2019 Community Health Needs Assessment

Kaiser Foundation Hospital: Sunnyside and Westside

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Approved by Kaiser Foundation Hospitals Board of Director's Community Health Committee

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KAISER PERMANENTE®

Kaiser Permanente Northwest Region Community Benefit

CHNA Report for KFH Sunnyside and KFH Westside

Contents

I. Introduction/background

A. About Kaiser Permanente (KP)

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. 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 12 million members in nine 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.

B. About Kaiser Permanente Community Health

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. Good health for the entire community requires equity and social and economic well-being. These are the vital signs of healthy communities.

Better health outcomes begin where health starts, in our communities. 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. Our community health strategy focuses on three areas:

- Ensuring health access by providing individuals served at KP or by our safety net partners with integrated clinical and social services;

- Improving conditions for health and equity by engaging members, communities, and Kaiser Permanente's workforce and assets; and
- Advancing the future of community health by innovating with technology and social solutions.

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.

C. 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 https://www.kp.org/chna.

D. 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 120 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 constitutes a health need in their community. Once all the community health needs were identified, they were 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 Sunnyside and KFH Westside will develop an implementation strategy for the priority health needs the hospital 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, https://www.kp.org/chna.

II. Community served

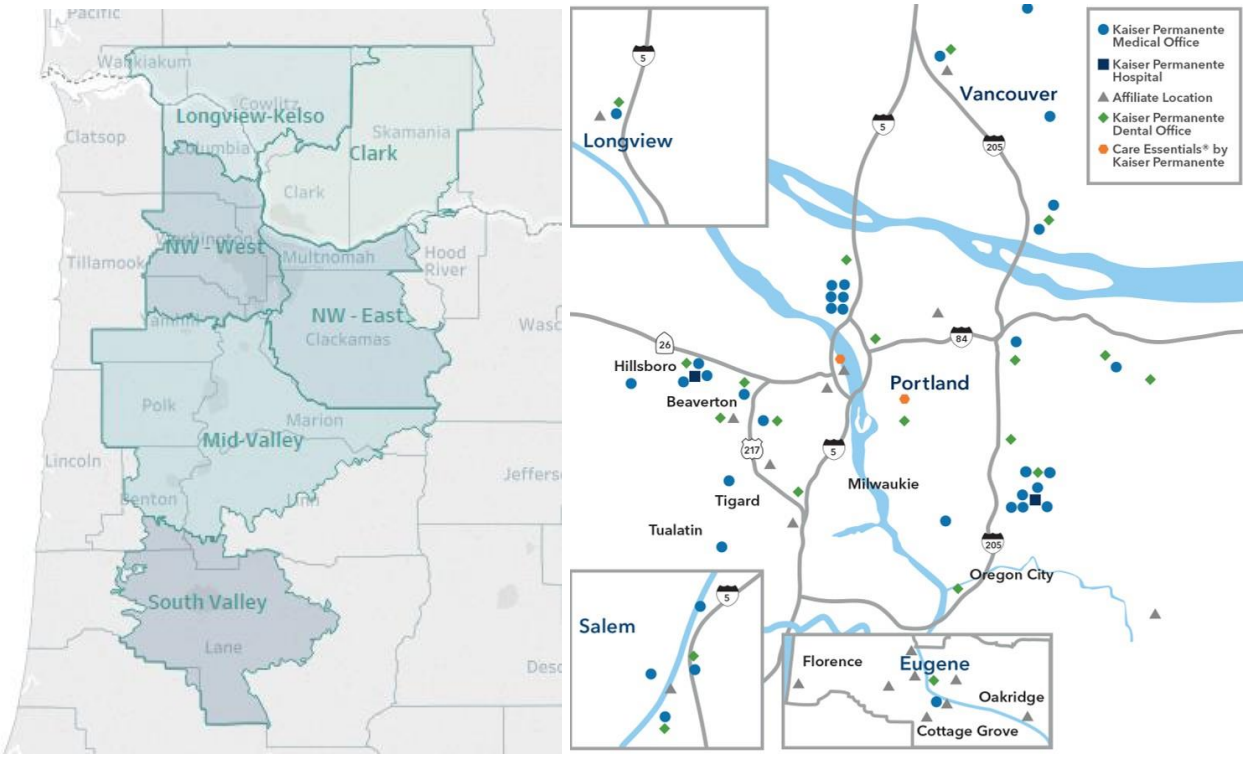
A. Kaiser Permanente's definition of community served

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.

B. Map and description of community served

i. Map

Kaiser Permanente Northwest Service Areas



ii. Geographic description of the community served

The KPNW region includes 14 counties in six service areas across two states, listed from North to South:

- Longview: Cowlitz, Wahkiakum and part of Columbia counties
- Clark service area: Clark and Skamania counties
- West: Washington, and parts of Columbia and Yamhill counties
- East: Multnomah, Clackamas counties
- Mid-Valley: Marion, Polk, Benton, Linn, and part of Yamhill counties
- South Valley: Lane County

The Kaiser Permanente Northwest (KPNW) Region includes two hospitals, KFH Sunnyside and KFH Westside, 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 primarily serve people living within the four county Portland metro area, which includes the Clark, West, and East service areas. KPNW also provides nonhospital services, has membership, and supports community health to the North in the Longview service area, and to the South in the Mid-Valley and South Valley service areas.

The total population of the region is 3,386,009. About 75% of region is white, 5% are Asian, 2% are Black/African American, 12% Hispanic, and less than 1% are Native American/Alaska Native. The East service area has the largest population (936,028), followed by West (857,049), and Mid Valley (648,006). The East Service has the largest population of Black/African Americans (41,477, 4%), Native Americans (8,051, 1%), and Native Hawaiian/Pacific Islander (5,331, 1%). The West Service area has the largest nonwhite (164,070, 19%), largest Asian (67,515, 8%), and multiple race (39,946, 5%) populations. Mid Valley has the largest Hispanic population (119,680, 18%).

iii. Demographic profile of the community served

Demographic profile: KPNW Region

Race/ethnicity		**Socioeconomic data**	
Total Population	3,386,009	Living in poverty (<100% federal poverty level)	14.5%
Race		Children in poverty	18.2%
Asian	5.0%	Unemployment	3.8%
Black	2.3%	Adults with no high school diploma	9.4%
Native American/Alaska Native	0.9%		
Pacific Islander/Native Hawaiian	0.5%		
Some other race	3.4%		
Multiple races	4.7%		
White	83.3%		
Ethnicity			
Hispanic	12.3%		
Non-Hispanic	87.7%		

III. Who was involved in the assessment?

A. Identity of hospitals and other partner organizations that collaborated on the assessment

This CHNA serves as a joint report for the Northwest Region's two hospitals, KFH Sunnyside and KFH Westside. The 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. This report will use KPNW to collectively refer to the two hospitals, integrated health care delivery system, and a health plan.

KPNW participates in the Healthy Columbia Willamette Collaborative (HCWC), a public-private partnership of 15 hospitals, four health departments, and one Coordinated Care Organization (CCO) 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. Health Insight is the contracted convener of the collaborative, responsible for data collection, analysis, and reporting. In addition to the partner organizations, the data subcommittee of the collaborative invited community-based organizations to help design and implement the data collection and structuring of the report to ensure the community was engaged from the very beginning.

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 Organization (CCO)

- 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 Healthcare

Non-Member Community Based Organization Partners

- Community Action
- Immigrant & Refugee Community Organization
- Oregon Community Health Workers Association
- Oregon Health Equity Alliance

- Our House of Portland

Through these relationships, HCWC works on strengthening a 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.

KPNW has incorporated the HCWC assessment into this CHNA report. Specifically, community town halls and listening sessions were conducted by Health Insight through the HCWC. Regional hospital emergency department and CCO data were also collected by Health Insight.

B. Identity and qualifications of consultants used to conduct the assessment

The Healthy Columbia Willamette Collaborative is facilitated by HealthInsight. They are responsible for convening the partners, hosting or organizing the meetings, town halls, and listening sessions, conducting quantitative analysis of data provided by the partner organizations, and writing the collaborative's shared Community Health Needs Assessment. Sections of that report were included in the KPNW CHNA.

HealthInsight is a nonprofit, community-based health care consulting organization dedicated to improving health and health care. HealthInsight has been engaged in health care quality consulting and providing quality improvement services for more than 40 years. HealthInsight is a national leader in assisting front-line providers and engaging health care stakeholders to improve care delivery and patient outcomes, with offices in Alabama, Alaska, California, the District of Columbia, Idaho, Kansas, Nevada, New Mexico, Oregon, Utah and Washington. Clients include the Centers for Medicare & Medicaid Services, state Medicaid and other government agencies, health plans and providers, federally qualified health centers, foundations and other privately funded organizations.

The Center for Community Health and Evaluation (CCHE) provided support with KP Platform data analysis. For over 25 years CCHE has provided evaluation, assessment, and strategic consulting services to foundations and health organizations to improve community health. CCHE brings experience conducting tailored needs assessments and engaging stakeholders to conduct planning and to prioritize strategies based on data. CCHE is part of the Kaiser Permanente Washington Health Research Institute.

IV. Process and methods used to conduct the CHNA

A. Secondary data

i. Sources and dates of secondary data used in the assessment

KPNW used the Kaiser Permanente CHNA Data Platform (http://www.chna.org/kp) to review 120 indicators from publicly available data sources. KFH KPNW also used additional data sources beyond those included in the CHNA Data Platform.

For details on specific sources and dates of the data used, please see Appendix A.

ii. Methodology for collection, interpretation, and analysis of secondary data

Kaiser Permanente's CHNA Data Platform is a web-based resource provided to our communities as a way to support community health needs assessments and community collaboration. This platform includes a focused set of community health indicators that allow

users to understand what is driving health outcomes in particular neighborhoods. The platform provides the capacity to view, map and analyze these indicators as well as understand racial/ethnic disparities and compare local indicators with state and national benchmarks.

As described in section IV.A.i above, KPNW also leveraged additional data sources beyond those included in the CHNA Data Platform. The sources included data from county Community Health Implementation Plans and other regional reports selected to highlight the strengths and needs of specific populations. For a full list of those reports, see Appendix A.

B. Community input

i. Description of who was consulted

A broad range of community members provided input through town halls and listening sessions. Individuals 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 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 individuals who provided input, see Appendix B.

ii. Methodology for collection and interpretation

Community Town Halls – HCWC conducted four town halls, one in each of the four Portland metro area counties, including Clackamas, Clark, Multnomah, and Washington. Leaders and staff from community-based organizations serving the local residents were invited to participate. The town halls used a world café style group learning exercise that mixed presenting, interpreting, and discussing community surveillance data. Group facilitators took notes, which were coded using Nvivo software. Two independent coders used a collaborative coding process to ensure reliability.

The findings from the town halls helped identify key themes, questions for further inquiry, and priority populations for the listening sessions. In particular, they identified the need to address the issues of equity and discrimination in both the data collection process and how the information was presented in the final report. The thematic analysis was also one of the criteria for the health need prioritization. Input from the town halls influenced this report by elevating the importance of health need areas such as Access to Care, Economic Security, and Mental Health. For a full list of the organizations that participated in the town halls, see Appendix B.

Community Listening Sessions – HCWC conducted 18 listening sessions with 217 participants across the four-county region from October to December 2018. Each listening session was hosted by a community-based organization serving the priority population. The hosting organizations were offered a stipend to cover the cost of hosting the session and recruitment of participants. HCWC committed to sharing the findings with the hosting organizations ensuring a reciprocal relationship with community stakeholders and building trust between HCWC's partner organizations and the community. Session participants were offered a $25 gift card for their participation.

Facilitators from the community organizations led the participants at each session through a semi-structured discussion about the health of their community, community vision, perceived

strengths, and needs. The listening session data were coded using Nvivo software from notes taken during the sessions. Two independent coders used a collaborative, open-coding process to analyze the data and ensure reliability. After the coders came to consensus on the themes, they presented them to convener staff to ensure the findings resonated with all staff members' experience of the Listening Sessions. Once themes were consensus coded, the coders went back to refine the coding to pull out specific participant examples and quotes to contextualize the themes. The individual Listening Session reports were shared with each hosting organization, who shared the reports with participants, to ensure their experiences were captured. For a complete list of community-based organizations that hosted listening sessions and the priority populations they recruited, see Appendix B.

