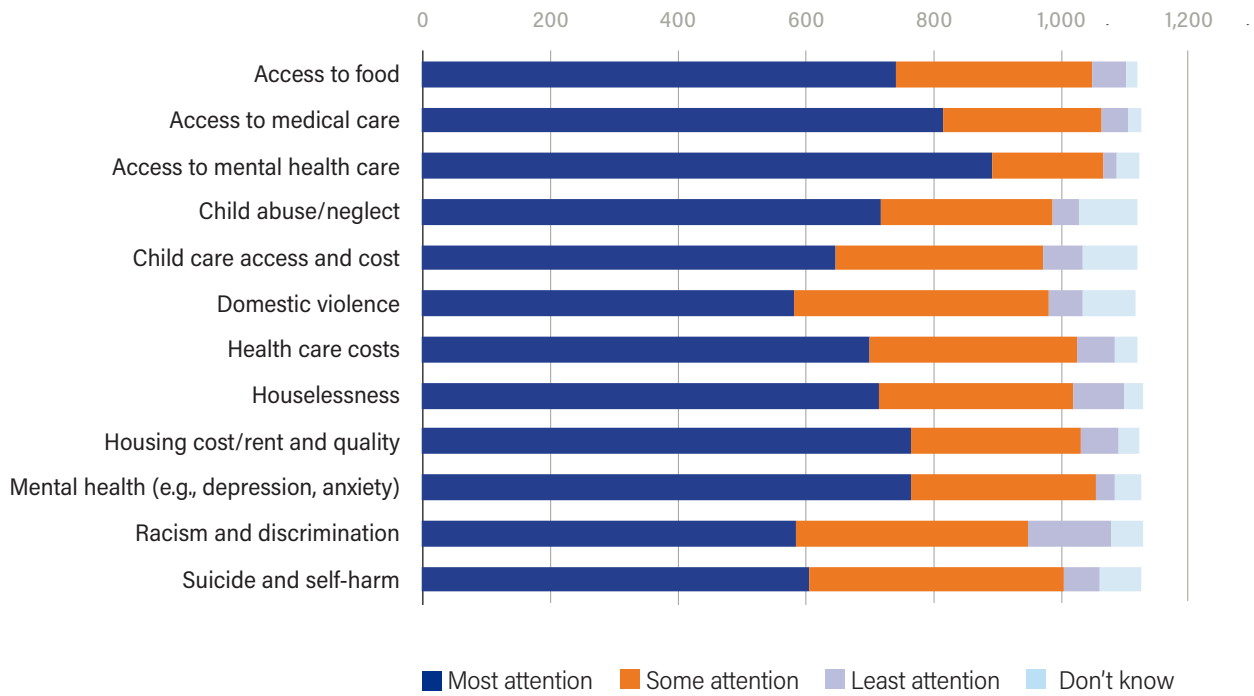


# COMMUNITY SURVEY RESPONSES

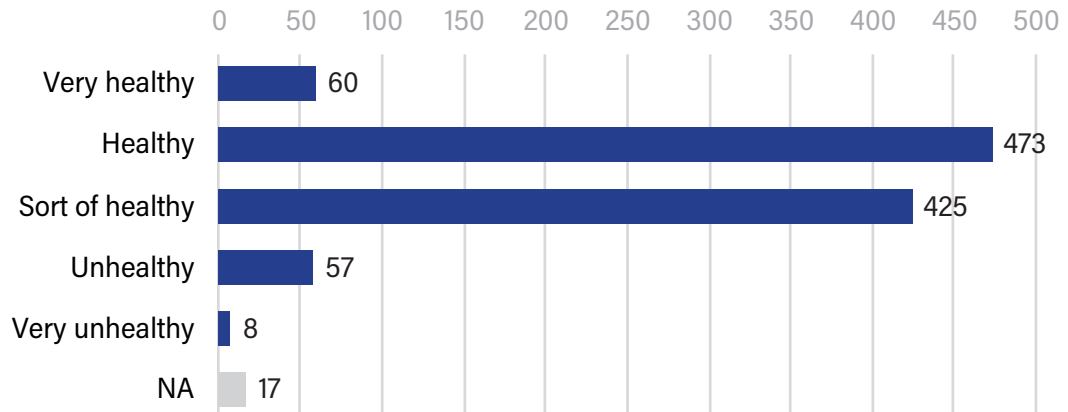
## How much attention should be paid to the following issues?



