

2022 Community Health Needs Assessment



Kaiser Permanente of the Northwest
Kaiser Permanente Sunnyside Medical Center

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Kaiser Permanente Westside Medical Center

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

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Kaiser Permanente of the Northwest 2022 Community Health Needs Assessment

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Kaiser Permanente of the Northwest 2022 Community Health Needs Assessment

Summary

Kaiser Permanente is an integrated health care delivery system comprised of Kaiser Foundation Hospitals, Kaiser Foundation Health Plan, and physicians in the Permanente Medical Groups. For 75 years, Kaiser Permanente has been committed to shaping the future of health and health care — and helping our members, patients, and communities experience more healthy years. We are recognized as one of America's leading health care providers and nonprofit health plans.

Every three years Kaiser Permanente of the Northwest conducts a community health needs assessment (CHNA). The CHNA process is driven by a commitment to improve health equity and is intended to be transparent, rigorous, and collaborative. Our Community Health team has identified and prioritized needs unique to our service area, based on community-level secondary data and input from those who represent the broad interests of the community. Wherever possible, we have applied a racial equity analysis to data collection and analysis.

For the 2022 CHNA, Kaiser Permanente of the Northwest has identified the following significant health needs, in priority order:

1. Housing
2. Access to care
3. Mental & behavioral health
4. Income & employment
5. Food insecurity

To address those needs, Kaiser Permanente of the Northwest has developed an implementation strategy (IS) for the priority needs it will address, considering both Kaiser Permanente's and the community's assets and resources. The CHNA report and three-year IS are publicly available at <https://www.kp.org/chna>.

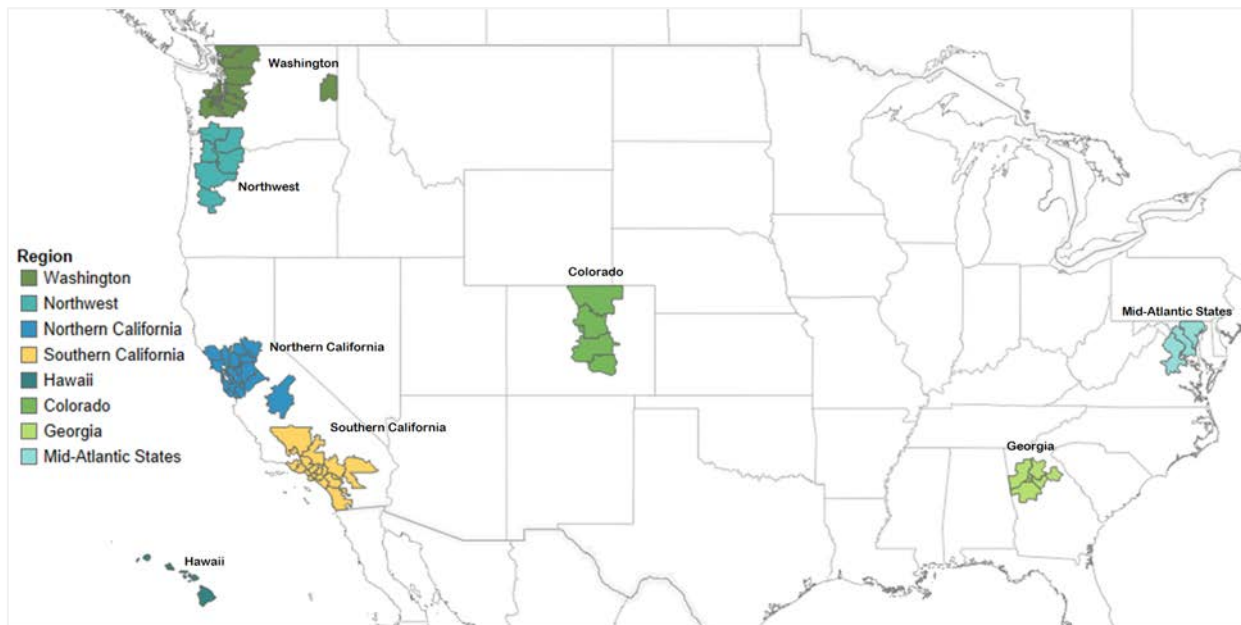
Introduction/background

About Kaiser Permanente

Kaiser Permanente is an integrated health care delivery system comprised of Kaiser Foundation Hospitals, Kaiser Foundation Health Plan, and physicians in the Permanente Medical Groups. For 75 years, Kaiser Permanente has been committed to shaping the future of health and health care — and helping our members, patients, and communities experience more healthy years. We are recognized as one of America’s leading health care providers and nonprofit health plans.

Kaiser Permanente is committed to helping shape the future of health care. Founded in 1945, Kaiser Permanente has a mission to provide high-quality, affordable health care services and to improve the health of our members and the communities we serve. We currently serve 12.5 million members in 8 states and the District of Columbia. Care for members and patients is focused on their total health and guided by their personal Permanente Medical Group 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.

Kaiser Permanente regions and CHNA service areas



About Kaiser Permanente Community Health

At Kaiser Permanente, we recognize that where we live and how we live has a big impact on our health and well-being. Our work is driven by our mission: to provide high-quality, affordable health care services and to improve the health of our members and our communities. It's also driven by our heritage of prevention and health promotion, and by our conviction that good health is a fundamental right.

As the nation's largest nonprofit, integrated health system, Kaiser Permanente is uniquely positioned to improve the health and well-being of the communities we serve. We believe that being healthy isn't just a result of high-quality medical care. Through our resources, reach, and partnerships, we are addressing unmet social needs and community factors that impact health. Kaiser Permanente is accelerating efforts to broaden the scope of our care and services to address all factors that affect people's health. Having a safe place to live, enough money in the bank, access to healthy meals, and meaningful social connections is essential to total health. Now is a time when our commitment to health and values compels us to do all we can to create more healthy years for everyone. We also share our financial resources, research, nurses and physicians, and our clinical practices and knowledge through a variety of grantmaking and investment efforts.

As we reflect on how 2020 changed the world, we must recognize that communities everywhere are coping with unprecedented challenges magnified by the COVID-19 pandemic and a renewed struggle for racial equity and social justice.

Through our continued focus on expanding our community health approach we laid the foundation for an acceleration of work to meet the challenges posed by the public health crises we now face. We dedicated ourselves to improving the social health of our 12.5 million members and the millions of people who live in the communities we serve.

Learn more about Kaiser Permanente Community Health at <https://about.kaiserpermanente.org/community-health>.

Kaiser Permanente's approach to community health needs assessment

The Affordable Care Act (ACA) was enacted in March 2010 to make health insurance available to more people, expand the Medicaid program, and support innovative medical care delivery to lower health care costs. The ACA also requires that nonprofit hospitals conduct a community health needs assessment (CHNA) every three years and develop an implementation strategy (IS) in response to prioritized needs.

Kaiser Permanente's CHNA process is driven by a commitment to improve health equity. Our assessments place a heavy emphasis on how the social determinants of health — including structural racism, poverty, and lack of access to health-related resources such as affordable housing, healthy food, and transportation — are affecting the health of communities. By analyzing community-level data and consulting individuals with deep and broad knowledge of health disparities, the Community Health team in each Kaiser Permanente service area has identified and prioritized needs unique to the community served. Each service area has developed an IS for the priority needs it will address, considering both Kaiser Permanente's and the community's assets and resources.