The listening session data were used as criteria in the health need prioritization. Input from the listening sessions influenced this report by elevating the importance of health need areas such as Access to Care and Mental Health. Community voice also influenced how those health needs were defined. Community members made it clear that access is more than affordable health insurance and available providers, it is having providers that look like the patients they serve, speak their language, and who understand how their culture and experiences influence their health and care needs. While clinical indicators identified mental health as a regional need, the community defined mental health more broadly than diagnosable mental illnesses. Mental health rose to the top of the list because the community discussed the impact of stress, isolation, racism, and discrimination. The listening sessions also clearly demonstrated the overlap between the health needs, both in how the needs influence each other and share common drivers and barriers. Issues such as discrimination, representation, isolation, and transportation impact many of aspects of health.

C. Written comments

KP provided the public an opportunity to submit written comments on the facility's previous CHNA Report through CHNA-communications@kp.org. This email will continue to allow for written community input on the facility's most recently conducted CHNA Report.

As of the time of this CHNA report development, KPNW has 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.

D. Data limitations and information gaps

The KP CHNA data platform includes approximately 120 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.

Marginalized communities, notably communities of color, LGBTQI communities, immigrants and refugees, and women and children, all experience the top morbidities, mortalities, and stressors

that influence access to social determinants of health disproportionately to their white counterparts. Due to outdated protocols, small population sizes, and mistrust of data collection processes, these communities are often misrepresented, inaccurately accounted for, or completely absent in quantitative data. As the demographic census data for the region indicates, the region's large white population makes it hard to collect statistically significant data that would allow for a robust analysis of health disparities and health outcomes in communities of color. Due to a small data pool that is statistically insignificant because of the small population numbers, data connecting the themes of the qualitative data collection to the quantitative data are limited.

Due to budget and time limitations, as well as the need to represent all four counties, the HCWC had to prioritize which marginalized groups to invite to listening sessions. As a result, some groups were not selected for their own listening session, most notably, the Native American community. However, Native Americans did participate in other listening sessions, such as the one focusing on rural youth. Additionally, some groups declined to participate, most notably people of color with disabilities.

V. Identifying and prioritizing of the community's health needs

A. Identifying community health needs

i. 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 those health outcomes. Health needs are identified by the comprehensive identification, interpretation, and analysis of a robust set of primary and secondary data.

ii. Criteria and analytical methods used to identify the community health needs

To identify the community's health needs, KPNW analyzed secondary data on 120 health indicators, gathered community input, reviewed local county Community Health Improvement Plans, local hospital emergency department and Coordinated Care Organization (Medicaid member) data, and other reports focusing on (See Appendix A and Appendix B for details.) Following data collection, KPNW followed the process below to rank health needs.

B. Process and criteria used for prioritizing of health needs

Required criteria:

Before beginning the prioritization process, KPNW chose a set of criteria to use in prioritizing the list of health needs. The criteria were:

- **Severity of need:** This refers to how severe the health need is (such as its potential to cause death or disability) and its degree of poor performance against the relevant benchmark.
- **Magnitude/scale of the need:** The magnitude refers to the number of people affected by the health need.
- **Clear disparities or inequities:** This refers to differences in health outcomes by subgroups. Subgroups may be based on geography, languages, ethnicity, culture, citizenship status, economic status, sexual orientation, age, gender, or others.

- **The community prioritizes the issue over other issues:** Community priority refers to the frequency with which the community expressed concern about a health issue during the CHNA data collection.

Process

1. Ranking synthesized seven sources of data: CHNA platform, community listening sessions, community town halls, county Community Health Improvement Plans (CHIPs), regional hospital emergency department data, regional Coordinated Care Organization (COO) data, and other recent regional reports focusing on specific populations.

2. Indicators in the **CHNA Platform** were clustered into 13 potential needs. In each of the six KPNW service areas, values for each indicator were compared with the state benchmark and standardized. Scores were assigned to each need category based on how many indicators for each need were performing worse than the benchmark. Each source was assigned a weight score based on three criteria: representing community voice, including information on populations experiencing inequities, and comprehensiveness of issues covered. The selection of indicators included in the platform and hospital emergency department data accounted for severity, while the pervasiveness of an indicators performance across the service areas accounted for magnitude.

3. Themes from the **community listening sessions** were coded to the 13 health needs. Themes could reference multiple health needs. For example, the theme of Language Barriers referenced Economic Security, Access to Care, and Oral Health. Scores were assigned based on the number of themes referencing the KPNW health needs. Scores were clustered and assigned a rating of 1 to 3. See Appendix B for a complete list of the partner organizations and target populations from the listening sessions.

4. Themes from the **town halls** were coded against the 13 health needs. Themes could reference multiple health needs. Scores were clustered and scored on a three-point scale.

5. Thirteen county **CHIPs** were reviewed from the KPNW service area. All of the priority health needs listed in the report were documented and coded to KPNW's 13 health needs. For example, if a CHIP mentioned transportation, it would be coded as Economic Security because transportation is included in the KPNW definition of that need. The number of mentions across all counties was calculated, and scores were clustered and scored on a three-point scale. See Appendix A for a complete list of the county CHIPs reviewed.

6. Regional **Hospital emergency department data** were collected from 15 hospitals in the four county Portland Metro area. The top diagnoses codes were ranked and from that list the top chronic diseases and other ambulatory care sensitive conditions were identified. The diagnoses were coded to the KPNW health needs and scored on a three-point

scale.

7. Three years of **CCO data** from the three Oregon Portland metro counties was collected and the top chronic disease diagnosis ranked and coded to the KPNW health needs. They were scored on a three-point scale

8. **Other reports** were identified through a literature scan focusing on population specific reports, especially with populations known to experience greater health inequities. All the of the priority health needs listed in the report were documented and coded to KPNW's 13 health needs. The number of mentions across all counties was calculated, and scores were clustered and scored on a three-point scale. See Appendix A for a complete list of the other reports reviewed.

9. **Disparities** data were identified in two sources, the data platform and the county CHIPs. The CHNA platform data assigned a score to each need category based on how many indicators indicated a disparity. All disparity data mentioned in the CHIPs were documented, and the number of mentions across all counties was calculated. Scores were clustered and scored on a three-point scale.

C. Description of prioritized community needs identified through the CHNA

High Priority Health Needs

1 – Access to Care – Access to comprehensive, affordable, quality health care is an important factor in determining quality of life, which is influenced by physical, mental, and social well-being. When communities across our region speak about access to care, they note the need for support in navigating the system, multiple language options, providers with cultural awareness and humility, and culturally diverse providers. Barriers to accessing care include racism and discrimination; financial insecurity due to medical and medication costs; cultural, social, and geographic isolation; lack of affordable and reliable transportation options; and lack of insurance and affordable and local care options. Community Health Workers are an integral part of overcoming barriers to health care access because they are from the community, speak the language, and are culturally aware.

In the KPNW region, 9.8% of the population is uninsured, with a high of 10.6% in both the South Valley and East service areas. There are disparities in the uninsured rate for Hispanic, Native American, Pacific Islander, and Other ethnic groups.

2 – Mental Health – Mental health affects all areas of life, including a person's physical well-being and ability to work, perform well in school, and participate fully in family and community activities. Communities across our region experience significant stress, often because of racism, discrimination, and exclusion due to their race/ethnicity, socio-economic status, LGBTQI identities, disability status, and citizenship status. They also describe the need for help easing depression and other mental health concerns. Culturally-specific community members often feel isolated from their support systems and express the desire for community spaces, support for

maintaining cultural values, and establishing a sense of belonging. While access to affordable, local, quality mental health programs and services is critical, strategies also need to include programs and services that strengthen resilience and promote social and emotional wellness for everyone in the community.

In the KPNW region, 16.7% of Medicare beneficiaries experience depression. Regionally, 15.3% of people have insufficient social and emotional support, with a high of 21.3% in the Longview service area. The region has a 15.8 per 100,000 suicide death rate, with a high of 19.9 per 100,000 in South Valley service area, compared to a national rate of 12.8.

3 – Economic Security – Social and economic conditions, including income, education, food security, and safe and stable housing are strongly associated with a person's health. Community members struggle with financial insecurity due to unaffordable housing costs, rent hikes, evictions, and instability in emergency housing. Racism and discrimination greatly impact economic security. Transportation barriers are also a concern. Financial insecurity impedes communities' ability to eat healthy foods and be physically active. Communities would like walkable access to grocery stores, farmer's markets, and community events. Immigrants and refugees face additional financial challenges, such as a lack of credit history to assist in financial endeavors, or the lack of transferrable job skills and education from their home countries. Community members in our region believe that investing in businesses — particularly family-oriented and culturally diverse businesses — would encourage economic growth and financial security for the entire community.

In the KPNW region, 36.1% of households are cost burdened, with a high of 39.2% in the South Valley. In both the East and South Valley service areas, 39% of the population have housing problems. Significant disparities exist in four of the top economic indicators (population below 100% FPL, children below 100% FPL, adults with no high school diploma, and SNAP benefit enrollment) for five racial ethnic groups, including Black, Hispanic, Native American, Pacific Islander, and other racial/ethnic groups.

Medium Priority Health Needs

4 – Obesity/HEAL/Diabetes – Elements of the physical environment, whether built or natural, can affect a community's access to healthy foods and safe spaces to play and exercise, which impacts its residents' risk for obesity and diabetes. Available community space and support for healthy eating and active living concern community members. Access to walkable resources is also a concern when assessing their physical environment. Participants emphasize the need for more community activities regarding healthy living choices that are rooted in community values and cultural traditions.

In the KPNW region, 26.4% of the population is obese, with a high of 32.3% in the Longview service area. Heart disease deaths are a rate of 69.1 per 100,000 for the region but are 92.0 per 100,000 for the Longview and 80.3 per 100,000 for the Clark service areas. Stroke hospitalizations are a rate of 8.6 per 1,000 for the region, and up to 9.7 per 1,000 for the Clark service area.

5 – Maternal and Infant Health – Maternal and infant health issues affect the quality of life of families and include teen births, low birth weight and infant mortality, breastfeeding, and access

to prenatal care. Community members note that prioritizing parenting and family-care responsibilities is an important part of overall community health. They emphasize insufficient resources available to help families including childcare, safe play spaces, lifestyle coaching, drug prevention, mental health services, and food assistance. Participants also describe sources of family trauma, such as generational abuse, substance abuse, neglect, and an increasing burden on children to provide food or care, as detrimental to health. Some community members also fear deportation and Immigration and Customs Enforcement (ICE), which inflicts trauma, keeps families confined to their homes, and causes children to miss school.

In the KPNW region, preschool enrollment is 44.2%, and drops to 35.5% for the Mid Valley service area. Infant deaths occur at a rate of 5.0 per 1,000 births for the region, and highs of 5.9 per 1,000 births and 5.7 per 1,000 births in the Longview and South Valley service areas, respectively. Eight of the ten Oregon counties in the KPNW region are considered childcare deserts.

6 – Substance Abuse – Substance use among individuals of all ages can raise health risks for cancer, damage mental health, and is a cause of death through overdose and motor vehicle crashes. Community members acknowledge that substance abuse poses safety and family welfare challenges, and they are concerned that available resources, including help for parents, drug use prevention, and mental health services are insufficient. In families challenged by substance abuse, the burden on children to care for younger siblings also increases, which impacts child welfare.

In the KPNW region, 20.3% excessively drink. Across the region, 34.0% of motor vehicle crash deaths are impaired driving deaths, with a high of 42.8% in the Longview service area.

D. Community resources potentially available to respond to the identified health needs

The service area for KPNW contains community-based organizations, government departments and agencies, hospital and clinic partners, and other community members and organizations engaged in addressing many of the health needs identified by this assessment.

A few key resources available to respond to the identified health needs of the community are listed below.

