Community Listening Sessions
Important Health Issues and Ideas for Solutions

July 2013

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Photo: Multnomah County

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"We need to be moving from an 'I' community to an 'Us' community."

-- Listening Group Participant

I. INTRODUCTION

Collaborative Origin

In 2010, local health care and public health leaders in Clackamas, Multnomah, and Washington counties in Oregon and Clark County in Washington began to discuss the upcoming need for several community health assessments and health improvement plans within the region in response to the Affordable Care Act and Public Health Accreditation[1]. They recognized these requirements as an opportunity to align the efforts of hospitals, public health and the residents of the communities they serve in an effort to develop an accessible, real-time assessment of community health across the four-county region. By working together, they would eliminate duplicative efforts, facilitate the prioritization of community health needs, enable joint efforts for implementing and tracking improvement activities, and improve the health of the community.

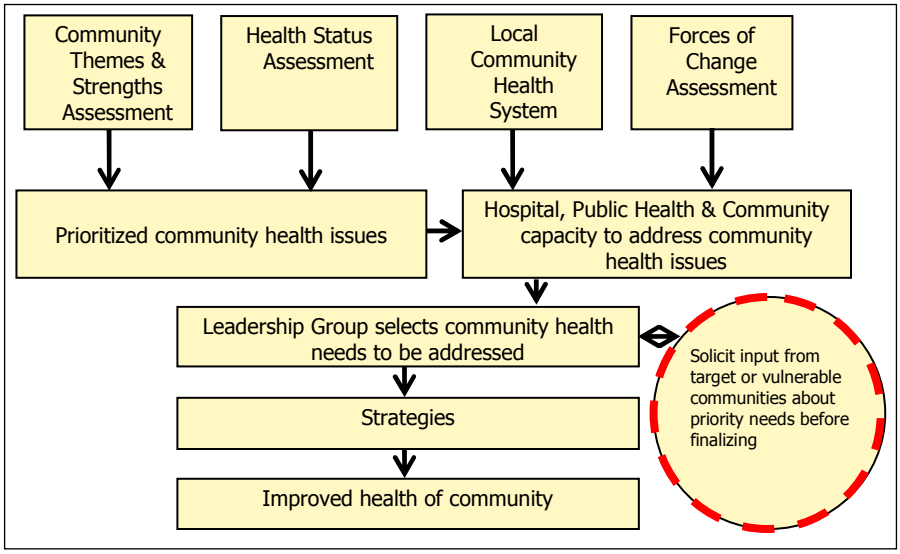
Members

With start-up assistance from the Oregon Association of Hospitals and Health Systems, the Healthy Columbia Willamette Collaborative (Collaborative) was developed. It is a large public-private collaborative comprised of 14 hospitals and four local public health departments in the four-county region. Members include: Adventist Medical Center, Clackamas County Health Department, Clark County Public Health Department, Kaiser Permanente, Legacy Emanuel Medical Center, Legacy Good Samaritan Medical Center, Legacy Meridian Park Medical Center, Legacy Mount Hood Medical Center, Legacy Salmon Creek, Multnomah County Health Department, Oregon Health & Science University, PeaceHealth Southwest Medical Center, Providence Milwaukie, Providence Portland, Providence St. Vincent, Providence Willamette Falls, Tuality Healthcare and Washington County Health Department.

Healthy Columbia Willamette Collaborative Assessment Model

The Collaborative used a modified version of the Mobilizing for Action through Planning and Partnerships (MAPP) assessment model[2]. See Figure 1. The MAPP model uses health data and community input to identify the most important community health issues. This assessment will be an ongoing, real-time assessment with formal community-wide findings every three years. Community input on strategies and evaluation throughout the three-year cycle will be crucial to the effort's effectiveness. This report describes the community listening sessions that were designed to solicit community members' feedback on the results from the earlier steps of this project. To see whether the Collaborative's process, "got it right."

Figure 1.
Schematic of the Modified MAPP Model



[1] The federal Affordable Care Act, Section 501(r)(3) requires tax exempt hospital facilities to conduct a Community Health Needs Assessment (CHNA) at minimum once every three years, effective for tax years beginning after March 2012. Through the Public Health Accreditation Board, public health departments now have the opportunity to achieve accreditation by meeting a set of standards. As part of the standards, they must complete a Community Health Assessment (CHA) and a Community Health Improvement Plan (CHIP).

[2] MAPP is a model developed by the National Association of County and City Health Officials (NACCHO)

Community Engagement Process

As part of the modified model adopted by the Collaborative, community input was collected during three distinct phases between August 2012 and April 2013.

The Community Themes and Strengths Assessment

The first phase of community engagement involved reviewing 62 community engagement projects that had been conducted in the four-county region since 2009. Findings from the 62 projects were analyzed for themes about how community members described the most important health issues affecting themselves, their families, and the community.

The Local Community Health System & Forces of Change Assessment

This second phase of community engagement involved 126 stakeholders participating in interviews or responding to surveys. This assessment was designed to solicit stakeholder feedback on the health issues resulting from the previous assessment work and epidemiological data. Stakeholders were asked to add and prioritize health issues they thought should be on the list, as well as describe their organizations' capacity to address these health issues. (For more information, see *Local Community Health System and Forces of Change Assessment: Stakeholders' Priority Health Issues and Capacity to Address Them.* July 2013.)

Community Listening Sessions

The third phase of community engagement was completed in May 2013. Fourteen community listening sessions were held with uninsured and/or low-income community members living in Clackamas, Clark, Multnomah and Washington Counties. In all, 202 individuals participated. During these meetings, community members were asked whether the issues—identified through the previously conducted community engagement/assessment work, epidemiological data, and the stakeholder interviews and surveys—were right. During these meetings, participants added additional health issues and each person voted for what they thought were the most important issues. A list of the locations and number of participants of these groups is included in Appendix I.

Because members of the Collaborative understand the importance of working with the community to ensure that the process yields the most accurate results and is trusted by the public, in years two and three of the project there will be more opportunities to engage multiple constituents in the process. These opportunities have yet to be developed, but this process will start during the summer of 2013.

II. COMMUNITY LISTENING SESSIONS

Purpose

The purpose of these discussions was to learn what low-income and uninsured residents of the four-county region feel are the most important issues affecting their health, their families' health, and the community's health. In addition, the groups were held to solicit ideas about how to address these health needs.

Methodology

During March and April of 2013, 14 community listening sessions were conducted in Clackamas, Multnomah, and Washington Counties in Oregon and Clark County, Washington. In total, 202 individuals participated, sharing their opinions with one another about important community health issues and how the community's health can be improved. A list of the locations, dates, and number of participants is in Appendix I.

Recruitment

In advance of the listening sessions, recruitment flyers were developed by hospital members of the Collaborative and translated into Spanish, Russian, and Somali by health department members. They were distributed to organizations, community networks, and community-accessible locations to be posted or handed out. Flyers specified that low-income/no income and/or uninsured adults were the intended participants, and advertised locations and times for sessions, as well as the provided food, childcare, and $25 gift card incentives. Examples of the recruitment flyers are in Appendix II.

Recruitment materials were posted and distributed primarily through agencies and community organizations that serve low-income populations. Over 100 organizations were able to help with recruitment, ranging from individual housing projects to community groups with constituents across the four-county area. Healthy Columbia Willamette Collaborative members also recruited among their own organizations' constituents where appropriate, and asked their colleagues in the community to help recruit participants. In addition, local Spanish-language and Russian-language radio stations promoted the meetings. The listening sessions lasted approximately an hour and a half, and free childcare services were offered on site. Hospital partners provided meals and childcare for each group. Hospitals also provided $25 Fred Meyer gift-cards for the first 25 participants in each group to acknowledge participants' time and contribution to the project.

