

Focus Group and Interview Report

OVERALL THEMES

There were several overall themes that emerged from Southern Oregon University Research Center's (SOURCE) analysis of the 12 focus groups and the 20 key informant interviews that we conducted. In the report below, each theme is briefly discussed, the methodology is presented, the specific information from each focus group and interview is detailed, the ways in which the various focus groups and interview respondents were recruited by members of the Community Health Assessment (CHA) committees (Appendix X), and the focus group and interview questions (Appendix X).

Discrimination

People of color, those whose primary language is not English (including those whose primary language is American Sign Language), people living with disabilities, those with substance use disorder, and people experiencing mental health issues reported both overt and covert discrimination from their healthcare providers. This differential treatment has led to distrust and fear, as well as a feeling of hopelessness. Attention and resources should be committed to efforts to directly address the interactions between these groups of people and medical staff.

Understaffing, Lack of Providers, and Wait Times

The pervasive problems of medical staffing in Jackson and Josephine Counties affect all residents. However, the populations represented by our focus groups and key informants are already more vulnerable to issues with continuity of care. This is only exacerbated by the post-COVID reduction of healthcare and mental healthcare workers in the valley.

Transportation

For those people who are elderly or live in more rural areas, transportation to healthcare appointments and services can be very challenging. While many did report that they knew of or had used medical transportation services, they also noted that those services were very limited. Participants could not always meet eligibility requirements or obtain transportation from the services when they needed them.

Hard to Find Information and Resources

This theme was omnipresent across all geographic areas, ages, racial/ethnic categories, income levels, education levels, and other categories. At minimum, participants expressed that health and social services were difficult to navigate, that it took many steps and phone calls to get answers to questions, and it was exhausting and time consuming to find information. Some groups need more sensitive information; for example, they need to be able to find providers who are truly “queer-friendly”, or who have experience working with diverse cultures, and this information was nonexistent outside of word-of-mouth recommendations. For those who were not plugged into a thriving social network, this was an impossible task. Even key informants who spoke on behalf of social service organizations frequently commented that it was difficult to know where to refer people or to find out what other organizations were doing. The lack of local data and information is a problem not just for individual community members, but for institutions and public health more broadly.

Housing

Participants in every modality referred to the often insurmountable cost of the local housing market and the lack of available housing.

Universal Healthcare

Almost all the focus group participants had Oregon Health Plan (OHP) or Medicare. Those few who did not wished for a universal healthcare system that would alleviate the stresses around insurance coverage and medical bills.

Cost of Daily Living

Most of the focus groups included discussion of the rising costs of daily life, particularly surrounding recent inflation of food prices. Food assistance, and raising the income limits to receive such assistance, would be helpful to many. Gas prices and transportation costs were another key concern, and many participants have changed their activities in order to save money.

METHODOLOGY

This CHA research was conducted by an interdisciplinary team from the Southern Oregon University Research Center (SOURCE). The team consisted of Dr. Eva Skuratowicz, SOURCE

director and sociologist; Dr. Katherine Fox, assistant professor of anthropology and healthcare administration, and medical anthropologist; Dr. Larry Gibbs, associate professor of sociology and healthcare administration, and demographer; and Dr. Trish Styer, assistant professor of business administration and healthcare administration, and data scientist. The research team also included student research assistants Zoe Bull, Brooke Carlton, Jordyn Kern, Milagros Morales, Lizbeth Parra, Susanna Perillat, Clark Serra, Katie Sheely, and Sophia Tribelhorn.

The SOURCE team constructed the official research instruments used for the All in For Health (AIFH) Jackson and Josephine Counties CHA, which included the survey questionnaire, focus group guide, photovoice group guide, and interview protocol. Dr. Gibbs and Dr. Styer concentrated on the survey questionnaire while Dr. Fox and Dr. Skuratowicz worked on the focus group guide, photovoice guide, and interview protocol. The CHA subcommittees were used in varying degrees to review all of the research instruments. The survey included validated questions from other health assessment instruments. SOURCE administered the focus groups, photovoice groups, and the interviews, and analyzed the resulting data. The All in For Health partnership administered the survey and Jackson County Public Health analyzed the resulting data.

The SOURCE researchers did not determine the priority populations that were selected for focus or photovoice groups nor the individuals chosen for the interviews. SOURCE was also not involved in the recruitment of participants. The AIFH steering committee and CHA subcommittees determined which priority populations were of interest. Recruitment for the focus and photovoice groups and interviews was done by representatives of the various CHA subcommittees. There was a variety of recruitment strategies that they used, which are outlined in [Appendix X](#).

Below is a table of the priority populations of interest identified by the AIFH steering committee and CHA subcommittees and how data were gathered from those groups. There are three ways in which the SOURCE team gathered data regarding a priority population: a focus group composed of members from that population, interviews with people who either work professionally with that population and/or are a member of that population, and people who were in other focus groups but could also speak to their own experiences being a member of that population.

Table 1: Priority Populations and Methods of Gathering Data

Priority population of interest	Focus Group	Key Informant Interview	Data from person in another focus group who shares priority population membership
Black community	Yes	Yes	No
Children’s well-being	No	Yes	Yes
Deaf/hard of hearing	Yes	Yes	Yes
Children and young adults with developmental disabilities	No	Yes	No
Domestic violence	No	Yes	No
Immigrants	No	Yes	Yes
Indigenous/Native American	Initially as a photovoice group, but unable to recruit enough people	Yes	Yes
Justice involved	No	Yes	No
LGBTQIA+	Yes	Yes	Yes
Low-income/edge parents*	Yes	No	No
Mental health diagnosis	Yes	No	Yes
Pacific Islander community	Yes	Yes	No
People with physical disabilities	Yes	Yes	No
Rural low-income	Yes	No	No
Rural older adults/seniors	Yes	No	No
Spanish speaking (primary language) Latino/a/x people	Yes	Yes	No
People with substance abuse disorder	No	Yes	Yes
Unhoused	Yes	Yes	Yes
Young adults (18-25)	Yes	No	Yes

*For the purposes of this assessment, the term “edge income” refers to those who make too much money to receive benefits from the state (such as the supplemental nutrition assistance program) but do not make enough money to comfortably afford basic necessities.

The SOURCE team submitted our protocols to the SOU Institutional Review Board and the research was determined to be exempt from full review. Informed consent is a critical aspect of the ethics of doing research on human subjects. Every focus group participant and interviewee received and signed (or in the case of online interviews verbally consented to) a document

outlining the researchers' responsibilities and a description of how the subject's data would be used.

Eleven focus groups and two initial photovoice sessions were conducted in April and May 2023. Very few photovoice participants actually took photographs, so the Indigenous young adult photovoice group transitioned into a key informant interview group and the Josephine young adult photovoice group transitioned into a focus group (for a total of twelve focus groups). Focus groups were one and a half hours long, although a few of them went for two hours. The average focus group size was eight people, with the smallest at three people and the largest at ten people. The groups were recorded and the research assistants used the software program Trint to help with transcription. Dr. Katherine Fox and Dr. Eva Skuratowicz facilitated the focus and photovoice groups and the research assistants took notes during the groups to aid in transcription.

CHA subcommittee representatives worked with outreach coordinators, who had ties to the priority populations, to choose appropriate locations that would be familiar and welcoming to participants. Dinner was provided for all focus groups. Transportation and childcare were offered to all groups and provided when needed. Sadie Siders and Steven Bagley from Jackson County Public Health were available before and after each focus group to answer questions and provide a \$40 gift card to a local grocery store to each participant upon completion of the group.

The Spanish-speaking Latino/a/x focus group was conducted by Dr. Fox, who is bilingual in English and Spanish. Milagros Morales and Lizbeth Parra, who are both bicultural Latinas and bilingual Spanish/English speakers, were the research assistants who worked at the focus group. Later, they transcribed the Spanish audio recording and translated the focus group questions and answers into English for analysis by the rest of the research team.

Interviews with 19 key informants were held in May 2023. An additional interview was held in August 2023 for a total of 20 interviews. Dr. Fox, Dr. Gibbs, Dr. Skuratowicz, and Dr. Styer all conducted either online or in-person interviews with the key informants.

The data analysis was methodologically rigorous. Data were gleaned from the focus groups and interview recordings in the same manner. First, the research assistants used Trint software to transcribe the recordings into a Word document. The research assistants used their notes from

the focus groups to supplement the audio recordings and to correct any mistakes or gaps in those transcriptions. Similarly, they used online recordings from Zoom and consulted with the original interviewer when necessary to ensure accuracy in the interview transcriptions.

The entire team met to review the transcripts and determine the thematic codes that would be used to sort the interview and focus group findings. The transcripts were entered into Dedoose, which is a qualitative software program that enabled the research team to search and classify interview and focus group data into thematic codes. Dedoose kept track of the frequency, prevalence, and co-occurrence of each thematic code, thus making it easier to ascertain which factors were most significant and among which populations. This process was headed by Dr. Fox. The thematic codes from the interviews and focus groups were used in this report to present what participants identified as the most significant issues for their priority population regarding community health and enabled us to look for universal themes across priority populations.

Photovoice projects are typically conducted in multiple sessions in small groups. However, only three participants in total completed the photovoice project. Dr. Fox met with these participants individually to discuss the significance of the photos and the information that would caption them. The final captions for the photos are the participants' own words from these discussions, with light editing by Dr. Fox for clarity and readability in text format.

FINDINGS

In the following sections, the findings from the focus and photovoice groups, as well as the interviews, are discussed. Rather than separate the data by methodology, we have presented the findings by the priority populations chosen by the AIFH Steering Committee and the CHA subcommittees. For each priority population, there is a brief description of the participants, the findings from the focus group, and then the findings from a key informant regarding that priority population.

LGBTQIA+

There were nine participants in this focus group. Their ages ranged from 30 to early 60s. There was a mix of gender identities. When one of the participants asked the others about their race, all of the participants indicated that they are white.

Participants felt that their local LGBTQIA+ communities were very supportive of each other, but that it was hard to tap into that resource if one didn't have the right social connections. They reported that it was very hard to find information about "queer-friendly" healthcare providers and whether certain resources exist at all in this region. As one participant described,

"[Providers] all going to say they accept [queer people], but that doesn't mean that they really will. So you really have to do quite a lot of like talking to your friends to get to an actual queer friendly provider."

They felt that part of the problem was that services and providers often like to list competence in LGBTQIA+ concerns, but that this is more about presenting an image than actually understanding. This was especially true in mental health spaces:

"When I was looking for a couples' therapist, it seems like every therapist in the area has LGBT. Every single one has that designator. It doesn't mean anything."

Another participant recounted experiences in which her primary care provider, whom she generally likes and finds to be a good doctor, still asks very heteronormative questions. Several participants agreed that their medical providers do not understand queer experiences, questions, or goals.

The group found it challenging to get accurate health information and best practices for a LGBTQIA+ person's medical needs (e.g. hormone therapy or mental health). Examples given by participants include:

"So like, if I'm having issues with hormones as I approach menopause, I need some help with balancing these hormones, but I don't want feminizing hormones and I don't want hormones that are overly masculine either. That's just not on their radar. So [it feels] like there's not scope for understanding."

"I had my first mammogram this year and it keeps coming up for me because my, my aunt had breast cancer a year or two ago. And I keep thinking like, you know, if that comes up for me in the next couple of years and I choose to have a mastectomy, am I going to be allowed here to like to have a chest contour? That's more transmasculine-like."

