

# Consumer Voice Listening Project Summary Report

HealthierHere, Center for MultiCultural Health, and Public Health Seattle &  
King County

May, 2021

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## Acknowledgements



- Abundance of Hope
- African American Health Board
- API Coalition Advancing Together for Health
- Association of Zambians in Seattle
- Being Empowered through Supportive Transitions (BEST)
- Center for Human Services
- Chinese Information and Service Center
- Civil Survival
- Congolese Integration Network
- Consejo Counseling and Referral Service
- Downtown Emergency Services Center
- Falis Community Services
- Gay City
- Interim-CDA
- Khmer Health Board
- Latino Community Fund
- Living Well Kent
- Lutheran Community Services
- Mother Africa
- NAKANI Native Program
- New Traditions
- Pacific Islander Health Board
- Pamoja Christian Church
- Peer Seattle
- Sisters in Common
- SOAR
- Somali Health Board
- TI-Plus
- Tlingit & Haida Indian Tribes of Alaska – Washington Chapter
- United Indians of All Tribes Foundation
- UNKITAWA
- Vietnamese Health Board
- Washington State Coalition of African Community Leaders
- Zanzibar Community of Washington USA (ZACUSA)

- Center for MultiCultural Health
- HealthierHere
- Public Health Seattle & King County

We also wish to thank community members who responded to the surveys.

## Introduction: A community-centered approach to data

The Consumer Voice Listening Project was implemented in 2018 and 2019, as part of [HealthierHere's](#) efforts to improve the healthcare system guided by the people and communities it serves. The project was co-led by the [Center for MultiCultural Health](#), and partnered with 34 grassroots and community-based organizations (CBOs) to engage with and gather insights from 2,860 individuals from over 40 different communities in King County, including the Afghan, African American, Angola, Congolese, DR Congo, Egypt, Gambia, Guam, Guinea, Hispanic, Iraqi, Jordan, Kenya, Khmer, LatinX, Libya, Malawi, Mali, Marshall Islands, Morocco, Palestine, Rwanda, , S. Sudan, Samoa, Somali, Somali Bantu, Sudan, Tanzania, Uganda, Vietnamese, Zambian, and Zanzibar community.

These individuals shared their experience with healthcare through surveys that asked about health conditions, barriers to accessing care, patient experience, and how healthcare experience could be improved. The surveys were available in Arabic, Dari, English, Farsi, French, Lingala, Portuguese, Russian, Somali, Spanish, Swahili, and Ukrainian.

The survey responses were collected in 2018 and 2019 by the following community organizations: Abundance of Hope, African American Health Board, API Coalition Advancing Together for Health, Association of Zambians, BEST, Center for Human Services, Chinese Information and Service Center, Civil Survival, Congolese Integration Network, Consejo Counseling and Referral Service, Downtown Emergency Services Center, Falis Community Services, Gay City, Interim-CDA, Khmer Health Board, Latino Community Fund, Living Well Kent, Lutheran Community Services, Mother Africa, NAKANI Native Program, New Traditions, Pacific Islander Health Board, Pamoja Christian Church, Peer Seattle, Sisters in Common, SOAR, Somali Health Board, TI-Plus, Tlingit & Haida Indian Tribes of Alaska – Washington Chapter, United Indians of All Tribes Foundation, UNKITAWA, Vietnamese Health Board, Washington State Coalition of African Community Leaders, and ZACUSA.

Thanks to the work of these organizations, the data collected includes the voices of those who are often not heard by government, mainstream media, and large institutions. Although we celebrate this accomplishment, we recognize that this data does not fully capture all communities. In this report, we look at survey answers by respondents' racial/ethnic communities. We also examine how results compare across neighborhoods, between respondents of different levels of English proficiency, housing situation, sexual orientation, and age.

Through the 34 CBOs mentioned above, the communities represented in this report were partners in collecting and interpreting the data, as well as in reviewing the report design and content. In the following pages, we present findings from this collective work.

The audience for this report is intended to be anyone who is interested in learning more about the experiences that diverse communities have with the healthcare system. When CBO partners were asked who they thought the audience for this report to be, they shared that they wanted this report to be read by individuals from the following entities: policy makers, health care providers, governmental agencies, public health institutions, health care organizations, and social service organizations.

# Executive Summary

## Communities highlighted in this report

This report presents findings from surveys done in 2018 and 2019 as part of the Consumer Voice Listening Project, implemented by [HealthierHere](#) and the [Center for MultiCultural Health](#). Thirty-four grassroots and community-based organizations (CBOs) involved a total of 2,860 individuals from over 40 different communities in King County in responding to these surveys.

The following groups/communities are represented in this report:

- Neighborhood of Respondents
- American Indian Alaska Native Respondents
- Asian Respondents
- Black/African American/African-born Respondents
- Latinx/Hispanic Respondents
- Middle Eastern North African (MENA) Respondents
- Native Hawaiian Pacific Islander Respondents
- Respondents who identify with more than one race or ethnicity
- LGBTQ & Two Spirit<sup>1</sup> Respondents
- Limited English Proficient Respondents
- Respondents experiencing homelessness
- Youth and Young Adult Respondents

An important thing to keep in mind is that there are many intersecting identities, and for that reason the data from a given respondent can show up in multiple sections. For instance, LGBTQ community members span across different racial identities. The reason for structuring the report this way is to highlight the experiences of the communities and the focus areas identified by the community-based organizations that guided this work. Although this report does not attempt to explore the intersectionality amongst the different groups, we recognize the importance of these intersecting identities in the way patients experience health care.

Another thing to keep in mind is that for the purposes of this report, we did not disaggregate racial categories beyond the list written above. We recognize that a lack of data disaggregation within racial categories can impair the understanding and visibility of different experiences within a community. For instance, the category entitled “Asian Respondents” does not adequately represent the diverse experiences within Asian communities from across the region. One reason for this report’s lack of more detailed disaggregation of data within racial categories is an effort to align this report with currently available public health data. While we believe that this approach to data collection can be helpful for integration within current mainstream approaches used in healthcare and public health policy and systems, we recognize that this approach creates limitations, namely limiting the ability to reflect the nuanced and varying needs within any given community. Finally, limitations resulting from the survey

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<sup>1</sup> *Two-spirit* is a term found in some Native American cultures, often involving birth-assigned men or women taking on the identities and roles of the opposite sex. A sacred and historical identity, *two-spirit* can include but is by no means limited to LGBTQ+ identities.

design also hindered the ability to further disaggregate racial categories. Respondents who identified in the survey as Black, African American, or African-born were grouped in one category as it was not possible to distinguish with certainty which responses identified as Black/African American versus African-born (see appendix).

## Health Conditions & Use of Health Care

**Behavioral/mental health was the number one health condition for the majority of the communities in this report**, and it is within the top 3 health conditions for all of them. The highest prevalence was among multi-racial (64%) respondents, those experiencing homelessness (55%), and LGBTQ and Two-Spirit (44%) respondents. The prevalence varied greatly amongst the regions in King County: while 42% of respondents in Central/South Seattle reported having a behavioral/mental health condition, only 20% of those in East King County did.

**Diabetes was another major health condition**, being the most prominent amongst Middle Eastern North African (MENA), Latinx, Limited English proficient, and Black/African American/African-born respondents.

**Asthma is also prevalent amongst most of the groups highlighted in this report.** In 8 out of the 11 communities, asthma was one of the top 3 health conditions. The highest prevalence was amongst the Latinx community, where 23% of respondents reported having this condition.

**The percentage of respondents who received a preventative exam in the previous year varied significantly across the different communities/groups.** The communities/groups with the highest percentage of respondents who received a preventative exam in the previous year were Youth (78%), Latinx (75%), and Middle Eastern North African (74%). Groups with the lowest prevalence included those experiencing homelessness (41%), LGBTQ (46%), and American Indian/Alaska Native (50%) respondents.

**The percentage of having a dental exam in the previous year was highest amongst Youth (82%), Latinx (65%), and Black/African American/African-born (58%) respondents.** The groups with the lowest percentage were people experiencing homelessness (30%), LGBTQ (39%), and those who identified with more than one race/ethnicity (40%).

## Access to Care & Ease of Utilization

**Concern about cost was one of the most common reasons for not seeking care** amongst all the groups for which we present data. This barrier was most common amongst the Latinx community, with 48% of respondents indicating cost as a reason for choosing not to seek health care.

**Not having staff that speak their language, understanding information at visits, and being uninsured or underinsured were also common barriers** to accessing care.

**Language of staff was a barrier reported by a large percentage of Middle Eastern North African, limited English proficient, and Native Hawaiian/Pacific Islander respondents.** When asked if there was a staff member at the clinic who spoke their language, only 47% of Middle Eastern North African, 45% of limited English proficient, and 44% of Native Hawaiian/Pacific Islander respondents said “yes”.

## Ways to Improve Care

**Having clinics stay open late and on weekends was the most frequently selected way to improve care** for most communities highlighted in this report. The prevalence was higher amongst respondents from the Latinx/Hispanic community (67%), Middle Eastern North African community (66%), and amongst Youth and Young Adults (60%).

**Transportation assistance to and from appointments was frequently pointed out** by survey respondents as a way to improve care. This suggestion was more common amongst respondents experiencing homelessness (46%) and Middle Eastern North African respondents (46%). It was also commonly reported by respondents living in Central/South Seattle (38%).

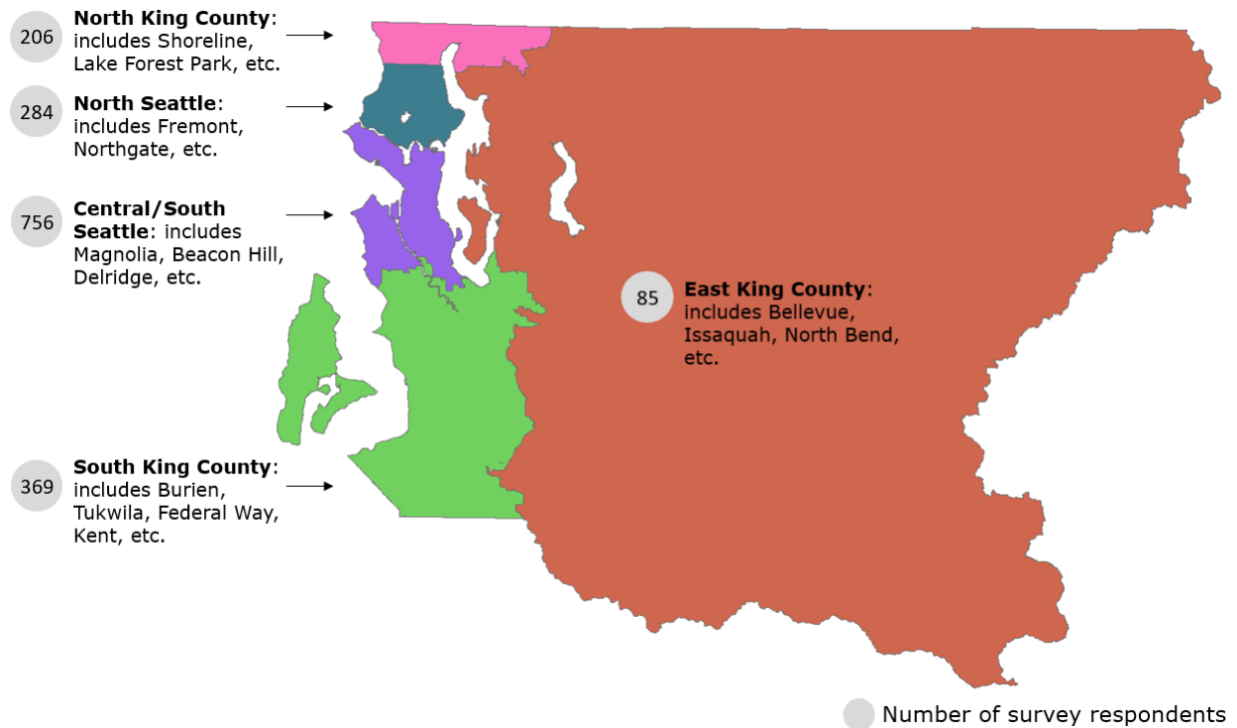
In the following page, we summarize some highlights of what is going well, what barriers to care have emerged, and how access to care could be improved for each of the communities/groups highlighted in this report.

