MARION – POLK COMMUNITY THEMES AND STRENGTHS ASSESSMENT (MINI-MAPP) - 2022

September 2022

Our Vision

"A diverse and inclusive community with a physical environment that facilitates optimal physical and social health, infrastructure that supports economic growth and stability, and an integrated health care system that promotes equitable access to whole person care."

Marion County
OREGON
Health & Human Services

Introduction

Beginning in 2014, Marion and Polk County in collaboration with local partners have regularly conducted Community Health Assessments (CHA) to evaluate the health of the community. As a result of a CHA, priorities are selected as areas of focus in a five-year Community Health Improvement Plan (CHIP). The overarching framework guiding these local efforts is referred to as Mobilizing for Action through Planning and Partnerships (MAPP)[1] and is considered the gold standard for community health improvement. In 2018, the community prioritized housing, substance abuse/use, and behavioral health supports. Since priorities change over time, it is necessary to periodically check in and review the relevancy of selected priorities. To achieve this, the CHIP Core Executive Team conducted a community-wide survey in Spring 2022 in alignment with the MAPP framework, albeit in a smaller form, so it was referred to as "Mini-MAPP", however the actual CHA component is known as the Community Themes and Strengths Assessment. This report documents the methods that were used for conducting the survey, results, and ultimately conclusions for moving forward with improving the health of the community. Additional details about the MAPP process can be found at the following link: Assessments (marion.or.us)

Given the COVID-19 pandemic, it was timely to assess the communities' attitudes towards local health and quality of life. In 2020 and 2021, 51,238 community members in Marion and Polk County were infected with the virus that causes COVID-19 and 681 of those died.[2] Additionally, many people became unemployed, businesses were impacted, daycare and schools were closed, and virtually every aspect of day-to-day life was disrupted. Therefore, it was important to evaluate what sort of affect this may have had on the views towards local health. Within the broader context of health in the community, Polk County has consistently ranked towards the top of the County Health Rankings (7th of 35 in 2022), with Marion County following close behind (10th of 35 in 2022).[3] At a higher level, Oregon has also consistently ranked as one of the healthiest states, ranking 12th of 50 in 2022.[4] Based on these evaluations, the community finds itself as one of the healthier counties in one of the healthiest states in the country, however that does not mean there is no room for improvement. Though a community at large may be healthier, that may not necessarily mean that health is equally shared among all who live there. Research continually shows that those who identify as American Indian/Alaska Native, Asian American, Black/African American, Hispanic/Latino, Native Hawaiian, and other Pacific Islander, suffer health disparities, or differences in health accessibility and exposures that put them at greater risk for disease.[5] This is also true for people who have a lower socioeconomic status, live rurally, or are of a sexual orientation and/or gender minority.[5] A specific example is that rural populations can have more difficulty accessing healthcare and may have lower income, higher unemployment, and lower educational achievement compared to urban areas.[6] Difficulty seeing a doctor who can diagnose and treat illnesses can often leave people unseen and untreated, creating a greater likelihood of a poor outcome. Additionally, fewer financial resources can strain household budgets, putting healthcare and healthy activities further down the list of priorities, which is a component of the health and wealth association in this country.[7] Surveying the population in Marion and Polk County can allow for the identification of these potential disparities and to prioritize outreach and interventions in the community to improve overall health equity.

Background and Methods

A survey was developed utilizing validated questions from a previously administered community survey that was distributed in 2018 as part of the CHA, supporting the Community Themes and Strengths Assessment. Questions included respondent demographics, healthcare access, community health priorities, and quality of

life (see Appendix A). Target respondents were anyone who worked, lived, and/or played in Marion and/or Polk County at the time the survey was administered. The survey was available online for just over a month (3/22/22 – 4/25/22) and was primarily electronic, however paper versions were made available for distribution and collection by community partners. Respondents were able to skip questions that they did not want to answer, and a skip-logic was deployed intermittently (respondents were not able to skip the first question assessing survey language preference). The survey was available in English, Spanish, Russian, and Marshallese. Non-English translations were performed by contract and/or volunteers who validated their language proficiency. Additional demographic questions were added this year to assess race, ethnicity, language, sexual orientation, and gender following the Oregon Health Authority REALD-D and SOGI format. The survey was distributed via email invitation with a link to SurveyMonkey™ by various community partners. Upon survey close, data was exported from SurveyMonkey™, reconciled, and analyzed by a Marion County Health & Human Services epidemiologist. Statistical analysis was performed with STATA™ software and tests were deemed statistically significant if they met or exceeded the pre-determined alpha level of 0.05. Results were reported out to the CHIP Core Executive Team and CHIP Steering Committee in May 2022.

Results

In total, 1,181 people took the survey, which was an increase of 90.2% compared to 2018 (621 responses). Most respondents (72.8%) finished the survey, and it took on average 9 minutes to complete even though it was marketed as 15 minutes based on internal testing.

Table 1. Survey Respondent Demographics (2022), American Community Survey 5-year Estimates (2020)

	# Responses (% of Sample)	County Estimate (Marion %, Polk %)
Survey language		
English	1,127 (95.4)	*
Marshallese	1-5 (**)	*
Russian	1-5 (**)	*
Spanish	51 (4.3)	*
Language(s) used at home		
Only English	767 (84.5)	(74.8 , 87.8)
Spanish	108 (11.9)	(20.4 , 9.1)
Asian/Pacific Islander	9 (1.0)	(2.2 , 1.6)
Russian	8 (0.9)	(1.4 , 0.4)
Indo-European[a]	9 (1.0)	(0.9 , 0.8)
Other	7 (0.8)	(0.3 , 0.3)
Educational achievement		
Less than HS grad/GED	22 (2.4)	(13.2 , 8.5)
HS grad/GED or higher	887 (97.5)	(86.7 , 91.5)
Bachelor's or higher	577 (63.4)	(32.1 , 30.5)
Household income per year		
Less than $50,000	221 (24.8)	(40.0 , 37.8)
$50,000 to $74,999	169 (19.0)	(19.9 , 18.3)
$75,000 to $99,999	167 (18.8)	(13.9 , 13.9)
$100,000 or more	333 (37.4)	(26.2 , 29.9)

