# Multnomah County Community Health Assessment

## Discussions with People Living In Mid-County and East County

## Focus Group Report

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MULTNOMAH COUNTY HEALTH DEPARTMENT

Public Health
Prevent. Promote. Protect.

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Innovative Housing, Inc

Human Solutions

Wood Village Baptist Church

## INTRODUCTION

This report presents findings from a series of 13 focus groups conducted in Multnomah County as part of the 2011 Multnomah County Community Health Assessment (MCHA). The purpose of these discussions was to learn what people in Multnomah County feel are the most important issues affecting their health and that of their families and communities.

The findings from the focus groups informed the Community Themes and Strengths Assessment, one of four complementary assessments based on the National Association of County and City Health Officials' (NACCHO) Mobilizing for Action through Planning and Partnerships (MAPP) model.

### Mobilizing for Action through Planning and Partnerships (MAPP)

The standard NACCHO MAPP process includes the following four assessments:

(1) The Community Themes and Strengths Assessment identifies the health-related issues that are most important to community members.

(2) The Community Health Status Assessment describes the health of the community through quantitative data on key health indicators (e.g., leading causes of death, rates of first trimester prenatal care).

(3) The Local Public Health System Assessment highlights the strengths and challenges of our current local public health system.

(4) The Forces of Change Assessment identifies the political, social, and economic issues that could affect the local public health system's ability to address health-related priorities.

### Multnomah County Modifications to the MAPP Model

The Multnomah County Assessment was tailored to capitalize on community engagement efforts previously conducted by community-based organizations and local government. These changes meant the Community Themes and Strengths Assessment could build on community input previously collected.

Additionally, the Local Public Health System Assessment and Forces of Change Assessment were combined because the information collected for each was obtained through 43 interviews with more than 50 leaders in public health, local government, community-based services, transportation, education, employment, and planning. All of whom were qualified to speak to the current capacity and future opportunities and uncertainties affecting the local public health system.

In order to conduct the Community Themes and Strengths Assessment, an inventory of past community engagement efforts and assessments was created to ensure that previous efforts were not duplicated and that findings from previous assessments were incorporated.

To create this inventory, staff reviewed 29 assessments and engagement efforts conducted in recent years[1] by community-based organizations, advocacy groups, and governmental agencies. Staff then compiled the findings and methodologies and interviewed stakeholders from each assessment in order to ensure that their findings and the populations involved were characterized accurately.

Once the findings from the inventory were completed, they were presented to the Multnomah County Community Health Assessment Advisory Group. This group was convened specifically for the community health assessment and was comprised of partners from several programs within the Multnomah County Health Department, city bureaus, and community-based organizations. The Advisory Group met five times between October 2010 and June 2011. Special efforts (i.e., phone conversations, e-mail, and meetings) were made to solicit feedback from members who were unable to make meetings, as well as from partners who were unable to formally join the Advisory Group but provided feedback during the process.

The 13 focus groups and a community health survey were conducted with people from these identified populations. The findings from both of these studies (i.e., focus groups and community health survey) were added to the inventory to complete the Community Themes and Strengths Assessment and answer the question, "What do people living in Multnomah County think are the most important health related issues?" This report presents findings from the focus groups. Findings from the community health survey can be found in a separate report. More information on it, as well as on other reports written as part of the Multnomah County Community Health Assessment, can be found in Appendix B.

## KEY FINDINGS

Many people wanted to become more active in public input activities that inform public decision making. Because of daily responsibilities, not knowing how to become involved, and, for some, not having the confidence, getting involved is difficult. Participants appreciated that this project, *"came to us"* and thought that more of their community members would participate if decision makers made the effort to come to their housing developments and other places they frequent regularly, such as churches and social service agencies.

[1] The majority were conducted within the last five years.

Focus group participants defined health and wellness as having comprehensive health care; connections with other people; choosing and having the ability to practice healthy behaviors; and the resources to prevent and manage serious health problems, such as diabetes and asthma.

There was strong agreement that people may be more likely to practice healthy behaviors if they have resources such as money, health care, affordable grocery stores, a variety of restaurants (not only fast food establishments), accessible transportation, and places where they can socialize and be physically active.

Most participants had difficulty answering whether their community was healthy. A common response to this question was, *"Some people are and others are not."* In most groups, as the conversation progressed, participants began talking about how they think that for the most part, their communities were not that healthy due to*, "stress from being poor."* People discussed the connections between the reality of being poor and the unhealthy things they observed in their communities.

Examples of these problems included drug use, criminal activity, *"directionless youth,"* unhealthy eating, hopelessness about finding work, and depression.

People wanted to be self sufficient, but felt that government has the responsibility to provide a safety net for those people who are unable to take care of themselves, whether this inability is due to individual limitations or hard economic times.

Most participants appreciated public safety-net services but felt that government could do a better job advertising the services, broadening the eligibility requirements, and making the application processes easier. There was a fairly strong sentiment that the system does not work when it cuts all help rather than maintain or prorate support for a short time while people are, *"getting on their feet"* (i.e., starting a job after being unemployed for a long time).