Resource provider name	Summary description
Central City Concern	The mission of Central City Concern is to provide pathways to self-sufficiency through active intervention in poverty and homelessness.
Healthy Living Collaborative of Southwest Washington	The Healthy Living Collaborative (HLC) as a core component of the Southwest Washington Accountable Community of Health (SW ACH), focuses on policy, systems and environmental change to improve health and wellness, strengthen families, neighborhoods and systems and ensure health equity
Oregon Children’s Theatre	The Oregon Children’s Theatre’s Educational Theatre Program offers performances, residencies, and workshops to schools and communities. Our

	offerings prompt thought and dialogue about the everyday decisions that shape the quality of our health and our lives.
Oregon Food Bank	The mission of the Oregon Food Bank is to eliminate hunger and its root cause because no one should be hungry.
Playworks	Playworks helps kids to stay active and build valuable life skills through play
Project Access Now	The mission of Project Access NOW is to improve our communities' health and well-being by creating access to care, services, and resources for those most in need.
Susan G Komen Oregon and SW Washington	Susan G Komen save lives by meeting the most critical needs in our communities and investing in breakthrough research to prevent and cure breast cancer.
Virginia Garcia Memorial Health Center	The Mission of the Virginia Garcia Memorial Health Center is to provide high quality, comprehensive, and culturally appropriate primary health care to the communities of Washington and Yamhill counties with a special emphasis on migrant and seasonal farmworkers and others with barriers to receiving health care.

VI. KPNW 2016 Implementation Strategy evaluation of impact

A. Purpose of 2016 Implementation Strategy evaluation of impact

KPNW's 2016 Implementation Strategy Report was developed to identify activities to address health needs identified in the 2016 CHNA. This section of the CHNA Report describes and assesses the impact of these activities. For more information on KPNW's Implementation Strategy Report, including the health needs identified in the facility's 2016 service area, the health needs the facility chose to address, and the process and criteria used for developing Implementation Strategies, please visit (https://share.kaiserpermanente.org/wp-content/uploads/2013/10/KFH-NW-IS-Report.pdf). For reference, the list below includes the 2016 CHNA health needs that were prioritized to be addressed by KPNW in the 2016 Implementation Strategy Report.

1. Access to Care
2. Economic Opportunity
3. Chronic Disease
4. Behavioral Health
5. Oral Health

KPNW is monitoring and evaluating progress to date on its 2016 Implementation Strategies for the purpose of tracking the implementation and documenting 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 in-kind resources. In addition, KPNW tracks outcomes, including behavior and health outcomes, as appropriate and where available.

The impacts detailed below are part of a comprehensive measurement strategy for Community Health. KP's measurement framework provides a way to 1) represent our collective work, 2) monitor the health status of our communities and track the impact of our work, and 3) facilitate shared accountability. We seek to empirically understand two questions 1) how healthy are Kaiser Permanente communities, and 2) how does Kaiser Permanente contribute to community health? The Community Health Needs Assessment can help inform our comprehensive community health strategy and can help highlight areas where a particular focus is needed and support discussions about strategies aimed at addressing those health needs.

As of the documentation of this CHNA Report in March 2019, KPNW has evaluation of impact information on activities from 2017 and 2018. These data help us monitor progress toward improving the health of the communities we serve. While not reflected in this report, KPNW will continue to monitor impact for strategies implemented in 2019.

B. 2016 Implementation Strategy evaluation of impact overview

In the 2016 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, as well as several internal KFH programs including, charitable health coverage programs, future health professional training programs, and research. Based on years 2017 and 2018, an overall summary of these strategies is below, followed by tables highlighting a subset of activities used to address each prioritized health need.

KFH programs: From 2017-2018, KFH 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 impacting 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 provided services for Medicaid beneficiaries, both members and non-members.
- 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 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. From 2017 to 2018, KPNW awarded 208 grants amounting to a total of $13,127,702.75 to address identified needs.

In-kind resources: In addition to our significant community health investments, Kaiser Permanente is aware of the significant impact that our organization has on the economic vitality of our communities as a consequence of our business practices including hiring, purchasing, building or improving facilities and environmental stewardship. We will continue to explore opportunities to align our hiring practices, our purchasing, our building design and services and our environmental stewardship efforts with the goal of improving the conditions that contribute to health in our communities.

From 2017 to 2018, KPNW leveraged significant organizational assets in service of 2016 Implementation Strategies and health needs, including the Surplus Property Donation Program, partnership support, technical assistance, and employee volunteerism and service. From 2017 to 2018, KPNW provided 52 donations of previously-used items ranging from office furniture to medical equipment such as exam tables, optical devices, lab refrigeration to 33 community-based organizations, including community clinics, schools, and other non-profits. These donations had a total value of $169,342 based on Property Accounting depreciating value calculations. From 2017 to 2018, KPNW partnered with the Nonprofit Association of Oregon to support 33 community-based organizations in building their capacity through consulting and training engagements. Organizations received support for fund development, financial management, board development, planning, technology consulting, and other organizational development activities. From 2017 to 2018, 26% of KPNW were active and volunteering in community in over 300 community-based organizations.

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), these collaborations and partnerships can make a difference in promoting thriving communities that produce healthier, happier, more productive people. From 2017-2018, KPNW engaged in several partnerships and collaborations in service of 2016 Implementation Strategies and health needs, including:

- Project Access NOW (PAN) in Multnomah, Clackamas, and Washington counties
- 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

C. 2016 Implementation Strategy evaluation of impact by health need

KPNW Priority Health Needs

Need	Summary of impact	Top 3-5 Examples of most impactful efforts
Access to Care	During 2017 and 2018, KPNW provided $63.4M in medical care services for vulnerable patients through our charity care programs (Medicaid, MFA & CHC) and provided services for 96,243 Medicaid members. During 2017 and 2018, KPNW awarded 52 grants totaling $5,739,666 in order to increase the ability of low-income and underserved individuals in our communities to receive the right care, at the right times, in the right settings, from a diverse workforce that meets their needs.	KPNW Medicaid and Charity Care: Over the course of 2017 and 2018, KP provided care to 96,243 Medicaid members, approved 20,145 applications for Medical Financial Assistance (MFA) - totaling $26.4M- and provided Charitable Health Coverage (CHC) to 6,530 members.
		3 to PhD The 3 to PhD initiative combines a private, nonprofit university; Title I, Pre-K to 8th grade public school; and an on-site wellness center to create a nexus of support for students and families living in Northeast Portland. It is the result of a partnership between Kaiser Permanente, Concordia University, Portland Public Schools' Faubion School, Trillium Family Services, and a new retail food and nutrition concept called basics. Faubion serves nearly 800 grade school children. In fall of 2017, the Kaiser Permanente 3 to PhD Wellness Center opened on the campus. Staffed by Kaiser Permanente clinicians, the clinic provides a full range of health care services — including dental, physical exams, screenings, immunizations, onsite lab services, and referrals — all aimed at ensuring that the community's children and their families are given every opportunity to build strong foundations for lifelong health. Since the school opened in September 2017, the clinic has 2299 medical encounters and 620 dental encounters, providing preventative care (for example, 956 vaccinations and 92 well child visits), and primary care (for example, 116 upper respiratory infections and 101 pharyngitis inflammations). In the first four months of the second school year, clinic utilization has increased by 95% over the previous year.
		Community-Supported Clinics Initiative Community-supported clinics are a vital component of the health care safety net, delivering care services to members of our local community who, because of a lack of resources, might not otherwise be able to access care. To assist these clinics, KPNW and Providence Health & Services partnered to offer a series of capacity-building grants in 2015. A total of $400,000 was awarded to 10 clinics ($40,000 per clinic) over two years (2016, 2017). As a result, several clinics were able to make major strides forward by 2017 — bringing on new staff members, expanding their hours of operation, and offering more services to patients. Other clinics focused on improving data collection and electronic medical records to help manage health issues proactively and report on outcomes in more detail. Still others focused on improving their ability to deliver culturally competent care that better meets the social, cultural, and linguistic needs

Need	Summary of impact	Top 3-5 Examples of most impactful efforts
		of patients. Taken together, these improvements have substantially helped community-supported clinics in our region to bridge the gaps in health care for thousands of residents. This success, led to the creation of the Health System Access to Care Fund at Oregon Community Foundation. Legacy Health and PeaceHealth joined Kaiser Permanente NW and Providence Health & Services each contributing $300,000 to pool available funding and simplify the process for these clinics to apply for funding from multiple organizations. In 2019, eight community clinics were awarded $50,000 with the ability to re-apply for another $50,000 for a 2nd year.
		Poder y Vida Latina Initiative In 2013, KPNW and Susan G. Komen of Oregon & SW Washington began a 5-year partnership focused on improving breast health and breast cancer outcomes in the local Latina community. KPNW awarded four grants, over five years, for a total of $200,000 and provided screenings, follow up care, and treatment at no cost to the women. The project used culturally and linguistically appropriate patient navigator services that integrated community and health system resources to increase access for Latinas to receive regular breast cancer screening, early breast cancer detection, timely access to treatment, and access to quality care. As a result: • 2675 Latinas received a mammogram thanks to the project • 528 women needed additional follow up • 11 women were diagnosed with breast cancer and are in treatment • 55% of the participants had not previously had a mammogram • Average age of Latinas who participated in the project was 45 years old • 46% of the Latinas served had less than 6 years of education • 90% had no health insurance • 88% participants had low English proficiency and needed an interpreter
		Community Partnership Model Pilot From January 2016 to December 2017, Kaiser Permanente physicians and clinic staff referred 217 Spanish-speaking patients to two embedded Familias en Acción Community Health Workers (CHWs) to help patients improve their health by accessing care and services and addressing their social needs through the Pathways Model. The Pathways Model allows CHWs to address the needs prioritized by the people they are serving and report on distinct outcomes for each participant. Each pathway is a unique need addressed in partnership with the CHW. KPNW awarded grants in 2016 and 2017, for a total of $56,000, to support the development of the model. As a result, participants improved their healthcare utilization across the following metrics: • Participants' primary care no-show rate decreased three times the comparison group rate.

Need	Summary of impact	Top 3-5 Examples of most impactful efforts
		• Participants' specialty care no-show rate decreased by 7% while the comparison group's rate increased by 25%. • While primary care utilization decreased for both the intervention and comparison groups, it decreased less for program participants. • Specialty care utilization decreased by 15% • Hospital utilization decreased by 51%. • External hospital utilization decreased by 85%. • Once outliers were removed, average change in cost per patient was a decrease of 11.5%.
Economic Opportunity	During 2017 and 2018, KPNW awarded 98 grants totaling $4,243,015.00 in order to increase economic opportunity for vulnerable populations in our communities, with a focus on educational attainment, skilled employment, and stable housing.	**Central City Concern / Housing is Health** In 2017, KPNW and five other health care organizations took a major step to address homelessness in the Portland region. Together with Adventist Health, CareOregon, Legacy Health, Oregon Health & Science University, and Providence Health & Services, KPNW invested a combined $21.5 million in a unique partnership with Central City Concern that will provide expanded health care and affordable housing through the development of 382 new housing units and a new health center in Southeast Portland. This investment leveraged an overall investment of more than $80 million. Two of the housing complexes opened in 2018. Charlotte B. Rutherford contains 34 1-bedroom units and 17 2- bedroom units at 30% to 60% Median Family Income (MFI). Hazel Heights contains 153 one and two-bedroom units, with 8 at 30% MFI, 30 at 50% MFI and 115 at 60% MFI. These units are targeted to clients who seek to exit transitional housing programs who have gained employment but still have barriers to housing and seek permanent housing. Currently, there are 39 units occupied with 64 total occupants at Rutherford, and 81 units occupied with 158 total occupants at Hazel Heights. The third complex, the Blackburn Building, will open in 2019 and will include affordable housing, health care facilities, a pharmacy and commercial retail space. The 6-story building will include 52 units of respite care transitional housing, 10 units of palliative care housing, 90 units of low-income single room occupancy housing and 34 studios of permanent housing. The integrated housing and clinical services will focus on recovery and mental health services, with some targeted primary care services. The clinic will serve about 3,000 patients annually. Support services at the building will include employment services, housing placement and coordination with other systems.
		Reducing Barriers to School Attendance Initiative Research shows that educational attainment is correlated with physical, social, emotional, and mental wellness. But for many people, it can be a challenge just to get to the classroom. Physical and mental health issues, housing and food insecurity, economic and transportation challenges, and systemic inequities can hinder students from being able to attend school.

