2016 Community Health Needs Assessment

Kaiser Foundation Hospitals Sunnyside and Westside
Joint Report
License #1073 and #14-1472

Approved by KFH Board of Directors
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CHNA JOINT REPORT FOR KFH SUNNYSIDE AND KFH WESTSIDE

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Kaiser Permanente Northwest Region
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CHNA JOINT REPORT FOR KFH SUNNYSIDE AND KFH WESTSIDE

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EXECUTIVE SUMMARY

The following report is a culmination of two and a half years of collaboration in the Kaiser Permanente Northwest Region (KPNW), which includes two hospitals, an integrated health care delivery system, and a health plan. The enclosed Community Health Needs Assessment and Evaluation of Impact was completed for Kaiser Foundation Hospital (KFH) Sunnyside and KFH Westside — collectively referred to as KFH NW throughout this report — and includes prioritized health needs for the community served jointly by the two hospitals.

KFH NW defines its shared Primary service area by a four-county grouping, referred to as the Metro service area. KFH NW also provides non-hospital services, has membership, and supports community health in a Secondary service area. The Secondary service area comprises three separate geographically defined areas known as Southwest Washington, Mid-Willamette Valley, and South Valley. The Primary and Secondary service areas span two states and 14 counties with a population of 3.35 million. KFH NW will use this report to inform strategies that address a selection of the prioritized community health needs in its service area.

COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) BACKGROUND

The Patient Protection and Affordable Care Act (ACA), enacted on March 23, 2010, included new requirements for nonprofit hospitals in order to maintain their tax-exempt status. The provision was the subject of final regulations providing guidance on the requirements of section 501(r) of the Internal Revenue Code. Included in the new regulations is a requirement that all nonprofit hospitals must conduct a CHNA and develop an Implementation Strategy (IS) every three years (http://www.gpo.gov/fdsys/pkg/FR-2014-12-31/pdf/2014-30525.pdf).

While Kaiser Permanente has conducted CHNAs for many years to identify needs and resources in our communities and to guide our Community Benefit plans, these new requirements have provided an opportunity to revisit our needs assessment and strategic planning processes with an eye toward enhancing compliance and transparency and leveraging emerging technologies. The CHNA process undertaken in 2016 and described in this report was conducted in compliance with current federal requirements.

In the 2016 CHNA process, KFH NW continued to partner in the Healthy Columbia Willamette Collaborative (HCWC). HCWC was formed to support member organizations in responding to the new ACA federal requirements and to catalyze the collective efforts of health and public health leaders in the Portland metropolitan area.

SUMMARY OF PRIORITIZED NEEDS

Through robust analysis of multiple primary data collection activities and secondary data analysis, KFH NW identified and prioritized the following nine health needs (listed in priority order), defined as:

Access to Care — *High Priority*

Access to high-quality, affordable, holistic, and culturally specific care.

Economic Opportunity — *High Priority*

The ability to meet basic needs, including access to healthy foods, housing, jobs, and education.

Chronic Disease — *High Priority*

Nutrition-, physical activity-, tobacco-, and environment-related chronic diseases and conditions such as obesity, type 2 diabetes, hypertension, heart disease, stroke, and cancer.

Behavioral Health — *High Priority*

Access to mental health care integrated with primary care and substance abuse treatment and care, as well as community safety and violence prevention.

Maternal and Infant Health — *Medium Priority*

Issues that affect the quality of life of mothers, children, and their families, including teen births, low birth weight and infant mortality, breastfeeding, and access to prenatal care.

Asthma — *Medium Priority*

A chronic lung condition affecting the airways of the lungs and exacerbated by environmental triggers such as tobacco smoke and poor air quality.

Oral Health — *Medium Priority*

Conditions of the mouth, teeth, gums, and throat, from dental caries to cancer, that cause pain and disability leading to poor overall general health and quality of life.

Sexually Transmitted Infections — *Medium Priority*

Sexually transmitted infectious diseases such as chlamydia and HIV/AIDS.

Climate and Health — *Lower Priority*

Climate- and weather-related changes that threaten access to clean air, water, and healthy food and also threaten human health, including asthma, allergies, and infectious diseases.

SUMMARY OF NEEDS ASSESSMENT METHODOLOGY AND PROCESS

To assess the community's health, KFH NW examined national and local secondary data, collected primary data, and conducted a meta-analysis of existing community health reports. Secondary data were accessed through the Kaiser Permanente CHNA Data Platform (http://www.chna.org/kp), where 150+ public indicators were analyzed at a service area and county level geography. Local secondary data sources were provided and analyzed by the region's county health departments, and Medicaid claims data were analyzed and reported by the region's Coordinated Care Organizations (CCO). Primary data were collected through two data collection activities, listening sessions, and an online (also offered in print) survey. The listening sessions gathered qualitative data from community members, representatives of underserved populations, and local health system leaders, including the region's community health workers. Lastly, a meta-analysis was conducted of community assessment projects that took place between 2012 and 2015 in the KFH NW Metro area.

The assessment outlined in this report included two processes: health needs identification and health needs prioritization. Both processes considered several data inputs against separate sets of criteria to identify and then prioritize a list of health needs most pressing in KFH NW. Data synthesis for input into the identification and prioritization criteria worksheets was conducted by KFH NW Community Benefit staff and an external consultant. In order to assess what resources are currently addressing or poised to address the most pressing health needs in the community, KFH NW staff and the consultant compiled a list of assets that includes safety net clinics and community providers, community- and government-based organizations, and local funders. The list compiled for the CHNA will serve as a tool for identifying partnership and collaboration in KFH NW to address selected health needs.

Participation in the Healthy Columbia Willamette Collaborative strengthened the KFH NW CHNA process. The collaborative partnerships among hospitals/health systems, CCOs, and county health departments was critical to gathering primary data and analyzing qualitative and survey data for the KFH NW Metro area. KFH NW is also participating in the Lane County Community Health Status Assessment.

Lastly, Health Need Profiles were compiled for KFH NW health needs and included in Appendix F of this report. The profiles serve as a tool for the community, outlining key data points and community input analyzed and captured throughout the process, making the case for the prioritized health needs in KFH NW.

IMPLEMENTATION STRATEGY EVALUATION OF IMPACT

The final component of the CHNA report is an Evaluation of Impact. KFH NW has taken actions since conducting the preceding CHNA (KFH Sunnyside 2013, KFH Westside 2014) to address significant health needs. This section of the CHNA report describes the outcomes and impact of these activities.

BACKGROUND

About Kaiser Permanente

Founded in 1942 to serve employees of Kaiser Industries and opened to the public in 1945, Kaiser Permanente is recognized as one of America's leading health care providers and nonprofit health plans. We were created to meet the challenge of providing American workers with medical care during the Great Depression and World War II, when most people could not afford to go to a doctor. Kaiser Permanente in the Northwest began with the establishment of a medical group to serve workers and their families during construction of the Grand Coulee Dam in northeastern Washington in the late 1930s. During World War II, the medical group also served workers and their families at the Kaiser shipyards in Portland, Oregon, and Vancouver, Washington. When the shipyards closed in 1945, enrollment was opened to the community.

Since our beginnings, we have been committed to helping shape the future of health care. Among the innovations Kaiser Permanente has brought to U.S. health care are:

- Prepaid health plans, which spread the cost to make it more affordable
- A focus on preventing illness and disease as much as on caring for the sick
- An organized, coordinated system that puts as many services as possible under one roof — all connected by an electronic medical record

Kaiser Permanente is an integrated health care delivery system comprised of Kaiser Foundation Hospitals (KFH), Kaiser Foundation Health Plan (KFHP), and physicians in the Permanente Medical Groups. Today we serve more than 10 million members in eight states and the District of Columbia. Our mission is to provide high-quality, affordable health care services and to improve the health of our members and the communities we serve.

Care for members and patients is focused on their Total Health and guided by their personal physicians, specialists, and team of caregivers. Our expert and caring medical teams are empowered and supported by industry-leading technology advances and tools for health promotion, disease prevention, state-of-the-art care delivery, and world-class chronic disease management. Kaiser Permanente is dedicated to care innovations, clinical research, health education, and the support of community health.

In the Northwest, Kaiser Permanente provides care for 542,976 medical and 255,106 dental members and patients in two licensed hospital locations, 32 medical offices, and 18 dental offices located throughout the region. KFH Sunnyside opened in 1975 in Clackamas County, Oregon. KFH Westside opened in July 2013 in Washington County, Oregon.

This CHNA serves as a joint report for KFH Sunnyside and KFH Westside (KFH NW). The two hospitals define their community served by a shared service area, and share the same centralized Community Benefit department. This structure promotes a single, comprehensive, region-wide approach to addressing community health needs. A detailed explanation of the joint service area for KFH NW is outlined in the Community Served section of this report (pg. 9).

About Kaiser Permanente Community Benefit

For more than 70 years, Kaiser Permanente has been dedicated to providing high-quality, affordable health care services and to improving the health of our members and the communities we serve. We believe good health is a fundamental right shared by all and we recognize that good health extends beyond the doctor's office and the hospital. It begins with healthy environments: fresh fruits and vegetables in neighborhood stores, successful schools, clean air, accessible parks, and safe playgrounds. These are the vital signs of healthy communities. Good health for the entire community, which we call Total Community Health, requires equity and social and economic well-being.

Like our approach to medicine, our work in the community takes a prevention-focused, evidence-based approach. We go beyond traditional corporate philanthropy or grantmaking to pair financial resources with medical research, physician expertise, and clinical practices. Historically, we've focused our investments in three areas—Health Access, Healthy Communities, and Health Knowledge—to address critical health issues in our communities.

For many years, we've worked side-by-side with other organizations to address serious public health issues such as obesity, access to care, and violence. And we've conducted Community Health Needs Assessments to better understand each community's unique needs and resources. The CHNA process informs our community investments and helps us develop strategies aimed at making long-term, sustainable change — and it allows us to deepen the strong relationships we have with other organizations that are working to improve community health.

Purpose of the Community Health Needs Assessment (CHNA) Report

The Patient Protection and Affordable Care Act (ACA), enacted on March 23, 2010, included new requirements for nonprofit hospitals in order to maintain their tax-exempt status. The provision was the subject of final regulations providing guidance on the requirements of section 501(r) of the Internal Revenue Code. Included in the new regulations is a requirement that all nonprofit hospitals must conduct a community health needs assessment (CHNA) and develop an implementation strategy (IS) every three years (http://www.gpo.gov/fdsys/pkg/FR-2014-12-31/pdf/2014-30525.pdf). The required written IS plan is set forth in a separate written document. Both the CHNA report and the IS for each Kaiser Foundation Hospital facility are available publicly at kp.org/chna.

Kaiser Permanente's Approach to Community Health Needs Assessment

Kaiser Permanente has conducted CHNAs for many years, often as part of long-standing community collaboratives. The new federal CHNA requirements have provided an opportunity to revisit our needs assessment and strategic planning processes with an eye toward enhanced compliance and transparency and leveraging emerging technologies. Our intention is to develop and implement a transparent, rigorous, and, whenever possible, collaborative approach to understanding the needs and assets in our communities. From data collection and analysis to the identification of prioritized needs and the development of an implementation strategy, the intent was to develop a rigorous process that would yield meaningful results.

Kaiser Permanente's innovative approach to CHNAs includes the development of a free, Web-based CHNA Data Platform that is available to the public. The Data Platform provides access to a core set of approximately 150 publicly available indicators to understand health through a framework that includes social and economic factors, health behaviors, physical environment, clinical care, and health outcomes.

In addition to reviewing the secondary data available through the CHNA Data Platform, and in some cases other local sources, each KFH facility, individually or with a collaborative, collected primary data through key informant interviews, focus groups, and surveys. Primary data collection consisted of reaching out to local public health experts, community leaders, and residents to identify issues that most impacted the health of the community. The CHNA process also included an identification of existing community assets and resources to address the health needs.

Each hospital/collaborative developed a set of criteria to determine what constituted a health need in its community. Once all of the community health needs were identified, they were all prioritized, based on identified criteria. This process resulted in a complete list of prioritized community health needs. The process and the outcome of the CHNA are described in this report.

In conjunction with this report, KFH NW will develop implementation strategies for the priority health needs the hospitals will address. These strategies will build on Kaiser Permanente's assets and

resources, as well as evidence-based strategies, wherever possible. The Implementation Strategy will be filed with the Internal Revenue Service using Form 990 Schedule H. Both the CHNA and the Implementation Strategy, once they are finalized, will be posted publicly on our website, kp.org/chna.

KFH NW takes a collaborative approach to conducting a CHNA by participating in regional collaborative efforts. KFH NW is a member of the Healthy Columbia Willamette Collaborative (HCWC) in the Primary hospital service area. KFH NW continues to collaborate in county-level health improvement processes, including working with Marion County, Oregon, and Cowlitz County, Washington, as in the 2013 CHNA process. Given the timelines for accreditation in local county health departments, neither Cowlitz nor Marion County is continuing health assessment work during the 2016 CHNA process. For this round of CHNA, KFH NW is a partner in the Lane County, Oregon, community health status assessment process to further understand and collaborate in community health improvement efforts in KFH NW's newest Secondary service area — South Valley.

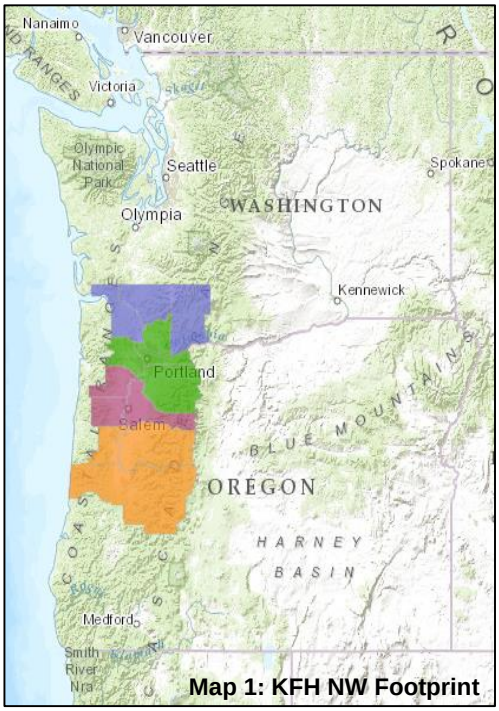
COMMUNITY SERVED

Kaiser Permanente's Definition of Community Served

Kaiser Permanente defines the community served by a hospital as those individuals residing within its hospital service area. A hospital service area includes all residents in a defined geographic area surrounding the hospital and does not exclude low-income or underserved populations.

The Kaiser Permanente Northwest Region (KPNW) includes two hospitals, an integrated health care delivery system, and a health plan, and provides high-quality primary and specialty care and community benefit activities to a 14-county geography. KFH Sunnyside and KFH Westside hospitals (referred to as KFH NW) has identified community served in terms of Primary and Secondary service areas (described below) to assess need for both the hospital service area and other communities where KFH NW also has an impact on health.

KFH Sunnyside and KFH Westside Service Area Definition



Map 1: KFH NW Footprint

KFH Sunnyside and KFH Westside hospitals (referred to as KFH NW) defines its shared service area by a four-county grouping, referred to as the Metro service area. 88.4% of inpatient discharges from KFH NW lived in the Metro area in 2015. The Metro area is the KFH NW **Primary** service area. The majority of the KFH NW community benefit activities are focused in the Primary service area.

KFH NW also provides nonhospital services, has membership, and supports community health in a **Secondary** service area. The Secondary service area comprises three separate geographically defined areas known as Southwest Washington (referred to as SW WA in this report), Mid-Willamette Valley (referred to as Mid-Valley in this report), and South Valley.

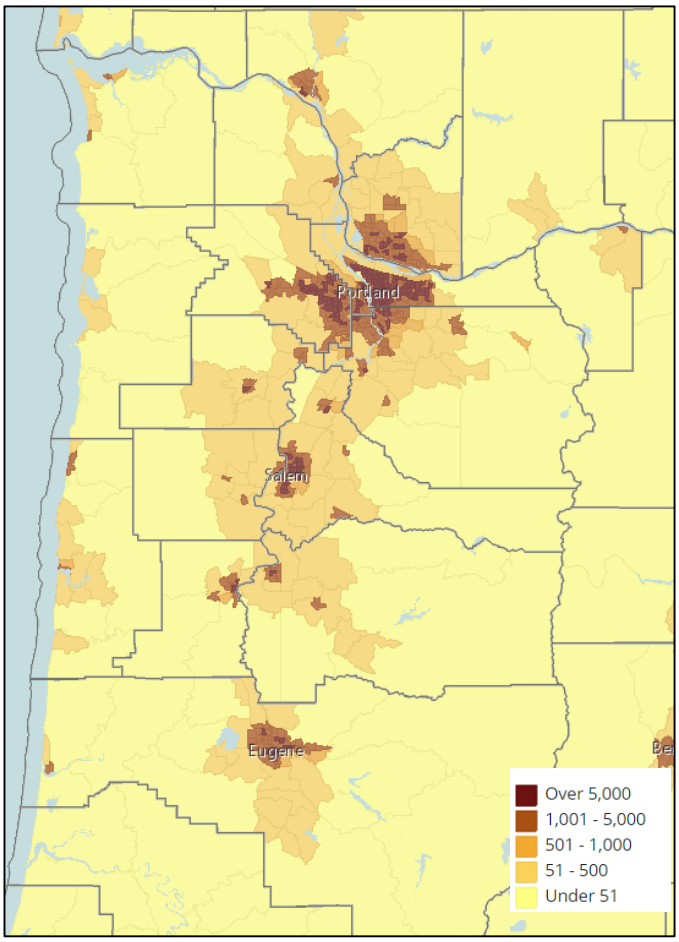
The Primary and Secondary service areas include counties in two Pacific Northwest states: Washington and Oregon (see Map 1: KFH NW Footprint). Table 1 and Maps 2 and 3 below show the Primary and Secondary service areas.

Table 1: Counties by Primary and Secondary Service Areas in KFH NW

PRIMARY SERVICE AREA	SECONDARY SERVICE AREA		
Metro	**Southwest Washington**	**Mid-Willamette Valley**	**South Valley**
Clackamas County (OR)	Cowlitz County (WA)	Marion County (OR)	Benton County (OR)
Clark County (WA)	Columbia County (OR)	Polk County (OR)	Lane County (OR)
Multnomah County (OR)	Skamania County (WA)	Yamhill County (OR)	Linn County (OR)
Washington County (OR)	Wahkiakum County (WA)		

Map 2: KFH NW Primary and Secondary Areas
By Oregon and Washington counties

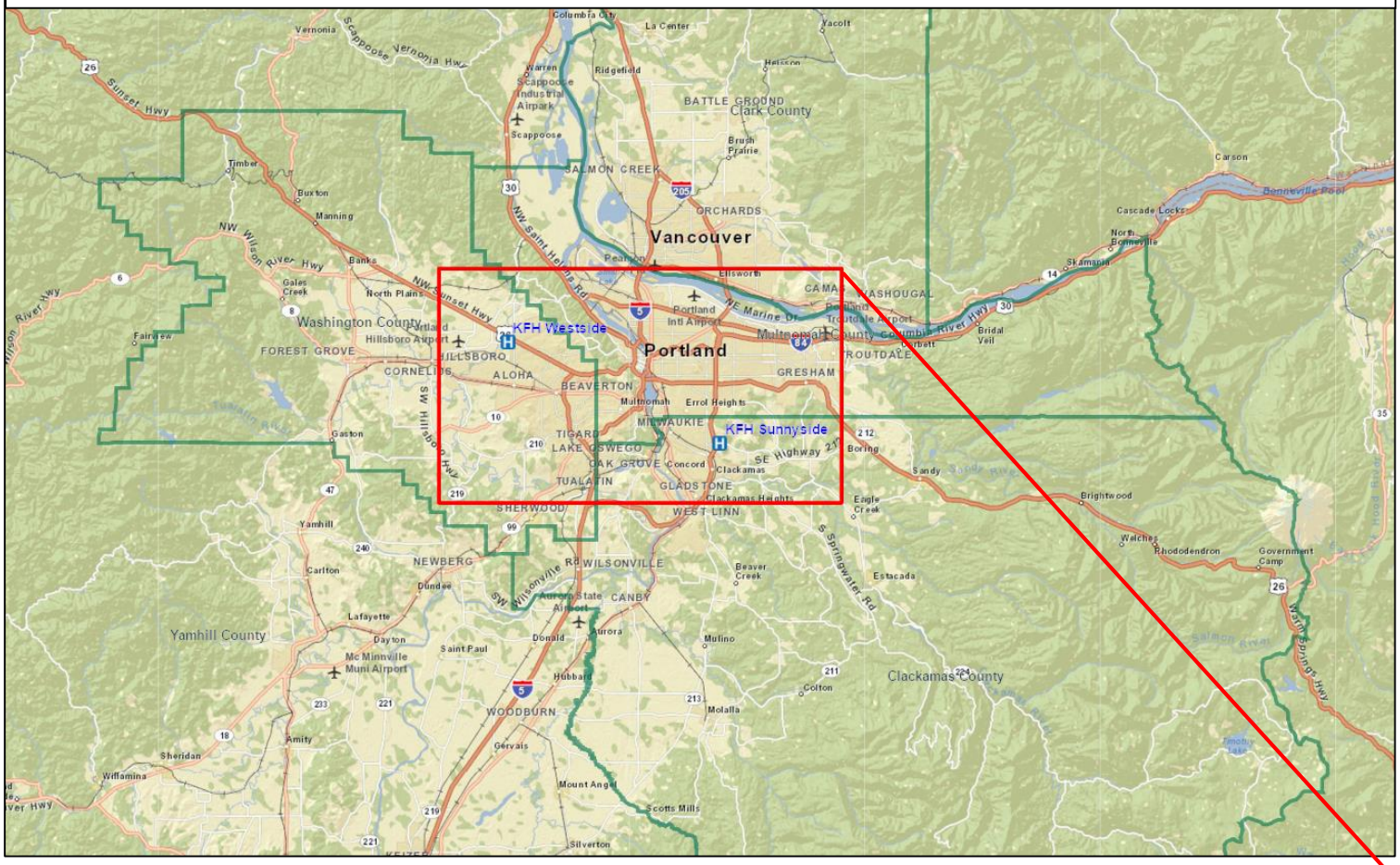
Map 3: KFH NW Population Density
Persons per square mile, by census tract (ACS 2010–2014)

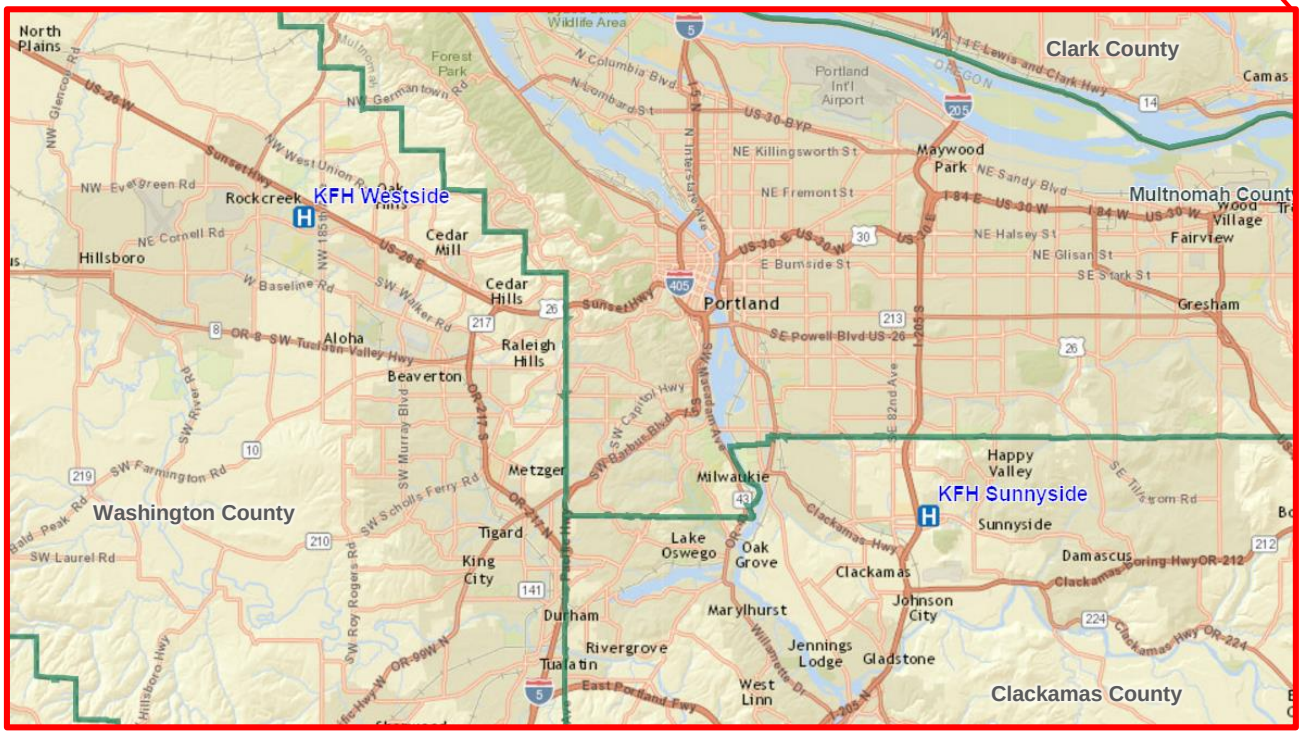


KFH Sunnyside, located off the major Interstate 205, is in Clackamas, Oregon. KFH Westside, located off major Highway 26, is in Hillsboro, Oregon (see street map below). The Portland metropolitan region includes Portland, the largest urban area in Oregon, and Vancouver, Washington, the third largest urban area in Washington. The KFH NW region covers many jurisdictional boundaries, including:

- 108 public school districts
- 8 community college systems
- 4 campuses of public higher education
- 7 educational service districts
- 5 regional councils of government
- 14 counties
- 127 incorporated cities

Map 4: KFH NW Primary Service Area and KFH Locations
Street map





Above: KFH NW Primary service area (counties outlined in green) with two KFH locations labeled with blue "H"

Right: Zoom-in view of city of Portland and surrounding areas, including green lines for county boundaries, and KFH locations

Service Area Profiles

The total population of the 14 counties that make up KFH NW is approximately 3.35 million people. The Metro area is the hub of the region with the highest population density (see Map 4) and just over 63% of the regional population share. Additional population centers exist around the city of Salem in the Mid-Valley area, and the city of Eugene in the South Valley area.

In order to understand the makeup of the KFH NW population, the consultant queried demographic data (race and ethnicity, primary language, age, and gender) and data around "key drivers" of health indicators — specifically poverty, educational attainment, and health insurance coverage from the Kaiser Permanente CHNA Data Platform. The demographics of a community affect its health profile given that different ethnic, age, gender, and socioeconomic groups may have unique needs and take varied approaches to health. These demographic and key driver data are displayed in tables and charts on the following pages, and are broken out by Primary and Secondary service areas with comparisons to the Oregon and Washington as well as the United States for reference. In addition, the Kaiser Permanente CHNA Data Platform was used to create a "vulnerable populations footprint" in order to understand the geographic variation of two key drivers of health: education and poverty. The mapped footprint is included below.

Demographics: *Race and Ethnicity*

KFH NW reflects both Oregon and Washington with the majority of the population, approximately 77%, identifying as non-Hispanic white. The largest subpopulation in the KFH NW area are people of Hispanic ethnicity, and the Mid-Valley area has upwards of 20% Hispanic individuals. The second largest subgroup in the region overall is the Asian population, with 6.16% of the Metro area being Asian, a higher rate than Oregon and the United States. The SW WA area is the least racially and ethnically diverse, with 87.15% of the population identifying as non-Hispanic white. The Metro area is home to KFH NW's largest black population; however, this population represents a much smaller share than at the national level, where 14.7% of the population identifies as black (versus 2.9% in the Metro area). Table 2 (below) shows the racial and ethnic breakdown of the Primary and Secondary service areas as compared to the KFH NW region as a whole, Oregon and Washington, and the United States.

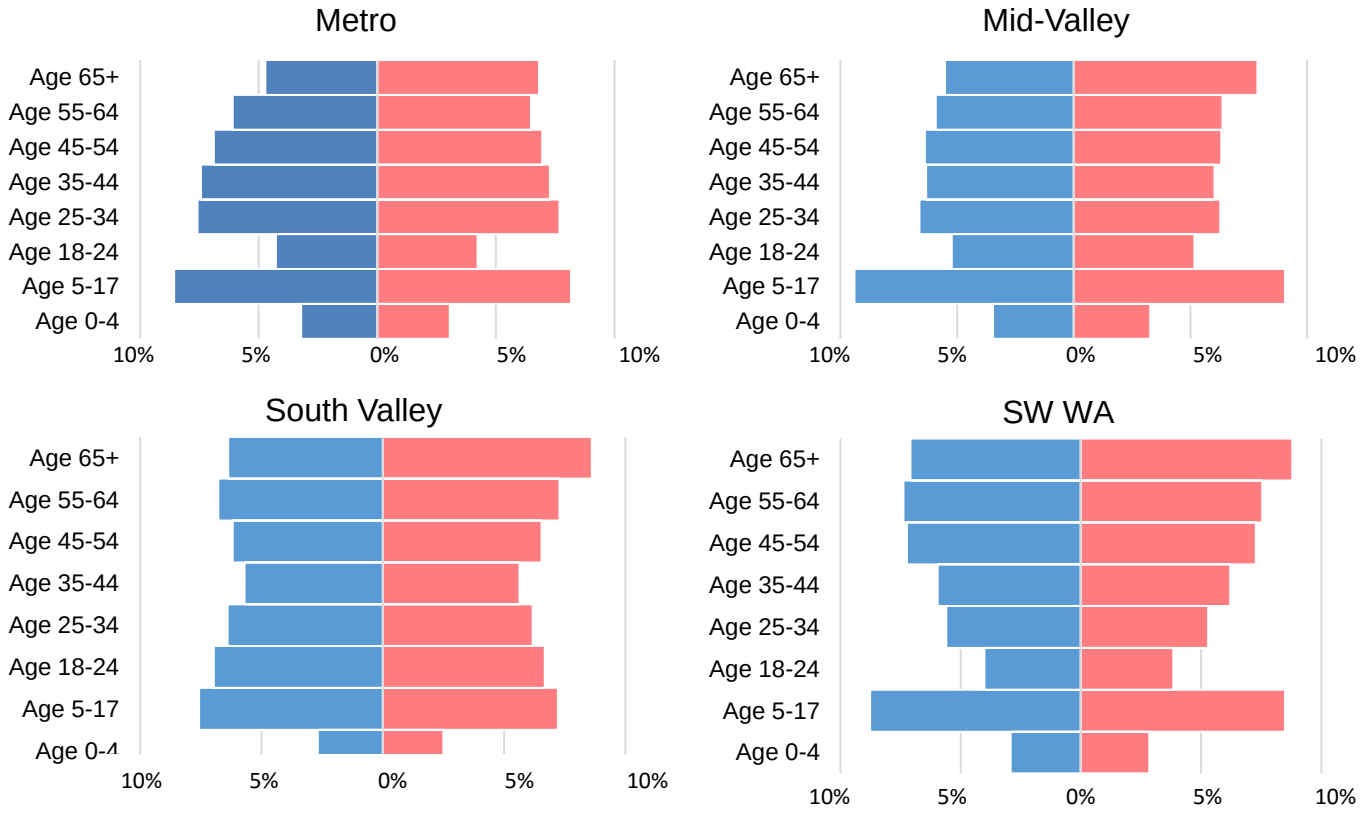
Table 2: Demographic Profile of KFH NW, American Community Survey, 2010–2014 5-Year Estimates

	Race (Non-Hispanic)							Ethnicity		Total Pop.
	White	Black	Asian	NA/AN	NH/PI	Other	Multi	Non-Hispanic	Hispanic	
United States	75.86%	14.7%	5.8%	0.79%	0.19%	0.23%	2.46%	83.38%	16.62%	317,746,048
Oregon	88.36%	1.96%	4.37%	1.1%	0.41%	0.18%	3.62%	87.85%	12.15%	3,900,343
Washington	81.26%	3.91%	8.2%	1.36%	0.65%	0.16%	4.45%	88.51%	11.49%	6,899,123
KFH NW	77.01%	2.11%	4.66%	0.71%	0.45%	0.17%	3.23%	88.35%	11.65%	3,350,864
Metro	75.4%	2.9%	6.16%	0.55%	0.51%	0.13%	3.36%	89%	11%	2,127,791
SW WA	87.15%	0.39%	1.26%	1.16%	0.13%	0.06%	3.27%	93.41%	6.59%	166,607
Mid-Valley	71.98%	0.82%	1.79%	0.87%	0.53%	0.42%	2.82%	79.21%	20.79%	497,398
South Valley	84.54%	0.81%	2.59%	1.03%	0.24%	0.13%	3.11%	92.46%	7.54%	559,068

Demographics: *Population Age*

The population in KFH NW is generally split evenly between male (blue bars) and female (red bars), as evidenced by the population pyramids in Figure 1. Females are more predominant in the 65+ age group, reflecting the trend that females live longer than males in the United States. The Metro area and SW WA area exhibit an aging population as evidenced by the top-heavy pyramids, with only a small share (less than 10%) of young adults aged 18–24 in either. Both service areas also have the largest shares of any age group in youth aged 5–17, indicating that college-aged youth (18–24) may leave the region for schooling or more job opportunities. Mid- and South Valley areas see similar effects, although South Valley is home to two major public universities, evidenced by the fact that the 18–24 year age range does not dwindle as in the three other service areas. Both Oregon and Washington are experiencing population growth from in-migration rather than increased birth rates; the bulk of the population is in the 25–65 year old age range with relatively small shares in the 0–4 (between 5%–10%).

Figure 1: Population Pyramids for Primary and Secondary Areas: Male *Female*



Demographics: *Primary Language*

A rich diversity of languages are spoken across the Portland metropolitan area and the KFH NW area. In the Mid-Valley area, nearly 9% of the population speaks English less than “very well” with more than 83.7% of that subset of the population speaking Spanish at home. Limited English proficiency is important because it can create barriers to health care access, provider communications, and health literacy and education. Furthermore, 4.5% of households in the Metro area are linguistically isolated, meaning that no household member 14 years and over (1) speaks only English at home or (2) speaks a language other than English at home *and* speaks English “very well.”

Of the languages spoken in KFH NW, Spanish is the highest share of languages spoken at home at 55.1%, with Asian and Pacific Islander languages at 25.9%. Vietnamese and Chinese are the most

commonly spoken Asian languages in KFH NW homes, and Russian and Arabic are also commonly spoken languages among the region's limited-English-proficiency households. Table 3 provides a picture of the diversity of languages spoken in the KFH NW community.

Table 3: KFH NW Linguistic Profile, American Community Survey, 2010–2014 5-Year Estimates

	Population Age 5+ with Limited English Proficiency	Share of Pop. with Limited English by Language Spoken at Home				Linguistically Isolated Households
		Spanish	Indo-European Languages*	Asian/Pacific Island Languages+	Other Languages#	
United States	8.6%	64.6%	13.6%	18.5%	3.4%	4.66%
Oregon	6.12%	62.4%	11.5%	22.9%	3.2%	3.36%
Washington	7.83%	46.1%	15.1%	33.4%	5.4%	4.27%
KFH NW	6.84%	55.1%	15.6%	25.9%	3.4%	3.88%
Metro	7.78%	46.8%	18.8%	30.7%	3.8%	4.52%
SW WA	2.36%	65.2%	12.1%	20.5%	2.2%	1.24%
Mid-Valley	8.83%	83.7%	6.9%	8.0%	1.4%	4.55%
South Valley	2.91%	60.8%	7.5%	26.4%	5.3%	1.65%

**e.g., German, Russian, French, Italian*
+e.g., Chinese, Japanese, Korean, Vietnamese, Khmer, Thai
#e.g., Native American languages, Arabic, African languages

Key Drivers: *Indicators of Health*

Kaiser Permanente has identified "key drivers" as indicators that are determined to be the most powerful predictors of health. These include poverty, high school graduation, and insurance coverage. Understanding the areas of highest need through these indicators can help communities target primary data collection with populations that may exhibit the most need. Additionally, these indicators are available at a sub-county geography, making it possible to assess specific populations and/or neighborhoods where the greatest needs exist.

A query of the Kaiser Permanente CHNA Data Platform for key drivers and for unemployment rates — a driver of poverty and often indicative of educational attainment — produced the results found in Table 4 below. The Metro area has the highest numbers of individuals in poverty; however, the Secondary service area has higher shares of people living at 100% and 200% of the poverty line. Mid- and South Valley poverty rates are higher than Washington, Oregon, and the nation, while SW WA benchmarks poorly to Washington and the nation. The Metro area has lower poverty rates but higher numbers of individuals and children in poverty given the population density and share of the regional population.

The unemployment rate in KFH NW is higher than that of the nation, indicating a slower climb out of the 2008 economic recession in both Washington and Oregon. Uninsured rates in KFH NW are lower than the nation largely because of Medicaid expansion efforts in both states and the work of Coordinated Care Organizations in Oregon. A more recent data report from Oregon indicates that uninsured rates may have even dropped below 5% by the end of 2015.[1] The highest rates of uninsured are in the Mid-Valley area, possible reflecting the large Hispanic migrant population who are largely undocumented

[1] http://www.oregon.gov/oha/Metrics/Documents/HST%20Annual%20Report%20-%202016.pdf

immigrants. Further, the same report from the Oregon Health Authority notes that rural Oregonians, communities of color, women, LGBTQ people, and low-wage working families in addition to immigrant children and adults are disproportionately represented in that rate. Low educational attainment, indicated by rates of adults with no high school diploma, are low in Oregon and Washington with a more educated populace than the nation as a whole. KFH NW also performs well in this indicator; however, Mid-Valley has the highest rates of population with no high school diploma.