## METHODOLOGY

### Focus Group Content, Facilitation, and Recruitment

During February and March 2011, 13 focus groups with 72 participants were conducted in Mid-County and East County. The purpose of these discussions was to learn what people in Multnomah County feel are the most important issues affecting their health and that of their families and communities. The questions asked during the groups were developed by staff from the Multnomah County Health Department and the Community Health Assessment Advisory Group. Demographic information from the participants was collected including: household income, education level, ethnicity, age, sex, and health insurance status. The focus group discussion guide is included Appendix A.

Eleven of the groups were facilitated by Multnomah County Health Department Staff (Health Assessment and Evaluation and the Community Capacitation Center) and two were conducted by an Advisory Group member from We Can Do Better (formerly the Archimedes Movement). Five of the groups were conducted in languages other than English (i.e., Somali, Spanish, and Amharic) with the support of the IRCO and the Community Capacitation Center.

The focus groups lasted approximately two hours and participants received $25 gift cards and a meal. Groups were scheduled during the day and evening and, when possible, very close (if not in) participants' housing complexes and social service providers' offices. There were, on average, six participants in each group; however, due to language considerations the range was between one and nine participants. Participants were asked to engage in discussions at the level they were comfortable, sign consent forms, and provide demographic information on a confidential form. The facilitators explained to participants that their answers would not be reported by the Health Department in a manner that would identify any individual.

Sixteen questions were included in the focus group guide; however, facilitators learned after a few groups that certain questions should be skipped if the content or direction of the conversation made the questions irrelevant or disrespectful. For example, when group members emotionally described being, *"desperate to find housing and food"* or being in, *"survival mode,"* asking questions about the difference between community health and public health were not appropriate. All groups were concluded by asking each participant to "vote" for the three most important health issues from a list of issues identified in the inventory along with any new issues that their group brought up.

The Multnomah County Health Department partnered with community-based organizations, churches, and public health stakeholders to recruit participants for these groups. Specifically, staff worked with the Immigrant and Refugee Community Organization (IRCO), Multnomah County Rockwood Health Center, Wood Village Baptist Church, and two low-income housing organizations in Mid-County and East County—Human Solutions and Innovative Housing, Inc. The list of focus groups is presented in Table 2.

**Participation**

The Advisory Group recommended that focus groups and a survey be conducted with community members from the groups highlighted in Table 1. Although a convenience sample was used, the majority of populations prioritized by the Advisory Group were included.

All of the focus group participants identified themselves as being from one or more of the populations identified; however, not all prioritized populations were engaged due to recruitment or facilitation challenges such as difficulty connecting with people living in rural or unincorporated areas of Multnomah County and limited resources for translation services.

Of the participants identifying a gender/sex, 35% identified themselves as male and 65% female. Almost 40% of the participants were between the ages of 26-39.

Participants were asked to identify their race and ethnicity.[2] Of those providing this information 46% were White, 21% were African, 14% were African American, 13% were Hispanic/ Latino, 4% were Native American, and 3% were Asian/Pacific Islander. The vast majority of participants had household incomes of less than $20,000 (79%); were unemployed (65%); and were renting their housing (81%). All of the participants lived in Mid-County or East County at the time the groups were conducted. Demographic information provided by participants is included in Table 3.

**Table 1: Prioritized Populations for Focus Groups**

| |
|---|
| **1. Populations between 20 and 40 years old (Emphasis on East and Mid-County)**:<br>Men and women of reproductive age<br>Young Latina mothers |
| **2. Rural communities/ unincorporated Multnomah County** |
| **3.Low-income people (Emphasis on East and Mid-County)**<br>People below 200% FPL ($44,100 for family of four) |
| **4. Immigrants & refugees**<br>African immigrants- especially elders<br>Slavic community- especially middle aged<br>Families who immigrated from rural areas of a developing country |
| **5. Communities of color (those engaged to a lesser degree in previous assessments)**<br>Native Americans/ American Indians<br>African Americans displaced to East and Mid-County<br>Asian/Pacific Islanders |
| **6. Population by housing status**<br>Homeless (all ages)<br>Transitional (all ages)<br>Renters & mixed income housing |

## FINDINGS

Focus group participants' responses are presented in six sections:
(1) Health and Wellness
(2) The Community's Health
(3) Public Health
(4) Barriers to Health
(5) Health Promotion
(6) Community Involvement

[2] Some participants identified more than one race/ethnicity.

## Health and Wellness

Prior to discussing issues affecting health, participants were asked to describe what the terms "health" and "wellness" meant to them. There were four general ways in which participants talked about these terms: (1) Health Insurance and Health Care, (2) Being Connected to Others, (3) Healthy Behaviors, and (4) the Prevention and Management of Serious Health Problems. Most participants used "health" and "wellness" interchangeably and there was very strong agreement that they have significant effect on one's life.