Need	Summary of impact	Top 3-5 Examples of most impactful efforts
		Kaiser Permanente awarded more than $1 million in grants to seven local organizations in the Northwest region in 2017 to help stem the tide of chronic absenteeism. The grant recipients — five nonprofit organizations and two education service districts — are working with 5,600 students, family members, and educators in 36 schools across the region to improve community awareness about the importance of being at school; reduce the barriers to school attendance; and increase connections to social and health support services for students, teachers, and staff.
		Community Health Careers Initiative Investing in the academic success of students, particularly those from diverse and low-income backgrounds, is an investment in the future health of communities. KPNW's Community Health Careers Initiative aims to improve community health by promoting educational attainment among these students to help diversify the health care workforce. KPNW works with local schools and nonprofits to provide programs that expose diverse and disadvantaged students to a broad array of health care professions. The Health Career Learning Crew takes David Douglas High School students on tours of the hospital, engages them in hands-on activities, and introduces them to caregivers who share insights about their jobs and educational pathways. In 2017, KPNW launched the Hippocrates Circle at two local middle schools, a program designed to encourage diverse and low-income middle school students to pursue careers as physicians. 30 seventh- and eighth-graders participated in 5 interactive venues designed to help inspire their interest in the practice of medicine. In 2017 and 2018, KPNW awarded a total of $1,090,000 to 342 high school and college students through the Kaiser Permanente Health Care Career Scholarship Program. In 2018, KPNW launched the Ignite scholarship by awarding an additional ten $5,000 scholarships to pre-health students that attend Portland State University, as part of a five-year, $250,000 commitment.
		Rosewood The Rosewood Initiative is addressing and improving economic security in the Rosewood neighborhood, in SE Portland, Oregon and Gresham, Oregon. About 14,000 people live in this neighborhood, which experiences disproportionately high crime rates and high poverty. Beginning in 2018, through two grants for a total of $210,000 funding, KPNW funded the community engagement and implementation of a three-year strategic plan for neighborhood transformation and joining the Purpose-Built Communities Network. The Purpose-Built Communities model accelerates holistic change and addresses long-term socioeconomic inequities and disparities in health outcomes through a focus on three pillars: housing, education and community wellness. Partners involved include local health systems, nonprofit organizations, area school districts, housing, and financial partners. The initiative is

Need	Summary of impact	Top 3-5 Examples of most impactful efforts
		exploring opportunities to secure partner control of sites to implement priorities arising out of community engagement work: several existing residential properties as well as sites for future mixed-income/mixed-use development and an early childhood center. In January 2019, in celebration of Martin Luther King and his commitment to service, 350 KPNW employees volunteered at Harold Oliver and Parklane Elementary, two high priority schools in Rosewood, where volunteers helped paint hallways, bathrooms, clean classrooms, sort schools supplies, and landscape the grounds.
		Food Insecurity Food insecurity influences health status in several ways: lack of access to adequate food and nutritious food is related to obesity, hypertension, high cholesterol, and diabetes. In addition, food insecurity affects child development and readiness to learn. KPNW is working to address food insecurity through direct service projects and systems change in the community and through partnerships with our clinic staff. • In 2015, KPNW awarded Zenger Farm $250,000 over three years for the *CSA Partnerships for Health* project. Through that grant, 104 families received discounted veggie boxes at four clinics in 2016, and 166 families in 2017. It was expanded to nine clinic-based distribution sites in 2017, including the KPNW Rockwood clinic, providing CSA to 251 families. This project involved nine clinics, five farms, 43 food demonstrations, and 16 youth physical activity days for the 20-week CSA length. • In 2018, KPNW funded the Oregon Veggie RX Summit, led by the Oregon Community Food Systems Network. It was attended by over 100 people from all parts of Oregon, including Healthcare organizations, CCOs and community food organizations. The summit increased interest, and discussion between healthcare and community organizations, especially about ways to fund Veggie RX and healthcare metrics. • At KPNW's request, the Rockwood Food Group was initiated and led by the Rockwood CDC to address access to food and nutrition-related issues in Rockwood neighborhood. KPNW is participating alongside medical and food partners, including Wallace Medical Concern and Zenger Farm. • KPNW provided SNAP training with Partners for a Hunger-Free Oregon to increase knowledge of 43 healthcare providers to assist patients to enroll in SNAP programs.
Chronic Disease	*During 2017 and 2018, KPNW awarded 21 grants totaling $1,395,948 in order to improve health and prevent chronic disease in populations with inequitable health*	**Active and Safe Transportation** KPNW awarded a $400,000 grant (2017-2019) to Safe Routes to School National Partnership to help create safe, convenient, and fun opportunities for children to walk, bike and roll to and from school. Kids that walk and bike to school are healthier, happier, and often do better in school. Highlights from 2017 and 2018 include:

Need	Summary of impact	Top 3-5 Examples of most impactful efforts
	outcomes through strategies that create healthy places and policies and empower individuals and families to prevent, manage, and treat their chronic disease(s).	• Supported Vision Zero action at Portland City Council to lower the speed limit on all residential streets to 20 miles per hour in January 2018. • Helped allocate more than $8 million for shape Routes to School infrastructure projects at Portland schools. • Advocated to ensure prioritization of school access in all projects and prioritization of active transportation projects and access to public transit near low-income housing and in those neighborhoods with the highest rates of racial diversity. • Wrote transportation policy recommendations for Multnomah County Commissioners to utilize in their policy and funding decisions in 2019. In support of active and safe transportation, KPNW has also supported the City of Portland's Sunday Parkways for 11 years, providing $310,000 from 2017 to 2019. Sunday Parkways promotes healthy, active living through a series of free events opening the city's largest public space - its streets - to walk, bike, roll, and discover active transportation while fostering civic pride, stimulating economic development, and represents the community, business, and government investments in Portland's vitality, livability, and diversity. Over 100,000 people participated in 2017 and 125,000 people participated in 2018.
		Healthy Eating and Active Living (HEAL) Communities Through the HEAL Communities grant initiative, Kaiser Permanente has dedicated $1.5 million over 3.5 years (2015-2019) to support six collaboratives and coalitions in our Northwest Region. Highlights from that initiative include: • **Screen and Intervene**: Clackamas County Public Health implemented three healthy eating related strategies in three public high schools. As a result, two high school-based health centers screened students for food insecurity; two student-led groups successfully applied for HEAL grant proposals from the Public Health Department for $16,000 and $8,990, respectively, to implement youth identified school improvements such as water fountains and grab-and-go healthy food carts; and $24,000 was awarded to implement school improvements such as offering healthy breakfast in the classroom. • **Fourth Plain Forward! Improving Central Vancouver's Health through Active Living**: Clark County Public Health implemented strategies to increase physical activity through improvements to the built environment and by developing community-based programming. As a result, four murals were painted to highlight the international business district; 40 high school students graduated from the Bike to Leadership program; and $46,500 of matching funds were awarded to sustain the Bike to Leadership program through 2018. • **Enhancing School Gardens for Healthy Nutrition**: Cowlitz County Health and Human Services implemented a healthy eating strategy aimed at comprehensive school garden support and expansion as well as supportive, wrap-around healthy school food environment activities in two school districts. As a

Need	Summary of impact	Top 3-5 Examples of most impactful efforts
		result, 916 elementary students received literacy lessons in the school gardens; three new school gardens were constructed; $4,000 of Title I funds were allocated to support after school garden clubs to improve math comprehension; and $900 were allocated to continue garden-based lessons.
		HEAL Cities campaign The HEAL Cities Campaign for the Northwest is an initiative of the Oregon Public Health Institute, in partnership with the League of Oregon Cities and Kaiser Permanente. Currently, 40 cities across the state have adopted policies and systems that promote access to healthy, affordable foods, convenient access to opportunities for physical activity and recreation, and workplace wellness for municipal employees. These policies set the framework for healthy, prosperous communities where people live, work, and play. This impacts the lives of 735,873 Oregon residents. The 2017-2018 HEAL Cities grant awards were distributed to the City of Sherwood for water stations and the Mid-Willamette Valley Council of Governments, which is working with the cities of Mt. Angel, Gervais, Dallas, and St. Paul on a comprehensive wayfinding project, in September 2017.
		Alliance for a Healthier Generation Kaiser Permanente is partnering with the Alliance for a Healthier Generation to offer its Healthy Schools Program (HSP) as a part of the Thriving Schools Initiative here in the Northwest. From 2013-2018, this partnership was offered to four school districts: David Douglas and Hillsboro districts in Oregon, and Evergreen and Longview districts in Washington. KPNW awarded the Alliance $263,053 in 2018 to support the program through 2020. Through these partnerships, 58 schools conducted initial and drafted action plans. As a result, 2 schools received Silver National Recognition Awards, and 18 received Bronze National Recognition Awards.
		Healthy Living Collaborative of Southwest Washington KPNW awarded the Healthy Living Collaborative (HLC) $90,000 in 2018 to evaluate their robust pool of funding to support a long-term process of social change. The HLC is made up of approximately 60 organizations representing multiple sectors across the four county SW Washington region. Highlights resulting from the partnership and collective funding include the following environmental and lifestyle change strategies: ▪ Served 155 families in through nutritious food truck products at worksites in partnership with Clark County Food Bank. ▪ The City of Longview opened a section of the Pacific Way Dike Trail, providing an additional 3.5 miles of connected trail for walking, recreating, and commuting. As well as the following health systems & community-clinical linkages strategies: ▪ Held blood pressure measurement training attended by 25 CHWs who were then equipped for outreach and education. ▪ Launched projects at three Free Clinics to address quality improvement for uninsured diabetic population.

Need	Summary of impact	Top 3-5 Examples of most impactful efforts
Behavioral Health	During 2017 and 2018, KPNW awarded 12 grants totaling $1,004,373.00 in order to improve the mental health and resilience of our communities through trauma-sensitive systems of care and prevention efforts and the integration of physical and mental health care in clinical and community settings.	**Housing for Health Initiative** For people experiencing mental health challenges or struggling with addictions, sometimes paying the rent or even finding a safe, secure place to live can be out of reach. Sadly, too many of our community members end up homeless or at risk of losing their housing. In 2016, Kaiser Permanente awarded nearly $2.3 million over three years to seven nonprofit organizations actively working with community members to get them the health care and social services they need and help them find and keep permanent housing. By employing peers and community health workers, bringing together housing and health care providers, and advocating for increased funding and services, these community organizations are already making great strides. As of December 2018, 295 individuals were given access to such services as addiction treatment, mental health support, vocation rehabilitation, primary care services, and parenting support, and 128 people were provided with safe, stable housing.
		Unity Center for Behavioral Health As the first behavioral health center of its kind in the region, the Unity Center for Behavioral Health is expected to become a national model for providing compassionate mental health care in times of crisis, without unnecessary waiting. This unprecedented collaboration of four health systems shares the goal of providing care for all those in need through a combination of emergency, inpatient and robust transition to outpatient services and embraces the concepts of hope, recovery and resilience. It was designed to create more options for people in Portland who might be experiencing a psychiatric emergency. The Unity Center is open to anyone in our community who needs immediate psychiatric care. It offers around-the-clock emergency treatment, as well as inpatient beds for 79 adults and 22 adolescents. With a living room feel and an outdoor garden area, the center is designed for healing. Unity opened in early 2017 after years of planning and significant contributions by Kaiser Permanente, Legacy Health, Adventist Health, and Oregon Health & Science University. KPNW has contributed $3 million in 2017 and $4.5 million in 2018 to cover start up and operational costs. The center cares for an average of 98 patients each day.

Need	Summary of impact	Top 3-5 Examples of most impactful efforts
		Trauma Informed Schools One of the most effective ways to enjoy lifelong health is to get a good education. Kids who are healthy—physically, mentally and emotionally—do better in school and go on to graduate. Poor mental health, trauma, or adverse childhood experience (ACEs) can severely impact a student's ability to perform well in school. KPNW supporting trauma informed schools through a number of programs: • **Building social and emotional resilience in school environments** is a multi-year pilot with school staff and administrators working with Washington State University's Collaborative Learning for Educational Achievement and Resilience (CLEAR) to adopt trauma-informed teaching practices and create a multi-tiered system of support and caring for all students. It is being implemented in four schools. KPNW awarded CLEAR $799,998 in 2017 to support the program through 2021. • **KP's Educational Theatre Program**, in partnership with Oregon Children's Theatre, offers performances, residencies, and workshops to schools and communities that prompt thought and dialogue about the everyday decisions that shape the quality of our health and our lives. KPNW provide $1,588,750 in funding to support programming in 2017 and 2018. Over that time period, Kaiser Permanente's Educational Theatre Program served 32,000 students and 1,700 adults, which offered workshops and productions designed to educate about mental health and well-being. • **Playworks**, with KP's long-term support, helps kids to stay active and build valuable social and emotional skills through play. Playworks programming includes in-school coaches, professional consulting on recess and engaging students in leadership building through the junior coach program. Annually, Playworks works 28 schools, with, on average, over 70% of students eligible free and reduced price lunch. Playworks received $200,000 in funding, annually, from 2017 to 2019.
Oral Health	During 2017 and 2018, KPNW awarded 5 grants totaling $120,000.00 in order to improve the quality and access to affordable,	**KPNW Dental Medicaid and Dental Charity Care** KPNW provided care to 2,109 Dental Medicaid members in 2017 and 10,440 in 2018. In 2017, KPNW processed 759 applications and provided $646,884 in Dental Financial Assistance. In 2018, KPNW processed 1062 applications and provided $804,099.[1]

[1] Dental Financial Assistance is included in the Medical Financial Assistance total under Access to Care. It is highlighted here for emphasis and should not be considered additional costs.