	<b>WHAT'S GOING WELL?</b>	<b>WHAT BARRIERS EMERGED?</b>	<b>WHAT COULD IMPROVE?</b>
Asian	<ul style="list-style-type: none"> <li>- Utilization of preventative exams</li> <li>- Access to clinic and pharmacy that accept insurance</li> </ul>	<ul style="list-style-type: none"> <li>- Low access to dental exams</li> <li>- Cost of care and language of staff</li> </ul>	<ul style="list-style-type: none"> <li>- Hours of clinic</li> <li>- Staff language abilities</li> </ul>
American Indian Alaska Native	<ul style="list-style-type: none"> <li>- Tribal and Indian Health Care</li> <li>- Native Traditional Healers</li> </ul>	<ul style="list-style-type: none"> <li>- Low access to dental exams</li> <li>- Cost of care and language of staff</li> </ul>	<ul style="list-style-type: none"> <li>- Hours of clinic</li> <li>- Staff language abilities</li> </ul>
Black, African American, and African-born	<ul style="list-style-type: none"> <li>- Utilization of preventative exams</li> <li>- Low reported rates of COPD / lung disease</li> </ul>	<ul style="list-style-type: none"> <li>- Un/under-insured and challenges renewing insurance</li> <li>- Cost of care and language of staff</li> </ul>	<ul style="list-style-type: none"> <li>- Hours of clinic</li> <li>- Medicine delivery and transportation assistance</li> </ul>
Latinx	<ul style="list-style-type: none"> <li>- Utilization of preventative and dental exams</li> <li>- Language access at clinics</li> </ul>	<ul style="list-style-type: none"> <li>- Insurance coverage and lack of insurance</li> <li>- Cost of care</li> </ul>	<ul style="list-style-type: none"> <li>- Hours of clinic</li> <li>- Staff language abilities and additional services at the clinic</li> </ul>
Middle Eastern North African (MENA)	<ul style="list-style-type: none"> <li>- Access to pharmacy that accepts insurance</li> <li>- Most feel welcome at the clinic</li> </ul>	<ul style="list-style-type: none"> <li>- Language of staff and understanding information at visits</li> <li>- Cost of care and getting to the clinic</li> </ul>	<ul style="list-style-type: none"> <li>- Hours of clinic</li> <li>- Staff language abilities</li> </ul>
Native Hawaiian Pacific Islander	<ul style="list-style-type: none"> <li>- Ease of getting an appointment</li> <li>- Most feel welcome at the clinic</li> </ul>	<ul style="list-style-type: none"> <li>- Language of staff</li> <li>- Cost of care and not having insurance</li> </ul>	<ul style="list-style-type: none"> <li>- Hours of clinic</li> <li>- Transportation assistance</li> </ul>
Multi-racial/ethnic	<ul style="list-style-type: none"> <li>- Access to pharmacy that accepts insurance</li> <li>- Language access at clinics</li> </ul>	<ul style="list-style-type: none"> <li>- Cost of care</li> <li>- Not knowing where to go for care</li> </ul>	<ul style="list-style-type: none"> <li>- Hours of clinic</li> <li>- Transportation, additional services at the clinic, medicine delivery</li> </ul>
Limited English Proficient	<ul style="list-style-type: none"> <li>- Utilization of preventative exams</li> <li>- Most feel welcome at the clinic</li> </ul>	<ul style="list-style-type: none"> <li>- Language of staff and understanding information at visits</li> <li>- Cost of care and lack of health insurance</li> </ul>	<ul style="list-style-type: none"> <li>- Hours of clinic</li> <li>- Staff language abilities and translation of materials</li> </ul>
LGBTQ & Two Spirit	<ul style="list-style-type: none"> <li>- Access to clinic and pharmacy that accept insurance</li> <li>- Ease of getting appointments</li> </ul>	<ul style="list-style-type: none"> <li>- Not feeling welcome or comfortable at clinic</li> <li>- Cost of care</li> </ul>	<ul style="list-style-type: none"> <li>- Hours of clinic</li> <li>- Support to navigate health care issues</li> </ul>
Respondents experiencing homelessness	<ul style="list-style-type: none"> <li>- Access to pharmacy that accepts insurance</li> <li>- Ease of getting an appointment</li> </ul>	<ul style="list-style-type: none"> <li>- Language of staff and understanding information at visits</li> <li>- Cost and getting to the clinic</li> </ul>	<ul style="list-style-type: none"> <li>- Transportation assistance</li> <li>- Hours of clinic</li> </ul>
Youth and Young Adults	<ul style="list-style-type: none"> <li>- Utilization of preventative exams (youth)</li> <li>- Access to pharmacy that accepts insurance (young adults)</li> </ul>	<ul style="list-style-type: none"> <li>- Cost of care (young adults)</li> <li>- Could not get time off work/school (youth)</li> </ul>	<ul style="list-style-type: none"> <li>- Hours of clinic (youth and young adults)</li> <li>- Having urgent care near home (youth) and transportation assistance (young adults)</li> </ul>



## Geography: Neighborhood of Respondents

Where you live matters to your health and wellbeing. Neighborhoods can play a role in housing options, food access, water and air quality, as well as access to employment, quality education, and health care services. Respondents who took the Consumer Voice Listening Project survey in 2019 highlighted different barriers to healthcare depending on the geographic neighborhood that they lived in. These five neighborhoods are described below.



Data from 2019 Consumer Voice Listening Project surveys.

## Health Conditions & Use of Health Care

Respondents from North King County and East King County had the highest rates for receiving a dental exam in the past year, 56% and 48%, while respondents from North Seattle reporting the lowest at 40%. For preventative exams, most neighborhoods were similar although Central/South Seattle has the highest rate at 55%. While most patterns of health conditions were fairly similar across neighborhoods, reported rates of behavioral/mental health conditions were twice as high in Central/South (42%) and in North Seattle (41%) compared to East King County (20%). Respondents from North King County generally reported the lowest rates of health conditions.

<b>Do you, or anyone that lives with you, have any of the following conditions?</b> (% of respondents that selected the condition)					
<b>Health Condition</b>	<b>East King County</b>	<b>Central/South Seattle</b>	<b>North Seattle</b>	<b>South King County</b>	<b>North King County</b>
Alcohol Use Disorder	14.1	16.9	10.9	15.2	9.2
Asthma	14.1	14.6	10.6	14.9	8.3
COPD/Lung Disease	3.5	4.6	3.2	3.5	2.4
Diabetes	12.9	13.4	8.5	11.4	10.2
Drug Use Disorder	5.9	17.3	9.2	13.0	6.3
Heart Disease	12.9	8.1	7.0	8.7	7.3
Behavioral/Mental Health Condition	20.0	41.9	41.2	33.9	28.6

Notes: 1) Darker shades of blue reflect options that were selected by a higher percentage of respondents.  
2) Data from 2019 Consumer Voice Listening Project surveys.

### Access to Care & Ease of Utilization

Not having clinic staff that spoke their language was a more common problem in East King County and South King County than others. East King County respondents also have the highest rates of difficulty understanding health information provided to them and not feeling understood. Respondents from North Seattle, Central/South and South King County encountered more difficulty understanding their insurance than others. Twenty percent of North Seattle respondents, for example, reported this experience, compared to 12% of those from North King County.

#### **Greater concern for cost in South King County.**

Across all neighborhoods, the most common reason for not seeking care was consistent: they were concerned about the cost. However, other barriers to care were experienced very differently based on the neighborhood respondents lived in. For those living in South King County, 25% did not seek care over the past year because they were unable to pay for their copay, whereas for respondents from North King County, only 16% experienced this as a barrier to healthcare.

#### **Competing necessities is experienced most by South King County, Central/South Seattle, and North Seattle neighborhoods.**

Over a quarter (27-29%) of respondents living in these three areas of King County did not seek care because they were dealing with other things such as getting food or finding housing. This compared to the East or North King County where 15% of respondents experience this barrier.

#### **Insurance for prescription meds is a greater barrier in Central/South Seattle than North King County.**

Twenty-seven percent (27%) of respondents in Central/South Seattle reported not filling their prescription because it wasn't covered by their insurance, compared to 15% in North King County. While 18-20% in East and Central/South Seattle reported lack of insurance as a barrier to filling prescriptions, 13% of those living in North King County did.

## Ways to Improve Care

**Consistent demand for clinics to stay open late and on weekends.** Across all neighborhoods, this message was clear. Having clinics open later and on weekends would make healthcare easier or better. In every neighborhood, over 40% of respondents agreed, making this the most frequently selected option.

**Transportation support for appointments a top priority for all.** For all neighborhoods, one of the most frequently selected ways to make healthcare better or easier was to provide transportation to get to and from appointments. The neighborhood where the highest percentage agreed was Central/South Seattle at 38%. This makes sense given that 62% of South King County respondents rely on bus or train to get to their appointments. They also are more likely to report walking, biking, or taking a taxi/Uber to get to appointments than the other neighborhoods. While only 28% of South King County respondents drive a car to get to appointments, the percentage of North King County respondents who do so is more than twice as much (70%).

*“Therapy near me [is not covered by insurance]. I would have to drive 20 miles a day to go to and get back from the one place that does offer me low cost therapy. Even then, time slots are limited ... have to drive through rush-hour.”*

East King County Survey Respondent

What would make healthcare easier and better for you?					
(% of respondents that selected the option)					
	East King County	Central/South Seattle	North Seattle	South King County	North King County
Clinic open late and on weekends	48.2	43.4	44.7	47.2	48.1
Urgent care near my home	20.0	25.0	28.2	26.8	26.7
Offer transportation to / from appointments	25.9	37.6	32.7	33.3	31.1
Childcare at the clinic	10.6	7.9	11.3	16.0	23.8
Clinic staff who speak my language	24.7	17.7	12.3	8.4	15.0
Clinic staff to help deal with health care issues	29.4	26.7	24.6	24.7	16.0
Written instructions in my language	14.1	16.7	8.8	10.3	10.7
Offer health services at other places in community	17.6	14.2	15.1	19.5	12.1
Medicine delivered to my home	15.3	23.3	20.1	24.7	20.4
Offer other services at the clinic	20.0	20.2	19.7	19.0	9.2

Notes: 1) Darker shades of blue reflect options that were selected by a higher percentage of respondents.

2) Data from 2019 Consumer Voice Listening Project surveys.

# Communities of Color: American Indian / Alaska Native Respondents

WHAT'S GOING WELL?	WHAT BARRIERS EMERGED?	WHAT COULD IMPROVE?
Tribal and Indian Health Care	Low access to dental exams	Hours of clinic
Native Traditional Healers	Cost of care and language of staff	Staff language abilities

## Health Conditions & Use of Health Care

Of the survey respondents who identified as American Indian and/or Alaska Native<sup>2</sup> (a total of 500), a high proportion (41%) reported a behavioral/mental health condition. The second most common condition selected was alcohol use (22%), followed by asthma (19%). A high percentage of respondents also reported drug use disorder (17%). Among these respondents who went to a Tribal Clinic or HealthCare Provider, 71% felt listened to by this provider and 75% recommended this provider. Among these respondents who went to a Traditional Native Healer, 72% felt listened to by this provider 68% recommended this provider.

