Pierce County COVID-19
Health Equity Assessment
Tacoma-Pierce County Health Department
December 30, 2020
Acknowledgements

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Executive Summary

Tacoma-Pierce County Health Department (Health Department) completed this assessment to inform COVID-19 response and recovery efforts. The assessment found that adverse social, economic, and environmental conditions make individuals and communities more susceptible to negative effects of the COVID-19 pandemic. Structural racism is a key driver of the disproportionate effects of COVID-19 among Black, Indigenous, and People of Color (BIPOC).

We analyzed surveillance data to determine risk groups and where cases are most concentrated. We measured the association between rates of COVID-19 infection and the prevalence of social and economic conditions that can affect health, such as race, income and educational achievement. Most importantly, we hosted listening sessions with those who are most at-risk to understand the effect the pandemic has had on them and their families, and how well they’ve found support during these difficult times.

Overall, we found an abundance of evidence suggesting the effect of COVID-19 on our community has been substantial, disproportionate and preventable. For example, people of color experience higher rates of infection compared to whites. Also, we found that people residing in areas with comparatively poor social and economic conditions (e.g., lower income or limited English) were much more likely to become infected.

Many listening session participants shared stories about making difficult choices to continue earning income for rent and food. Many lack resources necessary to abide by stay-at-home orders or remain in quarantine after exposure. Others described feeling economic and educational uncertainty, social isolation, and stress.

Many participants in most listening sessions reported mental health issues among adults and children. Some participants delayed care of existing health conditions for fear of contracting COVID-19 in healthcare settings and many already lacked access to healthcare.

Additional barriers for BIPOC to seek care include mistrust of public health and governmental institutions because of historic trauma (e.g., Tuskegee Syphilis study, Project 4.1). Some participants shared their underlying health conditions that place them at higher risk of COVID-19 are a direct result of historic trauma and violence (e.g., forced migration, war/conflict and nuclear testing).

As a result of this community input and with help from experts at the UW CoLab for Community and Behavioral Health Policy, we identified 10 policy areas to help inform recovery efforts for years to come:

- Behavioral and physical healthcare access.
- COVID-19 specific care.
- Early childhood development.
- Youth-centered behavioral health.
- Education access.
- Food affordability and accessibility.
- Healthy community planning and built environment.
- Economic stability.
- Affordable, accessible housing.
- Social connectedness.

“...do I want to die trying to pay rent?”
-listening session participant
Introduction

Purpose of This Report

We wrote this report primarily with community leaders in mind, many of whom participate in the Pierce County Health Equity Action Network (EAN). In collaboration with community partners, the Health Department created the EAN to engage communities experiencing health inequities during the COVID-19 pandemic. EAN works to achieve health equity by strengthening cross-sector partnerships and developing pro-equity actions and policies grounded in both science and community experiences and perspectives. EAN is a platform for community members to work together and with the Health Department and other partners to prevent and reduce harms from COVID-19.

Social, Economic, and Environmental Conditions

Figure 1 Social, economic, and environmental conditions influence health the most.

Our 2015 health equity assessment found social, economic, and environmental (SEE) conditions influence health outcomes the most (Figure 1). These conditions have an enormous impact on levels of power, opportunity and resources that people and communities need to be healthy.

Health inequities are avoidable and cause unfair differences in health outcomes. The main cause of health inequities is adverse SEE conditions such as poverty, structural discrimination, violence and pollution.

The 2015 assessment helped us understand which parts of our community are experiencing health inequities. For example, we found that American Indian/Alaska Native infants have higher mortality rates compared to white infants born in Pierce County. Similarly, we observed differences in life expectancy between residents of different neighborhoods. Many of these neighborhoods feature vastly different SEE conditions and health outcomes despite being near one another.
Structural Racism and COVID-19

The types of SEE conditions in which Black, Indigenous, and People of Color (BIPOC) live in directly result from historical and ongoing racist policies, institutional practices, and budgetary decisions (e.g., redlining, hiring bias, unequal educational resource distribution, etc.). Cumulative, generational effects of racism particularly affect Pierce County’s Black African Americans and American Indian/Alaska Native peoples.

In this report, we define racism as a form of discrimination rooted in the belief that the white race is superior to all other races. It involves individual and collective attitudes, actions, beliefs, and unequal power relations. Structural racism interconnects with individual forms of racism and often serves to reinforce discriminatory beliefs and values. For this reason, the concept of structural racism has been suggested to reflect the “totality of ways in which societies foster racial discrimination through mutually reinforcing systems of housing, education, employment, earnings, benefits, credit, media, healthcare and criminal justice”.