"I don't think I've ever talked to anyone who has sought gender affirming care solely within this valley. Almost everything- you're going to have to go outside of the valley at

some point, either to San Francisco or Portland. Um, there's like a couple of doctors for hormones, but anything beyond that, it's extremely limited here.”

They also felt that it is difficult to get proper care if a person is not good at being very assertive about their needs and desires, and they often found that they needed to be skilled in reading providers and in strategically changing their own presentation to get what they need. In one example, a participant described how they perform a certain way to get the needed services from their doctor:

“Any time I go talk to my prescribing doctor about my testosterone dosage or my prescription or whatever, I dress in my most masculine clothes-he does not know my pronouns. They are they/them. [The doctor] thinks my pronouns are he/him. Because...I don't know how he is about non-binary people, but I'm not trying to find out in a doctor's appointment while I'm trying to get my prescription.”

The group agreed that they rely on their own social networks and word-of-mouth referrals to know where to go, or even where is a safe place to ask questions. Privacy and safety are major concerns for this group, and they want to see more accountability for those who claim to be competent providers for queer people. They expressed interest in having some kind of resource center or centralized source of information that is vetted by LGBTQIA+ people. Additionally, they are concerned about the lack of services and community spaces for LGBTQIA+ youth. One participant comment made the final comment: “They [policy makers] always think it's about money, but it's not, it's about how people treat you.”

Key informant interview with a leader in a social justice focused organization in southern Oregon that works with regional LGBTQIA+ communities:

The focus group participants were mostly from Jackson County, whereas the informant is in Josephine County and spoke more to experiences in Cave Junction and Grant's Pass. The informant was, in some ways, more optimistic about the current environment for LGBTQIA+ people than the Jackson County focus group, despite being in an area with seemingly fewer sources of support. According to the informant, there are a lot of grassroots activities happening in Grants Pass, such as queer dance parties and trans storytelling circles. However, the LGBTQIA+ survey put out by the informant's organization shows that many people don't know where to find out about these activities:

“There's a lot that was interesting from the survey: 85% of folks said there is no queer community. It's scattered, can't find anybody. And then 10% or 15% of people were like, there's this really active, vibrant community.”

The informant also reiterated concerns about “queer-competent” healthcare providers and discrimination in the area. One particular issue that the informant discussed was that LGBTQIA+ people report that they do not feel safe accessing the outdoor recreation and nature opportunities that are a major asset of the region.

Additional insight from LGBTQIA+ participants in other focus groups:

A participant in the physical disabilities focus group expressed that they could never be sure if those living with a disability had the same issues in getting medical staff to talk to them, answer questions, call them back, etc. or if they were experiencing an extra layer of discrimination because of their LGBTQIA+ identity.

Mental Health Diagnosis

There were seven participants ranging from age 24 to 72. There was a mix of gender identities. At least one person did not personally have a mental health condition, but was the parent of a young adult with a severe mental health issue. Some participants were unhoused.

Participants in this group felt that the biggest issue was the absolute lack of resources and funding for housing, childcare, food assistance, mental health, and substance use disorder services. Some participants worked in social services, such as Options, and they spoke about how they felt powerless to do anything to help clients when the resources they needed did not exist and organizations had not yet received funding for the year.

“As a community worker who helps individuals get back on their feet and get connected to resources, it’s impossible. We’re given this job to help someone, but there’s nothing out there for us to connect them to. And so then they get upset because we’re supposed to help them, but the resources aren’t there. Half of the resources in Jackson County that we depended on last year haven’t even received their funding yet this year. We’re right in the middle to the end of April, almost the fifth month in the year and half of the resources we depend on in our community haven’t received their funding. How are we supposed to help people? I have a job where I countlessly have to sit in my car after I’m done helping a client and cry because I cannot help them. And I’m supposed to just keep scheduling appointments and keep telling them, ‘Oh, it’s going to get better.’”

Others spoke more generally about the challenges and costs in the area. They described it as a “miracle” if one could find an apartment under \$1000 per month, and others noted that even with two income earners in the household, they did not make monthly income of three or three and a half times rent which is a requirement for most units. A participant commented that she works two jobs and barely gets by because she has chronic illnesses and her medical expenses average \$1500 per month.

Focus group members also noted that it was the most difficult to obtain help when it was the most needed because of structural barriers. It was hardest to receive services when unhoused, because they didn't have regular hours, work, or transportation. It was much more difficult to get mental health care when they were mentally unwell, because of all of the requirements to make and keep appointments. As one participant described,

“[When I'm manic], there's not much people can do besides just like lock me up and hope that I stabilize. When I'm healthy, it's a lot easier to get mental health treatment than when I'm like really unhealthy, which is sort of a weird bind...I see my psychiatrist regularly, so that's good, though, like when I get manic, that's when a lot of psychiatrists are like 'I'm busy.' They just pass it off to the ER or the mental ward or whatever.”

Further, participants said that wait times are untenable and understaffing means that many services are simply not available when participants need them. “Finding mental health care is like catching a unicorn in the forest,” said one participant. “They tell you it's out there, and I think occasionally somebody sees a unicorn, but you never catch it.” Members of the focus group highlighted that they could only get help when things were already an emergency, which made it impossible to get to a stable place - they kept bouncing between different kinds of emergencies. This group wanted big, structural changes that would address poverty and related health challenges, both physical and mental.

Additional insight from participants with mental health diagnoses in other focus groups:

Continuity of care, or namely, the lack thereof, was a recurring theme for those needing mental health care. Many reported being unable to get needed prescriptions because they were unable to find a provider after their provider left the area, or they were unable to get appointments timely enough to refill their prescriptions without gaps. Continuity was also an issue for counseling/therapy, and often the most reliable therapy option seemed to be one involving telemedicine. Mental health therapy in any form, however, was cost-prohibitive or unavailable to many participants in the CHA, depending what, if any, health insurance coverage they had.

Josephine County Young Adults

All three participants in this focus group were 18-year-old women and in their final year of high school.

Participants in this group were clearly occupying two different social worlds, which led to two different sets of themes. Two of the teenagers conceptualized health and health problems in more “mainstream” ways: they spoke mostly about exercise, clean living (i.e. eating healthy, avoiding substance use and sometimes even medications they considered to be unnecessary),

and struggles with anxiety and depression. They believed their school was doing a good job of teaching them about wellness and providing resources to them, including classes on emergency medical skills and an on-site counselor. They participated in multiple extracurricular activities and were active in church communities, and while these things were positive, they also discussed the pressure and stress that they feel from all of these responsibilities.

Another perspective came from a youth attending an online high school. This participant spoke more about feeling lost and unprepared for major life transitions, and that the biggest struggle was just to graduate and figure out what to do next. While the first two noted the rise in vaping and marijuana use among teens, the third discussed use of meth, cocaine, and narcotics; reported that these drugs, especially meth, are cheap and easy to get, and stated that these drugs are increasingly contaminated or laced with other substances. The participants at the public high school then expanded on ways that this has become common knowledge and part of the curriculum:

Participant 1: "I've just known kids that were smoking meth since middle school and I feel like that is way more of an issue. Now it has fentanyl in it and people are just straight taking fentanyl, which is crazy. And, yeah, so many people have died from it. I know like, five that have died within the past four months or something. Meth, more specifically, because it is so cheap and it's everywhere around such a small town...it's not hard to find, it's not hard to access.

Participant 2: "Yeah, there was a kid back in January, he overdosed. He didn't know it was that, he thought it was something else, but it had fentanyl in it. And so our school did a whole lesson on like, how to stay away from it."

Teen pregnancy is also prevalent in the latter participant's social network, and they felt very "stuck" in their environment. Mental health was also a concern for this participant, but more in ways that were linked to isolation, substance abuse, and risky behaviors. This person discussed how many of their peers had not kept up with their schoolwork during the pandemic and now were scrambling to graduate, and how the lack of entertainment for youth led to experimentation with substances: "You can only go down to the river so many times. With the conditions of the world and how much bad stuff is going on, and how hard it is to afford things, I just don't think there's going to be much recovery from that, as a whole."

All participants in this group held at least one part-time job. In general, they were expected to pay for their own car expenses and extracurricular activities, and they spoke of saving money for college. Some needed to contribute to the household finances more directly from their own income. Though they did not report major health issues of their own, they all had concerns

about health problems within their family and the associated expense. One participant recounted needing to use illegal networks to obtain pain medication for a family member who was waiting to be seen by a doctor. To varying degrees, all thought they would have to relocate as they start their own lives because this area's cost of living is so high.

Unhoused

There were ten people in the focus group. The youngest participant was 28 years old and three described themselves as senior citizens. Two people stated that they were transgender. Several participants talked about their history of mental health issues and substance use disorders.

One major theme from this focus group involved the stereotypes, assumptions, and discrimination they faced as unhoused people from the general population as well as from healthcare providers. They struggle to stay physically clean, which hinders employment and opportunities to receive services; they are often assumed to be drug users and barred from help or services, so it is also difficult to stay clean in terms of substance use. People also assume that they are thieves, lazy, or mentally ill, and while they do report having mental health concerns, they explain that surviving as a homeless person requires a very different set of logistics and priorities that are usually inscrutable to the general public.

Food is a primary concern for this group, and they express that it is incredibly difficult to eat a healthy diet when they cannot afford and cannot store food. One participant with diabetes noted that the food offered to homeless people is frequently very carbohydrate-heavy, which further complicates her ability to manage her condition. She said,

“Carb-heavy food will skyrocket my blood sugar pretty high. I found out that I had Type 2 diabetes when I was, like, 11 years old. It's just been a battle trying to get it under control... the community gives out a lot of carbs.”

Others explained that the food they receive in the shelter does not include much produce and includes a lot of meats (mostly sausage), which they note is not particularly healthy. Because they cannot access kitchen facilities, they are unable to manage their own diets or even share resources effectively. In some ways, they felt they had more agency over food and nutrition choices when they were in camps, rather than in a shelter. Participants elaborated:

“So the problem with the food situation when you're homeless is, first of all, there's no way to refrigerate it. And secondly, there's no way to cook it, because the community

took away public cooking spots like barbecues and the fire department and the police will come if you start a fire.”

“We eat better out there than we [do] in the shelter. I mean outside, we cooked for each other, we had a fire... I had a cooler with ice. But we can't go into the kitchen at the shelter that's there to cook our own stuff.”

“We don't have a microwave there because some [expletive] decided to cook a Hot Pocket for 20 minutes. The thing caught a fire, and as it was smoking, still burning, they thought, 'Hey, let's put it inside the trash can with all these paper towels.' So the fire alarm went off and the fire department came and they took our microwave away. So the only thing we have to use is a toaster.”

There was a common theme of frustration, as they felt that their food choices were micromanaged and that everyone's options were curtailed because of the poor choices of a few.

In terms of health care, this group reports major challenges around dental and eye care, which is often poorly covered under OHP (it may only be covered in emergency situations). For general physical health services, participants said that they are usually covered by OHP, but that the wait times to see a provider are terrible. One said that he was told to schedule an appointment five months out and another said she has been on a wait list for eight months. They have also struggled to have their medical needs met in absence of continuous care. Multiple people reported being taken off and on medications for chronic conditions against their will because new doctors disagreed with previous diagnoses. It is especially difficult to get into mental health services, and having a substance use disorder (SUD) diagnosis complicates this because many SUDs services will not accept someone who has a mental health diagnosis. Assumptions that someone has a SUD also hinders care for mental illness, as one participant described:

“Especially if you have any kind of substance use disorder or dependency or anything like that on your record whatsoever, including alcohol, you will be kind of... Put into a certain box or like looked at through [a] certain lens...I need Xanax. Like I need to be able to calm down, because [I get panic attacks and] this is like a really scary thing that happens for me - in public places because I'm homeless! And lo and behold, I was freaking right and I never abused the [expletive]. Now, that's not everybody's story, but I mean, I know I'm not the only one who is like, 'I know what I need and nobody will freaking listen.' It's so disheartening to not be taken seriously or to even be like chastised, you know, shooed away by medical professionals that are supposed to be there to freaking help you.”