Top 3 Health Conditions Reported by American Indian/Alaska Native Respondents
41% Behavioral / Mental Health
22% Alcohol Use
19% Asthma

## Access to Care & Ease of Utilization

*“Multiple people I know had difficulty trusting medical care... They avoided medical care and waited until they really needed to go and then usually went to the emergency room. They are Native American and had a bad experience with medical providers and that’s something we should be concerned about.”*

**Staff member from Nakani Native Program**

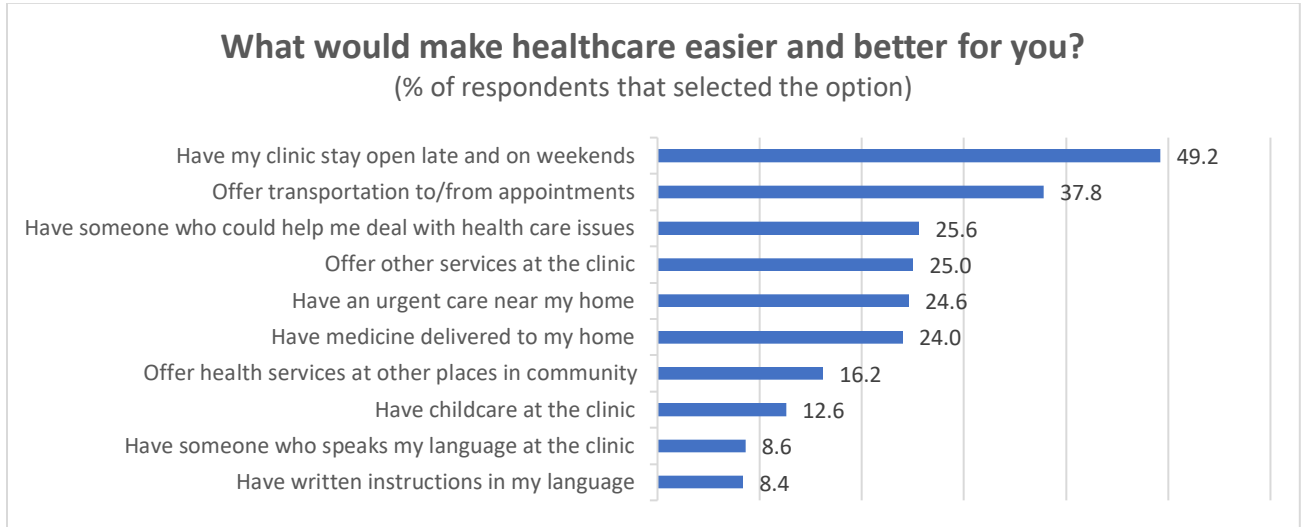
Very few respondents (6%) had trouble understanding the information received at appointments and the majority felt their provider understood what they were sharing about their health. The most common reason for not seeking care was being busy dealing with other things (34%), followed by concerns over cost (31%). A high percentage (23%) also did not have a way to get there or did not know where to go for care (21%).

## Ways to Improve Care

When seeking healthcare, most respondents (49%) thought having the clinic open later and on weekends would make healthcare easier for them. Offering transportation assistance to and from appointments was also a priority for 39% of respondents. Having extra support and services at clinic

<sup>2</sup> For more information about how racial/ethnic communities were defined, please refer to the Appendix. Detailed information on the racial/ethnic groups that responded the Consumer Voice Listening Project surveys is available on the project's [online dashboard](#).

sites would be useful for many American Indian/Alaska Native respondents as well; 26% would like to have someone help deal with healthcare issues, and 25% would like to see other services at the clinic. When asked what was not covered by their insurance, many respondents who identified as American Indian/Alaska Native wrote in traditional medicine, spiritual or traditional healers and/or sweat lodge.



Data from 2018 and 2019 Consumer Voice Listening Project surveys.

## Communities of Color: Asian Respondents

WHAT'S GOING WELL?	WHAT BARRIERS EMERGED?	WHAT COULD IMPROVE?
Utilization of preventative exams	Low access to dental exams	Hours of clinic
Access to clinic and pharmacy that accept insurance	Cost of care and language of staff	Staff language abilities

### Health Conditions & Use of Health Care

Of the survey respondents who identified as Asian<sup>3</sup> (a total of 393), over half (55%) reported not having any of the health conditions in the survey. Twenty-two percent reported having a behavioral/mental health condition (i.e. depression, anxiety), followed by diabetes and asthma. Most received a preventive exam in the past year, however 34% did not get a dental exam.

Top 3 Health Conditions Reported by Asian Respondents
22% Behavioral / Mental Health
13% Diabetes
13% Asthma

### Access to Care & Ease of Utilization

*“One time the pharmacy was too far from work and home and I don't have a car, so I didn't make it on time to pick up my prescription. Often, I have to go in late or leave early to get to the pharmacy on time.”*

Client from Interim CDA

When seeking healthcare, most did not report difficulty finding a clinic or pharmacy that accepts their insurance. However, at the appointments 25% of respondents said they never or never consistently had a staff member who spoke their language. Cost emerged as a barrier as well, with it being the most common reason (26%) for not seeking care and for not filling a prescription. Most get to their appointments by bus or train (51%), and transportation assistance was a priority for 36%.

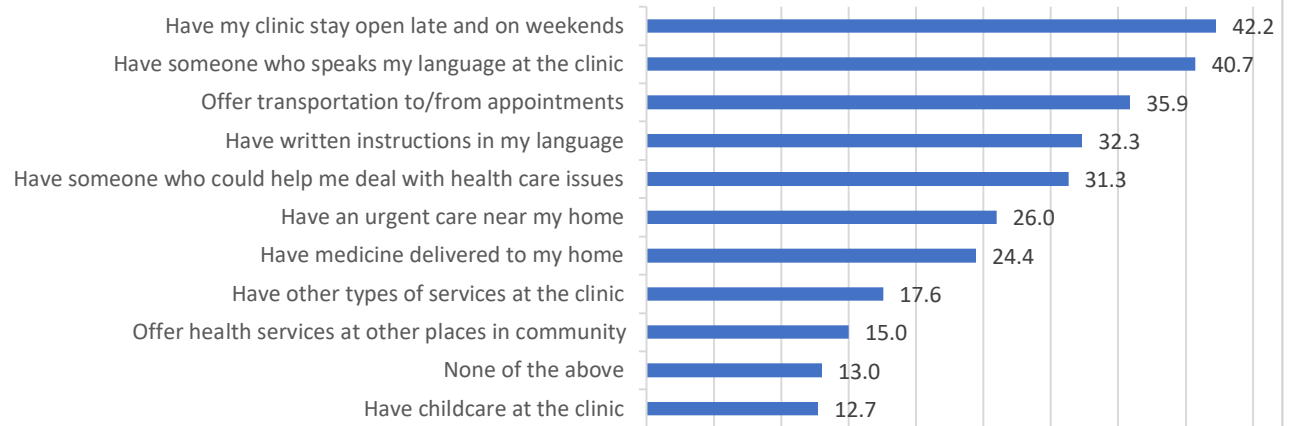
### Ways to Improve Care

The graph below shows expansion of clinic hours and staff language abilities are top priorities.

<sup>3</sup> For more information about how racial/ethnic communities were defined, please refer to the Appendix. Detailed information on the racial/ethnic groups that responded the Consumer Voice Listening Project surveys is available on the project's [online dashboard](#).

## What would make healthcare easier and better for you?

(% of respondents that selected the option)



Data from 2018 and 2019 Consumer Voice Listening Project surveys.

## Communities of Color: Black/African American/African-born Respondents

WHAT'S GOING WELL?	WHAT BARRIERS EMERGED?	WHAT COULD IMPROVE?
Utilization of preventative exams  Low reported rates of COPD / lung disease	Un/under-insured and challenges renewing insurance  Cost of care and language of staff	Hours of clinic  Medicine delivery and transportation assistance

### Health Conditions & Use of Health Care

For this section, results reflect findings from respondents who identified in the survey as Black, African American, or African-born<sup>4</sup> (a total of 529). We recognize that the lived experiences of these groups are unique and deserve specific findings. Unfortunately, there was no way to separate these groups for both surveys because we could not distinguish with certainty which responses identified as Black/African American versus African-born.

Top 3 Health Conditions Reported by Black/African American/African-born Respondents
25% Diabetes
16% Asthma
13% Behavioral / Mental Health

Amongst Black/African American/African-born respondents, the most common health condition was diabetes (25%), followed by asthma (16%) and behavioral/mental health conditions (13%). A participating community-based organization that serves African communities offers an important caveat: folks in these communities do not commonly talk about behavioral/mental health issues nor alcohol and drug use, as there is a lot of stigma associated with such conditions. For that, it is possible that the rates of behavioral/mental health issues, alcohol use, and drug use amongst African communities were underreported in the survey. Similarly, another participating CBO warns that the low rate of COPD reported in the surveys might be due to late diagnosis or lack of diagnosis. Although the majority (68%) of respondents received a preventative exam over the last year, a quarter (26%) did not and a high percentage (37%) did not access a dental exam.

### Access to Care & Ease of Utilization

A large percentage of Black/African American/African-born respondents (38%) highlighted that they did not have a staff member at their clinic who spoke their language. A lack of insurance or insufficient coverage was also a common barrier. Although half of Black/African American/African-born respondents found it easy to find a clinic or pharmacy that accepts their insurance, the most common reason for not seeking care was not having insurance (34%). The most common reason for not getting

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<sup>4</sup> For more information about how racial/ethnic communities were defined, please refer to the Appendix. Detailed information on the racial/ethnic groups that responded the Consumer Voice Listening Project surveys is available on the project's [online dashboard](#).



medication was because it was not covered by insurance (35%), followed by cost concerns (28%) and not having insurance (28%).

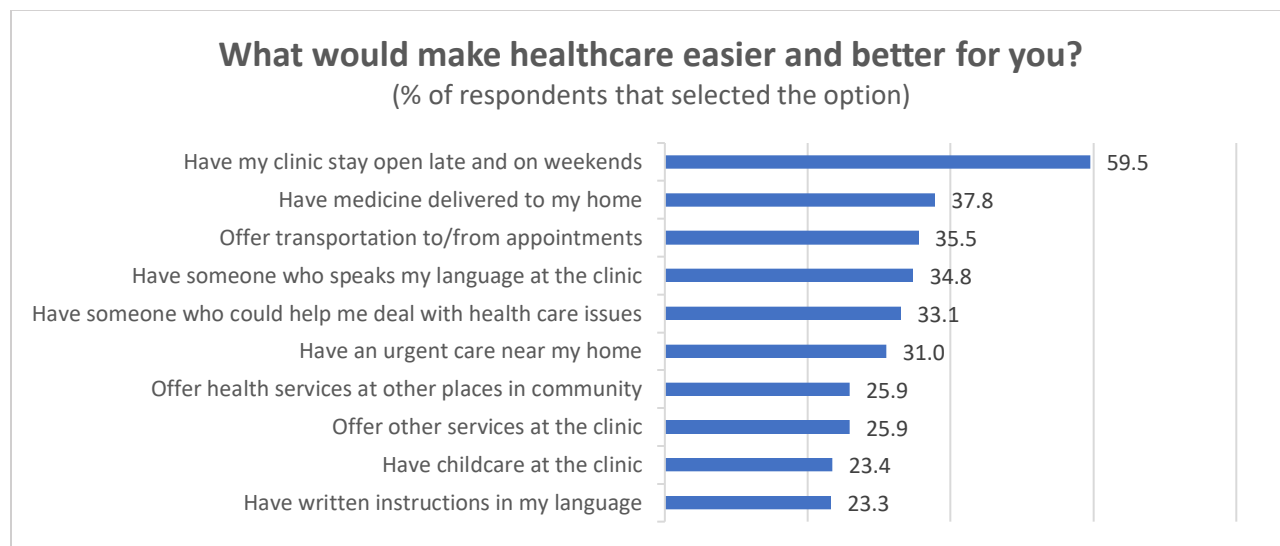
A quarter of respondents found it hard to understand how to renew their insurance and to understand what was covered by their insurance. A participating community-based organization shared a story that illustrates how understanding insurance policy can be a barrier to accessing care:

“I have received a client who walked into my office and needed help. This client is a young lady. She used the bus to reach out to me. Upon arrival, she handed over an envelope to me. When I opened the envelope; it contained a long list of her medical coverage and policy. I took time to read the main parts of the policy and explained to her what the coverage was and what she was entitled to. Then, I asked her a question if she goes from time to time to the dentist office? In her reply, she said no. When I asked why? She mentioned to me that she was afraid to see the dentist because the cost will be expensive. In fact, the dentist random checks which are routines are free in your coverage I said to her. She was surprised and shocked to learn that. She immediately asked me to help her in the booking of an appointment”

**Congolese Integration Network, participant CBO that serves the Congolese community**

## Ways to Improve Care

The majority of Black/African American/African-born respondents (60%) wanted their clinic to stay open later and on weekends. About a third of respondents wanted medicine delivery (38%), transport to/from (36%), someone who speaks language (34%), and have someone to help with healthcare issues (33%).