*"It is very important because you cannot do much if you are not healthy."*

*"[Health is] being able to work."*

The small number of participants who did distinguish "wellness" from "health" described wellness as including more than one's physical health.

*"More detailed; it encompasses more— like mental health, physical health, how you live your life. Other things contribute like employment, stress, being whole."*

### *Health Insurance and Health Care*

Across all groups, the most common definition of health and wellness was "health care and insurance." Almost one third of the participants did not have health insurance and another 40% were on public health insurance (the Oregon Health Plan (OHP)). Not surprisingly, health insurance and health care were also identified as one of the most significant barriers to health.

*"When I think of wellness I think of insurance to be protected."*

*"Health is… it's been such a long time since I thought about that. I just got OHP and before that I had no place to go for health."*

### *Being Connected to Others*

The importance of feeling connected to other people was discussed in almost all the groups as an important dimension of health and wellness. Participants who spoke about this issue gave examples of how relationships (or the lack there of) with other people affect their health.

*"[Health is having] a friend to take you to the doctor."*

*"Knowing I have family and neighbors to spend time with and who are looking out for me protects my health."*

A few participants described being alone and consequently feeling lonely, isolated, and worried. They discussed how their isolation was both a contributor to and a result of not being very healthy.

*"People are isolated. It isn't good for health."*

*"I am an elderly woman and have no one to turn to."*

***Healthy Behaviors***

In almost all of the groups, participants discussed the importance of living a healthy lifestyle. Being physically active, eating well, sleeping, reducing stress, staying away from drugs and alcohol and *"living a good life"* were common points. These behaviors were not discussed in any order of priority by participants; however, most participants indicated that practicing these behaviors was difficult due to limited access, affordability, and time.

*"I am too stressed. I don't have money or time to go to the gym and it is too far to walk to MAX to go somewhere I can get exercise."*

*"Fast food is so easy to get and much cheaper. I know it is unhealthy."*

Across all groups, participants placed a lot of responsibility on *"the individual"* to practice healthy behaviors; take care of their neighbors; voice their opinions about what is available in their communities (e.g., healthy food, public transportation, and places to walk); and advocate for themselves when working with social service agencies in order to avoid *"the run around"* they have experienced when applying for OHP, food stamps, and other support. It was evident from all the groups that many participants felt that, as individuals, they had some power over the factors affecting their health and saw this as a positive thing.

***Prevention and Management of Serious Health Problems***

Most participants knew that being overweight or obese increases risk for numerous chronic diseases including diabetes, coronary heart disease, stroke, and cancer. They also understood that high blood pressure can increase the risk of heart disease and stroke. The most common health problems brought up by participants included asthma, diabetes, heart disease, and mental health problems—specifically depression.

Most participants discussing these health problems talked about the importance of preventing these conditions in the first place through practicing healthy behaviors and having a doctor to see. Some talked about a connection between these health problems and the built environment (e.g., availability of healthy food and places to walk and exercise), although participants did not call these things "the built environment."

*"We're all low income. We can't afford the market and health club. Those things that bring up your health."*

When the groups included members with serious health problems this type of primary prevention was seen as less important due to the immediacy of existing health problems.

*"All those things like sidewalks and food are important, but they don't do much for me if I can't get my meds."*

**The Community's Health**

When asked whether their communities were healthy, almost all of the participants who answered said that they could not say whether their community was healthy. They discussed their different communities in terms of city, neighborhood, apartment complex, and ethnic or racial group. Most participants said that this was a confusing question and that no one can speak for an entire community.

*"Some people are healthy and others are not."*

The term "community health" was new and most people did not know what it meant. When trying to figure out what this question meant with fellow group members, most people started by discussing individual behavior, circumstances, and health issues. One recurring sentiment was that *"Health doesn't come in community. It's up to the individual."*

However, after further reflection on the health of their community, many discussions focused on what people see everyday. During the course of several groups' conversations, participants started to describe their community as not healthy because, "*Too many people are out of work and are worried about a job and don't have anything to eat so then they get sick."*

Some participants described how the struggles of one person in the community affect another's health. An example given was about people in their neighborhoods who are losing their homes. Participants explained that this loss is not only stressful to the individual, but it also leaves empty houses in the neighborhood, bringing down home prices and inviting crime.

*"[Neighbors] having to leave homes—that brings a lot of stress to the neighborhood and it depreciates the other home values and therefore we're all going down."*

Some participants talked about stress and how it appears to influence unhealthy lifestyles that can result in high blood pressure, stroke, obesity, and diabetes. One participant said, *"In my neighborhood people are sick from stress. They drink and smoke and are at no peace with themselves."*

As the conversations progressed, participants in several groups began discussing how health behaviors could be encouraged through changes in neighborhood conditions including access to food, affordable and safe transportation, and public safety. Participants described some of these problematic neighborhood conditions that contribute to unhealthy behaviors and poor health.