Structural racism hurts the health of our community by preventing BIPOC communities from attaining their highest level of health. Experiencing structural racism has direct physiological impacts on the body like elevated stress hormone, anxiety and depression. The stress of racism is associated with harmful coping behaviors such as smoking, alcohol and drug use. Elevated stress hormone also elevates inflammation, increases risk of chronic illness, and increases maternal-infant death.

Largely because of structural racism, BIPOC have persistently lower income, fewer educational and cumulative wealth opportunities, poorer health, and lower life expectancy. In Pierce County, BIPOC currently make up about 55% of Pierce County’s homeless population, but account for only 25% of the general population. Native Hawaiian and other Pacific Islander children are nearly twice as likely to experience poverty as white children. Hispanic/LatinX adults have averaged the least per capita income among all Pierce County races. Pierce County BIPOC residents disproportionately experience more asthma, heart disease, and diabetes. American Indian/Alaskan Natives have the highest rates of youth asthma and suicide. Life expectancy is worse for American Indian/Alaskan Native (74.7 years) and Black African American residents (76.1 years) compared to other race groups.

“(COVID) feels like a reoccurring trauma, along with (the killing of) black and brown folks by police.”
-listening session participant

References:
1 Structural racism and health inequities in the USA: evidence and interventions - The Lancet
2 Rac007.pdf (dph.org)
4 Toxic Stress. Harvard University Center on the Developing Child
5 Pierce County Human Services Interactive Infographic: Homelessness in Pierce County
In addition, BIPOC are less likely to trust government institutions because of historic medical experimentation, nuclear testing, ongoing law enforcement violence, and other forms of structural violence (discussed in listening sessions). Mistrust is a persistent barrier to access the information and resources needed during the pandemic. The lack of linguistically accessible and culturally grounded public health information and public services during the pandemic exacerbates that mistrust.

Some ways the COVID-19 pandemic uniquely affects BIPOC experiencing structural racism include:

- Preexisting health inequities may mean more underlying health conditions that leave bodies more vulnerable to COVID-19 infection and working harder to recover.
- Limited access to quality, affordable and unbiased healthcare can reduce the likelihood of early and fair testing and treatment.
- Lack of transportation, internet, legal status or limited ability to speak English means less access to information and resources that protect them from COVID-19, access benefits or safeguard them from discriminatory practices.
- Occupational segregation and discriminatory work policies means that many residents do not have jobs that support physical distancing, flexible schedules, sick leave or access to childcare when schools are cancelled.
- Lack of accumulative wealth, residential segregation and discriminatory rental and purchasing policies creates housing instability and homelessness. Shelters, motels, families “doubling up” and incarceration decrease opportunity for social distancing.
- Poor mental health from racism, social isolation and economic uncertainty puts many at heightened risks for incarceration, drug use, suicide, etc.

This assessment presents quantitative and qualitative evidence that preexisting adverse SEE conditions, including structural racism, create more susceptibility to negative impacts of the COVID-19 pandemic.

“"I haven't heard anything specific saying, 'hey we realize that like historically medicine impacts you (people of color) differently.' I wish they would be more bold in saying that, because I'm not really trusting the procedures.”
- Listening session participant

“"We’re working with a very high risk of getting infected...How can the Department of Health help us go to work safely?”
- Listening session participant

10 How COVID-19 Is Affecting Black and Latino Families’ Employment and Financial Well-Being
Assessment Approach

In early 2020 we developed a framework to help better visualize and explain our assessment work. This “health equity assessment framework” is described in Figure 2. Health inequity is the result of complex network of factors. A thorough, balanced evaluation of what’s driving health inequity requires looking at the problem from different angles, using or overlaying different kinds of information. We developed an area-based approach to not just detect health inequities, but measure and compare them in a standardized way. This allows us to estimate the size of disease burdens caused by specific inequities. Calculating those inequities in comparison unties the potential savings that could be achieved if these inequities were eliminated.

(The only component in the framework not included in this assessment is the Health Department’s “Internal Assessment,” which we will release in 2021.)

Methods

We used a mixed-methods approach involving both quantitative and qualitative data to identify and characterize health inequities caused by COVID-19.