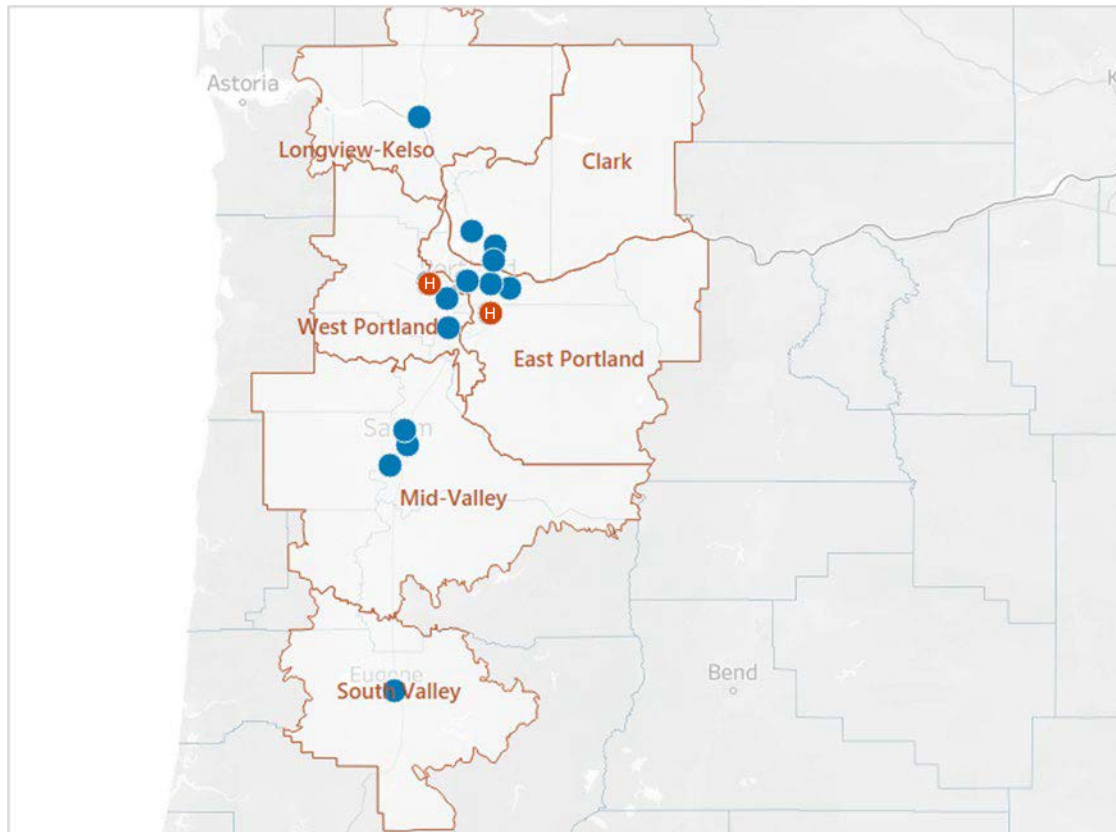
The Kaiser Permanente of the Northwest 2022 CHNA report and three-year IS are available publicly at <https://www.kp.org/chna>. In addition, the IS will be filed with the Internal Revenue Service using Form 990, Schedule H.

Community served

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

Northwest region and service areas

🏥 Kaiser Permanente hospital ● Kaiser Permanente medical offices



Northwest region demographic profile

Total population:	3,693,668
American Indian/Alaska Native	0.8%
Asian	6.0%
Black	2.4%
Hispanic	13.7%
Multiracial	3.7%
Native Hawaiian/other Pacific Islander	0.5%
Other race/ethnicity	0.2%
White	72.7%
Under age 18	21.7%
Age 65 and over	15.3%

Impact of structural racism in our communities

Hundreds of public health departments and other government agencies across the U.S. have declared racism a public health crisis. By structuring opportunity and assigning value based on how a person looks, racism operates at all levels of society and denies many individuals and communities the opportunity to attain their highest level of health. Racism is a driving force in social determinants of health like housing, education, and employment, and is a barrier to achieving health equity.

The inequality and disparities that have existed for people of historically underrepresented groups, such as communities of color, women, and low-income communities, have been made more visible by the COVID-19 pandemic. Data show that Hispanic, Black, and Indigenous populations are disproportionately affected by the disease and its economic impacts. In addition to the health crisis and amplification of existing health disparities, COVID-19 has also brought troubling reports of bias and discrimination against Asian Americans and others.

Since summer 2020, we've witnessed a raising of the consciousness of Americans and the world to a reality that we can no longer ignore: the treatment of Black Americans in our country is unacceptable. This is a moment in time when we must stand together against the racism and social injustice that remain endemic in our society and create long-term trauma that damages individuals' and communities' physical, mental, and social health. By pairing an acknowledgment of history with community-level data, we can work together to address the impacts of racism and discrimination.

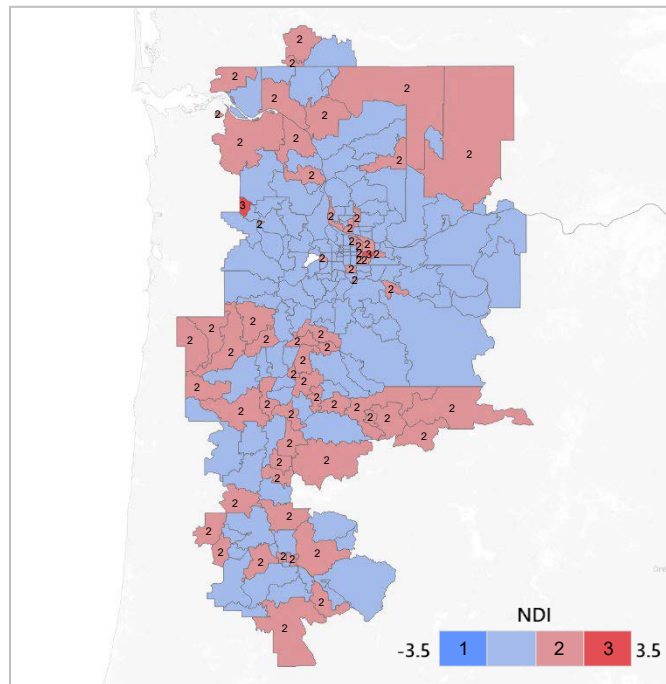
Neighborhood disparities in the Northwest region

The Neighborhood Deprivation Index (NDI) is a validated scale comprised of several of the social factors associated with lack of opportunity to be as healthy as possible. These measures are proxies for underlying determinants that disproportionately affect communities of color, including lack of employment opportunities, racist policies and practices, and unequal treatment by educational and criminal justice systems.

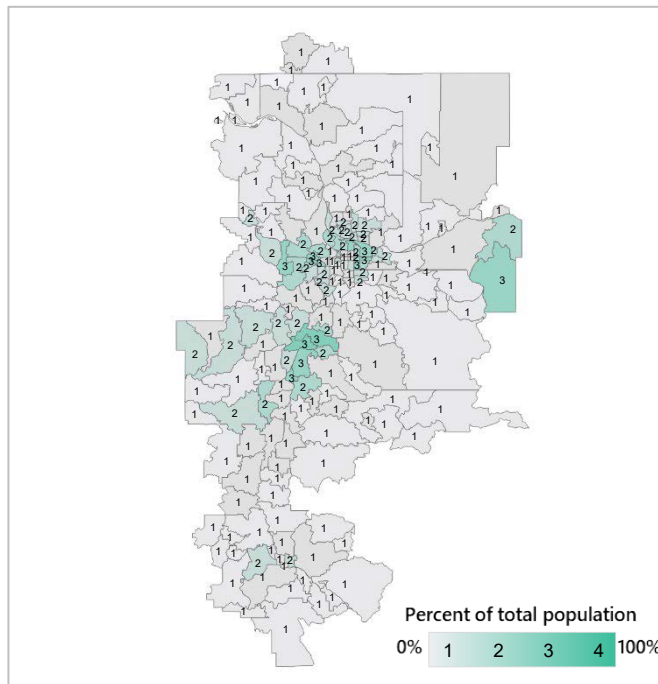
The map on the left shows the NDI for ZIP codes in the Northwest region. Areas with the highest NDI often are those with the highest proportion of people of color, shown in the map on the right.

NORTHWEST REGION

Neighborhood Deprivation Index



People of color



Kaiser Permanente's CHNA process

The CHNA process allows Kaiser Permanente to better understand the unique needs, stories, and opportunities to advance health and health equity in each of our communities. We are committed to gathering community perspectives on the disproportionate impacts of the COVID-19 pandemic as well as the impact of structural racism. Wherever possible, we have applied a racial equity analysis to data collection and analysis.

Identifying the highest priority needs for CHNA with an equity lens informs our community investments and helps us develop strategies aimed at making long-term, sustainable change, allowing us to deepen the strong relationships we have with other organizations that are working to improve community health. For the purposes of the CHNA, Kaiser Permanente defines a “health need” as a health outcome and/or the related conditions that contribute to a defined health need.

Hospitals and other partners that collaborated on the CHNA

No other hospitals or partner organizations collaborated on this assessment.

Consultants who were involved in completing the CHNA

The Center for Community Health and Evaluation (CCHE) provided support with secondary and primary data collection, data analysis, and the writing of this report. CCHE designs and evaluates health-related programs and initiatives throughout the United States and brings experience conducting tailored needs assessments and engaging stakeholders. CCHE is part of Kaiser Permanente Washington Health Research Institute.

Methods used to identify and prioritize needs

Secondary data

Kaiser Permanente's innovative approach to CHNA includes the development of a free, web-based data platform. The data platform provides access to a core set of approximately 100 publicly available indicators to understand health using the County Health Rankings population health framework, which emphasizes social and environmental determinants of health. The data platform is available to the public at kp.org/chnadata. Specific sources and dates of secondary data are listed in Appendix A.

Community input

In addition to reviewing the secondary data available through the Community Health Data Platform, and other local sources, each Kaiser Permanente service area collected primary data through key informant interviews with individuals and groups of individuals. To identify issues that most impact the health of the community Kaiser Permanente of the Northwest Community Health reached out to local public health experts, community leaders with expertise on local health needs, and individuals with knowledge and/or lived experience of racial health disparities. If available, insights from community partners' data collection were also considered in the assessment of needs. For a complete profile of community input, see Appendix B.