*"[In Gresham] there are too many fast food restaurants that are cheaper than real food."*

*"There is property stolen, houses broken into, and people wandering around that you don't recognize. There are gang situations and people being harmed at the MAX station."*

*"If you live in a community with a lot of crime, but you can't afford to live somewhere else [that is stressful]."*

One person described the community's health as being dependent on general access.

*"I think of class. People who are rich have parks, transportation, and decent food. When I lived in inner Southeast Portland things were three times cheaper. Now I have to take buses to get everywhere."*

**Public Health**

Similar to participants thinking "health" and "wellness" were primarily referring to health insurance and health care, "public health" was seen primarily as a network of low-income clinics and a source for immunizations. Very few participants mentioned any of the other public health functions such as environmental health, emergency preparedness, and early childhood services. One participant described public health as an *"umbrella term"* and another described how it is, *"[The] community coming together to find health solutions."*

*"I can see it as helping people who cannot afford insurance, it is a lower cost than regular health and more accessible."*

Several people talked about safety net clinics and specifically about the Multnomah County Health Centers. Many expressed that they were pleased with these clinics; however, there were several comments about these clinics having long waits, busy waiting rooms, and other undesirable conditions.

**Barriers to Health**

Several questions were asked to stimulate discussion about the barriers that make it hard for people to become and remain healthy. Following the recommendations of the Advisory Group these questions asked about parents' concerns; causes of stress, fear, and anxiety; and things that negatively affect people's health. During the focus group conversations, barriers discussed fell into five general categories: (1) Money and Employment, (2) Health Insurance and Health Care, (3) Eligibility and Navigation of the Public Safety-Net, (4) Accessible Public Transportation, and (5) Stress and Mental Health.

***Money and Employment***

Almost 70% of the participants were unemployed or underemployed, and 80% reported household incomes of less than $20,000. Understandably, almost all participants voiced that money was the most significant barrier to their health. There was strong agreement across all groups that not having enough money affected health in two important ways.

First, not being able to pay for basic needs creates a lot of stress for people and this stress causes people to get sick. Second, not being able to meet one's basic needs, including housing, food, health care, and transportation, makes it impossible to take care of one's health.

*"Money is the biggest thing to be healthy."*

*"If I can't pay for basics health really goes to the bottom of the ladder."*

Additionally, the rising costs of housing and resulting displacement of people to Mid-County and East County from neighborhoods close to downtown Portland was described by some as a significant barrier to accessing services.

*"Rents are higher the closer you get to downtown (Portland). Since I am low-income, I needed to move all the way out here. But we don't have access to things and services."*

Being self sufficient was an important value voiced during most of the focus groups. Participants described being burdens to their grown children, *"We are sitting on the shoulders of our children."*

Many participants described frustration about finding work, and several stated that they did not want to rely on the public safety net even if they were eligible.

*"My husband can't find a job. If he did that would really reduce stress."*

*"I don't want to be living in assistance, but I am. Self sufficiency is so important, but you have to be able to get there"*

***Health Insurance and Health Care***

Not having health care was discussed as a barrier by many participants, and as previously mentioned, was the most common issue mentioned when they were asked to describe "health and wellness." Most people mentioning health care barriers described how they were stopped from getting preventive care as well as medical care for a chronic or acute condition.

In many focus groups, conversations about the challenges to obtaining health insurance and health care were discussed. Many participants pointed out that there are two primary ways people get health insurance: employment or public systems. Some participants expressed frustration that they were unable to receive health insurance through either track.

"*You're supposed to get insurance from your employer, but no one can find a job—or one that gives insurance."*

*"I worked temporarily in the packing house and now they say we make too much money. We don't qualify for anything, not even head start."*

Some of these participants gave accounts of when they had to go to emergency departments or *"free clinics and vans,"* and made it clear that they would prefer to have insurance so they could get *"real health care."*

Other people discussed the downfalls of eligibility requirements for public insurance; one story depicts how the system may deter people from working in order to keep their health insurance.

*"For two years I was sick and didn't have insurance. I was on the waiting list. As soon as I started working again, because I started feeling better, I got called and found out that I was making a hundred dollars too much a month to qualify [for OHP]."*

***Eligibility and Navigation of the Public Safety-Net***

In many groups, participants talked about their lack of awareness of the resources available to help meet basic needs (e.g., food boxes, food stamps, rent assistance, housing, funds for utility bills, health care, tutoring, etc). Not knowing about resources was discussed as a barrier to taking care of one's family and ultimately their health. One participant described how many people, *"slip through the cracks"* when it comes to being able to access resources that could benefit their health.

*"People don't know about the resources in their communities. That's a huge barrier, people not knowing."*

Some participants put the responsibility on the social service programs and governmental organizations, explaining that *"They don't announce it enough."*

For those who were familiar with these resources, the number of agencies one needs to contact, the application processes, and transportation were barriers. *"[There are] too many systems to navigate."*

*"The medical forms, there are a lot of extra steps and they need information that is not relevant."* Another participant said that, *"People stop trying to get health because it is a very demanding experience*" and that "*They don't do things for men."*

A common recommendation from participants was that there should be a central hub for resources. *"If we had a central hub it would help [stop things from being] so hard to navigate. It is hard for me to make all my appointments in different spaces. Public agencies should have to work together."*

Some challenges unique to specific populations were discussed in several groups. These include eligibility barriers due to past convictions as well as the inability to know where to inquire about services and eligibility. These issues were brought up by men and there was agreement in the groups in which they were discussed that they disproportionally affected men.