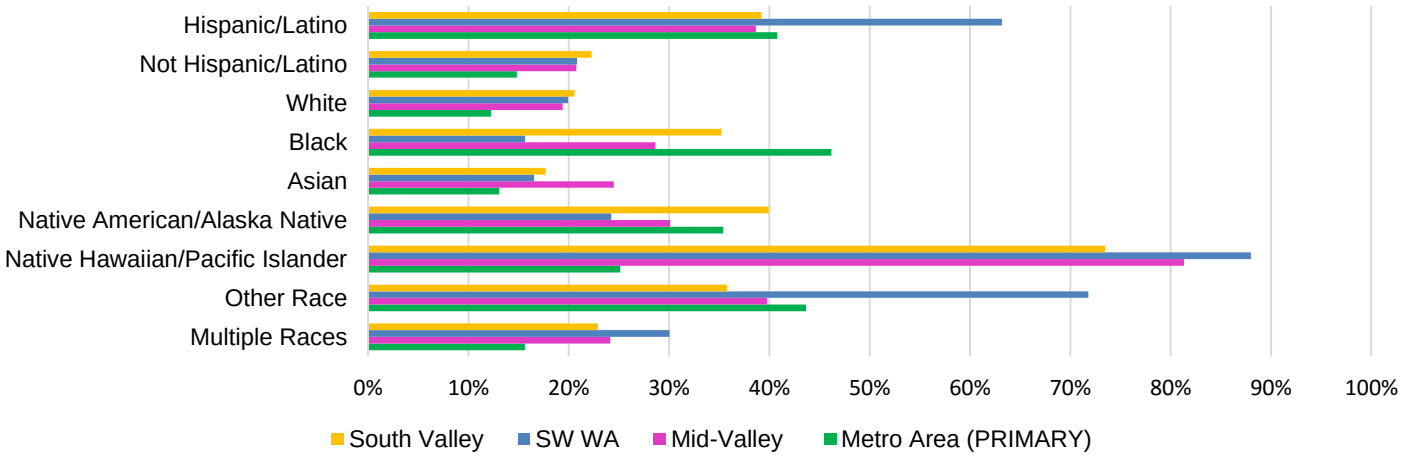
Table 4: KFH NW Social and Economic Indicator Profile, American Community Survey, 2010–2014 5-Year Estimates

	200% FPL	100% FPL	Children in Poverty (100% FPL)	Unemployment Rate (2015)*	Uninsured	No High School Diploma
United States	34.54%	15.59%	21.9%	5.4%	14.2%	13.67%
Oregon	37%	16.71%	22.12%	6.4%	14.41%	10.52%
Washington	30.34%	13.55%	18.13%	6.3%	12.93%	9.82%
KFH NW	34.6%	15.7%	20.34%	6.1%	13.51%	10%
Metro	31.33%	13.8%	17.87%	5.8%	13.11%	9.1%
SW WA	36.83%	16.6%	23.29%	8.3%	12.44%	11.7%
Mid-Valley	40.37%	18.3%	26.36%	6.6%	15.17%	14.7%
South Valley	41.45%	20.5%	23.47%	6.4%	13.92%	8.8%

**Data source: U.S. Department of Labor, December 2015*

Key Drivers: *Racial and Ethnic Inequity in Drivers of Health*[2]

Figure 2: Child Population by Ethnicity, Race Alone, Percent in Poverty (100% FPL)



Children experience poverty at higher rates than adults, and the highest poverty rates are seen disproportionately in communities of color in KFH NW. Across the most populous Metro area, black children and Hispanic/Latino children experience poverty rates above 40%. Native Hawaiians and Pacific Islanders experience the highest poverty rates in the three Secondary service areas, reaching

[2] Data source for all charts in this section: American Community Survey, 2010–2014 5-Year Estimates

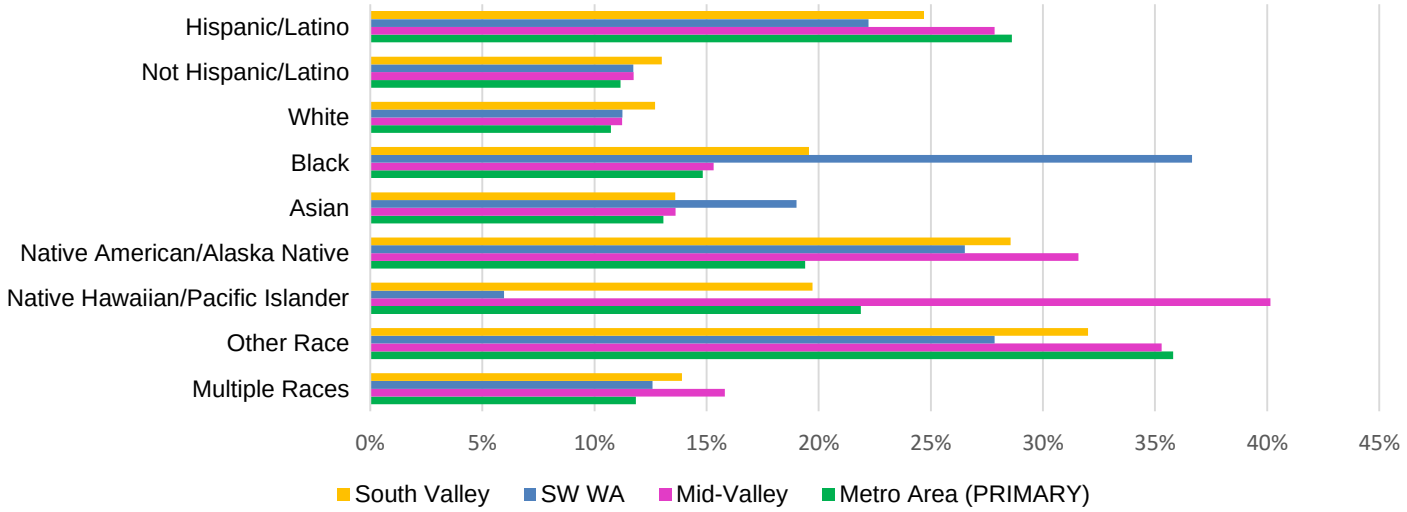
almost 90% in SW WA. See Figure 2 for more details.

Educational attainment is also disproportionately low in KFH NW communities of color as compared to non-Hispanic white adults. 50% of Hispanic and Latinos in the Mid-Valley area, a large farmworker community, and 30% of Hispanic and Latinos in the Metro area do not have a high school diploma. The South Valley area has the lowest rates of adults without a high school diploma, and Mid-Valley the highest among most of the demographic subgroups. Black, Asian, Native American/Alaskan Native, Native Hawaiian/Pacific Islander, and some other races in the Metro area make up the largest share of non-Hispanics in the Metro area without a high school diploma. See Figure 3 for more details.

Figure 3: Population by Ethnicity, Race Alone, Percent with No High School Diploma

Individuals without insurance are more common in communities of color in KFH NW, with the highest rates in the Metro area among Hispanic/Latinos and persons of some other race. For more details, see Figure 4.

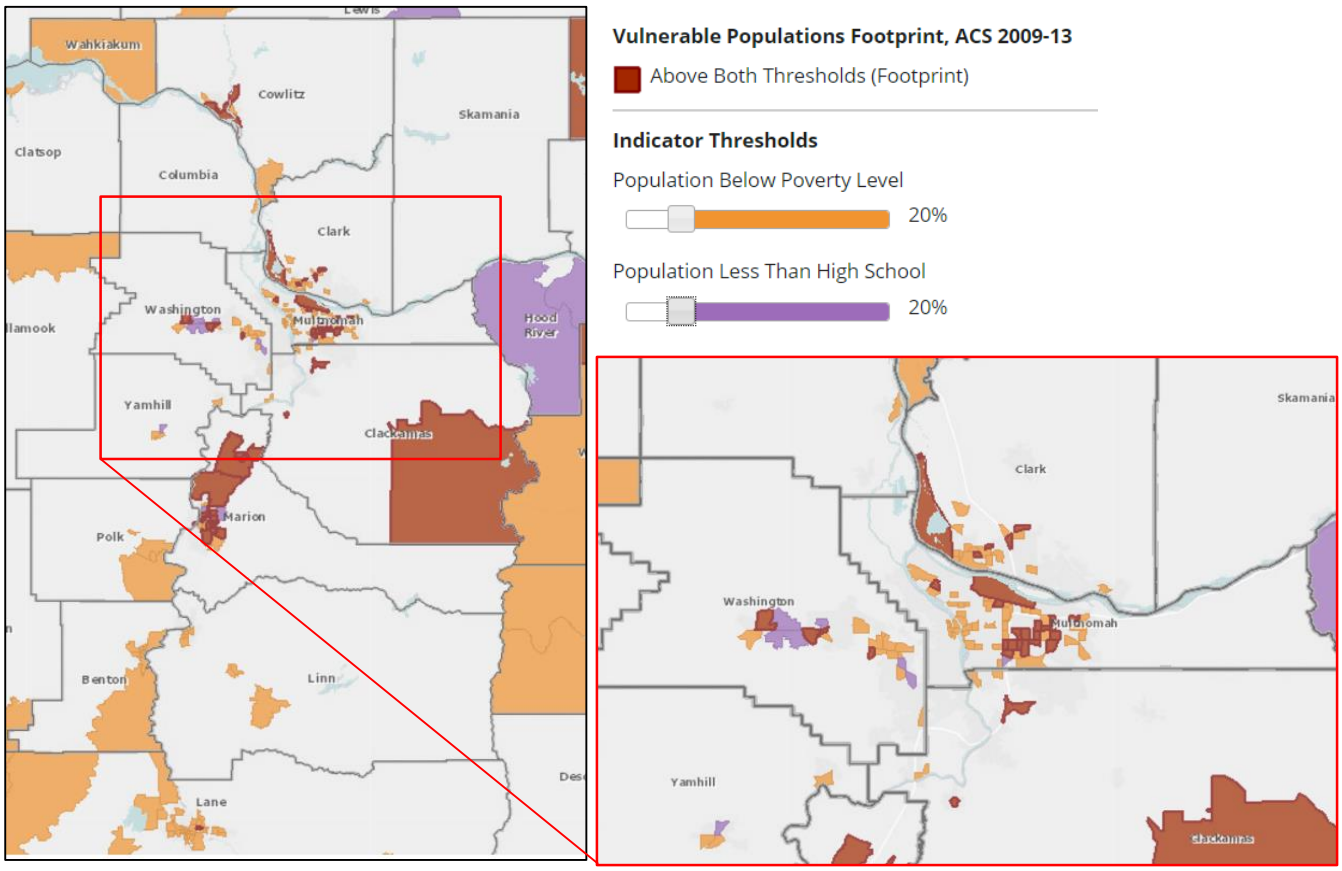
Figure 4: Population by Ethnicity, Race Alone, Percent Uninsured



Key Drivers: *Geography of Vulnerable Populations*

Below (Map 5) is a map of the CHNA Data Platform "vulnerable populations" footprint. The tool maps areas of high concentrations of populations in poverty and living without a high school diploma, identifying the neighborhoods where vulnerable populations are present. Both poverty and education are included in the tool, as they are two key social determinants of health. The orange census tracts below indicate where there is greater than 20% of the population living at the 100% poverty level, and the purple census tracts indicate where there is greater than 20% of the population with less than a high school diploma. The darker reddish color tracts indicate where above 20% of the population both is living in poverty and has less than a high school diploma. The Metro area and specifically East Portland, Vancouver, and Hillsboro have a greater rate of vulnerable populations. The Mid-Valley area, including the cities of Woodburn and Salem in Marion County, also have high rates of vulnerable populations.

Map 5: Vulnerable Populations Footprint (Education and Poverty)
KFH NW, and Primary Metro area zoom (on right)



WHO WAS INVOLVED IN THE ASSESSMENT

Partners who collaborated on the assessment

KFH NW was a founding member of the Healthy Columbia Willamette Collaborative (HCWC), a public–private partnership of 15 hospitals, four health departments, and two Coordinated Care Organizations (CCOs) in Clackamas, Multnomah, and Washington counties in Oregon and Clark County in Washington. HCWC was founded in 2010 with the intention of building stronger relationships between communities, CCOs, hospitals, and public health departments. Through these relationships, HCWC

works on strengthening community health needs assessment that leads to meaningful impact, and results in a platform for collaboration around health improvement plans and activities that leverage collective resources to improve the health and well-being of the communities HCWC member organizations serve. As a member organization, KFH NW has incorporated HCWC's assessment into this CHNA report, and will further use the assessment in the Implementation Strategy (IS) phase. Further, the regional assessment will be used to prioritize one or more health improvement strategies that HCWC member organizations commit to collectively work on in the Metro area.

HCWC comprises several workgroups with representation from some or all of the member organizations and interested community partners. KFH NW Community Benefit staff and the consultant participated in the following workgroups: the Leadership Committee, the Community Engagement Workgroup (CEW), and the Hospital Data Workgroup.

HCWC Member Organizations

County Health Departments

- Clackamas County Public Health Division
- Clark County Public Health
- Multnomah County Health Department
- Washington County Public Health Division

Coordinated Care Organizations (CCOs)

- FamilyCare Health
- Health Share of Oregon

Hospitals

- Kaiser Permanente (KFH Sunnyside and KFH Westside)
- Adventist Medical Center
- Legacy Health System
- Oregon Health & Science University
- PeaceHealth Southwest Medical Center
- Providence Health & Services
- Tuality Community Hospital

KFH NW also contributes to the efforts of a second collaborative in Lane County, Oregon, located in the South Valley Secondary service area. Partners involved in the *Live Healthy Lane* CHNA include United Way of Lane County, Lane County Public Health, PeaceHealth, and Trillium CCO.

Identity and qualifications of consultants used to conduct the assessment

KFH NW Community Benefit staff worked with an external consultant, Hayley Pickus, to support the data analysis process including the prioritization of health needs and the development of the CHNA report. Hayley Pickus has a master's degree in public health and urban and regional planning from Portland State University and brings four years of public health research experience. She formerly worked with the Kaiser Permanente Utility for Care Data Analysis group as a spatial data analyst and continues to support other regional evaluation efforts in KPNW.

Members of the HCWC convening team also participated in conducting this assessment, specifically in data collection, analysis, and reporting activities. The following organizations and their staff who participated in HCWC processes were instrumental to the KFH NW CHNA:

Providence Center for Outcomes Research and Education (CORE)

CORE is a nonprofit research laboratory committed to improving community health. Through surveys, interviews, social network analysis, and mapping techniques, CORE finds opportunities to do health

care better. CORE staff contributed to the design, facilitation, and analysis of the HCWC listening sessions.

Washington County Public Health Division — Epidemiology

Washington County's Public Health Division is part of the Department of Health and Human Services and provides prevention, protection, and support services and activities so that all people who live, work, study, and play in Washington County can be healthy, self-sufficient, and safe. Washington County is a founding partner of HCWC and provided key support in secondary data analysis.

Multnomah County Health Department

Multnomah County Health Department works in partnership with communities to ensure, promote, and protect the health of the people of Multnomah County. The Multnomah County Health Department is one of the founding members of HCWC and also serves as convener. The convening team was instrumental in overseeing processes, and county staff aided in analysis of the community survey as well as the meta-analysis.

Health Share of Oregon

Health Share is a CCO that works to provide integrated health care delivery and to ensure quality, cost-effective care for Oregon Health Plan members in the Tri-County Portland Metro area. Health Share staff assisted with analysis of hospital data contributed by member organizations, including the analysis used in this assessment of top chronic conditions in the Medicaid youth and adult populations.

Healthy Columbia Willamette Collaborative (HCWC) Workgroups

HCWC workgroups, made up of members of HCWC and, in the case of the Community Engagement Workgroup, included community stakeholders and partners, were instrumental in designing methods and vetting results of data collection and analysis. Without the engagement and active participation of HCWC members and stakeholders in these workgroups, this CHNA would not have been as comprehensive.

PROCESS AND METHODS USED TO CONDUCT THE CHNA

Secondary Data

Sources and dates of secondary data used in the assessment

KFH NW staff and the consultant used the Kaiser Permanente CHNA Data Platform (www.chna.org/kp) to review more than 150 indicators from publicly available data sources for this assessment. Data on gender and race/ethnicity breakdowns were analyzed when available. For details on specific sources and dates of the data used, please see Appendix A.

Resources in the Kaiser Permanente CHNA Data Platform were supplemented with the following four sources of secondary data:

- Oregon Healthy Teens Survey (OHT): The OHT is Oregon's effort to monitor the health and well-being of adolescents. An anonymous and voluntary research-based survey, the OHT is conducted among eighth- and 11th-graders statewide. Survey questions regarding topics such as tobacco and drug use, diet and exercise, and access to care are included in the survey. OHT indicators from the 2013 survey used in this CHNA include physical activity and BMI, mental health, access to primary care, and oral health indicators for Oregon eighth-graders.
- Washington Healthy Youth Survey (HYS): The HYS is a collaborative effort in Washington. The survey is coordinated among multiple agencies and administered every two years. The survey gathers state-level data for sixth-, eighth-, 10th-, and 12th-graders. HYS indicators from the 2014 survey used in this CHNA include physical activity and BMI, mental health, access to primary care, and oral health indicators for Washington eighth-graders.

- Hospital Medicaid data: HCWC member organizations accessed and analyzed quantitative data from participating hospital systems, Coordinated Care Organizations (CCOs) in Oregon, and Medicaid Managed Care Organizations in Washington. The data examined were claims data from self-pay or uninsured patients and from populations who are medically underserved and/or who are very poor (138% FPL) and are eligible to receive health coverage through Medicaid.
- Meta-analysis: The HCWC Community Engagement Workgroup (CEW) conducted a meta-analysis based on findings from health-related community assessment projects conducted in Multnomah, Clackamas, and Washington counties in Oregon and Clark County in Washington from 2012 through 2015. The analysis of these secondary data reports were compiled into themes that were used in this assessment.

Methodology for collection, interpretation, and analysis of secondary data

The primary resource used to collect, interpret, and analyze secondary data was the Kaiser Permanente CHNA Data Platform. The structure of the platform is such that each of the 150+ indicators is mapped to at least one health need and is designated as a "core" or a "related" indicator. Core indicators are indicators that directly relate to a health outcome of a health need. Related indicators are indicators that are upstream "drivers" to a health need. For example, obesity prevalence is a core indicator of the health need "obesity," while physical inactivity is a related indicator. Additionally, indicators are aligned with the County Health Rankings Mobilizing Action Toward Community Health (MATCH) framework for population health,[3] and include social and economic factors, physical environment, health behaviors, clinical care, and health outcomes. The three groupings of indicators — by health need, by core/related indicators, and by MATCH category — allow for a structured interpretation and analysis of the secondary data.

Secondary data available through the Kaiser Permanente CHNA Data Platform is compiled and made available in two formats: (1) an online interactive report and (2) a downloadable Preliminary Health Needs Identification Tool (PHNIT). The interactive report includes charts, graphs, tables, and maps of each indicator and is organized by health need or by MATCH category based on user preference. When data are available, indictors are also broken out by age groupings, race and ethnicity, and gender, and for several indicators, trend data are charted. The Excel-based PHNIT is available through download from the platform, and the spreadsheet flags individual indicators that do not benchmark well to the state, flags racial and ethnic groups that display inequity in indicators, and calculates "potential health need scores" that are used to identify and prioritize health needs. These scores are calculated based on a comparison to benchmark and an assessment of the magnitude of the difference when an indicator benchmarked well or poorly. Scores are rolled up to the category of indicators that make up a potential health need for one overall health need score. Both the interactive report and the PHNIT were used to collect and interpret secondary data from the platform for the KFH NW Primary and Secondary service areas. The health need scores served as inputs to several criteria for the identification and prioritization processes to determine priority health needs (see below).

The KP CHNA Data Platform includes a wealth of data and is a valuable resource in conducting CHNA. However, several data gaps exist within the platform, and KFH NW supplemented the indicators with local data that either was more up to date than what the platform contained or filled critical gaps in data that does not exist in the platform. When possible, these additional secondary data sources were recorded by service area and included in the PHNIT and health need scores, including indicators from the OHT and HYS.

The hospital Medicaid data were compiled from three of the four Metro area counties (Oregon only) for adults 18+ and children 0–18 who are enrolled in the Oregon Health Plan and assigned to either of the two CCOs in the KFH NW Primary service area — FamilyCare Health or Health Share of Oregon. The data were analyzed by the Healthy Columbia Willamette Collaborative (HCWC) to determine the top

[3] https://uwphi.pophealth.wisc.edu/programs/match/

five chronic conditions and/or risk factors diagnosed among adults and children separately. These chronic conditions and/or risk factors were used as criteria inputs in the identification and prioritization processes.

The final source of secondary data, the meta-analysis, included a total of 55 community assessment projects that were identified and analyzed for community-identified themes. (See Appendix A for a list of the assessments.) These assessment projects were chosen based on five criteria that ensured projects were within the geographic scope (Metro area counties), were completed in the past three years, included data collected directly from individuals in the community, focused on health-related topics or social determinants of health, and focused on HCWC-identified priority populations. Priority populations were identified by the HCWC CEW and defined as veterans, rural and unincorporated, LGBTQ, aging community and seniors, communities of color, homeless, immigrant and refugee, limited English speaking and other languages, low income, people with a disability, people with mental illness or addiction, uninsured, and youth.

HCWC created project summaries for each assessment in the meta-analysis and answered four research questions: (1) What makes a healthy/thriving community? (2) What are the things that currently help your community to be healthy/thriving? (3) What are the health/social determinants of health issues in your community? (4) What could be done to make your community more healthy/thriving? Based on the community-identified information in the project summary, 31 codes were created to capture health-related themes. Frequently occurring themes were then pulled for the top codes to illustrate a more in-depth picture of what people saw as health-related visions, needs, drivers, and solutions for their communities. Coded health needs served as criteria inputs to the identification and prioritization processes.

Community Input

Description of the community input process

Community input was provided by a broad range of community members through a community survey available in paper and online and community listening sessions. Individuals and organizations with the knowledge, information, and expertise relevant to the health needs of the community were consulted. These individuals included representatives from state, local, tribal, or other regional governmental public health departments (or equivalent department or agency) as well as leaders, representatives, or members of medically underserved, low-income, and minority populations. Additionally, where applicable, other individuals with expertise of local health needs were consulted. For a complete list of communities who provided input, see Appendix C.

Methodology for collection and interpretation

In partnership with HCWC, KFH NW collected primary data across the Metro area. Primary community data were gathered by two means: (1) a community-level survey that was offered both online and in print and (2) through 29 listening sessions conducted with underserved populations and/or populations where data gaps exist in public secondary data sources. For a complete list and more details about the survey and listening sessions, see Appendix C.

The HCWC CEW designed a survey to elicit community responses around four topics: (1) important characteristics of a healthy community, (2) challenges affecting community health, (3) risky behaviors affecting health, and (4) a rating of community health. The survey was based on the community health needs assessment developed by the National Association of County and City Health Officials (NACCHO). Demographics of survey respondents were collected, and to be more inclusive, the CEW modified the NACCHO survey to include more options for gender, sexual orientation, race, ethnicity, insurance status, and income. The survey was translated into Spanish, Vietnamese, Russian, and Simplified Chinese, four of the most commonly spoken languages in KFH NW and representative of difficult-to-reach populations. The survey was promoted through social media, emails, fliers,

presentations, radio, and direct outreach to organizations serving priority communities. The survey was online and available in paper from mid-September through December 2015.

HCWC analyzed the survey results to determine the demographics of survey respondents and the frequencies at which question responses were selected. Frequencies were analyzed by each type of demographic information collected so that it could be discerned if/how answers varied by county of residence, age, gender, and other demographic variables. In instances where responses were below 25 for any particular demographic category, data were aggregated to protect confidentiality. Just over 3,000 completed surveys were submitted for analysis. Frequencies in responses for topics 2 and 3 (challenges and risky behaviors) were analyzed to compile a list of top issues for the region. This list was included as criteria inputs in the identification and prioritization process. See Appendix D to view the survey instrument and Appendix C for demographics of survey respondents.

HCWC also conducted numerous listening sessions throughout the Metro area. The listening session format was chosen to enhance survey results. The open-ended question and answer sessions allowed community members to express their views and opinions on specific health-related prompts. Session selection and recruitment were based on preliminary community survey responses. Priority populations were identified for listening sessions based on demographic survey responses. Populations that the survey was not reaching were targeted for listening sessions and included the following: homeless, youth, aging, veteran, mentally ill or addicted, rural, African-American, immigrant and refugee, Latino, Asian or Pacific Islander, and Native American or Alaska Native.

A total of 29 listening sessions were conducted across the four-county Metro area (see Appendix C), nine of which were conducted in languages other than English (Somali, Vietnamese, Tongan, Russian, and Spanish). 298 total community members participated in the listening sessions. The average session size was 13 participants. See Appendix C for listening session participant demographics. Local organizations that reach the identified priority populations were contacted and invited to participate in the listening sessions. Organizations that agreed to participate (20 total) independently recruited community members or clients to attend listening sessions. Facilitators were designated by each participating community organization. Each facilitator received guidance and training on group facilitation. HCWC paid each participating organization a stipend of $650 to cover the cost of staff time for recruitment and facilitation, as well as the organization's costs for food, child care, transportation, and other logistics. The money was spent at the organization's discretion. In addition, HCWC provided $25 grocery gift cards to session participants in recognition of their contribution. See Appendix D for the listening session facilitator guide. Seven of the listening sessions were conducted in partnership with the Oregon Public Health Institute (OPHI), a statewide institute working to conduct a similar assessment in East Multnomah County, the BUILD CHIP. Three sessions were conducted in partnership with the Oregon Community Health Workers Association (ORCHWA).

Data were collected in the form of handwritten notes recorded by note takers and facilitators. Most sessions had two sets of notes recorded by note takers in addition to flip chart notes recorded by facilitators. Sessions were not audio recorded because of financial limitations for transcription and consideration of respondents' comfort. Note takers were trained in recording quotes, use of paraphrasing, and indication of group consensus or disagreements. At the end of each listening session, note takers and facilitators spent 20 to 30 minutes discussing the session dynamics, common themes within the areas of concern, and any bias or prompting that was present. This "debrief" was documented to capture the contextual elements of each session that were otherwise lost in note taking. Listening session notes, flip charts, and debrief notes were used for analysis.

HCWC completed qualitative analysis of listening sessions using Atlas.ti version 7.5.10, following a phenomenological method and coding process. The intent throughout the data collection and analysis was to make meaning of the community voice as a whole, without losing the individual voice. Two analysts read through the notes and developed preliminary coding dictionaries based on themes emerging in the data. Categories, codes, and definitions were compared between analysts, and

consensus was reached on 38 codes. The codes and definitions were brought to the HCWC CEW for consideration. Modifications to codes, coding categories, and definitions were made through group recommendations. The codes and resulting thematic analysis of community health needs were used as criteria inputs in the identification and prioritization processes.

Lastly, KFH NW partnered in CHNA work in Lane County, one of three counties comprising the region's South Valley area. The Lane County group followed the MATCH framework to conduct the assessment. After a robust needs assessment including 50 focus groups, 53 key informant interviews, and 2,295 survey responses, the community priorities for action include: (1) promoting health behaviors and engaging the community in healthy living and (2) promoting access to economic and social opportunities necessary to live a healthy life.

Written comments

Kaiser Permanente provided the public an opportunity to submit written comments on the previous KFH Sunnyside and KFH Westside CHNA report through chna-communications@kp.org. This website will continue to allow for written community input on the facilities' most recently conducted joint CHNA report.

As of the time of this CHNA report development, KFH Sunnyside and KFH Westside had not received written comments about previous CHNA reports. Kaiser Permanente will continue to track any submitted written comments and ensure that relevant submissions will be considered and addressed by the appropriate facility staff.

Data limitations and information gaps

The KP CHNA Data Platform includes approximately 150 secondary indicators that provide timely, comprehensive data to identify the broad health needs faced by a community. However, there are some limitations with regard to these data, as is true with any secondary data. Some data were only available at a county level, making an assessment of health needs at a neighborhood level challenging. Furthermore, disaggregated data around age, ethnicity, race, and gender are not available for all data indicators, which limited the ability to examine disparities of health within the community. Lastly, data are not always collected on a yearly basis, meaning that some data are several years old.

In KFH NW, there are limitations in the available data both for Oregon and Washington. Notably, secondary data indicators are lacking in oral health, behavioral health, youth asthma, and access to culturally competent care. In indicators that are readily available, gaps exist when it comes to data broken out by race and ethnicity, primary language spoken, and income in Oregon and Washington.

Gaps in race and ethnicity data are due to several factors. Where data are available such as through larger survey datasets conducted by the U.S. Census Bureau, there is evidence that many populations are significantly undercounted, and studies in the Portland Metropolitan area have found this to be the case locally.[4] Further, data in this region are often presented in the aggregate for many health indicators, often race and ethnicity are only reported at the state level making it impossible to discern local or even regional variation.

Data limitations of community gathered input fall along the lines of traditional qualitative data limitations. These include the use of convenience samples and small samples sizes in the survey and listening sessions, limited resources for data analysis, and the positionality of the CEW. Although CEW participants came from a variety of backgrounds and experiences and work with people from all walks of life, the majority of participants were white, able-bodied, heterosexual, and cis-gender (gender conforming). The identities and positionality of the CEW likely affected data analysis, and the homogeneity of the group was a limitation.

[4] http://www.scirp.org/journal/PaperInformation.aspx?PaperID=7874

IDENTIFICATION AND PRIORITIZATION OF COMMUNITY'S HEALTH NEEDS

Identifying community health needs

KFH NW Community Benefit staff and the consultant identified health needs using a predefined set of three criteria. The intent behind the criteria is to equally weigh the several data sources and data types (qualitative and quantitative) that served as inputs to the CHNA process. In doing so, the identified list of community health needs reflects a breadth of needs that were uncovered through primary and secondary data collection and analysis. The resulting list of identified health needs then went through a prioritization process using a second set of criteria, described in the next section.

Definition of "health need"

For the purposes of the CHNA, Kaiser Permanente defines a "health need" as a health outcome and/or the related conditions that contribute to a defined health need. Health needs are identified by the comprehensive identification, interpretation, and analysis of a robust set of primary and secondary data.

Criteria and analytical methods used to identify the community health needs

KFH NW Community Benefit staff and the consultant began the process to identify health needs by creating a succinct set of criteria, fully outlined in Appendix E. If the need met the first criterion and one of the two additional criteria, it was identified for the prioritization process.

Health Need Identification Criteria

1. The need met the Kaiser Permanente definition of a "health need" as described above.
2. The need was confirmed by multiple (2+) data sources (e.g., benchmarked poorly).
3. Disparities in health outcomes exist across racial/ethnic subpopulations.

KFH NW began with the list of 14 potential health needs from the KP CHNA Data Platform and ran through each set of criteria. "Overall Health" was not included in the list of identified needs, although it appears in the platform, because staff felt it was too broad of a need to define. If additional health needs were identified in community data collection or additional sources of secondary data, staff applied the criteria to determine whether to include the need in the list of identified health needs. No additional health needs were identified outside of the 13 from the KP CHNA Data Platform.

Process and criteria used for prioritization of the health needs

After a comprehensive list of community health needs was identified from primary and secondary data collection and analysis, the list was organized into priority order based on a second set of previously identified criteria. The prioritization criteria were developed collaboratively with KFH NW Community Benefit staff and then applied by the consultant. The result is a final list of prioritized health needs for KFH NW. The Health Need Profiles in Appendix F explore variation in the health needs across the Primary and Secondary service area.

Nine prioritization criteria were applied to the list of identified health needs. Each health need was scored based on the criteria scoring logic, and scores were then placed into rank order. For more details about the criteria and scoring logic, see Appendix E.

The prioritization criteria were selected intentionally, with four key components: (1) It was important to KFH NW staff that primary, community-driven data were given equal weight to the secondary data pulled mostly from the KP CHNA Data Platform. Therefore, three of the nine total criteria (Criteria 7–9) are based on the primary data alone. (2) Secondly, the criteria also weights the Metro area more heavily because it is the shared KFH NW area with the most inpatient discharges (88.4% in 2015). This was done by creating two criteria for the Metro area. The first looks at the presence of a health need across the Primary service area alone (Criterion 1). The second (Criterion 3) looks at the saturation

within the Primary service area by assessing county-level need within the four Metro area counties. (3) Third, KFH NW prioritizes health equity work and racial/ethnic health inequity data as an important element of prioritizing community health need (Criteria 4–5). Given the lack of data consistently reported by race and ethnicity in KFH NW, the scoring for these criteria was simplistic in nature. (4) Lastly, a criterion was applied in the prioritization process to include the health needs of the low-income population through an analysis of local hospital Medicaid data (Criterion 6). The following table outlines the KFH NW prioritization criteria. See Appendix E for more information and detail on scoring each criterion.

KFH NW Health Need Prioritization Criteria

1. The health need benchmarks poorly in the Primary service area.
2. The health need benchmarks poorly in the Secondary service area.
3. There is a saturation of the need in the Primary service area (county-level analysis).
4. There are health inequities in communities of color in the Primary service area.
5. There are health inequities in communities of color in the Secondary service area.
6. The health need is among the top chronic conditions of the Medicaid population.
7. The health need was regularly identified in the meta-analysis.
8. The health need was regularly identified in listening sessions.
9. The health need was regularly identified in the community survey.

The final list includes nine prioritized health needs categorized as high, medium, and lower priority. The originally identified 13 health needs are represented in this final list; however, KFH NW staff and the consultant combined several needs into logical grouping. This includes the creation of a more comprehensive “Chronic Disease” category that encompasses diabetes, obesity, cancers, and cardiovascular disease/stroke; and a “Behavioral Health” category that encompasses mental health, substance abuse, and violence. KFH NW staff and the consultant combined the prioritized list into these broader health needs for two reasons: (1) Many of the related indicators and in some instances core indicators were shared across the unique identified health needs and (2) the strategies for improvement are similar and would see benefits across the multiple identified health needs in the combined category.

Prioritized description of community health needs identified through the CHNA

This process resulted in the following list of prioritized community health needs, categorized as high, medium, and lower priority and listed in priority order. Following is a brief description of why each health need was prioritized. For more detail, see the Health Need Profiles compiled for prioritized needs in Appendix F.

High-Priority Health Needs	• Access to Care • Economic Opportunity • Chronic Disease • Behavioral Health
Medium-Priority Health Needs	• Maternal and Infant Health • Asthma • Oral Health • Sexually Transmitted Infections
Lower-Priority Health Need	• Climate and Health

Access to Care — *High Priority*

This health need is defined as access to high-quality, affordable, holistic, and culturally specific care. While access to health insurance has increased because of expanded coverage under the Oregon Health Plan and Washington Apple Health (Oregon and Washington State Medicaid), there are still barriers to accessing care in KFH NW, especially for communities of color. Difficulty navigating the complex systems, lack of holistic health care providers including mental health providers, and a need for more culturally specific care were highlighted in the community listening sessions and survey, and cost of care is still a barrier to many. Given that economic opportunity was identified as a high-priority need, the link between the two cannot be ignored. For these reasons, access to care was prioritized.

Economic Opportunity — *High Priority*

Economic opportunity is the ability to meet basic needs, including access to housing, jobs, education, and healthy foods. This health need is one of the most critical issues facing our community. Cities across KFH NW have declared states of emergency to address an ongoing "housing crisis" as the number of homeless individuals and families rises. KFH NW reflects nationwide trends of stagnant wages and growing income inequality, which has spurred legislation around minimum wage increases in both Washington and Oregon. Economic opportunity is a key community concern, as the ability to meet basic needs is critical to living a full, healthy life. Additionally, inequities in key indicators among racial and ethnic minority groups make this a critical health equity need across the KFH NW service area.

Chronic Disease — *High Priority*

This health need is defined as nutrition-, physical activity-, tobacco-, and environment-related chronic diseases and conditions such as obesity, type 2 diabetes, hypertension, heart disease, stroke, and cancer. Obesity- and tobacco-related chronic diseases are the most preventable in KFH NW. Key indicators such as overweight and obesity benchmark poorly compared to the best state average in the Primary and Secondary service areas, as do many drivers of these chronic diseases, including tobacco use. The community frequently mentioned the need for healthy food access and safer neighborhoods for physical activity, including the need for exercise-related infrastructure. Oregon and Washington both see racial and economic inequities in obesity and related chronic diseases. Given the magnitude of the need and potential for prevention, this health need is high priority.

Behavioral Health — *High Priority*

Behavioral health is defined as access to mental health care integrated with primary care and substance abuse treatment and care, as well as community safety and violence prevention. There are many issues related to behavioral health in the KFH NW region, including a lack of access to mental health providers and a housing crisis that has created a growing homeless population. Mental health, substance abuse (including alcohol and tobacco), and community safety were issues that rose to the top in both primary data collection and in looking at secondary data. For these reasons, behavioral health was prioritized.

Maternal and Infant Health — *Medium Priority*

Maternal and infant health encompasses issues that affect the quality of life of mothers, children, and their families, including teen births, low birth weight and infant mortality, breastfeeding, and access to prenatal care. While infant mortality rates in KFH NW outperform the Healthy People 2020 target, there are marked racial and ethnic inequities in communities of color at the state level. Lack of prenatal care is high in the Secondary service area, as is the teen birth rate. The community indicated aspects of maternal and child health as a need in the survey, listening sessions, and meta-analysis. Maternal and infant health sets the course for lifelong health and, for all of these reasons, was prioritized in the CHNA.

Asthma — *Medium Priority*

Asthma is a chronic lung condition affecting the airways and exacerbated by environmental triggers such as tobacco smoke and poor air quality. The burden of asthma in the Primary and Secondary service areas is substantially higher than the better state benchmark (WA) and the nation overall. There are clear inequities in the burden of the disease; in Oregon, more American Indian/Alaska Natives and African-Americans report having asthma than any other racial or ethnic group. Asthma is the most diagnosed chronic condition in youth when analyzing Medicaid data from three of the four Metro service area counties. Additionally, community input indicated the need for cleaner environments and healthier behaviors, including decreased smoking. This shows that many of the drivers of asthma are of concern to the KFH NW community.

Oral Health — *Medium Priority*

Oral health includes conditions of the mouth, teeth, gums, and throat, from dental caries to cancer, that cause pain and disability leading to poor overall general health and an array of other health problems. In the KFH NW Primary and Secondary service areas, there is a gap in understanding the true oral health crisis due to lack of comprehensive surveillance and monitoring. What we do know is tooth decay is a significant public health concern and causes needless pain and suffering for many children in Oregon and Washington. Very poor oral health in adults as indicated by rampant caries (6 or more) is a substantial health issue across KFH NW — especially in the Secondary service area where there is also an up to 100% shortage of dental health professionals. The community survey, listening sessions, and meta-analysis all indicated the need for improved health care, including oral health.

Sexually Transmitted Infections — *Medium Priority*

This health need includes sexually transmitted infectious diseases such as chlamydia and HIV/AIDS. In Washington and Oregon, sexually transmitted infections are the most frequently reported infections and account for more than 87% of notifiable diseases or conditions in Washington and almost two-thirds of reportable diseases in Oregon. Chlamydia is the most frequently reported sexually transmitted infection in both states and nationally and is trending upwards. Community input indicated a need for access to contraceptives and comprehensive sexual education for youth. For these reasons, sexually transmitted infections are prioritized in KFH NW.

Climate and Health — *Lower Priority*

This health need is defined by the climate and weather changes that threaten access to clean air, water, and healthy food and also threaten human health, including asthma, allergies, and infectious diseases. While climate and health received the fewest prioritization criteria points, there is still reason to include it as a prioritized need for KFH NW. Air quality in the Metro area is poor, with high levels of particulate matter 2.5 and adult asthma rates that benchmark poorly to the better state average (WA) and the nation. Drought severity is high in the Mid-Valley and South Valley areas. Although climate and health was not identified in the community input process as a need, Oregon and Washington statewide planning priorities and local jurisdictional climate action plans indicate that this health need should remain on the radar in KFH NW.

Community resources potentially available to respond to the identified health needs

KFH NW has a wealth of assets positioned to improve community health. The KFH NW Community Benefit department compiled a directory of assets that are present and potentially available to address the many health needs identified in this CHNA. The directory is organized by the type of asset, the primary health need that asset works to address, and where the asset is located (Primary or Secondary service area). Assets are categorized as follows:

- Federally Qualified Health Centers (FQHC)
- Community Supported Clinics (CSC)
- Coordinated Care Organizations (Oregon)/Accountable Communities of Health (Washington)
- Rural Health

- Tribal Health
- Health Systems
- School Based Health Centers
- Community Based Organizations/Nonprofits
- Coalitions and Collaboratives
- Local and Regional Funders
- Community Development Corporations
- Local/Regional Government and Jurisdictions
- Public Education Institutions

The entire community assets directory is located in Appendix G. KFH NW staff are continually refining and updating the assets directory.

KFH NW 2013 IMPLEMENTATION STRATEGY EVALUATION OF IMPACT

Purpose of 2013 Implementation Strategy Evaluation of Impact

KFH Sunnyside 2013 Implementation Strategy Report was developed to identify activities to address health needs identified in the 2013 CHNA. In 2014, KFH Westside was opened and adopted the KFH Sunnyside CHNA and Implementation Strategy Report as each facility has the identical hospital service area. This section of the CHNA report describes and assesses the impact of these activities. For more information on KFH Sunnyside and KFH Westside Implementation Strategy Reports, including the health needs identified in the facilities' 2013 service area, the health needs the facilities chose to address, and the process and criteria used for developing Implementation Strategies, please visit https://share.kaiserpermanente.org/wp-content/uploads/2013/10/IS-Report-Sunnyside.pdf for KFH Sunnyside and https://share.kaiserpermanente.org/wp-content/uploads/2015/01/IS-Report-Westside.pdf for KFH Westside. For reference, the list below includes the 2013 CHNA health needs that were selected by KFH Sunnyside and KFH Westside in the 2013 Implementation Strategy Report. For the purpose of this report, KFH NW will continue to be used to refer to both KFH hospitals, Sunnyside and Westside.

1. **Access to Care**
2. **Nutrition- and Physical Activity-Related Chronic Disease**
3. **Maternal and Infant Health**
4. **Oral Health**
5. **Mental Health**

KFH NW is monitoring and evaluating progress to date on the 2013 Implementation Strategies for the purpose of tracking the implementation of those strategies as well as to document the impact of those strategies in addressing selected CHNA health needs. Tracking metrics for each prioritized health need include the number of grants made, the number of dollars spent, the number of people reached/served, collaborations and partnerships, and KFH NW in-kind resources. In addition, KFH NW tracks outcomes, including behavior and health outcomes, as appropriate and where available.

As of the documentation of this CHNA report in March 2016, KFH NW had Evaluation of Impact information on activities from 2014 and 2015. While not reflected in this report, KFH NW will continue to monitor impact for strategies implemented in 2016.

2013 Implementation Strategy Evaluation of Impact Overview

In the 2013 Implementation Strategy (IS) process, all KFH hospital facilities planned for and drew on a broad array of resources and strategies to improve the health of our communities and vulnerable populations, such as grantmaking, in-kind resources, collaborations and partnerships, and several internal KFH programs including charitable health coverage programs, future health professional training programs, and research. Based on years 2014 and 2015, an overall summary, including several examples, of these strategies is below, followed by tables highlighting a subset of activities used to address each prioritized health need.

- **KFH NW Programs:** In 2014 and 2015, KFH NW supported several health care and coverage, workforce training, and research programs to increase access to appropriate and effective health care services and address a wide range of specific community health needs, particularly those affecting vulnerable populations. These programs included:

  - Medicaid: Medicaid is a federal and state health coverage program for families and individuals with low incomes and limited financial resources. KFH NW provided services for Medicaid beneficiaries, both members and nonmembers.

