2022

Community Health Needs Assesment

Virginia Mason Medical Center

Virginia Mason
Franciscan Health™
Virginia Mason Medical Center

Adopted in June, 2022

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About VMFH

A MESSAGE FROM KETUL J. PATEL

Dear Community Members,

At Virginia Mason Franciscan Health (VMFH), we are expanding access to care and improving the health of our communities by building on the strength of more than 300 sites of care, 11 top-tier hospitals, 18,000 team members, and over 5,600 physicians and advance practice providers (APPs). Together, we deliver world-class clinical excellence from basic health needs to the most complex, highly specialized care – with the patient always at the center of everything we do. By bringing together the best and brightest health care minds in the region and a commitment to investing in innovation, VMFH is delivering the most advanced therapies and technologies for our patients from some of the country's most prestigious experts and hospitals.

More than 100 years ago, the hospitals of Virginia Mason Franciscan Health were founded on the vision to provide comprehensive, high-quality care to everyone in our communities, with a focus on reaching the most vulnerable. We are proud to be the home of Bailey-Boushay House, the first skilled-nursing and outpatient chronic care management program in the United States designed specifically to meet the needs of people with HIV/AIDS, and Benaroya Research Institute, which is internationally recognized for autoimmune disease research.

Our commitment to building healthy communities runs deep. We work year-round with our local public health departments, other health care systems, sports partners and community stakeholders to raise awareness and address community health needs. I'm especially proud of the ways our team went above and beyond to care for patients, and one another, throughout the pandemic, while also considering the community's needs in expanding COVID-19 vaccine access or encouraging preventative health screenings.

As part of CommonSpirit Health, one of the largest health systems in the US, we are committed to building a nation of healthy communities. We embrace our responsibility to develop new ways to improve health for all, including innovative solutions for care delivery and reaching underserved communities. We are steadfast advocates for advancing health equity and reversing the long history of health disparities based on a person's race, location or means.

Every three years we conduct a community health needs assessment to understand the needs of our local communities and develop strategies to meet them. The findings of the assessment drive our community work and serve as a guide to help us improve the community's health status and overall quality of life, reduce health disparities within the community and increase access to preventive services.

On behalf of Virginia Mason Franciscan Health, I am committed to our common purpose of expanding access to care, advocating for the most vulnerable, and improving the health of our communities for generations to come.

Ketul J. Patel
Chief Executive Officer
Virginia Mason Franciscan Health
Division President, Pacific Northwest
CommonSpirit Health

About VMFH

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COMMUNITY HEALTH NEEDS ASSESSMENT

PURPOSE

The purpose of this community health needs assessment (CHNA) is to identify and prioritize significant health needs of the community served by Virginia Mason Medical Center. The priorities identified in this report help to guide the hospital's community health improvement programs and community benefit activities, as well as its collaborative efforts with other organizations that share a mission to improve health. This CHNA report meets requirements of the Patient Protection and Affordable Care Act that not-for-profit hospitals conduct a community health needs assessment at least once every three years.

COMMONSPIRIT HEALTH COMMITMENT AND MISSION STATEMENT

Virginia Mason Franciscan Health's dedication to engaging with the community, assessing priority needs, and helping to address them with the community health program activities is in keeping with its mission. As CommonSpirit Health, we make the healing presence of God known in our world by improving the health of the people we serve, especially those who are vulnerable, while we advance social justice for all.

KING COUNTY HOSPITALS FOR A HEALTHIER COMMUNITY

Virginia Mason Franciscan Health (VMFH) is a member of Hospitals for a Healthier Community (HHC). HHC is a collaborative of 10 hospitals and health systems in King County and Public Health-Seattle & King County. HHC members joined forces to identify important health needs and assets in the communities they serve. VMFH worked with HHC to develop a collaborative Community Health Needs Assessment (CHNA).

The HHC CHNA assessment includes a mixture of health data, community input and resources that help guide hospitals and the wider community in addressing needs.

DESCRIPTION OF COMMUNITY

This CHNA is a joint assessment and the whole of King County was identified as the primary service area in this CHNA. King County covers over 2,300 square miles, and has over 2.1 million residents.

Community Health Needs Assessments and Implementation Plan Strategies for all VMFH facilities can be found at https://vmfh.org/about-vmfh/why-choose-vmfh/reports-to-the-community/community-health-needs-assessment.html.

About VMFH

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A paper copy is also available upon request at the Virginia Mason Medical Center Administration office. Written comments on this CHNA report can be submitted to VMFHcommunityhealth@vmfh.org

PRIORITY HEALTH NEEDS

The King County Community Health Needs Assessment created priority health needs by integrating data with input from community organizations about assets, resources, and opportunities.

The priority health needs identified in the CHNA are:

- Mental health and substance use disorders
- Access to health care
- Chronic disease management
- Food insecurity

EVALUATION OF IMPACT FROM 2019 COMMUNITY HEALTH NEEDS ASSESSMENT

In its CHNA from 2019-2022, Virginia Mason Medical Center addressed three priority health needs, including:

- Access to care, transportation and healthy food.
- Housing and homelessness.
- Firearm violence prevention.

An impact evaluation is included at Appendix D.

Virginia Mason Medical Center invited written comments on the most recent CHNA report and Implementation Strategy both in the documents and on the website where they are widely available to the public. No written comments were received.

ADOPTION OF CHNA

The Virginia Mason Medical Center CHNA was adopted by the Virginia Mason Franciscan Health Board of Directors on June 22, 2022.

Dear reader,

As King County Hospitals for a Healthier Community (HHC), we represent 10 hospitals and health systems throughout the county in partnership with Public Health – Seattle & King County (PHSKC). In June 2020, PHSKC declared racism a public health crisis. We collectively acknowledge the historical and present-day impacts of systemic oppression and racism on the well-being of children, youth, adults, and families in King County. The COVID-19 pandemic has further exposed the intersection of structural racism and health. We oppose racism and are committed to pursuing equity, diversity, and inclusion in the care we provide along with the communities we serve.

The HHC vision is to participate in a collaborative approach for a joint Community Health Needs Assessment (CHNA). We also work together to share ideas and programs in response to community needs and assets, which helps us in ensuring high-quality healthcare and engaging in effective community health improvement. Our goal is to achieve better health and health equity for all King County residents.

We know that access to affordable, high-quality, and equitable healthcare is a key contributor to physical and mental well-being as well as overall community wellness. We also know that clinical care accounts for only a small portion of what contributes to health. The social conditions in which we are born, live, learn, work, and play contribute more to overall well-being. Racism and systemic oppression influence health outcomes by affecting social conditions as well as contributing to trauma that spans generations and persists throughout an individual's life span. Beyond its impact on access to high-quality healthcare, racism impacts access to education, housing, employment, nutrition, joy, and wellness — everything that communities need to thrive.

To illustrate these continuing inequities, this CHNA provides information organized by race, ethnicity and place. We have also learned about community-identified priorities to help guide us in what needs to be done. These findings will help inform our Community Benefit strategies, programs, services, and partnerships.

In this report, you will find examples of how we have collaborated with community-based organizations, as well as opportunities for clinics, public health, neighborhoods, and families to work together in developing locally driven and supported strategies to foster healthier, more equitable communities. We are committed to continuing to learn and respond to pressing needs, such as the impacts of COVID-19 on residents across King County. We can continue to build our understanding of what factors influence disparities — as well as support assets and strengths — by building relationships and listening to local organizations and families.

Our goal to decrease health inequities and improve well-being requires ongoing dedication, as racism has persisted for generations. The CHNA report and companion Community Health Indicators dashboard will help us identify opportunities, build on strengths, and continue to invest in community health toward achieving more equitable healthcare. We look forward to investing in and building upon collaborations that support, enhance, and embrace the livelihood and health of the diverse communities we serve throughout King County.

In collaboration,

King County Hospitals for a Healthier Community

King County Hospitals for a Healthier Community

Acknowledgements

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Executive Summary

Effective community health improvement programs respond to needs and build upon community strengths.

King County Hospitals for a Healthier Community (HHC) is a collaborative of 10 hospitals/health systems in King County, including Public Health – Seattle & King County. HHC jointly produces a Community Health Needs Assessment (CHNA) to learn about community inequities, strengths, and to fulfill Section 9007 of the Affordable Care Act. In accordance with those requirements, the report presents community identified priorities, a detailed description of the community, analyses of data on life expectancy and leading causes of death, and a review of levels of chronic illness throughout King County. In addition, this report provides a profile of the King County Medicaid beneficiary population as well as quantitative information about additional community health topics that were identified as priorities by HHC. The data presented in this report provides information about the health and social landscape in King County prior to the onset of COVID-19. As the COVID-19 pandemic has had unprecedented, widespread, and uneven impacts on community health and well-being, early data demonstrating these impacts are presented where available. Acknowledging that racism is a public health crisis and noting the importance of understanding and responding to inequities, this report continues to present data and key findings by race/ethnicity to highlight disparities, opportunities, and strengths among racial/ethnic groups.