Working with quantitative data means working with numbers. These data describe things we can count and support the development and use of standard metrics such as reported cases of infection and incidence rates. We use quantitative data to measure and compare risk for disease, estimate disease burden, and calculate cost-effectiveness of specific disease control strategies. This gives us the evidence we need to prioritize groups for service delivery and justify the allocation of limited resources in ways that are objective and transparent.

However, numbers can’t tell us everything we need to know. We also rely on community voices and stories (qualitative data) to provide much needed nuance, help us understand what factors add to or worsen harms from COVID-19, and how those harms might be prevented or reduced.
COVID-19 Risk and Socioeconomic Position (Quantitative)

Measuring health inequity usually starts with a comparison of health outcomes across different groups of people. Using surveillance data, we routinely compare measures of disease burden across populations with different demographic characteristics such as gender, race/ethnicity or place of residence. For example, Table 1 contains a breakdown of COVID-19 cases by age group, as featured in the Pierce County COVID-19 Data Dashboard. The bar chart in Figure 3 describes diagnosis rates by race/ethnicity, a standard slide we use in presentations to community groups.

Table 1 Screen shot from Pierce County COVID-19 Data Dashboard

Cases and deaths by age

<table>
<thead>
<tr>
<th>AGE</th>
<th>% CONFIRMED CASES</th>
<th>DEATHS</th>
<th>% DEATHS</th>
<th>% PIERCE COUNTY POPULATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-19 years</td>
<td>13.1%</td>
<td>1</td>
<td>0.4%</td>
<td>26.3%</td>
</tr>
<tr>
<td>20-29 years</td>
<td>20.7%</td>
<td>2</td>
<td>0.8%</td>
<td>13.6%</td>
</tr>
<tr>
<td>30-39 years</td>
<td>19.3%</td>
<td>1</td>
<td>0.4%</td>
<td>13.4%</td>
</tr>
<tr>
<td>40-49 years</td>
<td>16.1%</td>
<td>7</td>
<td>2.8%</td>
<td>12.4%</td>
</tr>
<tr>
<td>50-59 years</td>
<td>14.1%</td>
<td>15</td>
<td>6.1%</td>
<td>13.0%</td>
</tr>
<tr>
<td>60-69 years</td>
<td>8.6%</td>
<td>39</td>
<td>15.9%</td>
<td>11.5%</td>
</tr>
<tr>
<td>70-79 years</td>
<td>4.7%</td>
<td>70</td>
<td>28.5%</td>
<td>6.5%</td>
</tr>
<tr>
<td>80+ years</td>
<td>3.3%</td>
<td>111</td>
<td>45.1%</td>
<td>3.1%</td>
</tr>
</tbody>
</table>

In Table 1, we can see that age distribution of COVID-19 cases and deaths is different than in the county population, and that risk for death increases with age.

Figure 3 Pierce County COVID-19 diagnosis rates by race and ethnicity

Cumulative COVID-19 diagnosis rates by race/ethnicity, Pierce County, 2020 (as of 12/2/2020)
Figure 3 describes how rates of infection are much higher in some racial/ethnic populations than in others. For example, the rate among residents who are Native Hawaiians and Other Pacific Islanders (NHOPI) is nearly 4-times higher than the rate among white residents.

While this approach is valuable and a good place to start, it often creates more questions than answers. We need more information to determine not just where health inequities exist, but why they exist and how to prevent them. We must strive to understand the ways in which power and opportunity—or socioeconomic position (SEP)—affect health.

Since COVID-19 and other disease surveillance systems don’t routinely collect patient-level information about the SEE conditions in which people live, we often must look elsewhere for this information. One option is to use area-based measures such as those published by the U.S. Census Bureau. Neighborhood-level SEE characteristics can be a proxy measure for SEP and support the indirect measurement of health inequity.\textsuperscript{11 12 13} For our health equity assessment framework (see Introduction), we overlay SEE (equity) indicators with health outcomes information from our COVID-19 surveillance system.

We used COVID-19 surveillance data collected by disease investigators in Pierce County between Mar. 6, 2020 and Dec. 1, 2020. By collecting and geocoding residential address information, we determined the Census tract of residence for 97% of all confirmed cases ($n = 16,939$). To measure SEP, we used Census-tract level socioeconomic data and population estimates from the American Community Survey 2014-2018. Specifically, we used four common, area-based indicators available at the Census tract level:

- Median household income;
- Percentage of persons 25 and older who have attended any college;
- Percentage of persons 5 and older with limited English-speaking ability; and
- Percentage who are persons of color.