  - Medical Financial Assistance: The Medical Financial Assistance (MFA) program provides financial assistance for emergency and medically necessary services, medications, and supplies to patients with a demonstrated financial need. Eligibility is based on prescribed levels of income and expenses.

  - Charitable Health Coverage: Charitable Health Coverage (CHC) programs provide health care coverage to low-income individuals and families who have no access to public or private health coverage programs.

  - Workforce Training: Supporting a well-trained, culturally competent, and diverse health care workforce helps ensure access to high-quality care. This activity is also essential to making progress in the reduction of health care disparities that persist in most of our communities.

  - Research: Deploying a wide range of research methods contributes to building general knowledge for improving health and health care services, including clinical research, health care services research, and epidemiological and translational studies on health care that are generalizable and broadly shared. Conducting high-quality health research and disseminating its findings increases awareness of the changing health needs of diverse communities, addresses health disparities, and improves effective health care delivery and health outcomes

- **Grantmaking:** For 70 years, Kaiser Permanente has shown its commitment to improving Total Community Health through a variety of grants for charitable and community-based organizations. Successful grant applicants fit within funding priorities with work that examines social determinants of health and/or addresses the elimination of health disparities and inequities. In 2014 and 2015, KFH NW paid 237 active grants for a total of $16,097,308 in service of 2013 health needs.[5] Additionally, KFH NW has funded significant contributions to the Kaiser Permanente Community Fund in the interest of funding effective long-term, strategic community benefit initiatives within the KFH NW service areas. In 2014 and 2015, a portion of the KFH NW monies managed by the Northwest Health Foundation was used to award 23 grants totaling $3,000,330 in service of 2013 health needs.

- **In-Kind Resources:** Kaiser Permanente's commitment to Total Community Health means reaching out far beyond our membership to improve the health of our communities. Volunteerism, community service, and providing technical assistance and expertise to community partners are critical components of Kaiser Permanente's approach to improving the health of all our communities. In 2014 and 2015, KFH NW donated several in-kind resources in service of 2013 Implementation Strategies and health needs, including MLK Days of Service and the Surplus Property Donation Program.

- **Collaborations and Partnerships:** Kaiser Permanente has a long legacy of sharing its most valuable resources: its knowledge and talented professionals. By working together with partners (including nonprofit organizations, government entities, and academic institutions), Kaiser Permanente can make a difference in promoting thriving communities that produce healthier, happier, more productive people. In 2014 and 2015, KFH NW engaged in several partnerships and collaborations in service of 2013 Implementation Strategies and health needs. Partnership and collaboration examples include:

[5] An additional $96,310 was paid to five grants in Workforce Development. Combined with the five health needs, that is $16,193,618 paid to 242 active grants.

- Project Access NOW (PAN) in Multnomah, Clackamas, and Washington counties
- Medical Foundation of Marion and Polk Counties in Oregon
- Free Clinics of Clark County and Cowlitz County in Washington
- Providence Health & Services on the Community Supported Clinics Grant Initiative
- Oral Health Funders Collaborative
- Oregon Active Schools partnership with Nike and the Northwest Health Foundation
- Healthy Living Collaborative of Southwest Washington
- Healthy Columbia Willamette Collaborative

2013 IMPLEMENTATION STRATEGY EVALUATION OF IMPACT BY HEALTH NEED

KFH NW PRIORITY HEALTH NEED: ACCESS TO CARE

Long-Term Goal: Increase number of individuals who have access to and receive appropriate health care services in the KFH NW service area.

Intermediate Goals:

- Reduce barriers to enrollment and increase the number of low-income people who maintain health care coverage (e.g., Community Medical Financial Assistance Program and Chronic Care Program).
- Increase access to high-quality, culturally competent health care services for low-income uninsured/underinsured individuals via community access programs such as Project Access.
- Increase capacity of health care workforce. (See Health Need: Workforce Development, for additional programs and initiatives designed to address this goal.)

ACCESS TO CARE KFH NW ADMINISTERED PROGRAM HIGHLIGHTS

KFH NW Program Name	KFH NW Program Description	Results to Date
Medicaid	Medicaid is a federal and state health coverage program for families and individuals with low incomes and limited financial resources. KFH NW provided services for Medicaid beneficiaries, both members and nonmembers. See Health Need: Oral Health, for Medicaid Dental program highlights.	*Total Medicaid/CHIP Membership* *2014: 30,182* *2015: 41,369* *Total Medicaid/CHIP Losses* *2014: $57,176,631* *2015: $77,413.599*
Medical Financial Assistance	The Medical Financial Assistance (MFA) program provides financial assistance for emergency and medically necessary services, medications, and supplies to patients with a demonstrated financial need. Eligibility is based on prescribed levels of income and expenses. There are several community MFA programs run in collaboration with community-based organizations to provide charity care services to low-income uninsured patients at KFH NW facilities or from Permanente providers. Patients are referred to the community MFA	*Total Spend* *2014: $21,642,585* *2015: $22,395,643* *Unique Patients Served* *2014: 13,006* *2015: 12,731* *Community MFA Programs Patients Served* *Communitiy Access* *2014: 100* *2015: 216*

	programs by one of the community-based organizations. The community-based organization takes responsibility for pre-screening each patient to make sure they meet the eligibility criteria. These programs include Community Access, Chronic Care, Latina Initiative, and a Vision program. Except for Vision, utilization for those programs is a subset of the overall MFA numbers. See Health Need: Oral Health, for Dental Financial Assistance program highlights.	*Chronic Care* *2014: 600* *2015: 933* *Latina Initiative* *2014: 133* *2015: 741* *Vision* *2014: 433* *2015: 271*
Charitable Health Coverage	Charitable Health Coverage (CHC) programs provide health care coverage to low-income individuals and families who have no access to public or private health coverage programs. In the KFH NW service area, the CHC offering is the Child Health Plan. This program is open to children of low-income families who do not have access to other health coverage and who reside in KFH NW service areas which includes 26 school districts. The program provides comprehensive medical and prescription coverage to children in kindergarten through 12th grade. Children must come from a household with income less than 250% of federal poverty level and must not be eligible for or enrolled in any private or public health plan. See Health Need: Oral Health, for CHC Dental program highlights.	*Number of Members* *2014: 3,741* *2015: 3,819* *Total Spend* *2014: $7,285,392* *2015: $13,133,827*

ACCESS TO CARE GRANTMAKING HIGHLIGHTS			
Summary of Impact: In 2014 and 2015, there were 179 active KFH NW grants, totaling $12,526,997, addressing Access to Care in the KFH NW service area.[6]			
Grantee	**Grant Amount**	**Project Description**	**Results to Date**
Salem Free Clinic	2014: $50,000	**Diabetes Specialty Clinic and Patient Care Coordination —** To support our successful Diabetes Specialty Clinic (DSC). This grant will support Salem Free Clinic's DSC RN Coordinator (half time) and administrative costs associated with offering the DSC. The DSC Coordinator is responsible for tracking patient outcomes, entering data, scheduling and managing patient visits, and recruiting physicians to volunteer for the DSC. In order for the DSC to be successful, it needs an administrative champion fully focused on its operations. A Clinical Quality Improvement Initiative grant.	**The project established a new chronic conditions program.** The program improved outcomes and self-management for uninsured patients with diabetes through the hiring of an RN Diabetes Coordinator and increased capacity of the Diabetes Specialty Clinic (DSC). This project also equipped Salem Free Clinic with improved tracking and reporting abilities. Consistent improvement was seen in A1c over the course of the program: The average A1c of DSC patients went from 9.2% to 8.5%. This improvement showed the value of having a clinical person giving oversight and continuity for diabetic patients. Salem Free Clinic will use this as a blueprint for other chronic conditions and in overall clinical operations. The program reached more than 190 patients.
Clackamas County Health Department	2014: $75,000	**Salud y Vida —** The project focused on developing and implementing a behavior change intervention using the "Influencer Model" framework that contains six sources of influence arranged under the personal, social, and environmental elements in relation to motivation and ability. Employing Promotoras or community health workers is a key	**The project created a new community health worker position it continues to fund after the grant ended.** The "Salud y Vida" project improved outcomes and self-management for Latino patients with diabetes, primarily through the introduction of a Promotora who supported and guided patients toward better health outcomes. Through the integration of home visits, additional support/follow-up from the

[6] This total grant amount may include grant dollars that were accrued (i.e., awarded) in a year prior to 2014, though the grant dollars were paid in years 2014 and 2015.

		component of the success of the project. A Clinical Quality Improvement grant.	Promotora after Primary Care Physician visits, the formation of a Latino Diabetes Support Group, and activity offerings, the "Salud y Vida" program engaged more than 200 patients.
Polk County	2014: $40,000	**Central School District School Based Health Center (SBHC) —** To expand involvement and communication efforts by increasing the number of SBHC partners, enhancing knowledge of SBHC services/benefits, and boosting student and parent engagement. A School Based Health Centers Initiative grant.	**Established School Based Health Center after a planning grant.** Since opening in July 2015, the SBHC has established 315 new patients and 538 total visits. It estimates that by June 2016, that will increase to 1,000 patients and more than 1,600 total visits.
Portland Public Schools (PPS)	2014: $40,000	**Benson Polytechnic High School School Based Health Center —** Planning process to integrate medical and behavioral health care in order to comprehensively assess and treat Benson Polytechnic High School youth and staff. To develop the most appropriate, collaborative, integrated, and sustainable SBHC model to serve the physical and mental health needs of 3,500 students who attend classes at Benson Polytechnic High School (approximately 27.4% of all PPS high school students). A School Based Health Centers Initiative grant.	**Established School Based Health Center after a planning grant.** Receiving a Planning Grant supported Benson Polytechnic High School to increase mental health and other services through PPS District channels — from approximately two days of services per month to three or four days of services per week currently.
Oregon Primary Care Association	2014: $292,604	**It Takes A Neighborhood —** Pilot a new role, the Health Instigator, which can increase the capacity of safety net clinics and their partners in a broader "health neighborhood" to work together, break down barriers, and implement innovative solutions to health problems.	The Health Instigators (HI) were able to set several innovations into motion, including a collaboration with a Portland CCO to give a disenfranchised community a voice in its governance and fund an upstream intervention that served a high-risk population regardless of insurer. In Salem, the HI was able to effectively

			organize the community to provide a key resource to a high-need patient population and change the way the delivery system bills for services.
Oregon Public Health Institute/Oregon Community Health Workers Association (ORCHWA)	2014: $320,000 2015: $260,000 Total: $580,000	**Warriors of Wellness (WOW) —** The Oregon Community Health Workers Association (ORCHWA) is the lead organization in this multicultural collaborative that brings together five culturally-specific social service organizations that employ community health workers (CHWs). WOW CHWs have been working with members of their communities to improve chronic disease prevention and management, increase health knowledge and empowerment among participants, reduce health disparities and build a replicable model for community-based CHW integration with health systems.	Aims to build a model through which health care systems can partner with community health worker programs to improve health and decrease health disparities among communities of color in the Portland metro area. In 2015, WOW community health workers served 2,329 people through groups, home visits, community events, and one-on-one support. People who received intensive support reported significant improvements in their physical and emotional health and their sense of empowerment.
Salem Hospital	2014 - $5,476,440 2015 - $2,908,200 Total: $8,384,640	**Charity Care —** KFH NW has been partnering with Salem Hospital in the care of our members for nearly 20 years. Through a hospital services agreement, KFH NW agrees to support a portion of Salem Hospital's charity care services. The methodology is based on the ratio of Kaiser Permanente patients to all Salem Hospital patients.	KFH NW covers approximately 21.6% of Salem Hospital's charity care. Specific patients and utilization are not attributed to KFH NW. In 2014, Salem Hospital provided charity care to 6,676 unique patients. In 2015, Salem Hospital provided charity care to 6,401 unique patients.

ACCESS TO CARE COLLABORATION/PARTNERSHIP HIGHLIGHTS		
Organization/ Collaborative Name	**Collaborative/Partnership Goal**	**Results to Date**
Community Access	KFH NW is partnering with Project Access NOW (PAN) in Multnomah, Clackamas, and Washington counties; the Medical Foundation of Marion and Polk Counties in Oregon; and the Free Clinics of Clark County and Cowlitz County in Washington in a broad-based community initiative that builds access to health care for low-income and uninsured people through the provision of donated medical services. To implement this program, KFH NW and its community partners use the nationally recognized model of Project Access.	All program costs are covered by the Medical Financial Assistance program and summarized in the highlights table. In 2014, Community Access served 100 patients. In 2015, Community Access served 216 patients.
Susan G. Komen Oregon & SW Washington	**Poder y Vida —** To address high rates of late-stage breast cancer diagnosis in the Latina community in KPNW, by increasing screening rates, improving knowledge and awareness, and reducing late-stage diagnoses. This initiative involves multiple community partners, including several community-based organizations that employ Latina community health workers (Promotoras) who conduct targeted outreach, educate, and provide navigation and support for Latina women to access breast cancer screening and treatment.	As part of Community Medical Financial Assistance (MFA) programs, KFH NW donated mammography services for 741 (actual completed mammograms) women through the Susan G. Komen Oregon & SW Washington initiative in 2015. Additionally, the program has improved service to all Latina Kaiser Permanente members through requiring process improvements such as Spanish-language scheduling and culturally appropriate results notification.
Providence Health Systems	**Community Supported Clinics —** KFH NW and Providence Health & Services partnered to create the Community Supported Clinics Initiative that will support clinics that are expanding and adapting their current models	KFH NW and Providence Health & Services funded nine community supported clinics throughout Oregon and Southwest Washington that are working to provide health care to low-income and underserved people, including those who lack health insurance. A total of $360,000 was awarded to nine clinics ($40,000 per clinic)

	to respond to the changing needs of patient populations and the rapidly changing health care environment.	over two years in service areas within Oregon and Southwest Washington.
ACCESS TO CARE IN-KIND RESOURCES HIGHLIGHTS		
Recipient	**Description of Contribution and Purpose/Goals**	
Wallace Medical Concern	In 2014, as part of the MLK Days of Service Initiative, Kaiser Permanente employees assisted with Wallace Medical Concern's health fair on Martin Luther King Jr. Day. Vision professionals gave 22 exams and donated 20 pairs of glasses. Other KP volunteers taught CPR classes in English and Spanish, and took vitals as part of a Know Your Numbers education on hypertension and diabetes care and prevention. In 2015, staff returned to perform eye exams on uninsured adults. Office furniture, file cabinets, bookcase, and cork boards. To offset operating expenses and provide needed items for staff to efficiently run this clinic.	
Virginia Garcia Memorial Center	Medical equipment/office furniture, exam tables, exam lights, privacy screen, wheelchair, stainless steel trays, carts, otoscope, file cabinets, whiteboard. To offset operating expenses and provide needed items for staff to efficiently run this clinic.	
Salem Free Clinic	In 2014 and 2015, as part of the MLK Days of Service Initiative, Kaiser Permanente medical staff volunteers provided basic care to uninsured adults from the Salem community.	
Volunteers in Medicine	In 2014 and 2015, as part of the MLK Days of Service Initiative, Kaiser Permanente medical staff partnered with Volunteers in Medicine to provide medical care to those in need. 30 uninsured adults were seen, and 90% of those patients interviewed by the clinic rated their care experience as "Excellent." Kaiser Permanente also awarded the clinic an $8,000 grant for Martin Luther King Jr. Day.	
Free Clinic of Southwest Washington	In 2014 and 2015, as part of the MLK Days of Service Initiative, medical volunteers provided care, including podiatry, for uninsured, low-income adults.	
North By Northeast Community Health Center	In 2015, as part of the MLK Days of Service Initiative, medical staff provided basic medical care to uninsured and underinsured adults.	
Outside In	In 2015, as part of the MLK Days of Service Initiative, medical staff provided eye exams.	
IMPACT OF REGIONAL INITIATIVES ADDRESSING ACCESS TO CARE		
Clinical Quality Improvement (CQI) Initiative (KPNW Regional Grant Initiative) (2012–2014) From 2012 to 2014, KFH NW funded eight projects to improve clinical outcomes in patients with chronic illnesses, improve the data-reporting capacity and quality improvement processes among safety net providers, contribute to a reduction in documented health disparities and improved health equity, and improve readiness among safety net providers for outcome-reporting requirements under health care reform.		

The work of the CQI program enabled the grantees to improve patient experience and better connect with some of their most challenging patients, provide greater standardization of care, adopt a population health perspective, improve teamwork and communication, implement systems with the potential to affect other chronic disease management, and shift from a snapshot data approach to an improvement cohort approach. Key findings included that the programs were transformational for grantee clinics, grantees improved their data-reporting capacity and quality improvement processes, grantees demonstrated improved clinical outcomes as well as having a positive impact in the lives of their patients, and grantees were able to standardize protocols, policies, and procedures.

School Based Health Centers Initiative (KPNW Regional Grant Initiative) (2014–2017)
Schools have been a focal point for community health improvement for years. In many regions, partnerships with school based health centers have been leveraged to expand access to children, youth, and their families and to create new models of care delivery that are customized to meet the service needs of these populations. In 2014, KFH NW launched a three-year School Based Health Center (SBHC) funding initiative to support the development of new SBHCs in KPNW and increase the ability of existing SBHCs to provide behavioral health services to adolescents. This funding initiative was developed with input from safety net partners including the Oregon and Washington School-Based Health Alliances. Behavioral health continues to be a significant need facing schools and families, and SBHCs can be ideal settings for young people to receive these services. Grants to Polk County and Portland Public Schools are examples of the projects funded through this initiative.

Poder y Vida/Latina Initiative (KPNW Regional Initiative) (2014–2018)
Described above in Partnership Highlights under Susan G. Komen Oregon & SW Washington.

Community Supported Clinics Initiative (KPNW Regional Initiative) (2015–2017)
Described above in Partnership Highlights under Providence Health Systems.

MLK Days of Service (Kaiser Permanente National Initiative) (Started 2004)
MLK Days of Service is a program wide initiative that honors the legacy of Dr. Martin Luther King Jr. by providing Kaiser Permanente employees, along with their friends and family, the opportunity to serve on one of our numerous projects throughout the community. See Access to Care In-Kind Resources Highlights.

KFH NW PRIORITY HEALTH NEED: NUTRITION- AND PHYSICAL ACTIVITY-RELATED CHRONIC DISEASE

Long-Term Goal: Reduce obesity and concomitant chronic disease in the KFH NW service area with a focus on vulnerable populations.

Intermediate Goals:

- Increase healthy eating, including breastfeeding opportunities in community and institutional settings.
- Increase physical activity opportunities in community and institutional settings.
- Expand policies regulating healthy/unhealthy foods and accessing physical activity.
- Reduce morbidity and mortality from chronic disease in high-risk populations.

NUTRITION- AND PHYSICAL ACTIVITY-RELATED CHRONIC DISEASE GRANTMAKING HIGHLIGHTS

Summary of Impact: In 2014 and 2015, there were 34 active KFH NW grants, totaling $2,401,907, addressing Nutrition- and Physical Activity-Related Chronic Disease in the KFH NW service area.[7]

Grantee	Grant Amount	Project Description	Results to Date
Asian Health & Service Center	2015: $83,334	**Asians Building Livable Environment (ABLE) in Jade/Lents —** Asian Health and Service Center proposes to implement two physical activity-related strategies to improve the active-transportation environment and develop community-based programming to support physical activity and active transportation in the Jade District/Lents neighborhood in outer Southeast Portland, Oregon. A HEAL Communities Initiative grant.	Expected outcomes from this project include increased and improved physical activity policies and infrastructure, new and expanded community-based programs, increased grassroots advocacy by/for residents, and changes in physical activity practices at the population level. The intervention's target area has 9,669 residents, and 2,154 Asian residents will be targeted within that area.
Clark County Public Health	2015: $83,334	**Fourth Plain Forward! Improving Central Vancouver's Health Through Active Living —** Clark County Public Health proposes to implement strategies to increase physical activity through improvements to the built environment and by developing community-based programming in the Fourth Plain Corridor in Central Vancouver,	Expected outcomes from this project include: increased and improved physical activity policies and infrastructure, new and expanded community-based programs, increased grassroots advocacy by/for youth, increased and stronger partnerships, and changes in physical activity practices at the population

[7] This total grant amount may include grant dollars that were accrued (i.e., awarded) in a year prior to 2014, though the grant dollars were paid in years 2014 and 2015.

		Washington. A HEAL Communities Initiative grant.	level. The intervention's target area has 25,433 residents, including 5,906 youth.
Oregon Public Health Institute	2014: $301,850	**HEAL Cities Oregon —** The Healthy Eating Active Living (HEAL) Cities Campaign, funded by Kaiser Permanente, supports cities in their efforts to improve the physical environment and give residents more opportunities to be physically active and eat healthful foods. The program builds awareness among city officials about the role of the physical environment in promoting healthy habits and provides them with an array of practical support in adopting and implementing city policies that make it easier for residents to engage in healthy behaviors.	By 2015, 29 cities had joined the campaign. HEAL Cities benefit 511,875 residents (13% of Oregon's population) in 14 Oregon counties (40% of Oregon's counties). A majority of the cities are located in rural communities with more than 80% of HEAL Cities having populations under 16,000. Campaign staff provided technical assistance to HEAL Cities, resulting in the implementation of 80 HEAL policies. The top types of HEAL policies implemented by HEAL Cities were increasing walkability and bikeability (17); farmers markets (13); open space designation (12); capital improvements (8); nutrition standards (7); and community gardens (7).
Foundation for Healthy Generations	2015: $45,000	**Healthy Living Collaborative of Southwest Washington —** The collaborative established an infrastructure for creating cross-sector policy, systems, and environmental change that will lead to community-based health and wellness across a four-county region. To support improved health, this public and private partnership is focused on prevention through a "Health and Wellness in All Policies" approach that incorporates health considerations into decision-making across sectors and services that address root causes of unhealthy behavior and the circumstances that increase risk for chronic disease.	In 2014 the HLC has trained 28 community health workers (CHW) in three pilot sites. An evaluation of the pilot is currently under way, measuring transformation in the CHW's health knowledge, self-reported health status, health behavior, resources/support, psychological empowerment, and health outcomes. The evaluation is also measuring similar growth among community and community organizations with connections to CHWs. This project serves a community of 560,993.

Playworks Education Energized	2014: $200,000 2015: $200,000	**Powered by Playworks —** This funded work enhances Playworks' goals to lead, teach, and inspire play within partnering schools and communities. Playworks achieves its goals through a combination of direct service, training, and movement building. Playworks' efforts create an upstream, sustainable, and root-cause solution to health and education challenges in schools and communities. A Thriving Schools Initiative grant.	During the 2014–2015 school year, Playworks increased the access, opportunities, and impact of play for 50 to 75 schools and 30,000 to 40,000 school-aged children. In 2015, through Playworks programming, 96 to 98% of teachers reported an increase in the number of students who were engaged in healthy play, physically active, and using conflict resolution strategies. Additionally, 88 to 91% of teachers reported a decrease in number of bullying incidents, conflicts (physical or verbal), and disciplinary incidents.
Safe Routes to School National Partnership	2014: $100,000 2015: $100,000	**Safe Routes to School Network Project —** Safe Routes to School (SRTS) programs aim to create safe, healthy, convenient, and fun opportunities for children to use active transportation for the school commute. These initiatives promote livable, vibrant communities, increase physical activity, and improve unsafe walking and bicycling conditions throughout the community. A Thriving Schools Initiative grant.	In 2015, 13 cities had schools participating in the Walk + Bike Challenge month, logging almost 104,000 walk, bike, and other active trips. Almost 15,000 students are receiving Bicycle and Pedestrian Safety Education every year. Participation in the Fire Up Your Feet program has increased 25-fold in just two years. 189 schools have completed SRTS Action Plans. Jurisdictions in Oregon have received $11.9 million in infrastructure grants and $3.1 million in non-infrastructure grants from the Oregon Department of Transportation between 2008 and 2015.
Mt. Hood Community College, Head Start	No payments made in 2014 or 2015, but project active in 2014	**Farm-to-Head Start: Increasing children's access to regionally grown fruits and vegetables —** Mt. Hood Community College (MHCC) Head Start aims to increase children's access to and preference for a variety of fruits and vegetables by applying the farm-to-school concept at MHCC Head Start and Early Head Start child care	Head Start centers now serve locally grown, "featured," fresh produce in snacks and lunches. In the 2013–2014 academic year, "featured" produce was offered 72 times at centers serving around 900 three- to five-year-olds for a total of 61,000 meals served. This programming continues to be implemented thanks to the grant initiative.

		facilities. A Healthy Food Access Initiative grant.	The project also developed, and made publicly available, Harvest for Healthy Kids, a curriculum designed to help Head Start children (0 to 5) develop healthier eating habits. This curriculum continues to be used by MHCC Head Start.
Friends of Zenger Farm	No payments made in 2014 or 2015, but project active in 2014	**Accepting SNAP funds for CSA shares —** Zenger Farm will expand on an existing community supported agriculture (CSA) model for SNAP (Supplemental Nutrition Assistance Program, or food stamp) recipients. As CSA members, SNAP recipients will receive weekly shares of fresh produce using their SNAP benefits as payment. A Healthy Food Access Initiative grant.	10 community supported agriculture (CSA) farms offered 75 SNAP-paid shares serving an estimated 300 people during the 2013 and 2014 seasons. Additional farms continue to adopt SNAP-paid shares as part of their business model with support from the toolkit developed as part of this project. Additionally, Friends of Zenger Farm contributed to the United States Legislature authorizing prepayment of SNAP benefits for CSA shares in the 2014 Farm Bill.
Oregon Public Health Division, Oregon Department of Corrections	No payments made in 2014 or 2015, but project active in 2014	**Healthier food environment at Coffee Creek Correctional Facility (CCCF) —** The Oregon Department of Corrections will serve healthier food and teach gardening and food preparation skills to female inmates. By eating healthier, achieving better health outcomes, and developing new skills, these women will have improved employment opportunities and be able to contribute more productively to family and community upon release. A Healthy Food Access Initiative grant.	CCCF, housing 1,200 women inmates, expanded its community garden by 56%, producing 5,000 pounds of organic vegetables and herbs annually. It also installed a greenhouse and reduced daily menu calories by 25%. The project also influenced the Oregon Department of Corrections to expand healthier food options into the prison commissary in early 2015, and to promote these healthier options to inmates in all state facilities (about 14,000 inmates statewide). Coffee Creek Correctional Facility instituted menu labeling in 2012, and commissary menu labeling was extended to all facilities in 2015.

			Additionally, the project played a role in creating a comprehensive food waste composting system at Coffee Creek Correctional Facility. As a result, 20 cubic yards of garden soil are produced annually. Reduction of food waste has eliminated one large trash dumpster for a savings of $1,800 per month or $21,000 per year.
NUTRITION- AND PHYSICAL ACTIVITY-RELATED CHRONIC DISEASE COLLABORATION/PARTNERSHIP HIGHLIGHTS			
Organization/ Collaborative Name	**Collaborative/Partnership Goal**		**Results to Date**
Healthy Living Collaborative of Southwest Washington	The Healthy Living Collaborative of Southwest Washington (HLC) has established an infrastructure for creating cross-sector policy, systems, and environmental change that will lead to community-based health and wellness across a four-county region. To support improved health, this public and private partnership is focused on prevention through a "Health and Wellness in All Policies" approach that incorporates health considerations into decision-making across sectors and services that address root causes of unhealthy behavior and the circumstances that increase risk for chronic disease. Kaiser Permanente has been an active member of the collaborative since inception.		The HLC also championed two Washington legislative efforts: supporting the Neighborhood Safe Streets policy giving cities the authority to reduce speed limits making Washington's streets safer and more accommodating to people on bikes or on foot; and supporting the governor's bill that supports three state agencies: Department of Health, Department of Early Learning, and Office for the Superintendent of Public Instruction to provide staffing to develop coordinated plans among these three agencies to prevent childhood obesity. See Nutrition- and Physical Activity-Related Chronic Disease Grantmaking Highlights (above) for KFH NW's financial contribution.
Oregon Active Schools (OAS)	KFH NW is partnering with Nike and the Northwest Health Foundation (NWHF) to ensure every child in Oregon has opportunities to be physically active throughout the school day. The Let's Move Active Schools (LMAS) national effort — a coalition of private, public, and nonprofit		During the 2014–2015 school year, 56 Oregon elementary schools received OAS grants to support and/or encourage physical activity. These grants served 14,699 students. Grant funding supported infrastructure such as physical education and playground equipment and equipment and activities for children with different physical abilities. OAS member also joined the PEAK (Physical

	organizations — is the foundation for this regional partnership and our work together. The national partners in Let's Move Active Schools are able to streamline programs, resources, and professional development opportunities for schools and support a customized action plan, making it simple and actionable for teachers and administrators to implement at least 60 minutes of physical activity every day for every student before, during, and after school. Oregon Active Schools is using these national resources to support regional efforts of schools in Oregon. In Oregon, KFH NW, Nike, and NWHF will have a three-pronged approach including grantmaking, policy advocacy, and movement building.	Education for All Kids) Coalition to advocate for implementation of state-mandated physical activity minutes for students.
Intertwine Alliance	The Intertwine Alliance is a coalition of 150+ public, private, and nonprofit organizations working to integrate nature more deeply into the Portland-Vancouver metropolitan region. The collective vision is of a thriving, multijurisdictional, interconnected system of community and regional parks, natural areas, trails, open spaces, educational programming, and recreation opportunities distributed equitably throughout the region. KFH NW has been an active member of the Intertwine Alliance since inception, advocating and promoting access to outdoor activities throughout the Northwest.	KFH NW provided financial support to the Intertwine Alliance to convene and develop a strategic plan for a regional RxPLAY initiative. The expected outcomes for RxPLAY expansion include: increased number of partners on both recreation and health sides, expansion of the program to all ages, increased number of referrals, creation of expanded menu of options that are rated for different abilities and health impact, creation of sustainable staffing model, and gaining funding commitments.

NUTRITION- AND PHYSICAL ACTIVITY-RELATED CHRONIC DISEASE IN-KIND RESOURCES HIGHLIGHTS	
Recipient	**Description of Contribution and Purpose/Goals**
Partners for a Hunger Free Oregon	Office furniture, desks, conference table, chairs, lamps. To offset operating expenses and provide needed items for staff to efficiently run this clinic.
Oregon Children's Theatre	Office furniture/supplies, chairs, lamps, laptop case, letter tray. To offset operating expenses and provide needed items for staff to efficiently run this clinic.
Vernon Elementary	In 2014, as part of the MLK Days of Service Initiative, volunteers read aloud with fifth-graders from the children's book *Good Enough to Eat.* Copies of the book, which contains recipes for healthy snacks, were given to each student. A Dietician intern led an interactive game, a variation on the show *Chopped!* Using markers and poster board, KP volunteers and Vernon fifth-graders brainstormed and drew their healthy meal ideas. Students took turns presenting their poster boards on stage. The project wrapped up with school lunch and outdoor recess for all.
Boise-Eliot Humboldt Elementary	In 2014, as part of the MLK Days of Service Initiative, volunteers met two fifth-grade science, technology, engineering, and math (STEM) classes to facilitate discussion around feeding communities, irrigation, and garden building. In 2015, as part of the MLK Days of Service Initiative, KP staff read with third-graders and participated in a group activity around healthy nutrition and meal planning.
Clark County Food Bank	In 2014 and 2015, as part of the MLK Days of Service Initiative, staff repacked food donations.
Evergreen Park	In 2014, as part of the MLK Days of Service Initiative, staff cleared invasive blackberries to keep the trails safe and clear for walkers. In 2015, as part of the MLK Days of Service Initiative, staff beautified the park and trails at our adopted park, Evergreen Park, near KFH Westside.
Gateway Green	In 2015, as part of the MLK Days of Service Initiative, staff cared for a protected green space used for outdoor recreation.

IMPACT OF REGIONAL INITIATIVES ADDRESSING NUTRITION AND PHYSICAL ACTIVITY-RELATED CHRONIC DISEASE

Thriving Schools (Kaiser Permanente National Initiative) (Started in 2013)

Thriving Schools is a comprehensive program to create a culture of health and wellness for students, staff, and teachers in K–12 schools. KFH NW partners with national and local community organizations to deepen involvement in schools where there is both high need and readiness for health improvement efforts. Key partnerships in Thriving Schools include: (national) the Alliance for a Healthier Generation, Safe Routes to School National Partnership, (regional) Ecotrust, Playworks, School Based Health Centers, and Educational Theatre Program. In addition to community-based partnerships, KFH NW also supports the health of school students, staff, and teachers by offering KFH NW resources to improve health. These resources include health data reports, worksite wellness consultation, and health career scholarship to graduating high school seniors. In the 2013–2014 and 2014–2015 school years, Thriving Schools engagement across KFH NW service area included:

- **63 schools signed an MOU with the Alliance for a Healthier Generation committing to work on health improvement for three years.**
- **63 schools completed inventory, workshops, and action plans for health improvement efforts.**
- **34 schools received implementation grants for a total of $ 200,000.**

Healthy Food Access Initiative (KPNW Regional Initiative) (2011–2014)
From 2011 to 2014, KFH NW awarded $1.2 million to nine nonprofit and government agencies to increase access to healthier food in Oregon and Southwest Washington. Grant awards ranged from $60,000 to $180,000 over one to three years. Collectively, funded partners pursued seven policy and environmental strategies. Examples of grants funded through this initiative include the Mt. Hood Community College Head Start, Friends of Zenger Farm, and Coffee Creek Correctional Facility.

HEAL Communities Initiative (KPNW Regional Initiative) (2015–2018)
The HEAL (Healthy Eating Active Living) Communities Initiative funds six collaboratives working to improve places and systems that support healthier choices ultimately leading to better health outcomes. The work of this initiative is focused in schools and neighborhoods where people are disproportionately affected by chronic disease. We have dedicated $1.5 million and other technical assistance over 3.5 years to the six collaboratives in order to achieve improved community health. Examples of grants funded through this initiative include Asian Health & Service Center, Clark County Public Health, and Friends of Zenger Farm.

HEAL Cities Initiative (Kaiser Permanente National Initiative) (Started 2011)
The HEAL Cities Campaign is a national effort that develops and disseminates to city leaders the information, tools, and personalized assistance they need to reshape community environments by establishing local policies that advance population health and obesity prevention. HEAL Cities helps civic leaders create healthy communities across Oregon. In partnership with Oregon Public Health Institute and the Oregon League of Cities, the initiative focuses on facilitating Healthy Eating Active Living (HEAL) policy options, providing technical assistance on policy implementation, and catalyzing collective action to reduce health disparities and increase access to HEAL options. By the end of 2015, 29 Oregon cities joined the campaign and were on a path to create healthier communities.

Educational Theatre Program (KPNW Regional Program) (Started in 1989)
KFH NW and the Oregon Children's Theatre partner to deliver Educational Theatre Programs (ETP) free of charge to schools and community organizations across KPNW. Theatre-based programs are developed with the combined efforts of physicians, health educators, theater professionals, teachers, counselors, parents, and students. Professional teaching artists perform in productions, teach classes, and facilitate workshops that inspire people to make healthy choices and create healthy environments. Chronic disease programming included *Smarty Pants*, a fun and interactive game show that tests contestants' knowledge about making healthy choices, for themselves their families, and their communities. In 2015 ETP delivered 22 performances reaching 1,413 youth and adults.

MLK Days of Service (Kaiser Permanente National Initiative) (Started 2004)
MLK Days of Service is a program wide initiative that honors the legacy of Dr. Martin Luther King Jr. by providing Kaiser Permanente employees, along with their friends and family, the opportunity to serve in one of our numerous projects throughout the community. See In-Kind Highlights for Chronic Disease-Related Projects, such as addressing nutrition education, physical activity, and food insecurity.

KFH NW PRIORITY HEALTH NEED: MATERNAL AND INFANT HEALTH

Long-Term Goal: Reduce risk factors for poor birth outcomes and adverse childhood events with a focus on vulnerable populations in the KFH NW service area.

Intermediate Goal:

- Increase services and support to improve perinatal and early childhood health in vulnerable populations.
- Reduce risk factors for teen pregnancy with a focus on the Latina population.
- Increase opportunities for breastfeeding initiation and duration per national recommendations.

MATERNAL AND INFANT HEALTH GRANTMAKING HIGHLIGHTS

Summary of Impact: In 2014 and 2015, there were six active KFH NW grants, totaling $210,000, addressing Maternal and Infant Health in the KFH NW service area.[8] In addition, a portion of money managed by a donor-advised fund at Kaiser Permanente Community Fund (KPCF) was used to award 13 grants, totaling $1,579,000, in the focus area of Early Life and supporting KFH NW 2013 Maternal and Infant Health Implementation Strategies. These grants are denoted by an asterisks (*) in the table below.

Grantee	Grant Amount	Project Description	Results to Date
Oregon Foundation for Reproductive Health	2014: $50,000 2015: $50,000 Total: $100,000	**One Key Question: Integrating Reproductive Health into Primary Care —** OFRH created a new tool for pregnancy prevention screening, in order to better integrate these services into routine primary care. Our One Key Question Initiative ensures that providers ask, "Would you like to become pregnant in the next year?" followed by evidence-based preconception/interconception and contraception care depending on her response.	The project expects to provide 3,000 women with pregnancy prevention screenings.
Planned Parenthood Columbia Willamette	2015: $50,000	**Expansion of educational programming and preventive health services for Latinas in Marion County —** To advance PPCW's	The project expects to provide 4,355 youth with pregnancy prevention strategies.

[8] This total grant amount may include grant dollars that were accrued (i.e., awarded) in a year prior to 2014, though the grant dollars were paid in years 2014 and 2015.

		ability to deliver pregnancy prevention strategies in Marion County, especially to Hispanic teens in the Woodburn School District.	
ROSE Community Development*	2014: $50,000*	**Baby Booster Initiative (BBI) —** Modeled after the Best Baby Zone national initiative, this project's goal is to develop a cross-sectoral initiative that addresses the needs of women, young children, and their families who live in outer Southeast Portland neighborhoods and build toward improving birth outcomes and life course health.	ROSE CDC has assembled an advisory committee of community organizations and residents to steer the work of BBI. The implementation plan for BBI includes recruiting and training community health workers, and identifying and supporting community-led strategies that ensure every baby is born healthy into communities that enable them to thrive and reach their full potential.
Family Building Blocks, Inc.	2014: $10,000	**Serving the Most Vulnerable: Healthy Families Home Visits —** Family Building Blocks' specific objective with this grant is to identify and serve high-risk families in Marion County whose children are at risk of abuse and neglect. Healthy Families Oregon is part of a national, evidence-based initiative that works with parents of newborns to give children a healthy start to life. It is one of the most preventive programs we can offer, since it focuses on children age 0–3.	The project expects to provide 300 parents and children with home visits.
Native American Youth and Family Center*	2015: $200,000*	**Aligning, Advocating, and Advancing Native American Early Life Programming —** This project will support an Early Life Coordinator to align our portfolio of early childhood programming with local and statewide initiatives to increase the presence of culturally-specific needs for Native children pre-birth-5. This includes	The project is expected to serve 140 children and parents.

		providing advocacy and communication with early learning and K–12 systems, legislative leaders and community change-makers about the strengths and needs of Native children 0–5 and their families and the long-term social determinants of successful early life education and health.	
Black Parent Initiative (BPI)*	2015: $90,000*	**Northwest/Maternal and Infant Health —** Together We Can (TWC), a home-visit model that combines relationship-based home visiting with group-based support, education (now with closer ties to Parent University, which offers classes to address critical issues ranging from financial health to culturally specific parent education), and community engagement. TWC builds off past successes and is a more comprehensive approach to home-visiting, with greater continuity of services and follow-up with families.	The project is expected to serve 185 children and parents.
MATERNAL AND INFANT HEALTH COLLABORATION/PARTNERSHIP HIGHLIGHTS			
Organization/ Collaborative Name	**Collaborative/Partnership Goal**		**Results to Date**
Healthy Columbia Willamette Collaborative	The Healthy Columbia Willamette Collaborative (HCWC) includes 15 hospitals, four health departments, and two Coordinated Care Organizations in the Clackamas, Multnomah, and Washington counties of Oregon and in Clark County, Washington. This unique public–private partnership aims for stronger relationships between communities, Coordinated Care Organizations, hospitals, and public health departments; meaningful community health		Healthy Columbia Willamette Collaborative implemented a cross-sector initiative to coordinate and improve workplace policy and program support of breastfeeding/lactating mothers and their families. KFH NW participated in development of the best practice and model policy manual to be used by each HCWC member organization.

	needs assessments; and a platform for collaboration around health improvement plans and activities that leverage collective resources to improve the health and well-being of our communities. Kaiser Permanente is a founding member and provides financial support to the collaborative.	
Developmental Origins of Health and Disease	The Developmental Origins Strategy Collaborative (DOSC) is an innovative multisector group that aims to address community health issues via a new approach grounded in the science of *developmental origins of health and disease.* The goal of the collaborative is to support efforts and advocate for policies that ensure every baby is born healthy into communities that enable them to thrive and reach their full potential**.**	KFH NW provided financial support and leadership to DOSC infrastructure development and strategic priority setting. One area of emerging work is a Baby Booster Project, modeled after the national Best Baby Zone pilot site in outer Southeast Portland.