Group Structure

The Healthy Columbia Willamette Collaborative was interested in hearing specifically from low-income and uninsured residents from across the four-county area, and as mentioned above, efforts were made to reach this population during recruitment.

Listening sessions were opened with a large group introduction before splitting into small discussion groups of 10 or fewer participants. Each small discussion group was facilitated by a different Healthy Columbia Willamette Collaborative member or interpreter. Small groups were facilitated in English, Spanish, Russian, and Somali with the support of interpreters from participating health departments and the Immigrant and Refugee Community Organization (IRCO). In order to encourage attendance, meals were provided, and sessions were scheduled on both weekdays and weekends and at community-accessible locations across the four-county area.

Group discussions revolved around four questions:

- What does a healthy community look like to you?
- Are there other health issues that you think should be on this list? (The list of important health issues identified by the findings of the Community Themes and Strengths, Health Status, and Local Community Health System and Forces of Change Assessments. See Table 1 below.)
- What are the five health issues that you would like to see addressed first? (Participants selected from the issues in Table 1 and any health issues they added to the list.)
- What should be done to fix or address these health issues?

See Appendix III for the complete discussion guide and Appendix IV for the list of health issues used during the discussions in multiple languages.

Table 1. Important health issues identified by the findings of the Community Themes and Strengths, Health Status, and Local Community Health System and Forces of Change Assessments (in alphabetical order)

Access to affordable dental care	Data collection on the health of people from various cultures
Access to affordable health care	Injuries from falling
Access to affordable mental health services	Mental health
Access to services that are relevant/specific to different cultures	Oral Health
Accidental poisoning from chemicals, pesticides, gases, fertilizers, cleaning supplies, etc.	Perinatal health
Cancer	Sexually transmitted infections/diseases
Chronic disease and related health behaviors	Substance abuse

Participants

There were, on average, 14 participants attending each session, though the range in attendance between sessions was between one and 34 participants. Before small group discussions, participants were asked to complete an anonymous survey collecting demographic information. This was done on a voluntary basis and did not affect whether a person could participate or receive a gift card. Almost 96% of participants completed surveys. A copy of the survey in English is in Appendix V. The survey was available in English, Spanish, Russian, and Somali as well as in large font (in English).

Of participants specifying an income range on their survey, 62% came from households earning less than $20,000 per year. Of those indicating a health insurance status, 63% indicated they were uninsured with an additional 21% indicating they were on the Oregon Health Plan (OHP)[3]. Participants' ages ranged from 17 to 90 years, with an average age of 40 years. Almost three quarters of participants returning the surveys identified as female.

Participants were also asked to identify their race and ethnicity. Regionally, over half (53%) of those providing this information indicated that they were Hispanic, 25% were White, 7% were African, 6% were African American, 2% were Native American, 1% were Asian and 1% were Native Hawaiian/Pacific Islander. Individuals could select selected more than one race/ethnicity; only one participant did so.

The composition of participants involved in the listening sessions is not representative of regional race, ethnicity, or gender demographics. The sample may not be representative of other communities, (e.g., the LGBTQI, disability, and recovery communities). Given that hospitals have impending tax filing deadlines and requirements to focus on low-income and uninsured populations, the Healthy Columbia Willamette Collaborative members agreed for this first cycle, that recruitment for the community listening sessions would focus on people with low income levels and/or no health insurance. The Collaborative members recognized that by using only these criteria, people from other vulnerable communities might not be reached. In order to improve participation by other communities, the Collaborative worked with more than 100 community organizations to help with the recruitment. Examples of the communities these organizations helped recruit, include Native American, LGBTQI, disability, African American, recovery, immigrant/refugee, etc.

When looking at the participation in these community listening sessions and all previous assessment phases, (i.e., Community Strengths and Themes, Health Status, Local Community Health System and Forces of Change Assessments), it becomes clear that the Collaborative included the opinions from a wide array of stakeholders, including many people from culturally-identified communities. Moving forward, community members will be actively engaged to implement and monitor the health of the community. Table 2 presents participants' survey responses by county and region.

Participants lived throughout the four counties; however, not all areas of the four-county region were represented equally due to recruitment challenges such as difficulty connecting with people living in rural areas, or with people speaking languages other than English, Spanish, Somali, or Russian. Figure 2 illustrates the geographic reach of the listening sessions by indicating the percent of surveys responses (to this question) returned from residents living in each zip code in the four-county area. The darker the area on the map, the more participants reported living there.

Following each session, many participants expressed their appreciation for the opportunity to speak about their priorities and needs, and 26% of participants signed up on a contact list so they can be invited to other events, kept informed about how the information collected through the community listening sessions was used, and be informed about upcoming changes in health services and policies. Many participants also expressed that holding these types of groups is an effective way to help reduce social isolation and empower people to become involved in their neighborhoods.

[3] Clark County responses for health insurance type were not included in the regional calculation as the equivalent of OHP for Clark County was not on the survey).