	# Responses (% of Sample)	County Estimate (Marion %, Polk %)
Housing		
Unstably housed/houseless	1-5 (**)	(0.3 , 0.1)†
Average household size (people per household)	2.9	(2.9 , 2.8)
Insurance status		
Insured	893 (98.1)	(95.3 , 95.6)
Uninsured	14 (1.5)	(4.7 , 4.4)
Don't know	1-5 (**)	*
Type of insurance		
Group[b]	619 (69.3)	(44.9 , 49.5)‡
Individual	25 (2.8)	(3.4 , 4.6)‡
OHP (Medicaid)	53 (5.9)	(31.8 , 26.4)‡
Medicare	55 (6.2)	(13.8 , 13.4)‡
Other	11 (1.2)	*
Multiple	130 (14.6)	*
Race		
African American/Black	1-5 (**)	(1.1 , 0.7)
American Indian/Alaska Native	9 (1.2)	(0.9 , 1.8)
Asian	13 (1.8)	(2.2 , 1.5)
Native Hawaiian/Pacific Islander	1-5 (**)	(1.0 , 0.4)
Other or Multiracial	150 (20.5)	(16.4 , 9.1)
White	556 (76.0)	(78.3 , 86.5)
Ethnicity		
Hispanic or Latinx	103 (13.4)	(26.9 , 14.3)
Non-Hispanic or Latinx	667 (86.6)	(73.1 , 85.7)
Age		
Less than 18	0 (0.0)	(24.1)
18-25	47 (5.5)	(9.7)
26-39	234 (27.2)	(20.3)
40-54	291 (33.8)	(17.6)
55-64	167 (19.4)	(11.9)
65-80	113 (13.1)	(12.6)
80+	8 (0.9)	(3.7)
Gender(s)		
Woman or girl	620 (71.0)	*
Feminine leaning	25 (2.9)	*
Man or boy	162 (18.6)	*
Masculine leaning	12 (1.4)	*
Agender or no gender	1-5 (**)	*
Non-binary	13 (1.5)	*
Questioning	1-5 (**)	*
Don't know	1-5 (**)	*
Don't know what question is asking	15 (1.7)	*
Don't want to answer	63 (7.2)	*
Transgender		
Yes	6 (0.7)	(0.7)[1]
No	825 (98.4)	*
Other	7 (0.8)	*

	# Responses (% of Sample)	County Est. (Marion %, Polk %)
Sexual Orientation(s)		
Same-gender loving	12 (1.4)	*
Lesbian	17 (2.0)	*
Gay	11 (1.3)	*
Bisexual	52 (6.1)	*
Straight(attracted to other gender(s))	602 (70.6)	*
Pansexual	17 (2.0)	*
Asexual	7 (0.8)	*
Queer	23 (2.7)	*
Questioning	1-5 (**)	*
Don't know	8 (0.9)	*
Don't know what question is asking	26 (3.0)	*
Don't want to answer	131 (15.4)	*

* - Data not available

** - Data suppressed due to small counts, counts less than 6, not including zero, are suppressed to maintain confidentiality

[a] – French, German, Italian, etc. (does not include Russian)

[b] – Private coverage through employer or family member's employer, tribal, VA/TRICARE

† - Oregon Housing and Community Services, 2019

‡ - Oregon Health Insurance Survey, 2017 (insurance type) and 2019 (insurance status)

[1] - Oregon State Health Assessment (2018), State Estimate

Most survey respondents took the survey in English (95.4%), followed by Spanish (4.3%)(Table 1). Similarly, most respondents indicated that they only speak English in their household (84.5%), followed by Spanish (11.9%). Compared to county estimates, respondents from households speaking only English were overrepresented, while Spanish and Asian/Pacific Islander language households were underrepresented.[8] Most respondents had at least a high school diploma or GED (97.5%), which was higher than expected estimates and this was also true for those with a bachelor's degree or higher. Relatedly, respondents also had higher household incomes compared to county estimates. A small proportion of respondents were houseless or unstably housed at the time they took the survey, which was similar to expected estimates. Average household size also approximated known estimates. The vast majority of respondents had health insurance (98.1%) and this was slightly higher than expected. Most respondents indicated that they had group insurance (69.3%) and this was much higher than estimates, while respondents on Medicaid (Oregon Health Plan (OHP)) or Medicare was much lower than expected. Most survey respondents identified as White (76.0%), however compared to county estimates there was a smaller proportion who identified as African American/Black or Native Hawaiian/Pacific Islander. Respondents who identified as Other or Multiracial (20.5%) was higher than local estimates. Additionally, most respondents identified as Non-Hispanic or Non-Latinx (86.6%) and this was substantially higher than expected. Considering age, respondents under age 18 and over 80 were underrepresented on the survey, with most respondents falling into middle aged adulthood. Most respondents identified as woman or girl regarding gender(s) (71.0%), followed by man or boy (18.6%), and then other gender(s). Respondents who identified as transgender (0.7%) was very similar to statewide estimates from other sources. When asked about sexual orientation(s), most respondents identified as straight (attracted to other gender(s)) (70.6%).

Table 2. Survey Respondent Geography (2022), American Community Survey 5-year Estimates (2020)

	# Responses (% of Sample)	County Est. (Marion %, Polk %)
County of Residence		
Marion	617 (68.9)	(80.2)
Polk	247 (27.6)	(19.8)
Out of area	32 (3.6)	N/A
	# Responses (% of Sample)	**Response Rate per 100,000 population**
Zip code of Residence		
97002 (Aurora)	1-5 (**)	**
97020 (Donald)	0 (0.0)	0.0
97026 (Gervais)	8 (0.9)	*203.8*
97032 (Hubbard)	7 (0.8)	*134.4*
97071 (Woodburn)	16 (1.8)	51.6
97137 (St Paul)	1-5 (**)	**
97301 (Central Salem)	121 (13.5)	211.6
97302 (South Salem)	112 (12.5)	279.2
97303 (Keizer)	80 (8.9)	192.3
97305 (NE Salem, Brooks)	62 (6.9)	139.2
97306 (South Salem, Sunnyside)	67 (7.5)	204.6
97317 (SE Salem)	35 (3.9)	132.5
97325 (Aumsville)	16 (1.8)	234.0
97342 97346 (Detroit & Gates)	1-5 (**)	**
97352 (Jefferson)	1-5 (**)	**
97358 & 97384 (Lyons & Mehama)	8 (0.9)	*298.8*
97362 (Sublimity)	7 (0.8)	*162.0*
97375 (Scotts Mills)	1-5 (**)	**
97381 (Silverton)	25 (2.8)	152.3
97383 (Stayton)	17 (1.9)	166.9
97385 (Sublimity)	11 (1.2)	*327.9*
97392 (Turner)	13 (1.5)	228.3
97304 (West Salem)	84 (9.4)	259.0
97338 & 97371 (Dallas & Rickreall)	94 (10.5)	408.0
97344 (Falls City)	1-5 (**)	**
97347 (Grand Ronde)	0 (0.0)	0.0
97351 (Independence)	27 (3.0)	233.7
97361 (Monmouth)	39 (4.4)	311.3
N/A (Out of Area)	32 (3.6)	N/A
Marion County	617 (68.9)	179.5
Polk County	247 (27.6)	291.5
Urban[a]	607 (70.3)	N/A
Rural[b]	257 (29.7)	N/A