Using these area-based measures, we rank ordered the Census tracts from most advantaged to least, and then divided them into four equally size groups or quantiles, 43 tracts per group. We calculated diagnosis rates per 100,000 based on the aggregate cases living in each group of tracts. We compared the group-specific rates, using the group with the highest level of aggregate SEP as the reference group. We were then able to measure health inequity in the form of absolute and relative differences in disease risk between groups, and to estimate the potential reduction in disease burden (expressed as cases per 100,000 averted) if each group of tracts featured the same level of SEP as the reference group.

\textsuperscript{12} Krieger et al. Comparing individual and area-based socioeconomic measures for the surveillance of health disparities. American Journal of Epidemiology, Volume 164, Issue 9, 1 November 2006, Pages 823–834
\textsuperscript{13} Denny, K. and Davidson, MJ. Area-based socioeconomic measures as tools for health disparities research, policy and planning. Canadian Journal of Public Health/Revue Canadienne de Santé Publique Vol. 103, Supplement 2: Contemporary Use of Area-based Socio-economic Measures (September/October 2012), pp. S4-S6
Community Voices (Qualitative)

We collected qualitative data using a Community-Based Participatory Research (CBPR) framework. CBPR is the systematic collection and analysis of information for taking action and making change. CBPR emphasizes participation. Data collection and results both come from and go directly back to community members.

Our objective was to understand how the COVID-19 pandemic has impacted community members. We also wanted to identify strengths and capture stories of resiliency. Community partners initiated community outreach. They invited the Health Department to answer questions about COVID-19, offer resources and build community trust. Community leaders in the EAN conducted 15 listening sessions with standardized qualitative data collection methods.

Who did we want to talk to? (Selection criteria)

The surveillance data (discussed above) informed who we wanted to talk to. Community partners recruited participants based on the following selection criteria:

- People disproportionately impacted by COVID-19 cases: Hispanic/Latinx, Black/African American, Native Hawaiian and Pacific Islander, and Native American.
- People at higher risk of COVID-19 infection: healthcare workers, essential businesses, people living homeless, people with disabilities, youth/young adults, and people over 65.
- People experiencing racism among other adverse SEE conditions such as:
  - Black, Indigenous and People of Color.
  - LGBTQ.
  - Low-income households.
  - Rural communities.
  - People with disabilities.
  - Front-line workers (healthcare, grocery, delivery, farmworkers etc.).
  - Immigrants and refugees.

Community leaders recruited participants via email, text, and word-of-mouth (snowball sampling). Community members created flyers and posted them on partner websites (Figure 4). The Health Department and community organizations gave $30 gift cards and other incentives approved by community organizations to participants as fair compensation for their time.
How did we collect the data?

For consistency across listening sessions, we gave three facilitation trainings for community leaders with a moderator/facilitator guide (Appendix A). Listening sessions were in English and Spanish.

- Listening sessions were 60-90 minutes with 4-10 participants in each (many were initially larger with breakout groups).
- Each group had one facilitator and one notetaker.
- Sessions were virtual using ZOOM and recorded with participant consent for note-taking purposes.
- Participants gave consent to confidentially share their experiences with the Equity Action Network.
- Community members and facilitators reviewed and approved session notes before sharing with Health Department analysts.

Questions:

1. How is the COVID-19 pandemic impacting you, your family, and your community?
   a. Probe if needed – What would make you feel more protected from the virus?
   b. Probe if needed – What do you want TPCHD to do?

2. How are you, your family, and your community supporting each other during the COVID-19 pandemic? (Probe for stories of resilience)
3. *(For groups involved in pre-COVID assessments only: How have these priorities remained the same or changed for you during the pandemic? Social Connections, Food Access, Housing and Transportation)*

**How did we analyze the data?**

We used an inductive\(^\text{14}\) approach to analyze qualitative data. Analysts from the Health Department’s COVID-19 data and surveillance branch reviewed transcriptions of audio/video files and performed qualitative analysis manually and with nVivo software to determine emerging themes.