As other groups have mentioned, focus group participants describe not being able to receive mental health and SUDs services until they are in immediate danger, and recount times that they were turned away from treatment because they were not “messed up” enough:

“And the closest dual-diagnosis facility is in Grants Pass? That’s if I can get in. I still have to wait. The waiting is the problem. You can’t tell an addict, ‘Oh, we have to wait.’ ...You need it when you need it. And then when I went into detox, they didn’t let me in because I was clean for four days.”

Participants consistently highlighted the importance of sharing resources and support from their own community as part of their well-being. Some said they have built relationships with people and found more support than they had within their own families. While they did discuss many difficulties and local issues, some people who had experienced homelessness in other states noted that they were thankful for the healthcare offered by OHP and that Oregon is better than many other places.

Key informant interview with a person who lives in transitional housing and who sits on an advisory board for an organization that serves the unhoused:

This informant spoke to the successes that she has seen in healthcare:

“We’re all pushed to get our Jackson Care Connect. The Mobile Health Clinic, and we have that as well. They’re actually very good about the actual physical health. I mean, there’s not really a lack for that.

But also cautions that everyone has not seen that same success:

“But like I said, the demographic of people that I’ve seen that do struggle, there were some older people that were in the Hope Village, there’s some older people that were at the campgrounds. It’s a struggle for them.”

A topic that came up frequently during the interview was people in the “gray area”. The informant said, in relation to mental health care, medical care, and housing assistance, “People that are not messed up enough to get this help, but they’re not stable enough to be able to move forward completely.”

Barriers to healthy eating have been and continue to be a challenge for the informant, and this centers around cost and availability. When she was living on the streets,

“When I got supper, I ate like nobody’s business...now that I have the money to buy food, it’s being able to afford the proper food that’s healthy. Getting \$20 in food stamps isn’t going to be able to cover the healthier lifestyle.”

The informant’s own journey to sobriety, mental health services, and stable housing started with the Livability Team, (a program by the Medford Police Department; their effort is to find a balance between enforcement and outreach) which she praised as,

“Being so patient with me and being supportive of me, I don't think I would have ever made it out, you know? They provided a security, as well as a discipline. Like they didn't let me get away with things. But at same time there was, they just didn't let my homelessness affect the way they looked at me.”

Spanish-speaking Latino/a/x

Participants were identified for this group because they speak Spanish as their primary language. All six people in the focus group were women. All participants were first-generation immigrants from Latin America and all but one had children under 18.

This focus group was conducted in Spanish and the transcript was translated into English for this report. The focus group participants had major concerns about children's health and well-being. They worry about the impact of social media and technology on their children's mental health and social skills, especially in the wake of the pandemic, and they want to see more mental health services available in schools, as well as more limits on the technology they can access there and at the library. All of the parents with school-age children lamented that they don't feel like they have enough control over what their children are seeing online, and that they wish they had more tools to address these issues with their children. Related, they are concerned with violence in media and how it may exacerbate mental illness and bullying. They also feel that the understaffing issues that contribute to poor healthcare are also present in the school system, which is causing children's social and emotional needs to be overlooked. “I tell [my son] that you have to be respectful in school...but unfortunately, apart from us instilling good in them, our children must also learn to defend themselves, because at school they will encounter everything,” (translated) said one participant.

In comparison to other groups, participants in this focus group spoke more about job instability and lacking health insurance altogether. Getting time off and childcare were significant barriers to accessing healthcare services, and they often felt they were not treated well if they did not have insurance, could not wait for a long time, or brought their child with them. One participant explained the rules of a clinic that she felt were overly strict:

“The COVID thing has passed, but still now if you take someone with you, for example a child, they won't accept them. So then they make you miss the appointment. Because who is going to watch your child? If there is no one to pick up your child for you, they don't accept them at the appointment. So I say that sometimes it's really bad, it's like a lot of people are losing their day of work to go to the appointment and then you arrive and they don't attend to you.” (translated)

Focus group members also talked about language barriers in medical settings and the variety of problems that can arise when there is not an in-person interpreter (technology issues, different

dialects) or no interpreter at all (a child, relative, or friend may be asked to stand in without requisite training). Some examples shared by participants are as follows:

“It’s a half an hour to even make an appointment. When it gives you the option in Spanish, if you put the one in Spanish, you’ll last up to another half an hour waiting there so that they can speak to you in Spanish. So sometimes this is how you can make your appointment. I always say ‘well, in English’ because it’s faster.” (translated)

"My dad also lives with me part of the year. So, I accompany him to medical appointments and my dad is a little deaf and understands very little English. Then they brought the interpreter by video and it turned out to be a South American interpreter. To me, who still has a good hearing, I could understand her, but my dad was completely lost because it was another very different Spanish, with a different accent. He couldn't hear through the video. And there came a moment when my dad looked at me again and told me- my dad told me to tell the doctor to please remove the interpreter. It's easier to talk to the doctor than to the interpreter." (translated)

"My mother, when she goes for her eyes, my cousin goes because there they mostly speak only English...I can't take her, I would like to take her but I don't understand. So my cousin [goes with her]." (translated)

Some participants spoke of racism and discrimination in broad terms: they did not see Latino/a/x people in administrative and positions of authority and they needed Latino/a/x people in those decision-making roles. As one participant said, “You don't know what's best for me. Another Mexican like me knows what is best for me because they've lived it.” (translated)

Interviews with an immigration expert and a Latina educator who serves Latino/a/x families:

The immigration expert discussed fear of immigration authorities as a barrier to seeking health care, and the educator said that this also affects the services that children of Latino/a/x families receive. The educator also detailed the ways that she sees parents of her Latino/a/x students struggle to understand health information and navigate the healthcare system when few resources are automatically available in Spanish. She said that part of Latino culture is generally being trusting of the medical and education institutions, and that they often don't know the questions to ask or how to advocate for themselves to make sure they are getting the information or even someone to translate the information.

Pacific Islander Community

There were 10 focus group participants with an even split of women and men. The group included at least one senior and one person who seemed, from the discussion context, to be under 25 years old. Three or more people were first-generation immigrants.

The Pacific Islander (PI) group expressed many feelings of isolation and discrimination that interfere with their health and well-being. Many are far away from friends and loved ones, and their communities here are very small, so they frequently feel alone. They describe getting strange looks and stereotypes from the public as they go about their daily lives and assumptions from some people that they are dangerous because of their tattoos. One person commented that they hesitate before going into local spaces that lack diversity: "I just feel like I'm not comfortable every time I go to that store. Because someone's looking at you like, 'You're colored. Please don't do something violent.'" These feelings are compounded by lack of cultural competency within the healthcare field. One person explained, "It's really hard for me to feel comfortable...I struggled a lot with finding a therapist who wasn't mentally exhausting...for me to have to explain things and then have them sometimes reframing things that are very normal and safe for me as something potentially damaging."

In terms of physical health, the focus group participants want education and help to manage chronic conditions such as diabetes that are prevalent in the PI community, but they simultaneously face discrimination and weight stigma that discourages them from engaging with the healthcare system. One participant in this focus group works in medical spaces and observes routine occurrences of discrimination against people of color:

"Just the other day, one of our doctors didn't want to give service to a patient because she canceled so many times. He was like, 'I don't want to see her anymore because she's canceled a lot.' And for me, I look at it as like, 'Oh, this lady is Mexican and maybe she's going through some things.' Are providers not going to give her any service anymore, you know? I had to talk to this doctor and be like, 'Hey, you can't do that. Like, you can't just not give service to a patient who needs your service.' So just things like that...when I see brown people or people of color, they always come to me to get help. I notice that a lot. And so, I try to give help. And then I noticed that a lot of white people in my clinic give them (people of color) wrong information. Sometimes they'll give great information to some people. But then for others, it's like really bad information. And I'm like, 'Why? Why are you telling them that?'"

Others notice differential treatment between their children:

“One of my kids is a big baby, Samoan-like body, and the other one's small. And so I feel like the doctor's description, the way that he says, "Oh, your son needs to lose weight'...I know that he's just a Samoan baby. But then my daughter, I think she takes after her dad's side and has a white proportioned body. To them, she was healthy...the different body types are scrutinized.”

Several participants said that they deliberately seek out “Mexican providers”, because those providers are less likely to discriminate based on skin color and are more likely to understand Polynesian culture and experiences. One participant explained,

“There's understanding because they come from the background as well of having to translate for elderly people who don't even speak English at all. So there's just this common ground and it's a safe space. But in my experience with health care providers who are not of a foreign background, it's very, very cutthroat there. And then you kinda...so you don't talk about how you feel. So now we're on opposite sides and it's like, I just want to get out of here because I'm uncomfortable, because you've made me uncomfortable.”

The focus group participants spend considerable effort to be seen and recognized by institutions, including medical and education systems, and those efforts are not always fruitful. As such, they come to rely heavily on their own communities for support, information, and resources. They have strong social networks surrounding churches and their faith; they also feel strong obligations to support their own Polynesian communities. However, this has its own drawback: several participants, especially the women, articulated significant stress and impact on their own personal health due to the responsibility of caring for their community.

“I feel like I have to push myself a lot, especially like anyone who's mixed race and coming from a very small island, I have to prove myself every day. It's a lot of pressure. Like I feel like one mess up on my part is going to screw up everything for everybody else. A lot of times, I feel like I'm exhausting, like beyond belief, my mental and physical health.”

“I think it would be a lot easier for me if I wasn't the way that I am, trying to like, advocate and like be in the community so much. Maybe if I just minded my own business, I wouldn't I wouldn't have so much pressure on me. I wish I could be like that. I wish I could just stay in my own bubble, but I can't. I see my people around and they need help, they need resources, they need stuff, you know? And I just can't watch them be like that [while] I'm over here in my little fancy house, in my own little fancy things, you know?”

Information from interviews with two key informants who work in an organization that supports Pacific Islanders:

Pacific Islanders are often subsumed under the umbrella of “Asian” or “Asian Pacific Islanders”, but this often hurts them because they have very different needs and health profiles from Eastern Asian or even Southeast Asian groups. In some ways, they may have more in common

with indigenous groups - especially those who are Native Hawaiian - because their histories of marginalization and colonization are more similar.

Most PIs in the Rogue Valley have an immigration experience in that they are geographically distant from their homes. However they have very different judicial immigration experiences depending on their location of origin. People from Hawaii are U.S. citizens, as are people from American Samoa. However, the latter is the less populated of the two Samoan territories, and most Samoan immigrants are from Western Samoa (an independent state) and they need to go through a documentation process to legally reside in the U.S. Likewise, language barriers are experienced differently depending on where they originate: some are native English speakers and some speak very little English.

Low/Edge Income Parents

All three members of the focus group were both women and parents of children under 18. Two of the participants identified themselves as Indigenous and one of the participants identified themselves as biracial. One participant had a history of substance use. Additional insights are included here from parents in other focus groups.