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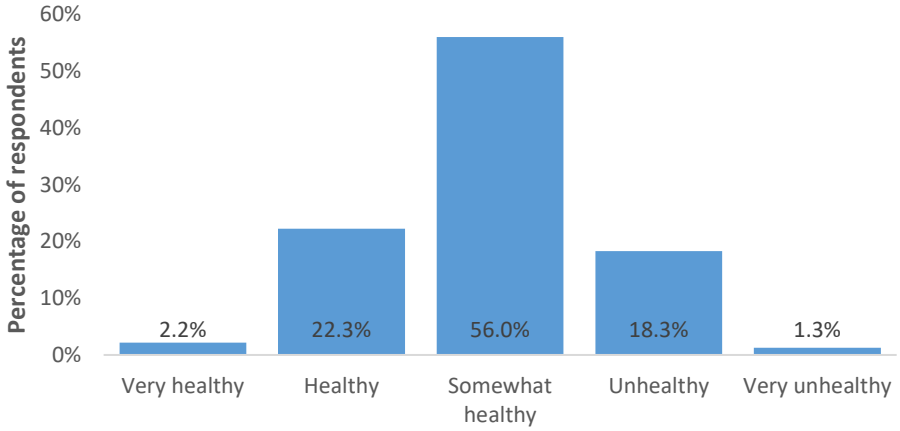
Italicized percentages or rates may be unreliable and should be interpreted with caution
N/A – Not available
[a] – Any geographic area in Oregon less than ten miles from the centroid of a population center of 40,000 people or more, Oregon Office of Rural Health (2020)
[b] - Any geographic area in Oregon ten or more miles from the centroid of a population center of 40,000 people or more, Oregon Office of Rural Health (2020)

Regarding geography, most respondents resided in Marion County (68.9%) followed by Polk County (27.6%), with a small proportion residing out of the area (3.6%)(Table 2). Marion represented a smaller proportion of the sample than expected and accordingly had a smaller response rate than Polk County (179.5 per 100,000 Vs. 291.5 per 100,000). Response rates were highest in Dallas/Rickreall, Monmouth, South Salem, and West Salem, while the lowest response rates were in Donald, Grand Ronde, and Woodburn.

Figure 1. How respondents perceive the overall health of people in their community, 2022



Respondents were asked to evaluate the overall health of people in their community with most indicating that their community is healthy to some degree (80.5%, 95% CI 78.1 – 82.8), however this was slightly lower than the 2018 result (83.0%, 95% CI 79.6 – 85.7), but the difference was not statistically significant (p = 0.27) (Figure 1).

Table 3. Survey Respondents who Perceive their Community to be Unhealthy by Demographics (2022)

	# (%) Unhealthy	95% CI for % Unhealthy	p value
Language(s) used at home			
Only English	144 (18.8)	16.0 – 21.5	Reference
Spanish	24 (22.2)	14.4 – 30.1	0.39
Asian/Pacific Islander	1-5 (**)	**	**
Russian	1-5 (**)	**	**
Indo-European[a]	1-5 (**)	**	**
Other	1-5 (**)	**	**
Household income per year			
Less than $50,000	33 (14.9)	10.2 – 19.6	0.03
$50,000 to $74,999	44 (26.0)	20.6 – 34.4	0.20
$75,000 to $99,999	25 (15.0)	9.6 – 20.4	0.06
$100,000 or more	74 (22.2)	17.8 – 26.7	Reference
Race			
Race other than White[b]	39 (22.2)	16.0 – 28.3	0.29
White	103 (18.5)	15.3 – 21.8	Reference
Ethnicity			
Hispanic or Latinx	23 (22.3)	14.3 – 30.4	0.48
Non-Hispanic or Latinx	129 (19.3)	16.3 – 22.3	Reference

	# (%) Unhealthy	95% CI for % Unhealthy	p value
Age			
Less than 18	0 (0.0)	N/A	N/A
18-25	*6 (12.8)*	*3.2 – 22.3*	*0.03*
26-39	66 (28.2)	22.4 – 34.0	*Reference*
40-54	55 (18.9)	14.4 – 23.4	0.01
55-64	33 (19.8)	13.7 – 25.8	0.053
65-80	*10 (8.8)*	*3.6 – 14.1*	*0.00*
80+	0 (**)	**	**
Gender(s)			
Woman or girl	127 (20.5)	17.3 – 23.7	Reference
Feminine leaning	1-5 (**)	**	**
Man or boy	28 (17.3)	11.5 – 23.1	0.36
Masculine leaning	1-5 (**)	**	**
Agender or no gender	1-5 (**)	**	**
Non-binary	1-5 (**)	**	**
Questioning	1-5 (**)	**	**
Don't know	1-5 (**)	**	**
Don't know what question is asking	1-5 (**)	**	**
Don't want to answer	15 (23.8)	13.3 – 34.3	0.54
Sexual Orientation(s)			
Same-gender loving	1-5 (**)	**	**
Lesbian	1-5 (**)	**	**
Gay	1-5 (**)	**	**
Bisexual	17 (32.7)	19.9 – 45.4	0.02
Straight(attracted to other gender(s))	113 (18.8)	15.7 – 21.9	Reference
Pansexual	1-5 (**)	**	**
Asexual	1-5 (**)	**	**
Queer	*6 (26.1)*	*8.1 – 44.0*	*0.38*
Questioning	1-5 (**)	**	**
Don't know	1-5 (**)	**	**
Don't know what question is asking	1-5 (**)	**	**
Don't want to answer	25 (19.1)	12.4 – 25.8	0.93

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Italicized percentages, rates, and p-values may be unreliable and should be interpreted with caution
Reference – the group to which another group is being compared
N/A – Not available
CI – Confidence interval
[a] – French, German, Italian, etc. (does not include Russian)
[b] - African American/Black, American Indian/Alaska Native, Asian, Native Hawaiian/Pacific Islander, Other or Multiracial

Respondents who indicated that their community was unhealthy were evaluated for potential differences by demographics. A slightly higher percentage of Spanish speaking households reported that their community was unhealthy compared to households who spoke only English (22.2%, 95% CI 14.4 – 30.1 Vs. 18.8%, 95% CI 16.0 – 21.5), however this difference was not statistically significant (p = 0.39)(Table 3). Households who reported income of $100,000 or more reported that their community was unhealthy at a higher percentage than those making less than $50,000 (22.2%, 95% CI 17.8 – 26.7 Vs. 14.9%, 95% CI 10.2 – 19.6) and this difference was statistically significant (p=0.03). A slightly higher percentage of respondents who identified as a race other than White reported that their community was unhealthy compared to respondents who identified as White (22.2%, 95% CI 16.0 – 28.3 Vs. 18.5%, 95% CI 15.3 – 21.8), however this difference was not statistically significant (p = 0.29). Respondents who identified as Hispanic or Latinx had a slightly higher percentage indicating that their community was unhealthy compared to Non-Hispanic or Latinx (22.3%, 95% CI