*"If you are convicted of a felony you can't get much. It is hard to be eligible for most things. I am trying but it is very hard."*

*"If you don't have custody of your kids, you aren't getting help. Men don't seem to be eligible for anything even if they aren't working."*

In the cases of language barriers, men were experiencing these because they were the heads of the households making decisions for the family. If women in the families took on this role, it may be just as much a barrier for them; however, due to cultural norms, men are expected to be the decision makers.

*"It would be a relief to have Section 8 or something to be able to save money and get where we need to be, but if you don't have the language, you can't even do this. I can't even express myself. And with those people you have to call and call and push for it. And I don't know the language."*

There was very strong agreement in most of the groups that all of these entities should treat, *"everyone as an individual with unique circumstances and not just rubber stamp their denials."*

***Accessible Public Transportation***

Transportation was another barrier to health mentioned by several participants. One participant described recent cuts to the number of bus routes and frequency of remaining routes. *"Now that my bus doesn't run anymore, I have to ride four buses to get there to get the resources and be able to get them on time."*

There was strong agreement across the groups that increased bus fares and underserved areas in East County were significant barriers.

*"A lot of buses run east to west, but no buses until Powell, which is about one mile."*

*"They stop too early and cost too much money. I have to walk to the max in the rain so that's a big thing."*

*"It is hard to go north from out here. I usually have to go through downtown, which is a big time suck."*

***Stress and Mental Health***

Most participants discussed stress as an, *"ever-present fact of life if you don't have what you need."* Sources of stress included all of the barriers previously mentioned (i.e., money, health care, accessing services, and transportation) in addition to worrying about the wellbeing of their children, aging parents, and their marriages or relationships with their significant others.

In several groups, participants described their worrying about the choices their kids make (e.g., using drugs*), "making sure they grow up to be good people."*

*"They act young and not mature. They don't look like they try to get jobs or be responsible. They are not taking care of themselves and then get involved in unhealthy things."*

Specific to children, in several conversations, participants described the stress people felt about not being able to afford care for their children. Issues mentioned include health insurance, vaccines, STD treatment, pregnancy, metal health, and addiction.

Mental health was brought up in every group, with participants sharing stories of their own pain or that of other people they know. The most commonly mentioned issues involved drug and alcohol addiction and depression. Inadequate mental health care was discussed as a major barrier to health as well as not having a support system to rely on when one is not mentally well.

*"I worry about how to cope, people to talk with about stuff, and just having people around."*

Another participant described how one cause of stress is, *"Pushing people away if you have mental illness and you are scared. You put up a wall and a lot of people don't really understand that."*

There were significant stressors described by some of the participants whose communities have been displaced in recent years to East County. These issues include, *"not being near my family, church, or stores that have my things"; "The housing is bad and no one will take care of the mold no matter how many times we say it"; and "The police bother us out here a lot more."* Feeling disconnected from others was described as a big problem and that it made many people want to keep to themselves.

## Health Promotion

Participants were asked to think about the types of things that were available or taking place in the community that promote health. Their responses fell into five categories: (1) Social/Public Services, (2) Schools, (3) Connection to Neighbors, (4) Public Participation, and (5) Public Safety.

***Social/Public Services***
Many gave examples of the public services described earlier (food stamps, OHP, housing, etc). In almost all the groups, people expressed gratitude that these resources were available even if they are sometimes hard to access.

Specific organizations and programs that were credited for promoting health include, Snow Cap, Wallace Medical Concern, the SNAP Program, mobile medical vans, Compassion Care, Community Connectors, Loaves and Fishes, Salvation Army, health vans set up at the WinCo parking lot, WinCo store, Closet to Closet, swimming pools, Head Start, the food pantry at the community college, food boxes, Harvest Share, the dental van, free car seat programs, Blazers-sponsored programs for kids, programs for the kids through the schools, summer lunch programs, Wood Village Church, and other local community churches.

***Schools***
In two groups comprised of mostly parents, participants talked about how schools were playing a role in promoting health. *"Schools step in and try to keep kids healthy."* They specifically described how schools providing physical education and healthy meals helped keep children healthy.

***Connection to Neighbors***
Many participants described how, *"Social stuff makes you happy."* Residents in the low-income housing developments, where many groups were conducted, described the on-site recreational centers and their neighbors as assets.