Written comments

Kaiser Permanente provides the public an opportunity to submit written comments on the service area's previous CHNA reports through CHNA-communications@kp.org. This email will continue to allow for written community input on the service areas' most recently conducted CHNA report.

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

Identifying priority health needs

Each Kaiser Permanente region analyzed and interpreted the primary and secondary data and used a set of criteria to determine what constitutes a health need in the community, including severity and magnitude of the need and evidence of clear disparities or inequities. Once all the community health needs were identified, they were prioritized, based on the criteria, resulting in a list of significant community health needs.

In conjunction with this report, Kaiser Permanente of the Northwest has developed an implementation strategy (IS) for the priority health needs it will address. These strategies will build on Kaiser Permanente's assets and resources, as well as evidence-based strategies, wherever possible. The IS will be filed with the Internal Revenue Service using Form 990 Schedule H. Both the CHNA and the IS will be posted publicly on our website, <https://www.kp.org/chna>.

Identification and prioritization of the community's health needs

Process for identifying community needs in the Northwest region

Before beginning the prioritization process, Kaiser Permanente of the Northwest Community Health chose a set of criteria to use in prioritizing the list of health needs:

- **Severity and magnitude of need:** Includes how measures compare to national or state benchmarks, relative number of people affected, impact of COVID-19 on the need.
- **Community priority:** The community prioritizes the issue over other issues
- **Clear disparities or inequities:** Differences in health factors or outcomes by geography, race/ethnicity, economic status, age, gender, or other factors

Measures in the Community Health Data Platform were clustered into 16 potential health needs, which formed the backbone of a prioritization tool to identify significant health needs in each service area. The prioritization tool aligned data collection methods with the set of criteria and could be customized to reflect important considerations in each community.

For secondary data, a score was assigned to each need (4: very high, 3: high, 2: medium, 1: lower) based on how many measures were more than 20 percent worse than national and/or state benchmarks. Themes from key informant interviews and other data sources were identified, clustered, and assigned scores on the same scale. Both the data platform and primary data informed scores for geographic, racial/ethnic, and other disparities.

In conversations with Kaiser Permanente of the Northwest Community Health stakeholders, each data collection method was assigned a weight, based on rigor of the data collection method, relative importance in ranking of needs (such as clearly identified racial disparities), and other considerations. Weighted values for each potential need were summed, converted to a percentile score for easy comparison, and then ranked highest to lowest to determine the five significant health needs.

Description of prioritized significant health needs in the Northwest region

1. Housing: Housing is a high need in the Northwest region. Residents experience higher than average housing costs and rents. Compounding access to affordable homeownership is an on-going housing scarcity that began in the pandemic. Currently, houses for sale are on the market for a few days and often receive multiple offers. This makes it hard for first time-home buyers and individuals with poor credit history, both factors that disproportionately impact people of color, to be competitive in the housing market. All key informants mentioned housing as an important need for the Northwest region to focus on addressing. Specific dimensions of housing to address include stability – especially among communities of color who experience greater risk of displacement and gentrification, affordability, overcrowding, and development of supportive housing.

2. Access to care: The Northwest region provides integrated health services, including medical, dental, and behavioral health, to best meet the needs of the community. Insurance coverage in the Northwest region is relatively high among both adults and children, in part due to the Cover All Kids Medicaid program that began in 2018. Even with high rates of insurance residents in the region still face challenges accessing care. Key informants serving rural communities shared that travel distance to facilities prevented residents from seeking preventative care and filling prescriptions. Across the region, access to providers who provide culturally relevant services is a challenge. In 2019, Oregon became the first state to allow dentists to provide vaccinations including seasonal flu and Human Papilloma Virus (HPV), bridging the gap between dental care and primary care. Oregon has enrolled most of its Medicaid patients in a program that includes comprehensive dental care for children. Yet, Oregon has one of the country's highest rates of childhood dental disease. Community leaders working with Black, Latino/a, and low income community members shared that dental care is often delayed or entirely neglected due to competing demands such as multiple jobs, lack of transportation, or lack of insurance. This may result in utilization of the emergency room to receive dental care.

3. Mental & behavioral health: In the Northwest region improving the mental health and well-being of the community requires addressing challenges such as adequate system support for depression, suicide, and unhealthy substance use. While access to mental health providers in the Northwest region is twice as high as the national average, mental health is a moderate need and disparities exist in both one's ability to access care and health outcomes among racial and ethnic groups. One key informant shared that there is a need for culturally conscious support and access to mental health care that's trauma informed. Many key informants shared concern for the mental health status of youth in the region. Part of this concern is born out of the isolation youth experienced during the pandemic as schools went online, and sports and other social activities were canceled.

4. Income & employment: Many factors, such as the COVID-19 pandemic, social unrest, and political divisiveness impact economic security in the Northwest region. During the onset of the pandemic, unemployment in Oregon peaked at just over 13 percent. As communities in the Northwest economically recover, unemployment rates continue to return to pre-pandemic levels. Access to jobs, and especially jobs that pay a living wage, is not equal, which creates disparities across the region. In most ZIP codes households earn less than the average national median household income. Throughout the region rates of preschool enrollment and elementary school proficiency index vary. ZIP codes with lower rates of preschool enrollment are more likely to have fewer students proficient in third grade reading. Community representatives stressed the importance of equitable funding and access to early childhood education.

5. Food insecurity: Since the onset of the pandemic many more Oregonian households have experienced food insecurity. In 2020, it is estimated that around 25 percent or 1 million Oregonians experienced food insecurity and that communities of color, immigrant communities, and LGBTQ+ communities were disproportionately impacted. At the end of 2020, 32 percent of Latino/a adults in Oregon living in households with children reported sometimes or often not having enough food to eat in the past week compared to 16 percent of the overall population. Food insecurity is in a recovery phase, slowly returning to pre-pandemic levels.

Health need profiles

Detailed descriptions of the significant health needs in the Northwest region follow.

Health need profile: Housing

Having a safe place to call home is essential for the health of individuals and families.

American families' greatest single expenditure is housing, and for most homeowners, their most significant source of wealth. Because of historic discriminatory lending policies and some current lending practices, people of color — especially Black community members — have been denied the opportunity to purchase a home, leading to enduring inequities.

Housing costs have soared in recent years, with many families experiencing difficulty paying for housing. Black and Hispanic renters in particular are more likely to live in cost-burdened households and face housing instability. Job loss associated with the COVID-19 pandemic, coupled with expiration of the federal eviction moratorium, has made many renters' situation even more precarious.

Homelessness across the U.S. was on the rise before the pandemic, including for families with children. In 2020, the number of single adults living outdoors exceeded the number living in shelters for the first time. Even more moved outside because of the pandemic, leading to a crisis in street homelessness in many American cities.

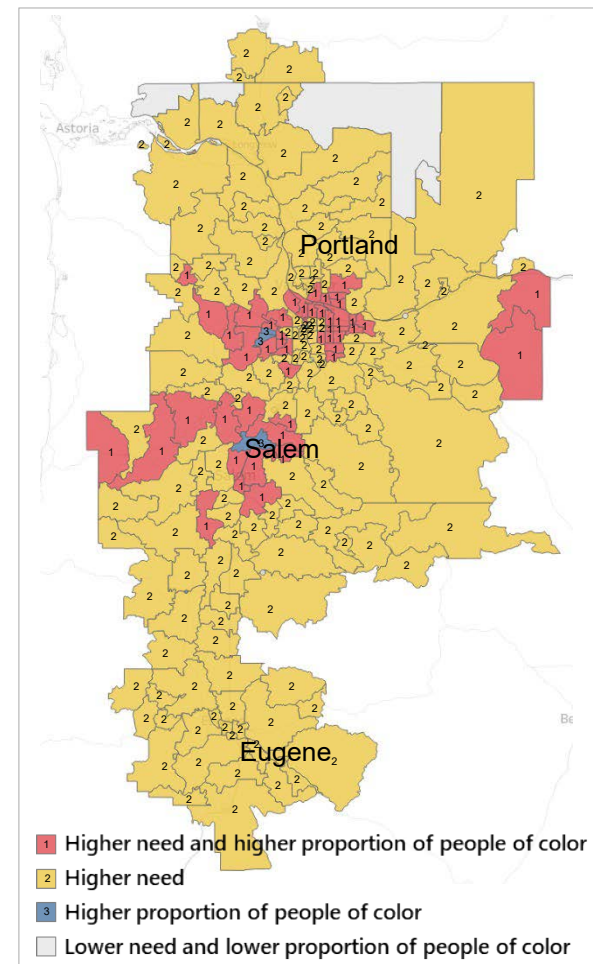
Housing is a high need in the Northwest region. Residents experience higher than average housing costs and rents, with more than 14 percent of homeowners experiencing a severe housing cost burden – spending more than 50 percent of their income on their mortgage. According to Zillow Research housing prices have increased in Oregon by 19.7 percent in the past year, which has resulted in an increase in the median house price to \$509,539. Compounding access to affordable homeownership is an on-going housing scarcity that began in the pandemic. Currently, Zillow Research reports that houses for sale are only on the market for 8 days and often receive multiple offers. This makes it hard for first-time home buyers and individuals with poor credit history, both factors that disproportionately impact people of color, to be competitive in the housing market.