Analysts transcribed audio recordings into text and used open and axial coding\(^\text{15}\) to discover patterns and recurring themes across all focus groups. Analysts considered a data point to be an emerging theme if two or more of the following criteria applied:

- Three or more participants in one group (>30%) mentioned the same data point.
- The data point was discussed in more than one listening session.
- The data point was discussed repeatedly and with acknowledgement/agreement from others (emotional response).

Health Department staff reviewed themes with session participants for their approval before sharing with the Health Department and EAN. The Health Department shared the raw data and analysis notes with the UW CoLab team who then used coding for policy analysis (another CARES Act funded project).

**Results**

**COVID-19 Health Outcomes (Quantitative)**

With few exceptions, and regardless of which area-based indicator we used, we found strong evidence that COVID-19 risk is inequitably distributed across Pierce County (Figure 5a - Figure 5e). Census tracts with higher aggregate levels of SEP had significantly lower rates of COVID-19 diagnosis. Residents living in the least advantaged areas were 50%-100% more likely to be diagnosed with COVID-19 infection compared to those living in the most advantaged areas. These results suggest that if all Census tracts shared highest level of SEP, 17% to 34% of confirmed cases—nearly 6,000 infections at the time of this report—could have been averted in Pierce County.

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\(^{14}\) The researcher looks for patterns in the data, working to develop a theory that could explain those patterns (vs a deductive approach which starts with a social theory, or hypothesis, then tests its implications with data).

\(^{15}\) Open coding – (first pass) to generate categories or main themes in data, and their properties; Also called “dis-assembling data”

Axial coding – (combine) Categories are systematically developed and linked with subcategories; Also called “re-assembling data.”
Figure 5a Pierce County COVID-19 rates by median household

In Figure 5a, COVID-19 rates vary from approximately 1,500 cases per 100,000 in the group with the highest median household income to 2,300 per 100,000 in the group with the lowest income. In other words, disease risk in the group with the least degree of advantage (lowest SEP) was roughly 50% higher than in the group with the most advantage (highest SEP).

Figure 5b Pierce County COVID-19 rates by college attainment

In Figure 5b, COVID-19 rates vary from approximately 1,400 cases per 100,000 in the group with the highest percentage of those who have attended college to 2,300 per 100,000 in the group with the lowest. Disease risk in the group with the least degree of advantage (lowest SEP) was about 60% higher than in the group with the most advantage (highest SEP).
In Figure 5c, COVID-19 rates vary from approximately 1,500 cases per 100,000 in the group with the highest level of English-speaking ability to 2,500 per 100,000 in the group with the lowest. Disease risk in the group with the least degree of advantage (lowest SEP) was about 70% higher than in the group with the most advantage (highest SEP).

In Figure 5d, COVID-19 rates vary from approximately 2,400 cases per 100,000 in the group with the highest percentage of residents who are persons of color to 1,200 per 100,000 in the group with the lowest. Disease risk in the group with the least degree of advantage (lowest SEP) was roughly 2-times that in the group with the most advantage (highest SEP).
In Figure 5e, COVID-19 rates vary from approximately 2,400 cases per 100,000 in the group with the highest percentage of residents in poverty to 1,400 per 100,000 in the group with the lowest. Disease risk in the group with the least degree of advantage (lowest SEP) was about 70% higher than in the group with the most advantage (highest SEP).

**Quantitative Data Limitations**

While area-based measures of socio-economic position can be useful, they are generalizations that can obscure the large amount of variability that likely exists between individual residents.

Because of substantial reporting delays and the need to aggregate across multiple years, tract level socioeconomic circumstances might not be in the same in 2020 as they were in 2014-2018.

The surveillance data included here are based on cumulative diagnoses reported through early December 2020. The data might not represent cases diagnosed more recently.

**Community Voices (Qualitative data)**

We conducted 15 listening sessions with a total of 201 participants representing the following communities:

- Four geographic communities of focus (East Tacoma, Key Peninsula, Parkland and Springbrook).
- Three racial/ethnic groups disproportionately impacted by COVID-19 (Black/African American, Hispanic/Latinx, and Native Hawaiian or Pacific Islander).
- Youth/young adults.

(Listening sessions currently scheduled or in-progress as of Dec. 28, 2020 will be shared at a later time including: Two geographic communities of focus [South Tacoma and White River], Native American community, people living homeless, LGBTQ community, and essential businesses.)
Emerging themes are displayed in two categories corresponding with the questions asked: 1) Impacts of COVID-19, and 2) Protection, Support and Resilience. Figures 6a and 6b highlight the combined themes across all the listening sessions. Figures 7a and 7b highlight the themes within sessions by community.