*"I have good friends and family. We are blessed in this building. We can go to each other and ask for help. We could go to almost any mom and ask them to watch our kids. We take care of each other."*

***Public Participation***
In each of the focus groups at least some participants stated that they liked being asked their opinions and about their experiences. A couple participants mentioned that they had participated in similar activities such as the Portland Plan Survey. The overall sentiment was that it helps people feel better when, *"They know that someone cares."*

***Public Safety***
Participants mentioned two programs that were addressing public safety. First mentioned was the neighborhood watch programs that were described as a way for people to meet their neighbors as well as see anything out of the usual.

*"People need to take responsibility for their community like with neighborhood watch—that's great. When I was a kid we knew everyone within a two block radius."*

The second program mentioned was the program facilitated by the Multnomah County Health Department that promotes positive relationships between youth and police officers.

*"Our young people are getting to know cops personally. This is good down the road. Maybe they won't be seen as problems when they are hanging out."*

**Health Promotion Ideas**

Participants were also asked for ideas on what else could be done to promote health and who they think should be responsible for making these things happen. There were two major themes. One was that government and other public services are responsible for taking care of people when they can't take care of themselves. The second was that individuals are responsible for participating in public decision making by letting their needs be known and holding the responsible party accountable.

Opinions shared in many groups focused on how government needs to provide a stronger safety net, especially in economic downturns. Some participants expressed frustration with how government funding is allocated.

*"You would think that the government would put more money in. Government always cuts social programs first and that should be the last thing to go."*

Several participants also described the need for, *"more sustainable services—educating people on how to become more self sufficient and improve health."* One participant said that *"Other countries do this way better. They take care of their sick. We need to help people out."*

Other participants described how different agencies are responsible for different things including Trimet, the schools, and the health department—which was not seen as government.

"*Health department, city planners, and individuals should work together."*

*"State, county, city should work together. What works for Portland may not work for Gresham."* In a conversation about elected officials, one participant said that *"They should try to make a difference first and then we will vote for you. First show us you can make a difference and then make something happen."* When asked for a specific example of what this would look like, she said, *"They could just start with something small like a free health clinic for a day or better books in the schools. Start small and then get bigger. It builds up."*

Another participant said that *"Politicians should get to know constituents. [They should] go out and get to know their issues and problems."*

Some participants gave examples of when they felt that government was not responsive to community needs and concerns. Two examples are provided, one that concerns child mistreatment and the other is about housing quality.

*"They [DHS] need to respond to reports of child abuse. They need to look into things that have been brought to their attention."*

*"[There needs to be] more inspections in the rentals. The landlords don't care about the properties. The apartments on Division are falling to pieces. No doors, sheets up instead. It is a terrifying situation and the landlords aren't doing anything. [Someone] needs to hold them to providing standard living conditions."*

In several groups, the idea of advocating for one's self and their community was discussed. Many people expressed the importance of voting in elections as well as speaking up and taking action when they see an unmet need in the community. In several groups participants were very vocal about the role of individuals in the political process.

*"It also falls on us. If you don't make yourself an active part; people don't understand that they have control over their government. They need to be an active participant."*

*"We need to take advantage of the activities they invite us to, like this group."* Some participants expressed the sentiment that *"We are all responsible for taking care of our immediate home and then seeing what we can do in our communities to help."*

## Community Involvement

The Advisory Group wanted to hear from focus group participants about their involvement with their communities and how this involvement could affect their health, as well as how they learn about things occurring within their communities. This information was collected to learn how to better engage community members in public decision making. The answers to these questions are presented in three parts: (1) Access to Information, (2) Feeling Connected, and (3) Sources of Information.

### *Access to Information*

Many people participating in the focus groups agreed that the most important benefits of being involved in their communities was that they would learn more about available resources and problems that could affect their families' health.

*"If you're involved you have way more access to information. You are more aware. Know more. [You can] find out more concerns."*

Several participants described how personal obligation and a sense of responsibility to their communities make some people get involved in their communities, *"They can't sit on the knowledge. [They] share the knowledge."*

***Feeling Connected***

The second most common response expressed by participants was related to neighborhood connectivity or involvement, *"Connecting with people is really important. See if they need help. That really could have an impact [on health]."*

*"It can give us a sense of community and that we're not alone out there. Helping people out makes you feel good and you're body reacts. It makes you feel better."*

Some people discussed barriers to being involved in their communities, *"It's a catch 22 because you're doing good but it's a drain."*

One participant said that there were very few opportunities for community involvement, *"It is hard to find community in Gresham. You can't go to a specific event. There are no coffee shops, no community spaces."*

***Sources of Information***

Most participants said that they hear about what is going on in their communities and neighborhoods primarily through their neighbors, friends, and churches. For those living in the low-income housing developments where focus groups were conducted, their on-site office and recreational center staff were very good sources of information. Other ways people learned about what was going on in their community include schools (i.e., teachers, principals, and flyers); community newspapers; bulletin boards; radio; and Facebook. A few participants suggested that community bulletin boards be developed at MAX transit centers, "*But only if they would be maintained and kept updated."*