KFH NW PRIORITY HEALTH NEED: ORAL HEALTH

Long-Term Goal: Improve oral health among high-risk populations in the KFH NW service area.

Intermediate Goal:

- Increase proportion of children and adults reached by dental treatment and prevention efforts.
- Increase capacity of oral health system infrastructure.

ORAL HEALTH KFH NW ADMINISTERED PROGRAM HIGHLIGHTS

KFH NW Program Name	KFH NW Program Description	Results to Date
Medicaid Dental	In 2014, Health Plan began to offer its dental services through Health Share of Oregon to up to 1,000 newly eligible Oregon Health Plan beneficiaries whose dental home would become the Rockwood Dental Office. Health Share auto-assigns newly eligible Oregon Health Plan members who sign up for Kaiser Permanente Medical and live in one of the three ZIP codes near the Rockwood Dental Office. The	• *2014 membership: 1,511* • *2015 membership: 1,955*

	program is designed to primarily serve adults. Beneficiaries are eligible if their Income is below or equal to 138% of poverty level.	
Dental Financial Assistance	The Dental Financial Assistance (DFA) program, operates similarly to the Medical Care Program, providing financial assistance to pay dental expenses for patients, both member and nonmembers. Eligibility is based on prescribed levels of income and expenses. KFH NW has several community DFA programs run in collaboration with community-based organizations to provide charity care services to low-income, uninsured patients at KFH NW facilities or from Permanente providers. The community-based organization takes responsibility for pre-screening each patient to make sure they meet the eligibility criteria. These programs include Free Dental Care Days, Dental Access Program, and Free Clinic of Southwest Washington. Utilization for those programs is included in the overall DFA numbers.	• *2014 cost:* $577,148 • *2014 applications approved: 527* • *2015 cost: N/A* • *2015 applications approved: N/A* *Community DFA Programs* • *2014 Free Dental Care Day patients served: 140* • *2015 Dental Care Day patients served: 206* • *2014 Dental Access Program patients served:* • *2015 Dental Access Program patients served: 9* • *2014 Free Clinic of Southwest Washington patients served:* 57
Charitable Health Coverage	The Child Health Program offers Dental Insurance to all enrollees.	• *2014 Dental membership: 3,658* • *2015 Dental membership: 3,916*

ORAL HEALTH GRANTMAKING HIGHLIGHTS			
Summary of Impact: In 2014 and 2015, there were 11 active KFH NW grants, totaling $518,404, addressing Oral Health in the KFH NW service area.[9]			
Grantee	**Grant Amount**	**Project Description**	**Results to Date**
Oregon Community Foundation (OCF; fiscal agent for Oregon Oral Health Funders Collaborative)	2014: $325,000	**Oregon Children's Dental Health Initiative —** To support a portion of projects depending on the size and scope of each project. A comprehensive evaluation will be part of the initiative, conducted by OCF internal evaluation staff. The multiple partnerships involved in this initiative are significant and represent a collective impact approach to addressing oral health issues in our region.	In 2015, the Oregon Children's Dental Health Initiative supported work via funding from eight (8) funders who awarded a total of $3,477,000.
Oregon Community Foundation	2014: $50,000	**Planning for Alternative Dental Workforce Pilot Projects in Oregon —** The proposed project will use the opportunity created by Senate Bill (SB) 738 to formulate workforce pilot projects in Oregon, in an organized planning process. The overall goal is to develop a plan to fund and demonstrate a telehealth-connected team system that will reach people in Oregon who traditionally do not receive dental care until they have advanced dental disease.	The project is expected to reach 5,000 people and provide them with a Virtual Dental Home.
Virginia Garcia Memorial Foundation	2014: $40,000 2015: $40,000 Total: $80,000	**Expansion of Oral Health Care at SBHCs —** Virginia Garcia seeks to implement our innovative program that provides dental services using mobile equipment to our new School Based Health Center (SBHC) at Century High School in Hillsboro. Like the	The project is expected to provide 700 students with dental screenings and preventive care.

[9] This total grant amount may include grant dollars that were accrued (i.e., awarded) in a year prior to 2014, though the grant dollars were paid in years 2014 and 2015.

		existing model, the expanded program will employ an expanded practice dental hygienist and dental assistant to provide screening and preventive care one day per week at the Century SBHC.	
Neighborhood Health Centers	No payments made in 2014 or 2015, but project active in 2014	The project aims to demonstrate a model of population-based oral health service delivery and employ the methods of the virtual dental home. An Oral Health Initiative grant.	Neighborhood Health Centers provided early prevention services and helped connect Head Start students with a dental home, resulting in a drop of nearly 20% in the # of students needing urgent care.
Community Health Centers of Benton and Linn	No payments made in 2014 or 2015, but project active in 2014	Co-funded with the Oregon Community Foundation — Provide dental screening, education, referral and services for low-income/Spanish-speaking children ages 0–5 and their families, elementary school aged children, youth living in residential or treatment settings. An Oral Health Initiative grant.	Benton-Linn County employed a Latino Oral Health Navigator to help increase services to Latino community members & advocated for dental screenings at a local homeless youth shelter.
ORAL HEALTH COLLABORATION/PARTNERSHIP HIGHLIGHTS			
Organization/ Collaborative Name	**Collaborative/Partnership Goal**		**Results to Date**
Oral Health Funders Collaborative	The Oral Health Funders Collaborative of Oregon and Southwest Washington is a partnership of 10 leading philanthropic organizations. The Collaborative has come together to raise awareness of oral disease, with a goal of identifying and implementing the most potent and cost-effective strategies to improve oral health for all residents of Oregon and Southwest Washington with a focus on reducing disparities in access and quality. Kaiser Permanente is a founding member of the		**Developed the Oregon Oral Health Strategic Plan** published in October 2014. The completed plan is intended to guide policymakers, funders, local coalitions, and other motivated stakeholders as they work together to improve Oregon's oral health system through 2020. This plan will periodically be revised and updated by the Oregon Oral Health Coalition (OrOHC). Progress reports and changes to the plan will be shared at OrOHC's annual conference. The Oregon State Public Health Division hired a Dental Health Director as a result of the advocacy efforts of OrOHC. Kaiser Permanente Dentists and KFH NW Community Benefit staff participated in and informed the process of the plan development.

	collaborative, providing leadership and funding for collaborative initiatives.	**Children's Dental Health Initiative** is an effort of the Oral Health Funders Collaborative — see above in the oral health grantmaking section for a description of results to date.
ORAL HEALTH IN-KIND RESOURCES HIGHLIGHTS		
Recipient	**Description of Contribution**	
Epaphras	Dental equipment/office furniture, Phoropter AO 11625B Ultramatic, Phoropter Maestro 11625, Digital Scale, Autorefractor Canon RK-F1 Keratometer, Canon Non-Mydriatic Camera, chairs. To offset operating expenses and provide needed items for staff to efficiently run this clinic.	
New Day Community Dental Clinic	In 2014, as part of the MLK Days of Service Initiative, Dental providers volunteered for a third consecutive year at New Day Community Dental Clinic in Vancouver. Clinicians provided over $8,700 worth of dental services, representing an increase of 74% over the previous year.	

IMPACT OF REGIONAL INITIATIVES ADDRESSING ORAL HEALTH

Oral Health Initiative (KPNW Regional Initiative) (2011-2014)
From 2011 to 2014 KFH NW awarded $1.5 million in grants to 13 different community organizations to improve oral health in Oregon and Southwest Washington. The Free Clinic of Southwest Washington, Neighborhood Health Centers, Benton-Linn County grants were part of this initiative. The Oral Health Initiative served 66,900 total people, while an additional 57,000 people received prevention education. Almost 200 organizations were linked to this oral health network in the first year, to just 6% unknown by the second year. By the third year, it had dropped to 3.5%. By collecting accurate demographic data, the initiative was able to target communities that were not being adequately served, including African-Americans and Native Americans.

Educational Theatre Program (KPNW Regional Program) (Started in 1989)
KFH NW and the Oregon Children's Theatre partner to deliver Educational Theatre Programs (ETP) free of charge to schools and community organizations across KPNW. Theatre-based programs are developed with the combined efforts of physicians, health educators, theater professionals, teachers, counselors, parents, and students. Professional teaching artists perform in productions, teach classes, and facilitate workshops that inspire people to make healthy choices and create healthy environments. In 2015, the Educational Theatre Program launched Tarter Patrol, a performance focused on making good choices to keep our teeth happy and healthy. 2015 metrics included 335 performances reaching 8,402 youth and 376 adults.

MLK Days of Service (Kaiser Permanente National Initiative) (Started 2004)
MLK Days of Service is a program wide initiative that honors the legacy of Dr. Martin Luther King Jr. by providing Kaiser Permanente employees, along with their friends and family, the opportunity to serve in one of our numerous projects throughout the community. See In Kind Highlights for Oral Health highlights.

KFH NW PRIORITY HEALTH NEED: MENTAL HEALTH

Long-Term Goal: Improve mental health among high-risk populations in the KFH NW service area.

Intermediate Goal:

- Increase understanding of mental health and substance abuse as health issues.
- Improve management of mental health symptoms in high-risk populations.
- Minimize risks for mental, emotional, and behavior disorders in vulnerable populations.

MENTAL HEALTH GRANTMAKING HIGHLIGHTS

Summary of Impact: In 2014 and 2015, there were seven active KFH NW grants, totaling $440,000, addressing Mental Health in the KFH NW service area.[10]

Grantee	Grant Amount	Project Description	Results to Date
Tigard Tualatin School District	2014: $50,000 2015: $50,000	The project will serve all students in the district through the School Based Health Centers at two high schools and the district's early identification system. Project services will support schools in identifying students with mental health problems through schoolwide mental health early identification, intervention and treatment services, including connection with primary care and substance abuse services. It aims to provide services in culturally and linguistically welcoming and appropriate ways; reduce disparities in mental health and health care access for students of color; pilot the integration of substance abuse treatment services at one or both SBHCs, and engage students in a mental health awareness campaign.	The project is expected to provide mental health care coordination services to 500 students.
Volunteers of America Oregon	2014: $50,000 2015: $50,000	The purpose of this project is to create a Youth Advisory Committee which will help	The project expects to serve 1,300 students.

[10] This total grant amount may include grant dollars that were accrued (i.e., awarded) in a year prior to 2014, though the grant dollars were paid in years 2014 and 2015.

		inform prevention planning. It will also support the prevention strategies in working with the Milwaukee High School SBHC, and will employ evidence-based prevention curriculum for those exhibiting risk factors for alcohol or drug use, while also providing Universal prevention strategies to the student body.	
Virginia Garcia Memorial Foundation	2014: $50,000 2015: $50,000	The purpose of this project is to meet the behavioral and physical health needs of children by creating an integrated, trauma-informed health home at the Forest Grove School Based Health Center that engages youth, schools and the community to promote overall health and wellness.	The project expects to provide 300 students trauma-formed care.
Comprehensive Options for Drug Abusers, Inc. (CODA)	No payments made in 2014 or 2015, but project active in 2014	CODA's project aimed to build a primary care medical home in a substance abuser treatment setting to serve people with serious substance abuse disorders and multiple chronic health care needs. The project aimed to do "reverse integration" bringing primary care services into a behavioral health environment. A Behavioral Health Initiative grant.	CODA implemented two new program offerings, Project Nurture, which offered on-site pre-natal care, and a smoking cessation program. CODA learned that the community does not need a new primary care mental health home, and focused instead on providing specialty care, creating connections to existing primary care, and expanding nursing care capacity for the population served.
Oregon Primary Care Association (OPCA)	No payments made in 2014 or 2015, but project active in 2014	OPCA integrated Screening, Brief Intervention, and Referral to Treatment (SBIRT) into nine Oregon Federally Qualified Health Centers (FQHCs). The goal was to implement universal screening: every patient at an Oregon FQHC would be screened for alcohol and substance abuse, improving health outcomes and reducing costs. A Behavioral Health Initiative grant.	OPCA worked to create two distinct SBIRT implementation guides: the health educator model and a hybrid model that addressed the challenge of sustaining a qualified health educator. OPCA provided technical assistance to six clinics in implementing SBIRT screenings and interventions. 100% of the participating clinics now include SBIRT in their staff training. The five clinics able to report data screened more than 31,000 patients with the SBIRT tool.

MENTAL HEALTH COLLABORATION/PARTNERSHIP HIGHLIGHTS		
Organization/ Collaborative Name	**Collaborative/Partnership Goal**	**Results to Date**
Providence Health & Services	**Behavioral Health Initiative —** Providence Health Plan and KFH NW partnered with Oregon Community Foundation to fund a grant initiative to address the prevailing needs within the mental and behavioral health arena. By funding innovative projects, the health systems seek to improve the mental health and well-being of our communities. Funded projects should advance the goals of health care reform for safety net populations by reducing the impact of mental health and/or substance abuse on individuals, the health system and the community.	The co-funded initiative funded four organizations for a total of $1,200,000 for projects lasting from January 2013 to December 2015. The total estimated number to be served is 200,000.
Healthy Columbia Willamette Collaborative	The Healthy Columbia Willamette Collaborative includes 15 hospitals, four health departments, and two Coordinated Care Organizations in the Clackamas, Multnomah, and Washington counties of Oregon and in Clark County, Washington. This unique public–private partnership aims for stronger relationships between communities, Coordinated Care Organizations, hospitals and public health departments; meaningful community health needs assessments; and a platform for collaboration around health improvement plans and activities that leverage collective resources to improve the health and well-being of our communities. Kaiser Permanente is a founding member and provides financial support to the collaborative.	Beginning in 2014, KFH NW along with Healthy Columbia Willamette Collaborative partner organizations worked to develop safe prescribing standards for chronic pain not caused by cancer or terminal conditions. Now, the same group is committing to first making sure providers understand the standards, know how to safely decrease unsafe doses, and most importantly to help patients find better ways to live with chronic conditions. KFH NW and the other organizations adopted a Community Standard for New Opioid Prescriptions for Patients with Chronic Non-Cancer/Non-terminal Pain.

Unity Center for Behavioral Health	KFH NW is collaborating with Legacy Health Systems, Oregon Health and Sciences University, and Adventist Health to provide Psychiatric Emergency Services (PES), including a 101-bed inpatient facility and emergency care services, in the KFH NW primary service area.	A joint operating agreement was signed among the four partners in August 2015 with an estimated opening date for the facility of November 2016.

MENTAL HEALTH IN-KIND RESOURCES HIGHLIGHTS	
Recipient	**Description of Contribution**
Albertina Kerr Center	Office furniture, desks, conference table, chairs, lamps, DVD player. To offset operating expenses and provide needed items for staff to efficiently run this clinic.
Bradley Angle House	Office furniture/supplies, desks, love seat, chairs, whiteboard, binders. To offset operating expenses and provide needed items for staff to efficiently run this clinic.
Lifeline Connections	Office furniture/supplies, desks, file cabinets, chairs, whiteboard, binders. To offset operating expenses and provide needed items for staff to efficiently run this clinic.

IMPACT OF REGIONAL INITIATIVES ADDRESSING MENTAL HEALTH

Behavioral Health Initiative (KPNW Regional Grant Initiative) (2013–2015)
Described above in Partnership Highlights under Providence Health and Services.

Educational Theatre Program (KPNW Regional Program) (Started in 1989)
KFH NW and the Oregon Children's Theatre partner to deliver Educational Theatre Programs (ETP) free of charge to schools and community organizations across KPNW. Theatre-based programs are developed with the combined efforts of physicians, health educators, theater professionals, teachers, counselors, parents, and students. Professional teaching artists perform in productions, teach classes, and facilitate workshops that inspire people to make healthy choices and create healthy environments. Many ETP performances address social and emotional health, including The Pressure Point!, a production focused on strategies for working through challenging decisions and responding to peer pressure. In 2015 ETP delivered 20 performances of Pressure Point! reaching 2,914 students reached and 112 educators. In addition, in 2015, ETP delivered 10 interactive performances of a production called Laughaceuticals focusing on the social and emotional wellness for school staff, reaching 356 educators.

KFH NW PRIORITY HEALTH NEED: WORKFORCE DEVELOPMENT

KFH NW WORKFORCE DEVELOPMENT HIGHLIGHTS

Long-Term Goal:

- To address health care workforce shortages and cultural and linguistic disparities in the health care workforce

Intermediate Goal:

- Increase the number of skilled, culturally competent, diverse professionals working in and entering the health care workforce to provide access to quality, culturally relevant care.

Summary of Impact: In 2014 and 2015, KFH NW awarded 5 Workforce Development grants, totaling $96,310 that served KFH NW.[11] In addition, a portion of money managed by a donor advised fund at Kaiser Permanente Community Fund (KPCF) was used to award 10 grants, totaling $1,421,330, in the focus area of Educational Attainment and supporting KFH NW's goals in Workforce Development. These grants are denote by an asterisks (*) in the table below. In addition, KFH NW provided trainings and education for 1,026 medical residents, interns, and fellows in their Graduate Medical Education program; 465 nurse practitioners or other nursing beneficiaries; and 1,139 community members from local county health departments, community health clinics, and members of the Oregon Primary Care Association through their Continuing Medical Education program. Additionally, KFH NW provided scholarships and travel stipends to 45 different safety net partners to access local and national training opportunities. In order to improve community health by promoting educational attainment and diversifying the local health care workforce, KFH NW also awarded $874,030 in scholarships to 304 high school seniors and college students, provided internships for 113 high school and college students, and provided teen volunteering opportunities to 146 high school students.

Grantee	Grant Amount	Project Description	Results to Date
Adelante Mujeres Chicas	2015: $20,000	**Health Care Summer Camp —** The Chicas Youth Development Program provides culturally specific life skills and leadership development, academic support, and parental involvement opportunities so participants graduate from high school and establish postsecondary goals. The week-long Chicas Health Care Summer Camp project will be preceded by after-school sessions focused on health care fields and college readiness. A Community Health Careers grant initiative.	25 to 30 Latina girls will attend the week-long Health Care summer camp with culturally responsive and skills-based services that address the academic and social challenges Latina girls face. Expected outcomes include 95% of seniors served will graduate from high school and 85% will enter post-secondary education or job training program.

[11] This total grant amount may include grant dollars that were accrued (i.e., awarded) in a year prior to 2014, though the grant dollars were paid in years 2014 and 2015.

I Have a Dream Foundation — Oregon	2015: $17,710	**Oregon Alder Dreamer Academic Intervention Program —** The Alder Dreamer Academic Intervention Program focuses on academic readiness for elementary-aged Dreamers. The grant supports the provision of AARP Experience Corps, a national, evidence-based model for improving K-3 student literacy in disadvantaged schools, as well as the implementation of a new Dreamer Mentor program matching high school Dreamers with elementary school Dreamers in an eight-week summer session. A Community Health Careers grant initiative.	The program will work with 500 students to improve academic outcomes for low-income students. Expected outcomes include participants will maintain or improve reading level from Spring 2016 to Fall 2016 avoiding the summer slump.
Girls Inc. of Northwest Oregon	2015: $20,000	**Eureka! Program with After-School Math+ Girls Groups —** This grant supports the Eureka! Program, as well as the implementation of After-School Math+ curricula in Girls Groups at three Eureka! feeder elementary schools in Multnomah & Marion counties. The ASM+ program immerses fifth- to seventh-grade girls in real world math, helping them to meet math standards that focus on data analysis, measurement, algebra, geometry, and more. A Community Health Careers grant initiative.	90 eighth- to 12th-grade girls participate in programming at three college campuses in Multnomah and Marion counties. Based on the national success of this program, expected outcomes include 80% of participants plan to attend a 4-year college and at least 50% of participants listed STEM careers for their future plans.
Native American Youth and Family Center*	2014: $200,000*	The project aims to increase graduation rates and higher education attainment for Portland's Native American youth, supporting the overall impact of lifting our community members out of poverty. The health disparities the community experiences will thus also be reduced in the long term.	The project serves a minimum of 350 students, with the average participant receiving 19 hours of college and career exploration and mentoring.
Open Meadow Alternative Schools*	2014: $200,000*	An innovative, college-prep, grades 7 through 12 school that, at scale, will serve 270 at-risk students in partnership with five East Multnomah County school districts including	Open School seeks to attain a 100% four-year graduation rate with its first class of seniors in 2020.

		Centennial, David Douglas, Gresham-Barlow, Parkrose and Portland Public Schools, and the University of Portland School of Education.	

IMPACT OF REGIONAL INITIATIVES ADDRESSING WORKFORCE DEVELOPMENT

Community Health Careers Program (KPNW Regional Program)

Community Health Careers initiative facilitates educational and career development for underrepresented and low-income youth through scholarships, paid internships, career learning programs, and special initiative grants. The objective is to improve community health by promoting educational attainment and diversifying the local health care workforce. The program includes scholarship programs, an internship program, a grant initiative, and career learning programs.

KFH NW PRIORITY HEALTH NEED: RESEARCH

KFH NW RESEARCH HIGHLIGHTS

Long-Term Goal:

- To increase awareness of the changing health needs of diverse communities

Intermediate Goal:

- Increase access to, and the availability of, relevant public health and clinical care data and research.

Summary of Impact:

In 2014 and 2015, KFH NW provided at total of $8,060,298 ($4,310,763 in 2014 and $3,749,535 in 2015) to the Center for Health Research (CHR) for both general operation support and specific research projects that meet identified community needs (listed below). CHR had a total of 302 active studies in 2014 and 309 in 2015, and published 240 research journal articles in 2014 and 167 in 2015.

In 2014 and 2015, Community Benefit provided dedicated funding for two studies:

1. **Topic Title: Veterans and Use of Psychiatric Service Dogs**
   Community Health Need: Mental Health
   Description: The goal of this project is to document the ways in which service dogs assist veterans with psychiatric problems. The study team will conduct surveys and interviews with veterans with post-traumatic stress disorder who have received service dogs.
2. **Topic Title: Spanish-Language Media Campaign to Promote Colorectal Cancer Screening among Latinos**
   Community Health Need: Nutrition & Physical Activity–Related Chronic Disease
   Description: This project's goal was to develop and carry out, using qualitative research and interviews with Latino patient advisory council members, a Spanish-language media campaign to raise awareness of colorectal cancer and promote the use of fecal immunochemical testing (FIT).

With support from Community Benefit, the Center for Health Research conducted numerous additional studies in 2014 that addressed identified community health needs. Five such studies are summarized below.

1. **Topic Title: Practices Enabling Adapting and Disseminating in the Safety Net (SPREAD-NET)**
   Community Health Need: Access to Health Care

   Description: This study compares the effectiveness of different strategies to support community health centers as they adapt and implement the ALL (aspirin, lovastatin, and lisinopril) intervention, which is designed to increase appropriate medication prescription for patients with diabetes.
2. **Topic Title: Understanding Disparities in Preventive Services for Patients With Mental Illness**
   Community Health Needs: Access to Health Care, Mental Health

   Description: The life expectancy of people with serious mental illnesses (SMI) — schizophrenia spectrum disorders, bipolar disorders— is 12-25 years shorter than that those without SMI. This is a four-year, mixed methods study to examine the role of modifiable regulatory-, organizational-, provider-, provider-, and patient-level factors contributing to disparities in preventive service use among patients with serious mental illness.
3. **Topic Title: National Dental Practice-Based Research Network**
   Community Health Need: Oral Health

   Description: The National Dental PBRN is a collaborative of practices and organizations across the United States that is engaging practitioners in research for the benefit of everyday clinical practice and patients. The goals are to: (1) support the infrastructure and conduct of national oral health research studies in dental practices on topics of importance to practitioners; (2) provide evidence useful in daily patient care; and (3) facilitate the translation of research findings into clinical practice.
4. **Topic Title: Health and Economic Effects of Light Rail Lines: A Natural Experiment**
   Community Health Need: Nutrition & Physical Activity–Related Chronic Disease

   Description: In 2015, a new light rail line will open in Portland, Oregon. We will study how the rail line affects people's health and the cost of their health care. We will compare health outcomes and costs among 4,000 members of an integrated health plan who live near the rail line to health and costs among a similar group who live elsewhere, both before and after the rail line opens.
5. **Topic Title: Healthy Moms**
   Community Health Need: Maternal & Infant Health

   Description: Obesity and excessive weight gain during pregnancy lead to increased risks of high blood pressure, gestational diabetes, large infants, and cesarean section. This study will test an intensive, weight management program for obese pregnant women to prevent too much weight gain and reduce risk of pregnancy complications.

APPENDICES CONTENTS

APPENDIX A: SECONDARY DATA SOURCES AND DATES

1. Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. 2006-2010.
2. Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. 2006-2012.
3. Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. 2011-2012.
4. Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. US Department of Health & Human Services, Health Indicators Warehouse. 2005-2009.
5. Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. US Department of Health & Human Services, Health Indicators Warehouse. 2006-2012.
6. Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2012.
7. Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. US Department of Health & Human Services, Health Indicators Warehouse. 2010.
8. Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. US Department of Health & Human Services, Health Indicators Warehouse. 2012.
9. Centers for Disease Control and Prevention, National Environmental Public Health Tracking Network. 2008.
10. Centers for Disease Control and Prevention, National Vital Statistics System. Centers for Disease Control and Prevention, Wide Ranging Online Data for Epidemiologic Research. 2006-2010.
11. Centers for Disease Control and Prevention, National Vital Statistics System. Centers for Disease Control and Prevention, Wide Ranging Online Data for Epidemiologic Research. 2007-2010.
12. Centers for Disease Control and Prevention, National Vital Statistics System. Centers for Disease Control and Prevention, Wide Ranging Online Data for Epidemiologic Research. 2007-2011.
13. Centers for Disease Control and Prevention, National Vital Statistics System. University of Wisconsin Population Health Institute, County Health Rankings. 2008-2010.
14. Centers for Disease Control and Prevention, National Vital Statistics System. US Department of Health & Human Services, Health Indicators Warehouse. 2006-2012.
15. Centers for Medicare and Medicaid Services. 2012.
16. Child and Adolescent Health Measurement Initiative, National Survey of Children's Health. 2011-2012.
17. Dartmouth College Institute for Health Policy & Clinical Practice. Dartmouth Atlas of Health Care. 2012.
18. Environmental Protection Agency, EPA Smart Location Database. 2011.
19. Federal Bureau of Investigation, FBI Uniform Crime Reports. 2010-2012.
20. Feeding America. 2012.
21. Multi-Resolution Land Characteristics Consortium, National Land Cover Database. 2011.
22. National Center for Education Statistics, NCES – Common Core of Data. 2012-2013.
23. National Oceanic and Atmospheric Administration, North America Land Data Assimilation System (NLDAS). 2014.
24. New America Foundation, Federal Education Budget Project. 2011.
25. Nielsen, Nielsen Site Reports. 2014.
26. Oregon Health Authority, Oregon Healthy Teens Survey. 2013.
27. State Cancer Profiles. National Institutes of Health, National Cancer Institute, Surveillance, Epidemiology, and End Results Program. 2007-2011.
28. University of Wisconsin Population Health Institute, County Health Rankings. 2012-2013.
29. University of Wisconsin Population Health Institute, County Health Rankings. 2014.
30. US Census Bureau, American Community Survey. 2009-2013.
31. US Census Bureau, American Community Survey. 2010-2014.
32. US Census Bureau, American Housing Survey. 2011, 2013.
33. US Census Bureau, County Business Patterns. 2011.
34. US Census Bureau, County Business Patterns. 2012.
35. US Census Bureau, County Business Patterns. 2013.

36. US Census Bureau, Decennial Census. 2000-2010.
37. US Census Bureau, Decennial Census, ESRI Map Gallery. 2010.
38. US Census Bureau, Small Area Income & Poverty Estimates. 2010.
39. US Department of Agriculture, Economic Research Service, USDA – Food Access Research Atlas. 2010.
40. US Department of Agriculture, Economic Research Service, USDA – Food Environment Atlas. 2011.
41. US Department of Agriculture, Economic Research Service, USDA – Child Nutrition Program. 2013.
42. US Department of Education, EDFacts. 2011-2012.
43. US Department of Health & Human Services, Administration for Children and Families. 2014.
44. US Department of Health & Human Services, Center for Medicare & Medicaid Services, Provider of Services File. June 2014.
45. US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File. 2012.
46. US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File. 2013.
47. US Department of Health & Human Services, Health Resources and Services Administration, Health Professional Shortage Areas. March 2015.
48. US Department of Housing and Urban Development. 2013.
49. US Department of Labor, Bureau of Labor Statistics. June 2015.
50. US Department of Transportation, National Highway Traffic Safety Administration, Fatality Analysis Reporting System. 2011-2013.
51. US Drought Monitor. 2012-2014
52. Washington State Department of Health, Healthy Youth Survey. 2014.

Community Reports Included in Meta-Analysis

Project Name, **Date**, ***Organization***, Link, and Project Description	Geographic Area
Adolescent Health Tribal Action Plan: A Five-year Strategic Plan for the Tribes of Idaho, Oregon, and Washington 2014-2018 (2014). *Northwest Native Adolescent Health Alliance.* http://www.npaihb.org/images/epicenter_docs/MSPI/THRIVE/2013/Adolescent%20Health%20Tribal%20Action%20Plan%20-%20Final.pdf This project used information from surveys to help promote and improve northwest native adolescent health.	Clackamas (OR) Multnomah (OR) Washington (OR)
Adventist Medical Center—Portland Community Health Needs Assessment Update (2014). https://www.adventisthealth.org/nw/Documents/Community%20Benefits/Adventist-Medical-Center-Portland-2014-Community-Health-Plan-Update.pdf This Community Health Needs Assessment identifies and prioritizes community health needs through the collection and analysis of data. A portion of this data comes from community members that completed an online health and quality of life survey. The results from this survey were used to identify and help develop plans to address substantial and health and community needs.	Multnomah (OR) Clackamas (OR)
The African Immigrant and Refugee Community in Multnomah County: An Unsettling Profile (2013). *Coalition of Communities of Color.* http://static1.squarespace.com/static/5501f6d4e4b0ee23fb3097ff/t/556d38c1e4b0d8dc09b24d1a/1433221313672/CCC_AfricanReport_FINAL.pdf Focus groups were used to gather information on the lived experiences of African immigrant and refugee communities in Multnomah county.	Multnomah (OR)
African Refugee and Immigrant Health Needs and Barriers: Report from a Community-Based House Meeting Project (2013). African Partnership for Health. http://www.ncbi.nlm.nih.gov/pubmed/24375177 This project used community-based participatory research (CBPR) methods to collect and analyze data from nine house meetings with 56 Africans from 14 countries in the Portland area. The data collected from this project was used to inform how to improve the health of the African community in Portland and define an agenda for future projects.	Multnomah (OR)
Aging and Disability Services of Multnomah County Older Americans Act Area Plan 2013-2016 (2013). *Multnomah County*. https://multco.us/file/11126/download This project used community dialogues and a community survey among adults 55 and to inform the older Americans area plan.	Multnomah (OR)
Area Agency on Aging and Disabilities of Clackamas County Older Americans Act Area Plan 2013-2016 (2013). *Health, Housing & Human Services Clackamas County.* http://www.clackamas.us/socialservices/documents/areaplan.pdf This area plan utilized input from seniors within the Area Agency on Aging and Disabilities of Clackamas County service area through one-on-one interviews and a telephone survey. This community input informs the development of new programs and approaches to effectively meet identified needs.	Clackamas (OR)
Area Agency on Aging and Disabilities of Southwest Washington 2016-2019 Area Plan (2015) *Area Agency on Aging & Disabilities of Southwest Washington*. file:///C:/Users/walkerch/Downloads/2016-2019-AP-Final-10-2-2015%20(1).pdf	Clark (WA)

This area plan outlines strategies to address and identified needs of older adults, adults with disabilities and family caregivers living within the Area Agency on Aging and Disabilities of Southwest Washington service area. Surveys and public hearings were used to identify community members input on unmet needs.	
The Asian and Pacific Islander Community in Multnomah County: An Unsettling Profile (2012). ***Coalition of Communities of Color.*** http://static1.squarespace.com/static/5501f6d4e4b0ee23fb3097ff/t/556d3a7ee4b0f81335be44b1/1433221758192/API_UNSETTLING_PROFILE.pdf This report documents the experiences of the Asian and Pacific Islander community in Multnomah County using data from the Census and the American Community Survey and leverages a range of input given by communities of color. The report also includes recommendations and calls for action.	Multnomah (OR)
Bradley Angle LGBTQ Needs Assessment (2012). ***Bradley Angle.*** http://www.doj.state.or.us/victims/pdf/directors_day_2013_bradley_angle_lgbtq_needs_assessment_summary_of_findings.pdf A 25 question online survey that asked LGBTQ-identified people in Portland, OR about their needs and wants in terms of intimate relationship support services informed this LGBTQ needs assessment.	Multnomah (OR)
Clackamas County Children's Commission Community Assessment (2012). ***Clackamas County Children's Commission Head Start, Clackamas Education Service District.*** http://cccchs.org/docs/community-assessment.pdf This assessment analyzed service data to promote program development per Head Start federal requirements. A survey asked questions to Head Start Families about their perceptions of the community, social connectedness, health system, and whether they think their family is healthy.	Clackamas (OR)
Clackamas County Community Health Improvement Plan (2012). ***Clackamas County Department of Health, Housing, and Human Services.*** http://www.clackamas.us/publichealth/documents/clackamas_chip.pdf This report was intended to both guide local efforts over the next five years to improve overall health of the Clackamas County population, and to meet the requirements of the Public Health Accreditation Board. Community meetings and listening sessions were held to identify priorities related to health, education and other topics.	Clackamas (OR)
Community Value Assessment of North by Northeast Community Health Center (2012). ***North by Northeast Community Health Center.*** http://nxneclinic.org/docs/download/North_by_Northeast_CVA.pdf The center conducted surveys, focus groups and phone interviews with the clinic's former and current patient base, interviewed community leaders, held a focus group with volunteers, and consulted staff and board members about health concerns and recommendations for the clinic to address health concerns for the future.	Multnomah (OR)
Council for the Homeless Clark County 10-Year Homeless Plan (2012) ***Clark County.*** http://www.councilforthehomeless.org/wp-content/uploads/2012/12/Final-CC-10-year-Plan-04.-2012.pdf The Clark County 10-year homeless plan was informed through community meetings, a survey of community members, focus groups and a survey of persons who are homeless.	Clark (WA)
Disability Rights Oregon Behind the Eleventh Door (2015). ***Disability Rights Oregon.*** https://droregon.org/wp-content/uploads/Behind-the-Eleventh-Door-Electronic-	Clackamas (OR) Multnomah (OR)

Version.pdf Inmates were interviewed to gather information on treatment and access to mental health services in prison.	Washington (OR)
Disability Rights Oregon 2014 Community Insights Survey Results (2014). ***Disability Rights Oregon.*** https://droregon.org/wp-content/uploads/DRO-2014-Community-Insights-Survey-Results.pdf Disability Rights Oregon conducted a broad survey to capture what issues are important to people who care about the rights of people with disabilities. Surveys were available in both English and Spanish.	Clackamas (OR) Multnomah (OR) Washington (OR)
Disability Rights Oregon Focus Group Results March 11, 2015 (2015). ***Disability Rights Oregon.*** https://droregon.org/wp-content/uploads/DRO-Focus-Group-Results-March-11-2015.pdf This project utilized a 90-minute focus group to hear about experiences with mental health treatment in hospital emergency departments and in hospitals.	Clackamas (OR) Multnomah (OR) Washington (OR)
Engaging Oregonians in Identifying Health Equity Policy Priorities: a Modified Policy Delphi Approach (2014). ***Oregon Health Authority Office of Equity and Inclusion.*** http://www.oregon.gov/oha/oei/reports/Engaging%20Oregonians%20in%20Identifying%20Health%20Equity%20Policy%20Priorities%20-%20a%20Modified%20Policy%20Delphi%20Approach.pdf Community forums and surveys completed by diverse community members informed this project.	Clackamas (OR) Multnomah (OR) Washington (OR)
Gresham Opportunity Mapping – Community Engagement Report (2014). ***The City of Gresham and Portland State University.*** https://greshamoregon.gov/opportunitymapping/ This project created “opportunity maps” that identified barriers to opportunity in the City of Gresham, OR. Community engagement efforts included interviews, listening circles and discussion groups, a questionnaire, technical adviser meetings, community celebration, and a city staff event.	Multnomah (OR)
Growing Healthier: Planning for a Healthier Clark County (2012)*. Clark County Public Health Advisory Council, Clark County Public Health.* http://www.clark.wa.gov/public-health/community/growing_healthy/documents/GrowingHealthierReport23Mar2012-1.pdf This report outlined policy recommendations on ways that Clark County’s Comprehensive Growth Management Plan can better address health Issues. Community voice and input was captured through public meetings, key stakeholder interviews and meetings, presentations to community groups, and online surveys.	Clark (WA)
Healthy Eating and Active Living (HEAL) Amenities on Affordable Multi-Family Housing Developments (2012). ***Oregon Public Health Institute.*** http://ophi.org/download/PDF/HKHC_Report.pdf Community-based PhotoVoice projects were used to help shape policies and neighborhood environments to increase healthy eating and active living for children and families living in Portland’s affordable housing communities.	Clackamas (OR) Multnomah (OR)
Healthy Oregon Partnership for Equity Coalition Five Year Health Equity Plan (2012). ***The Hope Coalition.*** http://www.apano.org/wp-content/uploads/2012/10/HOPE-COALITION-FIVE-YEAR-PLAN-FINAL_-Sept-26.docx	Clackamas (OR) Multnomah (OR) Washington (OR)

This plan identified the most pressing health equity needs for Multnomah, Washington, Marion, and Clackamas Counties. Interviews and community forums were utilized to capture missing voices from the region.	
Health Share Community Health Needs Assessment (2014). *Health Share*. http://www.healthshareoregon.org/pdfs/Final.CHA_.03.23.2014.pdf Health needs were identified for this assessment through a community-wide process. These processes included community-led self-assessments and community listening sessions.	Clackamas (OR) Multnomah (OR) Washington (OR) Clark (WA)
Hear Our Voices: Engage 2013 Survey Report IRCO (2014). *Immigrant & Refugee Community Organization.* https://www.portlandoregon.gov/oni/article/486422 This project used surveys to take a detailed look at the civic engagement behaviors and attitudes among diverse non-Hispanic immigrant and refugee communities that IRCO's diversity and civic leadership program serves in the Portland area.	Multnomah (OR)
Improving Healthy Food Access in Rockwood Using Community Voice and Mapping (2014). *Coalition for a Livable Future.* http://clfuture.org/sites/clfuture.org/files/pdfs/improving_health_food_access_in_rockwood_using_community_voice_and_mapping_final.pdf This community-based project examined barriers and solutions to accessing healthy food in the Rockwood neighborhood of Gresham, Oregon by using a combination of focus groups, survey, Community Food Security Assessment tool, and evidence from the Coalition for a Livable Future's Regional Equity Atlas 2.0.	Multnomah (OR)
Kaiser Foundation Hospital Community Health Needs Assessment – WESTSIDE (2014). *Kaiser Foundation Hospital.* http://share.kaiserpermanente.org/wp-content/uploads/2015/01/Westside-CHNA_2013.pdf This community health needs assessment engaged community members through focus groups and surveys.	Clackamas (OR) Multnomah (OR) Washington (OR) Clark (OR)
Kaiser Foundation Hospital—Sunnyside: Community Health Needs Assessment (2013). *Kaiser Foundation Hospital*. http://share.kaiserpermanente.org/wp-content/uploads/2013/09/Sunnyside-CHNA_2013.pdf This community health needs assessment engaged community members through focus groups, surveys, community listening sessions and public assemblies.	Clackamas (OR) Multnomah (OR) Washington (OR) Clark (OR)
Knowledge, Attitudes and Perceptions of Northwest American Indian/Alaska Native Community Members and Medical Providers Regarding Childhood Immunizations (2014). *Portland Area Indian Health Service/Northwest Portland Area Indian Health Board* http://www.npaihb.org/images/epicenter_docs/narch/2014/1g.pdf Information from community focus groups, interviews and surveys were used to capture knowledge, attitudes and perceptions of northwest American Indian/Alaskan native community members and medical providers regarding childhood immunizations.	Multnomah (OR)
Listening to Consumer Perspectives to Inform Addictions and Housing-Related Practice and Research (2014). *Portland State University, Classical Chinese Medicine/National College of Natural Medicine, Oregon Health and Science University, Central City Concern.* http://www.centralcityconcern.org/LiteratureRetrieve.aspx?ID=209324 This study used interviews to solicit personal experiences with housing, employment, and recovery programs.	Multnomah (OR)
Portland's 2035 Comprehensive Plan Update (2015) *City of Portland Bureau of*	Multnomah (OR)