14.3 – 30.4 Vs. 19.3%, 95% CI 16.3 – 22.3) and this difference was not statistically significant (p=0.48). Respondents who rated their community as unhealthy varied widely with age, with those in the lowest and highest age groups reporting the lowest levels of unhealthy communities. Those between the ages of 26 to 39 had the highest percentage of unhealthy ratings for their communities (28.2%, 95% CI 22.4 – 34.0) and this difference was statistically significant when compared with those between the ages of 40 and 54 (18.9%, 95% CI 14.4 – 23.4)(p=0.01). Respondents who identified as a man or boy had the lowest percentage of unhealthy ratings for their community (17.3%, 95% CI 11.5 – 23.1), however this was not significantly lower than those who identified as a woman or girl (20.5%, 95% 17.3 – 23.7)(p=0.36). Respondents who reported their sexual orientation as bisexual had the highest percentage reporting that their community was unhealthy (32.7%, 95% CI 19.9 – 45.4) when compared with those whose sexual orientation was straight (attracted to other genders)) (18.8%, 95% CI 15.7 – 21.9) and this difference was statistically significant (p=0.02).

Table 4. Survey Respondents who Perceive their Community to be Unhealthy by Geography (2022)

	# (%) Unhealthy	95% CI for % Unhealthy	p value
County of Residence			
Marion	134 (21.7)	18.5 – 25.0	Reference
Polk	35 (14.2)	9.8 – 18.5	0.01
Out of area	1-5 (**)	**	**
Zip code of Residence			
Urban[a]	135 (22.2)	18.9 – 25.5	Reference
Rural[b]	34 (13.2)	9.1 – 17.4	0.002

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Reference – the group to which another group is being compared
[a] – Any geographic area in Oregon less than ten miles from the centroid of a population center of 40,000 people or more, Oregon Office of Rural Health (2020)
[b] - Any geographic area in Oregon ten or more miles from the centroid of a population center of 40,000 people or more, Oregon Office of Rural Health (2020)

Residents of Marion County had a higher percentage reporting that their community was unhealthy (21.7%, 95% CI 18.5 – 25.0) compared to Polk County (14.2%, 95% CI 9.8-18.5)(Table 4). The difference in the percentage reporting that their community was unhealthy was significantly greater in Marion than Polk (p=0.01). A higher percentage of respondents living in zip codes designated as urban rated their community as unhealthy compared to those living in rural zip codes and this difference was statistically significant (22.2%, 95% CI 18.9 – 25.5 Vs. 13.2%, 95% CI 9.1 – 17.4)(p=0.002).

Table 5. Survey Respondent Satisfaction with Quality of Life in Marion and Polk County (2022)

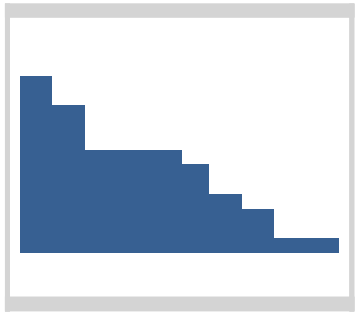
	Disagree # (%)	95 % CI for % Disagree
Question		
Affordable housing availability…	810 (78.7)	76.2 – 81.2
Good place to grow old…	333 (32.4)	29.6 – 35.3
Satisfied with quality of life…	294 (28.6)	25.9 – 31.4
Community support…	272 (26.4)	23.7 – 29.1
Good place to raise children…	238 (23.2)	20.7 – 25.8
Safe place to live…	234 (22.8)	20.2 – 25.4

CI – Confidence interval

Respondents were asked to evaluate the quality of life in the community. Most respondents were satisfied with the quality of life in the community, as a smaller portion (28.6%, 95% CI 25.9 – 31.4) indicated that they were dissatisfied (Table 5). Respondents were overwhelmingly dissatisfied with the availability of local affordable housing, with 78.7% (95% CI 76.2 – 81.2) indicating dissatisfaction and this was the highest level of dissatisfaction for any of the quality-of-life areas assessed. The next highest area of dissatisfaction was the community is a good place to grow older as 32.4% (95% CI 29.6 – 35.3) disagreed with this statement. Most respondents agreed that the community supported each other, was a good place to raise children, and was a safe place to live.

Table 6. Survey Respondent Neighborhood Health Assessment in Marion and Polk County (2022)

	Worse # (%)	95 % CI for % Disagree
Local Neighborhood Versus Other Areas		
Quality of available housing…	387 (40.7)	37.6 – 43.8
Public transportation…	335 (35.3)	32.3 – 38.3
Amount of crime…	259 (27.2)	24.4 – 30.1
Quality of public schools…	241 (25.4)	22.0 – 27.5
Quality of doctors/health services…	235 (24.7)	21.5 – 26.9
Local job opportunities…	210 (22.1)	19.5 – 24.8
Parks, green spaces, recreation…	162 (17.0)	14.6 – 19.4
Grocery store availability…	142 (14.9)	12.7 – 17.2
Air quality…	59 (6.2)	4.7 – 7.7
Drinking water…	58 (6.1)	4.6 – 7.6



CI – Confidence interval

When asked to evaluate how their neighborhood compared to other neighborhoods, a higher percentage of respondents identified the quality of available housing as being worse (40.7%, 95% CI 37.6 – 43.8) compared to other factors (Table 6). The second highest area of need was availability of public transportation, as 35.3% (95% CI 32.3 – 38.3) of respondents described this as being worse than other neighborhoods. The third highest area of need was the amount of crime in respondents' neighborhoods, with 27.2% (95% CI 24.4 – 30.1) describing their neighborhood as worse than other neighborhoods. The three factors that had the lowest need based on the areas assessed were grocery store availability, air quality, and drinking water quality.

Table 7. Survey Respondent Healthcare Access Assessment in Marion and Polk County (2022)

	# (%)	95% CI for %
Needed care in last 12 months		
Yes	764 (81.4)	79.0 – 83.9
No	174 (18.6)	16.1 – 21.0
Care needs met		
I/they got all the care they needed	470 (61.5)	58.1 – 65.0
I/they got some needed care	273 (35.7)	32.3 – 39.1
I/they got no care at all	21 (2.7)	1.6 – 3.9
Why they went without care (multiple responses)		
Couldn't get timely appointments	179 (64.6)	59.0 – 70.3
Cost	115 (41.5)	35.7 – 47.3
Offices not open when I/they can go	84 (30.3)	24.9 – 35.7
No regular provider	78 (28.2)	22.9 – 33.5
Can't take time off work	74 (26.7)	21.5 – 31.9
Other	68 (24.5)	19.5 – 29.6
Need a provider that understands their culture, lifestyle, identity, or language	35 (12.6)	8.7 – 16.5
Do not know where to go	28 (10.1)	6.6 – 13.7
Needed childcare	15 (5.4)	2.7 – 8.1
Needed transportation	14 (5.1)	2.5 – 7.6
Appointments with specialists[a] when needed		
Always	140 (15.2)	12.9 – 17.5
Usually	220 (23.9)	21.1 – 26.6
Sometimes	196 (21.3)	18.6 – 23.9
Rarely	115 (12.5)	10.3 – 14.6
Never	71 (7.7)	6.0 – 9.4
I/they didn't need an appointment	180 (19.5)	17.0 – 22.1
Why they went without a specialist appointment		
Could not get a convenient appointment	173 (44.8)	39.9 – 49.8
Not enough specialists to choose from	115 (29.8)	25.2 – 34.3
Health plan approval delayed	114 (29.5)	25.0 – 34.1
Desired specialist not in network	84 (21.8)	17.6 – 25.9
Specialists were too far away	81 (21.0)	16.9 – 25.0
No list of specialists in plan or network	54 (14.0)	10.5 – 17.5
Couldn't get timely appointments	41 (10.6)	7.5 – 13.7
Other	41 (10.6)	7.5 – 13.7