Need	Summary of impact	Top 3-5 Examples of most impactful efforts
	integrated oral health care in community and clinical settings.	**Community Dental Access Programs** The Free Clinic of Southwest Washington helped spread more healthy smiles to residents of Clark County, Washington, in 2017, thanks in large part to a partnership with Kaiser Permanente and our team of dental care providers. Through the partnership, low-income and under/uninsured residents in need of urgent dental care were able to access free services at various times throughout the year. Individuals were provided with care either through Free Clinic's screening and referrals of patients to Kaiser Permanente dental offices or through a series of community dental clinics offered on Saturdays. In 2017 alone, these dental access programs through Free Clinic provided care to 112 people in the community — a value of more than $67,000 in donated care. In 2018, they served 27 people for a value of $17,486 in donated care.
		Free Dental Care Days In 2017, KPNW provided $207,102 in free dental care to a total of 359 people through 11 free, one-day dental care events held across the region. 73 Permanente dental associates volunteered in 106 community events to support free dental care. In 2018, KPNW provided $254,227 in free dental care to a total of 379 people through 12 free events staffed by 165 volunteers.
		Children's Dental Health Initiative (2016) Oregon has one of the country's highest rates of childhood dental disease. At least 1 in 5 children in elementary school (first-graders to third-graders) has untreated tooth decay. To address this need, Kaiser Permanente has partnered with Oregon Community Foundation and 6 other funders to fund the Oregon Children's Dental Health Initiative. Funding supports school-based dental programs across the state that provide education, screening, and sealants to children in schools, along with help finding follow-up care for kids who need urgent care. Kaiser Permanente has contributed more than $350,000 to this initiative over 5 years. 14,718 oral health screenings conducted in 194 schools as part of the Children's Dental Health Initiative

VII. Appendix

A. Secondary data sources and dates
    i. KP CHNA Data Platform secondary data sources
    ii. “Other” data platform secondary data sources
B. Community Input Tracking Form
C. Health Need Profiles s

Appendix A. Secondary data sources and dates

i. Secondary sources from the KP CHNA Data Platform

	Source	Dates
1.	American Community Survey	2012-2016
2.	American Housing Survey	2011-2013
3.	Area Health Resource File	2006-2016
4.	Behavioral Risk Factor Surveillance System	2006-2015
5.	Bureau of Labor Statistics	2016
6.	Center for Applied Research and Environmental Systems	2012-2015
7.	Centers for Medicare and Medicaid Services	2015
8.	Climate Impact Lab	2016
9.	County Business Patterns	2015
10.	County Health Rankings	2012-2014
11.	Dartmouth Atlas of Health Care	2012-2014
12.	Decennial Census	2010
13.	EPA National Air Toxics Assessment	2011
14.	EPA Smart Location Database	2011-2013
15.	Fatality Analysis Reporting System	2011-2015
16.	FBI Uniform Crime Reports	2012-14
17.	FCC Fixed Broadband Deployment Data	2016
18.	Feeding America	2014
19.	Food Environment Atlas (USDA) & Map the Meal Gap (Feeding America)	2014
20.	Health Resources and Services Administration	2016
21.	Institute for Health Metrics and Evaluation	2014
22.	Interactive Atlas of Heart Disease and Stroke	2012-2014
23.	Mapping Medicare Disparities Tool	2015
24.	National Center for Chronic Disease Prevention and Health Promotion	2013
25.	National Center for Education Statistics-Common Core of Data	2015-2016
26.	National Center for Education Statistics-EDFacts	2014-2015
27.	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention	2013-2014
28.	National Environmental Public Health Tracking Network	2014
29.	National Flood Hazard Layer	2011
30.	National Land Cover Database 2011	2011
31.	National Survey of Children's Health	2016
32.	National Vital Statistics System	2004-2015
33.	Nielsen Demographic Data (PopFacts)	2014
34.	North America Land Data Assimilation System	2006-2013
35.	Opportunity Nation	2017
36.	Safe Drinking Water Information System	2015
37.	State Cancer Profiles	2010-2014
38.	US Drought Monitor	2012-2014
39.	USDA - Food Access Research Atlas	2014

ii. Additional sources

	Report Title	Organization	Dates
1.	Benton County Community Health Improvement Plan 2013-2018	Benton County Health Department	2013

2.	Blueprint for a Health Clackamas County 2017-2020	Clackamas County Public Health Division	2018
3.	Clark County Community Health Assessment 2015	Clark County Public Health	2015
4.	Clark County Community Health Assessment 2015	Clark County Public Health	2015
5.	Columbia Gorge Regional Community Health Improvement Plan 2017	Multiple community clinics, hospitals, public health and community partners in Hood River, Wasco, Sherman, Gilliam, Wheeler counties in Oregon and Skamania and Klickitat counties in Washington	2017
6.	Columbia Pacific Coordinated Care Organization: Regional Community Health Improvement Plan 2014 (Columbia County)	Columbia Pacific Coordinated Care Organization	2014
7.	Community Health Needs Assessment 2018-2020	Health Share of Oregon	2018
8.	Cowlitz County Community Health Improvement Plan	Cowlitz County Health and Human Services	2014
9.	Cowlitz County Community Health Improvement Plan	Cowlitz County Health and Human Services	2014
10.	Health Disparities among Pacific Islanders in Multnomah County – A supplement to the 2014 Report Card on Racial and Ethnic Disparities	Multnomah County Health Department	2015
11.	IRCO Community Needs Assessment	Immigrant and Refugee Community Organization	2017
12.	Lane County Regional Community Health Improvement Plan 2016-2019	United Way of Lane County	2016
13.	Leading with Race: Research Justice in Washington County	Coalition of Communities of Color	2018
14.	Lewis County Community Health Assessment 2014	Lewis County Public Health and Social Services	2014
15.	Lewis County Community Health Assessment 2014	Lewis County Public Health and Social Services	2014
16.	Linn County Community Health Improvement Plan 2012	Linn County Public Health	2015
17.	Linn County Community Health Improvement Plan 2012	Linn County Public Health	2015
18.	Marion and Polk County Health Status Report 2017	Marion and Polk County Health Departments	2017
19.	Multnomah County – OHEA Community Health Improvement Plan	Oregon Health Equity Alliance and Multnomah County Health Department	2016
20.	Oregon American Indian and Alaska Native Community Health Profile	Northwest Tribal Epidemiology Center and Northwest Portland Indian Health Board	2014
21.	Regional Community Health Improvement Plan 2014	Columbia Pacific Coordinated Care Organization (Columbia County)	2014
22.	State of Black Oregon	Urban League of Portland	2015
23.	Washington County Community Health Improvement Plan 2017	Washington County Public Health Division	2017

Appendix B. Community input tracking form

	Data collection method	Title/name	Number	Target group(s) represented	Role in target group	Date input was gathered
Organizations						
1	Town Hall - Clark County	Clark County Food Bank	1	Staff from community-based organizations serving Clark County	Leaders, Staff	6/18/2018
		Council for the Homeless	1			
		El Programa Hispano Catolico	1			
		ESD 112	1			
		Free Clinic of Southwest Washington	1			
		Greater Than	1			
		Meals on Wheels	1			
		National University of Natural Medicine	1			
		OR AIDS Education and Training Center	1			
		Planned Parenthood	1			
		Sea Mar CHC	4			
		Southwest Accountable Community of Health	1			
		WorkSource Vancouver	1			
		YMCA of Columbia-Willamette	1			
2	Town Hall - Clackamas County	Aging Services Advisory Council	2	Staff from community-based organizations serving Clackamas County	Leaders, Staff	6/12/2018
		City of Lake Oswego	1			
		Clackamas County Community Action Board	1			
		Clackamas Workforce Partnership	1			
		Coalition of Community Health Clinics (CCHC)	1			
		Housing Authority of Clackamas County	1			
		Micronesian Islander Community	2			
		NAYA Family Center	1			
		Northwest Family Services	1			
		Oregon AIDS Education and Training Center	1			
		Oregon Community Health Workers Association	1			
		Oregon Dairy and Nutrition Council	1			
		Oregon Food Bank	1			
		Oregon Health Equity Alliance	1			
		Oregon Office on Disability and Health	1			
		Oregon Oral Health Coalition	1			
		Planned Parenthood	4			
		Project Access NOW	1			
		Providence ElderPlace	1			
		Quest Center for Integrative Health	1			
		Society of St. Vincent de Paul	1			
		Transportation Policy Alternatives Committee	1			

	Data collection method	Title/name	Number	Target group(s) represented	Role in target group	Date input was gathered
		Vibrant Future Coalition/Northwest Family Services	1			
		YMCA of Columbia-Willamette	1			
3	Town Hall - Multnomah County	African Holistic Health Organization	1	Staff from community-based organizations serving Multnomah County	Leaders, Staff	6/13/2018
		CODA, Inc.	1			
		Compassion Connect	1			
		Neighborhood House	1			
		North Clackamas School District	1			
		Northwest Pilot Project, Inc	1			
		Northwest Abortion Access Fund	1			
		Oregon Health Equity Alliance (OHEA)	1			
		Our House of Portland	1			
		PACS Health Clinic	1			
		Project Access NOW	1			
		Quest Center for Integrative Health	1			
		Safe Routes to School National Partnership	1			
		GSK	2			
		Impact NW	2			
		Immigrant and Refugee Community Organization (IRCO)	2			
		OHSU Richmond Clinic	2			
		Rosewood Initiative	2			
		Oregon Health Authority	3			
4	Town Hall - Washington County	Adelante Mujeres	2	Staff from community-based organizations serving Washington County	Leaders, Staff	6/14/2018
		African Family Holistic Health Organization	1			
		ASSIST Program	1			
		Boys and Girls Club	1			
		Community Action	5			
		GSK	1			
		Immigrant and Refugee Community Organization (IRCO)	1			
		Neighborhood Health Center	1			
		Oregon Community Health Workers Association (ORCHWA)	1			
		Oregon Food Bank	1			
		Oregon State University Extension	1			
		Planned Parenthood Columbia Willamette	2			
		Project Access NOW	1			
		Proud Ground	1			
		Sexual Assault Resource Center	1			
		Washington County Animal Services	1			
		Washington County WIC	1			
		YMCA of Columbia-Willamette/Beaverton Hoop YMCA	1			

	Data collection method	Title/name	Number	Target group(s) represented	Role in target group	Date input was gathered
Community residents						
5	Listening Session	People with Mental Health Concerns in Clackamas County hosted by NAMI Clackamas	8	People with Mental Health Concerns	Community Members	10/18/2018
6	Listening Session	Older Adults living with HIV/AIDS in Multnomah County hosted by Our House of Portland	17	Older Adults Living with HIV/AIDS	Community Members	10/24/2018
7	Listening Session	LGBTQI Homeless Youth in Multnomah County hosted by Outside In	12	LGBTQ Homeless Youth	Community Members	10/24/2018
8	Listening Session	Momentum Alliance - Youth of Color hosted by Northwest Health Foundation	11	Youth of Color	Community Members	10/27/2018
9	Listening Session	Iraqi/Syrian Population in Multnomah County hosted by Catholic Charities	16	Iraqi/Syrian Population	Community Members	10/27/2018
10	Listening Session	Elderly (65+) Low Income in Multnomah County hosted by Friendly House	10	Elderly (65+) Low Income	Community Members	11/16/2018
11	Listening Session	Russian Orthodox Population in Clark County hosted by Home of God Church	11	Russian Orthodox	Community Members	11/18/2018
12	Listening Session	Community Health Workers in Clark County hosted by SWACH Vancouver	10	Community Health Workers	Community Members	11/19/2018
13	Listening Session	African Americans in Multnomah County hosted by Central City Concern	19	African Americans with Housing Concerns	Community Members	11/17/2018
14	Listening Session	Pacific Islanders in Multnomah County hosted by APANO/PI Coalition	16	Pacific Islanders	Community Members	11/26/2018
15	Listening Session	Latino Population in Multnomah County hosted by Latino Network	14	Latinx Population	Community Members	11/27/2018
16	Listening Session	Veterans in Washington County hosted by VFW Hillsboro	10	Veterans & Spouses of Veterans	Community Members	12/1/2018
17	Listening Session	Latino Population in Washington County hosted by Virginia Garcia Memorial Health Center	17	Latinx Population	Community Members	11/13/2018
18	Listening Session	Rural Youth in Clackamas County hosted by AntFarm Café	10	Rural Youth, Native American Youth, Homeless Youth	Community Members	12/5/2018