Planning and Sustainability. https://www.portlandoregon.gov/bps/article/541788 This plan brought together agency partners, thousands of residents, businesses and nonprofits to create strategic plan for a prosperous, healthy, educated and equitable Portland. Community members informed this plan through a community engagement project, listening sessions, public hearings, community outreach, and online feedback.	
Providence Health 2013 Community Health Needs Assessment, 2014-2016 Community Health Improvement Plans (2013). *Providence Health & Services* Retrieved from http://oregon.providence.org/~/media/files/providence%20or%20pdf/about%20us/2013chna.pdf This Community Health Needs Assessment (CHNA) was done in order to stay in line with the requirements of the Affordable Care Act and ensure that Community Benefit spending is directed to the needs of the poor and vulnerable in Providence's area of service. A community health survey and focus groups with people who are elderly and/or disabled, limited English proficiency folks, migrant or seasonal farm workers, and low income were used to inform this CHNA.	Clackamas (OR) Multnomah (OR) Washington (OR)
The Latino Community in Multnomah County: An Unsettling Profile (2012). *Coalition of Communities of Color.* Retrieved from http://static1.squarespace.com/static/5501f6d4e4b0ee23fb3097ff/t/556d3b37e4b0e36a9e0f3968/1433221943127/LATINO_REPORT.pdf This report was prepared to ensure that the experiences of communities of color are widely available. The information collected from community members was meant to determine and illustrate disparities that might not be seen in census data. Community-based participatory research and a community survey were used to inform this report.	Multnomah (OR)
Legacy Salmon Creek Hospital Community Needs Assessment, Community Health Improvement Plan (2015). *Legacy Health*. Retrieved from http://www.legacyhealth.org/our-legacy/legacy-values/in-the-community/community-needs.aspx This Community Health Needs Assessment (CHNA) was done in compliance with the Affordable Care Acts requirement to identify and address priority factors influencing the health of the community. This CHNA is also used to identify the hospital's resources and expertise that can be matched with external resources to address the health issues in the community. Community listening Sessions and Community Engagement Activities were used to incorporate community voice into the findings of this report.	Clark (WA)
Legacy Mount Hood Medical Center Community Health Needs Assessment/Community Health Improvement Plan (2015). *Legacy Health.* Retrieved from http://www.legacyhealth.org/our-legacy/legacy-values/in-the-community/community-needs.aspx This Community Health Needs Assessment (CHNA) was done in compliance with the Affordable Care Acts requirement to identify and address priority factors influencing the health of the community. This CHNA is also used to identify the hospital's resources and expertise that can be matched with external resources to address the health issues in the community. Community listening Sessions and Community Engagement Activities were used to incorporate community voice into the findings of this report.	Multnomah (OR)
Legacy Meridian Park Medical Center Community Health Needs Assessment/Community Health Improvement Plan (2015). *Legacy Health.*	Clackamas (OR) Washington (OR)

Retrieved from http://www.legacyhealth.org/our-legacy/legacy-values/in-the-community/community-needs.aspx This Community Health Needs Assessment (CHNA) was done in compliance with the Affordable Care Acts requirement to identify and address priority factors influencing the health of the community. This CHNA is also used to identify the hospital's resources and expertise that can be matched with external resources to address the health issues in the community. Community listening Sessions and Community Engagement Activities were used to incorporate community voice into the findings of this report.	
Legacy Good Samaritan and Medical Center Community Health Needs Assessment/Community Health Improvement Plan (2015) ***Legacy Health.*** **Retrieved from** http://www.legacyhealth.org/our-legacy/legacy-values/in-the-community/community-needs.aspx This Community Health Needs Assessment (CHNA) was done in compliance with the Affordable Care Acts requirement to identify and address priority factors influencing the health of the community. This CHNA is also used to identify the hospital's resources and expertise that can be matched with external resources to address the health issues in the community. Community listening Sessions and Community Engagement Activities were used to incorporate community voice into the findings of this report.	Multnomah (OR)
Legacy Emanuel Hospital and Health Center Community Needs Assessment/Community Health Improvement Plan (2015). (2015) ***Legacy Health.*** **Retrieved from** http://www.legacyhealth.org/our-legacy/legacy-values/in-the-community/community-needs.aspx This Community Health Needs Assessment (CHNA) was done in compliance with the Affordable Care Acts requirement to identify and address priority factors influencing the health of the community. This CHNA is also used to identify the hospital's resources and expertise that can be matched with external resources to address the health issues in the community. Community listening Sessions and Community Engagement Activities were used to incorporate community voice into the findings of this report.	Multnomah (OR)
The Native American Community in Multnomah County: An Unsettling Profile (2012). ***Coalition of Communities of Color.*** **Retrieved from** http://static1.squarespace.com/static/5501f6d4e4b0ee23fb3097ff/t/556d3bfae4b0f81335be4a04/1433222138695/NATIVE_AMERICAN_REPORT.pdf This report documents the experiences of the Native American community in Multnomah County using data from the Census and the American Community survey. It uses community-based participatory research and leverages a range of input given by communities of color. The report also includes recommendations and calls for action.	Multnomah (OR)
Native Voices: Project Red Talon, Northwest Portland Area Indian Health Board (2015). ***Native Voices.*** http://www.npaihb.org/images/epicenter_docs/PRT/VOICES/Native%20VOICES%20Community%20Report.docx The goal of this project was to adapt a video-based HIV/STI intervention for AI/AN teens and young adults. Focus groups and surveys were used to evaluate its impact among native youth.	Clackamas (OR) Multnomah (OR) Washington (OR) Clark (OR)
Oregon Child Development Coalition Community Assessment (2013). ***Oregon Child Development Coalition.*** *http://www.ocdc.net/wp-content/uploads/2014/08/Community_Assessment-2013-FINAL.pdf* Information gathered from focus groups, surveys and community meetings was used to	Clackamas (OR) Multnomah (OR) Washington (OR)

inform this community assessment.	
Oregon Disability and health Needs Assessment (2013). *Oregon Office on Disability and Health.* http://www.ohsu.edu/xd/research/centers-institutes/institute-on-development-and-disability/public-health-programs/oodh/upload/Needs-Assessment_final_AS_whj.pdf Telephone survey, written survey, and a web survey helped to inform this disability and health needs assessment.	Clackamas (OR) Multnomah (OR) Washington (OR)
Oregon's Healthy Future: A Plan for Empowering Communities (2013). *Oregon Health Authority.* *https://public.health.oregon.gov/About/Documents/oregons-healthy-future.pdf* Community voice was solicited through community listening and feedback sessions to help inform health improvement plans in Oregon.	Clackamas (OR) Multnomah (OR) Washington (OR)
Oregon Medicare-Medicaid Listening Groups: Final Report Oregon Health Authority (2012). *Oregon Health Authority.* http://www.oregon.gov/oha/OHPB/meetings/2012/2012-0214-oregon-listening.pdf Listening groups in five dually-eligible Medicaid-Medicare communities were held to solicit input on Oregon Health Authority's design contract.	Multnomah (OR)
Profiles of Hunger and Poverty in Oregon: 2012 Oregon Hunger Factors Assessment (2012). *Oregon Food Bank.* Retrieved from http://www.oregonfoodbank.org/~/media/files/publications/2012%20profiles%20of%20hunger%20and%20poverty%20in%20oregonpdf.pdf This report draws attention to the underlying problems that cause hundreds of thousands of Oregonians to seek help from their local food pantries. Findings from this report were based on the Hunger Factors Assessment Survey completed by 4601 emergency food box clients.	Clackamas (OR) Multnomah (OR) Washington (OR)
Providence Portland Medical Center—Community Health Needs Assessment (2013). *Providence Health & Services* http://oregon.providence.org/~/media/files/providence%20or%20pdf/about%20us/chna%20finalfull_appendix.pdf In order to understand and respond to local and statewide health care needs in the communities they serve, as well as comply with the Patient Protection and Affordable Care Act, Providence conducts a formal Community Assets and Needs Assessment every three years. This report reflects the needs of the community through incorporating findings from community stakeholder interviews, focus groups, and surveys.	Multnomah (Or)
Providence St. Vincent Medical Center—Community Health Needs Assessment (2013) *Providence Health & Services.* http://oregon.providence.org/~/media/files/providence%20or%20pdf/about%20us/chna%20finalfull_appendix.pdf In order to understand and respond to local and statewide health care needs in the communities they serve, as well as comply with the Patient Protection and Affordable Care Act, Providence conducts a formal Community Assets and Needs Assessment every three years. This report reflects the needs of the community through incorporating findings from community stakeholder interviews, focus groups, and surveys.	Clackamas (OR) Multnomah (OR) Washington (OR)
Reducing Substance Affected Pregnancies in Multnomah County – Community Forum Analysis, *Future Generations Collaborative* This project solicited community information on substance affected pregnancies in Multnomah county through a community forum.	Multnomah (OR)

Roadmap to Health Communities: A Community Health Assessment (2012). ***Clackamas County Department of Health and Human Services.*** http://www.clackamas.us/publichealth/documents/roadmap_update2012.pdf This project gathered information on needs and priorities for building a healthy community from as many diverse citizens as possible through online grassroots dialogue, survey, and community meetings.	Clackamas (OR)
Running on Empty: Services and Citizens Stretched to the Limit (2012). ***Washington County Anti-Poverty Workgroup*****.** http://commons.pacificu.edu/cgi/viewcontent.cgi?article=1051&context=casfac The purpose of this process was to explore through focus groups and interviews how residents had been faring during the recession, and to compare findings to an earlier needs assessment.	Washington (OR)
The Slavic Community in Multnomah County: An Unsettling Profile (2014). Coalition of Communities of Color. http://static1.squarespace.com/static/5501f6d4e4b0ee23fb3097ff/t/556d3c6be4b0728bb8d51045/1433222251042/Slavic-Report-FINAL-COMPLETE.pdf This report details the lived experiences of the Slavic community in Multnomah County. Interviews were used to capture disparities that might not be seen in the census data.	Multnomah (OR)
State of Black Oregon (2015). ***Urban League of Portland.*** http://ulpdx.org/wp-content/uploads/2015/05/State-Of-Black-Oregon-2015.pdf This project tells the story of many Black communities in Oregon to convey the continued urgency for social justice required for thriving communities. This report puts forward a strategy for community members and policy makers to take political action. The use of survey, interviews, and focus groups incorporated community voice into the findings of this report.	Clackamas (OR) Multnomah (OR) Washington (OR)
Using CBPR to Promote Healthy Pregnancies and Births Among the Native American Community in an Urban-Based Setting (2014). ***Multnomah County and Native American Youth and Family Center.*** http://www.npaihb.org/images/epicenter_docs/narch/2014/2f.pdf Community forums that included urban American Indian and Alaskan Natives and were facilitated by elders and natural helpers informed report.	Multnomah (OR)
Washington County Department of Health and Human Services Disability, Aging and Veteran Services Strategic Plan 2015-2017 (2015). This strategic plan was informed by online surveys and focus groups.	Washington (OR)

APPENDIX B: GLOSSARY OF TERMS

Accountable Care Organization (ACO)

A health care organization characterized by a payment and care delivery model that seeks to tie provider reimbursements to quality metrics and reductions in the total cost of care for an assigned population of patients. ACOs may be formed in the private commercial plan market and in the traditional Medicare fee-for-service system. (Centers for Medicare and Medicaid Services)

Aggregate data

Data extracted from individual level reporting (e.g., health records) or small number level reporting (e.g., data by race and ethnicity, block group) and combined to form de-identified information about groups of people, which can be compared and analyzed.

Benchmark

Something that serves as a standard by which others may be measured or judged. *(Example: Healthy People 2020)*

Coded data

Data that are translated into a standard nomenclature of classification so that they can be aggregated (e.g., thematically), analyzed, and compared.

Community Assets

Those people, places, and relationships that can conceivably be used in acting to bring about the most equitable functioning of a community. *(Example: FQHCs, primary care clinics, parks)*

Community Benefit

The set of initiatives and activities undertaken by nonprofit hospitals or health systems to improve health in the communities they serve; an expression of a nonprofit hospital's charitable mission; and serves as justification for its tax exemption.

Community Engagement Workgroup (CEW)

The CEW is one of the workgroups in the Health Columbia Willamette Collaborative (HCWC). The CEW was tasked with designing and implementing a community outreach strategy to ensure that the voices of community members in the four-county HCWC region were incorporated into the assessment. The CEW includes staff from HCWC member organizations, community members, and stakeholders from community organizations.

Community Health Needs Assessment

A systematic process involving the community to identify and analyze community health needs/assets.

Community of Color

Nonwhite racial and ethnic communities.

Community Served

Based on ACA regulations, the community served is to be determined by each individual hospital. It is generally defined by a geographic location such as a city, county, or metropolitan region. A community may also take into consideration certain hospital focus areas (e.g., cancer, pediatrics) but should not be defined so narrowly as to intentionally exclude high-need groups such as the elderly or low-income individuals.

Community Supported Clinic (CSC)

Community Supported Clinics are independent, nonprofit community health centers that provide health care services for low-income people, primarily those without health insurance or those not served by employer- or government-sponsored health insurance programs. They can also be known as "free clinics," although many request payment on a sliding scale, so services are not

always free. They are distinguished from Federally Qualified Health Centers (FQHCs) in that they do not receive federal grant dollars, but primarily rely on individual donors and local private foundation grants for revenue, along with any earned income from patient fees.

Coordinated Care Organization (CCO)

A network of all types of health care providers (physical health care, addiction and mental health care, and sometimes dental care providers) who have agreed to work together in their local communities to serve people who receive health care coverage under the Oregon Health Plan (Medicaid). CCOs are focused on prevention and helping people manage chronic conditions, such as diabetes. (Oregon Health Policy Board definition)

Data Analysis

The process of looking at and summarizing data with the intent to extract useful information and develop conclusions.

Drivers of Health

Risk factors that may positively or negatively affect a health outcome. For the purposes of KP's CHNA, they have been divided into four categories: social and economic factors, physical environment, health behaviors, and clinical care access and delivery.

Federal Poverty Level (FPL)

Guidelines established by the Federal government that determine the minimum amount of gross income that a family needs for food, clothing, transportation, shelter, and other necessities as determined by the Department of Health and Human Services. FPL varies according to family size.

Federally Qualified Health Center (FQHC)

Organizations that receive grants under Section 330 of the Public Health Service Act. FQHCs qualify for enhanced reimbursement from Medicare and Medicaid, as well as other benefits. FQHCs must serve an underserved area or population, offer a sliding fee scale, provide comprehensive services, have an ongoing quality assurance program, and have a governing board of directors.

Health Equity

When everyone, regardless of race, ethnicity, sexual orientation, gender orientation, immigration status, language, neighborhood, income, age, ability, or education, has the opportunity to attain their highest level of health.

Health Indicator

A characteristic of an individual, population, or environment that is subject to measurement (directly or indirectly) and can be used to describe one or more aspects of the health of an individual or population. *(Example: percentage of children overweight in Washington, breast cancer incidence in Clark County)*

Health Inequity

Avoidable inequalities in health status or in the distribution of health determinants between different population groups, created when barriers prevent individuals and communities from accessing conditions needed to reach their full potential.

Health Need

KP uses the MATCH framework to understand population health and defines a health need as any of the following that arise from a comprehensive review and interpretation of a robust data set: (a) a poor *health outcome* and its associated health driver and/or (b) a *health driver/factor* associated with poor health outcome(s), where the outcome itself has not yet arisen as a need. *(Example: breast cancer, obesity and overweight, asthma, access to health care)*

Health Outcomes

Snapshots of disease in a community that can be described in terms of both morbidity and

mortality. *(Example: breast cancer prevalence, lung cancer mortality, homicide rate)*

Healthy Columbia Willamette Collaborative (HCWC)

A public–private partnership of 15 hospitals, four health departments, and two CCOs in Clackamas, Multnomah, and Washington counties of Oregon and in Clark County, Washington.

Implementation Strategy

The nonprofit hospital's plan for addressing the health needs identified through the community health needs assessment (CHNA).

Incidence

A measure of the occurrence of new disease in a population of people at risk for the disease in a certain time period. *(Example: 1,000 new cases of breast cancer in 2011)*

Kaiser Foundation Hospitals (KFH)

Kaiser Foundation Hospitals is the legal entity for 38 licensed hospitals nationally and two licensed hospitals in the Northwest, KFH Sunnyside and KFH Westside. KFH is part of a larger entity, Kaiser Permanente, which is an integrated health care delivery system comprising Kaiser Foundation Hospitals (KFH), Kaiser Foundation Health Plan (KFHP), and physicians in the Permanente Medical Groups.

Kaiser Foundation Hospital Northwest (KFH NW)

For the purpose of this report and ease of reading, KFH NW refers to the two KFH licensed hospitals, KFH Sunnyside and KFH Westside, in the Northwest Region (KPNW).

Kaiser Permanente Northwest Region (KPNW)

The Kaiser Permanente Northwest Region includes two hospitals, an integrated health care delivery system, and a health plan. The region spans parts of two Pacific Northwest states, Oregon and Washington.

Key Drivers

Indicators that have been determined to be the most powerful predictors of population health and facilitate identifying communities with the most significant health needs. For the purposes of this CHNA, those key drivers are poverty rate, the percentage of population that does not have health insurance, and the proportion of adults without a high school diploma. Low-income, uninsured, and undereducated people have been found to be most at risk for poor health status. These key drivers are important to identifying areas likely to have the greatest health disparities.

Listening Session

An open-ended question and answer session facilitated in a small-group setting.

Meta-Analysis

As defined in this CHNA, a meta-analysis is a systematic review of community reports that combines pertinent qualitative information to develop a thematic analysis.

Mortality Rate

The rate or measure of the frequency of occurrence of death (in general or due to a specific cause) in a defined population over a period of time. *(Example: 1,000 deaths due to vehicle–pedestrian collision in 2010 in Oregon)*

Prevalence

The proportion of the total population that currently has a given disease. *(Example: 1,000 total cases of lung cancer in 2011 in Multnomah County)*

Primary Data

New data that are collected or observed directly from firsthand experience. Typically, primary data collected for CHNA is qualitative in nature; however, it can include survey data. *(Example: listening sessions)*

Primary Service Area

KFH Sunnyside and KFH Westside hospitals (referred to as KFH NW) define their shared service area by a four-county grouping referred to as the Metro area. 88.4% of inpatient discharges from KFH NW lived in the Metro area in 2015. The Metro area is the KFH NW Primary service area.

Qualitative Data

Typically descriptive in nature and not numerical; however, it can be coded into numeric categories for analysis. Qualitative data are considered to be more subjective than quantitative data but describes what is important to people who provided the information. *(Example: focus group data)*

Quantitative Data

Data that has a numeric value. Quantitative data are considered to be more objective than qualitative data. *(Example: state or national survey data)*

Risk Factor

Characteristics (genetic, behavioral, and environmental exposures and sociocultural living conditions) that increase the probability that an individual will experience a disease (morbidity) or specific cause of death (mortality). Some risk factors can be changes (e.g., smoking) while others cannot (e.g., family history).

School Based Health Center (SBHC)

In Oregon, SBHCs deliver quality, affordable, cost-effective health care to young people and function like a doctor's office located on school grounds. SBHCs are staffed like a pediatric or family practice clinic with administrative staff and clinical providers. At some sites, SBHCs also staff qualified mental health professionals.

Secondary Data

Data that has already been collected and published by another party. Typically, secondary data collected for CHNA is quantitative. *(Example: Behavioral Risk Factor Surveillance System, or BRFSS)*

Secondary Service Area

KFH NW also provides nonhospital services, has membership, and supports community health in a Secondary service area. The Secondary area comprises three separate geographically defined areas: Southwest Washington (SW WA), Mid-Willamette Valley (Mid-Valley), and South Valley.

Social Determinants of Health

The social determinants of health are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies, and political systems. (World Health Organization definition)

Stakeholder

Individuals, social groups, and organizations that affect or are affected by policies, systems, and environments and therefore have a vested interest in decision-making processes and outcomes.

APPENDIX C: COMMUNITY INPUT TRACKING

	Data Collection Method	Group / County	# of Participants	Member Groups Represented	Data Collection Date
1	Community Survey	Public / Multnomah, Washington, Clackamas, and Clark	3,078	Several	Sept - Dec, 2015
2	Listening Session	Ant Farm / Clackamas	15	Rural, youth	12/8/15
3	Listening Session	NAMI / Clackamas	12	Mental Health, Rural	12/3/15
4	Listening Session	Clackamas Service Center / Clackamas	14	Homeless	12/11/15
5	Listening Session	Hacienda / Clackamas	12	Latino, Immigrant and Refugee	12/29/15
6	Listening Session	ORCHWA / Clackamas	15	Community Health Workers	11/10/15
7	Listening Session	Lifeline Connections / Clark	12	Addictions	11/25/15
8	Listening Session	Calvary Church / Clark	14	Immigrant and Refugee	12/9/15
9	Listening Session	Free Clinic / Clark	12	Latino, Immigrant and Refugee	12/11/15
10	Listening Session	Free Clinic / Clark	4	Homeless, Latino	12/18/15
11	Listening Session	Healthy Living Collaborative CHW / Clark	14	Community Health Workers	11/9/15
12	Listening Session	Central City Concern / Multnomah	9	Homeless, mental health and addictions	12/14/15
13	Listening Session	Liberation Street Church / Multnomah	12	Homeless, mental health and addictions	11/24/15
14	Listening Session	Outside In / Multnomah	9	Homeless youth	12/2/15
15	Listening Session	Highland Haven / HARRP / Multnomah	16	Addictions, African American	12/17/15
16	Listening Session	ORCHWA / Multnomah	10	Community Health Workers	10/22/15
17	Listening Session	Adelante Mujeres / Washington	10	Rural, Latino, Immigrant and Refugee	11/23/15
18	Listening Session	Adelante Mujeres / Washington	12	Rural, Latino, Immigrant and Refugee	11/23/15
19	Listening Session	LifeWorks NW Hillsboro / Washington	11	Addictions	12/14/15

20	Listening Session	LifeWorks NW Beaverton / Washington	11	Addictions	12/7/15
21	Listening Session	ORCHWA / Washington	7	Community Health Workers	1217/15
22	Listening Session	Area Councils on Aging / Multi-County	19	Aging	10/30/15
23	Listening Session	IRCO (OPHI) / Multi-County*	15	Vietnamese, Immigrant and Refugee	1/7/16
24	Listening Session	IRCO (OPHI) / Multi-County*	10	Tongan, Immigrant and Refugee	1/6/16
25	Listening Session	IRCO (OPHI) / Multi-County*	17	Somali, Immigrant and Refugee	1/9/16
26	Listening Session	IRCO (OPHI) / Multi-County*	10	Russian, Immigrant and Refugee	1/11/16
27	Listening Session	Urban League (OPHI) / Multi-County*	12	African-American	12/28/15
28	Listening Session	NAYA (OPHI) / Multi-County*	21	Native American, youth	1/12/16
29	Listening Session	Latino Network (OPHI) / Multi-County*	19	Hispanic/Latino, Immigrant and Refugee	12/7/15
30	Listening Session	VA Hospital / Multi-County	10	Veterans	12/19/15

*Sessions were done with culturally-specific populations in partnership with the Oregon Public Health Institute for the BUILD CHIP.

Survey Respondent and Listening Session Demographics

The following two tables outline the age groupings, gender, ethnicity, and race identified by survey respondents (on the left) and listening session participants (on the right). In addition to these demographics, 7% of survey respondents were U.S. Veterans, 20% identified as having a disability, and 30% had some college or less.

Survey Respondent Demographics		
(N = varies)	n	%
AGE		
Under 18	37	1.2
19 – 25	241	8.0
26 - 39	984	32.8
40 - 54	839	28.0
55 - 64	544	18.1
64 - 79	325	10.8
80 and older	31	1.0
No Answer	77	2.5
GENDER		
Female	1,989	64.6
Male	897	29.1
Other / No Answer	192	6.2
ETHNICITY		
Hispanic	372	13.6
Non-Hispanic	2,356	86.4
RACE		
African American/Black	146	4.7
African	7	0.2
Arab American/Middle Eastern	5	2.9
Asian American/Asian	77	2.5
White/Caucasian	2,003	65.1
Native American/Alaska Native	76	2.5
Multiracial	234	7.6
Other	65	2.1
No Answer	465	15.1

Listening Session Participant Demographics		
(N = 298)	n	%
AGE		
Under 18	8	2.7
19 – 25	45	15.1
26 - 39	73	24.5
40 - 54	88	29.5
55 - 64	42	14.1
64 - 79	34	11.4
80 and older	4	1.3
No Answer	3	1.0
GENDER		
Female	166	55.7
Male	125	41.9
Other / No Answer	8	2.7
ETHNICITY		
Hispanic	76	25.4
Non-Hispanic	221	74.2
RACE		
African American/Black	41	13.8
African	7	2.3
Asian American/Asian	19	6.4
White/Caucasian	159	53.4
Native American/Alaska Native	40	13.4
Other	33	11.0
No Answer	38	12.8

HCWC Community Listening Session Guide

Large Group Introduction: (*Instruction: Convener team or Leadership group member will present this to larger group and Interpreters will translate this information to non-English speakers. This is just a guide. Information should be covered but doesn't need to be read as written.)*

Welcome

Welcome everyone. Thank you so much for coming out tonight/today to participate in this important project. My name is _____ and I work at _____. I want to give you a quick overview of why we are here, but first I want to take care of some housekeeping things.

Housekeeping

- First, if you have questions about childcare, please ask _____
- If you haven't already, please help yourself to refreshments.
- The bathrooms are located_____
- Please make sure that you have signed in.
- We will be done by _____

Project Overview

Today, we want to hear from you all about what are the most important health issues in the community. There are no right or wrong answers. We are here to hear your opinions and ideas. The information we hear from you today is going to be combined with information collected in ____ other groups just like this one.

We are hosting these meetings as part of the Healthy Columbia Willamette Collaborative. Several local hospitals, county health departments, and OHP organizations that work in the Clackamas, Washington, Multnomah counties, and Clark County Washington are working together to figure out the most important health needs of the community and what they can do to address them. By _____ we will have a final list of priority health issues and will start planning what we all can do about these issues.

We have a handout describing the Healthy Columbia Willamette Collaborative, as well as a sign-up sheet if you would like us to send you more information about the process as we move forward. They are both on the table.

I would like the group to break into smaller groups so that all of us have more of an opportunity to speak. In these small groups, you will have a facilitator who has some questions to ask you. But before we do this, does anyone have any questions?

Instructions: Ask people to break into groups of about ___ people. Each group will need at least one facilitator. If there are two available (preferred), have one take notes on poster sheets and the other ask the questions.

Small Group Discussion Questions:

INTRODUCTION

Okay, we have a little over an hour to talk. I'd like to start with a creative activity. Here's paper and crayons. I'd like you to start by thinking about your community. People might think of "community" in different ways. Maybe it's family, or maybe it's neighbors, or maybe it's coworkers or friends. For the next 5 minutes, draw a picture that represents **your community**.

Pause, give people ~5 minutes to draw. Facilitator should draw too.

So let's go around in a circle—tell me your name, and tell us something about your drawing I'll start.

Facilitator introduces self, models talking about community.

Then everyone goes in a circle, introducing self and saying a few words about their community.

Thank you. So you all told us your name and told us something about how you see your community. That leads into what we're going to talk about next: the health of your community. This is going to be an informal discussion. We want to hear about your ideas, experiences and opinions. Everyone's comments are important. They might be similar or very different, but they all should be heard. The goal today is to record everyone's opinions.

CONTEXT

What we were hoping to talk about today is: ***What makes a healthy community?***

PAUSE, but not long enough for people to pipe up with answers.

That's a difficult question, because it involves two ideas. First, there's ***HEALTH***. What do we mean by health? Do we mean freedom from disease? Having enough to eat? Feeling generally good about life? Being financially healthy?

PAUSE, but not long enough for people to pipe up with answers.

Then there's the idea of ***COMMUNITY***. What do we mean by community? Are we talking about each one of you, individually? Are we talking about your friends and family? Your neighborhood? Your church? Your racial or ethnic group? Your city or town?

We're not going to define these things for you. We're going to keep it open.

QUESTION 1. VISION . Now take a minute to think about your community—that community that is represented in your drawing. How can you tell when your community is healthy?

Instructions: write ideas on the poster.

QUESTION 2. STRENGTHS. So you've told us what a healthy community looks like. Let's explore this idea a little more. Communities have certain **resources** that can help them be healthy. It might be programs. It might be a park or a community center. It might be a really great teacher at your local school. It might be a local business or a local organization that helps people be healthy.

My question for you is:

What's working? What are the resources that CURRENTLY help your community to be healthy?

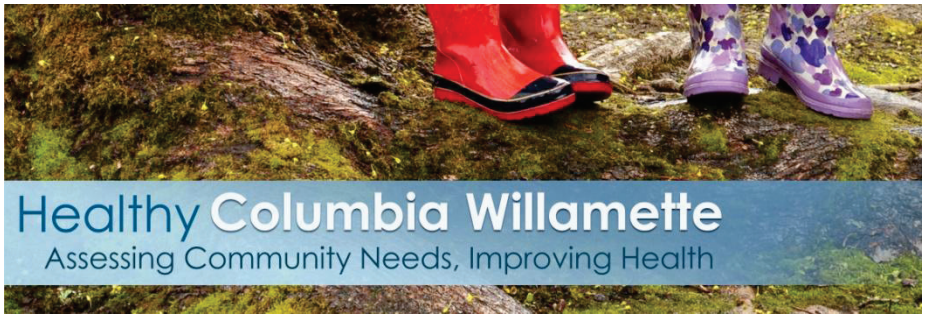
Instructions: write ideas on the poster.

QUESTION 3. NEEDS.

So we've talked about what current resources exist within your community that help you stay healthy. Now let's talk about what's not there or what you need more of.

What's needed? What more could be done to help your community be healthy?

Instructions: write ideas on the poster.



Community Survey

We need your help to make our community healthier! Please take 5-10 minutes to complete this survey. It is one of our ways to hear your opinions about your community. The results of this survey along with other information will be used to identify the most important health issues that can be addressed through the community efforts of hospitals, county health departments, and Coordinated Care Organizations (CCOs) in the region.

Your answers are anonymous--we will not be asking for your name. Please ask others to complete this survey so that we can hear from as many people possible. Thank you.

1) QUALITY OF LIFE: In the following list, what do you think are the five most important characteristics of a "Healthy Community"? (Those factors that most improve the quality of life in a community.)

Limit your answers to 5 selections

- ☐ Physical accommodations for people with disabilities
- ☐ Good place to raise children
- ☐ Healthy behaviors and lifestyles
- ☐ Clean environment
- ☐ Arts and cultural events
- ☐ Good daycare and preschools
- ☐ Religious or spiritual values
- ☐ Safe, nearby transportation
- ☐ Low level of child abuse
- ☐ Safe, affordable housing
- ☐ Good job training opportunities
- ☐ Good jobs to reach a healthy economy
- ☐ Good schools
- ☐ Access to healthy, affordable food
- ☐ Low deaths and disease rates
- ☐ Parks and recreation
- ☐ Supportive and happy family life
- ☐ Welcoming of diverse communities/people
- ☐ Access to physical, mental, and/or oral health care
- ☐ Low crime/safe neighborhoods
- ☐ Participating and giving back to the community
- ☐ Other: _____

2) ISSUES AFFECTING COMMUNITY HEALTH: In the following list, what do you think are the five most important "issues" that need to be addressed to make your community healthy? (Those topics that have the greatest impact on overall community health.)

Limit your answers to 5 selections

- [ ] Aging problems (e.g. memory loss, hearing/vision loss)
- [ ] Lack of good daycare and preschools
- [ ] Lack of physical accommodations for people with disabilities
- [ ] Lack access to safe, nearby transportation
- [ ] Dirty environment
- [ ] Bullying/verbal abuse
- [ ] Asthma/respiratory/lung disease
- [ ] Gang activity/violence
- [ ] Being overweight/obesity
- [ ] Few arts and cultural events
- [ ] HIV/AIDS
- [ ] Firearm-related injuries
- [ ] Lack of community involvement
- [ ] Mental health challenges (e.g. depression, lack of purpose or hope, anxiety, bi-polar, PTSD, eating disorders)
- [ ] Lack of needed job skills or training
- [ ] Unsafe streets (limited crosswalks, bike lanes, lighting, etc.)
- [ ] Lack access to physical, mental, and/or oral health care
- [ ] Homeless/lack of safe, affordable housing
- [ ] Domestic violence, child abuse/neglect
- [ ] Racism/discrimination
- [ ] Disabilities (physical, mental) and limited mobility
- [ ] Poor schools
- [ ] Unemployment/lack of living wage jobs
- [ ] Lack of safe and accessible parks/recreation
- [ ] Hunger/lack of healthy, affordable food
- [ ] Other: _____

3) In the following list, what do you think are the three most important "risky behaviors" in your community? (Those behaviors that have the greatest impact on overall community health."

Limit your answer to 3 selections.

- ☐ Tobacco use
- ☐ Dropping out of school
- ☐ Risky sexual behavior/unsafe sex
- ☐ Self-harm (e.g. cutting, suicide attempts)
- ☐ Not using birth control
- ☐ Not getting "shots" to prevent disease (immunizations)
- ☐ Poor eating habits
- ☐ Alcohol abuse/addiction
- ☐ Unsafe driving (e.g., not using seat belts/child safety seats, distracted driving)
- ☐ Lack of exercise
- ☐ Drug use/abuse
- ☐ Social isolation / loneliness
- ☐ Other: _____

4) How healthy would you rate your community as a whole?

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

Please answer the following questions so we can see how various parts of the larger community feel about local health issues.

5) Zip code where you live

_____

6) Please check the age group in which your age falls.

- ☐ Under 18
- ☐ 19-25
- ☐ 26-39
- ☐ 40-54
- ☐ 55-64
- ☐ 65-79
- ☐ 80 and older
- ☐ Prefer not to answer

7) Please check the box that corresponds with your gender.

- ☐ Male
- ☐ Female
- ☐ Transgender
- ☐ Gender non-conforming
- ☐ Prefer not to answer

8) Please select the box that best describes how you identify your sexual orientation.

- ☐ Gay or lesbian
- ☐ Bisexual
- ☐ Queer
- ☐ Heterosexual ("straight")
- ☐ Questioning or unsure
- ☐ Another sexual orientation
- ☐ Prefer not to answer
- ☐ Other: _____

9) Please check the box of the ethnicity you identify with.

- ☐ Hispanic
- ☐ Non-Hispanic

10) Please check the boxes of the racial group(s) you most identify with. Check all that apply.

- ☐ African American/Black
- ☐ African
- ☐ Arab American/Middle Eastern
- ☐ Asian American/Asian
- ☐ European American/White/Caucasian
- ☐ Native American/American Indian/Alaska Native
- ☐ Prefer not to answer
- ☐ Other: _____

11) Between birth and age 16, where did you spend the majority of your time?

- ☐ Inside the United States
- ☐ Outside the United States
- ☐ Prefer not to answer

12) What language do you primarily speak at home?

- ☐ English
- ☐ Spanish or Spanish Creole
- ☐ Chinese
- ☐ Vietnamese
- ☐ Korean
- ☐ Tagalog
- ☐ Japanese
- ☐ German
- ☐ Russian
- ☐ Slavic, other Slavic language
- ☐ French (including Patois, Cajun)
- ☐ Arabic
- ☐ Prefer not to answer
- ☐ Other: _____

13) Are you a Veteran of the military armed forces?

- ☐ Yes
- ☐ No
- ☐ Prefer not to answer

14) Do you identify as a person with a disability?

- ☐ Yes
- ☐ No
- ☐ Prefer not to answer

15) Education

- ☐ Less than high school
- ☐ High school diploma or GED
- ☐ College degree or higher
- ☐ Prefer not to answer
- ☐ Other: _____

16) Household income (what is the combined total income of all the people living in your household?)

- ☐ $0 to $12,000
- ☐ $12,001 to $23,500
- ☐ $23,501 to $32,000
- ☐ $32,001 to $40,000
- ☐ $40,001 to $48,500
- ☐ $48,501 to $57,000
- ☐ $57,001 to $65,000
- ☐ $65,001 to $73,500
- ☐ $73,501 to $82,000
- ☐ More than $82,000
- ☐ Prefer not to answer

17) How many people does this income support?

_____

18) How do you pay for your health care?

Check all that apply

- ☐ Pay cash (no insurance)
- ☐ Health insurance (e.g. from job, private insurance, Blue Shield, HMO)
- ☐ Medicaid/Oregon Health Plan (OHP)
- ☐ Medicare
- ☐ Veterans' Administration
- ☐ Indian Health Services
- ☐ Prefer not to answer
- ☐ Other: _____

APPENDIX E: IDENTIFICATION AND PRIORITIZATION TOOLS

Health Need Identification: Criteria Matrix

Step 1: Identification. First, identify health needs using criteria in the first column. A health need will be identified if it meets criteria 1 and also meets criteria 2 *or* 3.

Identification Criteria	Data Type: Source	Description
1. Meets definition of "health need"	Qualitative: KP Toolkit	The health need in question meets the KP definition of a "health need".
2. Confirmed by multiple data sources[1]	Quantitative: KP Platform	Indicators (core) benchmark poorly against the state or national benchmark in the primary or secondary service area.
	Quantitative: HCWC Hospital Data Workgroup	Health need appears in the list of top chronic conditions for Medicaid recipients in primary service area (adults and/or youth).
	Quantitative: HCWC Survey	Health need is identified in survey responses
	Qualitative: HCWC, KP Listening Sessions	Health need is identified in listening sessions
	Qualitative: HCWC meta-analysis	Health need is identified in meta-analysis of existing community health reports
3. Disparities exist across subpopulations	Quantitative: KP Platform	Disparity in the primary or secondary service area exists in Communities of Color for core indicators of a health need

[1] If the first sub-criteria OR if more than one individual criterion in this category is met, then criterion #2 is met.

Health Need Identification: Identification Table

	Meets definition of "health need"	Confirmed by multiple data sources*					Disparities exist in communities of color	Identified as a Health need (Y/N)
		KP Platform	*Hospital Data*	*Survey*	*Listening Session*	*Meta-Analysis*		
Obesity/HEAL/Diabetes	Y	Y	Y	Y	N	Y	Y	Y
Mental Health	Y	Y	Y	Y	N	Y	N	Y
Access to Care	Y	Y	N	Y	Y	Y	no data for core	Y
Asthma	Y	Y	Y	Y	N	N	no data for core	Y
Oral Health	Y	Y	N	Y	N	Y	no data	Y
CVD/Stroke	Y	Y	Y	Y	N	Y	Y	Y
Substance Abuse/Tobacco	Y	Y	Y	Y	N	Y	no data	Y
Violence/Injury Prevention	Y	Y	Y	Y	Y	N	Y	Y
Cancers	Y	Y	Y	N	N	N	Y	Y
HIV/AIDs/STDs	Y	Y	N	N	N	Y	Y	Y
Maternal and Infant Health	Y	Y	N	N	N	Y	Y	Y
Economic Security	Y	Y	N	Y	Y	Y	Y	Y
Climate and Health	Y	Y	Y	N	N	N	no data for core	Y

*If the first criteria (the platform houses multiple data sources) OR If more than one individual criterion in this category is met, then overall criterion is met.

Health Need Prioritization: Criteria Matrix

Step 2: Prioritization. Work through matrix with each identified health need to compile a prioritized list of all identified health needs (from step 1). Health needs with the most points have the highest priority.