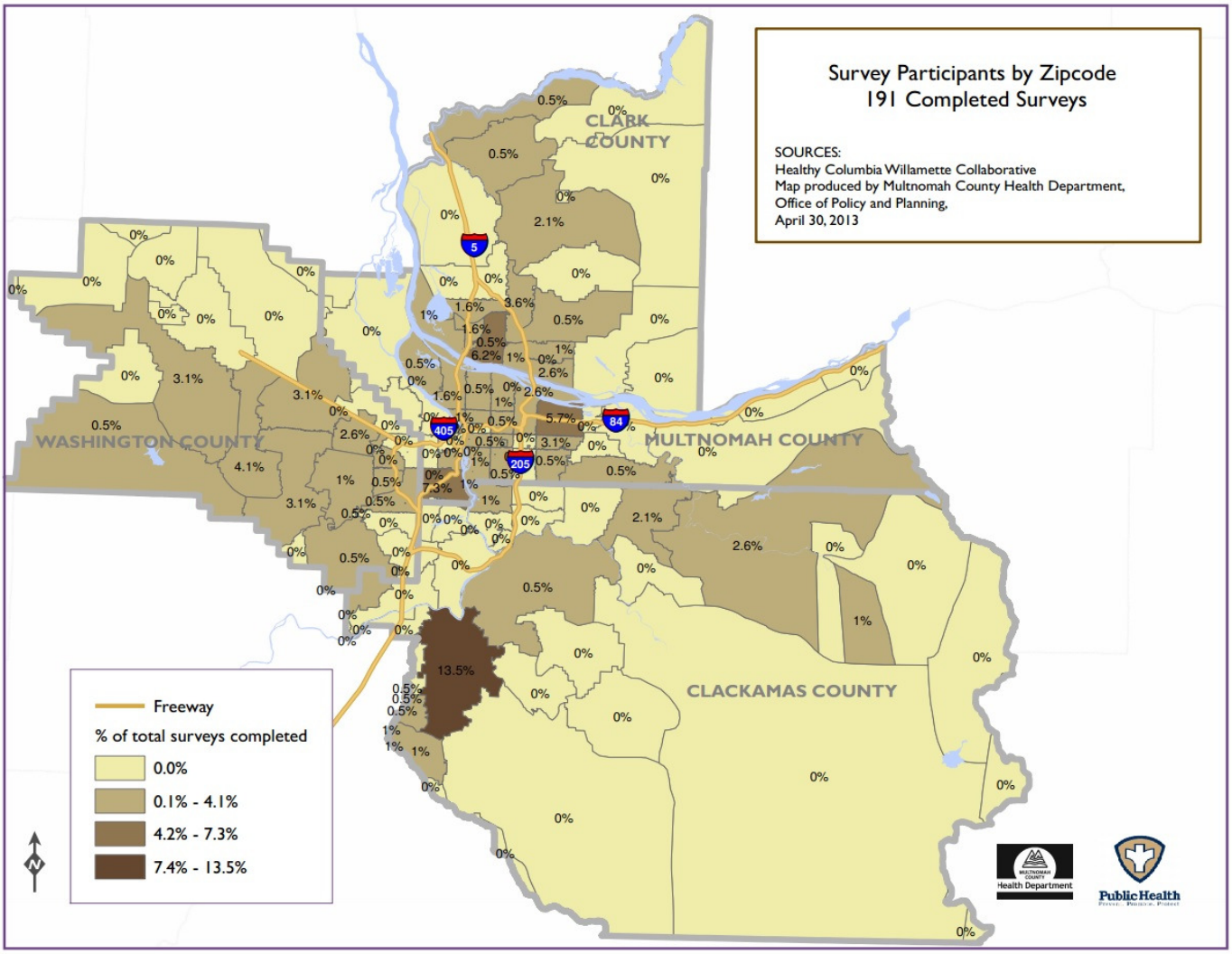
Table 2. Participant Demographics

	Clark	Clackamas	Multnomah	Washington	Region
Age					
Range	17-88 years	20-75 years	18-68 years	17-90 years	17-90 years
Average	44 years	40 years	44 years	45 years	40 years
Language					
English	66%	10%	48%	30%	39%
Russian	11%	0	2%	0	3%
Somali	0	0	9%	20%	7%
Spanish	23%	90%	41%	50%	51%
Race/Ethnicity					
African	0	0	9%	16%	7%
African American	0	0	12%	10%	6%
American Indian/Native American	0	0	5%	2%	2%
Asian	2%	0	0	0	1%
Hispanic	34%	88%	43%	52%	53%
Native Hawaiian/Pacific Islander	0	0	0	2%	1%
White	61%	12%	14%	18%	25%
Other/multiple	0	0	16%	0	5%
Gender					
Female	68%	74%	66%	76%	71%
Male	32%	19%	30%	24%	26%
Income					
Less than $10,000	45%	30%	34%	34%	36%
$10,000 to $19,999	32%	26%	18%	30%	26%
$20,000 to $29,000	9%	19%	23%	16%	17%
$30,000 to $39,000	5%	0	7%	6%	5%
$40,000 to $49,000	5%	2%	0	0	2%
$50,000 or higher	2%	2%	2%	2%	2%
Household Size					
Range	1-8 people	2-8 people	1-9 people	1-9 people	1-9 people
Average	3 people	3 people	4 people	5 people	4 people
Education					
Less than high school	23%	62%	36%	33%	38%
High school diploma/GED	19%	30%	30%	37%	30%
Some college	37%	5%	18%	13%	19%
College graduate or higher	21%	3%	15%	17%	13%
Health Insurance					
No insurance	73%	82%	53%	56%	63%
Oregon Health Plan	--	8%	27%	23%	21%
Medicare[4]	12%	5%	4%	9%	6%
Private insurance through work	14%	5%	15%	12%	11%
Private insurance purchased	0	0	1%	0	<1%
Do you have a health care provider?					
Yes	27%	23%	45%	50%	38%
No	63%	56%	33%	35%	45%
Sometimes	9%	21%	22%	15%	17%
Do you have a dentist?					
Yes	20%	13%	29%	24%	22%
No	74%	80%	64%	67%	71%
Sometimes	6%	7%	7%	9%	7%

Total may not equal 100% due to rounding.

[4] Clark County responses for health care type were not included in regional calculation. The equivalent of OHP for Clark County was not included on the survey.

Figure 2. Survey Participants by Zip Code in the Four-County Region[5]



Findings

The findings represent the opinions and experiences of 202 individuals living in the four counties. As a result of this small number and the use of a convenience sample, findings are presented for the region, not individual counties. There was a lot of agreement across individuals and between small discussion groups on what the important health needs are and what can be done to address them, which supports the possibility that these opinions are likely to be shared by a larger percentage of the population.

The findings are presented in two sections: 1) a description of what a healthy community looks like and 2) the important community health needs, as well as what can be done about them.

[5] 191 of the 196 survey respondents provided a zip code.

Discussing a Healthy Community

When initially asked how they would describe the elements of a healthy community, listening session participants tended to draw from current problems observed in their own communities. They generated a number of ideas about what might constitute a healthy community. The most common themes included people having 1) basic needs met (food, shelter and employment); 2) access to quality health services; 3) a connected and compassionate social system; 4) peer support, resources, and self-determination to practice healthy habits; and 5) access to education and other shared community resources.

In addition, there was strong agreement that a healthy community would have better access to public transportation, more recreation facilities to promote healthy behaviors, and expanded community programming catering to both individuals and families. They wanted to be able to feel safe from gang and street violence, to feel comfortable with the role and effectiveness of law enforcement, and to feel involved in and informed about their community's issues.

> Things have changed since growing up in the 60s. Today, moms have to be watching their kids and have them in view at every moment.

Perhaps most important to their definition of a healthy community, participants frequently stressed the importance of being socially connected to one's community in order to receive support in times of need and stress.

> We need to be moving from an "I" community to an "Us" community.

Important Community Health Issues and Strategies for addressing them

Several specific issues drawn from the Health Issues list (and from additional issues added by participants) recurred in discussions of communities' top health issues. When looking at voting results of all discussion groups, it is clear that there is strong agreement on what health issues are the most important. There are also frequently reoccurring ideas on strategies suggested for addressing these issues. These findings are presented in five sections, beginning with the most-prioritized health issue:

(1) Mental Health and Mental Health Services
(2) Chronic Disease and Related Health Behaviors
(3) Substance Abuse
(4) Access to Affordable Health Care
(5) Oral Health and Access to Oral Health Services

Mental Health and Access to Mental Health Services

Although mental health and access to mental health services were presented as two different health issues on the list, listening session participants most often voted to combine the two into a single issue. Even when this sentiment was not explicitly stated, discussion frequently treated the two together. Mental health stood out as the most voted-for health problem in the community.

Addressing Isolation and Anxiety as Contributing Factors to Mental Health Issues

In almost all groups, social isolation was a theme related to community mental health issues. Participants expressed significant concern over the detrimental impact of social isolation on mental and emotional health, and especially emphasized it as a cause and contributor to depression in their communities. They noted that isolation derived from many factors, including reliance on technology for communications, lack of employment, lack of cultural integration between different communities, being homeless, and family roles which tended to keep some women in the home or busy with childcare. Many also saw social isolation as a significant barrier to care, in that isolated individuals would feel less comfortable seeking out care themselves and would be less likely to be screened for mental health issues.

Most participants voiced that it was important, in confronting mental health issues, to promote social practices that would work against social isolation. In almost all groups, participants spoke about building a compassionate community that embraces diversity. This included working to eliminate racism, ageism and other forms of discrimination against individuals; as well as raising awareness of the different and special needs of individuals in their community.

> …Develop a sense of community where residents are motivated to care about each other, respect one another, connect with one another, and help out strangers and neighbors.