	Data collection method	Title/name	Number	Target group(s) represented	Role in target group	Date input was gathered
19	Listening Session	Elderly Rural Population in Clackamas County hosted by Estacada Center	6	Elderly (65+) Rural	Community Members	12/5/2018
20	Listening Session	People in Affordable Housing in Washington County hosted by The Knoll	10	People in Affordable Housing	Community Members	10/7/2018
21	Listening Session	Latino Farmworkers in Clackamas County hosted by Plaza Los Robles	10	Latino Farmworkers in Molalla	Community Members	11/16/2018
22	Listening Session	Arabic Population in Washington County	9	Arabic Speaking Population	Community Members	11/30/2018

Appendix C. Profiles for High Priority Health Needs

Access to Care

Why it is important

Access to comprehensive, affordable, quality health care is an important factor in determining quality of life, which is influenced by physical, mental, and social well-being. When communities across our region speak about access to care, they note the need for support in navigating the system, multiple language options, providers with cultural awareness and humility, and culturally diverse providers. Barriers to accessing care include racism and discrimination; financial insecurity due to medical and medication costs; cultural, social, and geographic isolation; lack of affordable and reliable transportation options; and lack of insurance and affordable and local care options. Community Health Workers are an integral part of overcoming barriers to health care access because they are from the community, speak the language, and are culturally aware.

Access to Care in the Kaiser Permanente Northwest Region

In the KPNW region, 9.8% of the population is uninsured, with a high of 10.6% in both the South Valley and East service areas, compared to 11.6% nationally. There are disparities in the uninsured rate for Hispanic, Native American, Pacific Islander, and other ethnic groups compared to the overall uninsured rate. The 30-day readmission rate for each service area is average for all service areas, except Longview where it is significantly worse (-2.6 Z-score). Similarly, the rate of Primary Care Physicians is average for all service areas, except for Longview, where it is worse (-1.3 Z-score). There are disparities between the percentage of white and black Medicare beneficiaries seeking care within the last year, 77.2% and 68.6% respectively. There are also disparities between the percentage of black women and women overall who have received one or more mammogram in the last two years, 56.5% and 61.3% respectively.

Factors related to health

- **Culturally Responsive Care –** Community members in town halls and listening sessions discussed how providers lack the bilingual and multicultural backgrounds necessary to serve all communities in the region, particularly in the mental health sector. There are limited culturally responsive services, culturally relevant information, and linguistic resources available across the region. In some areas of the region, community members must travel great distances to access services that are culturally responsive and linguistically diverse.

  Communities perceive that providers lack adequate education to work with communities that are culturally different from their own. Communities feel that providers can rely on stereotypes and fail to address cultural aspects of health concerns, such as nutrition or mental health. This leads to a lack of trust in health institutions. Information and resources are often not available in non-digital form or are only available in English. Lack of translation resources, targeted resources, and few community partnerships create even more barriers for racial and ethnic minority groups.

Upstream and long-term interventions are not seen as priorities in the region, and when they are, they are often not culturally responsive. Community members advocated for increased employment of bilingual and multicultural providers as well as community health workers to facilitate, advocate, and empower communities.

> "Lack of culturally responsive and affirming care, which in turn creates a culture of distrust and disdain towards health and institutions."- Town Hall Participant

- **Financial Burden** – Community members discussed their struggles with a lack of available resources for dealing with financial insecurity, specifically expressing a need for more affordable health care. Notably, the financial burden of medical care, namely the high cost of insurance and co-pays, were barriers accessing health services. Community members discussed having to choose between affording health and medications or providing for their families. They believe investing in businesses, particularly family-oriented and culturally diverse businesses, would encourage economic growth and financial security for all community members.

  > "Lack of affordable housing, high rents force people to have to make financial sacrifices, pay rent or buy medications." – Town Hall Participant

- **Language Barriers –** In the community listening sessions, discrimination based on language and a lack of translators were cited as significant barriers to accessing health care. Participants described being turned away by providers because they could not offer Spanish-speaking services. Many community members whose primary language was not English mentioned relying on their children or family members to be their translators, because they fear inaccurate translation services or that translators might not maintain confidentiality.

- **System Navigation** – Many community members discussed the need for more help navigating the health care system. Even for those who are insured, long wait times, difficulties scheduling appointments, and confusion about what their insurance covers challenge access to health care. For many who do not have government-issued identification cards, accessing available resources is a challenge. Community members relayed that trauma and stress in their lives pose challenges to asking for, and receiving, health care services. Immigrants noted that services are particularly difficult to access for elderly members of their communities, due to language and cultural barriers.

  > "Health care isn't a right here. There are a lot of situations where the community you live in dictates a lot of the resources you have access to." – Listening Session Participant

  > "The wait time for any physical intervention has become a massive issue in lower income communities." – Listening Session Participant

- **Community Health Workers** – Culturally diverse participants in listening sessions discussed how Community Health Workers are a great asset in their communities and there need to be more in communities. These participants discussed the importance of Community Health Workers in empowering community members by helping them communicate in their native language, express their culture, and providing education and support. There are, however, simply not enough Community Health Workers across the region to support all community members.

Health disparities in communities

In the Northwest region, 9.72% of the population is uninsured. That is better than the percentages for the nation (11.6%) and state of Oregon (10.4%). Four out of 16 counties significantly lead the benchmark. However, counties such as Marion (11.9%) and Hood River (13.1%) significantly trail the state benchmark.

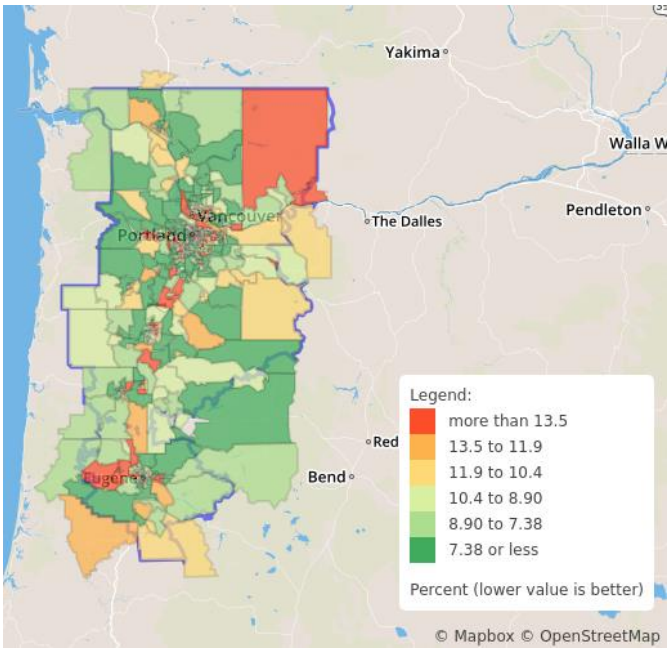


Figure 1. Percent of population that is uninsured.

Health disparities among people

There are significant disparities in the percentage of the uninsured population by race/ethnicity. In the Northwest Region, this indicator has 4 out of 8 sub-populations significantly trailing the benchmark. There are 5 sub-populations with significant disparity from the total population — 27.1% of the population identified as “other” are uninsured, and 21.6% of the Latino/Hispanic population is uninsured, 19.4% of the Native American/Alaskan Native population is uninsured, 18.6% of the Native Hawaiian/Pacific Islander population is uninsured.

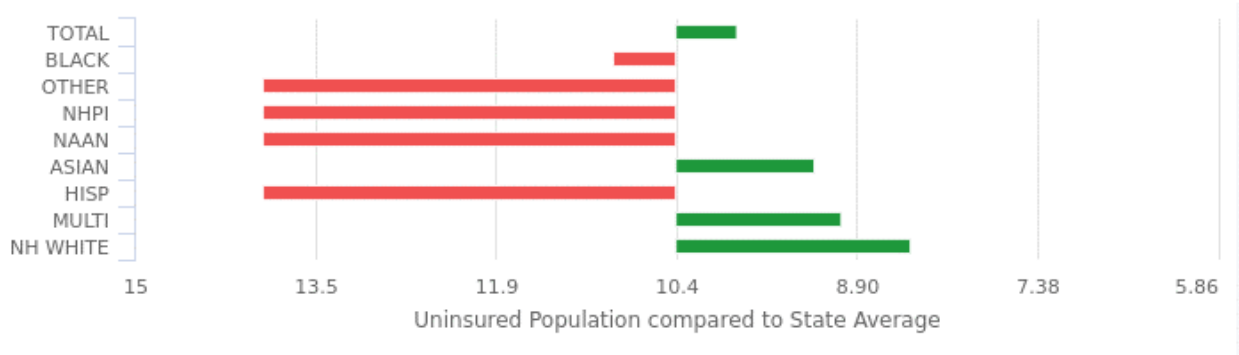


Figure 2. Uninsured population compared to state average.

Mental Health

Why it is important

Mental health affects all areas of life, including a person's physical well-being and ability to work, perform well in school, and participate fully in family and community activities. Communities across our region experience significant stress, often because of racism, discrimination, and exclusion due to their race/ethnicity, socio-economic status, LGBTQI identities, disability status, and citizenship status. They also describe the need for help easing depression and other mental health concerns. Culturally-specific community members often feel isolated from their support systems and express the desire for community spaces, support for maintaining cultural values, and establishing a sense of belonging. While access to affordable, local, quality mental health programs and services is critical, strategies also need to include programs and services that strengthen resilience and promote social and emotional wellness for everyone in the community.

Mental Health in the Kaiser Permanente Northwest Region

In the KPNW region, 16.7% of Medicare beneficiaries experience depression. Across all service areas, the percentage of Medicare beneficiaries is higher than the Oregon benchmark, but is worst in Longview and South Valley. Regionally, 15.3% of people have insufficient social and emotional support. In the Longview service area, 21.3% lack sufficient support, significantly worse than the Oregon benchmark (-2.9 Z-score). The region has a 15.8 per 100,000 suicide death rate, with a high of 19.9 per 100,000 in South Valley service area, compared to a national rate of 12.8. The regional age adjusted suicide mortality rate has been increasing since 2008. The number of poor mental health days are also higher in South Valley than in other service areas (-1.4 Z-score). Unfortunately, few of the available indicators capture the way the community speaks about mental health issues. And when available, they do not provide data by race and ethnicity.

Factors related to health

- **Racism and Discrimination –** Participants in community listening sessions and town halls discussed experiencing significant stress, often because of racism, discrimination, and feelings of exclusion from the community due to their race/ethnicity, socio-economic status, LGBTQI identities, disability status, and citizenship status. Participants who spoke languages other than English expressed feeling unwelcome in establishments where they are unable to speak the language. Community members described feeling stressed about the need to travel far for emergencies due to language barriers. Racism was mentioned as a driving factor for health inequity in the communities of color who participated in the listening sessions, with special emphasis on ignorance, social media, and the political climate as large drivers for their experiences of racism.

> "The community I was born and raised in is NE/N Portland, from Greely all the way to Broadway and to 82nd Ave. We were raised in this area, this was the area we lived in our whole lives — it's now gone. It's not healthy to have these communities gone …. Everything is gone. All the black people don't live here anymore." — Listening Session Participant

- **Isolation –** Community members spoke about cultural and social isolation, which included not being immersed in larger U.S. culture, not having access to walkable community-centered spaces, and the strain immigration puts on separated families. Culturally-specific community members described their communities as isolated from their support systems and they expressed desire to build stronger relationships with their neighbors. Isolation between different groups of people with opposing viewpoints or different identities was also noted as a common source of tension, and participants believe this exacerbates inequalities and mistreatment of community members.