Prioritization Criteria	Data Type: Source	Description	Prioritization Logic/Rule
1. Presence in Primary Service Area	Quantitative: KP Platform	Prioritization of the top 5 health needs in the primary service area compared to the national and better state benchmark.	**2** = Benchmarks poorly to the state AND/OR the nation and ranks in the **top 5** PHN (state + nation score) **1** = Benchmarks poorly to the state AND/OR the nation and ranks **below the top 5** PHN (state + nation score) **0** = Does not benchmark poorly (state + nation score) *Total Possible Points:* ***4***[1]
2. Presence in Secondary Service Area	Quantitative: KP Platform	Prioritization of the top 5 health needs across the secondary service areas compared to the national and better state benchmark.	**2** = Benchmarks poorly to the state AND/OR the nation, and ranks in the **top 5 in 3** secondary service areas (state + nation score) **1** = Benchmarks poorly to the state AND/OR the nation, and ranks in the **top 5 in 1-2** secondary service areas (state + nation score) **0** = Benchmarks poorly in 0 secondary service areas (state + nation score) *Total Possible Points:* ***4***[2]
3. Saturation in Primary Service Area	Quantitative: KP Platform	Identification of geographic saturation in the primary service area (County-level need) and prioritization of top 5 health needs compared to the better state benchmark.	**2** = Benchmarks poorly to the state and ranks in top 5 in 3-4 Primary SA counties **1** = Benchmarks poorly to the state and ranks in top 5 in 1-2 Primary SA counties **0** = Benchmarks poorly in 0 Primary SA counties (not in top 5) *Total Possible Points:* ***2***
4. Disparities in Communities of Color in Primary Service Area[3]	Quantitative: KP Platform	Prioritization of health needs exhibiting disparity in Communities of Color within the PRIMARY service area.	**2** = Exhibits disparity (2% point difference from SA in core indicators) in 2+ CoC **1** = Exhibits disparity (2% point difference from SA in core indicators) in 1 CoC OR no data **0** = Does not exhibit disparity in CoCs *Total Possible Points:* ***2***

[1] Points are assigned to the health need based on a comparison to the state and nation. If the health need benchmarks poorly to the better performing state (OR or WA) and ranks in the top five health needs in the service area, 2 points are scored for the state score. If a health need benchmarks poorly to the nation and ranks in the top five health needs in the service area, 2 points are scored for the nation score, for a total possible point count of 4. One point is assigned if the health need benchmarks poorly but is not in the top five needs, and 0 points are assigned if the health need does not benchmark poorly. For this criteria, the points assigned to the state and the nation benchmarks are added together.

[2] Points are assigned to the health need based on the secondary service area comparison to the state and the nation. If the health need benchmarks poorly to the better performing state and ranks in the top five health needs in all three Secondary service areas, 2 points are scored for the state score. If a health need benchmarks poorly to the nation and ranks in the top five health needs in all three Secondary service areas, 2 points are scored for the nation score, for a total possible point count of 2+2=4. 1 point is assigned if the health need is in the top five needs in 1-2 Secondary service areas, and 0 points are assigned in the health need does not benchmark poorly in any Secondary service area. For this criteria, the points assigned to the state and the nation benchmarks in the Secondary service areas are added together.

[3] Disparity for criteria 4 & 5 is only scored based on data available in the KP CHNA Data Platform

5. Disparities in Communities of Color in Secondary Service Area	Quantitative: KP Platform	Prioritization of health needs exhibiting disparity in Communities of Color within the SECONDARY service area.	**2** = Exhibits (2% point difference in platform) disparity in 2+ CoC **1** = Exhibits (2% points in platform) disparity in 1 CoC OR no data **0** = Does not exhibit significant disparity in CoCs *Total Possible Points: **2***
6. Presence in low-income (Medicaid) Population	Quantitative: HCWC Hospital WG	Prioritization of the top 5 chronic health needs among the low-income, Medicaid population in the primary service area.	**4** = Adult and youth chronic conditions were matched to KP health needs, tallied, and summed. Top 5 received 4 points **2** = Not in the top 5 **0** = No points tallied *Total Possible Points: **4***
7. Identified by Meta-Analysis of existing Community Data	Mixed: HCWC CE WG	Prioritization of health needs by meta-analysis of community reports from the past 3 years. Equity lens applied.	**4** = Needs coded in meta-analysis were matched to KP health needs, tallied by top occurrence, and summed. Top 5 received 4 points **2** = Not in top 5 **0** = No points tallied *Total Possible Points: **4***
8. Identified by – Listening Sessions	Qualitative: HCWC CE WG, KP CHW Sessions	Prioritization of top health needs from Listening Session Analysis. Equity lens applied.	**4** = Needs coded in listening sessions were matched to KP health needs, tallied by top occurrence, and summed. Top 5 received 4 points **2** = Not in top 5 **0** = No points tallied *Total Possible Points: **4***
9. Identified by Community – Survey	Qualitative: HCWC CE WG,	Prioritization of top health needs from Survey Analysis. Equity lens applied.	**4** = Needs identified in survey were matched to KP health needs, tallied by top occurrence, and summed. Top 5 received 4 points **2** = Not in top 5 **0** = No points tallied *Total Possible Points: **4***

Key

CE:	Community Engagement
CoC:	Communities of Color
HCWC:	Healthy Columbia Willamette Collaborative
KP Platform:	http://www.communitycommons.org/groups/community-health-needs-assessment-chna/
PHN:	Potential Health Need as identified in KP Platform
SA:	Service Area
WG:	Workgroup

Health Need Prioritization: Scoring Table

Step 2: Prioritization. Work through matrix with each identified health need to compile a prioritized list of all identified health needs (step 1). *Refer to the prioritization matrix for logic* around assigning points/scoring criterion. Health needs with the most points are highest priority (summed in final column).

	CHNA Data Platform (Secondary Data)					HCWC (Secondary Data)	HCWC (Primary/Community Data)*			Sum of Priority Points	Prioritized Rank
	1. Presence in Primary SA	2. Presence in Secondary SA	3. Saturation in Primary SA	4. Disparities in CoC in Primary SA	5. Disparities in CoC in Secondary SA	6. Presence in Low-income Population *(Primary SA only)*	7. Identified in Meta-Analysis	8. Identified in Listening Session	9. Identified in Survey		
Obesity/HEAL/Diabetes	3	1	2	2	2	4	4	0	2	20	3
Mental Health	3	1	2	0	1	4	4	0	4	19	4
Access to Care	2	4	2	1	1	0	4	4	4	22	1
Asthma	4	3	0	1	1	4	0	0	2	15	6
Oral Health	3	2	0	1	1	0	4	0	2	13	10
CVD/Stroke	2	0	0	2	1	4	4	0	2	15	6
Substance Abuse/Tobacco	1	0	1	1	1	4	2	0	4	14	9
Violence/Injury Prevention	3	1	1	2	1	2	0	4	4	18	5
Cancers	2	3	1	2	2	2	0	0	0	12	12
HIV/AIDs/STDs	2	2	1	2	2	0	4	0	0	13	10
Maternal and Infant Health	3	2	2	2	2	0	4	0	0	15	6
Economic Security	3	2	1	2	2	0	4	4	4	22	1
Climate and Health	4	0	1	1	1	4	0	0	0	11	13
Total Possible Points	*0-4*	*0-4*	*0-2*	*0-2 (4 overall)*	*0-2 (4 overall)*	*0-4*	*0-4*	*0-4*	*0-4*		
							*Primary Service Area Only				

APPENDIX F: HEALTH NEED PROFILES

High-Priority Health Needs	• Access to Care • Economic Opportunity • Chronic Disease • Behavioral Health
Medium-Priority Health Needs	• Maternal and Infant Health • Asthma • Oral Health • Sexually Transmitted Infections
Lower-Priority Health Need	• Climate and Health

The following pages include Health Need Profiles for needs identified and prioritized in this CHNA, arranged in priority order. The profiles were compiled to summarize the key data indicators and community input that led to the prioritization of the community health needs. The profiles will serve as tools in the selection process as KFH NW designs Implementation Strategies to address selected priority health needs.

Unless otherwise noted, data indicators and maps were retrieved from the CHNA Data Platform hosted by Community Commons, and original data sources are listed in the endnotes with full citations found in Appendix A. Icons used in the footers of each profile were downloaded from The Noun Project. Ates Evren Aydinel is the creator of the maternal and infant health icon, Hunotika created the oral health icon, and Ted Grajeda created the climate and health icon.

ACCESS TO CARE

About Access to Care

> **"Insurance does not mean people will be helped."**
> **—Listening Session Participant**

Access to high-quality, affordable, culturally specific care is important to physical, social, and mental health. Health insurance helps individuals and families access needed primary care, specialists, and emergency care, but does not ensure access on its own — it is also necessary for providers to offer affordable care within close proximity to patients.[1] Primary and specialty health care helps individuals manage their diseases and learn skills for healthy living. Health insurance reforms in this region, including the transformational Coordinated Care Organizations (CCOs), have led to record enrollment and eliminated patient cost-sharing for preventive services, making it more economical to obtain screenings and counseling. Expanded insurance coverage has reduced one barrier to care.

Why Is It a Prioritized Community Health Need?

While access to insurance has increased due to expanded coverage under the Oregon Health Plan and Washington Apple Health (Oregon and Washington state Medicaid), there are still barriers to accessing care in KFH NW. Difficulty navigating the complex systems, lack of holistic health care providers including mental health providers, and a need for more culturally specific care was highlighted in the community listening sessions and survey. Cost of care is still a barrier to many. Given that economic opportunity was identified as a high priority need, the link between the two cannot be ignored. For these reasons, access to care was prioritized for this CHNA.

Key Data Points: Indicators and Drivers of Access to Care

Two key indicators of access to care include the rate of primary care providers in an area — indicating the physical access to primary care, as well as the percentage of the population that is insured — indicating the potential financial ability to access care. Table 1 displays these two key indicators across the primary and secondary service areas. The highest rates of uninsured individuals are in the Mid-Valley service area and SW Washington has the lowest rate of primary care providers per 100,000 population.

Table 1: Access to Care Indicators

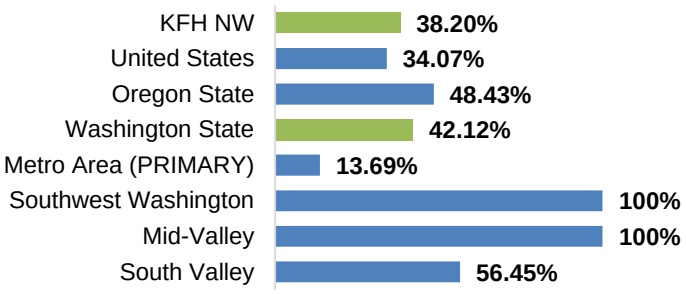
	Access to Primary Care (Rate per 100,000)[2]	*Uninsured*[3]
United States	**74.5**	**14.2%**
Oregon State	**90.5**	**14.4%**
Washington State	**83.1**	**12.9%**
Metro (Primary)	**97.5**	**13.1%**
SW WA	**52.9**	**12.4%**
Mid-Valley	**70.3**	**15.2%**
South Valley	**89**	**13.9%**

Related drivers to access to primary care and insurance include indicators that can be found in the health need profile for Economic Opportunity, such as poverty and education indicators. Other indicators related to access to care include the percentage of a population living in a health professional shortage area (HPSA), which indicates a shortage of primary medical, dental, or mental health care professionals. Indicators for routine and/or preventive

health screenings are additional indicators related to access to care (see Table 2). 100% of the population in two of the three KFH NW secondary service areas live in HPSAs (Figure 1).[4]

Table 2: Indicators Related to Access	*Screening: Pap Test (Women 18+)*[5]	*Screening: Colon Cancer (Adults 50+)*[6]
United States	**78.5%**	**61.3%**
Oregon State	**73.6%**	**63.0%**
Washington State	**75.4%**	**65.5%**
Metro (Primary)	**77.1%**	**67.2%**
SW WA	**70.9%**	**61.6%**
Mid-Valley	**73.5%**	**63.5%**
South Valley	**71.2%**	**64.7%**

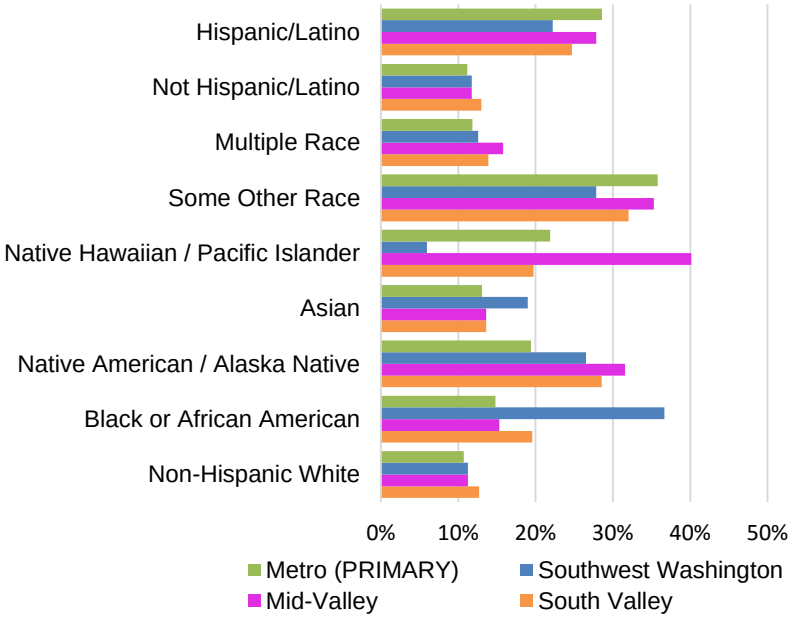
Figure 1: Population living in a Health Professional Shortage Area



Key Data Points: Health Inequity

There are racial and ethnic disparities in the population of uninsured in KFH NW, with variation between groups across each service area. The most insured group across the board is non-Hispanic whites, with various other racial and ethnic minorities reaching uninsured rates up to 40%, including the Native and Pacific Islander population in the Mid-Valley region. In the most-populous primary Metro service area, Hispanics and "some other Race" experience the highest rates of uninsurance. (See Figure 2)

Figure 2: Population by Ethnicity, Race Alone, Percent Uninsured



"Current health care programs for the Latino community are not sufficient"

—Listening Session Participant

Community Voices and Input

Exploring ways to expand how the community accesses health care, including outside of the traditional clinic walls, will be an important aspect of addressing this community health need. "Lack of access to physical, mental, and/or oral health care" was among the top five responses on the community survey conducted by Healthy Columbia Willamette Collaborative in the Metro service area. In listening sessions, access to health care repeatedly came up across priority

> **"Holistic health includes homes and schools."**
>
> **~**
>
> **"I can go one place and get the help that I need."**
>
> **—Listening Session Participants**

groups, especially related to affordability and insurance, regardless of immigration status. Immigrant and refugee groups in particular noted the difficulty in accessing care due to language barriers and general confusion around health care as a system. Cultural competence was a key theme in listening sessions as it relates to health care, including language-appropriate and compassionate care. The idea of a "one-stop-shop" or a coordinated resource where folks can get reliable and timely information about accessing health care and other resources was frequently mentioned.

Access to care was a top need in the thematic meta-analysis as well with similar themes from the listening sessions. The community wants access to affordable care and insurance that is culturally competent and simple to access. Mental health care and substance abuse– needs outlined in the Behavioral Health Need Profile — were consistently brought up in relation to access to care as the community feels there is not enough treatment and service options that are easily accessible and available.

Community Assets

Federally Qualified Health Centers (FQHCs, indicated by purple dots in Map 1[7]) are among the many assets currently existing in KFH NW. While numerous, access for individuals living in rural areas or in urban areas without regular and reliable transit can be difficult. Community Supported Clinics (CSCs) and other safety net providers help to fill the gap in many of these areas along with providing care to low-income populations — a few of which are highlighted below:

Free Clinic of Southwest Washington:

Founded in 1990 to address the health care needs of uninsured and under-served residents in SW WA.

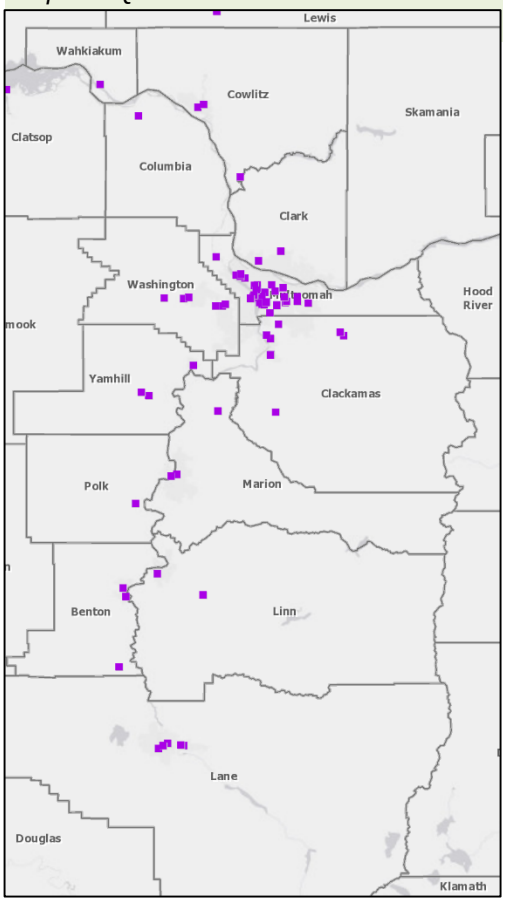
North by Northeast Community Health Center

Works to advance health equity and improve health outcomes by offering health screenings and basic medical services at no cost. Priority is given to African-Americans and low-income residents in this neighborhood clinic.

Care Oregon

A nonprofit health plan serving the health care needs of low-income Oregonians, including about one quarter of Oregon Health Plan (Medicaid) members.

Map 1: FQHC Locations Across KFH NW



[1] County Health Rankings. Our Approach Access to Care. Web. 2016.
[2] U.S. Department of Health and Human Services, 2012
[3] U.S. Census Bureau American Community Survey, 2010–2014
[4] U.S. Department of Health and Human Services, 2015
[5] Behavioral Risk Factor Surveillance System, 2006–2012
[6] Ibid.
[7] Center for Medicare and Medicaid Services. 2015. Map accessed from CHNA Data Platform hosted by Community Commons.

Profile of Kaiser Foundation Hospital Northwest Prioritized Health Needs

ECONOMIC OPPORTUNITY

About Economic Opportunity

Individuals and families need a strong economic foundation upon which to build healthy lives. Economic security is the ability for individuals and families to meet current needs and basic expenses. Without economic opportunity, healthy meals are a luxury and monthly rent payments difficult to meet, and it is near impossible to plan for unexpected expenses such as emergency health bills. Therefore, economic stability promotes good health and healthy communities. In addition to good paying jobs, access to stable, affordable housing is also an essential foundation for good health.

> **"A community can be poor and still be healthy if it has opportunity."**
>
> **—Listening Session Participant**

Lack of education and poverty, key measures of economic opportunity, are among the main social causes of poor health. Americans with fewer years of education have poorer health and shorter lives.[1] Families in poverty face significant barriers to better health, including lacking access to high-quality, safe and affordable housing. Substandard housing and homelessness tends to exacerbate physical and mental health issues. Similarly, poor economic circumstances can lead to chronic stress. The longer people live with stress, the greater their health suffers and the less likely they are to live a long, healthy life.

Why Is It a Prioritized Community Health Need?

Economic opportunity is one of the most critical issues facing our community. Cities across KFH NW have declared states of emergency to address an ongoing "housing crisis"[2] as the number of homeless individuals and families rise. KFH NW is reflective of nationwide trends of stagnant wages and growing income inequality, spurring legislation around minimum wage increases in both Washington and Oregon. Economic opportunity is a key community concern as the ability to meet basic needs is critical to living a full, healthy life. Additionally, inequities in key indicators among racial and ethnic minority groups make this a critical health equity need across the primary and secondary service areas.

Key Data Points: Indicators and Drivers of Economic Opportunity

Economic opportunity is strongly linked to health, and good wages and a decent income are important to economic security. Income — which can come from jobs, investments, government assistance programs, or retirement plans — provides economic resources that shape choices about housing,

Table 1: Economic Opportunity Indicators	*Unemployment Rate*[3]	*Population Below 100% FPL*[4]	*Population Below 200% FPL*[5]
United States	**5.3**	**15.6%**	**34.5%**
Oregon State	**6.4**	**16.7%**	**37.0%**
Washington State	**6.3**	**13.6%**	**30.3%**
Metro (Primary)	**5.8**	**13.8%**	**31.3%**
SW WA	**8.3**	**16.6%**	**36.8%**
Mid-Valley	**6.6**	**18.3%**	**40.4%**
South Valley	**6.4**	**20.5%**	**41.5%**

education, child care, food, medical care, and more. As income increases or decreases, so does health.[6] One indicator of income is measuring the population that lives near or below the federal poverty level (FPL), which is considered a key driver of health outcomes. Table 1 shows data for families living below 100% and 200% of the FPL. Employment, a major source of income for most individuals and families, is a second key indicator of a community's economic opportunity. Poverty rates are highest in the South Valley and Mid-Valley secondary service areas, while in the primary Metro service area rates equate to large populations, with just over 650,000 individuals in the four county area living at 200% of the FPL.

> **"People have to work 2 full jobs to make ends meet."**
>
> **—Listening Session Participant**

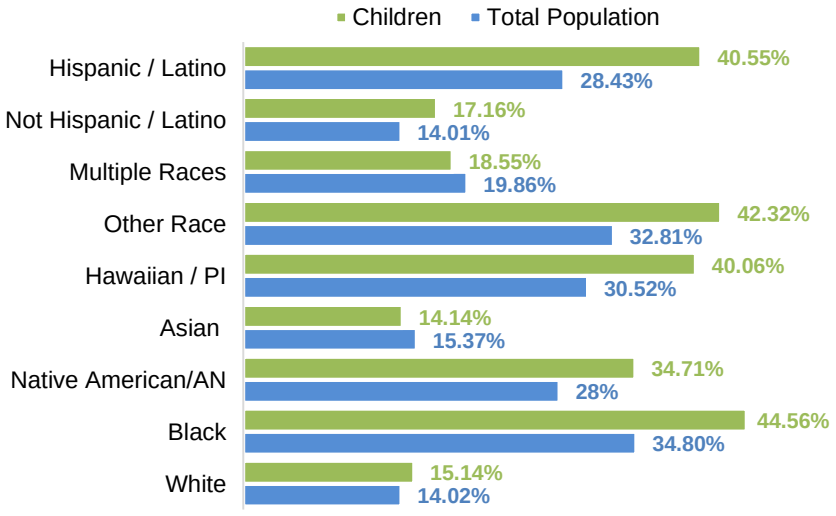
Table 2: Indicators Related to Economic Opp.	*Cost Burdened Households*[7]	*Assisted Housing Units (per 10,000 HH)*[8]	*School Enrollment Ages 3–4*[9]	*Free and Reduced Price Lunch Eligibility*[10]
United States	**35.5%**	**384**	**47.4%**	**52.4%**
Oregon State	**38.6&**	**301**	**41.0%**	**53.5%**
Washington State	**37.3%**	**293**	**40.1%**	**46.3%**
Metro (Primary)	**39.4%**	**288**	**45.4%**	**45.7%**
SW WA	**35.4%**	**343**	**41.1%**	**52.9%**
Mid-Valley	**38.9%**	**421**	**30.3%**	**59.4%**
South Valley	**39.4%**	**313**	**42.4%**	**53.2%**

Educational attainment is linked to health and a driver of economic opportunity. Individuals with low levels of education are prone to experience poor health outcomes and stress, whereas people with more education are likely to live longer, practice healthy behaviors, experience better health outcomes, and raise healthier children. Early education is one predictor of future educational attainment, and the primary and secondary service areas have low school enrollment for youth ages 3–4 as compared to the nation. Additional indicators related to economic opportunity are cost-burdened households (housing costs including rent or mortgage payments exceed 30% of household income), the number of assisted housing units available in a community (measured as a rate per 10,000 households), and free and reduced price lunch eligibility for public school children. See Table 2 for more details.

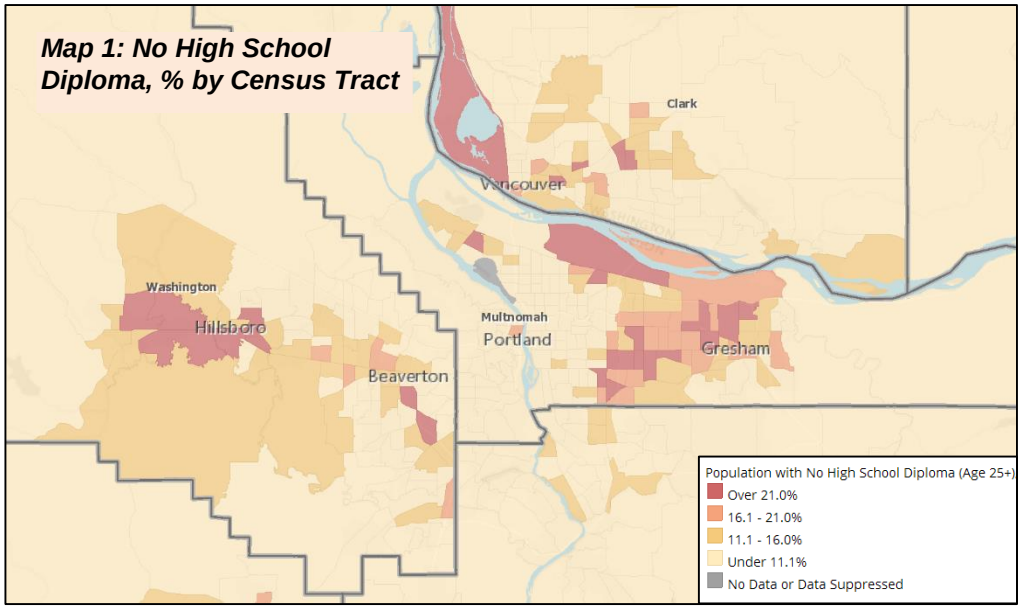
Key Data Points: Health Inequity

Inequities exist in KFH NW's burden of poverty across service areas. Racial and ethnic minorities experience up to three times the amount of poverty than their non-Hispanic white counterparts. Children have higher poverty rates than the total population in almost every racial and ethnic group breakdown where data is available. (See Figure 1) Drivers of poverty, including education and employment reflect these numbers — communities of color in the Primary Metro service area and the Secondary service areas have lower levels of education, income, and wealth.

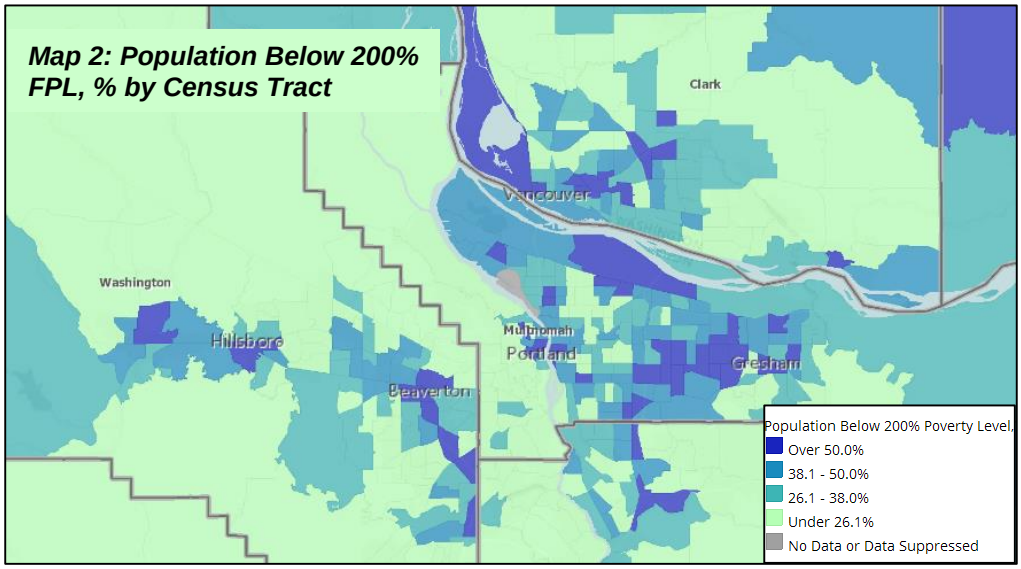
Figure 1: Ethnicity and Race Alone, Percent Population in Poverty in KFH NW (100% FPL)



Geographic inequities in economic opportunity exist across the KFH NW service area. The rural and urban divide in the Primary and Secondary service areas means that many communities have limited access to resources and services that tend to be located in urban centers. Further, Maps 1 and 2 to the left display geographic associations between areas with low educational attainment[11] and high poverty rates (200% FPL)[12] in the primary Metro service area. These geographic associations indicate potentially resource poor areas where access to basic needs such as quality affordable housing is especially pressing in the service area. These areas also tend to be the neighborhoods with larger shares of communities of color, reflecting inequities in access to quality education and living wage jobs for such communities.



Map 1: No High School Diploma, % by Census Tract



Map 2: Population Below 200% FPL, % by Census Tract

Community Voices and Input

Listening sessions conducted across the primary Metro service area indicated that the most pressing need in communities is the ability to meet basic needs, including access to safe and affordable housing, access to healthy affordable food, living wage employment and quality education, and access to affordable high-quality health care. Homelessness/Lack of safe, affordable housing was the number one identified community health need in the Metro area survey, while unemployment and the lack of living wage jobs was second. Across fifteen of the

disaggregated demographic groups, racism and discrimination was among the top most frequently identified community health concerns making it clear that the eliminations of racism and discrimination is critical to achieving more equitable health outcomes. The meta-analysis of community health assessments found the most frequent theme was income, jobs, and the economy. The community identified the ability to pay for basic needs such as food, housing, transportation, and childcare as the most pressing need. Equity was another top coded theme in the meta-analysis, especially as it relates to disparities in high school graduation rates in communities of color, income inequality and higher poverty rates experienced by communities of color.

"If you can't get up in the morning and take a shower and eat breakfast, how can you do anything else in life?"

~

"A country as wealthy as the United States should not have the homelessness that it does."

—Listening Session Participants

Community Assets

There are many nonprofit and community based resources throughout the Primary and Secondary service areas working with families and individuals to attain self-sufficiency through direct service, training, and housing provision. Several are highlighted below:

Adelante Mujeres

Adelante Mujeres provides holistic educations and empowerment opportunities to low-income Latina women and their families to ensure full participation and active leadership in the community.

Blanchet House of Hospitality

The Blanchet Hours offers hot meals six days a week to those in need. Blanchet Hours also operates a transitional shelter program for men struggling with addictions, unemployment or home and family issues.

Human Solutions

Human Solutions helps low-income families and homeless families and individuals gain self-sufficiency by providing affordable housing, family support services, job readiness training and economic development opportunities.

ROSE Community Development Corporation

ROSE Community Development is dedicated to revitalizing neighborhoods in the low-income outer southeast area of Portland through the development of good homes and economic opportunities.

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[1] RWJF. Education: It matters more to health than ever before. Web. 2014.
[2] Oregon Public Broadcasting. A Look Back at Oregon's Housing Crisis. Web. 2015.
[3] Department of Labor Bureau of Labor Statistics. December 2015.
[4] U.S. Census Bureau American Community Survey, 2010–2014
[5] Ibid.
[6] County Health Rankings. Health Factors Income. Web. 2016.
[7] U.S. Census Bureau American Community Survey, 2010–2014
[8] U.S. Department of Housing and Urban Development. 2013
[9] U.S. Census Bureau American Community Survey, 2010–2014
[10] National Center for Education Statistics, 2013–2014
[11] U.S. Census Bureau American Community Survey, 2010–2014
[12] Ibid.

Profile of Kaiser Foundation Hospital Northwest Prioritized Health Needs

CHRONIC DISEASE

About Chronic Disease

Chronic diseases are the leading cause of death and disability in the United States, causing seven out of ten deaths each year. Heart disease, cancer, and stroke alone cause more than 50% of all deaths each year.[1] Obesity is one of the biggest drivers of preventable chronic diseases in the United States, second only to tobacco.

> **"For a lot of us it's so expensive to afford fresh fruit and vegetables for our families."**
>
> **—Listening Session Participant**

Being overweight or obese increases the risk for many health conditions including type 2 diabetes, heart disease, stroke, hypertension, cancer, Alzheimer's disease, dementia, liver disease, kidney disease, osteoarthritis, and respiratory problems.[2] Tobacco use is linked to certain cancers and cardiovascular disease, two leading causes of death in the United States.

Healthy eating, active living, and abstaining from tobacco are key components to leading a healthy life and preventing chronic disease. The environments where we live, learn, work and play affect our access to healthy food and opportunities for physical activity which shape our health and our risk of being overweight and obese. There are also numerous health benefits that come from a lifestyle that includes healthy foods, exercise, and abstaining from tobacco use. An individual's physical and mental health improves and it reduces anxiety and depression.

Why Is It a Prioritized Community Health Need?

KFH NW defines this health need as nutrition-, physical activity-, tobacco-, and environmental-related chronic diseases and conditions that includes obesity, type 2 diabetes, hypertension, heart disease, stroke, and cancer. Obesity and tobacco related chronic diseases are the most preventable in the KFH NW service area. Key indicators such as overweight and obesity benchmark poorly compared to the best state average in the Primary and Secondary service areas, as do many drivers of these chronic diseases, including tobacco use. The community frequently mentioned the need for healthy food access and safer neighborhoods for physical activity, including the need for exercise-related infrastructure. Oregon and Washington both see racial and economic inequities in obesity and related chronic diseases. Given the magnitude of the need and potential for prevention, this health need is high priority.

Key Data Points: Health Outcomes and Drivers of Chronic Disease

Chronic disease rates in KFH NW vary by Primary and Secondary service area. Cancer mortality rates exceed coronary heart disease and stroke mortality rates across KFH NW, with the highest rates of cancer mortality in SW WA and South Valley. The highest rates of

heart disease, a leading killer in the United States, are seen in SW WA, while the highest rates of mortality due to stroke are seen in South Valley and Mid-Valley (Table 1). Diabetes prevalence (Figure 1) benchmarks poorly to Oregon and Washington in the SW WA and Mid-Valley areas, while the Metro area is reflective of both states, and performs better than the nation overall.

Table 1: Chronic Disease Mortality

	(All) Cancer Mortality per 100,000[3]	*Coronary Heart Disease Mortality per 100,000*[4]	*Stroke Mortality per 100,000*[5]
United States	**168.9**	**109.5**	**37.9**
Oregon State	**170.0**	**75.7**	**39.9**
Washington State	**165.5**	**94.1**	**36.2**
Metro (Primary)	**165.9**	**72.8**	**37.8**
SW WA	**185.0**	**100.6**	**33.3**
Mid-Valley	**168.7**	**76.1**	**39.5**
South Valley	**171.1**	**69.4**	**40.1**

Figure 1: Diabetes Prevalence

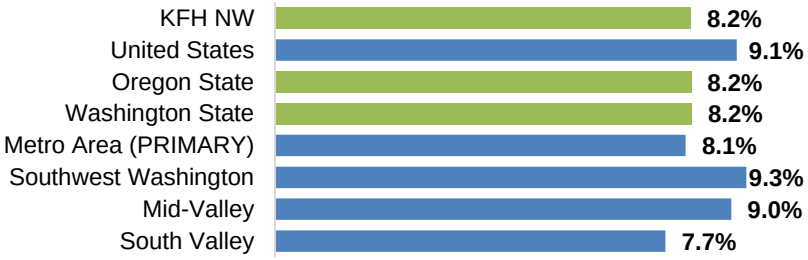
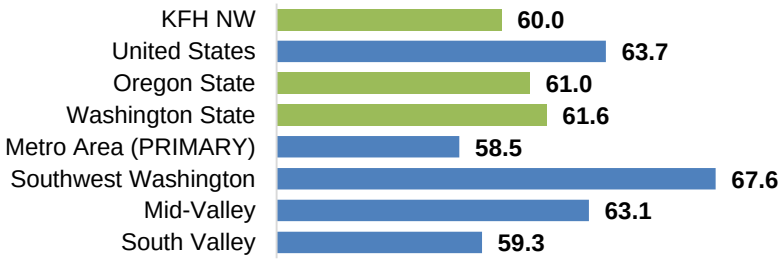


Figure 2: Lung Cancer Incidence per 100,000



Lung cancer, a prominent chronic disease caused in part by inhalation of and exposure to tobacco smoke has high incidence rates in SW WA and Mid-Valley as compared to Oregon and Washington, both of which have lower incidence rates than the nation overall (Figure 2).

According to self-reported data, overweight and obesity among adults and youth do not benchmark well to the better state average in all of the Secondary areas (Table 2). While the primary Metro area does better than the state average on aggregate, adult overweight and youth obesity benchmark poorly in Multnomah County, the most populous of the 4-county primary service area. In the KFH NW Primary and Secondary service areas, obesity and diabetes rates[6] have increased over the past ten years, paralleling national trends. Obesity is the number two cause of preventable death in Oregon and Washington as well as nationally, second only to tobacco use.

Many of the drivers and risk factors for obesity, such as eating behaviors, and physical activity benchmark poorly in several of the KFH NW Secondary service areas, and also in the Primary service area. Lack of affordable, accessible, healthy food create an added burden for people with lower incomes, people of color, people living in isolated areas, older adults, and youth to develop a healthy weight. Table 3 outlines several indicators that are key behavioral,

Table 2: Overweight and Obesity

	Youth Overweight[7]	*Youth Obesity*[8]	*Adult Overweight*[9]	*Adult Obesity*[10]
United States	**15.6%**	**15.7%**	**35.8%**	**27.1%**
Oregon State	**14.8%**	**10.1%**	**34.3%**	**25.9%**
Washington State	**13.6%**	**9.3%**	**35.0%**	**27.1%**
Metro (Primary)	**13.8%**	**11.5%**	**34.7%**	**24.1%**
SW WA	**18.0%**	**15.7%**	**35.2%**	**32.3%**
Mid-Valley	**16.5%**	**9.0%**	**36.8%**	**32.7%**
South Valley	**15.9%**	**10.7%**	**31.7%**	**27.1%**

> **"How I wish we had space to be active when it rains."**
> **—Listening Session Participant**

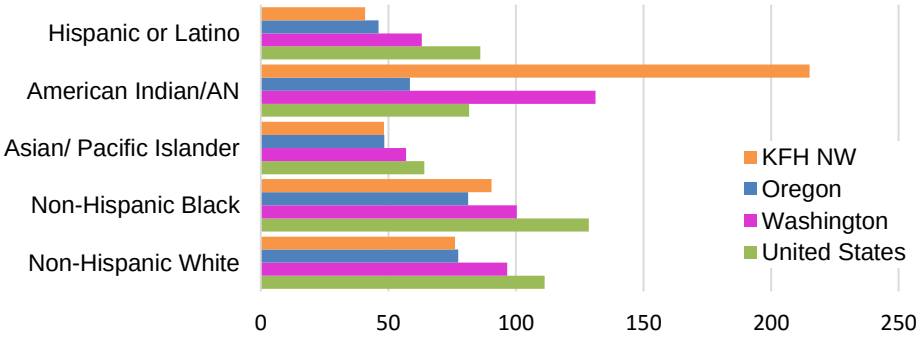
environmental, and policy drivers of chronic disease in the KFH NW service area. Adult physical inactivity (percentage of the adult population with no leisure time physical activity) as well as youth physical inactivity (0 days with 60 minutes or more of physical activity), and inadequate fruit and vegetable consumption are behaviors that affect chronic disease. Food insecurity is included in the table as Oregon ranks 13th worst in the nation and Washington 28th for food insecurity. Food insecurity rates almost double when looking at the youth population (0–18 years old) only, meaning that 1 in 4 children in Oregon and 1 in 5 in Washington are food insecure. Good nutrition is essential for health. Insufficient nutrition can hinder growth and development.

Table 3: Indicators Related to Chronic Disease	Physical Activity		Nutrition				Tobacco
	Youth Physical Inactivity[11]	*Adult Physical Inactivity*[12]	*Inadequate Fruit and Vegetable Consumption, Adult*[13]	*Food Insecurity*[14]	*Grocery Store Access (per 100,000)*[15]	*WIC-Authorized Food Stores (per 100,000)*[16]	*Tobacco Use*[17]
United States	**9.13%**	**22.6%**	**75.7%**	**15.94%**	**21.2**	**15.6**	**18.1%**
Oregon State	**6.2%**	**15.5%**	**73.6**	**15.8%**	**20.0**	**16.7**	**16.6%**
Washington State	**7.6%**	**18%**	**74.6%**	**14.9%**	**23.5**	**11.3**	**15.6%**
Metro (Primary)	**8.3%**	**14.7%**	**73.4%**	**14.6%**	**18.1**	**11.5**	**13.6%**
SW WA	**8.5%**	**20.4%**	**78.4%**	**15.7%**	**13.8**	**13.8**	**21.9%**
Mid-Valley	**6.3%**	**16.5%**	**74%**	**14.8%**	**14.7**	**15.6**	**15.8%**
South Valley	**7.5%**	**15.7%**	**74.7%**	**16.3%**	**17.5**	**16.1**	**17.4%**

Table 3 also indicates the number of grocery stores per 100,000 population and the number of food stores that are authorized to accept WIC (Women, Infants, and Children nutrition program) benefits per 100,000 population. Both of these indicators are important as they provide measures of food security and healthy food access as well as environmental influences on dietary behaviors. Lastly, tobacco use is a key indicator related to several chronic diseases, including cardiovascular disease and cancers. Self-reported data of adults who smoke shows high rates of tobacco use in the SW WA and South Valley areas, with the lowest rates in the Metro area. This data does not include youth tobacco use or means of tobacco use other than cigarettes (e.g., chewing tobacco, electronic cigarettes).