Many groups felt it was important to remove the stigma associated with mental health issues and treatment in order to help people feel supported by their communities and peers in seeking treatment:

> [Provide] support for people experiencing mental health issues so they can address what's happening and feel supported and secure with themselves.

Additionally, there was strong agreement that increasing opportunities for community involvement would also play a significant role in reducing the incidence of mental health issues. Examples suggested included volunteer programs, community classes and organized activities for individuals and families, more community recreation and arts centers, and sports programs for all ages. Several groups also mentioned the importance of services that could remove the barriers to participate for some people, including childcare, transportation, or providing visits to those who are home-bound.

In addition to isolation, most participants felt that depression in their community was caused by financial stress, the real-life stressors of poverty, homelessness, or adjusting to US systems and society as a member of an immigrant community. Participants generally agreed that, besides the social support discussed above, the way to ease such stress was to continue to work on improving the larger factors that influence a community's health—the economy, housing, and culturally competent services.

Improving Access to Mental Health Services

Many participants felt that there were too few mental health providers to meet community needs. Residents of more rural areas felt this was especially true, and many participants from non-English-speaking communities felt there was sometimes a complete lack of services that would be appropriate for them. Participants from these groups proposed increased training and community placement of mental health service providers, especially those offering therapy and counseling services. Non-English speaking communities hoped to see providers sourced and trained from their own communities.

For example, participants from Somali-speaking communities expressed feeling that Post Traumatic Stress Disorder (PTSD) and other trauma-related mental health issues were some of the most significant of all health issues in their communities. Such issues impacted entire families and communities—not just isolated individuals; and there was a general feeling among Somali participants that this problem was not sufficiently recognized by "western" providers. They expressed that in order to be effective, providers of therapy, counseling and other treatments would need to be much more culturally sensitive and better informed about the patients' backgrounds than they currently are.

Many participants indicated that affordability was an issue. It was frequently expressed that the inconsistency of insurance coverage offered for mental health services was a definite problem. Many participants suggested that in addition to pursuing universal health coverage, it would be important to put regulations in place to extend health coverage to include a full range of mental health treatment services.

Although they agreed that professional mental health services were very important, participants also felt it would be worth investing resources in community groups and support that contribute to good mental health and community-supported recovery. They named churches, peer support groups, and community health educators as examples things they would like to see developed or expanded activities in their communities.

Chronic Disease and Related Health Behaviors
Chronic disease and Related Health Behaviors ran a close second to mental health issues in the voting portion of the discussion. Many participants had stories to share about specific chronic disease issues they had experienced or witnessed in their families and communities. Most often their concerns focused on nutrition and exercise habits, diabetes, and heart disease.

Participants were particularly concerned about the lack of physical activity affecting all generations in their communities, not just adults as the epidemiology data identified. Many participants pointed out that motivation and opportunities for exercise in senior communities was extremely lacking. Participants largely attributed the lack of physical activity to an increasingly sedentary, technology-based society.

Across almost all groups, participants mentioned wanting to increase community programming that promoted physical activity for all ages—and to ensure that the opportunities be affordable. Some suggested that letting people rent or borrow equipment such as bicycles and helmets would help. Examples of programming included senior walking clubs, community gardening initiatives, and increased sports programs for youth. A few participants emphasized that some programming should be tailored to the needs of individuals already facing limiting chronic disease issues such as obesity and heart disease.

Several participants thought that their workplaces could benefit from programs encouraging wellness and physical activity on the job. Participants, whose jobs require sitting or standing in one place for long periods of time, recognized that this was especially detrimental to their health and even to their motivation to exercise outside of work.

Another concern was nutrition. Many participants felt that they could not afford or access the most nutritious food options, and were limited by the prices of produce and the lack of stores offering nutritious options in convenient locations. Participants wanted to see more nutritious options in the locations most convenient to them, such as convenience stores and chain grocery stores—and suggested the support of more farmers markets in their communities. Once again, participants suggested community gardening as an activity that promotes physical activity and provides healthy food to the community inexpensively.

Several participants suggested tactics to encourage low-income community members to choose healthy options where they are already available, such as subsidizing produce and limiting the kinds of food that could be purchased through the Supplemental Nutrition Assistance Program (SNAP). Many participants expressed feeling constantly tempted by "easy" inexpensive, unhealthy food offerings in vending machines and cafeterias and available through the numerous fast food restaurants near their homes. They wanted to see workplaces and schools make efforts to replace unhealthy food options with healthy ones, and wondered if there were a way to develop a "healthy fast food" that could make nutritious meals fairly cheap and easily accessible.

In some cases, working families felt overwhelmed about the cost and time that is required to provide healthy meals consistently to family members, and were unsure how to stop relying on quick and unhealthy food options. Participants from these families felt that they could benefit from community education focused on nutrition and cooking, and from a forum for sharing recipes that balance quick preparation and inexpensive ingredients with good nutrition.

Participants suggested other strategies addressing chronic disease issues that focused on creating educational and motivational opportunities for the community. They felt it was important to make sure the community was informed about the relationship between healthy habits and chronic disease, had skills and strategies for preparing nutritious food, and knew how to access information about chronic disease prevention and early symptoms. Ideas for implementing this education included a strong motivational media campaign, mailers, cooking classes, health fairs, and a stronger health curriculum in schools.

> Go back to the basics and get it into our curriculum.

Participants generally appreciated existing social services like WIC, but wanted to see this type of program expanded to reach more people not just women and children.

> [We need] NEW programs that educate and motivate people to make healthy choices, like a WIC program for adults.

Many participants felt that diabetes was a noticeable problem in their communities due in part to people's inability to recognize and manage symptoms of the disease. Similarly, they felt heart disease went largely unacknowledged and untreated even as it progressed due to unhealthy habits. There was general agreement that, in part, these diseases were going unmanaged as a result of a lack of community education about the diseases and symptoms. It was also stated that in some cases the lack of management was due to a lack of motivation to pursue treatment or lifestyle changes. Participants generally agreed that educating the public about the symptoms, behavioral links, and long-term consequences of these diseases would be the first step toward reducing their burden.

Substance Abuse

Substance abuse issues ranked third in importance to listening session participants. Discussions touched on several issues: smoking, alcohol abuse, misuse of over-the-counter medications, and methamphetamines. Participants were especially concerned about the lack of treatment programs they considered effective, the susceptibility of youth to addictive substances, the lack of clear information and facts about substance abuse issues, and a trend of substance abuse being socially acceptable.

Participants felt that the services currently available for treating substance abuse problems neglect "whole person" care and recovery; that is, they tend to focus too much on the clinical treatment of extreme incidents rather than using therapy, or the treatment of other health issues to support recovery. Prison, they felt, was too-often a substitute for effective treatment in this country. They recognized that residential treatment facilities do exist, but that they are largely targeted to higher-income individuals or are inadequate in capacity to meet the full need in the community. Many participants originally from other countries explained that treatment options in the US seemed significantly less effective than the highly-utilized residential treatment programs for substance abuse in their home countries.

Several groups' ideas involved strategies to create centralized substance abuse treatment services and make them available as part of a comprehensive treatment plan. Some groups wanted to create "case-worker" positions that could help individuals keep track of and coordinate different provider and community support services. Most groups discussing substance abuse mentioned feeling like they had a hard time getting access to unbiased information about the dangers of certain substances, and wanted to see clearly-presented materials developed that they could use as educational tools to protect themselves and their families. Also, as in their approach to mental health issues, participants generally felt that it was important to raise community awareness of existing substance abuse issues and available treatment. Some groups suggested media campaigns that warn, educate, and promote treatment options.