Being able to buy a home is a steppingstone to accumulating wealth, and one that Black families have historically and systemically been excluded from achieving through racist practices such as redlining. In the region, ZIP codes with the higher proportion of people of color have lower rates of home ownership.

All key informants mentioned housing as an important need for the Northwest region to focus on addressing. Specific dimensions of housing to address include stability – especially among communities of color who experience greater risk of displacement and gentrification, affordability, overcrowding, and development of supportive housing.

HOUSING AFFORDABILITY INDEX, 2015-2019

Housing costs are high across the Northwest region. ZIP codes shaded **yellow** (1) are places with low housing affordability, those **shaded red** (1) are places with low housing affordability and where more than 27 percent of the population is people of color.



Source: [Kaiser Permanente Community Health Data Platform](#)

Additionally, across the region there is a scarcity of rental homes. Respondents reported that families cannot find rental homes in the open market and housing agencies often have a wait list with more than 1,000 families. This results in overcrowding and unstable housing conditions, which may lead to homelessness. When rental units are available, they are often above market rent, making those units unaffordable over the long term.

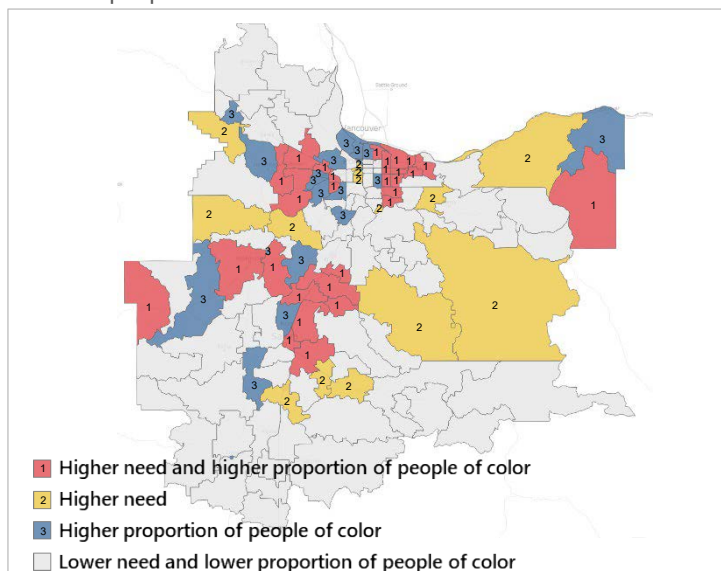
During the pandemic, our case investigators have been seeing trends like overcrowding in housing, and this is especially the case for families of racial and ethnic backgrounds where it's much more common to have intergenerational housing. We have stories of folks in Marion County who have 10 people living in a 2-bedroom home.

– Public health leader

As reported in the 2022 HCWC Community Health Assessment (draft), Portland, Oregon is the number one metropolitan area in the country where gentrification is occurring. It is a significant issue and opportunity not only for Portland but for the region, to prevent forced displacement in communities where gentrification is occurring through the investment in local small businesses, creation of new jobs or affordable housing in low-income neighborhoods. This was reinforced by key informants who shared that increasing opportunities to connect communities of color and low-income residents to capital, financial literacy, and homeownership accelerate pathways to accumulating wealth and maintaining a safe secure home.

OVERCROWDED HOUSING, WEST PORTLAND, MID VALLEY, AND EAST PORTLAND SERVICE AREAS, 2015-2019

ZIP codes shaded yellow (2) are places with overcrowded housing, those shaded red (1) are places with overcrowded housing and where more than 27 percent of the population is people of color.



Source: [Kaiser Permanente Community Health Data Platform](#)

If you get anyone experiencing any kind of barriers, it's nearly impossible to get them housed.

– Social service leader

Health need profile: Access to care

Access to comprehensive, quality health care services — including having insurance, local care options, and a usual source of care — is important for ensuring quality of life for everyone.

The Affordable Care Act (ACA) helped extend insurance coverage to many previously uninsured individuals and families, especially in Medicaid expansion states. Still, families with low income and people of color are more likely to be uninsured, and even with the ACA, many find insurance to be unaffordable.

Health insurance coverage increases use of preventive services and helps ensure people do not delay seeking medical treatment. Having an adequate number of primary care resources in a community also is important, including federally qualified health centers (FQHCs), which serve patients regardless of ability to pay.

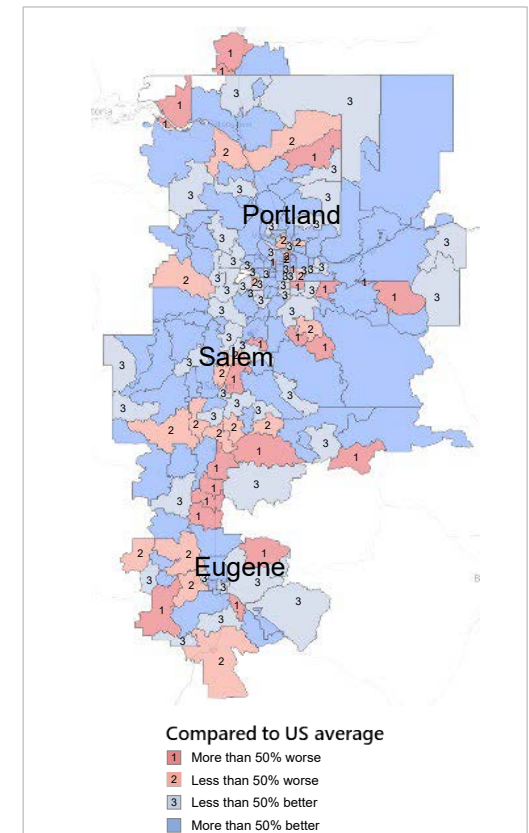
Insurance by itself does not guarantee access to appropriate care, and many community members experience barriers related to language, transportation options, and differential treatment based on race, as well as access to fewer health care resources.

Furthermore, the COVID-19 pandemic has disrupted health care for millions of Americans as health care resources were diverted from primary and preventive care, with telehealth becoming an increasingly important source of care. Existing racial and health inequities have been brought to light by the pandemic, with people of color accounting for disproportionate shares of COVID-19 cases, hospitalizations, and deaths.

The Northwest region provides integrated health services, including medical, dental, and behavioral health, to best meet the needs of the community. However, barriers exist to accessing care. Insurance coverage in the Northwest region is relatively high with only 6.3 percent of the population uninsured, which is 28 percent better than the national average. Coverage among children has greatly increased, in part due to the Cover All Kids Medicaid program that began in 2018. Currently 97 percent of children are insured, which far exceeds the national average. However, gaps in coverage among adults and children exist at higher rates in the Mid-Valley and South-Valley, especially along the I-5 corridor, as the map illustrates.

Even with high rates of insurance, residents in the region still face challenges to accessing care. Key informants serving rural communities shared that travel distance to facilities prevented residents from seeking preventative care and filling prescriptions. Across the region, access to providers who provide culturally relevant services is a challenge. This means more than just being able speak the language, it includes having similar lived experiences, understanding cultural norms, and understanding historical barriers to care. One health care leader shared that it is a challenge to “develop a culturally diverse workforce because we are growing and shifting, but we are still predominantly white and there are still just resource barriers and funding barriers to making sure that we’re delivering services in the most appropriate way that people will respond to.” When culturally relevant care is provided bias and discrimination are reduced and trust increases between patient and providers.

UNINSURED CHILDREN, NORTHWEST REGION, 2015-2019
Areas shaded **red (1)** are ZIP codes where the **percent of uninsured children is 50 percent worse** than the national average.



Source: [Kaiser Permanente Community Health Data Platform](#)

Impact of the COVID-19 pandemic

The switch to virtual visits during the pandemic allowed health systems to continue to provide care, but many patients faced challenges that included lack of access to a computer, internet, or a private space for a visit, as well as limited skills using digital platforms.

During the pandemic, many folks tried to make that transition to telehealth, but we have areas that don't have proper internet service. Or if you are a lower income household, and you don't have the appropriate technology to accommodate telehealth, then it is not really helpful. There's still some of those physical barriers”.

– Public health leader

Another unknown impact of the pandemic that respondents highlighted is the long-term impact of delayed care. At the onset of the pandemic, care, especially specialty care and dental care procedures, were canceled or postponed. Once restrictions were lifted the challenge was catching up and navigating long wait times (often more than 6 months) to reschedule procedures.