Data from 2018 and 2019 Consumer Voice Listening Project surveys.

## Communities of Color: Latinx/Hispanic Respondents

WHAT'S GOING WELL?	WHAT BARRIERS EMERGED?	WHAT COULD IMPROVE?
Utilization of preventative and dental exams	Insurance coverage and lack of insurance	Hours of clinic
Language access at clinics	Cost of care	Staff language abilities and additional services at the clinic

### Health Conditions & Use of Health Care

For this section, results reflect findings from respondents who selected or wrote in “Latinx/Hispanic” as their race or ethnicity in the survey, or who wrote into the open-ended option a country or region that corresponded to “Latinx/Hispanic” race or ethnicity.<sup>5</sup>

#### Top 3 Health Conditions Reported by Latinx Respondents

32% Diabetes  
28% Behavioral / Mental Health  
23% Asthma

Of the survey respondents in this group (a total of 254), 75% received a preventative exam over the last year and 65% received a dental exam. Diabetes was the most reported health condition, followed by behavioral/mental health conditions, and asthma. A high percentage of respondents reported an alcohol use disorder (11%) and drug use disorder (13%).

### Access to Care & Ease of Utilization

Most Latinx respondents reported it was easy to find a clinic that accept their health insurance (56%) and find a pharmacy that does so (61%). Only 8% reported that clinic staff did not speak their language, and 22% that *sometimes* clinic staff did not speak their language. When needing care over the past year, 48% of Latinx respondents stated they had decided not to seek it due to cost. Other common reasons included lack of insurance (36%) and not having money to pay the visit co-pay (30%). These reasons were similar for not filling a prescription; 33% did not have insurance coverage of the medicine, 30% could not afford copay, and 28% did not have insurance at all. A participant CBO shared a story about a client that reflect some of these barriers the Latinx community faces to access care:

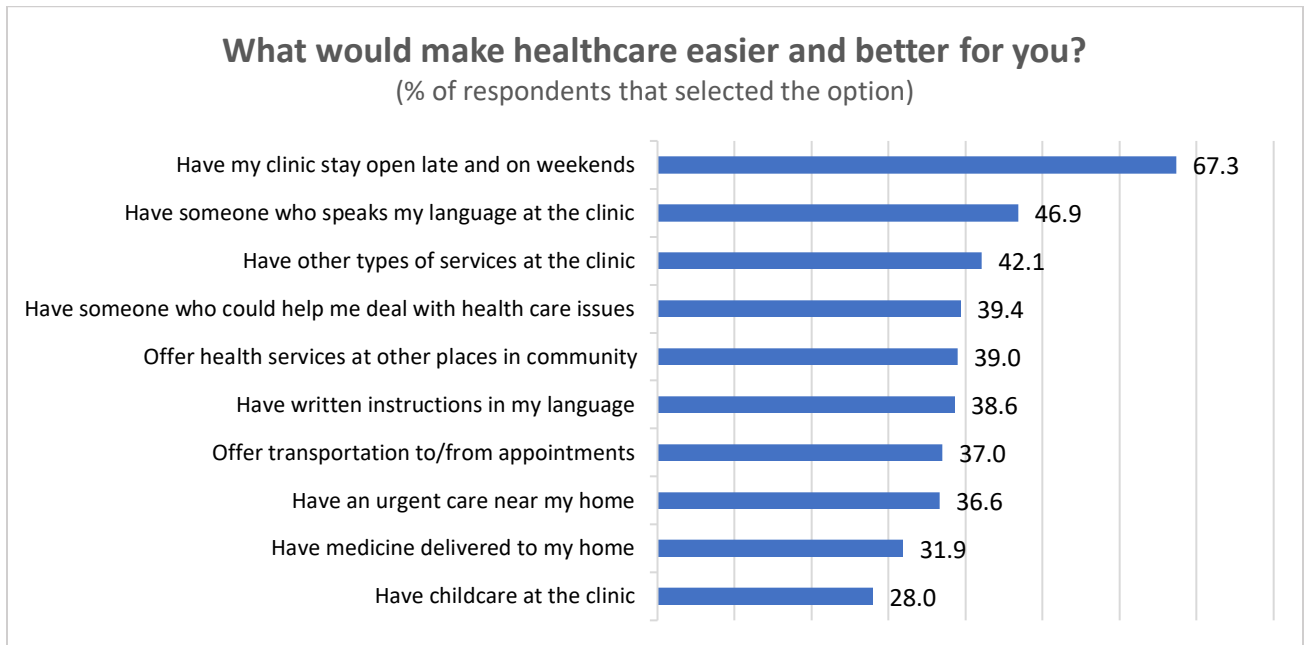
“[A client] said to us that she was a single mom with three children, she was their sole support, her mom and grandmother were both victims of cancer, so why would she even want a mammogram? There would be no way she could take time for treatment, even if she could afford the cost. And who would care for her children if she were incapacitated due to chemotherapy she simply said it was better for her not to know. This is not helplessness; this is a stunning grasp of reality.”

**Account from Consejo, a participant CBO, about a client they served**

<sup>5</sup> For more information about how racial/ethnic communities were defined, please refer to the Appendix. Detailed information on the racial/ethnic groups that responded the Consumer Voice Listening Project surveys is available on the project's [online dashboard](#).

## Ways to Improve Care

Among Latinx respondents, the top item for improving healthcare was to have clinic hours later and on weekends (67%). Other priorities included having staff who speak their language (46%) and other services available (42%). Every option for improving care was selected by at least 27% of respondents, suggesting they all have potential to improve the Latinx community's healthcare experience.



Data from 2018 and 2019 Consumer Voice Listening Project surveys.

# Communities of Color: Middle Eastern North African (MENA) Respondents

WHAT'S GOING WELL?	WHAT BARRIERS EMERGED?	WHAT COULD IMPROVE?
Access to pharmacy that accepts insurance	Language of staff and understanding information at visits	Hours of clinic
Most feel welcome at the clinic	Cost of care and getting to the clinic	Staff language abilities

## Health Conditions & Use of Health Care

Survey respondents were grouped as Middle Eastern North African (MENA) if in the 2018 survey they identified as being from any of the [19 MENA countries](#); as “Arab” or “Arabic”; or if they reported Mother Africa, Living Well Kent, or Lutheran Community Services as the name of the organization that asked them to take the survey.<sup>6</sup>

### Top 3 Health Conditions Reported by MENA Respondents

- 38% Diabetes
- 30% Behavioral/Mental Health
- 22% Heart Disease

Of the MENA respondents (a total of 102), 56% received a dental exam in the previous year and 74% received a preventative exam. Diabetes was the most reported health condition, followed by behavioral/mental health, and heart disease. A high percentage of respondents reported having asthma (21%).

## Access to Care & Ease of Utilization

Cost was the main reason for MENA respondents not to seek care in the year that preceded the survey: 34% did not seek care because they did not have health insurance, 30% were concerned about the cost, and 26% could not afford the co-pay. Transportation was also a significant issue among respondents, as 28% did not have a way to get to the health care location. When needing care, over half of MENA respondents had issues with clinic staff being able to speak their language - 25% said there was no staff that spoke their language, and 27% said that *sometimes* there was no staff that spoke their language.

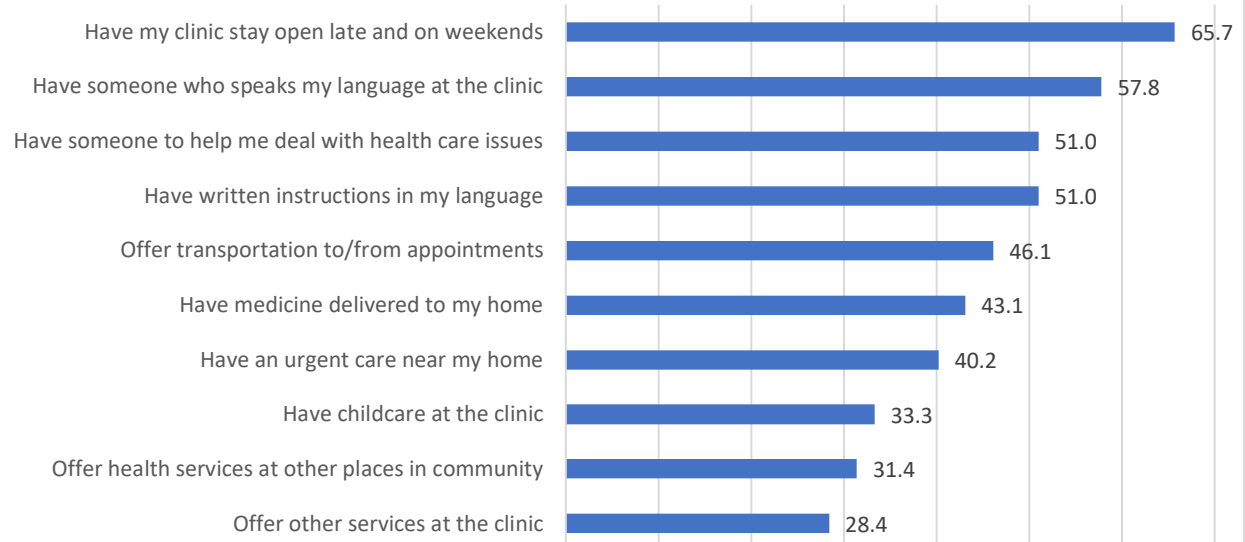
## Ways to Improve Care

Having clinics stay open late and on weekends was the most frequent response for how healthcare could be improved (66%). Having staff that speak the patient’s language, having someone to deal with patient’s health care issues, and having written instructions in their language were other responses selected by the majority of MENA respondents.

<sup>6</sup> For more information about how racial/ethnic communities were defined, please refer to the Appendix. Detailed information on the racial/ethnic groups that responded the Consumer Voice Listening Project surveys is available on the project's [online dashboard](#).

## What would make healthcare easier and better for you?

(% of respondents that selected the option)



Data from 2018 Consumer Voice Listening Project surveys.

# Communities of Color: Native Hawaiian/Pacific Islander Respondents

WHAT'S GOING WELL?	WHAT BARRIERS EMERGED?	WHAT COULD IMPROVE?
Ease of getting appointment	Language of staff	Hours of clinic
Most feel welcome at the clinic	Cost of care and not having insurance	Transportation assistance

## Health Conditions & Use of Health Care

Of the survey respondents who identified as Native Hawaiian/Pacific Islander<sup>7</sup> (a total of 147), 55% did not receive a dental exam over the past year and 42% did not receive a preventative exam. Behavioral/mental health was the most reported health condition, followed by diabetes, and asthma. A high percentage of respondents reported an alcohol use disorder (18%) and drug use disorder (13%).