A prominent theme discussed in this group is that maintaining health takes time, and time is not something they have as parents who are struggling to make ends meet. The mothers identified mental health, finances, parenting, and eating healthy as significant challenges they face which they do not have the time or resources to adequately address. All stated that it was a challenge to pay for standard living expenses, let alone any medical expenses that may arise. Financial constraints interfered with their ability to manage chronic health conditions, such as diabetes, high blood pressure, or high cholesterol - those things are best addressed with a combination of medical intervention and lifestyle changes, but the participants reported that healthier foods are often cost-prohibitive. All experienced difficulty in finding available healthcare providers and long wait times to get medical care for adults, particularly dental, but noted that children were seen more promptly. The parents described instances of going without medical care that they would have otherwise wanted because it was not covered by insurance or simply too difficult to access.

Members of the participants' households, including themselves, suffer from anxiety, addiction, alcoholism, and depression as well as diabetes and high cholesterol. Exchanges such as the

following suggest that some resources exist to address these problems, but perhaps there are not enough or they do not adequately address the challenges of this population.

Participant: And then the alcoholism. I would have to say a barrier definitely would just be...I'm going to say finances. It's easier to drink yourself into a coma than it is to buy organic food. For my partner, that's definitely the situation, why he would he have high blood pressure and cholesterol.

Focus group facilitator: And are there, is there resources available to address alcoholism in your area? And is that something he avails himself of?

Participant: So, he has been attending some meetings. Kind of just brings up more reasons to drink. Honestly.

When asked about the barriers to receiving mental health care, one participant, who is biracial stated, "Well, I think diversity, just not wanting to talk to somebody [who is] not like me. Because they've not experienced [what I have] and they can't relate. How can I trust that?"

There was a stark contrast between the two mothers who were covered by OHP and the one who was not. Those with OHP shared that they could not get a job because then they would lose health coverage for their children and themselves. Meanwhile, the focus group participant who was working was just above the income limits for OHP. She had employer-provided insurance with such high premiums and poor coverage that the other members of the family, including her young child, did not have medical insurance.

"My daughter doesn't have insurance, I have to go to tribal clinics (in Humboldt County, CA or Eugene, OR) to take her because she, it was \$600 a month to add her to my work insurance. So, she hasn't been to the dentist. She ain't going to the doctor. I can't afford to take her.

The common refrain from this group of parents was "We need universal healthcare." They would also like to see multiple kinds of expanded services, including broader health coverage, support for children and childcare, and more assistance with food expenses.

Additional insight from parents in other focus groups:

Among parents in other focus groups, lack of childcare was a recurring theme. There are few sources of childcare available, and those that exist are frequently cost-prohibitive. Families struggle with finances because they often cannot find work that pays enough to offset childcare costs. Childcare is also a major concern when a parent has to miss work because a child is sick or needs to be taken to an appointment of some kind.

Rural Seniors

There were ten focus group participants and all of them were seniors from rural areas in Josephine County. Based on self-presentation and comments, there were two men and eight women and all of them appeared to be white.

The lack of medical options dominated this Illinois Valley focus group discussion. Respondents pointed to the closing down of a lab that was run by Asante, the lack of specialists in the county, the lack of consistent primary care providers at the Siskiyou Clinic, a limited urgent care clinic, and a local pharmacy that is not open late or on the weekend.

Much of the conversation centered on the Siskiyou Clinic and the lack of continuity of care. One person explained, "My neighbor was talking to me the other day and she says every time she goes to Siskiyou Clinic, she sees a new person, the way they rotate it. And therefore, she is treated as a new patient." Two others commented on the problems that the Siskiyou Clinic has with recruiting and retaining medical providers. Another commented that an urgent care clinic is needed as the "walk-in clinic [at the Siskiyou Clinic] is Monday through Friday, nine to five."

Although the majority of focus group participants reported challenges with the Clinic, one person stated,

"I didn't want to have to go to Grants Pass for routine medical and health care. So I signed up with the Siskiyou Community Health Clinic and it took six months before they had enough people on staff to give me a real intake interview and so on. But in the interim, I could walk in there and be seen by one kind of practitioner or another. So, now my primary care practitioner is not an M.D. because they still don't have one, but she's a very competent nurse practitioner. And she referred me to a woman physician at Asante Women's Health in Grants Pass who's terrific. So, given my present state of good health and the fact that I don't need something like a weekly or monthly blood draw, I'm real happy with Siskiyou clinic."

There was a fair bit of confusion regarding how the clinic runs. One person stated, "[A]t the Siskiyou Clinic you'll have to be, I don't know, a member, or you have to sign on to their stuff in order to get your prescriptions filled there." There was a long back-and-forth conversation among various focus group participants about which insurance is accepted at the Clinic, with no clear consensus at the end. In addition, there was debate about which healthcare providers are currently working at the Clinic.

Living in a rural location and needing more healthcare as they age makes it challenging for these focus group participants to access more than primary care. One person who has colitis explained, "There is no real gastroenterologist in Josephine County. They have a surgeon or maybe two that will come into the emergency room and do a colonoscopy, but that's an emergency situation." According to this participant, in order to see a gastroenterologist, residents of Josephine County have to go to Medford. Another participant is frustrated that the Asante lab closed in the area. He explained that due to a "cardiac situation", he needs blood draws "from every week to every five weeks. But I have a very good blood thinner guy who's a pharmacist and he is very, very knowledgeable. But it's a pain in the rear to have to go to Grants Pass."

Transportation related to medical care was a significant point of discussion. When the group was asked about emergency care, one respondent said, "You call 911 and you pray a lot. Or get a friend to drive you to Grants Pass if you don't want to wait for the ambulance." Another responded, "Or you don't fall off your roof and you're okay." When alternatives such as Mercy (Air) Flights were discussed, there was some disagreement about the costs related to the discount membership rates offered by the company. They talked about other services such as Ready Ride and the volunteer program run through IV Wellness Resources that takes people to medical appointments. One very knowledgeable member of the focus group explained recent developments in emergency transportation:

"We had what we call divert, which is when they just shut the doors on the emergency room in Grants Pass and the ambulance has to go to Medford. That's now down to almost zero in the last three months. And they've improved AMR and they've got twelve lead electrocardiogram stuff on the ambulance. So, you get a call for chest pain, they alert Medford Mercy Flights with a helicopter on standby assuming the weather is such that they can fly, which many times it isn't. But then with the information on the twelve lead they can know whether they're dealing with a stroke, a heart attack or just another pain. And that allows them to figure out whether or not they need the helicopter and, also what to do if Medford can't fly. They have an agreement with Del Norte County, which is in California, to have a helicopter come in on occasion. They move the patients from their bedside to Selma because Selma is on the way to Grants Pass. So if something went wrong with the helicopter they'd be ten miles closer to getting you to Grants Pass. The flight times. are about ten or about- less than twenty minutes from Medford here and Medford back. So it's ten minutes each way- or 20 minutes each way."

This group was divided when speaking about the positives of living in a rural area. Everyone pointed to the beauty of the outdoors and a number commented on the joys of rural homesteading. Most talked about a strong sense of community. One participant recounted a recent house fire, "When the house burned down, you know, so many people came to help, so

much money was donated, total strangers, but here in the valley.” Others referred to all the opportunities for senior participation such as at the senior center, the library, the garden club, and the quilting club. However, others spoke to feelings of isolation, “I came from Talent [and] Ashland, where I lived for something like ten years, and I find it really isolating to live here. It's just, there's very little to do for older people and there are very few opportunities to meet. So I've lived here for two years and haven't met a soul, really.” After some discussion, one person commented, “I hear a lot of loneliness in this group.”

When talking about living in the Illinois Valley in general, the focus group participants referenced the high cost of housing and the “huge” substance use disorder problem. Fear of encountering people who want to rob them to pay for drugs leads many members of the group to avoid public trails, and there is even some concern for their own property. One person explained, “Safety on your properties, even. Even if you do live out. Cause you never know. You know, someone could come driving down the road and just, unfortunately, if they're high, or whatever, you don't know what they're going to do.”

Rural Low Income

There were ten people from the Illinois Valley in Josephine County in this focus group and they all appeared to be under 65 years old. No one identified as a person of color. Based on their comments, there were seven women and three men and one person identified as LGBTQIA+. At least two people had children under 18 years old. All of them, except one person, were on the Oregon Health Plan.

Many of the themes from the Josephine County seniors were reflected in this group, however as these participants were all low to very low income and were not seniors, there were more pronounced differences regarding the lack of medical providers and continuity of care, transportation, and medical costs. Some of these differences were due to the fact that a number of these participants had children under 18 or were still caring for young adult children. Continuity of care, including having shifting healthcare providers and/or not being able to schedule more appointments, has been a hardship for these rural focus group participants. One person explained, “As a neurodivergent person, I have been absolutely exhausted and they just want me to fill out another packet of paperwork and talk to a new person and another new person and another new person. And it just gets to be so overwhelming that you give up.” A parent explained,

“My two kids go to TLC Pediatric in Grants Pass, but their doctor switched suddenly in the winter, like someone just bought the practice, and so they had just sent us a letter about how the doctor was different suddenly. So I'm trying to get them into the Clinic as well, but again, it's going to take months...My father-in-law (who is at the VA)..it's always a different doctor.”

One participant commented that she waited eight months to see a provider at the Siskiyou Clinic and “she turfed me out to other people.” Another parent talked about their adult son who was recently diagnosed with bipolar disorder and the fact that Options would only see him once a month.

Similar to the rural seniors, this group reported transportation challenges. However, they were less focused on emergency situations and spoke more to the day-to-day obstacles of getting to appointments. Ready Ride, which was mentioned in the senior focus group, was discussed to a much greater extent by these participants. They explained that it is medical transport provided by insurance. The exchange below was particularly revealing about the unique circumstances of this type of transportation provided in a rural area:

Focus group participant #1: “The other problem with Ready Ride too, is that a lot of our addresses are not navigable with traditional GPS, which is what they use.”

Focus group facilitator: “It was funny to watch everybody's face when you said that.”

Focus group participant #2: “So, not only can they not find you, but we don't have phone service out here and they don't have internet service out here.”

Focus group participant #3: “No cell service”

Focus group participant #1: “So, not only can they not find you, they cannot call you or email or text you to try and locate you, to get you to this appointment.”

Another person explained that she works for a couple in their 80s who can't get to Medford for their pain medication, so she ends up driving them every three months to pick it up.

Four participants pointed to the ongoing hardship of healthcare costs, including increasing co-pays. One told us that, for people on Medicare and Medicaid, “The cost of treatments and prescriptions has increased and people have to drive to Grants Pass, often missing their prescription window because it's cheaper to go to Walmart or a specific place in that area because we do not have it out here.” The second outlined the choices that have to be made to receive dental care, “First you have to talk to them...you don't even get your cleaning yet, you get your x-rays...then you go back and get your cleaning and then you go again...I choose what do I want to pay for this time?” The third elaborated on a recent visit to the optometrist in which the office person said that AllCare would not cover the extensive exam that she just received.

The fourth participant noted that copays are going up for physical therapy and other affiliated healthcare services.