Key Data Points: Health Inequity

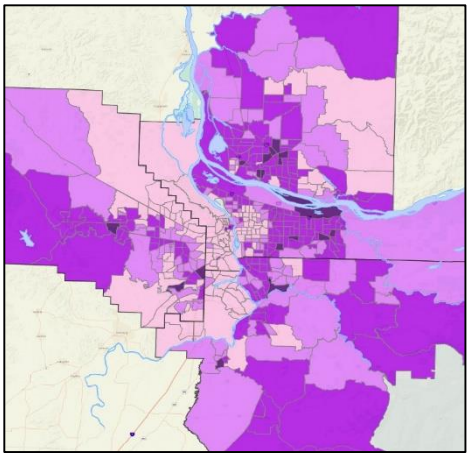
Figure 3: Coronary Heart Disease Mortality (per 100,000) by Race/Ethnicity

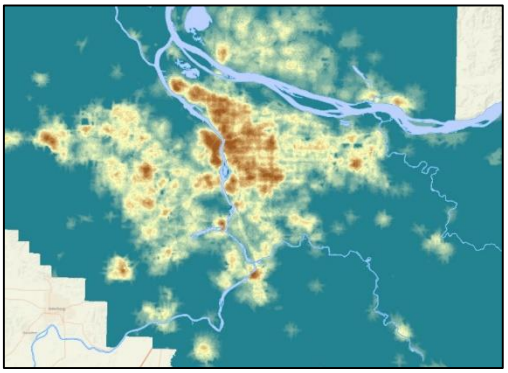


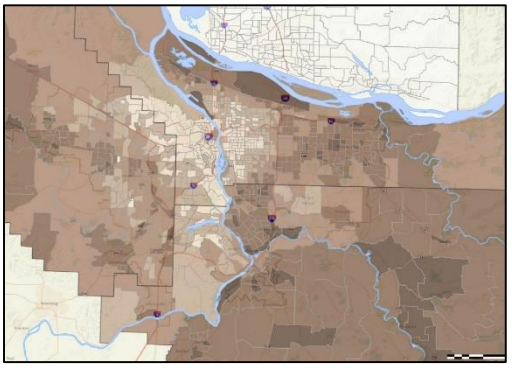
While most data about racial inequities are not available at a sub-state geography, there are a few data sets and sources that illuminate the racial and ethnic disparity in chronic disease. For example, heart disease (Figure 3) mortality in KFH NW is shockingly high in the American Indian and Alaskan Native population as compared to any other racial or ethnic group, and non-Hispanic blacks also

experience high rates of mortality due to coronary heart disease in KFH NW. According to the Oregon Health Authority, African-Americans, American Indians or Alaska Natives (AI/AN), and Latinos in Oregon have higher rates of obesity compared to non-Latino whites. The largest inequity is among the AI/AN population in Oregon, who are affected by obesity at a rate 55% higher than Whites.[18] These same inequities hold true in Washington where obesity rates are also higher in populations with lower income and education.[19]

One resource available in the Metro service area is the Regional Equity Atlas[20], a collaborative effort in the Portland metropolitan region to map the distribution of different communities and access to key resources such as food, transportation, and education. Equity Atlas Version 2.0 maps key health outcomes data points, including BMI (Oregon only) and diabetes. Comparing these maps to maps of key related indicators (see below), there is a clear geographic association between poor health outcomes and limited access to health promoting resources such as walkable neighborhoods.







Left: *Diabetes rates, darker purple indicates rates higher than 11%.* ***Middle:*** *Healthy Eating Active Living composite map, brown indicates more access to amenities such as parks and transit.* ***Right:*** *Body Mass Index, darker browns indicate higher BMI.*

Figure 4: Diabetes Diagnoses, Adult Medicaid Population (%)

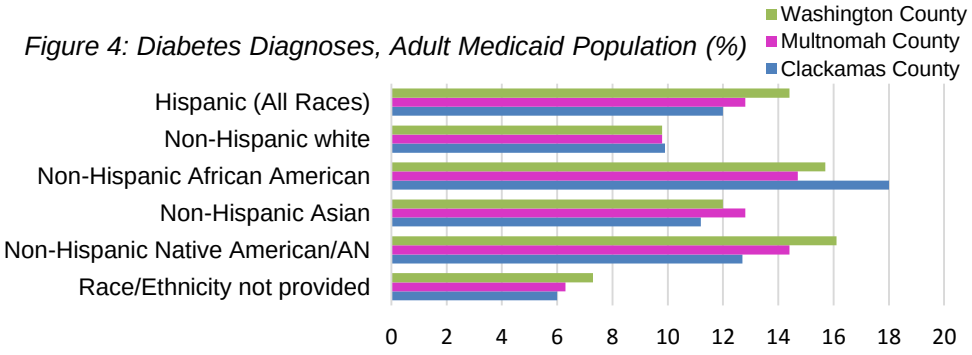
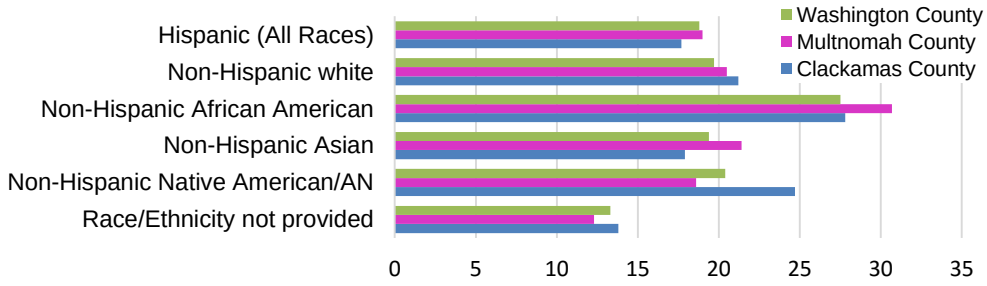


Figure 5: Hypertension Diagnoses, Adult Medicaid Population (%)



Further, when looking at diabetes and hypertension — two chronic diseases related to physical activity, nutrition, and tobacco use — diagnosed in the low-income Medicaid population in three of the four counties in the primary Metro service area, racial and ethnic inequities exist. African-Americans suffer the highest rates of diabetes and hypertension, and Hispanics and Native Americans also experience high rates of diabetes. See Figures 4 and 5 for more details.

Community Voices and Input

> **"If my family would have known that eating healthy, fruits and vegetables, and exercise were good, my family and my community in Mexico would not be suffering diabetes."**
>
> **—Listening Session Participant**

Survey respondents identified poor eating habits as a risky behavior that is affecting community health, it was the third highest response in the primary Metro service area. Hunger and lack of healthy, affordable food was identified by survey respondents as a community health need, the fourth most frequent response. Being overweight or obese was selected frequently as was unsafe streets (referring to limited crosswalks, bike lanes, lighting, etc.) — which is a deterrent to exercising.

Physical health, including obesity and nutrition, were frequently coded in the meta-analysis of existing community reports. Chronic diseases such as cancer, diabetes, and heart disease were also among the top coded themes in the analysis. Chronic disease management services were indicated as something a healthy community should include, as was access to physical activity.

During community listening sessions, the need for affordable healthy foods and nutrition education was a common theme among Latinos. Access to basic needs including healthy food was among the most frequent themes across all sessions, and a community where people exercise was a common vision for a healthy community.

Community Assets

Farmers Market Fund

Farmers Market fund administers Fresh Exchange, a money matching program available to low-income Portland residents receiving Supplemental Nutrition Assistance Program (SNAP) benefits. This helps to ensure everyone in the community has access to healthy, locally-grown food, including low-income, elderly and under-served populations.

Huerto de la Familia

Huerto de la Familia (The Family Garden) expands opportunities and training in organic agriculture and business creation to families with the least access, but who have great potential to benefit. Huerto de la Families works with Latino families on training and peer education in organic gardening, small scale farming, and small business creation.

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[1] Healthy People 2020 General Health Status, Chronic Disease Prevalence. Web. 2016.
[2] County Health Rankings. Our Approach. Web, 2016.
[3] Centers for Disease Control and Prevention, 2009–2013.
[4] Ibid.
[5] Ibid.
[6] Centers for Disease Control and Prevention, 2012.
7 WA: Healthy Youth Survey, 8th grade, 2014. OR: Healthy Teen Survey, 8th grade, 2013. Worst County reported in service area.
8 Ibid.
9 Adult overweight: Behavioral Risk Factor Surveillance System, 2011–2012. Adult obesity: Centers for Disease Control, 2012.
10 Ibid.
11 WA: Healthy Youth Survey, 8th grade, 2014. OR: Healthy Teen Survey, 8th grade, 2013. Worst County reported in service area.
[12] Centers for Disease Control and Prevention, 2012.
[13] Behavioral Risk Factor Surveillance System, 2005–2009.
[14] Feeding America, 2013.
[15] UC Census Bureau, County Business Patterns, 2013.
[16] US Department of Agriculture. 2011.
[17] Behavioral Risk Factor Surveillance System, 2006–2012.
[18] https://public.health.oregon.gov/About/Documents/ship/ship-obesity-priority.pdf
[19] http://www.doh.wa.gov/DataandStatisticalReports/DiseasesandChronicConditions/Obesity
[20] http://clfuture.org/equity-atlas

BEHAVIORAL HEALTH

About Behavioral Health

> **"Anyone who has been homeless knows that it is like being in combat. If you're out there for a long time you get post-traumatic stress disorder."**
>
> **—Listening Session Participant**

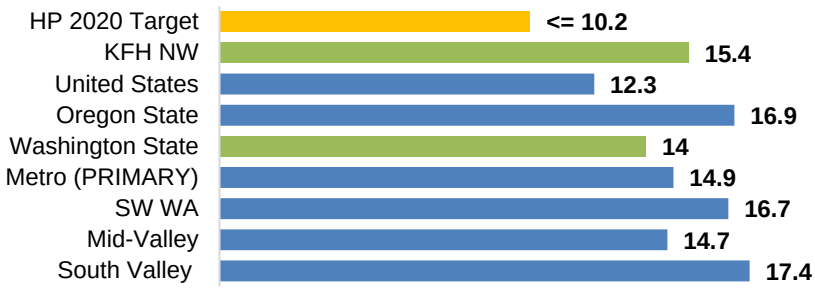
Behavioral Health as defined in this CHNA includes mental health, substance abuse, and violence. Poor behavioral health can affect all areas of an individual's life, including well-being, the ability to work and perform well in school, and to participate fully and meaningfully in society. Behavioral health status is an essential component of overall health and well-being and poor mental health, including the presence of chronic toxic stress has profound consequences on health behavior choices and physical health.[1] One related health behavior can be substance abuse, including use of alcohol, tobacco, and prescription drugs. Substance abuse harms individual and community health by increasing cancer risks, affecting mental health, and can lead to violence and injury. Safe communities contribute to overall health and well-being by promoting community cohesion and economic development. Safer communities free from substance abuse and crime provide more opportunities to be active and improve mental health while reducing untimely deaths and serious injuries.

Access to programs and services that promote social and emotional wellness is a critical factor in improving behavioral health. Efforts to improve access to and quality of services for mental health care and substance abuse treatment and counseling can dramatically improve the safety and quality of northwest communities.

Why Is It a Prioritized Community Health Need?

There are many issues related to behavioral health in KFH NW, including a lack of access to mental health providers and a housing crisis that has created a growing homeless population. Mental health, substance abuse, and community safety were issues that rose to the top in both primary data collection and in looking at secondary data.

Figure 1: Suicide Age-Adjusted Death Rate (per 100,000)



Key Data Points: Health Outcomes and Drivers of Behavioral Health

The rate of suicide in the primary and secondary service areas far exceeds the national and better state (WA) rate of suicide.[2] The SW WA service area rate is 6.5 per 100,000, greater than the Healthy People 2020 target rate. (Figure 1) The Northwest is known for high suicide rates and it is a key indicator of the behavioral health need in KFH NW.

In the Medicaid population in the KFH NW primary service area, Post-Traumatic Stress Disorder and Depression were among the top five diagnoses in children, and tobacco use and depression among the top five in adults.[3] Compounding the issues of behavioral health is the lack of access to mental health care providers, with the fewest resources in the SW WA and Mid-Valley areas.[4] The Metro area has higher rates of mental health care providers than the United States and the better state (OR), however given the density of the population and the vast need across the Metro area, more access is still needed. (Figure 2) Indicators that are related to mental health and included in the behavioral health need are substance abuse and violence (See Table 1 for more details).

Figure 2: Mental Health Care Provider Rate (per 100,000)

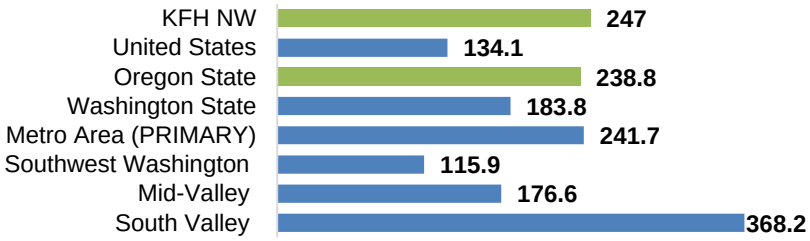


Table 1: Behavioral Health Indicators	*Adults Drinking Alcohol Excessively*[5]	*Tobacco Use*[6]	*Violent Crime Rate (per 100,000)*[7]
United States	**16.9%**	**18.1%**	**395.5**
Oregon State	**16.6%**	**16.6%**	**250**
Washington State	**17.2%**	**15.6%**	**302.4**
Metro (Primary)	**17.2%**	**13.6%**	**255.3**
SW WA	**18.7%**	**21.9%**	**239.9**
Mid-Valley	**12.9%**	**15.8%**	**211.5**
South Valley	**16.9%**	**17.4%**	**209.4**

"Addiction is the opposite of connection."

~

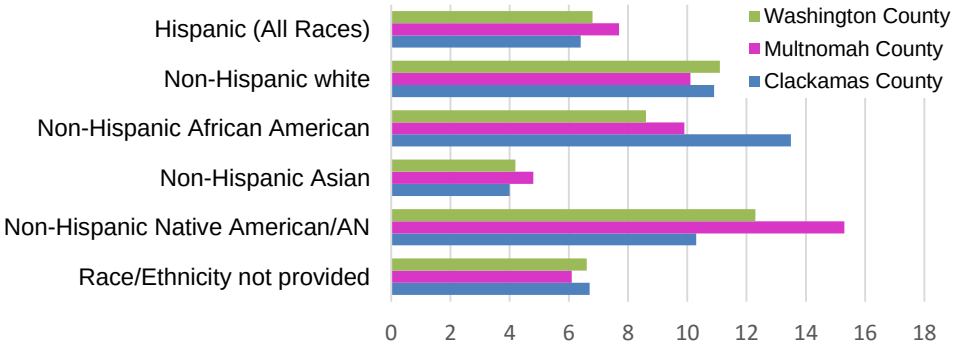
"That's what got me into drugs, not having anything to do."

—Listening Session Participants

Key Data Points: Health Inequity

Few indicators of mental health, substance abuse, or community safety report race and ethnicity data. As part of the Healthy Columbia Willamette Collaborative, the Hospital Workgroup compiled data from the two local Coordinated Care Organizations (CCO) working in Washington, Multnomah, and Clackamas counties in Oregon. These data represent the adult Medicaid population, and depression diagnosis is shown in Figure 3 by race and ethnicity. While this is only a small part of the larger KFH NW service area, it is data for three of the four counties in the most populous, Primary Metro service area and begins to help us understand inequities in depression diagnoses. Higher rates of depression diagnoses are seen in the Native American and Alaskan Native population in both

Figure 3: Depression Diagnoses, Adult Medicaid Population (%)



Washington and Multnomah Counties, while the highest rates of depression diagnoses in Clackamas County is among the African-American population. Non-Hispanic whites are diagnosed with depression at higher rates than non-Hispanic Asians and Hispanics of all races.

Community Voices and Input

> **"Hurt people, hurt people. This is what we are seeing..."**
>
> ~
>
> **"...if we don't have a way to get clean and fulfill our innate needs, the next step is to do crime."**
>
> **—Listening Session Participants**

Mental health challenges were indicated as a top need in the Primary Metro service area by survey respondents indicating mental health challenges such as depression, lack of purpose or hope, anxiety, bipolar, PTSD, and eating disorders as among the top health needs in their community. Among priority populations completing the survey (including racial, ethnic, and sexual minorities) violence and discrimination were among the most frequently indicated community health needs. The meta-analysis uncovered mental health as a top five most frequently coded health need. Community assessments indicated a need for increased access to mental health services and treatment as well as the increased pressures of mental health illness stigma. High rates of substance abuse were indicated in the Native American population specifically. The listening session's uncovered vast needs related to economic opportunity and access to care, many of which overlap with behavioral health as a community need.

Community Assets

While lack of access to and opportunities for mental health care and treatment were mentioned often by the community, several existing assets that provide behavioral health resources were noted in listening sessions and in the compilation of resources by KFH NW for this CHNA. A few of these are highlighted below:

Oregon School Based Health Alliance (OSBHA)

OSBHA works to build an effective school-based health care system throughout Oregon. School Based Health Centers address barriers to accessing care by providing all school-aged youth with care whether they have private insurance, public assistance, or no insurance. Many SBHCs focus on behavioral health.

Native American Rehabilitation Association of the NW (NARA)

NARA provides education, physical and mental health services and substance abuse treatment that is culturally appropriate to American Indians, Alaska Natives, and other vulnerable populations.

> **"A lot of people are broke — and if you are going through a mental health crisis you need help finding services."**
>
> ~
>
> **"If you can treat people before they get into a crisis situation, you can save a lot financially ... put the money into prevention."**
>
> **—Listening Session Participants**

[1] APHA Policy Statement. Support for Social Determinants of Behavioral Health and Pathways for Integrated and Better Public Health. Web. 2016.
[2] Centers for Disease Control and Prevention, 2009–2013.
[3] Healthy Columbia Willamette Collaborative Hospital Workgroup Findings.
[4] County Health Rankings, 2014.
[5] Behavioral Risk Factor Surveillance System, 2006–2012.
[6] Behavioral Risk Factor Surveillance System, 2006–2012.
[7] Federal Bureau of Investigation, 2010–2012.

MATERNAL AND INFANT HEALTH

About Maternal and Infant Health

Improving the health and well-being of mothers, infants, and children is critical to determining the health of the next generation. Maternal and infant health is a foundational public health need that addresses a range of issues that affect the quality of life of mothers, children, and their families. These include teen births, low birth weight and infant mortality, breastfeeding, and access to prenatal care.

"Work with kids. It's a good investment in early education."

—Listening Session Participant

There are approximately 3 million unintended pregnancies in the US each year, and rates are highest among poor, minority, young, and cohabiting women. Unintended pregnancy is associated with delayed prenatal care. Pregnant teens are more likely to have pre-term or low birth weight babies, and teen mothers are often at increased risk for sexually transmitted infections and repeat pregnancies, are less likely than their peers to complete high school, and more likely to live below the poverty level and rely on public assistance.[1]

Why Is It a Prioritized Community Health Need?

While infant mortality rates in KFH NW outperform the HP 2020 target, there are racial and ethnic inequities in communities of color at the state level.[2] Lack of prenatal care is high in secondary service areas as is the teen birth rate. The community indicated aspects of maternal and child health as a need in the survey, listening sessions and meta-analysis.

Key Data Points: Health Outcomes and Drivers of Maternal and Infant Health

High rates of infant mortality indicate the existence of broader issues pertaining to access to care and maternal and infant health. In KFH NW, both Oregon and Washington as well as the Primary and Secondary service areas outperform the nation and exceed the Healthy People 2020 target.[3] (Figure 1) However, clear inequities exist in communities of color in both states. While data is not available at a service area geography, both Oregon and Washington see higher rates of infant mortality in the non-Hispanic black and the Native American/Alaska Native populations, with rates as high as 8.7 and 14.5 respectively in Oregon in 2013.[4] Three indicators related to infant mortality, and maternal and child health in general, are outlined in Table 1. One driver of infant mortality is low birth weight.

Figure 1: Infant Mortality Rate (Per 1,000 Births)

Table 1: Maternal and Infant Health Indicators	*Low Birth Weight*[5]	*Lack of Prenatal Care*[6]	*Teen Birth Rate (per 1,000 Females Age 15–19)*[7]
United States	**8.2%**	**17.3%**	**36.6**
Oregon State	**6.1%**	**20.2%**	**30.8**
Washington State	**6.3%**	**28.4%**	**29.2**
Metro (Primary)	**6.2%**	**22.1%**	**26.0**
SW WA	**6.5%**	**no data**	**38.2**
Mid-Valley	**5.6%**	**26.0%**	**39.6**
South Valley	**6.2%**	**18.4%**	**22.5**

Low birth weight infants are at risk for health problems. A second is engaging in prenatal care, which decreases the likelihood of maternal and infant health risks. This indicator can also highlight a lack of preventive care, a lack of health knowledge, insufficient provider outreach, and/or social barriers preventing use of services. A third indicator for maternal and child health is the teen birth rate. Teen parents have unique social, economic and health care needs, and preventing unwanted teen pregnancy is one way to improve maternal and infant health.

Other drivers of maternal and infant health are those that indicate investment and participation in early childhood education. Access to education is a key driver and social determinant of health, and is associated with increased economic opportunity, access to social resources, and positive health status and outcomes. Two indicators of child education include the number of Head Start Program facilities available for children (Table 2), and school enrollment for children ages 3–4 (i.e., preschool, see Figure 2).[9]

Figure 2: School Enrollment, % of Population Age 3–4

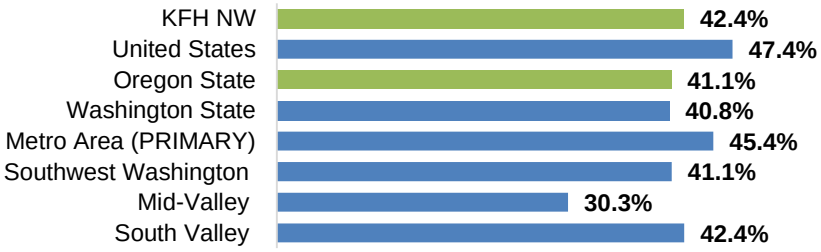
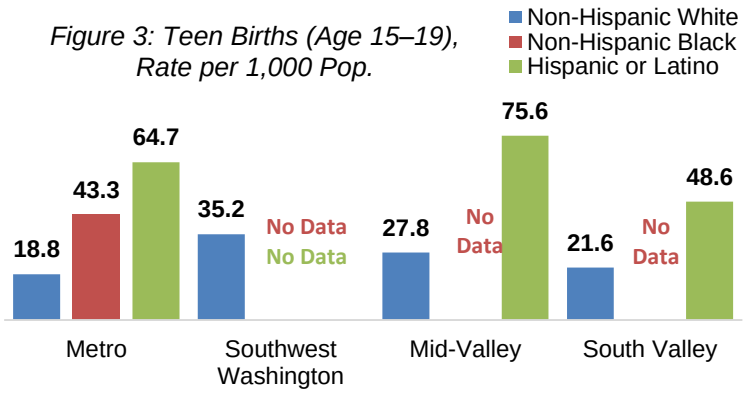


Table 2: Indicator Related to Infant Health	*Head Start Programs (per 10,000 Children)*[8]
United States	**7.62**
Oregon State	**8.84**
Washington State	**6.44**
Metro (Primary)	**6.13**
SW WA	**11.85**
Mid-Valley	**6.30**
South Valley	**8.71**

Key Data Points: Health Inequity

As noted above, limited data exists that can be analyzed at the KFH NW service area geography. Some service area and county-level data does exist for maternal and child health indicators by race and ethnicity, although not consistently across geographies. Nonetheless, looking at these data point to inequities that are likely replicated across KFH NW. For example, Figure 3 shows that in the primary Metro service area, Hispanic or Latino teen births are more than three times that of non-Hispanic white teen births, and non-Hispanic black teen births more than double that of whites. Similarly high rates of teen births in the Hispanic or Latino population are shown in Mid-Valley and South Valley where data are available. Data for low birth weight babies were available

Figure 3: Teen Births (Age 15–19), Rate per 1,000 Pop.



for the four counties that make up the primary Metro service area and are shown in Figure 4. Non-Hispanic black and Asian/Pacific Islander babies suffer higher rates of low birth weight than their Hispanic or White counterparts. Geographic disparity can be observed by mapping indicators, and below (Map 1) is a map of a related indicator to maternal and infant health, school enrollment for children ages 3–4. Rural areas and lower-income communities such as East Multnomah County and parts of Washington County have low school enrollment.

Map 1: School Enrollment, Children (Age 3–4), % by Census Tract

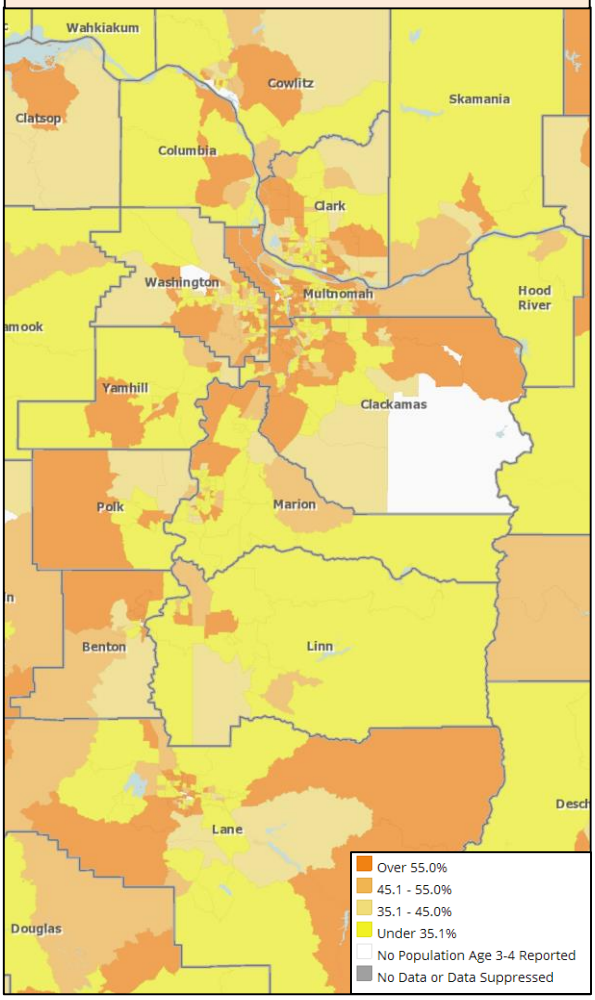
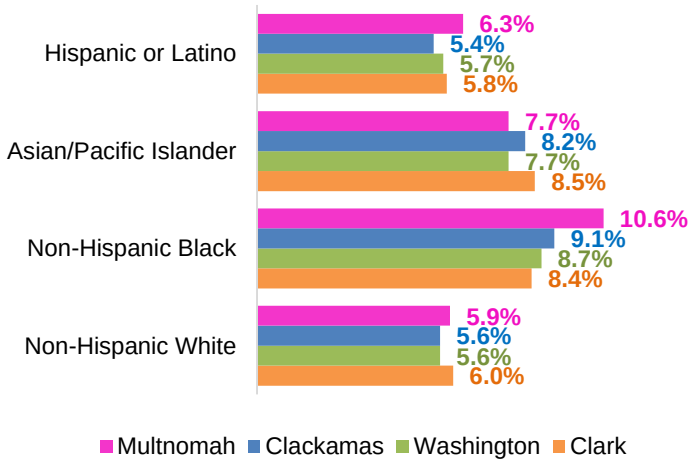


Figure 4: Babies Born with Low Birth Weight, Percent by Metro Service Area County



Community Voices and Input

Maternal and child health did not rank high in the survey, and was not mentioned in listening sessions or the meta-analysis with high frequency. The community survey identified risky sexual behaviors and not using birth control as a health need among one priority group. Access to care and economic opportunity are key to maternal and infant health, and therefore while not specifically indicated in the survey, the frequency of responses indicating that meeting basic needs was the most important community health issue are related to maternal and child health outcomes. Domestic violence/child abuse and neglect was frequently cited by uninsured and Spanish speaking survey respondents. The meta-analysis found a theme in the priority Native American/Alaskan Native population that low birth weight and infant mortality are issues of concern. Lastly, a listening session theme related to visioning for a healthy community among the Latino population was maternal and child health, family planning, healthy pregnancies, and healthy children.

Community Assets

There are many assets in KFH NW working on maternal and infant health needs and issues. A few are listed below, for a complete listing of assets identified in the KFH NW CHNA, see Appendix G.

Baby Booster Initiative
The Baby Booster initiative is a collective impact initiative working in the 97266 ZIP code of Southeast Portland to improve the health of babies and families with young children.

Black Parent Initiative
The Black Parent Initiative (BPI) was established in 2006 to help families achieve financial, educational and spiritual success. The BPI educates and mobilizes the parents and caregivers of black and multiethnic children to ensure they achieve success.

La Leche League
La Leche League of Oregon has the mission to help mothers worldwide to breastfeed, through mother-to-mother support, encouragement, information, and education. They work to promote a better understanding of breastfeeding as an important element in the healthy development of the baby and mother.

Developmental Origins Strategy Collaborative
The Developmental Origins Strategy Collaborative (DOSC) seeks to, through the co-creation of projects across multiple sectors and partners, create, build, expand, and accelerate opportunities for broad community engagement, economic development, and increased access to healthful foods to address the factors associated with the developmental origins of health and disease.

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[1] County Health Rankings, Our Approach, Web 2016.
[2] Oregon Public Health Division, State Health Profile, 2015.
[3] Centers for Disease Control and Prevention, 2006–2010.
[4] Oregon Public Health Division, State Health Profile, 2015.
[5] US Department of Health and Human Services, 2006–2012.
[6] Centers for Disease Control and Prevention, 2007–2010
[7] Centers for Disease Control and Prevention, 2006–2012.
[8] US Department of Health and Human Services, 2014.
[9] US Census Bureau American Community Survey, 2010–2014.

Profile of Kaiser Foundation Hospital Northwest Prioritized Health Needs

ASTHMA

About Asthma

> **"In apartments we can't breathe the air."**
> **—Listening Session Participant**

Asthma is a chronic lung disease that causes shortness of breath, coughing, and wheezing. Asthma is one of the leading chronic diseases of childhood with related morbidity and mortality rates among children increasing nationwide.[1] Asthma is often exacerbated by poor environmental conditions, and symptoms occur when a person is exposed to a trigger such as tobacco smoke, mold, poor outdoor air quality, or pollen. Crowded housing and impoverished living conditions are additional risk factors for asthma. Asthma symptoms are controllable with quality health care, correct medications at proper dosages, and patient-self management.[2]

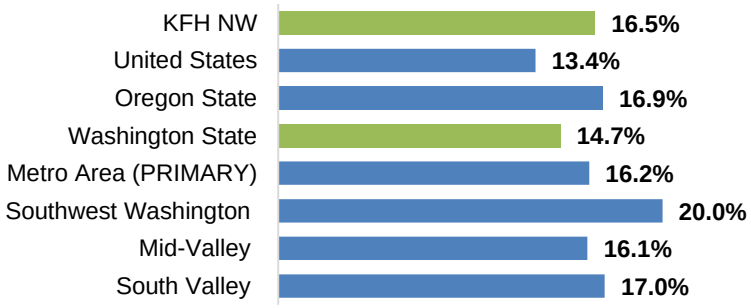
Why Is It a Prioritized Community Health Need?

The burden of asthma in the Primary and Secondary service areas is substantially higher than the better state benchmark (WA) and the nation overall. There are clear inequities in the burden of the disease; in Oregon more American Indian/Alaska Natives and African-Americans report having asthma than any other racial or ethnic group.[3] Asthma is the most diagnosed chronic condition in youth when analyzing Medicaid data from three of the four Metro service area counties. Additionally, community input indicated the need for cleaner environments and healthier behaviors including decreased smoking. This shows that many of the drivers of asthma are of concern to the KFH NW community.

Key Data Points: Health Outcomes and Drivers of Asthma

Asthma prevalence among adults is high in KFH NW as compared to the nation and the better performing state in KFH NW, Washington.[4] (Figure 1) A primary environmental driver of asthma is air pollution. Air pollution is associated with increased asthma rates and can aggravate asthma and other lung diseases, damage airways and lungs, and increase the risk of premature death from heart or lung disease. KFH NW service areas see higher rates of days where air particulate matter 2.5 is above national standards than Oregon and Washington averages and the nation. The highest rates are seen in the Mid-Valley service area where farming is a key activity and pesticide use is prevalent, and the Metro area, home to KFH NW's industrial base. (Table 1)

Figure 1: Asthma Prevalence (Adult)



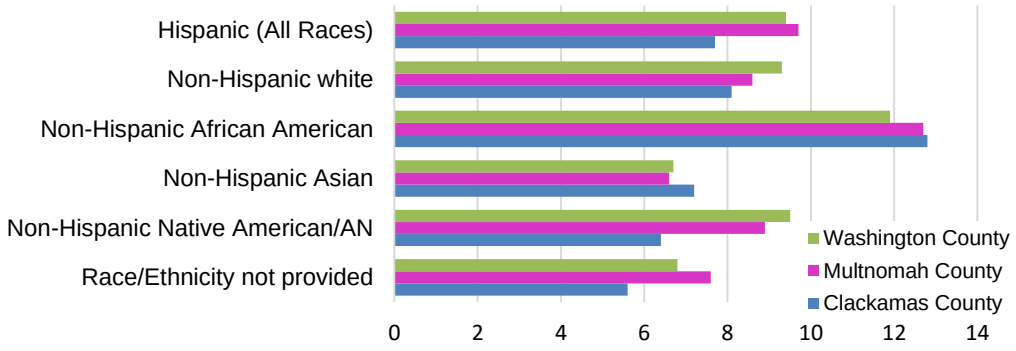
Asthma can be exacerbated by indoor allergens such as mold and dust, and in some cases asthma can be attributed to poor home ventilation or other indoor air quality concerns. While there is limited data to illustrate what this looks like in KFH NW, the quote from a listening session participant above indicates the need for higher quality indoor environments and housing options. Tobacco use is both related to asthma and a trigger for individuals with asthma, including children living in homes with an adult smoker. KFH NW Secondary service areas see the highest rates of tobacco use, with rates higher than the Oregon and Washington averages, and in SW WA in particular, higher than the national average. SW WA also has the highest rates of adult asthma in KFH NW. (Table 1)

Table 1: Asthma Triggers

	Air Quality: Particulate Matter 2.5[5]	*Tobacco Use*[6]
United States	**0.10%**	**18.1%**
Oregon State	**0.18%**	**16.6%**
Washington State	**0.05%**	**15.6%**
Metro (Primary)	**1.62%**	**13.6%**
SW WA	**0.59%**	**21.9%**
Mid-Valley	**1.66%**	**15.8%**
South Valley	**1.54%**	**17.4%**

Key Data Points: Health Inequity

Figure 2: Asthma Diagnoses, Child (0–18) Medicaid Population (%)



State-level data indicates inequities in the burden of asthma. In Oregon, for example, adult females report having asthma at higher rates than adult males, bisexual Oregonians have rates 60% higher than heterosexual Oregonians, and lower income Oregonians on Medicaid or without a college education are more likely to report having asthma than their higher income, more educated counterparts.[7] In the Primary Metro service area, asthma diagnoses data is available for three of the four counties for the youth Medicaid population. Asthma was the most diagnosed chronic disease among child Oregon Health Plan (Medicaid) recipients in the three Oregon counties that make up the Primary Metro service area. Within those diagnoses, there are clear inequities, with non-Hispanic black children suffering the highest rates of asthma. (Figure 2)

Community Voices and Input

Tobacco use and substance abuse were among the top responses indicated as a risky behavior in the community survey, potentially indicating that the community sees these related indicators of asthma as important and if improved, able to affect multiple health outcomes such as asthma. Asthma/respiratory/lung disease was a top response in the Medicare population that took the community survey, while “dirty environment” was indicated as a health need by youth under the age 18.

Asthma was not directly mentioned in listening sessions, although clean physical environments were noted as a strength of a healthy community. Access to basic needs and decreasing

poverty were also among the top themes during the listening sessions. All of these are drivers of asthma prevalence, living in impoverished conditions including poor quality and crowded housing exacerbates asthma. The meta-analysis identified chronic conditions as a top theme, however asthma was not specifically coded.

Community Assets

There are many assets in KFH NW working on asthma needs and issues. A few are listed below, for a complete listing of assets identified in the KFH NW CHNA, see Appendix G.

Neighbors for Clean Air

Neighbors for Clean Air is an advocacy group in Oregon who works to educate, motivate, and activate citizens in efforts to improve air quality in Portland and Oregon. They do this by working with elected officials to promote regulations and policies that best protect public health and children's health, as well as by working with businesses to increase their efforts in reducing emissions.

Multnomah County Health Department: Healthy Homes Program

Healthy Homes is a free program for low-income families that can help parents take control of their child's asthma. During the six month program, a nurse asthma educator makes home visits and provides education, medication management, and coordination with various resources such as healthy home improvement options.

Quit Now: Smoke Free Oregon

Quit Now is a free program through the Oregon Health Authority that helps individuals create an easy-to-follow quitting plan. It includes aids, guides, coaching support, and community resources to aid individuals in becoming a non-smoker.

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[1] APHA Policy Statement. Childhood Asthma a Major Public Health Problem.
[2] Oregon Health Authority. The Burden of Asthma in Oregon Executive Summary. 2013.
[3] Ibid.
[4] Behavioral Risk Factor Surveillance System, 2011–2012.
[5] Centers for Disease Control and Prevention, 2012.
[6] Behavioral Risk Factor Surveillance System, 2006–2012.
[7] Oregon Health Authority. The Burden of Asthma in Oregon Executive Summary. 2013.

Profile of Kaiser Foundation Hospital Northwest Prioritized Health Needs

ORAL HEALTH

About Oral Health

> **"Children not born in the USA do not have free dental and vision services."**
> **—Listening Session Participant**

Good oral health is essential to overall health. Strong and healthy teeth are a foundation for maintaining good health, happiness, and productivity. Poor oral health can threaten the health and healthy development of young children and compromise the health and well-being of adults. Conditions of the mouth, teeth, gums and throat, from dental caries to cancer, cause pain and disability for millions of Americans each year. Furthermore, untreated tooth decay worsens with age and can lead to poor overall general health into adulthood. Chronic oral infections have been associated with an array of other health problems, such as heart disease, diabetes, and unfavorable pregnancy outcomes.

Dental decay is preventable in early life and manageable without requiring expensive interventions. Preventing tooth decay can lower health care costs over a lifetime. In Oregon, adults and children frequently seek dental care at more expensive emergency departments, dental health is the number one reason kids visit emergency rooms in Oregon.[1]

Why Is It a Prioritized Community Health Need?

In the KFH NW Primary and Secondary service areas, there is a gap in understanding the true oral health crisis due to lack of comprehensive surveillance and monitoring. What we do know is tooth decay is a significant public health concern and causes needless pain and suffering for many children in Oregon and Washington. Very poor oral health in adults as indicated by rampant caries (6 or more) is a substantial health issue across KFH NW — especially in the three secondary service areas where there is also an up to 100% shortage of dental health professionals. The community survey, listening sessions, and meta-analysis all indicated the need for oral health care.

Key Data Points: Health Outcomes and Drivers of Oral Health

Comprehensive surveillance and monitoring of oral health does not exist in Oregon or Washington. Table 1 includes core oral health indicators from the KP CHNA Data Platform, including poor dental health in adults as indicated by self-reporting six or more removed permanent teeth, adults who have not accessed dental care in the past year, and the percentage of the population living in a dental health professional shortage area. The Secondary service areas benchmark poorly across all three indicators, while SW WA has the highest rate of poor dental

Table 1: Oral Health Indicators

	Poor Dental Health[2]	*Accessing Care — Adults with No Recent Dental Exam*[3]	*Population Living in Dental Health Professional Shortage Area*[4]
United States	**15.7%**	**30.2%**	**32.0%**
Oregon State	**13.6%**	**29.8%**	**68.0%**
Washington State	**12.0%**	**27.7%**	**34.7%**
Metro (Primary)	**9.6%**	**26.1%**	**19.*%**
SW WA	**16.8%**	**34.1%**	**70.4%**
Mid-Valley	**14.9%**	**28.1%**	**100%**
South Valley	**14.0%**	**30.2%**	**100%**

health among adults. Although this indicator is limited in that it only reports adults with six teeth that were pulled, rather than other signs of poor dental health, it does give a general indication of the need for increased dental services and care across KFH NW.