**Figure 6a Summary of themes for combined listening sessions: Effects of COVID-19**

Listening session participants shared how the pandemic is negatively affecting them economically, socially, emotionally, and on their health in general (Figure 6a). Many are risking their health to continue working and need urgent financial support for medical care and basic needs. Nearly all groups discussed an increase of stress/anxiety and depression due to social isolation, fear of illness and economic insecurity. Barriers to care include distrust in providers and government institutions due to lack of culturally grounded information, historic structural violence and racism, and fear of exposure to COVID-19 in healthcare settings.
Figure 6b Summary of themes for combined listening sessions: Protection, support and resilience

Community members shared how acts of services, mutual aid and focusing on gratitude are examples of building resilience (Figure 6b). Spending more time together, within family units and virtually, alleviated stress for many and helped people stay positive.
In nearly all listening sessions, participants shared an urgent need for economic support and basic needs assistance (Figure 7a). They also shared the toll the pandemic is having on their mental health. Black/African American, Latinx, and Pacific Islander communities shared how the disruption to cultural practices and social connections was especially difficult, along with recurring trauma related to racism and social injustices. The disruption in social connection from online school and social isolation is adding to stress/anxiety and depression among the youth and young adults.
Community members shared how acts of services, mutual aid and focusing on gratitude are examples of building resilience (Figure 7b). Spending more time together, within family units and virtually, alleviated stress for many and helped people stay positive.

### Qualitative Data Limitations

Focus group results may not be entirely generalizable to a larger population, and limitations to the strength of conclusions exist.

Instrumentation error (researcher bias): In one listening session, the facilitator listed all probing questions at once and as examples (which limits our ability to gather non-biased responses to the first question) and threatens validity for the results of this session. This error may bias our results by leading participants to give a particular response to probing questions.

In another session with two breakout groups, questions were asked differently in both breakout groups, which limits our ability to draw conclusions for the group as a whole and threatens the validity of the results of this session. This error makes it difficult to make do comparisons of two different questions.
Discussion

The quantitative and qualitative results of this assessment align with each other. Both methods of assessment provided substantial evidence that adverse SEE conditions make individuals and communities more susceptible to negative health, social, and economic impacts resulting from the COVID-19 pandemic. Across the board, our quantitative indicators of SEP and social advantage were strongly and inversely associated with disease risk. Likewise, our conversations with community members confirmed that adverse SEE conditions not only contribute to their disease risk, but exacerbate negative impacts on their families and neighborhoods, threatening their physical health as well as their emotional well-being.

Our area-based analyses demonstrated that median household income, poverty and college attainment are all strongly associated with risk for infection. This suggests that people with fewer economic resources are less able to avoid COVID-19 infection. Similarly, nearly all listening session participants spoke about the importance of economic insecurity. Many already lacked resources prior to the pandemic, including health insurance, to address underlying health conditions and shared they are now facing increased anxiety and depression. Many described the need to take risks in order to ensure economic stability. Many struggled to adhere to public health guidance due to a lack of social and economic resources.

Nearly all listening session participants spoke about the enormous strain the pandemic is having on their mental health. Many have delayed care of underlying conditions due to fear of becoming infected with COVID-19 in healthcare settings. Social isolation due to quarantine and remote learning are also contributing to their stress, and children are feeling the effects of this too. Youth, in particular, shared about the negative impact of social isolation on their mental health.

We also found substantial quantitative evidence that race/ethnicity and limited English-speaking ability are strongly and inversely associated with risk for infection. We believe this a result of structural racism. Our listening sessions reinforced broader research findings showing that BIPOC communities exhibit a mistrust of government and public health/medical providers due to their role in perpetuating structural racism. Similarly, we know that—as a result of centuries of discrimination and xenophobia, including current immigration policies—immigrants and refugees often face greater barriers to finding and using the resources they need to remain healthy. The listening sessions provided additional evidence that these adverse phenomena persist in our county, and that COVID-19 has only made things worse for the most disproportionately affected members of our community.