When speaking about non-healthcare subjects, the high cost of housing in the Illinois Valley came up repeatedly as well as the suboptimal housing situations that a number of the participants find themselves in due to high rents. Another topic of considerable discussion was the sense of community that lifts up people in the Illinois Valley. Nine participants specifically mentioned the support community members provide for each other. One person put it this way, "I love just the advocacy that comes from the heart of lots of our community members. It's just grassroots, we take care of each other, we check in with each other." Another participant elaborated, "And especially if you can't advocate for yourself, someone's always going to stand up in the shadows and be like, uh uh uh uh. We're gonna get this fixed." A third participant put community support into a wider context, "I think we lack diversity in a lot of ways, but there are a wide array of backgrounds and beliefs, and yeah like people have been saying, we all come together and figure stuff out and then go back to our, our separate corners and fight on Facebook."

Information from an interview with a key informant who is an elected official of a very rural community:

The informant explained that being up in the mountains severely limits access to medical and dental care for the inhabitants of the community. She stated,

"We really have a tough time trying to get doctors to come up here. And the second one, I think, would be the dental issues that we do have a dentist that comes up and I think he's only maybe once or twice a month if we're lucky."

Traveling down to Medford to see a medical provider, a therapist, or a dentist is a hardship for the elderly who no longer drive or for those with mobility issues.

Drug use is a significant concern for the community:

Our city park is one of the problems that we find a lot of drug paraphernalia in our bathrooms...Drug paraphernalia is left all over the grass...People take their dogs over there and the dogs can get into those foils. The dogs can get into the needles just like the little kids. And we even find it in our kiddy playground, is where there's needles and stuff over there as well. But the bathrooms are the worst...[O]ur public works people are over there 10 to 12 hours a week just cleaning up messes in the bathrooms. People go in there to use their drugs and then they hide them in the ceiling portions so they can come back and get some more."

Black Community

There were seven people from Jackson and Josephine Counties in the focus group, and all identified as Black. There was a mix of gender identities, and one person identified as a lesbian. With the exception of one person in their late 20s, all of the rest were retired or their responses indicated that they were seniors.

The theme that received the most sustained attention in the focus group was the explicit discrimination in medical settings that was faced by a number of these focus group participants. One woman recounted very disturbing interactions with three different medical providers. The first situation was her female physician who, during three consecutive visits, would not touch her, even to examine her. The second was a visit to the emergency department at Asante, where she had gone for heart problems. The ER physician told her, “Nothing is wrong with you. What do you want? What are you in here for?” This focus group participant understood those comments as the physician accusing her of drug-seeking behavior. The third incident was a phlebotomist who said she would be right with her, but then the phlebotomist came out two hours later and explained the delay by saying that she “had been napping.”

Two others described disturbing encounters. One participant told the group about the racist assumptions he faced seeking healthcare, “First time I went to a doctor here in southern Oregon, I was complaining of stomach problems, headache, general malaise. The guy swore up and down that I had AIDS. Another black man with AIDS.” The second participant recounted seeing a podiatrist who assumed, “Oh, you’re from Detroit?” She has never been to Detroit, but that didn’t stop the provider from continuing to talk about Motown.

The lack of medical providers of color and southern Oregon physicians’ lack of experience with people of color were also discussed. One person observed that there are no “medical personnel, even the receptionist, the janitor, the parking attendant, the ambulance driver – no people of color...[W]hen you don’t see people who look like you, you don’t feel heard, you don’t feel comfortable, you don’t feel believed.” The man who was misdiagnosed as having AIDS has continued to find that providers lack the experience of working with people of color. Another participant explained that he has had two people of color as healthcare providers and “it was always a good experience.” A fourth participant told the group that she had a healthcare provider of color and that person was harassed so much that she moved.

Other issues that came up were the cost of doctor visits, prescriptions, and providers not taking their health insurance, as well as the very long wait times many of the participants were having to endure to see a physician.

When asked about what is positive about their communities, a few people spoke about the challenges they face, but all of them also talked about the increasing sense of community that they are finding in southern Oregon. Two people explained,

“[W]hen I first got here (in 1989), I thought I was like one of three black people here...I know that’s not true. It’s just not a lot of things to draw black folks out...But that’s changing. I’m really seeing that positive change as far as people coming into the community in southern Oregon.”

“I think one of the biggest differences is the small-townness of it here. I feel like I have so many more personal, more intimate interactions with...casual people walking around. [W]hen I was in New York...so many people looked a lot more like me, but I didn’t necessarily have those...friendly interactions.”

Key informant interview with a member of various Black community organizations:

The key informant interviewee for the Black community spoke about the Black community’s longstanding distrust of healthcare professionals. “[O]ften (Black) people don’t access healthcare because they’ve had very degrading, discourteous, and insulting experiences doing so. People have said to me, ‘[W]henever I go, they talk down to me, they treat me like [expletive].’” Numerous Black parents report to her that when they take their children to the pediatrician, they get poor treatment and “they end up getting a lecture about parenting” from the pediatrician.

The interviewee’s own experiences function very much like a social experiment in the healthcare received by people of color in the valley. When the interviewee has accompanied her mother on medical visits, there have been numerous times when they have been treated badly. Then, as soon as the medical providers learn that the interviewee’s spouse is white and a physician, “they’re all smiles and rainbows.”

In terms of other subjects asked about in the interview, many of the Black people the key informant knows in the region are underemployed or have to work multiple jobs. In reference to the impact of climate change, the interviewee observed that when it is smoky, those who can afford it leave the area. “In the Black community, that’s not always the case”, and there are people who can’t leave and must stay in the unhealthy air quality.

Making change in healthcare is challenging, the interviewee noted, as it is systemic and “originates in generations past.” The interviewee recommends that the healthcare community “develop more trusting relationships which would go very far to invite Black people who have been excluded, who may have chosen self-exclusion, who are underserved, who do not feel welcome, or who feel that this system wasn’t created for me.”

Deaf & Hard of Hearing (D/HH)

There were ten people in the focus group. There was a mix of gender identities and ages, including two people under 25 years old, two seniors, one person who identifies as LGBTQIA+ and one person who is Latina.

With one exception, all participants in this focus group were either Deaf or extremely hard of hearing. A professional ASL (American Sign Language) interpreter was present and interpreted all of the spoken words into sign language. Some participants used their voice to express themselves and the remainder signed, which was then voiced by the ASL interpreter. The main themes that arose during this focus group were boundaries to access, discrimination, and language barriers that all of the respondents have commonly experienced in healthcare settings. This centered on the lack of ASL interpreters (both in-person and virtual) and assumptions made by medical providers about the hearing capabilities and mental capacity of D/HH patients.

Simply having an interpreter present at medical appointments is challenging. A number of focus group participants have been erroneously told by their physician’s office that they need to schedule an interpreter and they need to pay the interpreter themselves. On top of that, there are now very few interpreters to attend medical visits, “We lost our interpreters (during the pandemic) who didn’t come back,” explained one of the seniors in the focus group. The general lack of in-person interpreters, as well as the costs associated, have resulted in a heavy reliance on video remote interpreting (VRI).

The focus group participants uniformly found that using VRI in medical settings has been unsatisfactory. The following problems were discussed: the internet freezes up on a regular basis thus stopping the communication; it’s hard to hold a tablet in one hand and sign with the other; the interpreter does not “realize if you didn’t catch something and understand it clearly”; there are ASL dialects within the US and this can cause confusion and misunderstanding if the

patient and the interpreter do not use the same dialect; virtual interpreters cannot always detect the subtleties of facial expression and body language, which are crucial in sign language; and medical terminology can be complicated and the participants expressed that it was more difficult to get clarification with a remote interpreter.

Outside of a clinical office, there were additional healthcare challenges identified by the participants, which included being transported in ambulances and receiving counseling at pharmacies. One person described the problems she has faced in multiple ambulance rides:

“An ambulance comes and the communication - they have to ask you these questions, like ‘Do you have allergies?’. And how can I answer that? Have a conversation to tell them what allergy I have? They need to have the training to be aware of Deaf patients. All nurses, doctors, ambulance, EMTs. They have to know or be aware of how to work with Deaf people. I don’t understand, they’ve been to schools, they’ve had training. They’ve been licensed...[but] they have no training [about Deaf patients].”

At a fundamental level, a number of the participants experienced a lack of accommodation or understanding from their medical providers. One problem is that if Deaf or hard of hearing patients use their voice, the providers assume that they can hear and are resistant to providing any sort of accommodation. A participant described another common feeling of discrimination, “I’m just tired of doctors looking down on us, like we don’t have a brain...We’re tired of doctors and nurses being so disdainful. [They say] ‘Just go on, take this medicine.’ ‘What’s the medication for?’ They don’t tell you, [they say] ‘it’s just to help you.’ That is wrong.” Another elaborated:

“Repeatedly, all our lives, we are misunderstood, people make fun of us...[In the provider’s office] you’re not understanding the medical terminology. So, you might try to ask for repetition and you still don’t understand. We can read body language, and we know they’re getting impatient with us...So, we just clam up and don’t ask questions.”

Participants also gave examples of positive medical outcomes. One person described the interactions with his doctor in this way, “She’s awesome. If I don’t understand something, she slows it down and repeats words again and she’s like really understanding.” Two people were pleased with the “24 hours a day” interpreter availability at OHSU. Others chimed in that there is a live interpreter at the ICU at Providence and that Providence providers are “patient, kind, and polite.” A few respondents pointed out that AllCare provides an interpreter, however one elaborated, “...but it’s the doctor’s office, the provider, that does not call AllCare to get me an interpreter. Why? Because they’re worried about money.”

The primary solutions offered during the focus groups were increasing the number of in-person interpreters and establishing training for medical providers. According to one participant, the best approach would be “to have cultural competency training because being Deaf and signing is more than just that, it’s a culture. So, learning about Deaf culture, maybe picking up a little bit of sign, but just understanding. And if we ask you for an interpreter, if we ask you to say something again...we need to understand you.” He also went on to recommend a Deaf signifier option for My Chart so “it would help the doctor or the nurse to know, oh he’s Deaf, he needs an interpreter or needs masks off.”

Key informant interview with a person who is Deaf and serves the Deaf community:

The key informant for the Deaf and hard of hearing community elaborated on the same themes that we heard in the focus group. The interviewee explained that with such a small pool of interpreters in the Valley, it can be very uncomfortable when an interpreter a person uses in a work or educational setting is also interpreting for that same person in a medical or mental health setting. The interviewee said that there is “basically one medical interpreter for Jackson and Josephine Counties.” Additionally, medical providers often do not request an interpreter for this interviewee, who explained, “They don’t know to, they don’t what to do, they don’t understand what the ADA laws are.” Aftercare, such as physical therapy or occupational therapy, is also problematic to “navigate and deal with” as interpretation is often not provided.

The interviewee had plenty to say about virtual interpreting. The person noted that the upload and download speeds of the VRIs in medical settings are not adequate, and the glitches and delays that often happen cause “frustration and confusion” for the D/HH patient and the medical provider. If a person who is D/HH is in the hospital for a procedure, the VRI is an even greater barrier. The interviewee explained, “If you are in pain and you can’t move” or “drugged up and coming out of surgery” it can be very trying to manage communication with your medical team by trying to sign to a remote interpreter on a tablet.

The interviewee pointed to the Kaiser in Salem and the medical system in the Bay Area as facilities that were much easier to utilize as a Deaf person.

People Living with Physical Disabilities

There were ten people in the focus group; seven used wheelchairs and three were Deaf or hard of hearing. The ages of the participants ranged from 18 years old to at least one senior. There

was one Latino participant and the remainder appeared to be white. There was a mix of gender identities and one person self-identified as transgender.