CI – Confidence interval

[a] - Surgeons, heart doctors, allergy doctors, skin doctors, and other doctors who specialize in one area of health care

When asked to assess healthcare access, most respondents indicated that they or a family member needed care in the last 12 months (81.4%, 95% 79.0 – 83.9)(Table 7). However, 61.5% (95% CI 58.1 – 65.0) indicated that they got all the care that they needed, while 35.7% (95% 32.3 – 39.1) got some needed care and 2.7% (1.6 -3.9) did not get any care at all. Respondents who did not get all the care they needed identified lack of timely appointments as the primary reason (64.6%, 95% CI 59.0 – 70.3), followed by cost (41.5%, 95% CI 35.7 – 47.3). Respondents indicated a need for access to specialists, as 19.5% (95% 17.0 – 22.1) did not personally need or, a family member did not need, an appointment with a specialist in the last six months. About 39.1% of

respondents were always or usually able to get an appointment with a specialist, while 20.2% were rarely or never able to get an appointment when needed. When asked specifically why they went without an appointment with a specialist, the primary reason was that they could not get a convenient appointment (44.8%, 95% CI 39.9 – 49.8), followed by not having enough specialists to choose from (29.8%, 95% CI 25.2 – 34.3) and/or approval from their health plan was not authorized or delayed (29.5% 95% CI 25.0 – 34.1).

Table 8. Health Issue Voting and Ranking in Marion and Polk County (2022)

	# (% of Votes)	Rank
Health Issue		
Mental health problems	526 (18.0)	1
Homelessness	487 (16.6)	2
Housing needs, unsafe housing	462 (15.8)	3
Alcohol/drug abuse	437 (14.9)	4
Obesity	192 (6.6)	5
Aging problems	109 (3.7)	6
Discrimination/Racism	101 (3.4)	7
Diabetes	89 (3.0)	8
Child abuse/neglect	59 (2.0)	9
Cancers	55 (1.9)	10
Other	54 (1.8)	11
Heart disease and stroke	49 (1.7)	12
Domestic violence	41 (1.4)	13
Suicide	40 (1.4)	14
Bullying	38 (1.3)	15
Motor vehicle crash injuries	36 (1.2)	16
Infectious diseases (e.g., COVID-19, hepatitis, TB)	33 (1.1)	17
High blood pressure	32 (1.1)	18
Firearm-related injuries	24 (0.8)	19
Dental problems	23 (0.8)	20
Teenage pregnancy	13 (0.4)	21
Rape/sexual assault	10 (0.3)	22
Respiratory/lung disease	8 (0.1)	23
Murder	4 (0.1)	24
HIV/AIDS	3 (0.1)	25
Infant death	2 (0.1)	26 (tie)
Sexually transmitted diseases	2 (0.1)	26 (tie)
Total votes	2,929 (100.0)	N/A

Respondents were asked to vote for their top three health issues affecting the community and the results are provided above (Table 8). The top five issues by the overall votes were: mental health problems (526, 18.0%), homelessness (487, 16.6%), housing needs/unsafe housing (462, 15.8%), alcohol/drug abuse (437, 14.9%), and obesity (192, 6.6%).

Table 9. Health Behavior Voting and Ranking in Marion and Polk County (2022)

	# (% of Votes)	Rank
Behavior		
Drug abuse	496 (18.0)	1
Alcohol abuse	329 (11.9)	2
Poor eating habits	302 (11.0)	3
Drinking and/or using drugs while driving	221 (8.0)	4 (tie)
Lack of exercise	221 (8.0)	4 (tie)
Discrimination	206 (7.5)	5
Not getting shots (vaccines)	184 (6.7)	6
Racism	180 (6.5)	7
Texting/cell phone while driving	152 (5.5)	8
Dropping out of school	132 (4.8)	9
Tobacco use/or electronic cigarette use	81 2.9)	10
Overeating	73 (2.6)	11
Other	52 (1.9)	12
Not using birth control	48 (1.7)	13
Unsafe sex	22 (0.8)	14
Crime	17 (0.6)	15
Access to care	16 (0.6)	16
Homelessness	12 (0.4)	17
Not using seat belts and/or child safety seats	11 (0.4)	18
Total votes	2,755 (100.0)	N/A

Respondents were also asked to vote for their three top health behaviors affecting the health of the community and the results are above (Table 9). The top five behaviors affecting the health of the community were: drug abuse (496, 18.0%), alcohol abuse (329, 11.9%), poor eating habits (302, 11.0%), drinking and/or using drugs while driving (221, 8.0%), and lack of exercise (221, 8.0%).

Table 10. Health Issue Volunteerism in Marion and Polk County (2022)		
	# (%)	**Rank**
Health Issue		
Mental health problems	158 (23.7)	1
Homelessness	122 (18.3)	2
Housing needs, unsafe housing, unaffordable housing	96 (14.4)	3
Alcohol/drug abuse	42 (6.3)	4
Obesity	38 (5.7)	5
Aging problems (arthritis, hearing/vision loss)	34 (5.1)	6
Any issue	31 (4.7)	7
Discrimination/Racism	27 (4.1)	8
Child abuse/neglect	22 (3.3)	9
Diabetes	17 (2.6)	10
Other	112 (16.8)	N/A
Total unique respondents	666	N/A

In addition to selecting their top three health issues, respondents were also asked if they would be willing to personally volunteer to improve an issue (Table 10). Overall, 56.4% of respondents personally volunteered to improve health issues. The top five health issue volunteered for were: mental health problems (158, 23.7%), homelessness (122, 18.3%), housing needs (96, 14.4%), alcohol/drug abuse (42, 6.3%), and obesity (38, 5.7%).