COMMUNITY INPUT

Ongoing and meaningful community engagement can significantly improve hospital/health system efforts to address community health and social outcomes, in addition to improving patient experience. Local community needs assessments, strategic plans, and reports (from 2018 to 2020) that included aspects of community engagement were reviewed to identify needs, provide context to the quantitative data presented, and enhance our understanding of King County residents' priorities and strengths leading up to the COVID-19 pandemic. Key themes that emerged from these assessments of health and well-being include:

- Housing access and quality
- Access to healthcare and other services (such as transportation and food)

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- Support for youth and families (including mental health)
- Community growth and development

Descriptions of each theme are presented in the *Community Identified Priorities* section of the report.

COVID-19 IMPACTS

Many of the analyses included in this report highlight inequities that help us understand life in King County prior to the onset of the COVID-19 pandemic. These findings describe areas in which people may have been more vulnerable to the impacts of the pandemic and may continue to be disproportionately burdened even after the pandemic. The uneven economic impact of COVID-19 has increased many existing inequities, including poverty and unemployment for communities of color in King County. Communities of color are also overrepresented in COVID-19 cases, deaths, and hospitalizations. Since COVID-19 information changes quickly and data are updated frequently, the COVID-19 section of the report highlights some ongoing disparities throughout the pandemic. Links to resources and regularly updated dashboards, including the timeliest data, are included throughout the report. In addition, recent analyses (2020) and discussions of known COVID-19 impacts are integrated throughout the report.

MEDICAID PROFILE

Using data from 2019, the profile of the King County Medicaid beneficiary population[i] provides a demographic description with a focus on analyzing primary diagnoses to understand leading causes of emergency department (ED) visits based on Medicaid claims. This profile was identified by HHC to help inform quality improvement efforts within hospitals/health systems and identify ways to support Medicaid beneficiaries in accessing care, resources, and programs.

Key findings from the Medicaid profile include:

- In 2019, the King County Medicaid beneficiary population was more racially/ethnically diverse than the overall King County population. People of color made up the majority of Medicaid beneficiaries for both adults and children — white adults represent 49.9% of adult Medicaid beneficiaries and white children represent 35.4% of child Medicaid beneficiaries (children of color also represent the majority of the overall King County population for children).

- There were differences in leading causes of ED utilization among adults and children.

[i] *For this report, the Medicaid population is defined as Medicaid beneficiaries who had seven or more cumulative months of Medicaid full benefit coverage and less than five months of Medicare dual eligibility or third-party liability coverage in 2019.*

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- Top three for adults: Abdominal pain, pregnancy/childbirth complications, heart disease

- Top three for children: respiratory infections, fever of unknown cause, ear conditions

■ More than half (54%) of all Medicaid beneficiaries in King County with five or more ED visits had no visits to a primary care provider (PCP) in 2019. A majority (86%) of these individuals were adults (age 18+).

■ Analysis of Medicaid claims from January 1 to April 30, 2020 compared to the same time period for 2019 revealed a decrease in overall ED visits with no significant difference in causes of ED use. The decrease in ED visits in early 2020 from the avoidance of ED use during the first couple of months of the COVID-19 pandemic is consistent with national trends.[1]

The online dashboards available on community health indicators to accompany the results presented in the Medicaid profile include options to view all diagnoses. This resource may provide additional learnings about the underlying social and health context of individuals who seek care in the ED. The Medicaid profile section of the report also provides findings for individuals who have more than five visits to the ED without any visits to a primary care provider in 2019. These results can help hospitals/health systems understand barriers to accessing services, as well as inform outreach and engagement efforts to connect people with primary care providers or complex care coordination.

ACROSS KING COUNTY OVERALL, WHAT'S GETTING BETTER?

A review of recent King County data reveals key successes that stand out.

■ The overall obesity rate in King County has been stable and the rate of **obesity among American Indian/Alaska Native residents** appears to be declining. Since the 2010–2012 estimate, in which more than half of AIAN residents were obese, the obesity rate among this group has declined by more than 50%. While estimates may be imprecise due to small population numbers, a concurrent increase in the percentage of AIAN adults that are overweight, but not obese, signals improvement in overall body mass index (BMI), a measure used in healthcare to assess obesity.

■ **Cigarette smoking among adults** has continued to decline county-wide. The adult smoking rate dropped from 13.9% (2011–2013) to 11.1% (2014–2018). Though South Region adults are still significantly more likely to be smokers than the average King County resident, the adult smoking rate is steadily declining in the South Region.

■ Consumption of **sugar-sweetened beverages among youth** has decreased in King County. Comparing data from 2014 and 2018, fewer students reported daily consumption in all King County regions.

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- More pregnant mothers received **early and adequate prenatal care** — which is defined as initiating prenatal care in the first trimester and having at least 80% of the medically recommended number of prenatal visits. This county-wide success increases the likelihood of families having healthy pregnancies and births.

- **Homelessness has declined for unaccompanied youth and young adults.** From 2018 to 2019, the number of individuals, youth, and families experiencing homelessness as well as the percentage of the homeless population that were unsheltered declined. Most notably, the number of unaccompanied youths under the age of 18 decreased by more than 50%.

The previous 2018/19 CHNA report highlighted improvements in health insurance coverage as well as declining rates of cigarette smoking, youth substance use, and youth consumption of sugar-sweetened beverages. Among those previous successes, the rates for adult cigarette smoking and youth consumption of sugar-sweetened beverages continue to decline, and the previous improvement in decreasing rates of youth substance use was sustained.

ACROSS KING COUNTY OVERALL, WHAT HAS GOTTEN WORSE SINCE THE LAST CHNA?

Several indicators show little or no improvement since the previous report. However, the following indicators showed downward trends, or are worse compared to the last CHNA report, as new areas of concern. The findings presented here are reflective of data collected through population health surveys prior to the COVID-19 pandemic that should be closely monitored. Without substantial support, the strain that COVID-19 has placed on communities will likely result in worsening health and social conditions.

- While overall life expectancy of King County residents has not significantly changed, recent analyses reveal worsening racial/ethnic **disparities in life expectancy.** Life expectancy of Native Hawaiian/Pacific Islander King County residents (72.2) has declined by more than five years from the 2011–2013 average life expectancy of 77.8 years to the 2016–2018 average of 71.9 years for this group. Hispanic residents' life expectancy is declining as well — by 3.6 years during that same time period. Life expectancy among South Region residents has declined for the past 10 years.

- More county residents are dying from **unintentional injuries,** with poisoning (by legal

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and illegal drugs, alcohol, gases and vapors, such as carbon monoxide and automobile exhaust, pesticides, and other chemicals and noxious substances), falls, and motor-vehicle-traffic incidents as the leading causes.

- While rates of **food insecurity** were declining overall and trending toward improvement, there was a large jump in food insecurity among Black residents even before the onset of the pandemic. The gap between white and Black food-insecure households quadrupled between 2013 and 2018.

- Communities of color continue to be disproportionately uninsured — before and after implementation of the Affordable Care Act. Racial/ethnic disparities in **insurance coverage** have widened following an initial narrowing of gaps in coverage in 2014.

- More King County youth are obese. After a relative decline in 2012, **youth obesity** rates have been increasing in King County. Youth obesity rates increased significantly between 2014 and 2018.

- Use of electronic cigarettes, also known as **e-cigs or vape pens,** among youth was not reported in the previous CHNA. However, as rates of youth who report smoking cigarettes have continued to decline in King County, the percentage of youth who report using e-cigarettes has significantly increased since 2016.

The previous 2018/19 CHNA report highlighted additional indicators that were worsening or not improving at that time, including insufficient physical activity for youth, youth mental health, and drug-induced deaths, which continue to worsen and are areas of concern in King County.

COVID-19: INITIAL CONCERNS AND AREAS TO MONITOR

While most data are available only for time periods prior to the onset of the pandemic, recent information from various sources during 2020 reveals the following concerning impacts of COVID-19. We will continue to monitor these new data sources alongside our ongoing population health data — see the COVID-19 section of this report for related dashboards and resources.