## Highest priorities in Benton County according to the community survey.

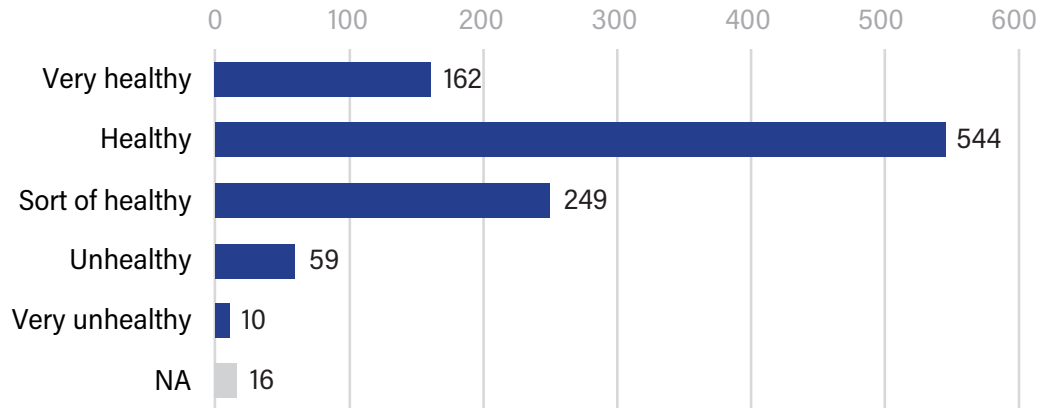


## How healthy is your community?



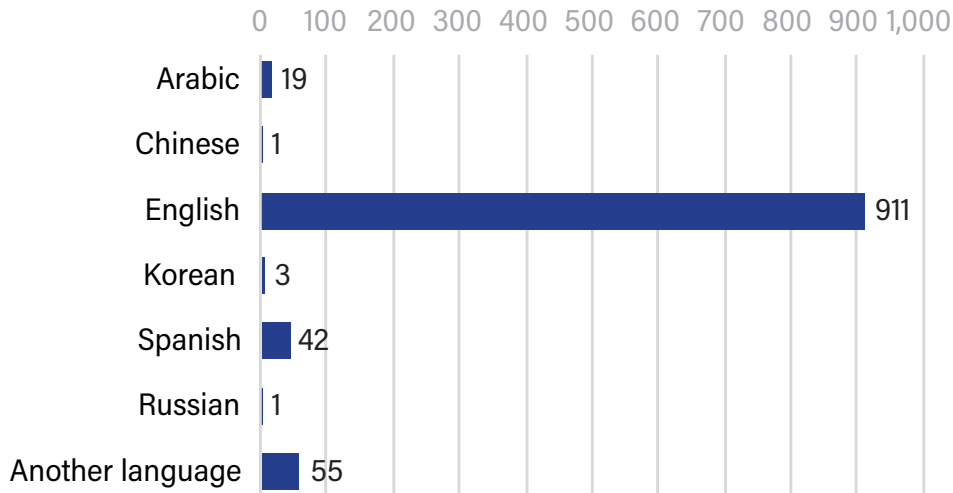
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## How healthy are you?



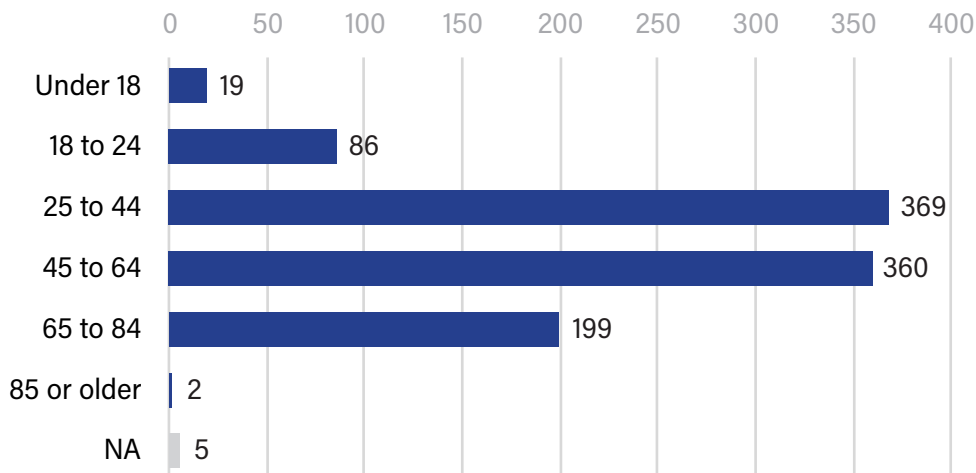
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## What language do you usually speak at home?