Discussion

Community respondents by and large felt that people in their community were healthy, which was similar to what has been found in previous surveys. Although a slightly lower percentage of respondents viewed their community as healthy compared to 2018, this result was not found to be statistically significant. Potential explanations for this finding may be the COVID-19 pandemic as it is hard to imagine respondents feeling that their community was healthier now compared to before this event, but the difference was small and surprising in the greater context. This may hint at community resilience or a feeling that the pandemic or other current world events are not as impactful as perhaps thought with regards to opinions of local health. When asked to vote on their top three health issues in the community, infectious diseases (including COVID-19) ranked 17th out of 27, further suggesting that the community did not view this to be as high of a priority when compared to other issues.

Looking deeper into perceptions of health in the community, individuals who identified with certain groups rated the health of members of their community as being worse compared to other groups. This was specifically observed in populations from Spanish speaking households, races other than White, Hispanic or Latinx, younger age groups (26-39), women or girls, and people who reported their sexual orientation as bisexual. Although these differences were not all statistically significant, they are nonetheless compelling. Given the well-established finding that members of minority populations suffer from health disparities or differences in exposures, health outcomes, and healthcare in the United States that are worse than majority populations, it would be expected that respondents from these groups would also rate the health of their communities as worse. These results provide further evidence of the impact of health disparities on these populations and emphasizes the need to prioritize these groups for outreach and improvement of health care access and quality

of services received. A surprising finding was that members from higher income brackets viewed the health of community members as worse than those from lower income brackets. Given the strong association between wealth (income) and health the opposite would be expected. This finding is challenging to reconcile and may have to do with survey sampling that was predominantly obtained through communication channels with healthcare providers or others who may work to directly improve the health of the community. These individuals may have skewed the results in that they perhaps base their feelings about the health of the community on what they see or experience every day, which may be very different from people who do not work in this field. Another possibility is that given the low respondent turnout from lower income groups that this difference could not be detected, as those who make closer to the higher income threshold for the lowest income group may have very different experiences from those on the lower end, closer to the federal poverty level. Another unexpected finding was 26–39-year-olds perception that the health of their community was worse than older age groups. As health deteriorates with age, it would be expected that this would be reversed. A potential explanation was the size of the sample from lower age groups, which may have been too small to detect a difference. Another possibility is that younger people may work or be otherwise exposed to people in worse health as they are in the earlier stages of their careers than those who are older or that are either retired or working in professions that do not interact as much with these populations. Additionally, younger adults in this age group are less likely to have health insurance than older age groups, thus creating a barrier to accessing healthcare, which may influence their views of health in the community.[9] Younger adults might also have less disposable income to spend on healthcare or procedures, or they just might not view health as high of a priority compared to older groups. Another important difference is generational, as generations or cohorts have different life experiences, it is possible that this could affect their views on health or what it means to be healthy.

For geography, those living in urban zip codes viewed their community as less healthy compared to rural zip codes and this result was statistically significant. Typically, this result is reversed, in that those living rurally tend to have lower incomes, higher unemployment, lower educational achievement, difficulty accessing providers, and challenges receiving health information that can affect health literacy, all of which can contribute unhealthy behaviors that can lead to poor health outcomes. A possible explanation is that those living in urban environments may see more issues leading to the perception that their community is not as healthy, such as decaying infrastructure, homelessness, unhealthy behaviors, lack of green spaces, traffic, pollution, and other various elements of urban life. Also, urban or rural designations in this community might be very different from urban designations in large metropolitan areas or rural designations in frontier regions. Another significant finding was that residents of Marion County had a higher percentage of respondents describe their community as unhealthy compared to Polk County residents. As previously mentioned, Polk County consistently rates higher in terms of health rankings in Oregon than Marion County. Marion also has a greater percentage of people from lower socioeconomic groups and demographics that experience health disparities than Polk, possibly contributing to this finding.[10]

The survey results overwhelmingly suggest that respondents in general are satisfied with the quality of life in the community. However, local housing affordability was identified as an area of high dissatisfaction and aligns with the CHIP as a priority area. The quality of housing was also identified as area of need, along with public transportation, and crime.

Concerning local healthcare, most respondents said that they or a family member needed care in the last year, indicating a high utilization of healthcare resources. Many respondents needed care but went without and identified lack of timely appointments and cost as the primary reasons for not accessing care. Specialists were

also in high demand based on the survey results and a sizable portion of respondents were not able to see one when needed. Like general healthcare, lack of convenient appointments, small selection of specialists, and delays or refusal of healthcare plans to cover services were key barriers experienced. These findings along with other community data suggests that there are simply not enough healthcare resources to go around and specifically not enough providers.[10]

Respondents were asked to identify their three top health issues in the community. In close alignment with the results in 2018 and the current CHIP priorities, the top five areas were: mental health problems, homelessness, housing needs/unsafe housing, alcohol/drug abuse, and obesity. Given that these issues continue to manifest as improvement areas suggest that they are persistent and need to be addressed. These results remain unchanged despite a pandemic and other emerging health threats. Based on these results, the CHIP Core Executive Team decided to continue focusing on the three current priority areas: housing, substance abuse/use, and behavioral health supports. Additionally, they decided not to adopt a fourth priority area, obesity prevention, due to capacity limitations and the overwhelming need to address the current issues.

The results of this survey clearly suggest that the community is focused and ready to mobilize around the CHIP priorities. Most respondents indicated that they would be willing to spend their own personal time to work on these issues, indicating a high degree of potential success around new community initiatives and grassroot movements. The results identified groups that continue to suffer from health disparities and if health equity is to be achieved then barriers to care must be eliminated and targeted health promotion efforts must be at the forefront when planning interventions. Healthcare is clearly needed in the community and there are not enough providers of any type to go around, which further illustrates the importance of maximizing current resources and working upstream to prevent health issues from arising that further burden an already overburdened healthcare system.

Given the design and inherent nature of surveys, this study had several limitations that may have affected the results. One of the largest limitations was that the survey sample was not representative of the general population in Marion and Polk County, which was evident from the Census and other estimates. Notably, households speaking Spanish and/or Pacific Islander languages were underrepresented along with people from lower income households and those with lower educational attainment. Regarding healthcare access, which is closely related to health insurance status, those with no insurance or were on Medicaid and/or Medicare were underrepresented. People who identified as Black or African American, Native Hawaiian or Pacific Islander, and/or Hispanic or Latinx were also underrepresented. Regarding age, those in the lowest and highest age groups were underrepresented. People who identified as a girl or woman were overrepresented compared to people who identified as a boy or man. Finally, Marion County was underrepresented compared to Polk County. As many of the underrepresented groups are communities who have long been identified as suffering from inequities, it is reasonable to believe that the results are better than would be expected regarding community health, quality of life, and other factors.