Many participants with children were extremely concerned by the susceptibility of their children to social pressure from peers and drug dealers to try drugs in schools and other settings outside the home. Several talked about how it seemed to be more and more difficult to talk to kids about these issues before they are approached about drugs. Many of these participants wanted to work with schools to develop a strong anti-drug curriculum targeted towards very young children.

Some participants were worried about themselves or their children becoming the targets of violence related to drug culture. As with their discussion of chronic disease prevention, participants wanted to see an increase in accessible recreation facilities and affordable sports and arts programming available to provide safe and enjoyable spaces. They felt that such spaces and activities—for both youth and adults—are important alternatives to opportunities for substance abuse.

In addition to street drugs, several participants also commented on the widespread abuse of tobacco and alcohol despite ongoing media campaigns they've seen to warn against the use of these products. Many participants repeatedly indicated that smoking and drinking excessively around children in the home is a problem that they witness in their communities on a regular basis. In a few groups, the abuse of over-the-counter drugs was of particular concern. Participants tended to be concerned with an apparent social acceptance of these practices.

Several individuals were frustrated by the role that media plays in marketing certain substances to the general public. A few participants stated that alcohol commercials send mixed messages. Others, especially those originally from other countries where media is differently regulated, found it troubling to constantly see advertisements for over-the-counter and prescription drugs – products, they felt, that didn't need to be advertised and were frequently abused. These participants suggested banning television advertisement for these products.

There were varying suggestions about regulation and policy changes that participants wanted to see established to confront substance abuse issues. On the whole, suggestions were aimed at restricting access to substances and to promotional media. Examples included drug laws with harsher penalties for selling illicit drugs, school policies that punish drug abuse and distribution more severely, more restrictions on medical marijuana, strict rules for medication and alcohol advertisements, and regulations to monitor provider prescriptions and patient need for medications.

Access to Affordable Health Care

As an issue unto itself, access to affordable health care was ranked below mental health, chronic disease and substance abuse issues. However, it is important to remember that many participants tended to incorporate specific access to care issues into their discussion of the health issues listed above, as well as their discussion of other less-prioritized issues.

Most participants felt that their most significant barriers to health care services were financial. Many participants expressed simultaneous concern over both their inability to get sufficient insurance coverage for the services they needed, as well as the often prohibitively expensive cost of insurance premiums. Participants frequently called for the cooperation of health care providers to lower rates for the health services not covered by their insurance, and of insurance companies to offer affordable health coverage. A common suggestion was the widespread adoption of sliding fee scales based on a family's income so that services and coverage could be obtained at a rate that is affordable.

When they could find more affordable services, participants from rural areas often had to travel significant distances and rely on infrequent public transportation to see providers. Many participants, who were struggling to maintain employment—and did not have time off, worried because they could not find affordable care at all outside of regular working hours. Many participants who had to pay for childcare, described the expense of this due to the travel and wait time necessary to access affordable health care, (e.g., waiting in line at a free clinic).

Several participants suggested extending the operating hours of existing providers and creating childcare options on-site. In addition, there was strong agreement between most groups that more free and low-cost clinics, providers, and urgent-care options be created in their communities. Most participants felt that expanding a workforce to provide these services locally, at low cost, would ultimately be a better long-term goal than improving transportation options to bring patients already-busy urban clinics.

In almost every group someone had a story to share about being unable to receive the care they needed – especially for non-emergency issues. Participants routinely noted that preventative care and screenings were especially out of their reach. Making the trip, missing work or even going into debt were not reasonable options, resulting in delays in care until an emergency medical situation developed. In response to this problem, participants suggested lowering the cost of, and even incentivizing preventative screenings, routine checkups and other care that could help low-income community members avoid waiting until they required costly emergency procedures.

Several participants wanted to loosen eligibility requirements for services like the Medicaid (Oregon Health Plan), SNAP and other programs that help low-income community members to maintain good health and regular access to medical care.

They felt that the current system of public assistance sometimes discouraged recipients to pursue employment out of fear of losing benefits even if it were only a seasonal or temporary increase in income. There was some concern expressed by participants that people living in the US without documentation are not getting the care they should be and having to wait until their situation is an emergency. These participants wanted to see policy changes aimed at granting access to government aid programs and essential health care services for those without basic legal paperwork.

Oral Health and Access to Oral Health Services

Several participants came to listening sessions with worries about oral health issues that were affecting them and their families. In many cases, the pain and distraction resulting from untreated oral health issues had greatly impacted their health, lives, and work.

Almost three quarters of participants responding in the participant survey said they did not have a dentist they could go to, and many participants indicated in discussion that they did not have any kind of coverage for dental services even if they did have health coverage. As with other health issues, participants largely agreed that the cost of dental services was prohibitively high, and that this often resulted in community-members waiting until their oral health problems had become serious issues before seeking treatment. Similar to discussions of strategies for improving access to health care, participants frequently suggested a cooperative agreement between their community's oral health service providers to lower the cost of services. Having providers drop prices specifically for preventative services and/or offer payment plans for costly ones were ideas that came up more than once.

Many participants also wanted to approach the problem of affordability by expanding dental insurance coverage for their communities. This included both expanding the number of people eligible for dental coverage, and expanding the number of important dental health services covered under such policies.

In several groups participants wanted to make dental insurance standard as part of any health insurance package, including those offered through the government, those offered by employers, and those purchased independently. It was also suggested that routine checkups for children and all significant services for adults, including dentures should all be covered under any dental insurance plan. The idea behind this was to create a standard of dental coverage that all parties could understand and expect.

Several participants also expressed a specific need in rural communities for more affordable oral health service providers in order to eliminate the need for repeated travel to urban centers to access these services. In one group participants expressed interest in the idea of funding mobile clinics to meet the on-going dental health needs of agricultural workers and other more-remote community members.

Over-Arching Strategies for Approaching Health Issues in the Community

In almost all of the groups, discussion included similar, over-arching strategies for improving community health.

Increase Health Education

Notably, in almost every discussion group participants mentioned a general desire to increase health education that focused on each community's major health issues. Examples of what could be done included, increasing the number of community health educators, working with schools to develop strong health curriculums supported by activity and nutrition programs, launching media campaigns targeting specific health issues, and engaging the community regularly through events such as nutrition classes, talks, and health fairs in accessible locations.

Improve Community Access to Health Data and Information about Health Services

Similarly, many participants called for easily accessible health information. They especially mentioned creating community information centers where all residents could go to access health data and research, as well as information about available health services—including eligibility requirements and instructions on how to apply. In some groups it was suggested that having staff who could provide reference services would be very helpful in such a setting in order to help people navigate the vast amount of information.

Improve Cultural Competency of the Health Care System
Improving cultural competency at all levels of the health care system was talked about in most discussions about health issues. Many participants emphasized the need to make sure that any efforts made to improve health care and services in the four-county area would benefit *all* community members. Specifically, this meant producing materials and resources in languages other than English and making them available to cultural communities that may not frequent the same locations as others. This also meant ensuring quality interpretation services at all levels of health care and training providers to better meet the specific needs of the cultural communities they serve.