Top 3 Health Conditions Reported by Native Hawaiian/Pacific Islander Respondents
31% Behavioral / Mental Health
29% Diabetes
22% Asthma

## Access to Care & Ease of Utilization

A very high percentage (45%) of Native Hawaiian/Pacific Islander respondents stated that there was not staff at the clinic that spoke their language. Over 20% also found it difficult to understand what their insurance covered and difficult to renew their insurance. When needing care, 18% of stated that finding a clinic that accepted their insurance was hard. The primary barrier to filling prescriptions and to seeking care when needed was cost. Over 30% reported this for care and 35% for prescriptions.

“In speaking and taking a HH survey with a family of 5 about healthcare, affordability and cost was a barrier that this family faced daily. Both parents who are Pacific Islanders works for Wal-Mart in low minimum wage jobs and their employers do not offer healthcare because both fall under hours (3 hours under fulltime) that they do not qualify for healthcare. One of the parents has diabetes and the 3 children were in good health and their ages ranged from 8, 12, 16 years of age. Concern about cost for out of pocket medicine expense, sometimes the parent with diabetes would go without.”

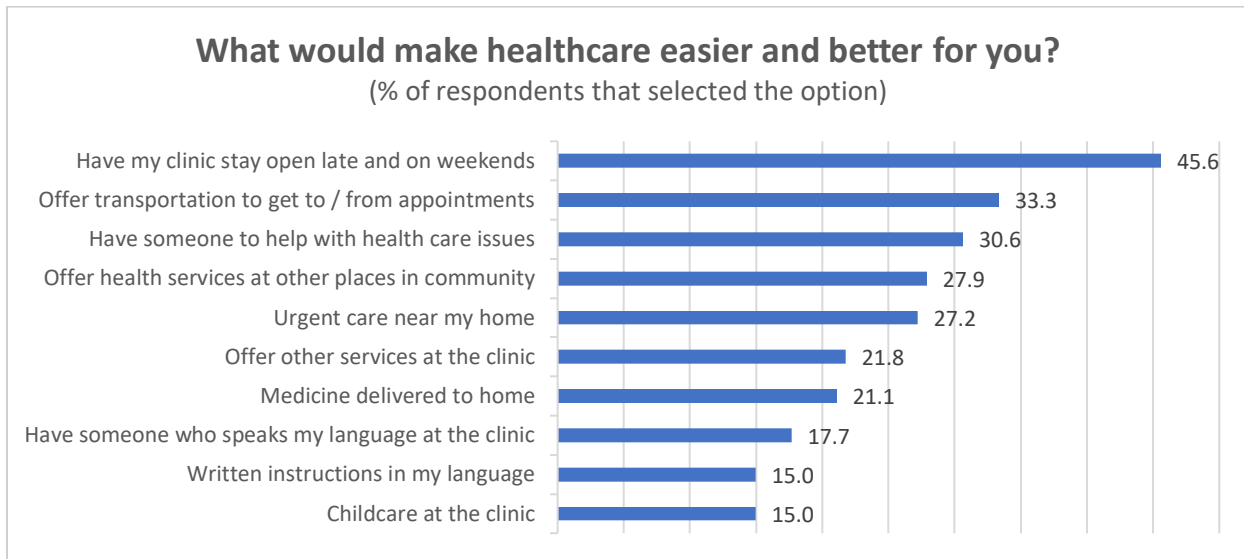
**Account from a Pacific Islander community organizer, shared by API Coalition Advancing Together for Health**

## Ways to Improve Care

The most frequent response for improving healthcare, as seen in the graph below, was to have clinic hours later and on weekends (46%). In addition, transportation assistance was of interest to one-third of

<sup>7</sup> For more information about how racial/ethnic communities were defined, please refer to the Appendix. Detailed information on the racial/ethnic groups that responded the Consumer Voice Listening Project surveys is available on the project's [online dashboard](#).

respondents. While the most common mode of transportation to appointments was by car (52%), 40% rely on bus or train, and 27% get a ride from family or friends.



Data from 2018 and 2019 Consumer Voice Listening Project surveys.

## Communities of Color: Respondents who identify with more than one race or ethnicity

WHAT'S GOING WELL?	WHAT BARRIERS EMERGED?	WHAT COULD IMPROVE?
Access to pharmacy that accepts insurance Language access at clinics	Cost of care Not knowing where to go for care	Hours of clinic Transportation, additional services at the clinic, medicine delivery

### Health Conditions & Use of Health Care

Amongst respondents who identify with more than one race or ethnicity<sup>8</sup> (a total of 136), the most common health condition was behavioral/mental health condition (64%), followed by drug use disorder (36%) and alcohol use disorder (28%). Fifty-three percent of respondents received a preventative exam over the last year, a quarter (26%) did not. The same percentage of respondents received a dental exam (40%) as did not receive one.

Top 3 Common Health Conditions Reported by Multi-racial/ethnic Respondents
64% Behavioral / Mental Health
36% Drug Use Disorder
28% Alcohol Use Disorder

### Access to Care & Ease of Utilization

Seventy-two percent of respondents found it easy to find a pharmacy that accepted their insurance and 63% found it easy to find a clinic that accepted their insurance. The majority (91%) stated that there was a person who spoke their language at their clinic. The majority felt they understood the information they received about their health (69%) and the majority also felt what they shared about their health was understood (64%). For transportation, 61% percent of respondents reported taking bus or train to their medical appointments. The most common reason for not seeking care among these respondents was due to concerns with cost (34%), dealing with other things (32%), or not knowing where to go for care (23%).

### Ways to Improve Care

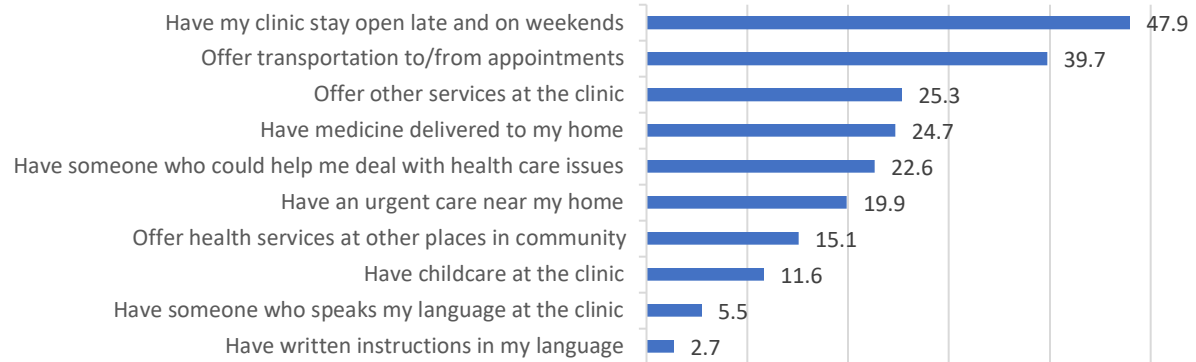
Of all the ways to improve their care, the most common response was (48%) to have their clinic stay open later and on weekends. Over a third of respondents wanted transportation assistance to their appointments (40%), a quarter wanted to have other types of services at their clinic, and a quarter also wanted to have medicine delivered to their home.

<sup>8</sup> For more information about how racial/ethnic communities were defined, please refer to the Appendix. Detailed information on the racial/ethnic groups that responded the Consumer Voice Listening Project surveys is available on the project's [online dashboard](#).



## What would make healthcare easier and better for you?

(% of respondents that selected the option)



Data from 2018 and 2019 Consumer Voice Listening Project surveys.

# LGBTQ and Two-Spirit Respondents

WHAT'S GOING WELL?	WHAT BARRIERS EMERGED?	WHAT COULD IMPROVE?
Access to clinic and pharmacy that accept insurance	Not feeling welcome or comfortable at clinic	Hours of clinic
Ease of getting appointments	Cost of care	Support to navigate health care issues

## Health Conditions & Use of Health Care

Survey respondents were grouped as LGBTQ/Two-Spirit if they identified as transgender, transfeminine, transmasculine, non-binary, two-spirit, asexual, bisexual, gay, lesbian, pansexual, queer, or pansexual.

Respondents were grouped as non-LGBTQ if they identified as cisgender man and straight, or cisgender woman and straight. Although some participating community-based organizations currently prefer to use "LGBTQ+", "LGBTQ" is used in this report to be consistent with the terms used in the survey. As it is true of many communities represented in this report, the LGBTQ and Two-Spirit community members span across racial/ethnic identities. The table on the right shows the breakdown of these identities for the 2019 survey respondents.

How LGBTQ/Two-Spirit Respondents identified themselves by race/ethnicity
20% American Indian/Alaska Native
16% Asian
9% White
8% Multi-racial/ethnic
8% Native Hawaiian/Pacific Islander
2% Black/African-American
2% Latinx/Hispanic

Of the survey respondents who identified as LGBTQ (a total of 739), the most common health condition was behavioral/mental health at 44%, much more common than for the 1,156 non-LGBTQ respondents (34%). Rates of other health conditions were comparable, and sometimes less, than the non-LGBTQ population. Of the survey respondents who identified as LGBTQ, 46% had received a preventative exam in the previous year and 39% received a dental exam.

Top 3 Health Conditions Reported by LGBTQ/Two-Spirit Respondents	Top 3 Health Conditions Reported by non-LGBTQ Respondents
44% Behavioral / Mental Health	31% Behavioral / Mental Health
13% Asthma	15% Alcohol Use Disorder
13% Drug Use Disorder	13% Asthma

## Access to Care & Ease of Utilization

When identifying what kept them from seeking care, a higher percentage of LGBTQ respondents were concerned with cost, were dealing with other things, didn't have money for paying for the visit, and didn't know where to go for care – compared with non-LGBTQ respondents. Notably, LGBTQ respondents were more likely to report avoiding care because they did not feel comfortable or welcome: 14% compared to 8% of non-LGBTQ. LGBTQ and non-LGBTQ respondents reported similar rates for some