I found that our population got sicker through COVID. In my line of work, I probably lose 3 to 5 individuals per year. They just pass away to a myriad of reasons. The last 18 months I lost four times that. It was extreme because people couldn't get to their doctor. They couldn't get to the prevention they needed.

- Housing representative

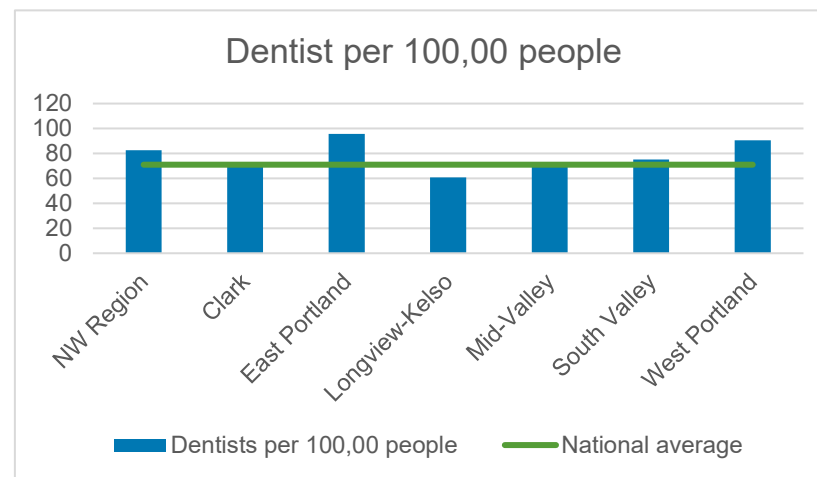
Oral Health

In 2019, Oregon became the first state to allow dentists to provide vaccinations including seasonal flu and Human Papillomavirus (HPV), bridging the gap between dental care and primary care. Oregon has enrolled 90% of its Medicaid patients in a program that includes comprehensive dental care for children. Yet, Oregon has one of the country's highest rates of childhood dental disease. At least 1 in 5 children has tooth decay and in low-income households more than half of all children experience some form of tooth decay.

Dental issues are a huge problem. Like when somebody has an abscess and they don't have access to regular dental care, then it becomes infected, and then we're trying to help them get care as fast as possible and that is usually at the ER.

– Social service leader

Access to dentist is a moderate need with 82.6 dentists per 100,000 people, which is better than the national average of 71.0 dentists per 100,000 people. Across the region, access to dentists varies – in the East Portland service area there are 95.6 dentists per 100,000 people, while in the Longview-Kelso service area there are 60.9 dentists per 100,000 people. Community leaders working with Black, Latino/a, and low income community members shared that dental care is often delayed or entirely neglected due to competing demands such as multiple jobs, lack of transportation, or lack of insurance. This may result in utilization of the emergency room to receive dental care.



Source: [Kaiser Permanente Community Health Data Platform](#)

Health need profile: Mental & behavioral health



Mental health affects all areas of life, including a person's physical well-being, ability to work and perform well in school and to participate fully in family and community activities.

Anxiety, depression, and suicide ideation are on the rise due to the COVID-19 pandemic, particularly among Black and Hispanic Americans.

Those facing challenges related to lower economic opportunity often experience high levels of stress in their daily lives, coupled with fewer resources for coping. Children and youth experiencing stress have an increased likelihood of poorer mental and physical health.

Deaths of despair — those due to suicide, drug overdose, and alcoholism — are on the rise, and males, American Indian/Alaska Native people, and those who are unemployed are at greater risk.

Communities across the country are experiencing a critical lack of capacity to meet the increased demand for mental health services. At the same time, rapid adoption of digital platforms for behavioral health services has helped reduce barriers to in-person mental health care.

Gaps in the need for service and capacity of the mental and behavioral health system

Addressing mental and behavioral health for all residents is a high need for the Northwest region. Improving the mental health and well-being of the community requires addressing challenges such as adequate system support for depression, suicide, and unhealthy substance use. In the region there are 517 mental health providers per 100,000 population, which is twice as high as the national average (247 per 100,000 population).¹ However, Oregon has the fourth highest rate of unmet need for mental health treatment in the country.²

Oregon's behavioral health workforce has been characterized by a lack of racial/ethnic diversity, with Latino/a providers representing a particular shortage. For example, in 2018, only 5 percent of prescribers identified as Latino/a, although 13 percent of the state's population is Latino/a.³ When physicians and clients share the same race, clients may experience greater satisfaction and better care. One key informant reinforced that there is a need for culturally conscious support and access to mental health care that's trauma informed.

The Oregon Tribal Behavioral Health Strategic Plan – 2019 to 2024 states that the American Indian/Alaska Native population experience the same behavioral health challenges common across the state, "but they face significant disparities in morbidity, mortality, health outcomes, and access to care." Specific challenges related to providing comprehensive culturally responsive services include a workforce that is defined by non-native culture, systems that do not follow trauma-informed approaches and on-going relationship building between the state and tribal/urban systems.

Community safety

Informants also shared that that people of color don't feel safe in Marion County, home to the state capital – Salem. There are often rallies in the area, such as the Proud Boys, additionally, there have been conflicts around topics such as Black Lives Matter, and COVID-19 restrictions and mandates. This turbulence creates unrest and adds stress, which overtime can lead to an increase in anxiety, substance misuse, and depression. The historical and present-day trauma impacting communities of color requires transformation of policies, systems, and places to create communities where well-being thrives.

I think we struggle with having a sense of unifying political leadership and that is preventing us from making a difference in the social and political determinants of health.

– Public health leader

Youth mental health

Many key informants shared concern for the mental health status of youth in the region. Part of this concern is born out of the isolation youth experienced during the pandemic as schools went online, and sports and other social activities were canceled. According to a 2020 report by Mental Health America, Oregon ranked 47th in the nation for prevalence of mental illness among youth.

Deaths by suicide

In the Northwest region, the age-adjusted suicide rate is higher than the national average in all service areas. The suicide rate is lowest in the West Portland service area and highest in the South Valley service area. According to the Center for Disease Control and Prevention factors linked to death by suicide include substance misuse, job or financial problems, relationship problems, physical or mental health problems. These factors may be exacerbated in rural counties with less social connectivity and limited access to services.

Unhealthy substance misuse

Another issue that service providers face in region across social support systems is the complexities around managing people with co-occurring mental health disorders and unhealthy substance misuse. There are fewer deaths from opioid overdoses than the national average. However, in most of the Northwest service areas a higher percent of the population reports excessive drinking and there is a higher percent of deaths caused by impaired driving.

Health and wellbeing

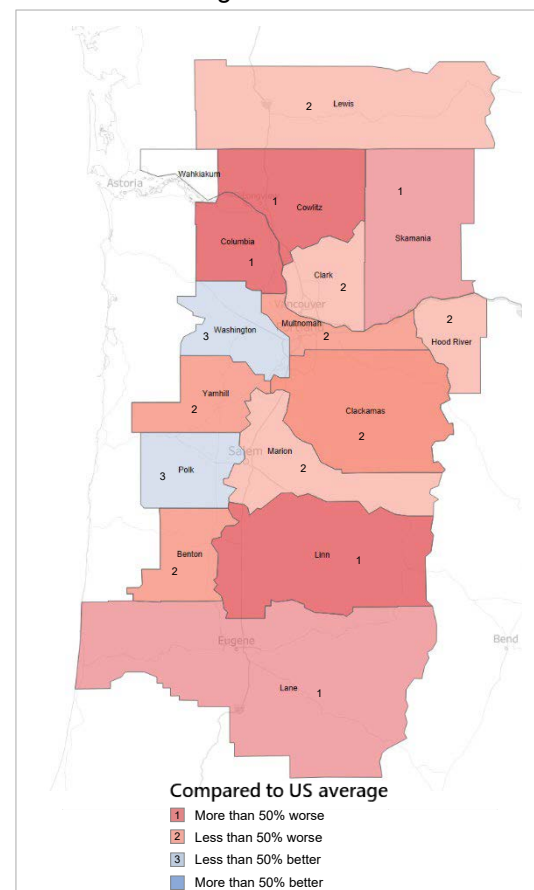
Healthy People 2030 describe health and well-being as “as how people think, feel, and function—at a personal and social level—and how they evaluate their lives as a whole.” In the Northwest many key informants shared that there is promising work underway to improve the well-being of communities. Specific strategies include working to build trust among community members, creating inclusive spaces for dialogue and understanding, and investing in communities that have historically been neglected.

I was just in a conversation with behavioral health and homeless service providers and there's a lot of challenges working with this population in particular. First figuring out where a substance use disorder ends and where other mental health disorders began, and then figuring out how to treat those and manage the care across different services.

– Public health leader

SUICIDE DEATHS, NORTHWEST REGION, 2020

Areas shaded **dark red (1)** are ZIP codes where the rate of **suicide deaths is 50% worse** than the national average.