Another key limitation was the use of an online survey as the primary means of data collection. Although paper versions were available, they were not widely distributed and required the respondent to connect with a local partner for data entry. The method of distribution, which was mainly by email invitation, selected in certain groups and likely made it more difficult for others to participate, thus skewing the survey sample. Given the sample demographics and the known distribution chains, it is likely that many respondents worked either directly or indirectly to support the local healthcare system and thus they likely have different views and

experiences around health, access, and quality of life than the general population. The survey was also available for just over a month in the spring, and may have been affected by the time of year, as seasonality can affect results. The nature of surveys is that they capture a moment in time, so it is not possible to know what things would have looked like in this population before or after the survey was administered, which has implications during a pandemic that has broadly affected populations in direct and indirect ways.

Future data collection efforts should strive to not only collect more responses, but responses from populations that are underrepresented. As a survey is likely not the best way to reach these populations, it is advisable that other data collection methods be utilized such as key informant interviews, community listening sessions, or broader participation at places where underrepresented groups gather.

Conclusion

In summary, this study served to identify the key health issues of interest in Marion and Polk County along with measuring various aspects of quality of life and healthcare access locally. The community viewed the current CHIP priorities of housing, substance abuse/use, and behavioral health supports as still relevant and requiring focused improvement going forward. Overall, the community was viewed as healthy by many who live, work, and play here, however this opinion differed when comparing various demographics and geography, highlighting that health was not equally shared by all. Quality of life was considered high in the community, but some sectors, especially housing affordability, indicated a high level of dissatisfaction. Healthcare continues to be in high demand and many community members were not able to get all the care that they needed. Lack of providers, timely/convenient appointments, cost, and healthcare plan coverage continue to be barriers to care. This information, along with other local data, will be used to inform community health initiatives going forward.

Appendix A: Marion and Polk County Community Health Survey 2022

Welcome!

By taking this survey you will help us learn more about the health of Marion and Polk Counties. We want to know what it's like to live in your neighborhood/communities. We also want to learn how easy or hard it is for you to get health care for yourself and your family when you need it. The information in this survey will be used to create a plan to make our communities even healthier. This survey is voluntary and the information that you provide will be kept private and confidential. You may choose to skip questions, or end the survey at any time. The survey should take 15 minutes or less to complete. Thank you and if you have any questions, please contact the survey administrator (Marion County Health & Human Services) at HealthData@co.marion.or.us.

1. How would you rate the health of people in your community?

- Very healthy
- Healthy
- Somewhat healthy
- Unhealthy
- Very unhealthy

Quality of Life

This section will ask questions about your quality of life (health, comfort, and happiness). Think about your well-being and how safe you feel where you live. Also think of if you are able to get places when you want to, and whether there are fun and healthy things to do near you. Please indicate your level of agreement with each of the following statements.

2. I am satisfied with the quality of life (standard of health, comfort, and happiness) in my community

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree

3. My community is a good place to raise children. (Think about access to good public schools and safe places for children to learn, grow, and play.)

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree

4. My community is a good place to grow old. (Consider elder-friendly housing, transportation to medical services, shopping, elder day care, social support for the elderly living alone, meals on wheels, etc.)

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree

5. My community is a safe place to live.

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree

6. My community supports people and families during times of stress and need.

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree

7. There is enough affordable housing available in my community.

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree

Most Important Health Issues

8. In the following list, what do you think are the **3** most important health problems affecting the people in your community? **(Check only 3)**

- ☐ Aging problems (arthritis, hearing/vision loss)
- ☐ Alcohol/drug abuse
- ☐ Bullying
- ☐ Cancers
- ☐ Child abuse/neglect
- ☐ Dental problems
- ☐ Diabetes
- ☐ Discrimination/Racism
- ☐ Domestic violence
- ☐ Firearm-related injuries
- ☐ Heart disease and stroke
- ☐ High blood pressure
- ☐ HIV/AIDS
- ☐ Homelessness
- ☐ Housing needs, unsafe housing, unaffordable housing
- ☐ Murder
- ☐ Infant death
- ☐ Infectious diseases (e.g. COVID-19, hepatitis, tuberculosis)
- ☐ Mental health problems
- ☐ Motor vehicle crash injuries
- ☐ Obesity
- ☐ Rape/sexual assault
- ☐ Respiratory/lung disease
- ☐ Sexually transmitted diseases
- ☐ Suicide
- ☐ Teenage pregnancy
- ☐ Other (tell us) _____

9. Of the problems that you marked, which one would you be most likely to volunteer to improve? _____

10. In the following list, which **3** behaviors have the greatest impact on your community? **(Check only 3)**

- [ ] Alcohol abuse
- [ ] Discrimination
- [ ] Drinking and/or using drugs while driving
- [ ] Dropping out of school
- [ ] Drug abuse
- [ ] Lack of exercise
- [ ] Overeating
- [ ] Poor eating habits
- [ ] Not getting shots (vaccines) to prevent disease
- [ ] Racism
- [ ] Texting/cell phone while driving
- [ ] Tobacco use/or electronic cigarette use
- [ ] Not using birth control
- [ ] Not using seat belts and/or child safety seats
- [ ] Unsafe sex
- [ ] Other (please specify)

Neighborhood Health

For the next questions, please think about whether the neighborhood where you live is better, worse, or about the same as other neighborhoods in the community when it comes to:

11. Availability of grocery stores where you can buy fresh fruits and vegetables

- ○ Better
- ○ About the same
- ○ Worse

12. Air quality (the degree to which air is pollution free)

- ○ Better
- ○ About the same
- ○ Worse

13. Quality of drinking water (Is the water safe to drink, cook with, and bathe in)

- Better
- About the same
- Worse

14. Quality of available housing

- Better
- About the same
- Worse

15. Quality of available doctors and health care services (Are there doctors that provide services that ensure health, comfort, happiness, and cures diseases if possible)

- Better
- About the same
- Worse

16. Quality of public schools (Do the schools have reasonable class sizes, diverse staff, and services for all students)

- Better
- About the same
- Worse

17. Availability of local job opportunities

- Better
- About the same
- Worse

18. Amount of crime

- Better
- About the same
- Worse

19. Availability of parks, green spaces, and recreational areas

- Better
- About the same
- Worse

20. Availability of public transportation options

- Better
- About the same
- Worse

Health Care Access

This section will ask about health care access. When you answer these questions think about cost, availability, quality, and options for health care.

21. In the last 12 months, did you or a family member have an illness, injury, or condition that needed care?

- Yes
- No

22. When you or a family member needed care, how often did you/they get care all the care needed?

- I/they got all the care needed
- I/they got some but not all needed care
- I/they got no care at all
- I don't know

23. The most recent time you or a family member went without needed health care, what were the main reasons? (**Mark all that apply)**

- [ ] Cost
- [ ] No regular provider
- [ ] Can't take time off of work
- [ ] Do not know where to go
- [ ] Couldn't get appointments quickly enough
- [ ] Offices aren't open when I/they can go
- [ ] Needed childcare
- [ ] Needed transportation
- [ ] Not having a provider that understands my/their culture, lifestyle, identity, or language
- [ ] Not applicable, I/they received care when I/they needed it
- [ ] Other reason (tell us):

24. Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and other doctors who specialize in one area of health care. In the last 6 months, how often did you or a family member get an appointment to see a specialist as soon as you/they needed?