- **Unemployment:** Mandated closures of nonessential businesses began on March 15, 2020, in King County, as one of many community mitigation efforts to slow the spread of COVID-19. With the resulting job losses, the number of people seeking unemployment benefits increased rapidly. Roughly one in three workers (34.5%) in King County filed

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initial unemployment insurance (UI) claims with the Washington State Employment Security Department between March 1 and November 7, 2020, totaling 529,027 claims. Native Hawaiian/Pacific Islander workers filed the highest number of claims per capita, followed by Black workers. King County industries with the largest number of employees filing unemployment claims included accommodation and food services, manufacturing, retail, construction, and healthcare and social assistance.[2,3]

- **Food insecurity:** The number of local families experiencing food insecurity has increased throughout 2020. Food insufficiency has almost doubled after implementation of mitigation strategies to slow the spread of COVID-19, such as business closures and limits on nonessential work. Enrollment in the U.S. government's Basic Food assistance program increased by 18% among King County households from January to June 2020 — an increase of 17,300 households. Food needs were the second most common reason for King County residents to call seeking assistance with social services in spring 2020.[4] Food insecurity is especially high among households that are low-income, include children, or have recently had or expect job loss.

- **Access to healthcare:** Analysis of recommended vaccination rates (series 4:3:1:3:3:1:4) for children ages 19-35 months as of June 30, 2020 showed a decrease in vaccination coverage compared to rates as of December 31, 2019, likely reflecting decreased access to and use of healthcare services during the COVID-19 pandemic. Rates of incomplete vaccination coverage increased for the county overall, among South Region families, and among families living in high-poverty neighborhoods.

- **Mental and behavioral health:** While most of the data in the mental health and substance use section of this report were collected prior to 2020, it's important to note that during the COVID-19 pandemic, some patterns may be changing. Washington state survey data show the number of people with symptoms of depression had increased by more than 30% between April and May 2020. Those who expect to lose employment or lost employment, those with incomes less than $25,000 per year, and people self-identifying their race/ethnicity as 'other' or multiple race categories were most likely to report feeling depressed or hopeless. The number of calls to King County's behavioral health crisis line increased after the start of social distancing, and in April — as well as between June and October — were significantly higher than those in the same months of 2019. These measures will continue to be monitored given the expected increases in mental health concerns.[5,6]

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HOSPITALS FOR A HEALTHIER COMMUNITY (HHC) PRIORITIES

Throughout the production of this report in 2020, systemic racism and COVID-19 response and vaccine distribution have emerged as high priorities for hospitals, health systems, and public health. While historical and present-day impacts of systemic racism contribute to many of the health and social inequities described in the report, the COVID-19 pandemic has further exposed the intersection of structural racism and health. Furthermore, advancing equity throughout all elements of the COVID-19 response — assuring access to care including testing and vaccinations, promoting healthy behaviors, as well as community recovery — is critical. Systemic racism and the COVID-19 response will continue to shape and affect the health of King County communities and have been identified as both short- and long-term priorities across HHC members.

In addition to ***systemic racism*** and the ***COVID-19 response***, the HHC collaborative has also identified the following priority areas to address jointly, as well as individually:

- ***Mental health & substance use disorders***
- ***Access to healthcare***
- ***Chronic disease management - specifically obesity, cancer, diabetes, heart disease/ hypertension***
- ***Food insecurity***

As part of this prioritization, HHC will seek opportunities to align efforts across organizations, learn about best practices to support these areas, and encourage organizations to collectively invest in data, programs, and policies to promote health among King County residents. Collaboration and partnerships between public health, health systems, behavioral health systems, and community organizations will continue to be important in developing effective community health improvement plans to address these areas.

COVID-19

The COVID-19 pandemic has especially impacted communities that were already experiencing inequities in King County. As a compounded ailment, it aggravated existing burdens and introduced new ones.

By the time this report was created in 2020, the COVID-19 pandemic had touched nearly every aspect of life for communities and families across King County and Washington state. Washington state was the original national epicenter of COVID-19 as the first area in the United States to report a case. The public health response to early outbreaks in King County garnered national attention.[5,6] To slow the spread of COVID-19, community mitigation and social distancing measures were initiated county-wide, which have impacted the economic, social, mental, physical, and behavioral health of communities. Large-scale and coordinated actions to increase resources to communities and promote access to and knowledge of COVID-19 testing, isolation and quarantine facilities, and hospital care are priorities in our current local public health efforts. Thorough and ongoing review of timely data is essential to support these efforts to slow the spread of COVID-19. This section highlights some persistent patterns and includes links to relevant dashboards and resources developed by Public Health – Seattle & King County.

In King County, coronavirus has disproportionately affected communities of color and residents of South King County.[7] Communities of color are overrepresented in COVID-19 cases, deaths, and hospitalizations. They are also more likely to be negatively impacted by community mitigation strategies due to social or economic conditions preceding the pandemic. For example, communities of color are disproportionately reflected in many industry sectors that have been significantly impacted by COVID-19 and had the largest number of employees filing unemployment claims, including accommodation and food services, retail, and healthcare and social assistance.[2]

Racial/ethnic disparities: As of November 2020, case rates and hospitalization rates for nearly all communities of color are higher, with statistical difference, than for whites. The rate of confirmed cases is highest among Native Hawaiian/Pacific Islander (NHPI) and Hispanic communities, followed by Black and American Indian/Alaska Native (AIAN) populations.[i] Compared to white residents, Hispanic and NHPI residents are significantly more likely to die from COVID-19.

[i] *Small numbers, limited availability of testing, and missing data should be considered when interpreting the data.*

COVID-19

Continued

Geographic disparities: Patterns of testing, positivity, hospitalizations, and deaths differ by geography. Compared to other King County regions, South King County neighborhoods have some of the highest rates of positive cases, test positivity, hospitalizations, and deaths, with relatively lower rates of people getting tested.

A robust set of dashboards and surveillance systems inform ongoing community mitigation strategies, contact tracing, isolation and quarantine, and prioritization of community resources and supports during our county-wide pandemic response. Ongoing monitoring of case counts, hospitalizations, and death rates helps inform our hospitals and health systems to prepare to meet the needs of King County residents. Public Health – Seattle & King County is monitoring changes in selected measures of social, economic, and overall health in King County throughout the pandemic.

King County COVID-19 dashboards include:

- Race/ethnicity dashboard
- Economic, social, and overall health impacts dashboard
- Health insurance and access to healthcare
- Family violence
- 2-1-1 calls to identify community needs
- Behavioral health needs and services
- Daily traffic
- Food insecurity
- Unemployment claims
- King County Eviction Prevention and Rental Assistance Program

Data reports and infographics related to COVID-19 include:

- Computer and internet access in King County
- Economic, social, and overall health impacts
- Increases in food needs
- Behavioral health needs and services
- Changes in transportation patterns
- Unemployment claims

As of January 4, 2021

The CHNA report presents data on indicators prior to the onset of the pandemic, and highlights areas in which community members were most vulnerable and may continue to be disproportionately burdened. Data are presented for the most recent years we have data available — in most cases, from 2018 or before. Discussion of the known COVID-19 impacts to dates are included in the relevant sections of the report, where available. In some cases, this includes expected impacts and considerations for long-term monitoring. We also recognize the importance of monitoring key community health indicators along with ongoing community priorities and needs during and after the pandemic to support the longevity, health, and well-being of our diverse communities.

Introduction

The King County Hospitals for a Healthier Community (HHC) collaborative, which includes 10 hospitals/health systems in King County and Public Health – Seattle & King County, produces this joint community health needs assessment to better understand and serve the needs of families and communities in King County. As cornerstone institutions across the county, hospitals and health systems support community health through programs and investments that work to improve health through education and outreach, as well as address social conditions and determinants of health (such as housing, transportation, and food) that impact health outcomes.

The 2018/2019 King County Community Health Needs Assessment described a community that was rapidly being reshaped by an economic boom, growing diversity, and economic growth that disproportionately advantaged some residents over others. Community members and stakeholders identified a list of concerns to prioritize for improvement, which included inequities in access to services (such as childcare and healthcare), unaffordable housing, residential displacement, transportation barriers, and disparate access to high-quality education by race and place. The health and social indicators in the report revealed county-wide successes in health insurance coverage as well as improvement in a variety of health behaviors, such as cigarette smoking, youth substance use, and consumption of sugary beverages, alongside persistent disparities in a number of other health and social indicators, including youth mental health, tobacco use, and household income.

Regularly monitoring data and community experiences over time sheds light on emerging disparities and improvements as well as where continued investments need to occur. Three years later, this 2021/2022 report includes a set of health and social indicators similar to those in the previous report. Indicators describe community conditions after a period of continued economic growth, demographic change, and community investments to promote health and thriving. The impact of local investments and programs that focus on improving the social, physical, and mental health of populations requires ongoing investment, since changes in population data generally occur slowly and over time. As described in the *Executive Summary* and corresponding report sections for the 2021/2022 report, disparities and inequities remain in many health indicators, while some community and county-wide successes stand out.