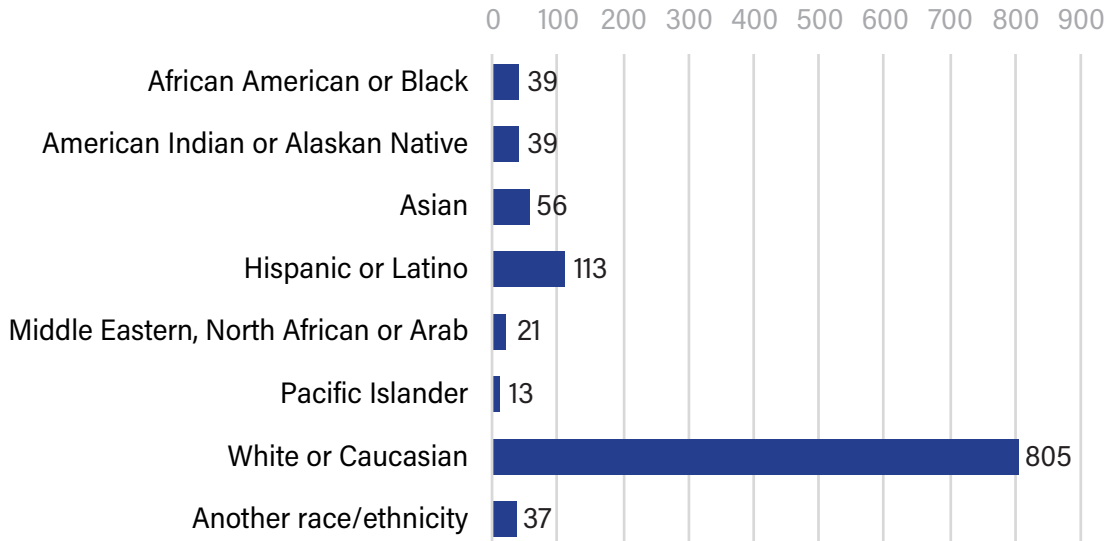
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## How old are you?



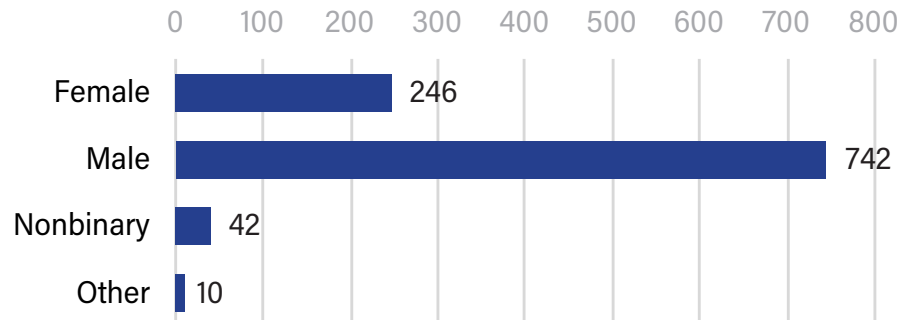
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## What race or ethnicity do you identify as?



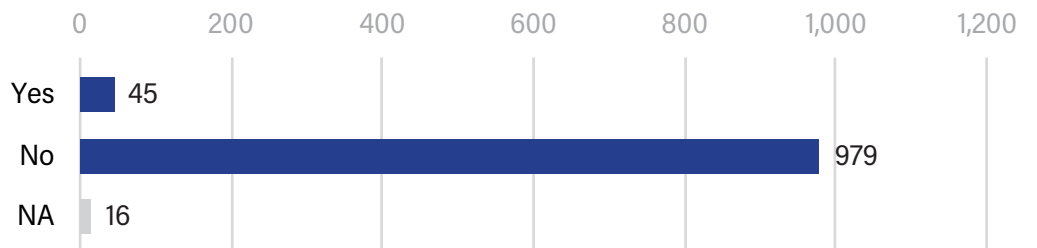
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## What is your gender identity?