There were two professional ASL (American sign language) interpreters present for this focus group and they interpreted all of the spoken words into sign language. The three D/HH participants voiced their responses. The major themes for this group were access, mobility, transportation, discrimination, and the importance of community/family.

Inaccessibility was the biggest topic of conversation in the focus group. Every person who used a wheelchair brought up multiple instances of not being able to access ATMs, entrances to buildings, doors, groceries on higher shelves, events in the community, and handicapped parking spaces taken up by able-bodied people, as well as having their vehicle ramps blocked by other cars.

Accessibility is also a problem in healthcare settings. One participant elaborated,

“When you go into some doctor's offices or dental office -- I have both a manual and power chair. So I go in with my manual chair and they're telling me, ‘We can't transfer you to the chair. Because [for] our staff [it] would be a liability.’ They said, ‘Then you'll have to be on your own power chair in order for us to be able to operate on you in a dental office or a doctor's office.’”

Another person explained that he's been to the emergency department twice in the last year and both times the shuttle was not running, “So I had to push up the emergency room ramp both times. There's no signage that says that for people with a disability or a walker, wheelchair or whatever, 'Take entrance C and walk through the hospital.’” The current construction at Asante has made navigating the hospital more difficult. A third focus group participant talked about an ongoing medical accessibility issue, “My doctor's office, I only do telehealth appointments because it's not accessible. The ramp is so steep. And the building is so old that it is grandfathered in.”

Transportation is also a significant problem for people in wheelchairs. As one person put it, “Not everybody can drive a vehicle, and so it would be nice to have an alternative that doesn't cost [so much].” This impacts medical transportation also. Another person recounted,

“I had an episode (in the middle of the night), I didn't want to call an ambulance. But my wife couldn't drive. So it's a really good thing that the bad thing that the E.R. said would more than likely happen eventually did not happen that night because I was not able to get to the emergency room until 18 hours later.”

There was a prolonged discussion in the focus group about a local wheelchair company that was not providing much-needed adaptations to the wheelchairs of two participants. This prompted an insightful comment from a third member of the group:

“And then also one of the big things for us folks in this room, for wheelchair users and stuff, there's no preventative medicine. I have a small pressure sore on my fanny right now. As I saw that the redness was starting to appear, I didn't have the cushion I needed in my car especially. And my insurance would not pay for that until I got a pressure sore. And then they would pay for it. So it's just, you know, ask nice and stuff like that, that later on the insurance ends up paying so much more with wound care once a week, and doctor's visits. All those things I have to get in my car for and drive to anyway. So if we got the cushion that I needed in the first place. It could have eliminated all this and saved them a shit ton of money.”

Members of this focus group identified the challenges they face, but they also put forth answers. One participant pushed for “Discharge planners at the hospital. Both hospitals. Not only do they need to be trained better, but there needs to be a better list of community resources when people get discharged from the hospital.” Another made the case for a

“[H]ealth care and a disability ADA authorized ombudsman that a person in the community can call and say, 'I'm having difficulty with this business or with this accessibility issue and I can't seem to get anywhere and I need some help. I feel like I may be discriminated against and or can't get the services that I feel that I can reasonably get.

A third person, who works in healthcare, stated, “I think that especially in the valley there are some issues. But I think training and education can address it. And then self-advocacy.”

Indigenous/Native American

n=3 for photovoice session 1. All women, college students, 18-25.

n=1 key informant interview - female college student

n=2 participants from low-edge parent focus group

n=1 participant from JoCo youth focus group

All participants in this community health assessment who identified themselves as indigenous people were women; we were not able to speak to any indigenous men. Among the college-aged students, participants stressed feelings of isolation. They have very few indigenous people in their local social networks. They feel as though indigenous people are either minimally present in Jackson and Josephine Counties, or they are invisible; they mention having to really “track down” other indigenous students. There is a loss of identity when moving to this area, because they are distant from their own communities and cannot wear their normal cultural symbols or participate in practices without calling attention to themselves. Those interactions are usually negative: people either accuse them of “trying to make a statement” or single them

out to speak for entire populations of indigenous people. They often feel tokenized, as if no one wants to hear their voice, but people want their image or for them to be visibly present.

Indigenous participants of all ages reflected on the ways their identity impacts their healthcare. Both parents and college students expressed frustration with the lack of cultural competence and discrimination from healthcare providers who make assumptions about their compliance or investment in their own health. They also discourage use of traditional healing modalities and associate use of these practices with poor education and health literacy.

“If I had a provider acknowledge my medicine and acknowledge that it worked and told me to use it. That would be...mind blowing. I'm so often told, not only that I don't deserve Western health care, but the stuff that I use is stupid and it doesn't work. And so if I had a provider who would work with me with that...Oh, I love that idea. That's ideal. That's everything.”

Participants felt fortunate to have access to tribal clinics, which provided health care that they would otherwise not have, but noted that it was not always feasible to use them because they are so far away. Several participants were enrolled in tribes in Northern California and they needed to travel back for any medical care.

Adults and Children/Youth Living with Developmental Disabilities

n=1 key informant who works with children with developmental disabilities

n=1 participant from Spanish-speaking Latino/a/x focus group

N=1 key informant who works with adults with developmental disabilities

Children/Youth Living with Disabilities

Two of our sources spoke about children and youth living with developmental disabilities. The key informant highlighted the ways in which this region lacks sufficient specialists and services for those with developmental disabilities. These services are expensive and it is incredibly challenging for families to navigate the bureaucracies of insurance and school systems. She noted that they frequently must travel to Eugene or Portland to receive all but the most basic services because of the lack of local providers. Further, she emphasized the challenges of having dual diagnoses of conditions that are considered under the umbrella of developmental disabilities (e.g., autism spectrum disorders) and those considered to be mental health diagnoses: she referred to this as “no man’s land” because neither type of service/facility will accept someone with both diagnoses. In addition, a participant in the Spanish-speaking Latino/a/x focus group who works in this field touched upon the added barriers for Latino/a/x

and immigrant families, who are often unfamiliar with these concepts and services, and who lack the linguistic and cultural capital to advocate effectively for their children.

The key informant explained that we have qualified professionals who are committed to these issues in the Rogue Valley, but that they can only do so much with the current resources and structures available. She explained that she can only speak to what is available for young people and has no idea what to do or where they should go for assistance after they turn 21. Additionally, she noted that this work has gotten more difficult since the pandemic, because children who missed opportunities to learn and socialize often present similarly to children with autism spectrum disorder, but they don't all have autism. This further complicates questions of who needs resources for developmental disabilities and how to best provide those supports.

Adults living with intellectual and developmental disabilities:

Our key informant who worked with adults described a general tendency on the part of her clients to refuse health care.

“Seeing a doctor can be intimidating, virtual appointments and things like that have happened in the last couple of years are difficult, particularly for people that have communication barriers, barriers in understanding the information being relayed by medical professionals. “

She went on to explain:

“Providers [need to] have enough time to get to know somebody and their communication style...Frequently they aren't able to articulate exactly what is going on in their health...So then it's kind of like a double-edged sword. We want the provider to focus on the person and listen to them, whatever their communication style is. But then we also want them to, if the person's coming with a support person, listen to that support person, with the same degree of focus.

Other health concerns for people with developmental/intellectual disabilities include “unhealthy eating and not exercising”, diabetes, and obesity. Clients of this informant's organization don't have the resources to purchase “higher quality food, but then also the knowledge for some to be able to prepare that food.” They had success in the past implementing a health and wellness initiative which pairs people together to exercise. However, “with the workforce shortage and ... not having like a grant or something to devote time to those programs, it's hard to be able to match people together, to be able to go exercise.”

Mental health issues are significant among people with intellectual/development disabilities and the informant explained that they need “mental health providers [who] understand the co-occurrence of a developmental disability and a mental health diagnosis.” The informant pointed

to the lack of affordable housing as another local condition that adversely impacts the health of their clients.

Immigrants

n=1 key informant who is an immigration lawyer

n=6 Spanish-speaking Latino/a/x focus group participants

Additional insights from Pacific Islander focus group and key informants

Additional insight from key informant who works with youth from disadvantaged backgrounds and Latino/a/x youth

In our focus groups, those who reported having no health insurance at all were primarily immigrants. While OHP is available regardless of immigration status, the immigration lawyer described his clients' hesitancy to access healthcare and related services because they fear repercussions related to their judicial status. Particularly during the Trump administration, even naturalized citizens became concerned that they would somehow get in trouble if they accessed public benefits. The informant said that it is difficult to assess how well the healthcare system is serving this community because they are often too afraid to use these services. Youth who are citizens sometimes do not receive services because their parents are immigrants. Those who did access healthcare reported feeling a stigma for not having insurance or for being on OHP; they felt they were treated as though they were irresponsible or were not treated as well as those with private insurance. Another theme was that immigrant groups, in part because of their limited access to healthcare, felt they were hit harder by the COVID-19 pandemic.

Immigration issues frequently overlap with language issues. There are some options for Spanish-speakers to receive care in their native language, but interpretation and bilingual services are far more limited for other immigrant groups. As such, they face heightened barriers to health literacy and the ability to navigate health resources. There are some local nonprofits, such as UNETE and the Samoan Pacific Development Corporation, that have been working on community health outreach, especially as it pertained to COVID-19 vaccination.

Children's Well-Being

n=1 key informant who works with youth from disadvantaged backgrounds

n=1 key informant who is a school district staff member who works with Latino/a/x youth

N=1 key informant who works in an organization that promotes and supports early learning

Lack of childcare came up as a theme in several focus groups. A key informant explained,

“That is something that's really difficult right now for parents - to be able to get a job, to get off TANF [Temporary Assistance for Needy Families], to get on their feet. They need someone to take care of their child. And right now, that's as much as they're going to be

making at their job. And yes, DHS [Department of Human Services] has some aid to help, but you have to find somebody that's registered through DHS that is accepting children that you also feel safe to drop your children off with. You know, I feel like that could really help if we had some more funding towards child care, especially younger ages...a lot of people don't watch children that are under three. And I don't know what they expect parents to do for the first three years of the child's life if no one, if the state won't even cover for someone to take care of them."

For young children, the lack of childcare also represents a lack of early learning opportunities. A region is considered a childcare desert if there are available childcare slots (daycare, pre-K, etc.) for less than 33% of children. Another key informant stated,

"We're under 30% in both counties for the 0 to 2 population and the 3 to 5 population and for the 0 to 2, we're actually under 10%. So fewer than 10% percent of infants and toddlers have access to a slot. And under 30% of preschool age children do. And that's just access to any slot."

This data corroborates the shortages that focus group participants experienced. Childcare access rates are much lower among low-income families, and other populations including Spanish-speaking households; households with a parent with a disability, mental illness, or substance use disorder; rural households that lack transportation to services; and teen parents. Childcare for children under five years old is a space for socialization, developmental skills, and preparation for kindergarten; children often have a more difficult transition to school when they are not exposed to these learning opportunities. Meanwhile, without childcare, parents cannot pursue higher education, skills training, or employment that would contribute to financial stability. A key informant echoed the parent focus group in saying that food and diaper expenses are difficult for families to cover.