- **Access and Representation –** Across the region, community members noted the continued need for additional mental health services and supports, either through greater access to providers, or providers who are more culturally responsive to the communities in which they work. Increased access to services may help alleviate some of the burden felt by these communities. Listening session participants discussed the lack of mental health providers who look like them or identified with their identities and experiences. Participants found this disconnect between the providers and their experiences to be a challenge when trying to access mental health care.

  > "We need a Starbucks on every corner, but for mental health." — Listening Session Participant

  > "There aren't a lot of therapists who look like us." — Listening Session Participant

- **Community Space and Support –** Participants in community listening sessions and town halls placed an emphasis on community support, as a crucial component to maintaining cultural values, establishing a sense of belonging, and helping to ease depression and other mental health concerns. Participants emphasized the importance of community members supporting one another in all aspects of life and believe establishing a culture of trust and resilience in their community is important to maintaining and improving their health. When asked what community means to them, participants expressed a desire for more community spaces that would allow them to become more involved in schools, churches, workshops, and culture. These community hubs serve as anchors to connect them to sources of support and provide a space to share resources and information with fellow community members.

  > "To be strong is to feel the connections and support each other through things happening with children and with jobs. To have people stand by you and understand what you are going through is what is critical to health." — Listening Session Participant

- **Family Welfare –** Community members expressed great concern that there are not enough resources available to help parents and children facing mental health issues. Participants described sources of family trauma that were detrimental to the health of community members. Generational abuse, substance abuse, neglect, and an increased burden on children to provide food for families or care for younger siblings were mentioned as barriers to child welfare. Another source of trauma discussed is the fear of deportation and Immigration and Customs Enforcement (ICE), which keeps people

confined to their homes and causes children to miss school. Immigrants and refugees in sessions linked to their health the strain immigration puts on their community— many of their loved ones are still in their home countries, making them feel isolated from their support systems.

> "We don't have that much social life here. I am always cooking or working or cleaning here, back home we get together with family and friends regularly." — Listening Session Participant

Health disparities in communities

Deaths by suicide, drugs, or alcohol vary widely across the service area and regularly exceed the National rate of 41 per 100,000. They are consistently high in Southwest Washington and South Valley, with rates of 116 in Wahkiakum, 68.1 in Skamania, 63 in Cowlitz, 50.2 in Linn, and 52.2 in Lane counties.

In the Northwest region, insufficient social and emotional support trails the Oregon and national benchmarks in 11 out of 16 counties, with the highest rates in Cowlitz and Wahkiakum.

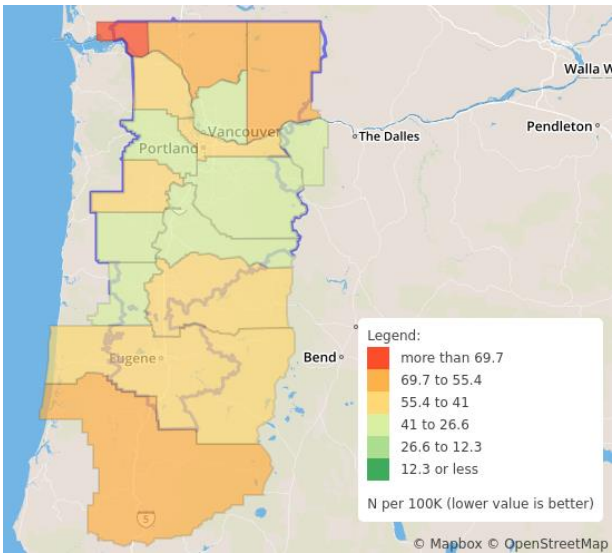


Figure 3. Deaths by Suicide, Drug or Alcohol Rate Map.

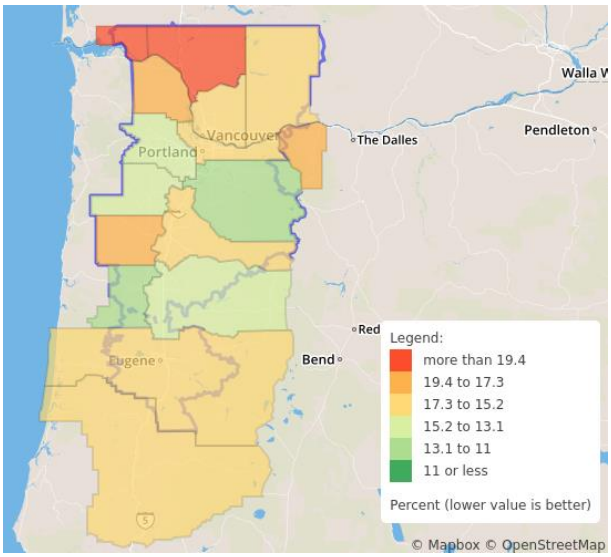


Figure 4. Insufficient Social and Emotional Support Map.

Health disparities among people

The highest rates of suicide mortality are for non-Hispanic whites and American Indian/Alaskan Native populations. Rates for American Indians/Alaska Natives are significantly higher in Washington than the rest of the United States.

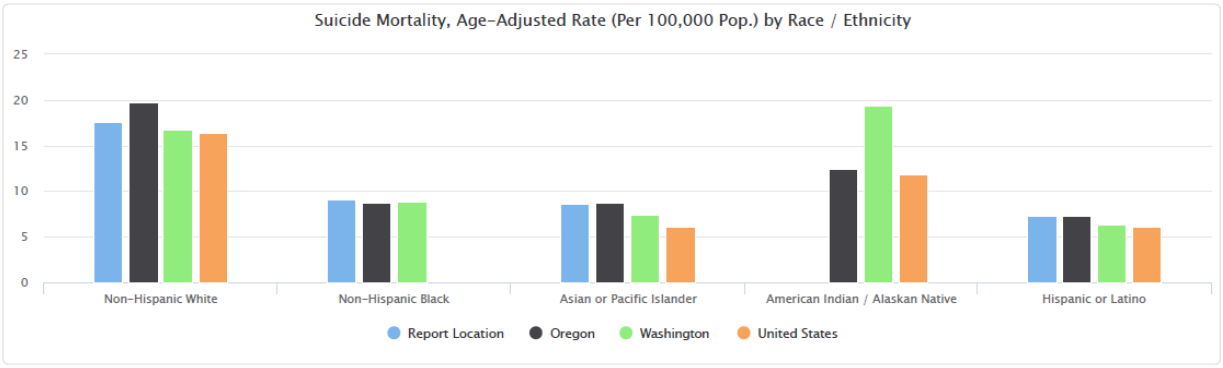


Figure 5. Suicide mortality rate by race/ethicity.

Economic Security

Why it is important

Social and economic conditions, including income, education, food security, and safe and stable housing are strongly associated with a person's health. Community members struggle with financial insecurity due to unaffordable housing costs, rent hikes, evictions, and instability in emergency housing. Racism and discrimination greatly impact economic security. Transportation barriers are also a concern. Financial insecurity directly impacts communities' ability to eat healthy foods and be physically active. Communities would like walkable access to commercial services such as grocery stores, farmer's markets, and community events. Immigrants and refugees face additional financial challenges, such as a lack of credit history to assist in financial endeavors, or the lack of transferrable job skills and education from their home countries. Community members in our region believe that investing in businesses — particularly family-oriented and culturally diverse businesses — would encourage economic growth and financial security for the entire community.

> "This is a big problem for all of us — have a degree back home that is not recognized here and so you have to choose: work or study." — Listening Session Participant

Economic Security in the Kaiser Permanente Northwest Region

In the KPNW region, 36.1% of households are cost burdened, with a high of 39.2% in South Valley. In both the East and South Valley service areas, 39% of the population have housing problems. Significant disparities exist in four economic indicators (population below 100% FPL, children below 100% FPL, adults with no high school diploma, and SNAP benefit enrollment) for five racial ethnic groups, including Black, Hispanic, Native American, Pacific Islander, and other racial/ethnic groups. 36.8% of the region have housing problems, where the housing is substandard, or housing costs represent over 30% of the household income. 19.6% have severe housing problems, where the housing is substandard, or housing costs represent over 50% of the household income.

Factors related to health

- **Housing** - A pillar of a healthy community is access to affordable housing. Unaffordable housing costs and rent increases greatly contribute to community member stress. Overall, community members expressed the struggle to access resources that provided affordable housing, emergency shelters, assistance in paying utility bills, and wished these topics would be higher priorities for policy makers. Community listening session and town hall participants described experiencing evictions and housing insecurity, even in emergency housing. Being denied housing due to immigration status and race/ethnicity was cited as major issue among participants. The houselessness crisis emerged as two distinct concerns, often expressed simultaneously: the fear of community safety due to the number of houseless people in their neighborhoods, and the fear of becoming houseless themselves due to lack of financial security and housing stability.

  Among those who had stable housing, they expressed concerns about safety, sanitation issues, and negligent landlords not addressing property maintenance. Community

members with mental health concerns described how case workers are pivotal to addressing mental health concerns that can lead to housing insecurity, but hospitalization is the most viable route to gain access to their services. Youth who are LGBTQI and housing insecure described the need for more resources available for young adults over the age of 25, especially with housing and day-time programs that keep them safe and connected to their community and resources. Many described feeling adrift when they aged out of youth services, as this age gap disqualified many youths in need from access to services that they rely on to survive.

> "[Housing sanitation and apartment management is] impacting people's physical, emotional, and mental wellbeing. It is stressful living in a neglected community." — Listening Session participant

> "Affordable resources and housing is a big barrier. Families have to choose if they are going to eat today, or pay their rent." — Town Hall Participant

> "If housing is not affordable, what kind of good health or life are you going to have?" — Listening Session Participant

- **Discrimination and Displacement** – Listening session and town hall communities of color, immigrants, refugees, and LGBTQI participants described how profiling, discrimination, and racism contributed to feelings of unsafety in their neighborhoods. The impacts of gentrification—a lack of culturally-specific business owners, black-owned businesses and being pushed out of neighborhoods to the margins of their cities — stress these communities. Displacement has destroyed community centers and community gathering spaces and has left many communities feeling ostracized in their own neighborhoods, workplaces, schools, and communities. Participants directly linked experiences of profiling, racism, discrimination with having limited access to housing security, job security, and other opportunities.

> "I'm experiencing a lot of discrimination and bias. All the whites help their race move up and get bigger and better positions." — Listening Session Participant

> "Not many jobs fit us…most of our education from back home doesn't count, we have to get evaluated and re-get degrees" — Listening Session Participant

- **Representation –** Participants discussed at length how the city of Portland's majority white population and politics shape laws and policies in the state. Minority and rural communities do not believe that their interests and needs are reflected in those policies unless they align with Portland's. Participants discussed feeling they were underrepresented in government and decision-making organizations that serve their community. Due to this lack of representation, participants noted that current policies regarding their communities were often outdated or misinformed due to inaccurate data. Community members discussed the need to establish institutional solutions that include shared power in decision making. There was an emphasis on communities making their

voices heard through voting and social media to influence decisionmakers. Participants shared that being a part of neighborhoods, workplaces, schools, and communities with little diversity limited their opportunities to advance as people of color.

> "The demographic makeup of people in leadership positions is a barrier; elected officials and other decision-makers don't reflect the communities most impacted." — Town Hall Participant

- **Mental Health** – Community members discussed how mental health concerns can keep individuals in a cycle of poverty, and they advocated for greater emphasis on affordable, low-cost preventive care and screening for mental health conditions. They advocated increasing emergency, temporary, and transitional shelters or alternative housing options to the many people in the region who are in need. No-cost, school-based interventions and community center-based, family-focused programs would ensure that the community had more access to resources to help them establish and maintain economic stability. Participants emphasized the importance of ensuring access to mental health services and resources for residents who may not have health insurance or who are culturally or geographically isolated.

  > "I think my community would be more healthy if we were supported by good health insurance, good resources for jobs and education, and had cultural and social centers." — Listening Session Participant

- **Transportation –** Transportation emerged as both a community strength and a community need by listening session participants. Participants who were able bodied, in an urban area, and lived near bus and Max lines described robust public transportation as a huge asset to their neighborhood. Town hall participants, however, described how the lack of public transportation infrastructure in much of the region leaves them without access to services, healthy foods, and quality housing. The value of efficiency that comes with having health care services available in one location is a barrier for residents who are unable to reach those service locations due to the cost of transportation, the time it takes to travel there, and traumas or anxieties related to transportation barriers.