Throughout 2020, COVID-19 has had a rapid and tremendous impact on every aspect of our lives as well as on the overall health and well-being of our communities. Many of the data analyses included

Introduction

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in this report highlight inequities that help us understand the conditions in King County prior to the onset of the COVID-19 pandemic along with more recent analysis, where available, to shed light on the initial impacts of COVID-19 on community health and priorities. King County hospitals and health systems have been a cornerstone of pandemic response by addressing the health needs of patients, as well as by partnering with local communities and organizations to support the recovery and resilience of King County residents.

KING COUNTY HOSPITALS FOR A HEALTHIER COMMUNITY

The King County Hospitals for a Healthier Community (HHC) collaborative comprises 10 hospitals/health systems and Public Health – Seattle & King County through the fiscal administrative support of the Washington State Hospital Association (see Appendix C for a full list of hospitals/health systems).

Formed in 2012, the HHC seeks to work together to identify community needs, assets, resources, and strategies toward ensuring better health and health equity for all King County residents. The collaborative was created to eliminate duplicative efforts; lead to the creation of an effective, sustainable process and stronger relationships between hospitals and public health; and, identify opportunities to improve the health and well-being of our communities.

Through the HHC, King County hospitals/health systems have identified opportunities to coordinate outreach and engagement efforts as well as share best practices and strategies. HHC members have worked jointly to support open enrollment under the Affordable Care Act (ACA), pledge to increase access to healthy food choices in their facilities, support food security for local communities, distribute safety items such as firearm lock boxes, as well as create tools to address the healthcare barriers and opportunities of LGBTQ+ youth and young adults. This shared approach helps to align efforts and ensure that hospital community benefit programs focus resources to address the community's most critical health needs.

COMMITMENT TO HEALTH EQUITY

HHC members are committed to providing services and resources that respond to the health and social conditions of local communities. To achieve and create systems that promote health equity, hospitals and health systems must engage in the ongoing assessment, monitoring, and quality improvement of the healthcare delivery system. This includes review of population data in several ways, including race/ethnicity, income, geography, and sexual orientation whenever possible, to inform improvements and initiatives.

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PURPOSE

This report documents the health needs of King County communities and provides a foundation to meet the Affordable Care Act (ACA) and Washington state requirement for nonprofit hospitals to conduct a Community Health Needs Assessment (CHNA) every three years. This is the third CHNA conducted by HHC in collaboration with Public Health – Seattle & King County.

REPORT METHODS

HHC members used a population-based community health framework to identify indicators within each topic while also considering local and national priorities, actionable metrics, and timeliness of the information. Health is defined broadly to include social, cultural, and environmental factors that affect well-being. This joint CHNA report provides baseline data on community health indicators for all hospitals to use and apply to their own CHNAs. This work also supports hospital community benefit programs, systems, and services by providing data to describe community needs and highlight disparities. While hospitals and health systems reached consensus on a core set of topic areas, each hospital may also gather additional information specific to its service area and populations served.

In accordance with the Affordable Care Act, this report includes:

- Community identified priorities
- Community description
- Leading causes of death
- Levels of chronic illness

In addition, this report provides quantitative information about the following additional priorities and health needs:

- COVID-19 deaths and hospitalizations by race/ethnicity
- Medicaid profile: Medicaid demographics, top 10 causes of emergency department (ED) visits, and high numbers of ED visits among people who have not had a primary care visit in the last year
- Access to healthcare and use of preventive services
- Mental health and substance use
- Maternal and child health
- Physical activity, nutrition, and weight
- Violence and injury prevention

Additional data for each indicator included in this report, as well as indicators for more health topics, are available online at www.kingcounty.gov/chi. Detailed data are reported, when available, for neighborhoods, cities, and regions in King County, and by race/ethnicity, age, income/poverty, gender, and other

demographic breakdowns. When possible, the latest single-year rate for King County also includes the approximate number of affected individuals.

Community themes and priorities were gleaned from an inventory of more than 48 community assessment/engagement reports conducted over the past three years.

REPORT LIMITATIONS

There are some notable limitations to this report. See *Appendix B* for more information about report definitions and structure, including data limitations.

TIMING OF DATA

Many of the ongoing population survey data included in this report reflect data from 2018 and 2019, which provides information on the health and social context of King County populations prior to COVID-19. Since COVID-19 has the potential to have long and lasting impacts on community needs and has already influenced population health and well-being through health, social, and economic impacts, it is critical to use the data presented in this report as a benchmark to assess and monitor impact moving forward. In addition, where applicable, we have included more timely data sources and information to shed light on the initial impact of COVID-19 in 2020.

BROAD CATEGORIES FOR RACE/ETHNICITY

Racial and ethnic comparisons are made using broad race categories based on a narrow range of options for self-identification in surveys. It is important to report data by race/ethnicity to track progress toward health equity. Comparisons made between groups throughout the report are meant to highlight inequities by race/ethnicity where they exist, and not to imply that any specific race/ethnicity is the standard to which others should be compared. However, the vast diversity within race/ethnicity categories does not allow us to distinguish among ethnic groups or nationalities within categories. Our ability to report data by the many ethnic groups and nationalities living in King County is also limited by small numbers and how various surveys collect self-reported racial and ethnic data. Also, for most data sources, the most recently available data comes from 2018, not 2019 or 2020. A positive change is that as of 2018, detailed Asian ethnic groups were available for the Healthy Youth Survey (HYS); some of these findings are included in the narrative of this report and results can be found at www.kingcounty.gov/chi.

LIMITED DATA AND RESOURCES

For some topics, we have incomplete or limited quantitative data and a lack of qualitative information to contextualize findings.

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Finally, space and resource limitations prevent us from mentioning all of the valuable organizations, hospital/health system collaborations, and assets in our communities. A continuously updated statewide database of health and human service information and referrals for Washington state can be found at https://search.wa211.org/.

RACISM AS A PUBLIC HEALTH CRISIS

Public Health – Seattle & King County leads with race and recognizes racism as a public health crisis underlying the health inequities that persist in our county and state. The uneven economic impact of COVID-19 has heightened many existing inequities, including poverty and unemployment for communities of color. This report helps us understand the conditions leading into the pandemic — in many cases setting the stage for disproportionate community impacts of COVID-19 and the measures to slow the spread of disease. It also highlights community assets and resilience factors that help in improving health and well-being.

The following sections describe what we have learned from data monitoring. Community needs are described in the *Community Identified Priorities* section of the report. We have primarily focused on differences by race/ethnicity while also recognizing how geography, rural, urban, and other indicators illustrate what's happening in our county.

WORKING TOGETHER TOWARDS HEALTHIER COMMUNITIES

During the previously conducted 2018/2019 Community Health Needs Assessment, HHC members focused on the following joint priorities for collective and individual focus:

- Mental health and substance use disorders
- Access to healthcare and transportation
- Physical health with a focus on obesity, cancer, and diabetes
- Housing and homelessness

Examples of how HHC members have been addressing these priorities are included as assets in the *Community Identified Priorities* section of this report. Based on the updated data, as well as community priorities highlighted in this 2021/2022 CHNA report, HHC members have identified new or ongoing priorities as described in the *Executive Summary* section of this report.

Examples of current Seattle and King County initiatives that include Public Health – Seattle & King County, hospitals/health systems, and community partnerships include:

Introduction

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MEDICAID TRANSFORMATION

There are nine regional Accountable Communities of Health (ACHs) in Washington state, each bringing together community members, cross-sector partners, and other experts to explore new approaches to improving health and wellness as part of the Washington State Medicaid Transformation. HealthierHere serves as the ACH for King County, bringing people and organizations together from across sectors to improve health and advance equity in our community. To better support the health and social needs of people in King County, HealthierHere builds and strengthens partnerships, develops networks, shares resources, and tests innovations in the delivery of healthcare and social services.

COMMUNITIES OF OPPORTUNITY

Between 2019 and now, Communities of Opportunity (COO) has deepened and increased commitments to place-based and cultural community collaboratives and groups working for more equitable and just housing, health, and economic systems via policy, systems, and environmental changes. COO also launched the Learning Community strategy, which provides space and resources for the capacity building, transformational visioning, model development, and sustained relationship building of community partners. COO has supported more than 3,129 capacity-building, community, and workforce development events, 77 new community partnerships, over 410 community members to take on new leadership positions, and seven community-led policy changes — all work aligned toward transforming future conditions so that all families and communities in King County thrive.

BEST STARTS FOR KIDS

Approved by King County voters in 2015, Best Starts for Kids (BSK) supports safe and healthy childcare settings by consulting with childcare professionals, making the resources of nurses, nutritionists, and child health specialists available to childcare providers across King County. Best Starts for Kids partners with schools and community-based organizations to invest in programs that offer safe, supportive environments that create a sense of belonging and purpose through mentoring, leadership, positive identity development, healthy relationships, and participating in out-of-school opportunities.