Source: [Kaiser Permanente Community Health Data Platform](#)

¹Mental Health Providers per 100,000 population. Kaiser Permanente Community Health Dashboard.

²Behavioral Health Workforce Report to the Oregon Health Authority and State Legislature. Center for Health Systems Effectiveness at Oregon Health & Science University. February 2022.

³An Analysis of Oregon's Behavioral Health Workforce: Assessing Capacity of Licensed and Unlicensed Providers to Meet Population Needs. Farley Health Policy Center, March 2019.

Health need profile: Income & employment

Economic opportunity provides individuals with jobs, income, a sense of purpose, and opportunities to improve their economic circumstances over time.

People with steady employment are less likely to have an income below poverty level and more likely to be healthy.

Currently around 11 percent of people living in Kaiser Permanente communities — and 14 percent of children — live in poverty. Those not having enough resources to meet daily needs such as safe housing and enough food to eat are more likely to experience health-harming stress and die at a younger age.

Americans with lower incomes are more likely to live in neighborhoods lacking access to healthy food and safe physical activity and have higher exposure to environmental pollutants. Compared to white Americans, those who identify as Black, Hispanic, or American Indian are more likely to have lower incomes, fewer educational opportunities, and shorter life expectancies

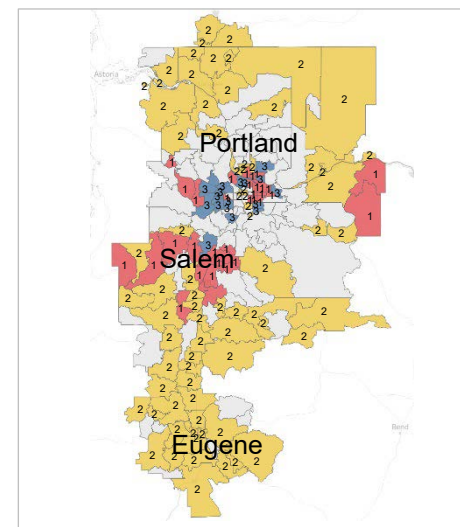
Income inequality has been increasing over recent decades. During the first year of the COVID-19 pandemic, higher levels of economic inequality were associated with higher levels of COVID incidence and deaths.

Many factors, such as the COVID-19 pandemic, social unrest, and political divisiveness impact economic security in the Northwest region. During the onset of the pandemic, unemployment in Oregon peaked at just over 13 percent. As communities in the Northwest economically recover, unemployment rates continue to return to pre-pandemic levels.

Household Income

Access to jobs, and especially jobs that pay a living wage, is not equal, which creates disparities across the region. The map below shows that in most ZIP codes (areas shaded yellow and red) households earn less than the average national median household income (\$70,036). Areas shaded red are ZIP codes where a relatively higher proportion of people of color reside and earn less than the national average median household income.

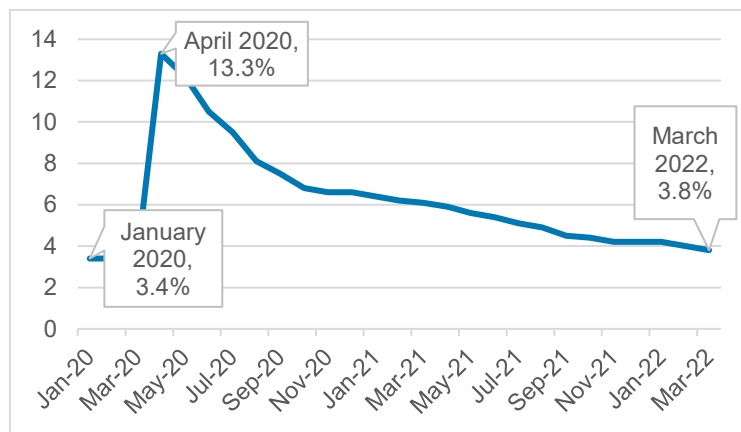
MEDIAN HOUSEHOLD INCOME, NORTHWEST REGION, 2015-2019



- Higher need and higher proportion of people of color
- Higher need
- Higher proportion of people of color
- Lower need and lower proportion of people of color

Source: [Kaiser Permanente Community Health Data Platform](#)

SEASONALLY ADJUSTED UNEMPLOYMENT, OREGON, 2020-2021



Source: [US Bureau of Labor Statistics](#)

In addition to the gap in household income across racial and ethnic groups, gender pay differences continue to persist in the Northwest region. In Oregon, women earn .82 cents for each dollar earned by men, this is close to the national average where women earn .80 cents for each dollar earned by men. Informants shared that women of color were particularly impacted during the pandemic often serving in frontline jobs and providing additional family support for children and extended family members. Access to equal pay reduces economic instability and increases economic stability for households. Respondents shared that businesses should continue to address bias in employment practices and create equitable inclusive workplaces.

I cannot imagine the stress and strain that the last two years would have on a single parent. Maybe somebody who didn't have a job or somebody who had a job and had to leave that job to support kids that were home. And that that's got to be incredibly stressful in a toxic way.

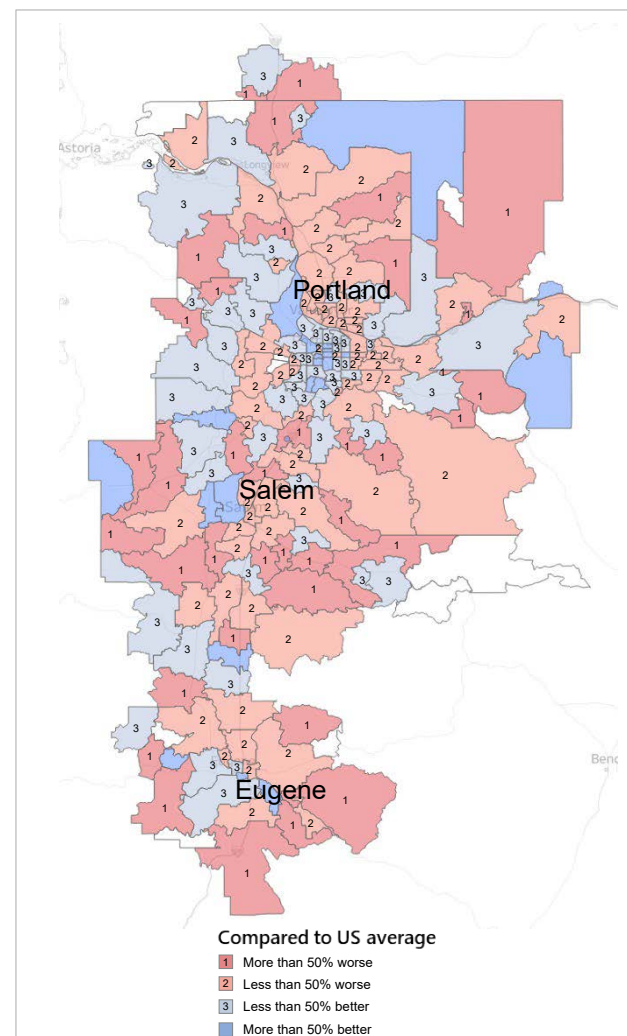
– Coalition member

Education

Throughout the region rates of preschool enrollment and elementary school proficiency index vary. ZIP codes with lower rates of preschool enrollment are more likely to have fewer students proficient in third grade reading. According to County Health Rankings, school achievement is a predictor of future academic outcomes, which is connected to better health outcomes including increased educational and employment opportunities. Advancing strategies that create equitable access and funding to support education opportunities is key.

PRESCHOOL ENROLLMENT, NORTHWEST REGION, 2015-2019

Areas shaded **dark red (1)** are ZIP codes where **preschool enrollment is 50% worse** than the national average.



Source: [Kaiser Permanente Community Health Data Platform](#)

Health need profile: Food insecurity

Many people do not have enough resources to meet their basic needs, including having enough food to eat to lead an active, healthy life.

Black and Hispanic households have higher than average rates of food insecurity; disabled adults may also be at higher risk because of limited employment opportunities and high health care expenses.