Table 2: Indicators Related to Oral Health	*Soft Drink Expenditures — % HH Budget*[5]	*Drinking Water Safety Issues*[6]	*Youth Absences Due to Tooth Pain*[7]
United States	**4.01%**	**10.2%**	**No data**
Oregon State	**4.16%**	**11.5%**	**2.6%**
Washington State	**3.75%**	**0.3%**	**No data**
Metro (Primary)	**4.01%**	**19.8%**	**2.5%**
SW WA	**4.08%**	**2.2%**	**No data**
Mid-Valley	**4.12%**	**3.4%**	**3.0%**
South Valley	**4.34%**	**1.5%**	**2.2%**

Indicators related to oral health include soft drink expenditures, as the consumption of sugar-sweetened beverages is related to poor dental health, and drinking water safety. Reported as a percentage of adults who gets water from public systems with at least one health-based violation, safe drinking water allows individuals to safely and affordably meet their daily fluid intake needs and may reduce consumption of sugar sweetened beverages related to obesity and oral health. A third indicator, only reported in the Oregon Healthy Teen Survey, reports the percentage of eighth-grade students reporting mouth and tooth pain as causing at least one absence from school. (see Table 2)

A major environmental risk factor for oral health in KFH NW is a lack of community fluoridated water. While studies have shown that fluoride prevents tooth decay throughout the lifespan and that fluoridated water is an effective preventive public health measure, only 22.6% of the population in Oregon and 63.6% of Washington receives the benefits of fluoridated water.[8] Much of the public water supply in the most populated part of KFH NW, the primary Metro service area, is not fluoridated. As a benchmark, the Healthy People 2020 community water fluoridation objective is 79.6% of the population have the benefit of optimally fluoridated water.[9] Without broad public health measures in place, oral health will continue to be a need in KFH NW.

Key Data Points: Health Inequities

Figure 1: Adults with Poor Dental Health, % by Race and Ethnicity

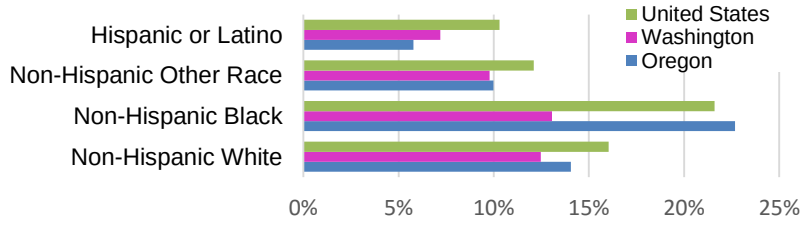
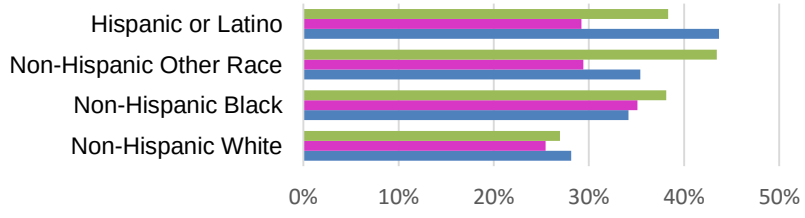


Figure 2: Adults w/o Recent Dental Exam, % by Race and Ethnicity



Given the lack of monitoring and tracking data of oral health outcomes, there are no reportable indicators of oral health by race and ethnicity at a sub-state geography. However, the inequitable impacts of poor oral health on communities of color are reported at the state level in the KP Platform as well as in local data sources such as Smile Surveys, giving some insight into possible trends occurring at the local level. Figures 1 and 2 indicate poor dental health by race and ethnicity in Oregon and Washington. High rates of poor dental health are seen in the non-Hispanic black population in Oregon and Washington as compared to other racial and ethnic groups. While rates appear low in the Hispanic population,

that may be due to the fact that there are such high rates of Hispanic or Latinos who have not had recent dental exams, indicating that there are potential barriers to accessing dental health care for this population.

The Smile Surveys conducted in Washington (2010)[10] and Oregon (2012)[11] give additional insight to the oral health need in KFH NW. Findings from the Oregon survey stated that children from lower-income households had substantially higher cavity rates compared to children from higher-income households (63% vs. 38%), almost twice the rate of untreated decay (25% vs 13%), and more than twice the rate of rampant decay (19% vs. 8%). Hispanic/Latino children experienced particularly high rates of cavities, untreated decay, and rampant decay compared to white children. Black children had substantially higher rates of untreated decay compared to white children. Similar findings are reported in Washington, where children from low-income families, Hispanic families, and families who spoke another language at home were more likely to have more decay experience, rampant decay, and treatment needs than higher income and white, non-Hispanic children and children from English speaking households.

Community Voices and Input

Lack of access to physical, mental, and/or oral health care was among the top five survey responses in the primary Metro service area, indicating a community need for access to care. Dental health services and access to dental health care was a top coded theme in the community meta-analysis. Although not mentioned as frequently in the community listening sessions, access to dental services was identified as a strength of a healthy community by the Latino population during listening sessions.

> **"The dentist is very expensive."**
>
> **—Listening Session Participant**

Community Assets

Creston Children's Dental Clinic

The Creston Children's Dental Clinic is one of the few places in Portland where large numbers of low-income children can receive regular, high quality dental care in a clinic setting. Patients receive comprehensive dental care including 6-9 month exams, sealants, fluoride varnish applications, x-rays, dental supply kits, and more.

Oregon Oral Health Coalition

The Oregon Oral Health Coalition works to create connections, pool resources, and maximize the benefits of the oral health care industry for the optimal oral health of all Oregonians.

Oregon Health Authority: School-based Oral Health Program

The Oral Health Program manages two school-based oral health programs that are free for eligible schools, the School Fluoride Program and the School-based Dental Sealant Program. Both programs provide effective ways to reduce cavities and improve youth dental health.

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[1] Upstream Public Health. Dental Health, Web, 2016.
[2] Behavioral Risk Factor Surveillance System, 2006–2010.
[3] Ibid.
[4] U.S. Department of Health and Human Services, 2015.
[5] Nielsen Site Reports, 2014.
[6] County Health Rankings, 2012–2013.
[7] OR: Healthy Teen Survey, 8th grade, 2013. Worst County reported in service area.
[8] http://www.cdc.gov/fluoridation/statistics/2012stats.htm
[9] https://www.healthypeople.gov/2020/topics-objectives/topic/oral-health/objectives
[10] Washington Smile Survey, 2010. Web.
[11] Oregon Smile Survey, 2012. Web.

SEXUALLY TRANSMITTED INFECTIONS

About Sexually Transmitted Infections

For the purpose of this CHNA, sexually transmitted infections (STIs) encompasses HIV, AIDS, and other sexually transmitted infections. Sexually transmitted infections are often the result of risky sexual behavior and have lasting effects on health and well-being, especially for adolescents. High-risk sexual practices such as unsafe sex and higher numbers of lifetime sexual partners can lead to sexually transmitted infections and unplanned pregnancies, which can affect immediate and long-term health as well as the economic and social well-being of individuals, families, and communities. Risky sexual behaviors can have high economic costs for communities and individuals. [1]

"No access to free contraceptives [is a problem]. Sexual education programs should be institutionalized in schools."

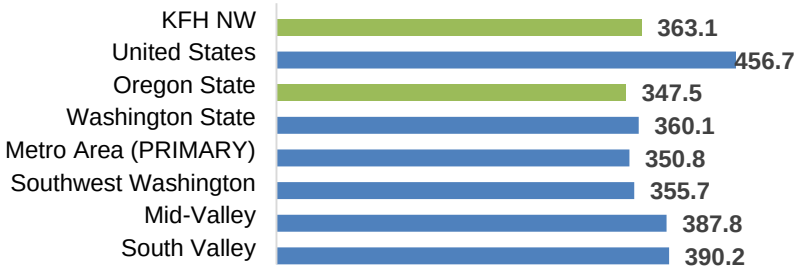
—Listening Session Participant

Why Is It a Prioritized Community Health Need?

In Washington[2] and Oregon[3], sexually transmitted infections are the most frequently reported infections and account for more than 87% of notifiable diseases or conditions in Washington and almost two-thirds of reportable diseases in Oregon. Chlamydia is the most frequently reported STI in both states and nationally and is trending upwards. Community input indicated a need for access to contraceptives and comprehensive sexual education for youth.

Key Data Points: Health Outcomes and Drivers of Sexually Transmitted Infections

Figure 1: Chlamydia Infection Rate (per 100,000)



Infection (incidence) and prevalence rates are key indicators of the burden of sexually transmitted infections in a community and of the rate at which the burden is increasing. Chlamydia, the most frequently reported STI, has an incidence rate[4] in KFH NW that is better than the nation but above the state that performs best in the region, Oregon. Highest rates are seen in the secondary service area, although the primary Metro service area has higher incidence than Oregon as a whole. (Figure 1) HIV Prevalence rates, the burden of the disease in the KFH NW community, is low as compared to the nation, but higher than the Oregon.[5] The highest rates are seen in the primary Metro service area. (Figure 2) Related indicators to sexually transmitted infections include screening rates such as

HIV screenings and Pap test screenings. Such health screenings are relevant because engaging in preventive behaviors allows for early detection and treatment of health problems. Teen births, another indicator related to sexually transmitted infections, are associated with unsafe sexual activity.[6] Evidence suggests teen pregnancy significantly increases the risk of repeat pregnancy and of contracting STIs. (See Table 1)

Figure 2: HIV Prevalence Rate (per 100,000)

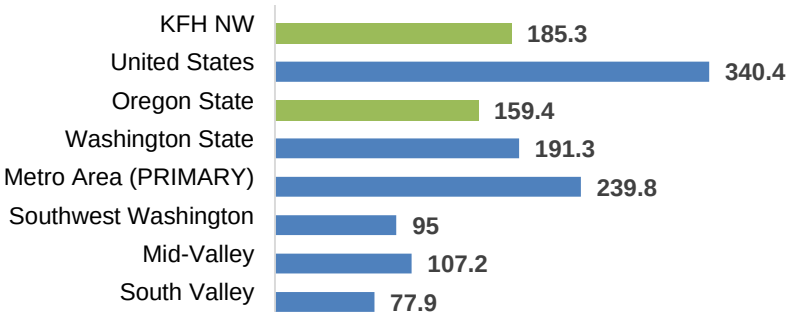


Table 1: Indicators Related to STIs

	Screening: HIV (% Adults Never Screened)[7]	*Screening: Pap Test (Women 18+)*[8]	*Teen Birth Rate (per 1,000 Females Age 15–19)*[9]
United States	**62.8%**	**78.5%**	**36.6**
Oregon State	**65.6%**	**73.6%**	**30.8**
Washington State	**63.7%**	**75.4%**	**29.2**
Metro (Primary)	**63.4%**	**77.1%**	**26.0**
SW WA	**56.0%**	**70.9%**	**38.2**
Mid-Valley	**68.3%**	**73.5%**	**39.6**
South Valley	**66.5%**	**71.2%**	**22.5**

Key Data Points: Health Inequities

Data to illustrate the racial and ethnic inequities in sexually transmitted infections were not available for this CHNA at the geographic level of service area. However, state-level chlamydia incidence rate data for Oregon and Washington were available, and can indicate trends that are likely present in the smaller service areas as well. (Figure 3) County-level data in the primary Metro service area were available by race and ethnicity for HIV prevalence. Non-Hispanic blacks suffer the highest rates of sexually transmitted infections in the data available, sometimes at substantially higher rates than their White counterparts. (see Figure 4)

Figure 3: Chlamydia Incidence Rate by Race/Ethnicity (per 100,000)

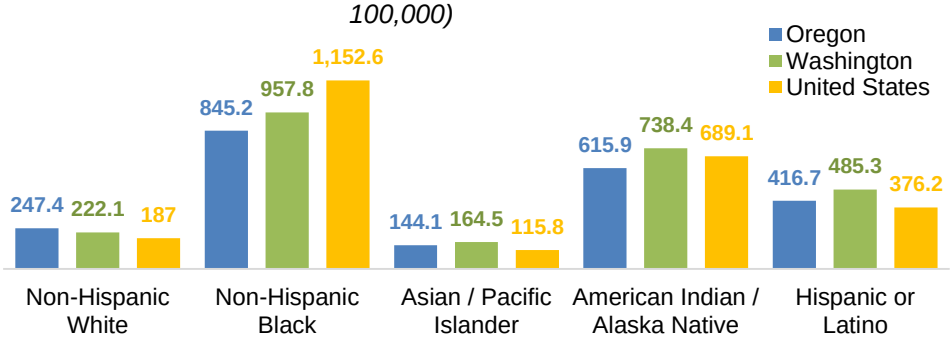
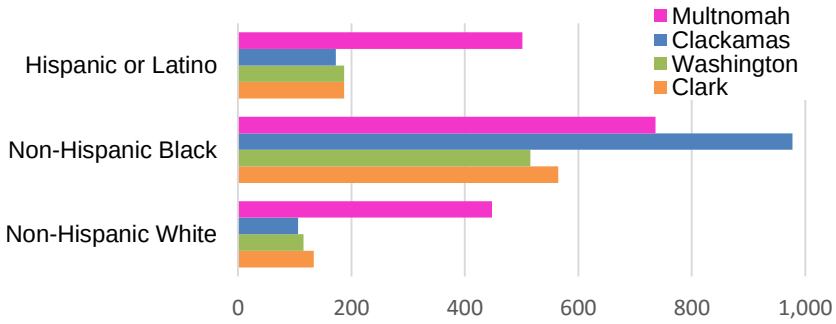


Figure 4: HIV Prevalence, Rate per 100,000 by Race/Ethnicity



Community Voices and Input

Not using birth control and risky sexual behavior including unsafe sex were identified by the young adult population as a top risky community behavior in the Healthy Columbia Willamette Survey of the primary Metro service area community. While sexually transmitted infections were not a theme from the listening sessions (potentially given the private nature and stigma around such issues), access to comprehensive health care including preventive care was a theme. The meta-analysis identified sexually transmitted infections as a top community health need in the Native American population.

Assets and Opportunities

There are many assets in KFH NW working on needs and issues related to sexually transmitted infections and overall sexual health. A few are listed below, for a complete listing of assets identified in the KFH NW CHNA, see Appendix G.

Q Center | LGBTQ Community Center

The Q Center provides a safe space to support and celebrate LGBTQ diversity, equity, visibility and community building. One of its four core areas includes Health and Wellness with programming for addiction support and recovery, healthy relationships classes, and HIV and STI testing and family planning.

Planned Parenthood Columbia Willamette

Planned Parenthood Columbia Willamette (PPCW) is the largest nonprofit family planning and reproductive rights organization in Oregon and Southwest Washington. PPCW provides a wide range of education programs and health care services, including low-cost birth control, emergency contraception, cancer screenings, STI testing and treatment.

Outside In

Outside In is a Federally Qualified Health Center and a licensed Mental Health Agency that works with homeless youth and other marginalized people to move towards improved health and self-sufficiency. Services offered include HIV/STI testing and counseling and a syringe exchange.

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[1] County Health Rankings. Our Approach. Web. 2016.
[2] Washington Department of Health. Sexually Transmitted Infections Fast Facts. Web. 2014.
[3] Oregon Health Authority. Sexually Transmitted Disease. Web. 2016.
[4] Centers for Disease Control and Prevention, 2012.
[5] Centers for Disease Control and Prevention, 2010.
[6] County Health Rankings. Our Approach. Web, 2016.
[7] Behavioral Risk Factor Surveillance System, 2011–2012.
[8] Behavioral Risk Factor Surveillance System, 2006–2012.
[9] Centers for Disease Control and Prevention, 2006–2012.

CLIMATE AND HEALTH

About Climate and Health

Human health has always been influenced by climate and weather. Changes in climate and climate variability, particularly changes in weather extremes, affect the environment and threatens our access to clean air, clean water, food, and shelter. This affects access to the most basic needs for human survival. With climate change, the frequency, severity, duration, and location of weather and climate phenomena — like rising temperatures, heavy rains and droughts, wildfires and more are changing. Areas already experiencing health-threatening weather and climate phenomena, such as severe heat or hurricanes, are likely to experience worsening impacts, and some areas will experience new climate-related health threats. Climate change can affect human health in two main ways: first, by changing the severity or frequency of health problems that are already affected by climate or weather factors; and second, by creating unprecedented or unanticipated health problems or health threats in places where they have not previously occurred."[1]

Climate already threatens human health in Oregon and Southwest Washington. The Pacific Northwest is experiencing increased wildfires that start earlier in the spring, last later into the fall, and burn more acreage. Risks of increased storms and flooding in the winter and spring come alongside the potential for increased heat waves and drought in the summer. By limiting greenhouse gas emissions and adapting communities to be more resilient, climate action can result in unprecedented, concrete and rapid improvements to public health. [2]

Why Is It a Prioritized Community Health Need?

According to the Oregon Health Authority Climate and Health Program, summers in Oregon are getting hotter and drier, more precipitation will fall as rain rather than snow increasing the risk of floods and landslides, and Oregon is likely to experience more extreme events like heat waves, wildfires, and storms. The Washington governor has made climate change one of the state's top priorities, recognizing the public health threats to the state given that the economy and quality of life of Washingtonians are very connected to natural resources.

Climate change could increase and worsen chronic diseases such as asthma and mental health issues such as depression and anxiety. Drought in Oregon or elsewhere could increase food insecurity, especially among vulnerable populations. Hospitalizations increase during extreme heat events, and the Pacific Northwest does not have a history of dealing with extreme heat in residences and commercial areas. Increased particulate matter in the air from greenhouse gas emissions and industrial pollution increases cardiovascular disease mortality risk and rates of emergency room visits for asthma related events.

Key Data Points: Health Outcomes and Drivers of Climate and Health

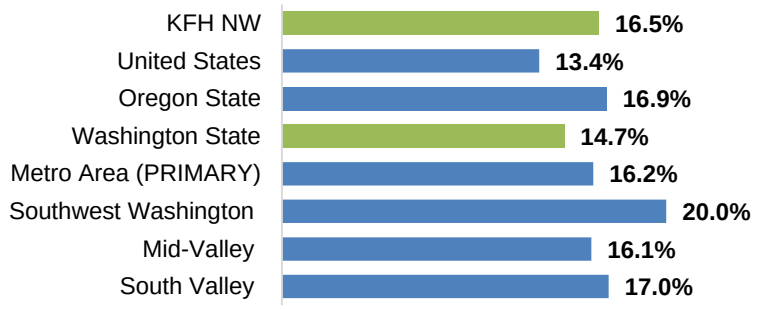
While Climate and Health received the fewest prioritization criteria points, there is still reason to include it as a prioritized need for KFH NW. Air quality in the Metro area is poor, with high levels of particulate matter 2.5 seen across the Primary and Secondary areas. Table 1 shows the percentage of days exceeding air quality standards. Drought severity is another relevant

indicator to climate and health because it highlights areas vulnerable to the effects of drought as it relates to the health impacts of decreased air, water, and food system quality. Table 1 shows the percentage of weeks in drought from the beginning of the year 2012 through the end of 2014. Drought includes any severity in this case, although KFH NW did not experience "extreme" or "exceptional" drought during this time period ("abnormally dry" through "severe" drought make up the percentages shown in the table). Drought severity is highest in the Mid- and South Valley Secondary areas.

Table 1: Climate and Health Indicators

	Air Quality: Particulate Matter 2.5[3]	*Drought Severity*[4]
United States	**0.10%**	**45.9%**
Oregon State	**0.18%**	**44.1%**
Washington State	**0.05%**	**19.0%**
Metro (Primary)	**1.62%**	**31.4%**
SW WA	**0.59%**	**28.7%**
Mid-Valley	**1.66%**	**38.8%**
South Valley	**1.54%**	**45.8%**

Figure 1: Asthma Prevalence (Adult)



Asthma is a chronic condition that is affected by climate change. Adult asthma rates in KFH NW already benchmark poorly to the better state average (WA) and the nation (see Figure 1), and it is the most diagnosed chronic disease in the youth Medicaid (low income) population. See the *KFH NW Asthma Health Need Profile* for more information. Other chronic conditions that climate change is likely to worsen are included in the *KFH NW Chronic Disease Health Need Profile*. Behavioral Health, including poor mental health, is likely to worsen as well with climate change. See the *KFH NW Behavioral Health Need Profile* for more information.

Key Data Points: Health Inequities

According to the American Public Health Association (APHA), vulnerable populations such as communities of color, the elderly, young children, the poor, and those with chronic illnesses bear the greatest burden of disease, injury, and death related to climate change.[5] Chronic conditions likely to be affected by climate and health already have inequities in prevalence and mortality (see other KFH NW Health Need Profiles), inequities that could worsen if climate change and resiliency planning is not focused on the most vulnerable communities in KFH NW.

Community Voices and Input

Climate related concerns were not identified by the KFH NW community in listening sessions, the survey, or the meta-analysis of community assessments and projects. The survey did not directly allow for this particular need to be selected, the closest option that may have indicated concern about climate and health was "dirty environment" which may have different meanings and interpretations for individuals completing the survey. Climate change and its impact on health is only recently gaining bandwidth in broader circles, and only recently gaining traction in state and local health departments. Although climate and health was not identified in the community input process as a need, Oregon and Washington statewide planning priorities and local jurisdictional climate action plans indicate that this health need should remain on the radar in KFH NW.

Assets and Opportunities

There are many adaptation and mitigations planning efforts under way in both Oregon and Washington to prepare for the changing climate. One such program is outlined below along with two Portland-based nonprofits working to foster climate resiliency. For a full list of assets in KFH NW, see Appendix G.

State of Oregon Climate and Health Program

Together with local health jurisdictions, state agencies, and nonprofit partners, the Oregon Climate and Health Program is identifying the state's most vulnerable populations and developing strategies that build community resilience across Oregon. The website includes resources such as a resilience planning toolkit and climate and health training materials.

Depave

Depave is a nonprofit organization based in Portland, Oregon that promotes the removal of unnecessary pavement from urban areas to create community green spaces and mitigate storm water runoff. Through community partnerships and volunteer engagement, Depave strives to overcome the social and environmental impacts of pavement to reconnect people with nature and inspire others.

Ecotrust

Ecotrust works to foster a natural model of development that creates more resilient communities, economies, and ecosystems here in the Northwest and around the world. They work in systems that are significant to overall well-being, including in oceans and fisheries, climate and energy, water and watersheds, and food and farms.

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[1] USGCRP, 2016. *The Impacts of Climate Change on Human Health in the United States: a Scientific Assessment.* Web.
[2] Ibid.
[3] Centers for Disease Control and Prevention, 2012.
[4] US Drought Monitor. 2012-14.
[5] APHA. Climate Change Topics and Issues. Web. 2016.

APPENDIX G: COMMUNITY ASSETS DIRECTORY

	Primary Health Need														Service Area	
	KEY DRIVERS	Access to Care	Asthma	Cancers	Climate and Health	CVD/Stroke	Economic Security	HIV/AIDS/STD	Maternal and Infant Health	Mental Health	Obesity/HEAL/Diabetes	Oral Health	Substance Abuse/Tobacco	Violence/Injury Prevention	Primary	Secondary
Federally Qualified Health Centers (FQHC) *see below for SBHC*																
Central City Concern (11 sites)	X	X							X	X	X	X	X		X	
Clackamas County Community Health Division (7 sites)	X	X								X		X	X		X	
Community Health Centers of Benton and Linn Counties (5 sites)	X	X							X	X		X	X			X
Community Health Centers of Lane County (4 Sites)	X	X							X	X	X	X				X
Cowlitz Family Health Center (5 Sites)	X	X							X	X	X	X				X
Multnomah County Health Department (7 sites)	X	X						X	X	X	X	X	X		X	
Native American Rehabilitation Association of the Northwest (NARA NW) (4 sites)	X	X						X	X	X	X	X	X		X	
Neighborhood Health Center (6 sites)	X	X							X	X	X	X			X	
Northwest Human Services, Inc. (4 sites)	X	X							X	X		X	X			X
OHSU Family Medicine at Richmond Clinic (1 site)	X	X						X	X	X		X	X		X	
Outside In (2 sites)	X	X						X	X	X		X			X	
Sea Mar Community Health Centers (5 sites)	X	X							X	X	X	X			X	
Virginia Garcia Memorial Health Center (9 sites)	X	X							X	X		X			X	X
The Wallace Medical Concern (2 sites, 1 mobile clinic)	X	X								X	X	X			X	
White Bird Clinic (4 sites)	X	X								X		X	X			X
Yakima Valley Farm Workers Clinic (3 sites)	X	X								X		X			X	X
Community Supported Clinics (CSC)																
Battle Ground HealthCare		X													X	
Children's Community Clinic		X													X	
Clackamas Volunteers in Medicine (The Founders Clinic)		X													X	X
Cowlitz Free Medical Clinic		X														X
Creston Children's Dental Clinic		X										X			X	
Free Clinic of SW Washington		X													X	
Health Centers of University of Western States (alternative)		X													X	
Mercy & Wisdom Healing Center (alternative)		X													X	
National College of Natural Medicine (alternative)		X													X	
New Day Community Dental Clinic		X										X			X	
New Heights Clinic		X													X	
North by Northeast Clinic		X													X	
Oregon College of Oriental Mediciane		X													X	
Portland Adventist Community Services (PACS) Family Health Center		X													X	
Quest Center for Integrative Health		X													X	
Salem Free Clinics (4 sites)		X														X
Southwest Community Health Center (2 sites)		X													X	
Springfield Volunteers in Medicine		X														X
Coordinated Care Organization / Accountable Communities of Health (CCO/ACH)																
Columbia Pacific CCO		X								X		X				X
Family Care, Inc.		X								X		X			X	
Health Share of Oregon		X								X		X			X	
Intercommunity Health Network CCO		X								X		X				X
NW Regional Health Alliance		X								X		X				X
Trillium Community Health Plan		X								X		X				X
Willamette Valley Community Health, LLC		X								X		X				X
Yamhill CCO		X								X		X				X
Rural Health																
Canby Health Care Clinic LLC		X													X	
Legacy Clinic St. Helens		X														X
Legacy Medical Group - Firwood		X													X	
Mckenzie River Clinic		X														X
Mt. Angel Family Medicine		X														X

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NorthShore Medical Group		X														X
OHSU Family Medicine at Scappoose		X														X
Orchid Health		X														X
PeaceHealth Medical Group - Dexter		X														X
Vernonia Health Center		X														X
Woodburn Family Medicine		X														X
Woodburn Internal Medicine		X														X
Woodburn Pediatric Medicine		X														X
Tribal Health																
Chemawa Indian Health Center		X														X
Coos, Lower Umpqua and Siuslaw Tribes Clinic		X														X
Cowlitz Indian Tribal Health Clinic		X							X						X	X
Grande Ronde Health and Wellness Center		X														X
Health Systems and Hospitals																
Adventist Medical Center		X													X	
Doernbecher Children's Hospital		X													X	
Legacy Health		X													X	X
McKenzie-Willamette Medical Center		X														X
Oregon Health and Sciences University		X													X	X
PeaceHealth		X													X	X
Providence Health and Services		X													X	X
Samaritan Health Services		X													X	X
Shriner's Hospitals for Children		X													X	
Tuality Healthcare		X													X	
Veterans Affairs Health Care System		X													X	X
School Based Health Centers																
Benson Tech SBHC	X	X								X		X	X		X	
Bethel Health Center (Cascade Middle)	X	X								X		X	X			X
Canby High SBHC	X	X								X		X	X		X	
Centennial SBHC	X	X								X		X	X		X	
Century High SBHC	X	X								X		X	X		X	
Cesar Chavez K-8 SBHC	X	X								X		X	X		X	
Churchill High SBHC	X	X								X		X	X			X
Cleveland High SBHC	X	X								X		X	X		X	
David Douglas High SBHC	X	X								X		X	X		X	
Forest Grove High SBHC	X	X								X		X	X		X	
Franklin High SBHC	X	X								X		X	X		X	
George Middle SBHC	X	X								X		X	X		X	
Grant High SCBHC	X	X								X		X	X		X	
Harrison Park K-8 SBHC	X	X								X		X	X		X	
Jefferson High SBHC	X	X								X		X	X		X	
Lane Middle SBHC	X	X								X		X	X		X	
Lincoln Health Center	X	X								X		X	X			X
Lincoln Park Elementary SBHC	X	X								X		X	X		X	
Madison High SBHC	X	X								X		X	X		X	
Marshall High SBHC	X	X								X		X	X		X	
Merlo Station High SBHC	X	X								X		X	X		X	
Milwaukie High SBHC	X	X								X		X	X		X	
Monroe SBHC	X	X								X		X	X			X
North Eugene High SBHC	X	X								X		X	X			X
Oregon City High SBHC	X	X								X		X	X		X	
Parkrose High SBHC	X	X								X		X	X		X	
Portsmouth Middle SBHC	X	X								X		X	X		X	
Roosevelt High SBHC	X	X								X		X	X		X	

	Primary Health Need														Service Area	
	KEY DRIVERS	Access to Care	Asthma	Cancers	Climate and Health	CVD/Stroke	Economic Security	HIV/AIDS/STD	Maternal and Infant Health	Mental Health	Obesity/HEAL/Diabetes	Oral Health	Substance Abuse/Tobacco	Violence/Injury Prevention	Primary	Secondary
Sandy High SBHC	X	X								X		X	X		X	
Springfield High SBHC	X	X								X		X	X			X
Tigard High SBHC	X	X								X		X	X		X	
Wade Creek Clinic	X	X								X		X	X			X
Willamina High SBHC	X	X								X		X	X			X
Community Based Organizations / Non-Profits																
211 Info.	X														X	X
Adalante Mujeres							X				X				X	
Albertina Kerr										X					X	
Alliance for a Healthier Generation	X										X				X	X
American Red Cross					X										X	X
ARC Lane County							X									X
Asian Family Center															X	
Asian Health and Service Center		X									X				X	
Asian Pacific American Network of Oregon							X								X	X
Bicycle Transportation Alliance											X				X	
Big Brothers Big Sisters Columbia Northwest	X														X	X
Black Parent Initiative	X								X						X	
Blanchet House of Hospitality							X								X	
Boys and Girls Clubs															X	X
Bradley Angle									X					X	X	
Bridge Meadows							X		X						X	
CAPACES Leadership Institute	X						X									X
Care Oregon		X							X						X	X
Caring Hand to Mouth												X				X
Oregon CASA									X						X	X
Casa Latinos Unidos de Benton County							X									X
Cascade AIDS Project								X							X	
Cascade Health Solutions		X														X
Cascadia Behavioral Healthcare		X								X			X		X	
Catholic Community Services	X									X					X	X
CDM Caregiving Services		X													X	X
Center for Community Counseling										X						X
Center for Dialogue and Resolution														X		X
Center for Intercultural Organizing															X	
Centro Cultural de Washington County	X						X								X	
Centro Latino Americano								X		X						X
Children's Cancer Association				X											X	
Childrens Community Resources		X							X							X
Community Action							X		X						X	
Community Cycling Center							X				X				X	
Community Home Health and Hospice		X													X	X
Community House on Broadway							X									X
Community Services Northwest							X			X			X		X	
Compassion Connect	X														X	
Comprehensive Options for Drug Abusers, Inc (CODA)													X		X	
Depave					X										X	
Domestic Violence Resource Center														X	X	
Ecotrust					X						X				X	
Ecumenical Ministries of Oregon (and member oragnizations)											X				X	X
El Programa Hispano							X		X	X				X	X	
Elders in Action							X								X	
Exceed Enterprises, Inc.							X								X	
Family Building Blocks		X							X							X

	Primary Health Need														Service Area	
	KEY DRIVERS	Access to Care	Asthma	Cancers	Climate and Health	CVD/Stroke	Economic Security	HIV/AIDS/STD	Maternal and Infant Health	Mental Health	Obesity/HEAL/Diabetes	Oral Health	Substance Abuse/Tobacco	Violence/Injury Prevention	Primary	Secondary
Family Forward Oregon							X		X						X	X
Farmer's Market Fund											X				X	X
FolkTime										X					X	
FOOD for Lane County	X										X					X
Friends of Zenger Farm					X		X				X				X	
Gales Creek Camp Foundation											X				X	
Girls Inc							X								X	
Goodwill Industries- several							X								X	X
Growing Gardens											X				X	
Guide Dogs for the Blind							X								X	
Habitat for Humanity							X								X	X
Healthy Moves											X					X
Hispanic Metropolitan Chamber							X								X	
HIV Alliance								X								X
Housing Independence	X						X								X	
Huerto de la Familia	X						X				X					X
Human Services Council		X													X	X
Human Solutions	X						X								X	
I Have a Dream Foundation Oregon	X														X	
Immigrant and Refugee Community Organization	X	X					X								X	
Impact Northwest							X								X	
Incight	X						X								X	
Innovative Changes (IC$)	X						X								X	
Innovative Services NW							X								X	
International Center for Traditional Childbirth									X						X	
Janus Youth Programs, Inc.											X				X	
Latino Business Alliance	X						X									X
La Leche League									X						X	
Latino Network	X						X							X	X	
Leukemia and Lymphoma Society				X											X	X
Lifeline Connections		X								X			X		X	
Lifeworks NW										X			X		X	
Lower Columbia School Gardens											X					X
Marion Polk Food Share	X										X					X
Meals on Wheels	X										X				X	X
Medical Foundation of Marion and Polk Counties		X														X
Metropolitan Family Service	X						X								X	
Micro Enterprise Services of Oregon (MESO)	X						X								X	
Multicultural Integrated Kidney Education (MIKE)	X														X	
Muslim Educational Trust	X														X	
National Association for the Advancement of Colored People (NAACP)	X														X	X
National Alliance on Mental Illness (NAMI), Oregon chapters										X					X	X
Native American Youth and Family Center (NAYA)	X	X					X								X	
Neighborhood House, Inc.							X								X	
Neighbors for Clean Air			X	X	X										X	
Northwest Down Syndrome Association		X													X	
Northwest Family Services															X	
Northwest Housing Alternatives							X								X	X
Northwest Youth Corps							X									X
OneAmerica	X															X
Open Meadow Alternative School	X														X	
Oregon School-Based Health Alliance		X													X	X
Ophelia's Place									X	X						X
Oregon Children's Foundation / SMART	X						X								X	X

	Primary Health Need														Service Area	
	KEY DRIVERS	Access to Care	Asthma	Cancers	Climate and Health	CVD/Stroke	Economic Security	HIV/AIDS/STD	Maternal and Infant Health	Mental Health	Obesity/HEAL/Diabetes	Oral Health	Substance Abuse/Tobacco	Violence/Injury Prevention	Primary	Secondary
Oregon Children's Theatre										X	X	X			X	X
Oregon Community Health Worker Association															X	X
Oregon Food Bank and partner food pantries															X	X
Oregon Foundation for Reproductive Health									X						X	X
Oregon Primary Care Association		X													X	X
Oregon Public Health Institute	X														X	X
Oregon Walks											X				X	
Organizing People Activating Leaders (OPAL)															X	
Our House of Portland								X							X	
Pathfinders of Oregon	X	X								X			X	X	X	
Parenting Now!									X							X
Partners for a Hunger-Free Oregon											X				X	X
Pathways 2020											X					X
Physicians for Social Responsibility					X										X	X
Planned Parenthood		X						X	X						X	X
Playworks											X				X	X
Project Access Now		X													X	
Public Health Foundation of Columbia County		X														X
Q Center | LGBTQ Community Center		X						X		X			X		X	
REAP, Inc.	X														X	
Regional Arts and Cultural Council	X														X	
Relief Nursery									X	X			X	X		X
Rosewood Initiative															X	
Safe Routes to School											X				X	X
Salem Keizer Education Foundation											X					X
Salvation Army							X								X	X
Schools Uniting Neighborhoods (SUN) Community Schools (81 total)	X						X								X	
School Garden Project of Lane County											X					X
Self-Enhancement Inc.	X														X	
Sexual Assault Support Services														X		X
Share	X						X								X	
Shelter Care							X									X
Slavic Community Center															X	
SnowCap Community Charities							X								X	
Southwest Washington Center of the Deaf and Hard of Hearing		X					X								X	
St. Vincent de Paul							X								X	X
State of Oregon Office of Multicultural Health															X	X
Store to Door											X				X	
Sunshine Division	X						X								X	
Susan G Komen OR and SW WA				X											X	X
Transition Projects							X								X	
Upstream Public Health	X						X				X	X			X	X
Urban League of Portland															X	
Verde															X	
Vision Action Network	X														X	
Volunteers of America		X								X					X	X
Western States Center	X						X								X	X
Willamette Family Inc.		X								X			X			X
Womenspace										X				X		X
YMCA - several											X				X	X
Coalitions and Collaboratives																
African American Health Coalition											X				X	
Alliance for Healthy Families											X					X
Coalition of Communities of Color	X						X								X	

	Primary Health Need														Service Area	
	KEY DRIVERS	Access to Care	Asthma	Cancers	Climate and Health	CVD/Stroke	Economic Security	HIV/AIDS/STD	Maternal and Infant Health	Mental Health	Obesity/HEAL/Diabetes	Oral Health	Substance Abuse/Tobacco	Violence/Injury Prevention	Primary	Secondary
Coalition of Community Health Clinics		X													X	
Cowlitz on the Move											X					X
Devolopmental Origins Strategy Collaborative							X		X						X	
East County Caring Community	X						X								X	
Healthy Kids Learn Better Statewide Coalition	X									X	X				X	X
Healthy Living Collaborative of Southwest Washington											X				X	X
Lane Coalition for Healthy Active Youth											X					X
Lane Senior Support Coalition							X									X
Oregon Community Food Systems Network	X						X				X				X	X
Oregon Farm to School Coalition											X				X	X
Oregon Health and Housing Collaborative							X								X	
Oregon Health Equity Alliance	X	X					X								X	
Oregon Latino Health Coalition	X	X													X	X
Oregon Oral Health Coalition												X			X	X
Oregon Perinatal Collaborative									X						X	X
Salem Keizer Coalition for Equality							X									X
Willamette Farm and Food Coalition							X				X					X
Local and Regional Funders																
Black United Fund of Oregon																
Collins Foundation																
Ford Family Foundation																
Gray Family Foundation																
The Lazar Foundation																
Meyer Memorial Trust																
Nike Foundation																
Northwest Health Foundation																
Oregon Community Foundation																
Social Justice Fund Northwest																
Social Venture Partners Portland																
Spirit Mountain Community Fund																
United Way																
Community Development Corporations																
Hacienda CDC							X								X	
Americans Building Community							X								X	
Housing Development Corporation of Northwest Oregon							X								X	
Neighborhood Economic Development Corporation (NEDCO)							X									X
Portland Community Reinvestment Initiatives (PCRI)							X								X	
REACH Community Development							X								X	
Rose CDC							X								X	
Local / Regional Government / Jurisdictions																
Metro															X	
Mid-Willamette Valley Council of Governments																X
Oregon Cascades West Council of Governments																X
Lane Council of Governments																X
Cowlitz Wahkiakum Council of Governments																X
City Government: 46 incorporated cities in Primary Service Area															X	
City Government: 81 incorporated cities in Secondary Service Area																X
County Health Departments of: 14 total															X	X
Benton County Health Department																X
Clackamas County Public Health Division															X	
Clark County Public Health															X	
The Public Health Foundation of Columbia County																X
Cowlitz County Health and Human Services																X
Lane County Public Health																X

	Primary Health Need														Service Area	
	KEY DRIVERS	Access to Care	Asthma	Cancers	Climate and Health	CVD/Stroke	Economic Security	HIV/AIDS/STD	Maternal and Infant Health	Mental Health	Obesity/HEAL/Diabetes	Oral Health	Substance Abuse/Tobacco	Violence/Injury Prevention	Primary	Secondary
Linn County Health Department																X
Marion County Health Department																X
Multnomah County Health Department															X	
Polk County Public Health																X
Skamania County Public Health																X
Wahkiakum County Health and Human Services																X
Washington County Public Health															X	
Yamhill County Health and Human Services																X
Local Parks and Recreation Departments															X	X
WorkSource Oregon and partners															X	X
County and City Public Libraries															X	X
Public Education Institutions																
School Districts: 108 across KPNW	X						X								X	X
Community College Systems: 8 across KPNW	X						X								X	X
Clark and Lower Columbia CC (WA)	X						X								X	X
Portland, Mt. Hood, Chemeketa, Linn-Benton, Lane, and Clackamas CCs (OR)	X						X								X	X
Public Higher Education - 4 year Universities: 5 across KPNW	X						X								X	X
Washington State University - Vancouver Campus (WA)	X						X								X	X
Oregon State U., Portland State U., University of Oregon, Western Oregon U. (OR)	X						X								X	X
Oregon Head Start Association ~169 total programs across KPNW	X						X								X	X
Educational Service Districts, 7 total across KPNW:	X						X								X	X
ESD 112 (WA)	X						X								X	X
Northwest, Multnomah, Clackamas, Lane, Linn Benton Lincoln, Willamette ESD (OR)	X						X								X	X