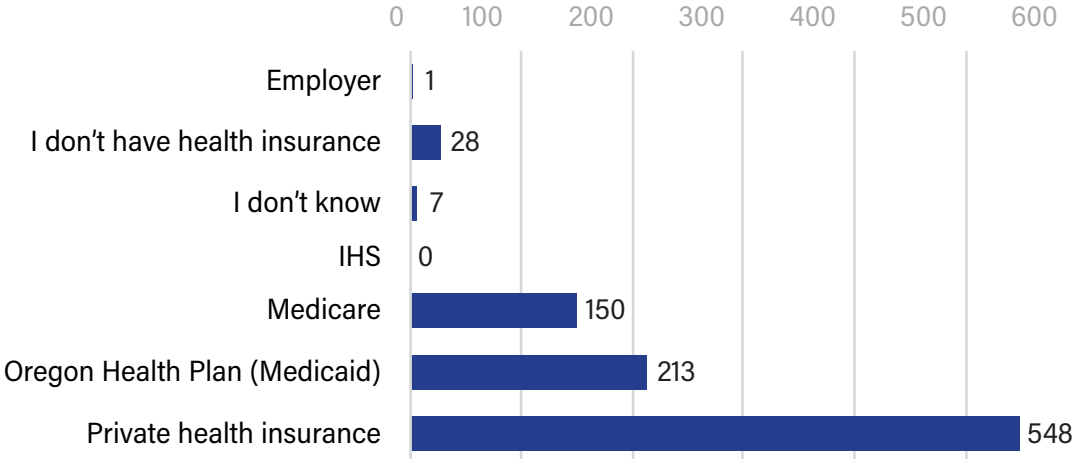


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## Are you a veteran?



## Where do you get your health insurance?





## FOCUS GROUP RESULTS

Qualitative information from focus groups is used primarily to inform and confirm the overall CHNA narrative and to provide quotes that illuminate common health concerns, 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 Benton County included representatives of Spanish-speaking and bilingual communities, Arabic-speaking communities, the African American community, the unhoused or unstably housed population, the international student population, and health or social service providers.

The status of international students in Benton County is a unique area of concern; focus group participants stressed the difficulty of navigating the system; the lack of culturally and linguistically competent patient advocates; the special obstacles students face in regard to insurance coverage and household income; cultural differences in complaining about the quality of care; and the stark differences between the U.S. health care system and the medical procedures, costs and norms in their home countries.

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, stress relating to racism and discrimination, and 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; 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 have chronic conditions, so I should go every month to the doctor. I just avoid that to avoid the copay, because I don't have OHP — I had it only when I was pregnant.
- Often, we go into doctor's office and we feel very pressured—very stressed. They seem to always want to get it done and rush out.
- In the Latin community, we tend to ignore signs when our bodies are telling us that something is wrong. We wait to decide to go see the doctor until there is really no other option.
- Recently, I was told to get OHP for my DDS service by a DDS social worker because [her child's] doctor recommended ABA [Applied Behavior Analysis] therapy. It costs like \$10,000 a month, so we were referred to OHP. And we were told no, we earn too much money. How can I even afford \$10,000 a month without OHP?
- 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.

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** encompasses institutional bias and inequity, lack of workforce diversity, identity-based trauma shame and stigma, and lack of culturally and linguistically appropriate care.

- I'm looking for a social worker and advocate figure that will push for things. It's not like a medical staff; this person has to be more pro-patient and able to express what we want to the doctor directly and fight for the benefit of the kids.
- I feel like I see some cultural differences in American and other cultural values. There's like a disconnect that we don't match. Like with education and health care... Americans have a different expectation than internationals. And so I

wonder if there's a way for providers to be more culturally aware—to understand where some of these international families are coming from?

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.

- 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.
- LGBTQ+ is really lacking in supports, at least within our school. ... [T]here really are no supports for that community. Statistically, you're way more likely to have suicidal ideation or follow-through without the supports there.

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.