"...right now, there are many people who are without a job... so if they don't have a job, they don't have insurance, or if they apply for government insurance, some can't have it because of status.”
- listening session participant

"I’m suffering from sudden anxiety attacks; I went into a store...I just grabbed some basics and ran out.”
- listening session participant

"Few people know that medical experimentation took place in the Marshall Islands. No one would expect people who were part of these experiments to have faith in medical providers after this.”
- listening session participant
Despite these challenges, community members shared stories of resiliency and how they are supporting one another during the pandemic. Acts of services, mutual aid and sharing information with one another were some examples, along with focusing on gratitude to build resilience. Spending more time together within family units and virtually alleviated stress for many and helped people stay positive. Others spoke of the power of sharing openly about their infection status to protect loved ones, despite the stigma and shame they may experience. Highlighting and building on the resiliency within the community can be a huge asset in COVID-19 recovery efforts.

We need to build bridges of trust between communities experiencing health inequities and public health/medical providers to ensure health access. Evidence shows that community health workers are extremely successful in closing these gaps to promote health, particularly with medical providers.

**Policy Areas for Recovery**

Policy is an important tool for advancing health equity. People living in adverse SEE conditions generally have less power and influence to shape public policy in ways that meet their needs. The Health Department, UW CoLab for Community & Behavioral Health Policy, UW Northwest Center for Public Health Practice, and EAN collaborated to identify pro-equity policy areas to reduce avoidable and unfair negative effects resulting from the COVID-19 pandemic.

These policy areas provide a strategic high-level policy direction for COVID-19 recovery for the next several years. The policy areas reflect the themes we heard from community listening sessions and the UW’s CoLab for Community & Behavioral Health Policy and the Northwest Center of Public Health Practices’ research on evidence-based health equity policy.

Policy Areas for Recovery:

**Behavioral and Physical Healthcare Access**: a community’s ability to easily obtain medical and health services. Strategies include restructuring healthcare to increase access as well as improving social, economic, and environmental conditions of health (housing, employment).

**COVID-19 Specific Care**: policies that decrease or eliminate the inequitable economic and health impacts of COVID-19 among racial and ethnic groups. Strategies include short-term recommendations around vaccine distribution and workplace policies, as well as longer term focus on structural inequities.

**Economic Stability**: having enough financial resources to afford basic needs. Strategies include employment resources and direct financial assistance.

**Housing Affordability and Accessibility**: ability to comfortably pay for housing within one’s existing income. Strategies include rental and housing eligibility policies as well as land trusts and inclusionary zoning.

**Youth Behavioral Health**: the emotional, psychological, and social well-being of youth. Strategies include school and community partnerships to support the delivery of effective parenting and youth mental health services.
Health Community Planning and Built Environment: community-led neighborhood planning processes focused on human-created surroundings. Strategies include green spaces, accessible food and accessible transportation options.

Early Childhood Development: policies that support the social, cognitive, emotional, and physical development of children birth to three. Strategies include supporting the sustainability of high-quality childcare and education programs.

Education Access: the ability of schools to ensure high quality education and advancement for all students. Strategies include high school completion programs and ending zero tolerance school discipline policies.

Food Affordability and Accessibility: how well individuals can afford to buy healthy food without straining their income. Strategies include incentives for health purchases and developing spaces for community gardening.

Social Connectedness: the experience of belonging to a certain group or social network. Strategies include encouraging providers to provide “social prescriptions” for mental and behavioral health needs, as well as community planning to develop or preserve spaces for social gathering (e.g., community gardens).

The Health Department is using these policy areas to engage community leaders in a participatory policy making process. We recommend these policy areas inform decision-making and investments in COVID-19 recovery efforts.

Learnings/Opportunities for Improvement

In addition to the data limitations outlined in other sections, we would like to acknowledge some areas of improvement for us as a Health Department, in terms of this assessment and future work:

Continue meaningful and respectful community engagement to build trust and make reparations for past harms.

We were not able to reach all communities that we intended to host listening sessions with, including Native American community members, LGBTQ, as well as hosting special sessions with people experiencing homelessness, people with disabilities, and essential workers.

Apply culturally and linguistically appropriate health information and services (CLAS standards).

We are committed to applying CLAS standards to make data and information accessible to everyone, but we aren’t there yet. The Health Department has made improvements such as more website translation, more translated and accessible materials, improved building signage and advances in partnerships to produce culturally appropriate messages. And we want to continue to strengthen our efforts to provide culturally and linguistically appropriate health information and services. We’ve already acted on some of the suggestions focus group participants made to improve communications during the COVID-19 response, and we look forward to working with our community partners to improve this area.
Improve transparency and accessibility of data.