In 2019–2020, BSK continued to expand partnerships and programs. Of note, in 2020 BSK expanded Help Me Grow in King County, building a network of coordinated access partners. Trusted community organizations play a key role in helping families

Introduction

Continued

navigate resources, supporting successful connections to timely resources and services, and improving access to high-quality, holistic developmental screenings.

ZERO YOUTH DETENTION

The Zero Youth Detention (ZYD) initiative is King County's strategic plan not only to further reduce the use of secure detention for youth, but to launch King County on a journey to eliminate it. Building on 20 years of reducing the secure detention population, this region begins the journey to ZYD with momentum. Informed by youth and their families, communities, and employees whose work touches the lives of youth, the Road Map to Zero Youth Detention outlines practical solutions designed to improve community safety, help young people thrive, keep them from entering the juvenile legal system, divert them from further legal system involvement, and support strong, unified communities. ZYD is interested in creating conditions that allow young people to be healthy, hopeful, safe, and thriving to reduce the number of young people in secure detention.

KING COUNTY PLAY EQUITY COALITION

The King County Play Equity Coalition aims to increase the number of youth in King County who meet CDC guidelines for physical activity to improve the quality of life for youth. In order to achieve this, the coalition focuses on reducing inequities, increasing opportunities, and improving quality of sport and play opportunities for King County youth. Coalition members include health systems, such as Seattle Children's Research Institute and The Sports Institute at UW Medicine, as well as a variety of cities, organizations, schools, businesses, and foundations. Through policy advocacy, research and data, community-driven partnerships, information sharing, and programming, this coalition envisions a King County where:

- All youth are active to a healthy level
- Access to sport and outdoor recreation is not determined by ZIP code, language, or race
- Youth physical activity is a regional policy priority
- King County is a national model for inclusive and healthy youth sports, free play, and outdoor recreation

Community Identified Priorities and Resources

King County hospitals and health systems are uniquely positioned to improve community health by offering comprehensive healthcare services as well as through collaborations and investments that address the root causes of health outcomes and inequities, such as access to housing, transportation, food, and chronic disease prevention. To best serve the needs of the community, hospitals and health systems assess health and social outcomes across changing demographics, as well as engage with and listen to the emerging priorities voiced by local communities.

Since the last CHNA, community-based organizations and clinics, state and local agencies, coalitions, schools, and hospitals have continued to engage with the people they serve to help elevate specific community concerns and strengths. To enhance our understanding of King County residents' priorities leading up to the COVID-19 pandemic, we reviewed 48 community needs assessments, strategic plans, or reports produced between 2018 and 2020 (see Appendix A for a full list). We sought publicly available information representing regions throughout King County, specific populations, and focus areas including food, physical activity, housing, and transportation. Each resource had a community engagement component from which we summarized themes shared across the documents. Since this report was produced at the end of 2020,

Priorities expressed by multiple communities include housing and homelessness, access to healthcare and other services, support for youth and families, and community growth and development as areas of need.

Community Identified Priorities and Resources

Continued

emerging themes identified through this review illustrate vulnerabilities that have been amplified by the pandemic throughout 2020, warranting close monitoring and focused interventions in 2021 and beyond.

COMMUNITY IDENTIFIED PRIORITIES AND RESOURCES

- Housing access and quality
- Access to healthcare and other services (such as transportation and food)
- Support for youth and families (including mental health)
- Community growth and development

Some community needs have been compounded due to the pandemic, while others may have been de-prioritized by more pressing needs that have arisen. Many community-based organizations across King County are actively working toward addressing these and other community identified priorities. King County hospitals and health systems have opportunities to create partnerships with community members and organizations to address community needs via direct input and engagement.

There are several local programs, initiatives, and partnerships working to build on the strengths in King County and address community priorities. Examples of how HHC members and community organizations work together in collaboration to meet the needs of King County residents are shared throughout this section. Though not exhaustive or comprehensive, examples provided in each priority section include collaborative programs and initiatives between HHC members, community organizations, and Public Health – Seattle & King County.

HOUSING ACCESS AND QUALITY

Almost every referenced resource called out some aspect of homelessness, housing affordability, or housing quality as a priority. The COVID-19 pandemic has affected housing for many King County residents who have lost income or experienced disruptions in their housing and family structure. More than half of all calls to 2-1-1 between August and September 2020 requested housing-related assistance, and communities of color are disproportionately represented in these calls. Given the severe housing inequities that existed prior to the pandemic, we can anticipate that many housing needs and priorities outlined by the community are even greater today. Without support for social safety nets, such as shelters and transitional housing, and in the absence of efforts to intentionally increase the availability of affordable

Community Identified Priorities and Resources

Continued

and safe housing, these inequities will continue to increase.

Homelessness is an ongoing crisis in King County, affecting children, families, older adults, and veterans, and disproportionately impacts transgender residents and certain communities of color. While King County is housing more people every year[8], there is a continued need for more shelters and resources for individuals experiencing homelessness or housing insecurity. Communities identify the need to expand services to prevent homelessness among low-income and housing-unstable families, and to support families who are experiencing homelessness with secure housing and social services.

Lack of affordable housing was a recurring theme across reports. High costs of living in many areas of the county create conditions where families living well above the poverty line struggle to make ends meet. Affordable housing has decreased county-wide as a result of rapid economic growth and gentrification. The impacts are felt by individuals and families all over the county, affecting neighborhood demographics, displacement, and community cohesion, as well as access to resources and services. Residents living in densely concentrated urban areas, as well as residents in rural areas, including in East King County, voice concern for the growing cost burden among renters and homeowners. King County residents from multiple communities — especially in South King County — called for more affordable housing; more options for older adults; and access to financial assistance programs, such as rent subsidies, utility assistance, and assistance for families who are forced to move or are otherwise displaced.

Community Collaborations

- **Housing security and homelessness:** Hospitals and health systems in King County continue to support advocacy efforts to address homelessness and increase access to safe and affordable housing. One example is Virginia Mason Franciscan Health's Bailey-Boushay House overnight shelter for homeless clients in their HIV Outpatient Program, which is the first – and only – homeless shelter in the country that exclusively serves people with HIV. Another example is Kaiser Permanente, which actively screens patients for housing instability in order to provide housing resources. Harborview Medical Center operates clinics within Plymouth Housing and Downtown Emergency Service Center (DESC). Furthermore, several HHC members — including those already mentioned as well as Overlake Medical Center & Clinics, MultiCare Health System, and Virginia Mason Franciscan Health — provide financial support or partner with community-based organizations to improve care for unsheltered patients who are discharged from the hospital, as well as address housing security and homelessness across King County.

Community Identified Priorities and Resources

Continued

- **Affordable housing advocacy and investments:** Opportunities exist for hospitals and health systems to advocate for affordable housing by making investments to increase the number of affordable housing units available to King County residents. Investments that direct funding for geographical areas and populations disproportionately impacted by unstable housing and homelessness can bolster a community's ability to provide adequate, affordable, and safe housing. For example, Navos provides safe and affordable housing in apartment buildings and family-sized homes for over 300 people with serious mental health conditions, which is notable given the difficulty for this population to secure safe and affordable housing. Virginia Mason Franciscan Health's Bailey-Boushay Housing Stability Project administers a federal rental assistance program to benefit homeless men and women with HIV in the Seattle area. Kaiser Permanente contributes funding to provide low-interest loans to affordable housing developers to build new or renovate existing affordable housing. In addition, Seattle Children's invests in affordable housing in partnership with HomeSight in Southeast Seattle, where Odessa Brown Children's Clinic, an early learning site, and direct access to public transportation create a community design that supports the housing, health, and transportation needs of families.

ACCESSING HEALTHCARE AND OTHER SERVICES

The COVID-19 pandemic is likely to have long-term effects on healthcare in the United States. Hospitals and health systems are challenged as they push to expand capacity, increase telehealth, and purchase equipment and supplies to meet the needs of patients with COVID-19 and other conditions.[9] Nationally, visits to primary care physicians and specialists have declined since the pandemic. It is expected that this shift in priorities will further compound mental and behavioral health concerns, increase suicide risk, and widen persistent gaps in access to affordable healthcare coverage, preventive services, and prevalence of chronic illnesses, especially for people of color.[10]

Disparities in access to basic needs, such as food and transportation, existed among communities of color and low-income residents in King County prior to COVID-19. Many of these same residents have been hit hardest by the pandemic in terms of economic instability due to job loss and business closures. This has further increased food insecurity risk, as well as disparities in accessing transportation and healthy food for thousands of King County residents.