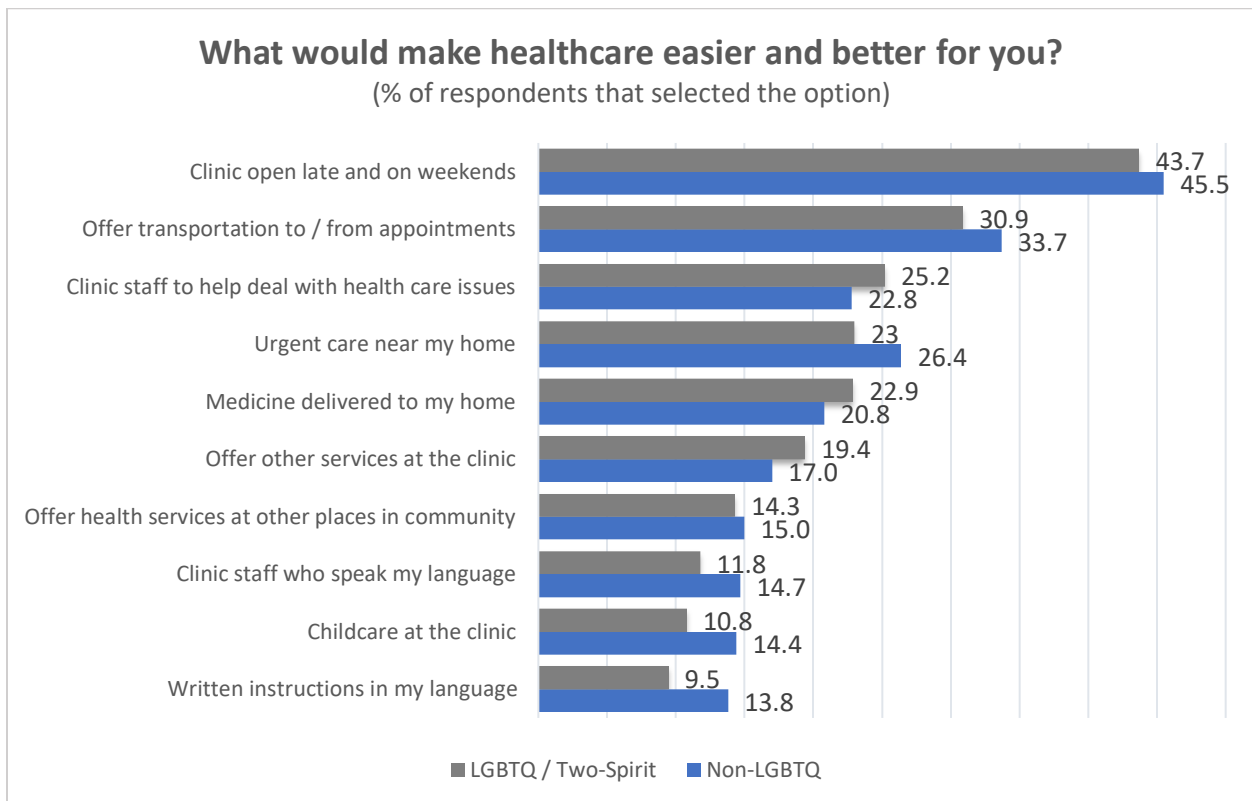
barriers to care: 74-75% reported having staff at clinic that speak their language, and 64-68% said they felt understood at the clinic when talking about their health. Regarding the easiness to understand information received from the clinic, 59% of LGBTQ respondents reported it was easy compared to 66% of non-LGBT respondents. Both groups responded similarly on how easy it was to find a pharmacy or clinic that accepted their insurance. It was easy to find a pharmacy that accepted insurance for 60-61% of respondents, and easy to find a clinic that accepted insurance for 52-57% of respondents.

*"I have great insurance, but the stress of finding new providers as a trans/queer person has made me avoid care since I moved back to Seattle a year ago."*

Client from Gay City

## Ways to Improve Care

In order to improve their health care experience, most LGBTQ and non-LGBTQ had similar priorities: having clinic open late and on weekends, and offering transportation to and from appointments. Full results are visible in graph below.



Data from 2019 Consumer Voice Listening Project surveys.

## Limited English Proficient Respondents

WHAT'S GOING WELL?	WHAT BARRIERS EMERGED?	WHAT COULD IMPROVE?
Utilization of preventative exams	Language of staff and understanding information at visits	Hours of clinic
Most feel welcome at the clinic	Cost of care and lack of health insurance	Staff language abilities and translation of materials

### Health Conditions & Use of Health Care

Of the survey respondents identified as limited English proficient (a total of 459), the most common health condition was diabetes, followed by behavioral/mental health condition, and asthma. A high percentage of the 1,837 English proficient respondents (40%) reported having a behavioral/mental health condition, followed by asthma and alcohol use disorder. Most limited English proficient respondents received a preventative exam in the last year (73%) compared to 52% of those who were English-proficient respondents.

Top 3 Health Conditions Reported by Limited English proficient Respondents	Top 3 Health Conditions Reported by English proficient Respondents
27% Diabetes	40% Behavioral / Mental Health
14% Behavioral / Mental Health	16% Asthma
13% Asthma	15% Alcohol Use Disorder

### Access to Care & Ease of Utilization

In general, a slightly higher percentage of English proficient respondents said that it was easy to get an appointment when needed, easy to renew insurance, and easy to find a clinic and pharmacy that accepted their insurance. Limited English proficient speakers faced more barriers related to insurance and were more likely to avoid filling a prescription or seeking care because of lack of insurance.

When comparing English proficient to limited English proficient respondents, the biggest difference emerges in questions about language access. While 77% of English-

proficient respondents stated that there was always a staff member that spoke their language, this was true for only 45% of limited English proficient respondents. When seeking healthcare, limited English proficient respondents were also less likely to feel they were understood at appointments and less likely

*“Community members agreed about the way the [survey] results mirrored their experiences with accessing and using healthcare services. Specifically, lack of transportation to / from appointments, clinic hours and having someone at the clinic who spoke in their mode of communication (e.g. Portuguese).”*

**AZISWA** (Organization)

Reflection from sharing results to community members in English and Portuguese

to understand the information being shared. While 70% of English proficient respondents stated that they understood information shared at appointments, this was true for only 48% of limited English proficient respondents.

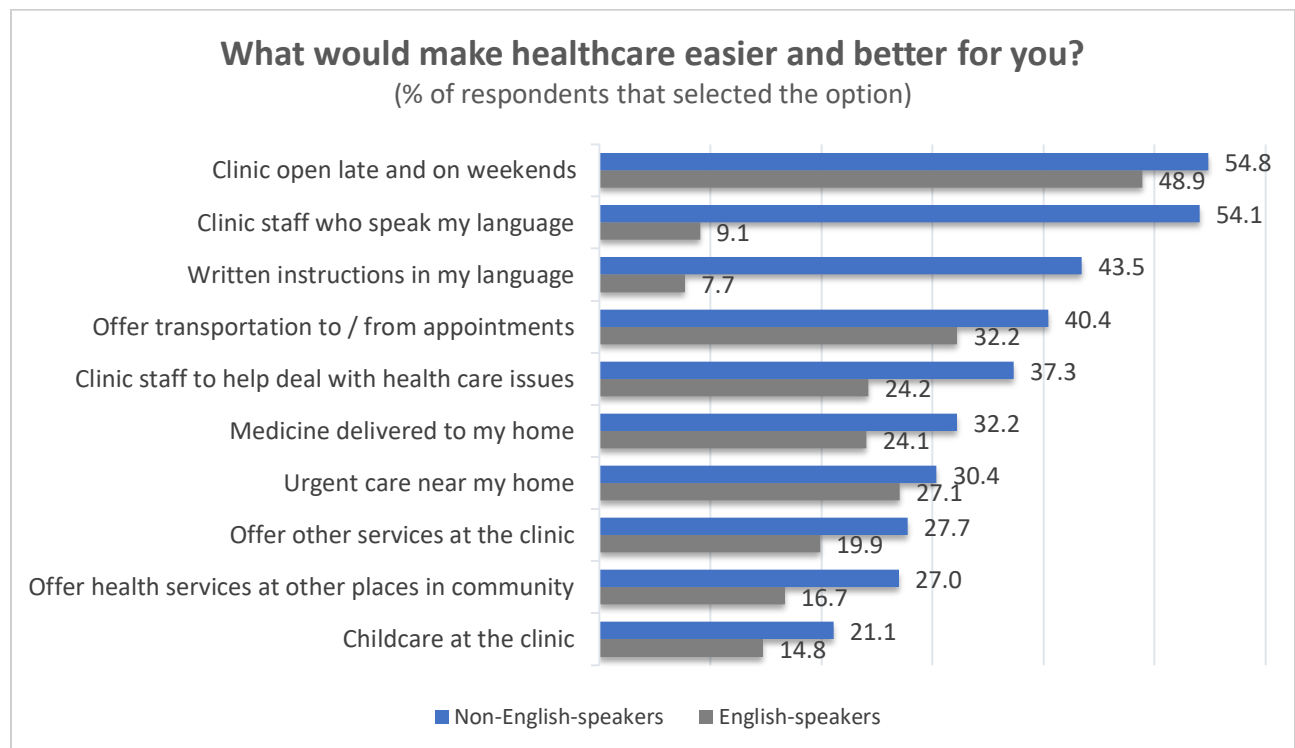
A community-based organization that participated in the Consumer Voice Listening Project offered an additional insight into the language barriers to access healthcare. They highlight the lack of institutional understanding or consideration of the distinct dialects within countries:

*“A lot of people come from [the] same country, have [the] same language but different dialect. If we don’t consider that, we will leave some people out [as they won’t be] accessing the language they really feel comfortable with.”*

Falis Community Services, a participant CBO

### Ways to Improve Care

All respondents were provided options for improving their healthcare experience and across all, a higher percentage of limited English proficient respondents consistently selected each option compared to the English proficient respondents. This suggests a higher need for improvements to the healthcare experience of limited English proficient respondents. The desire for later and weekend hours for their clinic was a top priority for both groups, however demand for clinic staff who speak their language was a priority for 54% of limited English proficient, compared to 9% of English proficient respondents. A similar gap was found for having written instructions in their language.



Data from 2018 and 2019 Consumer Voice Listening Project surveys

## Respondents experiencing homelessness

WHAT'S GOING WELL?	WHAT BARRIERS EMERGED?	WHAT COULD IMPROVE?
Access to pharmacy that accepts insurance	Language of staff and understanding information at visits	Transportation assistance
Ease of getting an appointment	Cost and getting to the clinic	Hours of clinic

### Health Conditions & Use of Health Care

Survey respondents were considered as “experiencing homelessness” if they answered “I am houseless/homeless”, “I live in temporary housing”, or “I live outside”. Respondents were grouped as “not experiencing homelessness” if they selected “I live in a home that I rent or own” or “I live in a home that is rented/owned by someone else”.

Of the survey respondents who experience homelessness (a total of 598), 41% of respondents received a preventative exam and 30% received a dental exam in the previous year. The most common health condition was behavioral/mental health and at 51%, much more common than for the 1,918 respondents who were not experiencing homelessness (27%). Compared to other respondents, folks experiencing homelessness had worse rates for all the health conditions surveyed, being diabetes the only exception.

Top 3 health conditions reported by respondents experiencing homelessness	Top 3 health conditions reported by respondents not experiencing homelessness
51% Behavioral / Mental Health	27% Behavioral / Mental Health
30% Alcohol Use Disorder	17% Diabetes
28% Drug Use Disorder	14% Asthma

### Access to Care & Ease of Utilization

The main reason for respondents who were experiencing homelessness not to seek care was having to deal with other things such as getting food and finding housing. That was a barrier for 41% of these respondents, and for 18% of those who were not experiencing homelessness.