- I look back to when I was growing up: I moved out extremely young, but I could rent a room for \$350 or share a house for \$350. And now to rent just a room is \$800 a month. I've got students that are right on the edge. And it's pretty overwhelming and scary, and I can't imagine what it feels like to be 18 right now. It's definitely discouraging, which also plays into mental health a lot.

### Selected answers to focus group questions

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

- The high cost of insurance and rent is the big challenge for some international families with kids.
- 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+.

- I'm educated and all that good stuff, got a master's degree. However, I am very unhealthy. I have a very poor quality of life because I come from struggle. ... So, people with lifelong stress are people that I view as having poor health and a poor quality of life — just coming from struggle.
- 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.

#### Which social determinants of health most affect your community?

- You can't be a medical professional and live in Alsea, because there is no place to live there. And if you find someplace, it's not affordable. And transportation is a challenge; it's hard to live here and then find a consistent source of transportation to your job.
- Our health care system is not responding to the need of the community. As mentioned earlier, it takes up to three months to get an appointment, and sometimes that appointment is canceled because there is no doctor available. In addition to that, finding transportation to go to the doctor's appointment is very difficult. Even in cities like Corvallis that offer free transportation, you have to plan up to two hours prior to your appointment just to get there on time.
- The substance abuse issue, like the poverty issue for me — the social narrative we have is that those are personal moral failings. And they're not. They're actually societal failings. They're systemic failings.
- When you look at Maslow's hierarchy of needs, it's food, clothing and shelter. But there's also nurturing—that's the one people always leave out. I think you have to attend to that set of things.
- Inflation is impacting housing, food, health care decisions and job opportunities. Some people can't afford the gas to get to work or school.
- If you feel discriminated against you do not want to speak up. Like, there is no point in speaking up if you are not going to be heard.
- 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.
- Every park here in Benton County — in Corvallis — was for practical purposes named after a Ku Klux Klan member. ... We have tried to name more parks around local, influential Black leaders in Benton County and Corvallis. And we have not been successful.

- 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 prevents those in your community from seeing the doctor, counselor or dentist when needed?**

- The process to apply for medical insurance is very difficult and invasive. I have been asked about income and how I use my income. I realized that I never ask 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.
- The health care system in general is not reflective of cultural differences and cultural beliefs. ... And there is no one to help families understand the cultural differences.
- Sometimes its stigma around getting help for certain conditions — the stigma in our own [Black] community, particularly mental health services. ... I think that's changing a bit, but it's still pretty prevalent in our in our culture — that mental health services are not something that is for us.

**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.
- I live downtown, so we have a lot of homeless people. And sometimes they say things to us, like racial things.
- 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, because there's things that were said, you know, and opinions that differ.
- 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.

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

- I think nonbiased advocates. I know there are caseworkers. But it's still "you need to turn in this, this, this and this by this date. And it needs to look like this. Your home needs to have this, this and this in it." 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."

- Public health-related funding for Blacks — specifically Black people, not BIPOC.
- 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.
- Samaritan used to offer gym access free of charge, but they do not do it any longer. I wish my children had access to youth sports and activities free of charge, because I cannot afford to pay for classes and all the needed uniforms, shoes, etc.

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

- If I was going to do one thing, it would be a community center for Black people that's can be welcoming to the rest of the community, but it would be something like the Black Cultural Center on campus, but for the area at large.
- Build groups that inform the community of their rights and resources available in their community.
- Culturally appropriate community resources; no one would ask about your citizenship status.
- Facilitate any channel, or any kind of plan, to give more information to the community about the health care services in Corvallis. Just let them know what they can ask, and how and where they can get the services. Because I really don't know anything about the services in the city.
- [At OSU], I got more than 50 hours of training in different social concepts here—intersectionality, social justice, environmental justice—but no information about health care. So I think you can ask them to put a syllabus and topic on that pre-education of international students to get some information about the facilities of the university and also Corvallis.
- What really helps was my advocate—just call them and push them. And this is what often moms are uncomfortable to do, because we already in distress. ... I would like to see a position just for that. Because the thing is, we are not comfortable to push like you Americans. You guys don't hang up until you get the answer! We just... "Alright, bye." You know?
- I would love to see more postpartum care for moms. I feel like our culture is good about checking on new babies, but they're not always checking on mom.



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