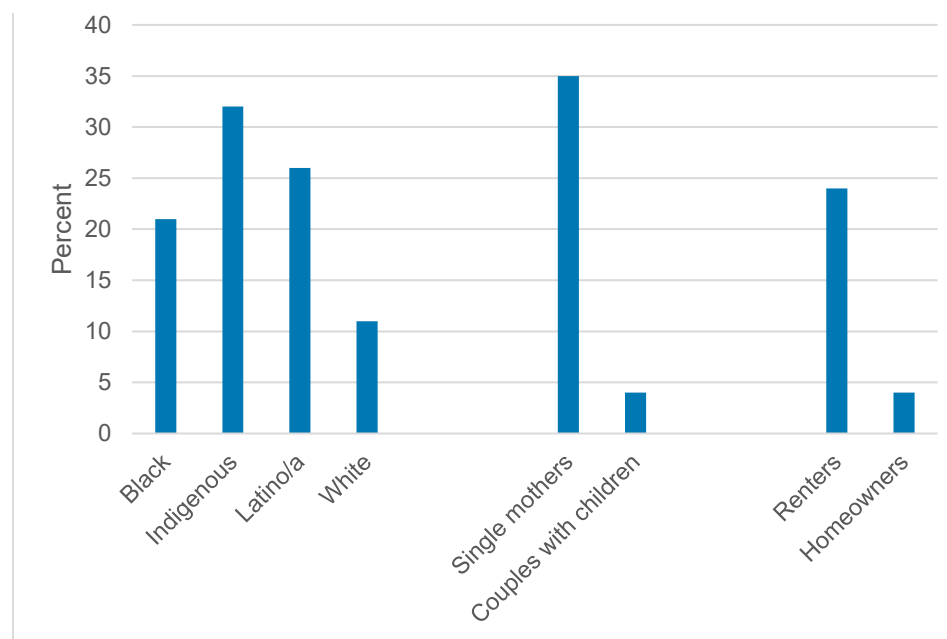
Many diet-related conditions, including diabetes, hypertension, heart disease, and obesity, have been linked to food insecurity. Having both Supplemental Nutrition Assistance Program benefits and convenient access to a supermarket can improve diet quality as well as food security.

Rates of food insecurity increased among families experiencing job loss because of the COVID-19 pandemic — as a result of the pandemic, there has been an estimated 60 percent increase in U.S. food insecurity. As the pandemic worsened, many who qualified for food assistance did not sign up for benefits, in part because of fear related to enrolling in government programs, uncertainty about eligibility, and worry about health risks of in-person appointments.

In the Northwest region, 11.2 percent of population was food insecure in 2018, which is close to the national average of 11.8 percent of the population for that same year. However, disparities exist among racial ethnic groups, single mothers, and renters.

FOOD INSECURITY, OREGON, 2018

Percent population experiencing food insecurity by race, relationship status, and homeownership.



Source: [Oregon Huger Task Force](#)

Since the onset of the pandemic many more Oregonian households have experienced food insecurity. In 2020, it is estimated that around 25 percent or 1 million Oregonians experienced food insecurity and that communities of color, immigrant communities, and LGBTQ+ communities were disproportionately impacted. At the end of 2020, 32 percent of Latino/a adults in Oregon living in households with children reported sometimes or often not having enough food to eat in the past week compared to 16% of the overall population. Food insecurity is in a recovery phase, slowly returning to pre-pandemic levels.

SNAP Enrollment

Many ZIP codes in the Northwest region have Supplemental Nutrition Assistance Program (SNAP) enrollment that is more than 50 percent higher than the national average. Households rely on SNAP resources to for additional economic support. During the pandemic, SNAP benefits were expanded to include additional access to meals and supplementary food. However, if a household lacked transportation to meal distribution sites, they were unable to receive the benefits. Key informants shared that in rural areas school districts used school buses to deliver food to homes, following the established bus routes.

This [CHNA] cycle basic needs are not being met. It's a humanitarian crisis, you go to downtown Eugene and there's just people without housing, access childcare, healthy food, and just basic health care. There's no availability and the pandemic has exacerbated this as well.

– Social service representative

FOOD BUDGET SHORTFALL, 2020

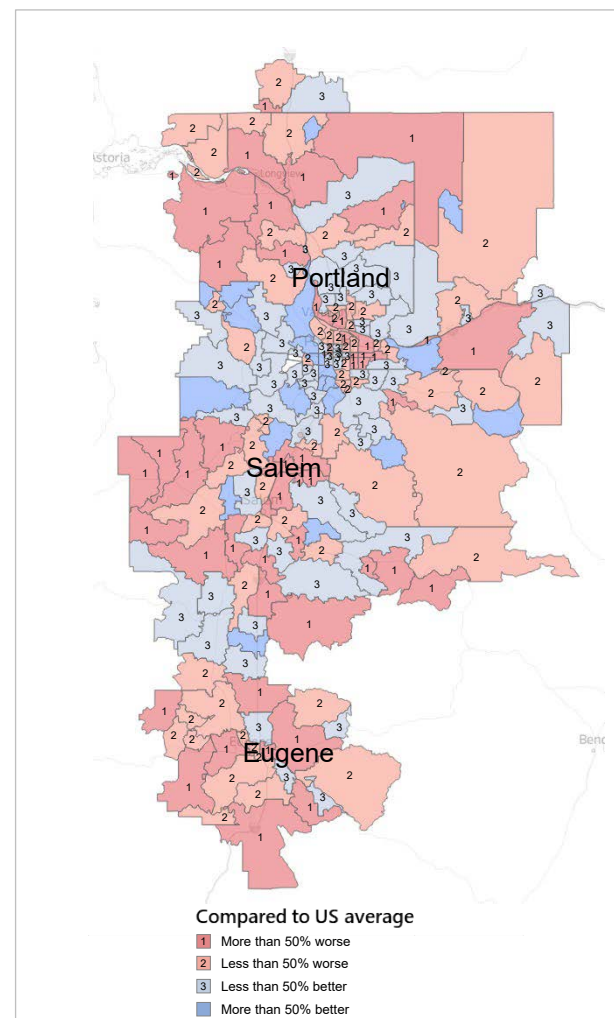
Amount of food benefits needed to ensure nobody goes hungry.

	Annual food budget shortfall
Region	\$ 140,638,164
Clackamas	\$ 22,305,789
Multnomah	\$ 59,185,810
Washington	\$ 30,296,160
Clark	\$ 28,850,404

Source: *Map the Meal Gap. Feeding America.*

SNAP ENROLLMENT, NORTHWEST REGION, 2015-2019

Areas shaded **dark red (1)** are ZIP codes where SNAP enrollment is **50 percent worse** than the national average.



Source: [Kaiser Permanente Community Health Data Platform](#)

Community resources potentially available to respond to health needs

The CHNA process included an identification of existing community assets and resources to address health needs. The Northwest region includes community-based organizations, government departments and agencies, hospital and clinic partners, and other community members and organizations that address many community health needs.

Key resources available to respond to the identified health needs of the community are listed in Appendix C.

Kaiser Permanente of the Northwest 2019 Implementation Strategy evaluation of impact

In the 2019 IS process, all Kaiser Permanente service areas planned for and drew on a broad array of resources and strategies to improve the health of our communities, such as grantmaking, in-kind resources, and partnerships, as well as several internal Kaiser Permanente programs including Medicaid, the Children's Health Insurance Program (CHIP) and other government-sponsored programs, charitable health coverage, medical financial assistance, health professional training, and research. In addition to our direct spend, we also leveraged assets from across Kaiser Permanente to help us achieve our mission to improve the health of communities. This comprehensive approach includes activities around supplier diversity, socially responsible investing, and environmental stewardship.

Kaiser Permanente of the Northwest's 2019 Implementation Strategy (IS) report identified activities to address significant health needs prioritized in the 2019 CHNA report. The impact of those activities is described in this section; the complete 2019 IS report is available at <https://www.kp.org/chna>.

Kaiser Permanente of the Northwest 2019 Implementation Strategy priority health needs

1. Access to care
2. Mental health
3. Economic Security

2019 Implementation Strategy evaluation of impact by health need

Grants to community-based organizations are a key part of the contributions Kaiser Permanente makes each year to address identified health needs, and we prioritize work intended to reduce health disparities and improve health equity. Kaiser Permanente also serves the community through programs to improve access to care, including Medicaid, charitable health coverage, and medical financial assistance. At the time this CHNA report was completed, Kaiser Permanente of the Northwest Community Health had information on the impact of these activities from 2020 and 2021 and will continue to monitor strategies implemented in 2022.

Kaiser Permanente of the Northwest addresses community health needs in multiple ways, including grantmaking, access to care programs, and socially responsible investing. Several of those activities during 2020-2021 are highlighted in the table below.

Additionally, the Kaiser Permanent Northwest has funded significant contributions to the Oregon Community Foundation in the interest of funding effective long-term, strategic community benefit initiatives. During 2020-2021 a portion of money managed by this foundation was used to award 17 grants totaling \$2,158,500 in service of 2019 IS health in the Northwest region.

One example of a key accomplishment in response to our 2019 IS includes partnering with the Inner City Capital Connections (ICCC) to address economic security. During 2019-2021, three cohorts totaling 291 small businesses owned by people of color utilized resources to expand their business acumen, gain access to capital spurring growth, and create jobs for local residents.