Community Identified Priorities and Resources

Continued

ACCESS TO HEALTHCARE

Access to high-quality healthcare is a key contributor to physical, mental, and behavioral health. Barriers to access include economic, language, cultural, and/or geographic concerns.

Despite the large number of hospitals and healthcare providers in King County, community members continue to cite **barriers to accessing healthcare due to high cost, lack of health insurance, or the limited availability of services and providers.** Even among those with insurance, many express challenges with accessing services, such as specialty care, behavioral health, and dental care due to coverage limitations or limited providers. Young adults (18–25) and low-income residents are most likely to report problems finding a health provider.

- Finding **culturally competent providers** who demonstrate cultural awareness and respect is a barrier especially for immigrants, people of color, residents with limited English proficiency, and those seeking gender-affirming care. In order to effectively and appropriately serve diverse communities, it is also important to have translated materials, as well as interpretation services, available to community members.

- **Accessible transportation** to and from healthcare appointments is an additional barrier that community members identified. This is especially challenging when residents must travel long distances to get to clinics that provide specialty care or to services that are culturally and linguistically appropriate.

- Lack of **access to childcare** was cited as a barrier to scheduling time for medical appointments.

Community members also described specific needs related to healthcare and behavioral health, including:

- The need for **increased access to healthcare services** in the evening, on weekends and through telehealth was expressed as well as delivery of medications.

- Limited resources for **chronic disease management,** especially for diabetes, obesity, cancer, and heart disease/hypertension. Communities called for additional support within healthcare systems for culturally relevant materials and patient education as well as increasing opportunities to support a healthy lifestyle in the community through access to healthy food and physical activity.

- The need for increased access to **mental and behavioral health** resources, including subspecialty care providers and counseling services for mental health and substance use disorders.

Community Identified Priorities and Resources

Continued

ACCESS TO OTHER SERVICES

The lack of reliable and affordable transportation affects the ability to access services, particularly for older adults, youth, low-income adults, individuals with disabilities, and those experiencing homelessness in the community. Mobility and transportation affect economic stability and growth in multiple ways, impacting a person's ability to obtain and secure employment, healthy food, safe places to play, education, and healthcare. Some residents describe unsafe conditions related to poor lighting and lack of security at transit stops as an additional barrier. In addition, some areas of South King County have many streets without sidewalks and long distances to get to a bus stop, which can be difficult for older adults and individuals with disabilities and increases the risk of vehicle and pedestrian injuries.

Food insecurity, limited access to healthy food, and the lack of culturally relevant nutrition education were highlighted by diverse communities across King County. Access to healthy, nutrient-rich foods is limited in some low-income and rural areas, where residents are less likely to have a grocery store close to home. Families who use public transportation to purchase groceries or access food banks face longer travel times and are limited in how much they can carry at a time. In addition, the increasing costs of housing can affect families' ability to afford food. Chronic hunger and access to healthy food were specifically called out as issues affecting the health of older adults and parents, many of whom report cutting or skipping meals because they did not have enough money for food.

Language and cultural barriers impact the ability of many immigrant residents to access employment, public transportation, housing, healthcare, and educational opportunities — all of which are key to economic stability. Many fear asking for support. Examples that community members noted include:

- Public transportation signs and fare lists at bus stops are primarily only in English.
- Barriers to accessing services (e.g., scheduling appointments) based on limited availability of interpreters.
- Language and cultural barriers prevent youth from participating in recreation programs when registration is only in English or requires registering in person.
- First-generation families may lack information about the process to enroll their kids into college or technical schools.

Community Identified Priorities and Resources

Continued

- Cultural barriers may negatively impact access, even with shared language. For instance, American Indian/Alaska Native communities shared that non-Native healthcare providers should be aware of the importance of family and the long-term impacts of generational trauma on Native lives, behaviors, and choices in order to thoughtfully and appropriately serve them.

Community Collaborations

The following are examples of how HHC members have responded to address community needs related to accessing healthcare and other services in collaboration with community-based organizations.

- **Affordability of healthcare:** All HHC members provide information and help with financial assistance in multiple languages. Many HHC members, such as EvergreenHealth, Overlake Medical Center & Clinics, and Virginia Mason Franciscan Health, provide financial and clinical support to Project Access Northwest (PANW) and Seattle/King County Clinic to improve access to healthcare for low-income and uninsured patients. Numerous King County hospitals, including Virginia Mason Franciscan Health, help support Edward Thomas House Medical Respite at Harborview, which is a unique, harm-reduction program that provides recuperative care to people experiencing homelessness who are too sick to return to the shelter or streets, but do not require hospital-level care.

- **Chronic disease management:** Many HHC members invest in a variety of health outreach programs for patients and communities, such as diabetes education that integrates culturally relevant and translated materials. Furthermore, several have developed partnerships with resources in the community. As an example, Swedish Health Services, Overlake Medical Center & Clinics, and MultiCare Health System partner with the YMCA for chronic disease management programs. Seattle Cancer Care Alliance provides cancer prevention and screening through community outreach events that include other organizations. Harborview Medical Center's Community House Calls Program has two Diabetes Navigators who work with Spanish- and Somali-speaking patients to manage their disease in a culturally congruent manner.

- **Mental and behavioral health:** Mental and behavior health services continue to be a high need for communities and a high priority for HHC members. For example, Navos focuses entirely on providing culturally competent resources and services for King County residents vulnerable to mental illness and substance use disorders. All HHC members invest in a variety of services within their health systems and the broader community,

Community Identified Priorities and Resources

Continued

such as integrating behavioral and physical health within their health system; embedding therapists and counselors within school districts and teen centers; and organizing events and trainings for youth, adults, and providers. Several HHC members, including Overlake Medical Center & Clinics, Kaiser Permanente, and Virginia Mason Franciscan Health, partner with the National Alliance on Mental Illness to provide supportive mental health services to local communities. EvergreenHealth offers in-home mental health counseling for Medicaid beneficiaries. Navos provides training for community-based peer educators. Seattle Children's has partnered with ARC of King County to provide education to families about autism. A number of HHC members train youth and adults in Mental Health First Aid, including Virginia Mason Franciscan Health, which has trained over 5,000 people to date.

- **Language and culture:** HHC members provide patient education, health, and outreach materials that are translated and available in a variety of languages. Interpreters in person, via video, and/or through the telephone are also available to support patients during appointments. Several HHC members, including Seattle Cancer Care Alliance and MultiCare Health System, invest in clinical patient navigator programs to provide specialized outreach and support for a variety of demographic, diagnosis-specific, cultural, and race/ethnicity groups to provide cultural and language resources. Community health clinics, such as Sea Mar and International Community Health Services, are examples of healthcare settings that are primarily focused on specific communities. Over a dozen Community Health Boards — voluntary community-based organizations that represent and advocate for the health of specific cultural groups — help connect King County families to health and social support resources. Harborview Medical Center's Interpreter Services Department has a robust language interpretation and translation program for in-patient and ambulatory settings; houses the Community House Calls Program that connects with Limited English Proficient communities within and outside of the hospital; and EthnoMed.org, an educational website for providers to learn about the immigrant populations they serve and provide localized healthcare resources for their patients.

- **Transportation:** In response to concerns around transportation, many hospitals and health systems have invested resources in free or reduced-cost programs with community partners to:

  » Create transportation departments, provide shuttle services, or establish partnerships with local transit centers to help families and patients navigate between campuses, clinics, and neighboring communities. For example, Seattle Cancer Care Alliance has shuttles that are open to patients and

Community Identified Priorities and Resources

Continued

families to assist them in getting around UW Medicine and South Lake Union Housing, and EvergreenHealth supports patients to enroll in ADA Paratransit services.

» Set up a transportation help desk inside the lobby to coordinate rides, reduce patient wait time, and assist with other Medicaid transportation providers. Several HHC members contract with Hopelink for a transportation help desk, including UW Medicine, Overlake Medical Center & Clinics, Swedish Health Services, EvergreenHealth, and Seattle Children's

» Partner with and provide financial assistance to support local community partners. Virginia Mason Franciscan Health, for example, provides financial assistance to SeaTac-based Refugees Northwest for a free bus ticket program for clients to get to and from medical and childcare appointments.

■ **Food security:** Many HHC members provide financial support for the Fresh Bucks program in Seattle and SNAP Market Match across King County to support access to healthy, affordable food at farmers markets and selected grocers. To address food insecurity for their patients, Seattle Children's screens families for food insecurity so food-insecure families can access an onsite food pantry to get food that will help last until their next appointment. In addition, UW Medicine has a partnership to bring a weekly food/produce stand onsite, such as Clean Greens Farm & Market, to make organic produce easily accessible for staff and surrounding communities.