- ○ Always
- ○ Usually
- ○ Sometimes
- ○ Rarely
- ○ Never
- ○ I/they didn't need an appointment with a specialist

25. Were any of the following a reason why you/they did not get an appointment with a specialist as soon as you/they needed? **(Mark all that apply)**

- [ ] Your/their health plan approval or authorization was delayed
- [ ] You/they did not have a list of specialists in your health plan or network
- [ ] The specialists to choose from were far away
- [ ] There were not enough specialists to choose from
- [ ] The specialist you/they wanted did not belong to your/their health plan or network
- [ ] You/they could not get an appointment at a convenient time
- [ ] Other (please specify)

Demographics

This information will only be used to improve health and availability of services in your community.

26. What is your zip code?

27. What language or languages do you use at home? **(Mark all that apply.)**

- [ ] English
- [ ] Marshallese
- [ ] Russian
- [ ] Spanish
- [ ] Other language(s) (please specify)

28. What is the highest level of education that you have completed?

- ○ Less than high school
- ○ High school diploma or GED
- ○ Vocational training or 2 year degree
- ○ Bachelor's degree
- ○ An advanced or graduate degree

29. Are you currently employed or self-employed?

- Yes, employed by someone else (business, company, government organization, etc.)
- Yes, self-employed
- Not currently employed
- Retired

30. About how many hours per week, on average, do you work at your current job(s)? Your best estimate is fine.

- I don't currently work
- Less than 20 hours per week
- 20-39 hours per week
- 40 or more hours per week

31. Are you currently

- Married/living with a partner
- Divorced
- Separated
- Widowed
- Never married
- Other (please specify)

32. Household income in a year

- Less than $12,000 per year
- $12,001 to $19,999
- $20,000 to $29,999
- $30,000 to $49,999
- $50,000 to $74,999
- $75,000 to $99,999
- $100,000 or more

33. How many people live in your household?

- I am unstably housed or houseless
- I live alone
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9+

34. What kind of health insurance do you have? **(Mark all that apply)**

- Medicaid/Oregon Health Plan (OHP)
- Medicare (Federal coverage for 65 and older or people with disabilities)
- VA/TRICARE or other military health care
- Tribal Health Services from individual Tribe
- Private coverage through an employer or family member's employer
- A private plan I pay for myself
- I don't have health insurance now
- I don't know
- Other (please specify)

35. If you don’t have health insurance, why don't you have health insurance? **(Mark all that apply)**

- Too expensive
- I don't know how to get it
- I don't need it
- I don't qualify
- Other reason (please specify)

36. How do you identify your **race, ethnicity, tribal affiliation, country of origin, or ancestry**? You can use any words you like

37. Here are some more specific categories. Which of these describe your **racial or ethnic identity**? Please check **ALL** that apply.

- ☐ American Indian or Alaska Native - Alaska Native
- ☐ American Indian or Alaska Native - American Indian
- ☐ American Indian or Alaska Native - Canadian Inuit, Metis, First Nation
- ☐ American Indian or Alaska Native - Indigenous Mexican, Central American, South American
- ☐ Asian - Asian Indian
- ☐ Asian - Cambodian
- ☐ Asian - Chinese
- ☐ Asian - Communities of Myanmar
- ☐ Asian - Filipino
- ☐ Asian - Hmong
- ☐ Asian - Japanese
- ☐ Asian - Korean
- ☐ Asian - Laotian
- ☐ Asian - South Asian
- ☐ Asian - Vietnamese
- ☐ Asian - Other Asian
- ☐ Black or African American - African American
- ☐ Black or African American - Afro-Caribbean
- ☐ Black or African American - Ethiopian
- ☐ Black or African American - Somali
- ☐ Black or African American - Other African (Black)

- [ ] Black or African American - Other Black
- [ ] Hispanic or Latinx - Central American
- [ ] Hispanic or Latinx - Mexican
- [ ] Hispanic or Latinx - South American
- [ ] Hispanic or Latinx - Other Hispanic or Latino/a/x
- [ ] Middle Eastern or North African - Middle Eastern
- [ ] Middle Eastern or North African - North African
- [ ] Native Hawaiian or Pacific Islander - Chamorro (Chamoru)
- [ ] Native Hawaiian or Pacific Islander - Communities of the Micronesian Region
- [ ] Native Hawaiian or Pacific Islander - Marshallese
- [ ] Native Hawaiian or Pacific Islander - Native Hawaiian
- [ ] Native Hawaiian or Pacific Islander - Samoan
- [ ] Native Hawaiian or Pacific Islander - Other Pacific Islander
- [ ] White - Eastern European
- [ ] White - Slavic
- [ ] White - Western European
- [ ] White - Other White
- [ ] Don't know
- [ ] Don't want to answer

Other (please specify)

38. If you checked **more than one** category above, is there **one** you think of as your **primary** racial or ethnic identity?

- ○ Yes (Please circle your primary racial or ethnic identity above)
- ○ I do not have just one primary racial or ethnic identity.
- ○ No. I identify as Biracial or Multiracial.
- ○ Not applicable. I only checked one category above.
- ○ Don’t know
- ○ Don’t want to answer

39. How do you describe your **gender**? You can use any words you like.

40. In addition to the response that you indicated in the previous question, are there other terms or categories you use for your **gender identity**? You can choose as many as you want. Check all that apply.

- ☐ Woman or girl
- ☐ Feminine leaning
- ☐ Man or boy
- ☐ Masculine leaning
- ☐ Agender or no gender
- ☐ Non-binary
- ☐ Questioning
- ☐ Don't know
- ☐ I don't know what this question is asking
- ☐ I don't want to answer
- ☐ Not listed (please specify)

41. Do you identify as transgender?

- ○ Yes
- ○ No
- ○ Don't know
- ○ I don't know what this question is asking
- ○ I don't want to answer
- ○ Other (please specify)

42. How do you describe your **sexual orientation** or **sexual identity**? You can use any words you like.

43. In addition to the response that you indicated in the previous question, are there other terms or categories you use for your **sexual orientation** or **sexual identity**? You can choose as many as you want. Check all that apply.

- [ ] Same-gender loving
- [ ] Lesbian
- [ ] Gay
- [ ] Bisexual
- [ ] Straight (attracted primary or only to other gender(s))
- [ ] Pansexual
- [ ] Asexual
- [ ] Queer
- [ ] Questioning
- [ ] Don't know
- [ ] I don’t know what this question is asking
- [ ] I don’t want to answer
- [ ] Not listed (please specify)

44. How old are you?

- ○ Under 18
- ○ 18-25
- ○ 26-39
- ○ 40-54
- ○ 55-64
- ○ 65-80
- ○ Over 80

References

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