For school-aged children, mental health is a primary concern. Many children in the area have suffered adverse childhood experiences and need counseling, social skills development, and assistance in developing coping strategies for stress, according to the key informant who works in the school district. Children often complain of stomachaches when the root cause is some kind of stress, and parents do not always see the pattern when the stress is coming from school (i.e., the children seem fine at home), or they do not think a stomachache is a serious health concern. Ideally, there would wraparound services for the whole family to educate and provide mental health care for them, as well. Other major health concerns the informant sees are lack of eye care and dental care. There are few options for dental care under OHP, and it often takes months to be seen. She reported that OHP also does not cover orthodontics. Regarding eye care, since it is not a standard part of medical care, parents may not realize that their children

need glasses if they are not complaining. These issues are all exacerbated by understaffing in the healthcare field. The informant described situations in which she had referred families to needed services, but no one from the provider's office returns the families' calls because they are full or busy.

With high school students, concerns about mental health, social media, and bullying are on the minds of both students and staff of organizations that serve them. The school district key informant says that she often sees older students who want to access health services but are concerned about privacy - they do not want their parents or their peers to know. (These concerns also came up in the Josephine County young adult focus group, in which all participants were high school students.) Another key informant discussed the additional challenges that arise for children in immigrant families, who may be afraid to seek health care or may have low English proficiency. These families are more likely to be low income and work in industries with shifting schedules, so it becomes difficult for them to attend medical appointments or pay for medical expenses. In the Rogue Valley, Latino/a/x families were hit particularly hard by COVID because of these barriers. She has also witnessed extensive discrimination against Black and Latino/a/x people in Josephine County in schools and medical institutions. Further, there are cultural barriers in Latino/a/x families that hinder access to mental health care.

People Living with Substance Use Disorders

n=1 key informant from an organization that serves people who are unhoused

n=1 key informant from an organization that serves people with substance use disorders (SUDs)

Additional insights from the unhoused focus group

There is substantial overlap between unhoused populations and populations with SUDs, and the interview with the interviewee from the organization that serves people with SUDs highlights this. She explained that substance users often become unhoused and lose their IDs, which prevents them from accessing medical care. While on the streets, their belongings frequently get stolen, which contributes to the problem of lost IDs but also makes them unwilling to enter medical spaces where they are required to leave their belongings unattended. For these reasons, she said that the most successful and accessible forms of health care for these populations are the street teams, including those staffed by OSHU nurses and Options (Jackson County only). Her organization primarily provides naloxone and wound care, but she stated that dental care, food, and warmth are also major needs. She also felt that grief is a major issue in

this population, that unhoused people and substance users experience a lot of trauma and that healing from trauma and grief is an important component to improving their conditions.

From the other interviewee's perspective, SUDs issues are even more intertwined with mental health issues than with housing. She works in a rural area of Josephine County, where geographic isolation and lack of transportation present barriers to receiving services. As a caseworker, she often travels to people's homes to facilitate connection to both SUDs and mental health treatment. Because many of the most rural areas lack cell phone service or broadband internet, her office offers a space in which people can take telehealth appointments. Though it can still be challenging for rural poor and elderly to get to her office, it offers a more accessible option than having to travel to Grants Pass. Transportation is a huge issue in this area, and if a person misses an appointment due to a transportation issue, they may lose their spot in line to receive these services - which compounds the problem, because mental health and SUDs care are often urgent needs.

This key informant sees a different aspect of the intersections between substance use, mental health, and housing. She stated that nearly everyone smokes cigarettes and marijuana, and that they usually don't even think to mention that as substance use. However, there is a history of illicit marijuana activity, and connected to that, other types of substance use. These make people wary of authorities and of engaging with institutions, and this seeps over into other areas of life. For example, she noted that many people are in substandard housing because they cannot afford to fix problems or don't want anyone coming to their property. People suffering from chronic pain or mental illness are also less able to maintain their living conditions, and these stressors often are linked to ongoing challenges with mental health and substance use.

Many participants from focus groups are concerned about substance use in the community in a general way, whether it is because it contributes to homelessness or because they are concerned about the accessibility of drugs to youth. The unhoused focus group brought up an additional public health concern related to IV drug use: there are organizations that provide free and clean needles, etc. but there are no places to dispose of that paraphernalia, so needles litter public spaces and become a danger to anyone who may step on them.

Both key informants and focus group participants discussed the stigma and discrimination surrounding drug use within the medical institution. People are often denied care if providers

believe that they are drug seekers, and those with a history of SUDs (even if it is in the past) frequently experience discrimination from providers.

Justice-Involved People

n=1 key informant who works for an organization that provides support after a person is released from incarceration

n=1 key informant who functions as a mentor for juvenile offenders and runs a business that makes opportunities available for those who have been justice involved

The interviewee from the post-incarceration support organization identified three primary barriers to adequate healthcare for those who are justice involved: lack of health insurance, mental illness/dual diagnosis, and continuity of care. The interviewee noted that often a person loses their health insurance upon incarceration, and getting back on it when they are released can be difficult. This leads to exacerbating existing problems, as they are “not receiving any type of medical, dental, mental health treatment...really just not any type of care, whether they don’t have insurance or they don’t know what types of things their insurance covers.” Assisting those with mental illness in getting care is particularly difficult, as those with “severe and persistent mental illness...can’t keep track of doctor’s appointments, can’t go six weeks in between seeing a therapist.” According to the interviewee, a dual diagnosis of mental health problems and substance leads to few healthcare options as there is “just a lack of culturally responsive services that are available.” One example of a positive healthcare model for those who have been justice involved is La Clinca’s Birch Grove. The interviewee described it as “an amazing system... an agency that exists to support. It’s a number of different services in one location (including primary care physicians, peer support and mental health).”

The other key informant echoed some of these points – when a juvenile or an adult is released from incarceration, they often do not know how to access health insurance or the healthcare that they need. Elaborating on this, the interviewee noted that juveniles and adults who were incarcerated also often lack the knowledge and skills to manage employment, housing, and other systems.

People who Experience Domestic Violence

n=1 a key informant who works for an organization that houses victims of domestic violence and/or trafficking

The interviewee stated that the number one issue for survivors of domestic violence is affordable and available housing. The second is access to healthcare:

“Survivors of domestic violence don’t always have access to [healthcare] or cannot access for their children and the reason for that is...[the] coercive power and control that

abusers have over them. Not wanting [to let that] secret out. And so they will isolate or keep their family close and that sometimes means that their children or themselves aren't able to access dental care or basic medical routine care because they don't want anything to come up those interactions that would be reported to law enforcement or child welfare."

She went on to say that survivors have told her that the healthcare they have access to is through their children's school-based healthcare program, and that's been helpful, but it is minimal. "It's not uncommon for people to come into our shelter and have lots of healthcare needs that have been neglected for a long period of time and not hav[e] any established care." Additionally, the survivors often have difficulties navigating the healthcare system. Her organization only provides emergency shelter and it is often weeks or months until a survivor can get connected with a primary care provider. Recently the waiting times have become longer, and access is more limited. On top of that, the interviewee noted that those survivors with a history of mental illness or substance use disorder don't get the same level of medical care as others.

The limited childcare available for these families has an impact on the survivor's ability to receive necessary mental health treatment. The interviewee explained:

"A parent wants to get some personal mental health therapy for themselves because they've just gone through a trauma, and they need to recover from that...Let's say they don't have childcare and so the alternative is that they'll schedule an online appointment. But then their mental health professional won't actually talk to them about the things that they need to process...because their kids might be too nearby."

Even when a family is approved for 20 hours a week of childcare by DHS, the parent has to search for childcare that will accept those benefits. The interviewee said this is further complicated by the "particularly high barrier for folks whose children have special needs...on the spectrum or have some behavioral issues."

The interviewee would like to see agencies like hers to partner with or "create better partnerships with the CCOs [Coordinated Care Organizations]."

Appendix A – Recruitment Strategies Used for Focus Groups

Black Community Focus Group

Geneva Craig, PhD., R.N. I represented BASE, that is Black Alliance Social Empowerment. BASE represents individuals who identify as Black, or, Black American. I serve in a volunteer role. I recruited participants for the Focus Group. At BASE's 2023 Black History Celebration Event, which was held in Saint Mary's School Gym. An announcement was made about the upcoming need for volunteers who would be interested in being interviewed. There was a table with pens, index cards and an outline of what contact information was needed. Folk completed the cards and placed them into a sealed box that had a slit to slide the completed cards into the box. This was to protect individual's private information. I collected the box and kept the information secure until the time to contact them came about.

Deaf/Hard of Hearing Focus Group

My name is John Curtis and I am a disabled/hearing volunteer for the Disability Services Advisory Council for Aging and People with Disabilities in Jackson and Josephine Counties. When asked to offer suggestions of participants for the D/HoH focus group, I chiefly relied on my knowledge of Deaf and Hard of Hearing who, at some point over the past six years, have participated in a workgroup (an ad hoc committee of the DSAC that is open to D/HoH and healthcare providers) that I co-facilitate to improve effective communication in healthcare settings. Two of the most active and more English literate Deaf advocates from this workgroup were asked by me to reach out for names of people in both counties who would be interested in being focus group participants. One of the two deaf suggested that a Child of a Deaf Adult (CODA) also be included and she offered a name. An ASL interpreter also was asked to suggest names of Deaf and CODAs. Past and present Hard of Hearing workgroup participants were also asked to suggest names.

Indigenous Photovoice Session

My name is Sadie Siders and I'm the Health Equity Coordinator for the Jackson County Public Health division. To recruit for this photovoice session, I attended the Southern Oregon University (SOU) Native American Student Union (NASU) meeting. This meeting consists of both Native and non-Native SOU students. At the meeting I explained what the All in For Health Jackson/Josephine County Community Health Assessment is and the purpose of it. Then, I explained what a photovoice session is and how it's a powerful tool to elevate and amplify Indigenous voices in Southern Oregon.

Jackson County Spanish focus group:

- Nancy McKinnis ella/she/her – Health Equity Program specialist
- Jackson Care Connect
- In Jackson Care Connect we serve the Medicaid population, so folks that are on Oregon Health Plan.
- Our strategy to recruit was to share with our Community Advisory Council, which I made up of people who serve OHP members, and OHP members themselves. We also reached out to community partners that serve the specific population that we are

recruiting for. Connecting with them and making that ask for support was easier due to the long trusting relationships with these organizations. We also have build relationships with community members and have reached out to them and invited them to participate.

- Overall our recruitment strategy has been reaching out to:
 - Our member networks
 - Community members
 - Community partners
 - While doing outreach inviting to participate

Josephine County Young Adults (18-25) Photovoice/Focus Group

- My name is Randi and I am one of two Grants Pass High School Whatever It Takes advisors. Many of the students in my program are focusing on credit retrieval and overcoming barriers in an effort to graduate. For this focus group I recruited two of my students who just completed their graduation requirements.
- My name is Bailey Reed and I am the Project Youth+ Whatever It Takes Advisor at Southern Oregon Success Academy (SOSA). Our organization works with low in-come, first generation and under-represented students who seek support academically to be able to graduate. We prepare students for post-secondary success and life skills. For the focus group, I recruited my students by specifically seeking students who were on contract with me and 18 years old. When picking students, I kept in mind which students could drive, have easy access to get to the office, and were available at that time. I chose students who I knew would be reliable in attending both sessions through their attendance at school and consistency in school work.

Low to edge income parents Focus Group

Kim Handloser, Rogue Community Health

Stacey Daniszewski and Amber Lease of Head Start were recruiting partners for the Parents who identify as low or edge income but were unable to get any parents to commit to the group. Caren Caldwell had planned to recruit from NAMI but was unable to procure the NAMI Southern Oregon mailing list so did not have the contacts she needed. Ultimately, a major role in recruitment was played by Sandra Maxwell, a member of AllCare's Community Advisory Committee. Information about the focus group was also sent to The Family Connection, Peter Buckley of Southern Oregon Success, Illinois Valley Community Development Organization (IVCDO) and others to share with their networks (or as individuals to join the group). Flyers were posted in Grants Pass by JCPH.