  Participants identified a need for more transportation services that address geographic limitations faced by residents, such as mobile medical units to provide medical outreach for people experiencing houselessness or virtual appointments with providers. Listening session participants wanted more places that are walkable, particularly grocery stores, farmer's markets, and community events, and felt that people living in their communities without a car were socially isolated**.**

  > "Transportation is a huge barrier to health and to connecting to resources." — Town Hall Participant

  > "[I] have a car but don't get on the freeway, so can't go to things that you have to go on the freeway to get to." — Listening Session Participant

Health disparities in communities

In the Northwest, the greatest percentage of cost-burdened households are in the urban areas, especially in Multnomah (39.5%) and Lane (38.9%) counties, surrounding Portland and Eugene. Within Portland, most cost burdened households are in East Portland, which is also home to some of Oregon's most culturally diverse neighborhoods.

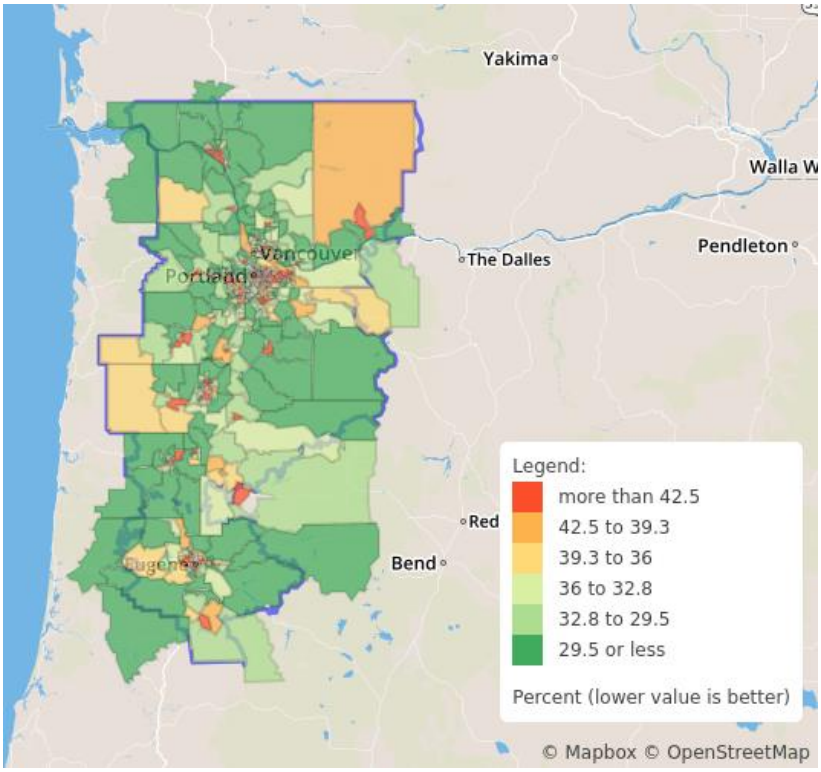


Figure 6. Map of cost burden households.

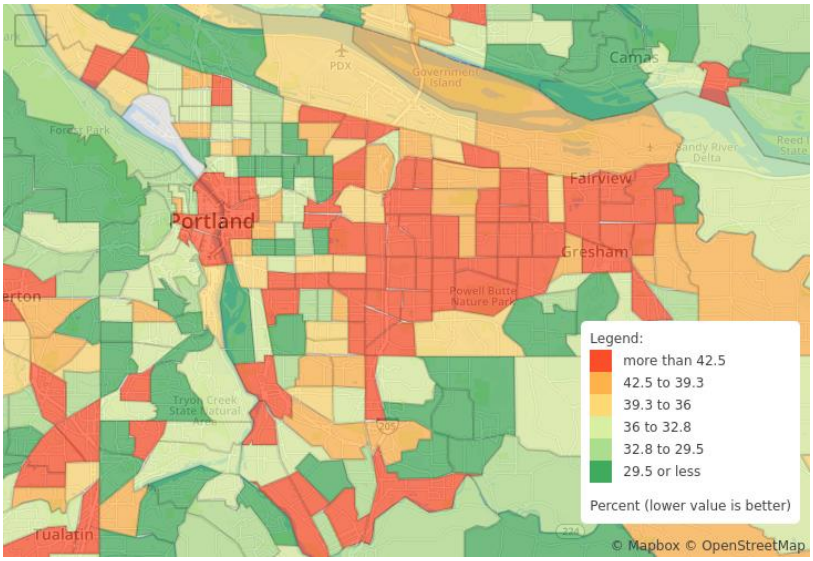


Figure 7. Map of cost burden households in Portland metro area

In cities such as Portland and Salem, the Area Deprivation Index, which allows for rankings of neighborhoods by socioeconomic status disadvantage in a region, identifies similar areas to the cost burdened household maps. It includes factors for the theoretical domains of income, education, employment, and housing quality. However, it also identifies more rural areas, such as Cowlitz County.

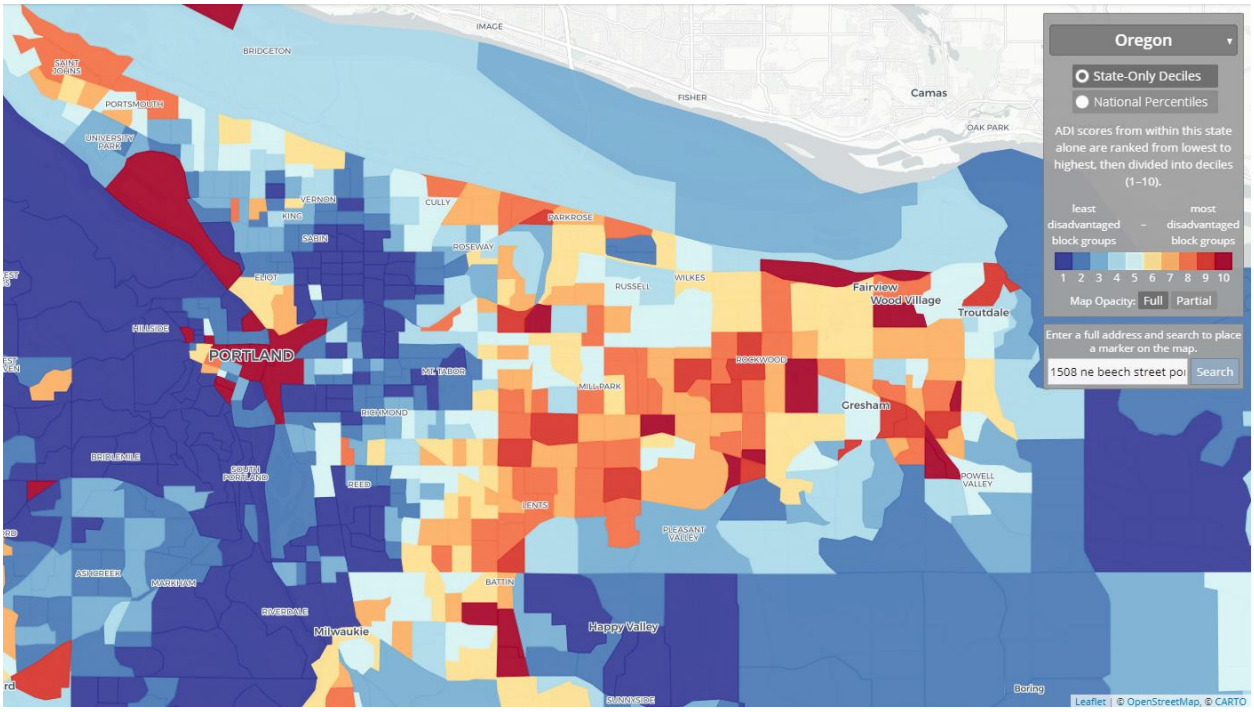


Figure 8. Map of Area Deprivation Index in Portland metro area.

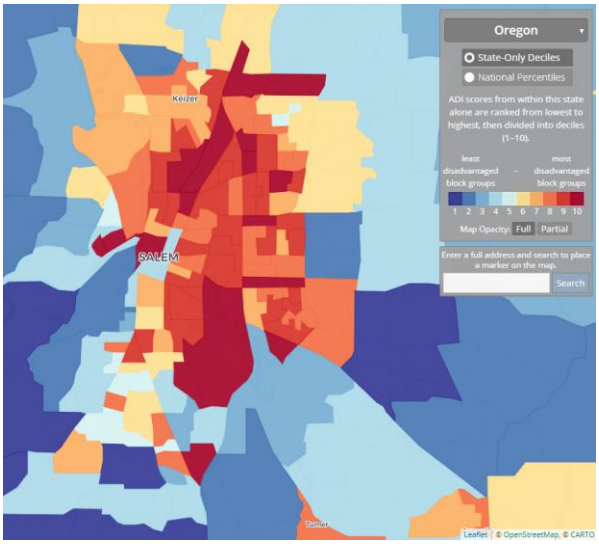


Figure 9. Map of Area Deprivation Index in Salem area

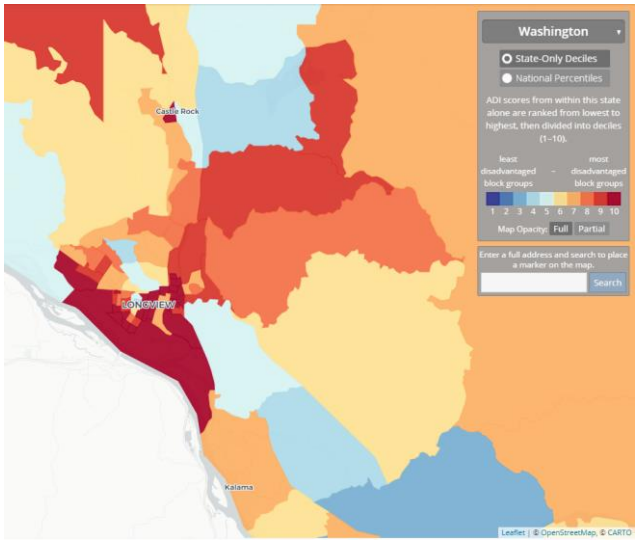


Figure 10. Map of Area Deprivation Index in Longview area

Health disparities among people

Across most economic security indicators on the KPNW data platform with race / ethnicity data, there are significant disparities for Black, Hispanic, Native American/Alaska Native, Native Hawaiian/Pacific Islander, and other. For the Black population there are significant disparities for Children Below 100% FPL, Population Below 100% FPL, and SNAP Benefit Enrollment. For the Hispanic population there are significant disparities for Adults with No High School Diploma, Children Below 100% FPL, Population Below 100% FPL, and SNAP Benefit Enrollment. For Native American/Alaska Native population there are significant disparities for Adults with No High School Diploma, Children Below 100% FPL, Population Below 100% FPL, and SNAP Benefit Enrollment. For Native Hawaiian/Pacific Islander population there are significant disparities for Adults with No High School Diploma, Children Below 100% FPL, Population Below 100% FPL, and SNAP Benefit Enrollment. For the population identified as other race/ethnicity there are significant disparities for Adults with No High School Diploma, Children Below 100% FPL, Population Below 100% FPL, and SNAP Benefit Enrollment.

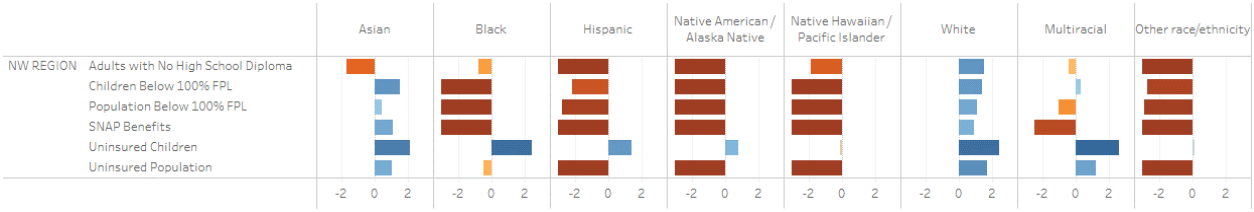


Figure 11. Z-scores for economic security indicators by race/ethnicity.