Limitations

The information and ideas generated during these listening sessions came from participants recruited as part of a convenience sample. The sample does not represent the whole geographical scope of the four-county area. The opinions and ideas collected from 202 individuals through these listening sessions cannot be generalized to the overall population. The goal was to provide an opportunity for community members to express their needs and perspectives in order to help inform Healthy Columbia Willamette Collaborative members as they begin to develop plans to better serve the communities in which participants live. There was much agreement between the top health issues prioritized by participants of the listening groups, the findings from previously conducted community engagement/assessment projects, and the epidemiological data.

Resources

The following resources are referenced above and may be useful for background information:

- New Requirements for Charitable 501(c)(3) Hospitals under the Affordable Care. Internal Revenue Service. Available from: http://www.irs.gov/Charities-&-Non-Profits/Charitable-Organizations/New-Requirements-for-501(c)(3)-Hospitals-Under-the-Affordable-Care-Act
- Public Health Accreditation. Public Health Accreditation Board. Available from: http://www.phaboard.org/
- Mobilizing for Action through Planning and Partnerships (MAPP). National Association of County and City Health Officials. Available from: http://www.naccho.org/topics/infrastructure/mapp/
- Healthy Columbia Willamette regional website. Healthy Columbia Willamette Collaborative. Available from: http://www.healthycolumbiawillamette.org.

APPENDIX I: Schedule of Healthy Columbia Willamette Community Listening Sessions

	Date	Location	Time	Languages Available	Number of Participants
Clark County	**March 19th (Tues)**	**Jim Parsley Community Center** Vancouver, WA 98661	5:30pm–7pm	English, Spanish, Russian	**15**
	March 20th (Wed)	**Maple Grove Middle School** Battle Ground, WA 98604	5:30pm-7pm	English, Spanish, Russian	**11**
	April 11th (Thurs)	**Jim Parsley Community Center** Vancouver, WA 98661	6pm-7:30pm	English, Spanish, Russian	**16**
Washington County					
	April 1st (Mon)	**Tuality Education Center** Hillsboro, OR 97123	5:30pm–7pm	English, Spanish	**2**
	April 8th (Mon)	**Centro Cultural** Cornelius, OR 97133	5:30pm–7pm	English, Spanish	**21**
	April 13th (Sat)	**Beaverton City Library** Beaverton, OR 97005	1pm-2:30pm	English, Spanish, Somali	**28**
	April 17th (Wed)	**Forest Grove Senior and Community Center** Forest Grove, OR 97116	1pm-2:30pm	English	**5**
Multnomah County					
	April 14th (Sun)	**Human Solutions** Gresham, OR 97203	3–4:30pm	English, Spanish, Russian	**12**
	April 16th (Tues)	**Markham Elementary** Portland, OR 97219	1:30pm–3pm	English, Spanish	**13**
	April 18th (Thurs)	**Catholic Charities** Portland, OR 97202	5:30pm–7pm	English, Spanish, Somali	**18**
	April 20th (Sat)	**Matt Dishman Community Center** Portland, OR 97212	11:30am–1pm	English, Spanish, Somali	**12**
Clackamas County					
	April 23rd (Tues)	**Milwuakie High School** Milwaukie, OR 97222	6pm–7:30pm	English, Spanish	**1**
	April 24th (Wed)	**Sandy High School** Sandy, OR 97055	6pm–7:30pm	English, Spanish	**14**
	April 25th (Thurs)	**Canby High School** Canby, OR 97013	6pm–7:30pm	English, Spanish	**34**

N = 202 Clackamas County n= 49, Clark County n= 42, Multnomah County n= 55, Washington County n= 56

APPENDIX II: Recruitment Flyers

¿Qué Problemas de Salud Son Importante para Ud., Su Familia y Sus Amigos?

Queremos saber de Ud.

Estamos reclutando adultos del Condado de Clackamas para participar en reuniones para discutir los tipos de problemas de salud que son importantes para personas viviendo en este condado. Vamos a utilizar la información que recogemos para desarrollar y apoyar servicios diseñados para mejorar la salud de todos los que vivimos en el Condado de Clackamas.

Los primeros 25 participantes recibirán una tarjeta de regalo de $25 de parte de Fred Meyer. Limite una tarjeta por hogar.

Adventist Health — Care you can have faith in.

LEGACY HEALTH

Health, Housing & Human Services — CLACKAMAS COUNTY

KAISER PERMANENTE

PROVIDENCE Health & Services

Jueves, 25 de abril
6pm-7:30pm
Se abren las puertas a las 5:45pm

Canby High School
Cafeteria/Commons
721 SW 4th, Canby, OR 97013

Se provee cuidado de niños y una comida ligera.

Para participar, Debe de:

- Ser 18 años de edad o más y
- No tener seguro de salud o tener ningún/poco ingreso

Preguntas? Por favor, llame Jamie Zentner, 503-742-5939

Este proyecto está dirigido por la Colaboración Saludable de Columbia Willamette del Condado de Clark en Washington y Multnomah, Washington, y Clackamas condados en Oregon.

Какие вопросы здравоохранения важны для вас, вашей семьи и друзей?

Мы желаем услышать ваше мнение.

Мы приглашаем взрослых, проживающих в округе Кларк для принятия участия в встречах, где будут обсуждаться вопросы здравоохранения, которые важны для людей, проживающих в этом округе.

Полученная информация будет использована для разработки и поддержки обслуживания, предназначенного для улучшения здоровья всех, проживающих в округе Кларк.

Первые 25 участников получат подарочную карту на сумму 25 долл. в магазин Fred Meyer. Ограничено одним предложением на семью.

Подробная информация о встрече:

В Clark County состоится два заседания. Пожалуйста, приезжайте к тот, который будет рядом с вами.

Meeting 1:
Tues, March 19, 5:30-7:00pm
Doors open at 5:15pm
Jim Parsley Center – ***2901 Falk Rd, Vancouver, WA 98661***

Meeting 2:
Wed, March 20, 5:30-7:00pm
Doors open at 5:15pm
Maple Grove Middle School Cafeteria - ***610 SW Eaton Blvd, Battle Ground, WA 98604***

Предоставляем легкие закуски и присмотр за детьми.

Для участия, вы должны удовлетворять следующим требованиям:

- Возраст: 18 лет и старше и
- Не иметь медицинской страховки или
- иметь низкий доход/не иметь никакого дохода

For any questions, please call Devin Smith at 503-988-3663, ext. 22412

Данный проэкт проводят Healthy Columbia Willamette Collaborative of Clark County, Washington and Multnomah, Washington, and Clackamas counties in Oregon.

What Health Issues are Important to You, Your Family and Your Friends?

We want to hear from you.

We are recruiting adults from Multnomah County to participate in meetings to discuss the types of health issues that are important to people living in the county. We will be using the information we learn from you to develop and support services designed to improve the health of all of us living in Multnomah County.

The first 25 participants will get a $25 Fred Meyer gift card. Limit one card per household.

Adventist Health — Care you can have faith in.

LEGACY HEALTH

Multnomah County Health Department — Public Health

OREGON HEALTH & SCIENCE UNIVERSITY

PROVIDENCE Health & Services

Meeting Details:

There are four meetings in Multnomah County. Please attend the one that is closest to you:

Meeting 1:
Sun., April 14th, 3pm-4:30pm
Human Solutions
Multi Services Center, Main Floor
124 NE 181st Ave., Gresham, 97230

Meeting 2:
Tues., April 16th, 1:30pm-3pm
Markham Elementary
10531 SW Capitol Highway
Portland, OR 97219

Meeting 3:
Thurs., April 18th, 5:30pm-7pm
Catholic Charities
4th Floor
2740 SE Powell Blvd, Portland, OR 97202

Meeting 4:
Sat., April 20th, 11:30am-1pm
Matt Dishman Community Ctr.
77 NE Knott St., Portland, OR 97212

Childcare and a light meal will be provided.