LGBTQIA+IA+

Outreach coordinators: Erin Greene, Liz Reeder

Organizations: Rogue Community Health; Healthcare Coalition of Southern Oregon

Recruitment: The outreach coordinators used their personal connections to recruit for this focus group.

Mental Health Focus Group

I am Sarah Small, the Development and Integrated Health Coordinator at Options for Southern Oregon. I was one of the focus group coordinators for the People Living with Mental Health Diagnoses. Recruitment occurred by having the flyer posted at all our outpatient facilities, asking our program managers to ask clients if they would be interested in participating in the group, and sharing information about the group in community partner meetings such as NAMI and Southern Oregon Success' Youth Development Work Group. We did recruit from some of our clients, as well as some of our staff members who have mental health diagnoses.

Older adults/seniors Focus Group

Name: Laura Mancuso

Organization: Illinois Valley Wellness Resources

I recruited focus group volunteers by passing the "All In For Health" letter on to key community-based organizations and also connected with people that I knew from my Illinois Valley Wellness Resource List. Once I had interested older adults, I confirmed that they were on my list and then 2 days before the event I sent them an email or called them to confirm that they were coming. All 10 participants ended up showing and so far the feedback has been very positive.

Pacific Islander Focus Group

Outreach coordinators: Ria Galo; Apaau Fuataga; Johnny Vaigafa

Organizations: Southern Oregon University (SOU); Samoan Pacific Development Corporation (SPDC)

Recruitment:

- SOU Pacific Islander/Samoan Student Union
- Pacific Islander/Samoan community members served by SPDC
- Outreach to people they already know as being members of this community

People living with physical disabilities focus group

Kim Handloser, Rogue Community Health

For the People Living with Physical Disabilities focus group, I was primarily assisted by Casey Moore and Hannah Rarick of Oregon Spinal Cord Injury Connection. They personally networked within their community to bring voices to the table. LeAnne Turnbull, Program and Advocacy Coordinator with Rogue Valley Council of Governments (RVCOG) also shared the information with her extensive network. Additionally, recruitment for the focus group was supported through the Deaf and Hard of Hearing Services Coordinator at SOU. Flyers and personal invitations were also emailed to other groups and individuals throughout the recruitment period as the opportunity presented itself.

Rural Low-income Focus Group

Anna Wiley, Communications and Outreach Manager Illinois Valley Community Development Organization:

I have been leveraging personal connections, the connections that we have with other local organizations, and the power of networking.

- First, I created a very short survey form to capture the information of people who might be interested (Name, Email, Phone, and a brief reason why they wanted to participate). The "reason why" screening question was included to get a feel for their level of interest in participating and ensuring I have a diverse group of voices from our community.
- A well-connected and highly engaged Board Member of IVCDO sent me over an initial list of possible focus group participants that I emailed the survey to. I also posted the survey in a couple select, hyper-local Facebook groups. I had a great turnout from the list as well as the survey. I only had a couple responses from folks that might not be a good fit for the focus group, based on their response to the screening question.
- Then, I reached out individually to folks interested to provide more information about the focus groups and expectations for participation. Majority of folks who seemed interested have confirmed their attendance.
- Once confirmed, I asked them to help recruit people from their personal networks by either forwarding the survey link or tagging on Facebook. This has also been productive!

Unhoused focus group:

- Heather Voss
- Oregon Health & Science University
- We recruited participants who the Street Nursing Team Serves, The program is grant funded and under the umbrella of OHSU SoN
- I worked with Kelly Shelter in Medford and the Street Nursing Team to recruit participants.

Appendix B – Focus Group and Interview Questions

Focus Group Guide	
Major topic	Example Questions/Prompts
Introductions	<p>Go around the table and state name</p> <p>1. What makes you most proud of your community/what do you like about your community?</p> <p><i>For this group, we invited people who [focus group characteristic]. Today we'd like to talk about some of your experiences as someone who is part of that group.</i></p>
General Health Questions	<p>2. When you think about the healthy people in your community, what does that look like? Who is healthy and why?</p> <p><i>[Prompts: What makes some people healthier than others? Are there any other factors that help people be healthy?]</i></p> <p><i>When we discuss health, we mean more than just physical health - we also want to include things like mental, social, and emotional health, and overall quality of life.</i></p>
Challenges and Stressors	<p>3. What are the biggest problems that you struggle with in day-to-day life?</p> <p>3a. How about your family/household?</p> <p><i>[Prompt: How is that connected to health concerns?]</i></p> <p>4. What health-related issues do you face? What about your family/household?</p> <p>5. What health-related issues do you think are most important to address in your community?</p>
Health Resources and Help-Seeking	<p>6. When you need help with [health issue], what do you usually do?</p> <p>7. What kinds of resources have you found to be most helpful and why?</p> <p>7a. What kinds of resources do you need but can't get?</p> <p>8. What do you think your community does well in helping people to get or stay healthy?</p>
Group-specific questions	<p><i>Room for 1-2 questions tailored to each group, e.g.,</i></p> <p><i>9. What do you think are the unique health challenges for [Deaf & hard of hearing/LGBTQIA+/Latino/a/x/adult caregivers/etc.]?</i></p>
Conclusion	<p><i>Brief summary and review of main points of discussion; give participants opportunity to clarify any points.</i></p> <p>10. Is there anything else related to health that I didn't ask about or that we haven't yet discussed today that you think we should know?</p>

Focus Group Guide	
Major topic	Example Questions/Prompts
Introductions	<p><i>Nombres</i></p> <p>1. ¿Qué es lo que más le gusta de su comunidad? ¿Qué le hace sentir orgulloso?</p> <p><i>Prompt:</i> Para este grupo, invitamos a personas que hablan español como idioma principal. Hoy nos gustaría hablar sobre algunas de sus experiencias como hispanohablantes en Jackson/Josephine County.</p>
General Health Questions	<p>2. Cuando piensa en la salud y bienestar, ¿qué significa eso para Ud.? ¿Quién está, o puede ser, sano y por qué?</p> <p>[Prompts: ¿Qué hace que algunas personas sean más saludables que otras? ¿Existen otros factores que ayuden a las personas a estar sanas?]</p> <p><i>Prompt:</i> Cuando hablamos de salud, hablamos de cosas más que a la salud física; también queremos incluir cosas como la salud mental, social y emocional, y la calidad de vida en general.</p>
Challenges and Stressors	<p>3. ¿Cuáles son sus problemas mayores en la vida diaria?</p> <p>3a. Y para sus familiares o las personas en su hogar?</p> <p>[Prompt: ¿Cómo se relaciona eso con los problemas de salud?]</p> <p>4. ¿Qué problemas tiene relacionados con la salud? ¿Qué problemas relacionados con la salud hay en su familia u hogar?</p> <p>5. ¿Qué temas relacionados con la salud cree que son los más importantes en su comunidad?</p>
Health Resources and Help-Seeking	<p>6. Cuando necesita ayuda con [problema de salud], ¿qué suele hacer?</p> <p>7. ¿Qué tipos de recursos o asistencia han encontrado más útiles y por qué?</p> <p>7a. ¿Qué tipo de asistencia necesitan pero no puede obtener?</p> <p>8. ¿Qué cree que hace bien su comunidad para ayudar a las personas a estar o mantenerse saludables?</p>
Group-specific questions	<p>9. ¿Cuáles creen que son los problemas únicos para los hispanohablantes? ¿Hay problemas únicos para los latinos incluso si hablan bien el inglés?</p>
Conclusion	<p><i>Brief summary and review of main points of discussion; give participants opportunity to clarify any points.</i></p> <p>10. ¿Hay algo más relacionado con la salud que no yo haya preguntado o que aún no hayamos hablado hoy, que crea que deberíamos saber?</p>

Interview Questions

Introduction

- Hello, I'm _____ and I'm part of a research team from Southern Oregon University. We are conducting interviews for the Jackson and Josephine Counties Community Health Assessment with people who are knowledgeable about specific populations in our area. Every five years, the county public health departments and coordinated care organizations have to do an assessment to identify the health needs and gaps in the community and then create a plan to address them. The information from these interviews will be used to create the health priorities for our community.
- As part of the assessment, we are interviewing community leaders and community representatives as a way of understanding and identifying the priority health needs of Jackson and Josephine counties.
- (If Zoom) – we will delete the video part of this recording and use the audio for transcription.

- | |
|---|
| <ul style="list-style-type: none">● Community representative: You've been selected for an interview because we believe you can speak to the experiences of _____ in Jackson Co/Josephine Co |
|---|

OR

- | |
|--|
| <ul style="list-style-type: none">● Organizational representative: You are being asked to share what you have observed about the clients your organization serves. |
|--|

- We anticipate that the interview will take about 45 minutes.
- You received a document called the Interview Informed Consent, which explains that this is a confidential interview and your name will not be linked to your responses or comments. We are asking a fixed set of questions and we will be recording your responses. By agreeing to go forward with this interview, you are indicating that you have read the Interview Informed Consent document and agree to participate.
[wait for verbal assent before continuing]
- We appreciate very much the time you are taking to participate in the interview.

General concerns:

1. Based on your experience, what are the top three issues that you are most concerned about [in your community] [among clients you serve]?

2. What would you say are the top three issues specific to health or healthcare that you are most concerned about [in your community] [among clients you serve]?
(Prompt – delve into lots of specifics on this answer. Rephrase and refer to question 1 if there were healthcare issues mentioned there.)

Healthcare:

3. From your perspective, what are the most significant barriers that keep [people in your community] [the clients you serve] from accessing health care when they need it?
(Prompt – modify the approach to get into greater depth)
- 4a. [Only community representatives] Are there specific groups within your community that are not being adequately served by local health services? If yes, which groups are underserved?
- 4b. [Only organizational representatives] Are there specific populations among your clients who are not being adequately served by local health services? If yes, which groups are underserved?

Health and lifestyle:

5. [Only community representatives] What do you think are your community's strongest assets?
6. [Only community representative] What is working well for members of your community in terms of their health and quality of life?
- 7a. [Only organizational representatives] What is working well inside your organization for clients in terms of their health and quality of life?
- 7b. [Only organizational representatives] What is working well outside your organization for clients in terms of their health and quality of life?
8. What challenges do the [people in your community] [clients you serve] face in trying to maintain a healthy lifestyle?
(Prompt – which resources or services that are missing or difficult to access?)
9. What challenges do the [people in your community] [clients you serve] face in trying to manage chronic health conditions?
(Prompt – which resources or services that are missing or difficult to access?)

10. Have recent wildfires and wildfire smoke affected the health of the [people in your community community] [clients you serve]?
11. Have you seen any other impacts of climate-related issues such as extreme heat or extreme cold [in your community] [among the clients you serve]?
12. Are you seeing ongoing effects of COVID-19 [in your community] [among clients you serve]?
(Prompt – physical, mental, organizational impact)

Ideas or recommendations

13. What recommendations or suggestions do you have to improve health and quality of life [in your community] [among clients you serve]
14. What else do you think is important that we haven't covered today?

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- Thank you for your time. We appreciate your participation and willingness to share your and your community members' concerns the concerns of the clients you serve.
 - The complete Community Health Needs Assessment is anticipated to be released later in 2023 and will be publicly available.