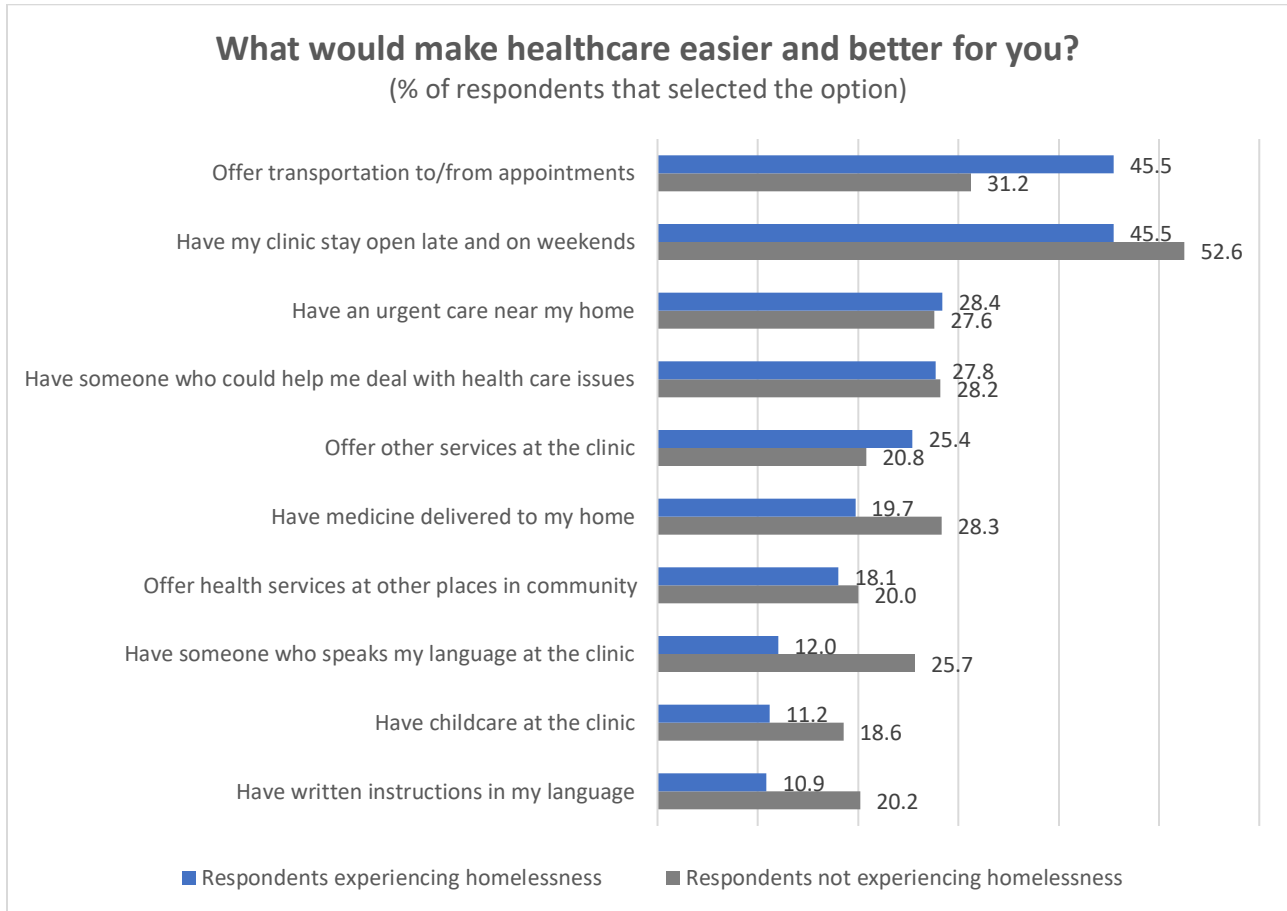
Respondents experiencing homelessness were also more likely to report avoiding care because they did not have a way to get to the provider: 28% compared to 13% of those not experiencing homelessness. Both groups reported similar rates for how easy it was to find a clinic that accepted their insurance.

*“[One client] had a variety of issues to deal with ranging from homelessness to sexual identification to addiction. He... said he did not feel comfortable or welcome in the health care world.”*

**Peer Seattle, participant CBO**

## Ways to Improve Care

For both respondents that were experiencing homelessness and those who were not, the two major ways to improve care was to have clinics stay open late and on weekends, and to offer transportation to and from appointments. The chart below shows how the different ways to improve care compared across the two groups.



Data from 2018 and 2019 Consumer Voice Listening Project surveys.

## Youth and Young Adult Respondents

WHAT'S GOING WELL?	WHAT BARRIERS EMERGED?	WHAT COULD IMPROVE?
Utilization of preventative exams (youth)	Cost of care (young adults)	Hours of clinic (youth and young adults)
Access to pharmacy that accepts insurance (young adults)	Could not get time off work/school (youth)	Having urgent care near home (youth) and transportation assistance (young adults)

### Health Conditions & Use of Health Care

The table below describes how survey respondents were grouped as youth, young adults, and adults.

Group	Definition	Sample size
Youth	17 years old and younger	107
Young Adult	18 – 26* years old *For 2018 Survey this category was 18-24	452
Adult	27 years old and older *For 2018 Survey this category was 25 years old and older	2,052

Youth survey respondents reported much higher rates of asthma and much lower rates of behavioral/mental health conditions compared to young adults. Youth also had rates of diabetes (16%) that were twice as high as for young adults (8%). A high percentage (36%) of young adults and adults (32%) reported a behavioral/mental health condition. Youth were the most likely to receive a preventative exam in the last year (78%), whereas young adults were at 46% and adults at 60%. Youth had similarly high rates of dental exam utilization in the previous year (82%) compared to young adults (47%) and adults (48%).

Top 3 Health Conditions Reported by Youth Respondents	Top 3 Health Conditions Reported by Young Adult Respondents	Top 3 Conditions Reported by Adult Respondents
26% Asthma	36% Behavioral / Mental Health	32% Behavioral / Mental Health
16% Diabetes	14% Asthma	18% Diabetes
14% Behavioral / Mental Health	11% Alcohol Use Disorder	15% Asthma

### Access to Care & Ease of Utilization

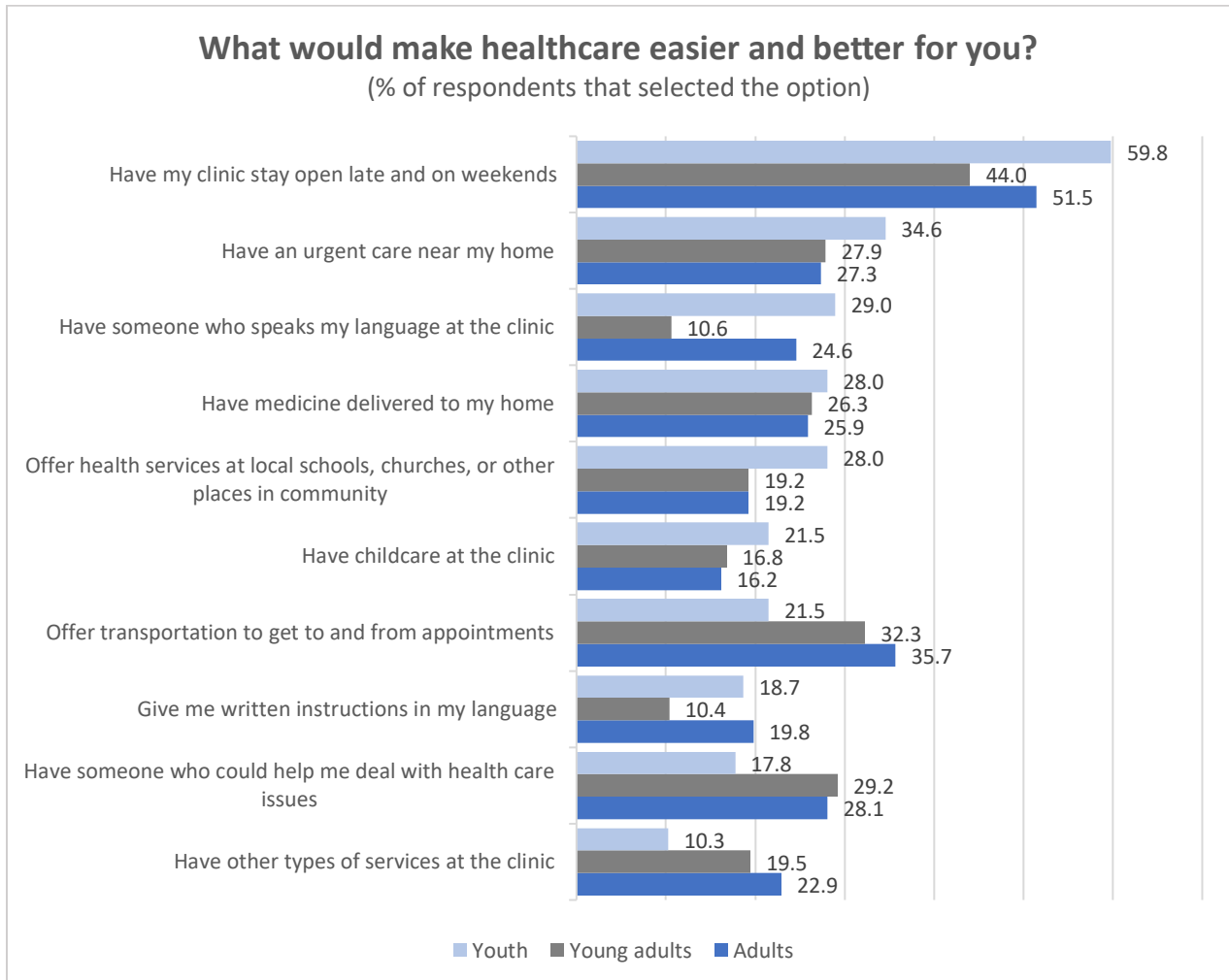
Higher rates of adults encountered difficulty with language of staff at their clinic (18%) compared to youth (15%) and young adults (10%). Youth were slightly less likely to report ease of understanding the information they received from their provider (59%) compared to young adults (65%) and adults (63%) but were more likely to feel the information they shared was understood by their provider (66%) compared to young adults (57%) and adults (62%). When filling prescriptions, youth had the lowest reported barriers related cost (19%), whereas approximately a quarter of young adults (27%) and adults (25%) didn't fill their prescription because it cost too much. Eight percent of youth reported not filling a prescription due to not understanding how to take their medication, which was much higher than young



adults (1%) and adults (2%). Youth were much less likely to delay or not seek care due to lack of money for their co-pay (13.1%), compared to young adults (24%) and adults (23%). Youth were also less likely to not know where to go for care. The most common reason for not seeking care for youth was that they could not get time off work/school. This was experienced by 32% of youth, compared to 24% of young adults and 17% of adults.

## Ways to Improve Care

To improve their health care experience, the top item selected was consistent for adults, young adults, and youth. They would like to see their clinic stay open late and on weekends; 60% of youth compared to 44% of young adults and 52% of adults. An additional priority for youth was having an urgent care near their home (35%) and have someone who speaks their language (29%). For young adults, the most respondents would like an urgent care near their home (44%) followed by wanting to see hours expanded to later and on weekends. Survey responses reveal that youth are more likely to prioritize health services in other community sites and childcare at the clinic, while adults and young adults were more likely to prioritize transportation and having clinic staff to help deal with health care issues.



Data from 2018 and 2019 Consumer Voice Listening Project surveys.

## Reflections from the community on the survey data

The 34 grassroots and community-based organizations that are partners in the Consumer Voice Listening Project reviewed a preliminary version of this report and offered some reflections about the survey data. Below we present a compilation of their reflections.

### Health Conditions & Use of Health Care

- A number of participating CBOs shared that the **prevalence of mental/behavioral health conditions** amongst communities of color as well as other minority groups presented in the report called their attention. They shared that, although healthcare needs and conditions vary across these communities/groups, the prevalence of mental/behavioral health condition is a common factor. Another reflection is the expectation that this health issue could be intensified by the COVID-19 pandemic – which is supported by [data](#) by Public Health Seattle & King County. According to this data, there was an increasing trend in the number of people feeling depressed, worried, anxious, and having no interest from April to July 2020. Participant CBOs also reported a growing demand for mental health services amongst the communities they serve due to the COVID-19 pandemic. “The isolation, the economic instability, the food instability... it is really affecting our folks” – they added.
- Upon reviewing the survey data, one of the reflections from community is that it is important to think about the **link between mental/behavioral health and other health conditions**. As one of the participating organizations contemplates: “behavioral/mental health can be looked at as a foundation upon which the other health conditions presented in the report (Alcohol Use Disorder, Asthma, COPD/Lung Disease, Diabetes, Drug Use Disorder, and Heart Disease) are hinged”.
- Another participating organization offers a **caveat regarding the mental/behavioral health data** from the Consumer Voice Listening Project surveys: the surveys were answered during winter months, a time when it is common for people to be affected by [seasonal affective disorder](#), which could have impacted the results. Also, the organization highlights that the Pacific Northwest region has a higher rate of mental/behavioral health issues compared to other regions of the country. As a reference, the Centers for Disease Control and Prevention (CDC) offers [data on mental health by state](#).