As the health and economic toll of COVID-19 continued to mount, Kaiser Permanente accelerated efforts to broaden the scope of our care and services to address all factors that affect people’s health. For example, in 2020 Kaiser Permanente provided grants totaling \$6.3 million to strengthen COVID-19 prevention and response for people experiencing homelessness across our regions and service areas. And in 2021, the Northwest partnered with Medical Teams International to administer 9,046 vaccine doses and provide 818 dental visits at 325 community-based mobile health clinics across the region in underserved, culturally specific communities including those experiencing homelessness, immigrant and refugee populations, people recovering from substance abuse disorders, seniors, veterans, and children ages 5-11 at clinics hosted by local schools.

Kaiser Permanente of the Northwest 2019 IS priority health needs and strategies

Access to care

Care and coverage: Kaiser Permanente of the Northwest ensures health access by serving those most in need of health care through Medicaid, the Children’s Health Insurance Program (CHIP) and other government-sponsored programs, charitable health coverage, and medical financial assistance.

	Individuals served		Amount	
	2020	2021	2020	2021
Medicaid, CHIP and other government-sponsored programs	66,751	75,467	\$27,605,858	\$25,650,096
Charitable Health Coverage	927	942	\$1,168,748	\$449,971
Medical Financial Assistance	8,894	7,982	\$12,417,318	\$10,791,292
Total care & coverage	76,572	84,391	\$41,191,924	\$36,891,359

Other access to care strategies: During 2020-2021, 66 grants were awarded to community organizations, for a total investment of \$7,825,377 to address access to care in the Northwest region.

Examples and outcomes of most impactful other strategies

Health Systems Access to Care Fund

Oregon Community Foundation funded the Health Systems Access to Care Fund at the Oregon Community Foundation. The Fund provided direct support to community clinics in Oregon and SW Washington to serve approximately 10,000 uninsured and underinsured people with no other access to care.

Safety Net Vaccine Equity Initiative

Oregon Primary Care Association connected patients to vaccines and ensure equitable vaccine access across our communities. Federally Qualified Health Centers and other safety net providers will work with partners to increase rates of vaccinations, build vaccine administration capacity, and expand vaccination access to 226,000 residents.

The Community Care Collaborative (CCC)

Project Access Now was awarded \$2,110,878 over three years to increase the inclusivity, efficiency, and accessibility of available health care services. The program supported 15,000 members of immigrant and refugee communities, those for whom English is not a primary language, and communities of color in the Portland metropolitan region with increased services.

Mental health

During 2020-2021, 16 grants were awarded to community organizations, for a total investment of \$1,352,498 to address mental health in the Northwest region.

Examples and outcomes of most impactful strategies

Safe Disposal for Safe Communities

Lines for Life was awarded \$200,000 over two years to address improper medication disposal. This program provided 365 resident access to safe medication disposal and ensured that the use of safe medication disposal is simple, easy, and available to all consumers.

Improving Social and Academic Success through Trauma-informed Schools

Washington State University was awarded \$799,998 over 41 months to deliver CLEAR in four elementary schools under the Thriving Schools Initiative. CLEAR is a consultation model engaging school staff and leadership with support from a trauma specialist working with the school two days each month over three years. This program will provide 3,000 students with supports to improve behavior which will reduce the need for referrals, suspensions, and expulsions.

Boys & Girls Club of Southwest Washington – Community-Clinic Integration

The Boys & Girls Club of Southwest Washington was awarded \$24,500 to incorporate the Community-Clinic Integration initiative into existing programming with a specific focus on youth violence prevention work. This initiative is expected to serve 50 youth with a combination of small group mentoring case management, youth development programming, and family outreach.

Economic opportunity

During 2020-2021, 40 grants were awarded to community organizations, for a total investment of \$1,753,086 to address economic opportunity in the Northwest region.

Examples and outcomes of most impactful strategies

Phoenix Program: Transitional Housing Project

ShelterCare was awarded \$300,000 over 24 months to provide transitional housing individuals with chronic histories of homelessness, medical fragility, high system use, and/or a serious behavioral health diagnosis with the intent to move them to stable permanent housing. The program provides 93 individuals supportive housing and coordinated health and behavioral health care.

Housing for Health at Redwood Crossing

The Mid-Willamette Valley Community Action Agency will house the most vulnerable individuals experiencing homelessness in Marion County. Through safe and stable housing, daily support, robust case management, and partnerships with health providers, 120 residents were provided permanent and supportive housing that facilitates positive health outcomes and a greater quality of life.

Inner City Capital Connections Portland 2021

The Initiative for a Competitive Inner City Inc. built the capacity of under-resourced Portland-based entrepreneurs to access capital and achieve sustainable growth in revenue and employment. This program will provide a cohort of 50-75 entrepreneurs access to capacity-building executive education, coaching and mentoring, connections to business networks and contracting opportunities, and access to capital.

Appendix

- A. Secondary data sources
- B. Community input
- C. Community resources

Appendix A: Secondary data sources

Kaiser Permanente Community Health Data Platform

Source	Dates
1. American Community Survey	2015 - 2019
2. Behavioral Risk Factor Surveillance System	2020
3. CDC, Interactive Atlas of Heart Disease and Stroke	2016 - 2018
4. Center for Medicare & Medicaid Services	2018
5. CMS National Provider Identification	2019
6. Dept of Education ED Facts & state data sources	Varies
7. EPA National Air Toxics Assessment	2014
8. EPA Smart Location Mapping	2013
9. Esri Business Analyst	2020
10. Esri Demographics	2020
11. FBI Uniform Crime Reports	2014 - 2018
12. Feeding America	2018
13. FEMA National Risk Index	2020
14. Harvard University Project (UCDA)	2018
15. HRSA Area Resource File	2019
16. HUD Policy Development and Research	2020
17. National Center for Chronic Disease Prevention and Health Promotion	2018
18. National Center for Education Statistics	2017 - 2018
19. National Center for Health Statistics	2018
20. National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention	2018
21. NCHS National Vital Statistics System	2015 - 2019
22. NCHS US Small-area Life Expectancy Estimates Project	2010 - 2015
23. NCI State Cancer Profiles	2013 - 2017
24. NCI United States Cancer Statistics	2013 - 2017
25. NHTSA Fatality Analysis Reporting System	2014 - 2018
26. US Geological Survey; National Land Cover Database	2016
27. USDA Food Environment Atlas	2016

Additional secondary data sources

Source	Dates
1. Feeding America. Map the Meal Gap.	2020
2. FRED Economic Data	2020-2021
3. Oregon Oral Health Surveillance System	2019
4. Oregon Hunger Task Force	2019
5. Zillow Research	2022

Appendix B. Community input

	Data collection method	Affiliation	Number	Perspectives represented	Role	Date
1	Key informant interview	United Way of Lane County	1	Nonprofit, rural	Leader	09/15/2021
2	Key informant interview	Centro Latino Americano	1	Latino/a	Leader, member	11/05/2021
3	Key informant interview	Willamette Health Council	1	Rural	Leader, representative	11/03/2021
4	Key informant interview	Pacific Source	1	Health care, equity, Coordinated Care Organization	Leader	09/15/2021
5	Key informant interview	Mid-Willamette Community Action Agency	1	Social services, emergency assistance, people experiencing poverty	Leader	10/29/2021
6	Key informant interview	Youth & Family Link	1	Youth and families experiencing homelessness	Leader	09/01/2021
7	Key informant interview	Lower Columbia CAP	1	Social services, emergency assistance	Leader	10/28/2021
8	Key informant interview	Pacific Source Lane County	1	Health care, Coordinated Care Organization	Leader	8/23/2021
9	Key informant interview	Marion County Health & Human Services	1	Public Health	Leader	8/25/2021

Appendix C. Community resources

Identified need	Resource provider name	Summary description
Multiple needs	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, 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.
Access to care	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.
Mental/behavioral health	Oregon Health Authority – Behavioral health services	To help Oregonians to achieve physical, mental and social wellbeing by providing access to health, mental health, and addiction services and supports.
	National Alliance on Mental Illness: Oregon	Our mission is to improve the quality of life for individuals living with mental illness and for their families and other loved ones through education, support, and advocacy. We offer programs through our 15 local chapters across Oregon, both in person and online via Zoom.
Housing	Central City Concern	The mission of Central City Concern is to provide pathways to self-sufficiency through active intervention in poverty and homelessness.
	Mid-Willamette Valley Community Action Agency	We have designed a spectrum of breakthrough programs that help low-income people move from instability to self-sufficiency. Brought together, these services benefit the individual and our society by solving poverty’s root causes.

Identified need	Resource provider name	Summary description
Food security	Oregon Food Bank	The mission of the Oregon Food Bank is to eliminate hunger and its root cause because no one should be hungry.
	Partners for a Hunger-Free Oregon	Partners for a Hunger-Free Oregon envisions an Oregon where everyone is healthy and thriving, with access to affordable, nutritious and culturally appropriate food. To bring that vision into reality, we raise awareness about hunger, connect people to nutrition programs, and advocate for systemic changes.