## Table 2: Focus Group Schedule

| Group Participants | Date | Location | Participants |
|---|---|---|---|
| African Immigrant elders group (Somali) | Feb 15 | IRCO Africa House<br>631 NE 102nd<br>Portland, OR 97220 | 5 |
| Rockwood Health Center neighborhood group | March 2 | Rockwood Health Center Basement Conference Room<br>800 Southeast 181st Avenue<br>Portland, OR 97233-4947 | 6 |
| African American community members displaced to Mid-County and East County | March 14 | The Pines Apartments<br>140 SE 188th Ave.<br>Portland, OR 97233 | 8 |
| Human Solutions: Low income people living in Mid-County and East County | March 15 | Rockwood Station<br>19100 East Burnside Street<br>Portland, OR 97233 | 4 |
| Innovative Housing Inc: Low income people living in Mid-County and East County | March 17 | Village Square Apartments<br>1625 SE Roberts Dr.<br>Gresham OR, 97080 | 3 |
| African American community members displaced to Mid-County and East County | March 17 | The Pines Apartments<br>140 SE 188th Ave.<br>Portland, OR 97233 | 9 |
| Innovative Housing Inc: low income people living in Mid-County and East County | March 18 | Hewitt Place<br>846 SW 29th Way<br>Troutdale, OR 97060 | 6 |
| African Immigrant elders group (Eritrean) | March 22 | IRCO Africa House<br>631 NE 102nd<br>Portland, OR 97220 | 1 |
| African Immigrant elders group (Ethiopian/ Amharic) | March 29<br>. | IRCO Africa House<br>631 NE 102nd<br>Portland, OR 97220 | 7 |
| Innovative Housing Inc: Low income people living in Mid-County/East County | March 29 | Village Square Apartments<br>1625 SE Roberts Dr.<br>Gresham OR, 97080 | 8 |
| Young Latino parents group | March 29 | WOOD VILLAGE BAPTIST CHURCH<br>23601 W. Arata Road<br>Wood Village, OR 97060 | 2 |
| Innovative Housing Inc: Low income people living in Mid-County/East County | March 30 | Hewitt Place<br>846 SW 29th Way<br>Troutdale, OR 97060 | 7 |
| Young Latino parents group | March 31 | WOOD VILLAGE BAPTIST CHURCH<br>23601 W. Arata Road<br>Wood Village, OR 97060 | 6 |

## Table 3: Demographic Information Provided by Participants

| Characteristic | Response (n) | Response (%) |
|---|---|---|
| Age | | |
| 25 or Less | 12 | 16.9% |
| 26-39 | 28 | 39.4% |
| 40-54 | 14 | 19.7% |
| 55-64 | 7 | 9.9% |
| 65 or Over | 10 | 14.1% |
| Total | 71 | 100% |
| | | |
| Sex | | |
| Female | 46 | 64.8% |
| Male | 25 | 35.2% |
| Total | 71 | 100% |
| | | |
| Ethnicity (Can select more than one) | | |
| White/Caucasian | 35 | 45.5% |
| African American/Black | 11 | 14.3% |
| African | 16 | 20.8% |
| Hispanic/Latino | 10 | 13% |
| Native American/American Indian | 3 | 3.9% |
| Asian/Pacific Islander | 2 | 2.6% |
| Total | 77 | 100% |
| | | |
| Income | | |
| Less than $20,000 | 54 | 79.4% |
| $20,000-$29,999 | 7 | 10.3% |
| $30,000-$49,999 | 4 | 5.9% |
| Over $50,000 | 3 | 4.4% |
| Total | 68 | 100% |
| | | |
| Number of people in household | | |
| 1 | 12 | 16.9% |
| 2 | 15 | 21.1% |
| 3 | 15 | 21.1% |
| 4 | 10 | 14.1% |
| 5 | 6 | 8.5% |
| 6 or more | 13 | 18.3% |
| Total | 71 | 100% |
| | | |

| Characteristic | Response (n) | Response (%) |
|---|---|---|
| Education | | |
| Less than High School | 20 | 27.4% |
| High School Diploma or GED | 34 | 48% |
| College Degree or Higher | 12 | 16.4% |
| Other | 6 | 8.2% |
| Total | 72 | 100% |
| | | |
| Employment | | |
| Full-time | 9 | 14.3% |
| Part-time | 2 | 3.2% |
| Unemployed | 41 | 65.1% |
| Retired | 7 | 11.1% |
| Other | 4 | 6.3% |
| Total | 63 | 100% |
| | | |
| Health Insurance Status | | |
| Pay cash (no insurance) | 19 | 28% |
| Health Insurance (private) | 15 | 22.1% |
| Medicaid (OHP) | 26 | 38.2% |
| Medicare | 5 | 7.4% |
| VA | 0 | 0 |
| HIS | 0 | 0 |
| Other | 3 | 4.4% |
| Total | 68 | 100% |
| | | |

**Appendix A**

## Community Health Priorities Multnomah County
## Community Engagement Effort
## Focus Group Guide

### Purpose of the Group:

We asked you to come here today to provide input into Multnomah County Health Department's community health assessment project. The purpose of the focus group is to learn from you what you think about health and what, in your opinion, affects your, your family's, and your community's health and wellness. We will also think about what we can do to promote health.