We heard the requests of community to further disaggregate COVID-19 case rate data. For example, community members wanted to see COVID-19 rates for Cambodian and Korean and Vietnamese communities instead of the larger Asian category. We recognize the importance and value of this disaggregated data and continue to face challenges in sharing small numbers of cases (e.g., fewer than five) while still protecting personal health information and maintaining patient confidentiality. We are currently working to develop solutions with community leaders to be more transparent with data, while abiding by HIPAA laws to not reveal protected health information.

Conclusion

Adverse SEE conditions make individuals and communities more susceptible to negative health, social, and economic impacts resulting from the COVID-19 pandemic. Largely due to structural racism, BIPOC communities disproportionately experience adverse SEE conditions. This has resulted in disproportionate COVID-19 infection rates and the worsening of socio-economic conditions among BIPOC and low-income communities. Disease prevention and mitigation strategies must therefore focus on improving adverse SEE conditions. This includes meaningfully engaging those most affected by adverse SEE conditions and working across agencies, systems, and sectors to address racism, poverty, xenophobia, housing and education.

Our findings support the development of targeted, universal strategies aimed to increase resilience and promote recovery among individuals and communities experiencing adverse SEE conditions. We recommend pro-equity programs and policies that increase power-sharing and help build trust between BIPOC communities and government institutions.

The COVID-19 pandemic has brought into stark focus this truth: when some parts of the community are less able to protect themselves from disease than others, it increases health risk for the rest of the community. Until the entire community is healthy and able to thrive, our work continues.
Appendix A: Listening Session Moderator/Facilitator Guide

Tacoma Pierce County Equity Action Network - COVID-19 Needs Assessment 2020

This is a general and simple guide. The most important piece is that the two assessment questions are asked exactly how they are worded. We encourage incorporating culture, arts, and other things that support a meaningful discussion.

Opening remarks/ground rules:

“Welcome. My name is [NAME] and I work for __________. We are here today to learn about how COVID-19 is impacting you, your family and your community. This information will guide Pierce County decisions to better support your health during COVID-19. I will be the moderator for today’s discussion. Thanks for taking the time to be here today. Our discussion will last about one hour.

(If incentive is applicable to your group) As a token of our appreciation we will provide a $30 gift certificate to __________.”

This (virtual platform) seems to work best if we all mute ourselves unless we are talking, so there is no background noise. Also please use the ‘raise hand’ function if you have a question or put your question directly into the chat box (for large groups especially).

“There are no right or wrong answers to the questions I am about to ask. Please feel free to share your point of view even if it’s different from what others have said. To show our respect to the group I ask that we be mindful to not interrupt each other.

“We’re interested in hearing from all of you. So, if you’ve shared already, please give others a chance to speak first. If you aren’t saying much, I may call on you. We just want to make sure we hear from all of you.

*IF RECORDING CONVERSATION:

“We are recording the conversation today because we don’t want to miss any of your comments and can’t write fast enough to get them all down. We will be on a first name basis, and we won’t use any names in our reports. Transcripts of this conversation will only be seen by data analysts at TPCHD (introduce APD staff notetaker if they are present) and the recording will be deleted immediately after our summary is complete. What you share will be confidential and your participation in this group will not affect your participation in Health Department programs or from receiving any services. Is everyone ok with us recording this conversation?

“Are there any questions before we begin?”
Questions

1. How is the COVID-19 pandemic impacting you, your family, and your community?

   Probe if needed:
   What circumstances put you at risk of contracting COVID?
   What would make you feel more protected from COVID?
   What should the Health Department do?

2. How are you, your family, and your community supporting each other during the COVID-19 pandemic?

   Probe if needed:
   Would anyone like to share something positive that’s happened to you or your family/friends during this pandemic?

3. (For TPCHD COF staff only and if applicable to your group) Present current assessment themes: Social Connections, Food Access, Housing and Transportation. How have these priorities remained the same or changed for you during the pandemic?

   Probe if needed:
   What would you say is your top priority right now during this pandemic?

Closing

(Synthesize any collective action items that came out of the meeting – read aloud or send out notes following the meeting).

“You’ve shared a lot today with us about what you need most in your communities. Thank you for your participation today. If anyone is willing to participate in groups like this in the future, please leave your contact info in the chat box and we will be sure to contact you for our next assessment. We will also use that contact to share findings from the assessment.”