» Through the CARES Act Food Security Assistance Program, PHSKC has been able to support agencies across King County from September to December 2020 in distributing food vouchers and culturally appropriate foods to impacted populations across King County.

SUPPORT FOR YOUTH AND FAMILIES

Measures to control and limit the spread of COVID-19 — such as closures of school, childcare, and recreational facilities — have affected the social and emotional well-being of children and families. Learning disruptions, social isolation, and high levels of parental stress in balancing work and schooling impact physical and mental health for children and families.[11,12] The pandemic has also heightened the disparities in resources and services to support low-income families and families who have children with disabilities, and the permanent closure of several childcare facilities has limited available childcare slots. These impacts will have long-term adverse effects on education and academic performance for many youth and families who were already vulnerable.[13] Focused interventions will be needed to support vulnerable families with the resources required to enhance learning and development.

Community Identified Priorities and Resources

Continued

King County residents highlight the need for increased services in their neighborhoods to support families and youth development in order to help their communities thrive. This continues to be a recurring theme from past years, with requests for more:

- **Youth engagement opportunities,** including mentorship, after-school activities, educational supports, and job training programs that are ethnically and culturally responsive. This includes educational pathway navigation support for gang-influenced youth, first-generation and immigrant students, and those entering school from the foster system. Additional resources to engage families and youth with social and trauma-informed services would support positive mental and behavioral health for youth.

- **Childcare, early learning, and support for families to access affordable childcare.** The high cost of childcare is a barrier to economic growth for families, as well as to children's health and development. King County residents also highlight a need for more early learning programs to prepare young children to succeed in school, especially for low-income and working families.

- **Opportunities for physical activity and sports** for youth to participate in outside of school, such as city and neighborhood leagues and safe places to play.

Community Collaborations

- **Youth support:** Virginia Mason Franciscan Health invests in organizations led by communities of color in South King County to engage youth in positive activities with the goal to reduce youth violence and support youth of color to thrive. This has involved helping community members start their own culturally relevant non-profit organizations in Federal Way and Des Moines, including walking through how to register with the IRS, start a board, and fundraise.

- **Best Starts for Kids:** King County voters approved the Best Starts for Kids (BSK) Levy (Ordinance 18088) in late 2015, creating a vital six-year source of funding to ensure that children, families, and communities are happy, healthy, safe, and thriving. Now in its fifth year, BSK has funded more than 280 community partners and 480 programs and has increased access to services and supports for hundreds of thousands of children, youth, and families, with a focus on advancing racial equity. BSK also supports the workforce with whom families interact, builds capacity for the organizations families trust, and works to influence the systems that impact children and families. It is considered the most comprehensive approach to childhood development

Community Identified Priorities and Resources

Continued

in the United States. Best Starts for Kids outlined investments in five key areas:

» Invest Early: Support pregnant individuals, babies, very young children during their critical developmental years, and their parents, with a robust system of support services and resources that meet families where they are: at home, in community, and in childcare.

» Sustain the Gain: Continue the progress made with school- and community-based opportunities for children to learn, grow, and develop through childhood, adolescence, and into adulthood.

» Communities of Opportunity: Support communities to create safe, thriving places for children to grow up.

» Youth and Family Homelessness Prevention Initiative: Prevent young people and their families from losing housing.

» Results Focused and Data Driven: Use data and evaluation to know what strategies are benefiting children and communities.

COMMUNITY GROWTH AND DEVELOPMENT

Community mitigation efforts to limit the spread of novel coronavirus (COVID-19) have had profound impacts on the economic and social health of communities. The closures of nonessential businesses on March 15, 2020, resulted in a sudden and dramatic job loss for many residents, with more than 500,000 new unemployment claims filed between March and October 2020.[2] Job loss has especially impacted King County young adults, workers of color, and workers with a high school or equivalent education. The impacts of the pandemic on the economy will be far reaching. Community priorities related to educational attainment, economic security, employment opportunities, and community connectedness that were identified prior to the pandemic paint a picture of many unmet needs. These unmet needs made some communities especially vulnerable to the pandemic — underscoring the importance of ongoing monitoring and investment with renewed vigor to support community growth and development.

Community members continue to elevate the impacts of deeply rooted inequities by race and place on community health. King County residents face growing income inequality and unequal access

Community Identified Priorities and Resources

Continued

to economic opportunity. As the cost of living continues to rise across the county, more and more working families are living in poverty and unable to meet all their basic needs. Families of color are disproportionately impacted. A common set of needs were expressed to support families' ability to thrive:

- Support for **educational attainment** toward income/wealth generation. Residents note the need for expanded opportunities to attend school or job training programs to secure higher-quality jobs and earn higher wages.

- **Economic security,** including a higher minimum wage, and financial assistance for families living in poverty to access needed services. Communities request job training opportunities that align with growing industries to support workforce development.

- **Local economic opportunities for individuals and businesses,** including addressing wealth gaps, increasing home ownership among renters, and bolstering community development that brings economic opportunity and businesses to the local area, rather than displacing current residents and businesses.

- **Community connectedness and civic engagement** to support advocacy into action. South King County cities describe the importance of supporting a community's ability to organize, engage, and communicate with legislators and decision-makers to bring community voices to decision-making. Enhancing community connectedness was highlighted as a key area that could contribute to more community cohesion and social support for individuals and families to improve mental health for many community members.

Community Collaborations

- **Jobs skills for youth:** Partnering with Year Up since 2013 — a free, yearlong job skills training program — Swedish Health Services has provided 10 internships with the medical center's information technology help desk. The six-month internship prepares students to gain full-time employment in the community.

Description of Community

Surging economic growth, development, and growing demographic diversity continue to shape the landscape of King County. While King County has many meaningful initiatives, investments, programs, and organizations that support our increasingly diverse communities – such as by race and ethnicity, geography, sexual orientation, socioeconomic status, age, and disability status – notable disparities continue to exist. This section of the report highlights social determinants of health that significantly contribute to the overall quality of life, including the economic, behavioral, mental, and physical health of King County residents. A deep understanding of the local community, including how demographics and social outcomes are changing, further informs the priorities and assets described in the Community Identified Priorities section of the report. To address these underlying factors that impact health outcomes, community partners must be engaged and their voices elevated in identifying ways to change the systems, policies, and practices that influence these disparities. Many of the data and key findings included in this report describe conditions leading up to the onset of COVID-19. Where applicable, we have also integrated recent data collected during 2020 as well as some of the known impacts of COVID-19. COVID-19 has added to many of the vulnerabilities expressed in this report, and a renewed investment to support diverse communities will be critical to support the recovery and health of everyone in King County.

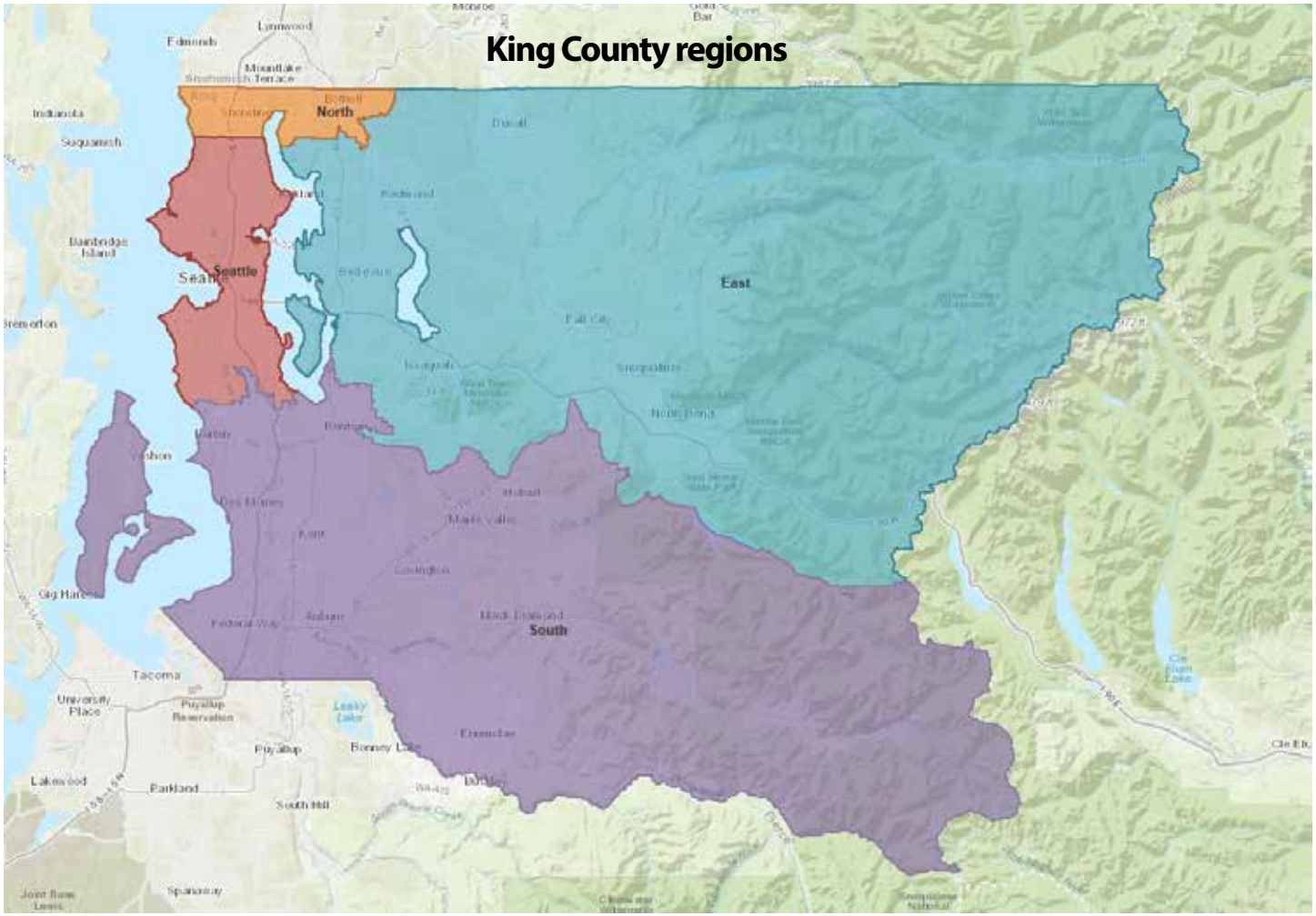
A review of inequities in health and social conditions among King County residents describes the environment leading into the COVID-19 pandemic — in many cases setting the stage for disproportionate impacts of COVID-19 and the measures taken to slow the spread of disease.