### Access to Care & Ease of Utilization

- A participant CBO commented that low-income BIPOC communities face a number of **barriers to access health care**. These barriers include fewer programs that provide culturally competent care, having staff that speak their language, and limited access for uninsured and non-Medicaid individuals.

- Participant CBOs talked about how the health disparities experienced by communities highlighted in this report are evident<sup>9</sup> in and were worsened by **the COVID-19 pandemic**. One of these organizations talked about the impact on people experiencing homelessness:

“the Covid-19 pandemic... [has] exacerbated existing health inequities experienced by this population. People living homeless in King County are disproportionately Black, Indigenous, and People of Color, and the effects of racism compound these health and housing inequities.”

**DESC, a participant CBO that serves individuals experiencing homelessness**

The community-based organizations also pointed out that this report depicts the health inequities experienced by communities prior to the pandemic, and thus provide a good baseline to think about such inequities in the context of COVID-19 as well as what to strive for:

“[What] we saw as ‘normal’... is actually huge health disparities. So, we don’t want to go back to normal. We want to move forward to a better reality than what we are coming from. We can use the struggles of today as a way to move forward.”

**United Indians of All Tribes Foundation, a participant CBO that serves LGBTQ/Two Spirit, Native American, and formerly incarcerated individuals**

- A concern shared by participant CBOs is regarding **cost as a barrier to accessing care**. One organization observed that patients who have insurance deductible and co-insurance “are less likely to access care because they have to balance having food at the table or accessing care”. Another CBO commented on the issue that those who qualify for Medicaid due to their income often have to remain at a low wage job, because their salary increase means that they no longer qualify for Medicaid but is not enough for them to afford the insurance premium.
- Participant CBOs serving Native Americans and other minority communities argued that in addition to the reasons for not seeking care available in the survey as response options, another common barrier to care is **fear of seeking care**. That fear can be related to how the individual will be treated by clinical staff, in consequence of a previous situation experienced firsthand or by others in the community. A following story illustrates this barrier to accessing care:

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<sup>9</sup> Data and analysis published by Public Health Seattle & King County also highlight this issue: 1) [“Race and ethnicity data dashboard”](#); 2) [“New analysis shows pronounced racial inequities among COVID-19 cases, hospitalizations and deaths”](#).

“We had an African American client that needed to get back on her anti-depressant but she didn’t feel comfortable talking to the doctor about it, thinking they might not give it to her or not take her seriously. The same client switched her OB doctor at 8 months pregnant because her OB doctor was always busy and kept rescheduling her appointments. At that point, she had not done the diabetic (glucose) test yet, even though she was getting very uncomfortable with swollen feet. Her OB agreed to transfer her. The client contacted a new clinic on the same day but they would not take her, or even make an appointment with her, until they received paperwork from the previous clinic. We both called them a few times a day for about a week until they actually made an appointment with her.”

**Participant CBO about the experience of an African American client**

- Insights on the barriers that **American Indians/Alaska Natives who live in the urban setting** face were shared:

“Since we do not live on reservation our urban native population, we do not have access to our own clinic and we do not have an Indian Health Service in Washington. Our AI/AN urban folks without good insurance utilize the Seattle Indian Health Board. Some of [their] services are limited to in clinic only so there is a need for referrals to other health organizations who sometimes do not take Apple health insurance and will charge a copay. Those who are unable to pay a copay will usually put off seeking the medical attention they need. According to your data this is 20% of our urban native population.”

**Tlingit & Haida Indian Tribes of Alaska – Washington Chapter, participant CBO that serves American Indian/Alaska Native communities**

- **Youth of color** have a hard time finding mental health support, according to a participant community organization.

“A story that we hear time and time again is the cycle of finding mental health supports such as therapists or counselors, and how daunting and inaccessible this search can be for low-income youth of color. Some of these barriers are insurance, which we know often times does not cover counseling services. Many students of color search for low-cost or free [counseling] services, but find that even when they do secure a counselor, that person does not come from the same or community as them.”

**SOAR, participant CBO that serves youth of color**

- Regarding the data about the reasons why individuals do not seek care, an organization that serves **formerly incarcerated folks** shared an important insight:

“The data around not seeking care is a great example of how the littlest barriers feel insurmountable for our hard to reach population of formerly incarcerated people. We often won’t try for things because a. we are overwhelmed meeting basic needs or b. we are used to anticipating barriers due to our convictions and even before that due to issues like poverty and/or racism. When you are actively experiencing multiple hardships and barriers at the same time the smallest things feel insurmountable.”

**Civil Survival, participant CBO that serves formerly incarcerated individuals**

- Reflections were also shared by organizations participating in the Consumer Voice Listening Project about **barriers to refill prescription medication**:

“Once a medication is prescribed and obtained, the process for refilling the prescription can become an obstacle if the person does not have a bank account or credit/debit card or reliable internet or cell phone access to ‘call-in’ a prescription. To obtain a refill, the person must then arrange time and transportation to and from their pharmacy to get ahold of their needed medication.”

**Consejo, participant CBO that serves Latinx and immigrant communities**

- Another participant CBO offered insights on **how to mitigate the language barriers** to accessing care:

“The survey shows that majority of communities found that it was difficult or they could not find doctors that speak their language of origin and many other issues that make it unfriendly to seek medical or healthcare treatment. I think this is a significant problem and can take many years to solve but I think one way to help solve it is to encourage the community of color to get into high medical school. This way not only they can speak our language but also understand our community better because they are one of us.”

**ZACUSA, participant CBO that serves the Zanzibar community**

## Ways to Improve Care

- One participant CBO pointed out that another way to improve care is for clinical organizations to develop authentic **partnerships with more non-profits**, and community clinics within the communities. According to them, this measure would also contribute to mitigating the language barriers to accessing care.
- According to a participant CBO, another way to improve care would be to have an **immigration** consultant in the communities who can help those who need assistance with their immigration status. They remind us that, unlike those who are U.S. citizens or formally recognized as U.S. residents, undocumented individuals have severely limited options for obtaining free or low-cost health insurance through Washington State.

- A participant CBO argued about the **importance of changing systems** when it comes to improving care, as health care goes beyond clinical services:

“One consumer shared a story about how they had been hospitalized and then discharged ‘back to the cold street.’ They spoke about how hard this experience was. This story is important because it illustrates that conventional healthcare services don’t meet everyone’s needs, and it’s important to look at our systems and listen consumers to understand how systems and services are—and are not—meeting people’s needs. This story also shows that what happens between healthcare encounters (beyond the walls of a clinic or hospital) can have a tremendous impact on people’s health, well-being, and safety. Health is more than just clinical services—social determinants of health and other resources also have an important role in supporting the health of community members. And in turn, they impact barriers captured in this data, such as challenges traveling to and accessing clinical healthcare services.”

**DESC, a participant CBO that serves individuals experiencing homelessness**

- **Expanding services that are already available at community clinics** is argued by a participant CBO as a good way to improve care without taking too long: “increasing the services to our clinic that already in place such as; interpreters, opening late evening hours, and weekends, we can... minimize the healthcare bottleneck in our communities.”
- A participating organization serving Asian Pacific Islanders and youth came up with an innovative way of improving care. Through the classes they offer to the community, they are **encouraging and supporting the development of leaders within the communities**. The idea is that these leaders can support others on the weekends and during other times when community health works and community organizers are not available.

### Suggestions for future data collection and analysis

- A number of participating organizations talked about the need to further disaggregate data on how communities experience care, particularly for Asian and for Black/African American/African-born respondents. Additionally, one CBO talked about the second generations of immigrants: “you will... have to think about the second generation of African-born, and what category and how can you collect data for this particular generation and what category they can be put in” – they said.
- Participant CBOs highlighted the need to look at intersectionalities in the data, such as LGBTQ/two-spirit by race/ethnicity. They argued that these additional breakdowns can help uncover disparities in how people experience healthcare.

## Appendix: How racial/ethnic communities were defined

The sections of this report that focus on specific racial and ethnic communities reflects data from 2018 and 2019 surveys combined. A key difference between these two surveys is that the 2018 survey asked about race and ethnicity as a write-in (open-ended) response only, while the 2019 survey provided specific categories to select as well as an 'Other' (open-ended) response option.

In order to combine the survey data from both years, open-ended respondents were re-categorized into the following response options: (1) American Indian/Alaska Native, (2) Asian, (3) Black/African American/African-born, (4) Latinx/Hispanic, (5) Multi-racial/ethnic, (6) Native Hawaiian/Pacific Islander, and (7) White. To re-categorize open-ended responses, we used a report from the Agency for Healthcare Research and Quality (AHRQ) titled *Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement* (<https://www.ahrq.gov/research/findings/final-reports/iomracereport/reldataaptabe1.html>) as a guide and to consistently make these decisions. Some additional 2019 survey questions asked about community membership and tribal affiliation, and these were also used to represent racial or ethnic identity. The definitions for each of the racial or ethnic community represented in this report are described in the table below.

Racial / Ethnic Community	Definition
American Indian/Alaska Native	Any respondent who: <ul style="list-style-type: none"> <li>A. Selected "American Indian/Alaska Native" as their race or ethnicity</li> <li>B. Wrote into the open-ended option a response that corresponded to "American Indian or Alaska Native" (AHRQ report linked above)</li> <li>C. Selected "Native/Indigenous/ American Indian / Alaska Native" as their community membership</li> <li>D. Reported a tribal affiliation as American Indian or Alaska Native</li> </ul>
Asian	Any respondent who: <ul style="list-style-type: none"> <li>A. Selected "Asian" as their race or ethnicity</li> <li>B. Wrote into the open-ended option a country or region that corresponded to "Asian" race or ethnicity (AHRQ report linked above)</li> <li>C. Selected "Asian" as their community membership</li> </ul>
Black/African American/African-born	Any respondent who: <ul style="list-style-type: none"> <li>A. Selected "Black/African American" as their race or ethnicity</li> <li>B. Wrote into the open-ended option a country or region that corresponded to "Black or African American" or "African-born" race or ethnicity (AHRQ report linked above)</li> </ul>
Latinx/ Hispanic	Any respondent who: <ul style="list-style-type: none"> <li>A. Selected "Latinx/Hispanic" as their race or ethnicity</li> </ul>

	<p>B. Wrote into the open-ended option a country or region that corresponded to “Latinx/Hispanic” race or ethnicity (AHRQ report linked above)</p>
Middle Eastern North African (MENA)	<p>Any respondent who:</p> <ul style="list-style-type: none"> <li>A. Wrote into the open-ended option a country that corresponded to one of the <a href="#">19 MENA countries</a></li> <li>B. Wrote into the open-ended option “Arab” or “Arabic”</li> <li>C. Anyone who reported Mother Africa, Living Well Kent, or Lutheran Community Services as the name of the organization that asked the respondent to take the survey</li> </ul> <p>Note that this definition was only possible/relevant for the 2018 survey</p>
Native Hawaiian/Pacific Islander	<p>Any respondent who:</p> <ul style="list-style-type: none"> <li>A. Selected “Native Hawaiian/Pacific Islander” as their race or ethnicity</li> <li>B. Wrote into the open-ended option a country or region that corresponded to “Native Hawaiian or Other Pacific Islander” race or ethnicity (AHRQ report linked above)</li> <li>C. Selected “Pacific Islander” as their community membership</li> </ul>
Multi-racial/ethnic	<p>Any respondent who:</p> <ul style="list-style-type: none"> <li>A. Selected “Multi-racial/ethnic” as their race or ethnicity</li> <li>B. Selected multiple race or ethnicities</li> <li>C. Wrote into the open-ended option a response that corresponded to multiple race or ethnic categories</li> </ul>
White	<p>Any respondent who:</p> <ul style="list-style-type: none"> <li>A. Selected “White” as their race or ethnicity</li> <li>B. Wrote into the open-ended option a county or region that corresponded to “White” race or ethnicity (AHRQ report linked above)</li> </ul>