To Participate, You Must:

- **Be 18 years or older and**
- **Have no health insurance or have no/low income**

For any questions, please call Devin Smith at 503-988-3663, ext. 22412

This project is being conducted by the Healthy Columbia Willamette Collaborative of Clackamas, Multnomah, and Washington counties in Oregon and Clark County, Washington

Waa maxay arimaha caafimaad ee kuu muhiimsan adiga, qowsakaaga iyo saaxiibayaashaada?

In aan adiga kumaqalno ayaan dooneynaa.

Waxaan isugu yeereynaa dadka waaweyn ee kunool xaafada Washington County, in ay kaqeybqaataan wadakulanyo looga hadlayo arimaha caafimaadka ee muhiimka u ah dadweynaha kunool county ga. Murtida laga gaaro wada hadalkani, waxaa loo is ticmaalayaa sidii loo badinlahaa, arimaha gargaarka oo loogu talagalay in ay wanaajiyaan caafimaaka umadeenaan ku nool xaafada Washington County.

Labaatan iyo shanta 25 ruux oo ugu soo horeeya wexey helayaan $25.00 labaatan iyo shan dollar oo Fred Meyer hadiyad ah. Qowskiiba hal hadiyad baa looga talagalay.

PROVIDENCE Health & Services

KAISER PERMANENTE

LEGACY HEALTH

Tuality Healthcare
Building a healthier community.

WASHINGTON COUNTY OREGON
Department of Health and Human Services

Arimaha wada kulanka:

Beaverton City Library
12375 SW 5th St. Beaverton, OR 97005 (Qolka A)
Sabtida, bisha April, 13
1-2:30galabnimo
Doors open at 12:45pm

Wada kulanka iyo wada hadal dhacaya luqada Ingiriis baa lagu hadlayaa, Balse waxaa lagu turjibaanayaa afka Isbanishka iyo Somali ba.

Qof caruurta haye iyo cunta fudud ayaa labixinayaa.

Kaqeybqaadashada, waa in aad:
- Ahaataa, 18 sano jir ama kaweyn
- Oona ka tirsana qoosaska dhaqaalaha yar.

Hadii aad qabtid wax su'aal ah, fadlan la xiriir Shamsa Hussein telefonkaan: 503-846-5722.

Borogramkan waxaa isku daba riday, The Healthy Columbia Willamette Collaborative of Clackamas, Multnomah, and Washington counties in Oregon and Clark County, Washington.

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Childcare and a light meal will be provided.

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For any questions, please call Devin Smith at 503-988-3663, ext. 22412

This project is being conducted by the Healthy Columbia Willamette Collaborative of Clackamas, Multnomah, and Washington counties in Oregon and Clark County, Washington

APPENDIX III: Discussion Guide

Healthy Columbia Willamette Collaborative
Community Listening Session Guide

Large Group Introduction: (*Instruction: Convener team or Leadership group member will present this to larger group and Interpreters will translate this information to non-English speakers. This is just a guide. Information should be covered but doesn't need to be read as written.)*

Welcome
Welcome everyone. Thank you so much for coming out tonight/today to participate in this important project. My name is _____ and I work at _____. I want to give you a quick overview of why we are here, but first I want to take care of some housekeeping things.

Housekeeping
- First, if you have questions about childcare, please ask _____
- If you haven't already, please help yourself to refreshments.
- The bathrooms are located_____
- Please make sure that you have signed in. The 25 adults who arrived and signed in first will receive Fred Meyer gift cards at the end of the meeting.
- We will be done by 7:00 sharp.

Project Overview
Today, we want to hear from you all about what are the most important health issues in the community. There are no right or wrong answers. We are here to hear your opinions and ideas. The information we hear from you today is going to be combined with information collected in 13 other groups just like this one.
We are hosting these meetings as part of the Healthy Columbia Willamette Collaborative. It is a collaborative of 14 hospitals and 4 health departments in Clark County Washington, and Clackamas, Multnomah and Washington Counties in Oregon.

The goal of this project is to identify the most important needs of the community and find ways that we can all work together to work on them. In June we will have a final list of priority health issues and will start planning what we all can do about these issues.

We have a handout describing the Healthy Columbia Willamette Collaborative, as well as a sheet that you can sign if you would like us to send you information about the process as we move forward. They are both on the table. I would like the group to break into smaller groups so that all of us have more of an opportunity to speak. In these small groups, you will have a facilitator who has some questions to ask you. But before we do this, does anyone have any questions?

Instructions: Ask people to break into groups of about 10 people. Each group will need at least one facilitator. If there are two available, have one take notes on poster sheets and the other ask the questions.

Small Group Discussion Questions:
Okay, we have a little over an hour to talk about health and what health issues are the most important in our community. This is going to be an informal discussion. We want to hear about your ideas, experiences and opinions. There are no wrong answers. I am also going to request that we let everyone have a chance to speak. The goal today is to have everyone's opinions recorded rather than come to an agreement. If we all end up agreeing however, that is just fine too.

Okay, let's start with a general question.

What does a healthy community look like to you? For this question, please define community however you like. It could be only people, or it can include things like the job market, housing, conditions of your neighborhood, etc.

Instructions: Please document the answers on a poster sheet.

Now I would like to talk about this list of health issues. *(Refer to poster or handout.)* These health issues have been identified as the most important issues affecting our community through a series of activities similar to this one and through data. Let's go over this list and make sure we have the same understanding of each issue. Then we are going to identify health issues that we think need to be added to the list. After that, we will each pick the five issues that each of us consider to be the most important. Remember there are no right or wrong answers.

Instructions: Go over the list as a group so that people understand what each issue is.

Are there other health issues that you think should be on this list?

Instructions: Write the new issues on a separate handout or poster sheet—assign a letter to each new issue so it fits in the existing list.

Alright, now we get to each pick the five issues that are the <u>most important</u> ones. The five issues that you would like to see addressed first. This is going to be a challenge because all of these issues are important.

Instructions: Read out each health issue (those you started with and any additional ones that were added). As you read through the list, ask participants to vote for their top five (only five). Having people vote with a show of hands is the best option; however, if you feel that group members may not feel comfortable to share their vote publicly, ask them to write down their votes. Make sure to record the votes on a poster sheet.

Okay, it looks like # issues have been voted for. Let's now brainstorm ideas on what we think should be done to fix or address the issue. Let's start with the issue with the most votes and work through all of the ones that at least one person voted for.

Instructions: On a poster sheet, write the issue down (or just its letter) and write down the ideas that participants come up with to address/fix the issue. Do this for each issue that received a vote, but start with the issue receiving the most votes in case you run out of time.