The Health Department is sponsoring these groups, and the information will be used to increase our understanding of community health issues and for planning our programs and services so that they fit the needs of the community. If the issues that come up during the meeting today are outside what the health department can do, we will work with our community partners to address them.

Once we hear from the other groups, we can send information about what we learned and what we are doing with the information to anyone who is interested. We will also have a final report and action plan that details everything we hear during these meetings.

### Discussion Questions:

1) **These first questions are to explore how people think about health and wellness. Some of the questions refer to the "community" which can mean something different for everyone- it could mean your neighborhood, your racial or ethnic group, your friends, people you work with, etc.**
   a) What comes to mind when you hear the words "health" or "wellness"?
   b) What do you think of when you hear "public health"? "Community health"?
   c) Do you think people in your community/neighborhood are healthy? Why? Why not?

2) **These next questions are to learn what people think/feel are the strengths and resources that help support and enhance individual, family, and community "health." We are also going to ask about some of the barriers to health for you, your family, and your community.**
   a) What is happening in the community that promotes health and supports a thriving community?
   b) What is happening in the community that stands in the way of health?
   c) Who do you feel should be responsible for the issues that have the most impact on health?
   d) What do you think the (City/County/Individuals/Schools/or whatever group was mentioned) could do or would need to support and enhance health?

3) **These questions are to learn what people think/feel are the issues and factors affecting individual, family, and community "health." We are asking about health in a very broad sense. It can mean different things to different people. So, some of these questions might touch on topics such as stress (and other issues brought up in this discussion) rather than strictly "health."**
   a) What affects your health the most?
   b) What do the mothers, in families that you know, worry about?
   c) What do the fathers, in families that you know, worry about?
   d) From your experience, what are some causes of stress, anxiety and fear in the community?
   e) What do you think affects people's health the most?

4) **These next questions are to learn what people think about people being involved and connected in their neighborhoods and communities.**
   a) How do you normally hear about what is going on in your community or neighborhood?
   b) How do you think that being involved in a neighborhood or community might make a difference in someone's health?
   c) In your opinion, what are reasons people choose to be involved in their neighborhoods or communities?

5) **A lot of people in Multnomah County have been involved in other community engagement meetings similar to this one. We are trying to build on these efforts. I would like to show you a list of issues that people identified (in these other meetings) as important to their health and the health of their family and larger community. We (may) have already touched on a lot of these issues as well as additional ones (that have been added to this list). Can you each select three issues that have the most impact on your, your family's, and/or your community's health?**

- Economic and employment opportunities (examples: livable wages, training, loans to encourage the development of small businesses)
- Education opportunities
- The ability to live in a neighborhood with side walks, bike paths, parks, safe routes for children to get to school, nearby sources of healthy food, trees, etc. (healthy built environment)
- The ability to live in a house/neighborhood that does not have high levels of pollutants, mold, and lead when compared to other houses/ neighborhoods
- Access to affordable, safe, and stable housing
- Crime prevention and public safety in your neighborhood
- Access to public transportation
- Access to health care (insurance as well as enough doctors to see everyone)
- Access to mental/behavioral health services
- A strong sense of community and cultural diversity
- Public policies that address unfair (inequitable) consequences of racism (equitable health care spending, public health programming, research)
- Access to technology (computers, internet)
- Services that support child health and welfare
- Availability of culturally specific community health promotion activities & services

**Appendix B**

**MULTNOMAH COUNTY COMMUNITY HEALTH ASSESSMENT REPORTS**

The following six reports, written by the Health Assessment and Evaluation and Grants Development Teams, describe the methodology and findings of the multiple components of the Multnomah County Community Health Assessment.

*Multnomah County Community Health Assessment Mobilizing for Action through Planning and Partnerships (MAPP) to Identify Health-Related Priorities*
**Summary Report, August 2011**
Christine Sorvari, MS and Erin Mowlds, MPH

*Multnomah County Community Health Assessment: Identifying the Most Important Health Issues through Multiple Community Engagement Processes*
**Community Themes and Strengths Assessment, August 2011**
Christine Sorvari, MS

*Multnomah County Community Health Assessment: Discussions with People Living In Mid-County and East County*
**Focus Group Report, August 2011**
Erin Mowlds, MPH and Christine Sorvari, MS

*Multnomah County Community Health Assessment: A Survey of Multnomah County Residents*
**Survey Report, August 2011**
Maya Bhat, MPH and Emily Francis, MPH

*Multnomah County Community Health Assessment: Using Quantitative Data to Measure the Community's Health*
**Community Health Status Assessment, August 2011**
Claire Smith, MURP

*Multnomah County Community Health Assessment: Interviews with Local Public Health System Stakeholders about Future Opportunities and Challenges*
**Local Public Health Care System & Forces of Change Assessments, August 2011**
Erin Mowlds, MPH and Nicole Hermanns, MA

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