APPENDIX IV: List of Health Issues

Health Issues (English)

A) Mental health
- depression
- trauma
- stress
- mood disorders
- anxiety
- suicide

B) Substance Abuse
- prescription drug abuse
- illegal/street drug use
- alcohol abuse
- Adult smoking

C) Chronic Disease and related health behaviors
- adults not eating enough fruits and vegetables
- adults not being physically active
- obesity or being overweight
- heart disease
- diabetes

D) Sexually transmitted infections/diseases (Chlamydia, Syphilis, HIV, Herpes, etc)

E) Accidental poisoning from chemicals, pesticides, gases, fertilizers, cleaning supplies, etc

F) Injuries from falling

G) Cancer

H) Oral Health (gum disease, tooth decay, etc)

I) Perinatal health

J) Access to affordable mental health services

K) Access to affordable dental care

L) Access to affordable health care

M) Access to services that are relevant/specific to different cultures (such as African American, Latino, Native American, Asian, Slavic, refugee/immigrant, LGBT, disability communities, etc)

N) Data collection on the health of people from various cultures (such as African American, Latino, Native American, Asian, Slavic, refugee/immigrant, LGBT, disability communities, etc)

(Health Issues List, Spanish)
Problemas de la Salud

A) Salud Mental
- depresión
- trauma
- estrés
- trastornos del estado de ánimo
- angustia
- suicidio

B) Abuso de Sustancias
- Abuso del medicamento recetado
- Uso de drogas ilegales/de calle
- Abuso del alcohol
- Fumar adulto

C) Enfermedad crónica y conductas relacionadas con la salud
- adultos que no comen bastantes frutas y verduras
- adultos no siendo fisicamente activos
- obesidad o ser demasiado pesado
- enfermedad cardiáca
- diabetes

D) Infecciones/enfermedades transmitidas sexualmente (Chlamydia, Sifilis, VIH, Herpes, etc)

E) Envenenamiento accidental de productos quimicos, pesticidas, gases, fertilizantes, productos de limpieza, etc.

F) Heridas de caída

G) Cáncer

H) Salud oral (enfermedad periodontal, caries, etc)

I) Salud perinatal

J) Acceso a servicios de salud mental económicos

K) Acceso a cuidado dental económico

L) Acceso a asistencia médica económica

M) El acceso a servicios que son relevantes /especificos para culturas diferentes (como el afroamericano, Latino, americano indigena, asiáticos, eslavos, refugiado/inmigrante, LGBT, comunidades de invalidez, etc)

N) Recogida de datos en la salud de la gente de varias culturas (como el afroamericano, Latino, americano indigena, asiáticos, eslavos, refugiado/inmigrante, LGBT, comunidades de invalidez, etc)

(Health Issues List, Russian)
Вопросы Здравоохранения

A) Психическое здоровье

- депрессия
- травма
- стресс
- расстройство настроения
- страх
- самоубийство

B) Злоупотребление различными веществами

- злоупотребление лекарственными препаратами
- употребление наркотиков
- злоупотребление алкоголем
- курение (для взрослых)

C) Хронические болезни и ответственность за собственное здоровье

- Взрослые, не употребляющие достаточного количества фруктов и овощей
- взрослые, ведущие малоподвижный образ жизни
- ожирение или избыточный вес
- болезни сердца
- диабет

D) Заболевания, передающиеся половым путём (Хламидия, Сифилис, ВИЧ, Герпес и др.)

E) Случайное отравление химикатами, пестицидами, газом, удобрением, материалами для уборки и др.

F) Повреждения от того, что вы упали

G) Рак

H) Гигиена полости рта: заболевание десен, кариес зубов и др.

I) перинатального здоровья

J) Доступное лечение психического здоровья

K) Доступное стоматологическое обслуживание

L) Доступная медицина

M) Доступ к получению обслуживания, которое особенно важно или относительно для разных культур, т.к. афроамериканцев, латиноамериканцев, коренных американцев, азиат, славян, беженцев/иммигрантов, лезбиянок, геев, бисексуалов и трансгендерных людей, лиц с ограниченными возможностями и др.)

N) Сбор информации о здоровьи людей с разных культур (таких так афроамериканцев, латиноамериканцев, коренных американцев, азиат, славян, беженцев/иммигрантов, лезбиянок, геев, бисексуалов и трансгендерных людей, лиц с ограниченными возможностями и др.)

(Health Issues List, Somali)
Cudurada Caafimaadka

A) Cudurada Meskaxda
- Murugo
- Walaac/dhibaadooyin kugu dhacay oo xasuus xunleh
- Walwal/Walbahaar
- Isbadbadalka Dareenka
- kurbo
- isidilid

B) Isticmaalka Xaddhaafa daroogada
- Isticmaalka Xaddhaafa Daawada Laguu qoray
- Daawa aan laguu qorin/ama jidadka kazoo gadatay
- Isticmaalka Alkolada
- Qofka weyn sigaarka cabaaya

C) Cdurada Hoose iyo dhaqamada caafimaad
- dadka waaweyn oo aanan cuneyn qudaarta
- dadka waaweyn oo aanan aalmiiteyneynin
- cayilaka ama cayilka xeddhaafka ah
- cudurka wadnaha
- cudurka sokorowka

D) Cudurala isu taga ee infakshanka leh, ee leyska qaado (Chlamydia, Syphilis, HIV, Herpes, etc)

E) Sunta la cuno ama lasiiyo qofkale ayadoon loola jeedin, sida kimikadoo kale, suntan xayawaanka disha, sunta wax lagu dhaqdo, gaaska iyo wax yaaba badan.

F) Jabista laga qaada marka ladhoco

G) Cuduka Kaankaraha

H) Caafimaadka afka gudihiisa (Cudurka Ciridka, Ilka jajabka, iyo waxyaaba badan)

I) Caafimaadka Perinatal

J) Helista caadimaad raqiiska ah oo cudurka meskaxda

K) Helista caafimaad raqiiska ah ee dhaqaaleenta ilkaha

L) Helista caafimaad raqiiska ah

M) Helista brogaramya u gaar ah/loogu talagalay dadweynaha heysta dhaqanyada kala duwan (sidiiba African American, Latino, Native American, Asian, Slavic, refugee/immigrant, LGBT, disability communities, etc)

N) Gurbiska xisaabta caafimaadka ee dadka kakala imaaday dhaqanyo kala duwan (sidiiba African American, Latino, Native American, Asian, Slavic, refugee/immigrant, LGBT, disability communities, etc)

Appendix V: Healthy Columbia Willamette Collaborative Community Listening Session: Participant Survey

This information will be used to describe who participated in the discussions. This is an anonymous survey, so please do not put your name on it.

1) **What is your gender?**
   - ☐ Female
   - ☐ Male
   - ☐ Other

2) **What is your age?** _____years

3) **How would you describe your race/ethnicity? Please mark all that apply:**
   - ☐ African American/Black
   - ☐ American Indian/Native American
   - ☐ Asian
   - ☐ Hispanic
   - ☐ Native Hawaiian/Pacific Islander
   - ☐ White
   - ☐ Other (please specify): _____

4) **What is you household's yearly income?**
   - ☐ Less than $10,000
   - ☐ $10,000 to $19,999
   - ☐ $20,000 to $29,000
   - ☐ $30,000 to $39,000
   - ☐ $40,000 to $49,000
   - ☐ $50,000 or higher

5) **How many people live in your home?**
   1 2 3 4 5 6 7 8 9 or more

6) **What is your zip code?** _____

7) **Do you have a health care provider you can see?**
   - ☐ Yes
   - ☐ No
   - ☐ Sometimes

8) **Do you have a dentist you can see?**
   - ☐ Yes
   - ☐ No
   - ☐ Sometimes

9) **How much school have you had?**
   - ☐ Less than high school
   - ☐ High school diploma/GED
   - ☐ Some college
   - ☐ College graduate or higher

10) **What kind of health insurance do you have?**
   - ☐ No insurance
   - ☐ Oregon Health Plan
   - ☐ Medicare
   - ☐ Private insurance through work
   - ☐ Private insurance that you pay for