Description of Community

Continued

POPULATION TRENDS

King County and Seattle are the most populous county and city in Washington state, respectively. In addition to Seattle, King County includes 38 cities and towns as well as unincorporated areas. The county is divided into four geographic regions: Seattle, North, South, and East. Across four regions, 19 public school districts (as well as charter schools, private schools, and the Muckleshoot Tribal School) and many community health centers, hospitals, and health systems serve King County families.

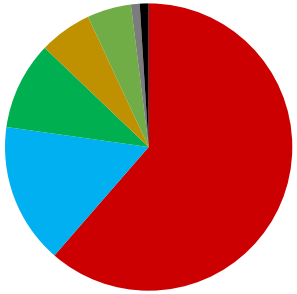


Description of Community

Continued

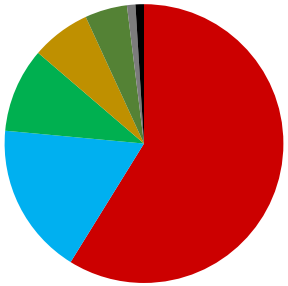
The county is continuing to experience population growth, though the rate of growth is slowing. In 2018, the King County population was 2,190,200, and state results from the 2020 Census will be available in early 2021. Between 2016 and 2018, the county population grew by more than 85,000 residents. It has approximately doubled since 1990, with increasing diversity and centered in cities.[14] King County is now 60% white, compared to 62% in 2016. The Asian population experienced growth in King County from 16% of the total population in 2016 to 18% in 2018. More than half of King County children are children of color. The growth rate has slowed in recent years, from ~2.6% in 2015–2016 to 1.7% in 2017–2018.[i] Despite declining annual growth rates county-wide since 2016, recent analyses show that King County has had the decade's third-largest growth among U.S. counties.[15]

King County, 2016
Population: 2,105,100



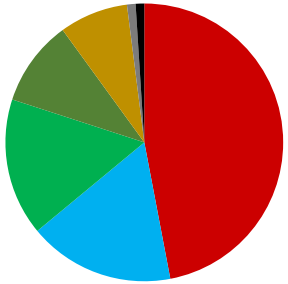
White/non-Hispanic	62%
Asian/non-Hispanic	16%
Hispanic/Latino	10%
Black/African American non-Hispanic	6%
Multiple race	5%
American Indian/Alaska Native/non-Hispanic	1%
Native Hawaiian/Pacific Islander/non-Hispanic	1%

King County, 2018
Population: 2,190,200



White/non-Hispanic	60%
Asian/non-Hispanic	18%
Hispanic/Latino	10%
Black/African American non-Hispanic	7%
Multiple race	5%
American Indian/Alaska Native/non-Hispanic	1%
Native Hawaiian/Pacific Islander/non-Hispanic	1%

Population under age 18, King County, 2018
Population: 454,526



White/non-Hispanic	47%
Asian/non-Hispanic	17%
Hispanic/Latino	16%
Multiple race	10%
Black/African American non-Hispanic	8%
American Indian/Alaska Native/non-Hispanic	1%
Native Hawaiian/Pacific Islander/non-Hispanic	1%

Data source: WA Office of Financial Management 2016 & 2018

Percentages may not add up to 100% due to rounding

[i] *Growth rate from 2014 to 2018 was calculated by taking the population difference between years divided by the total population of the previous year, i.e., (2015 population - 2014 population) / 2014 population.*

Description of Community

Continued

HEALTH AND WEALTH

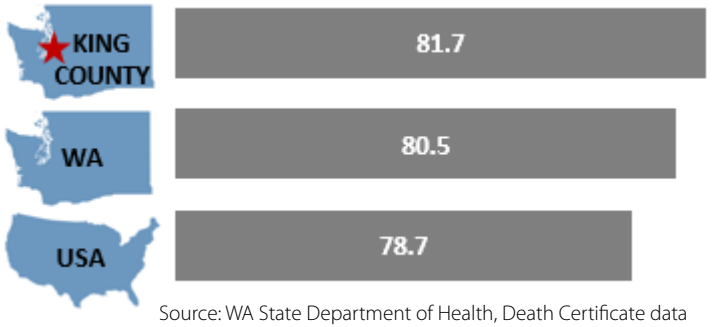
King County continues to rank among the top counties in the U.S. on county-level measures of health and wealth.

Averaging data from 2014–2018 for King County, life expectancy at birth was 81.7 years. Life expectancy in King County has been stable since 2014, averaging 81.7 years. In 2018, King County life expectancy exceeded the national and state averages. After implementation of the Affordable Care Act, the rate of uninsured King County adults decreased significantly. Strong and coordinated local efforts to increase enrollment among county residents contributed to a historic low rate of 6.7% uninsurance in 2016 (7.2% in 2019) compared to over 16% prior to implementation of the ACA.

Disparities in life expectancy reveal the impacts of differences in experiences throughout the life course. In King County, Native Hawaiian/Pacific Islander, America Indian/Alaska Native, and Black adult life expectancy is four to nine years shorter than the life expectancy of white adults.

Communities of color continue to be disproportionately uninsured — before and after implementation of the ACA. Racial/ethnic disparities

Life expectancy (years)
King County, Washingon state, USA (2018)



Source: WA State Department of Health, Death Certificate data

in insurance coverage have increased since an initial narrowing of gaps in coverage in 2014. In 2019, Hispanic adults were seven times as likely as non-Hispanic whites to be without health insurance coverage. American Indian/Alaska Natives and Black adults were two to three times less likely to have insurance compared to white adults.

While resources like increased access to telehealth visits, drive-through flu vaccinations, and free COVID-19 testing have eliminated barriers for many, the shift to COVID-19 response has introduced new barriers to accessing primary and preventive care in some areas. Access to healthcare is additionally challenged in the current era of COVID-19 among the most vulnerable communities, when many have lost access to employee-sponsored healthcare plans and reliable income. Medicaid enrollment is increasing in King County, particularly among adults.

Description of Community

Continued

Household income has increased rapidly over the past 20 years, as the number and types of high-paying, tech-sector jobs increased, along with increasing wages. In 2018, median household income in King County was $95,009 — higher than other U.S. counties that are comparable in size by employment (as measured by the U.S. Bureau of Labor Statistics).[16] In 2019, median household income in King County reached six figures ($102,594) for the first time.[17]

The median net worth of a household in King and Snohomish counties is nearly $400,000, which ranks 10th among more than 100 metro areas.[18] However, despite the appearance of county-wide prosperity, **racial gaps in health and wealth** have been repeatedly documented in King County.

In Seattle, the median net worth for Black households represents only 5% of the median net worth of white households. Homeownership is a path to building wealth, and one of the biggest assets for a household. The median net worth for a household that owns its home in the Seattle area is nearly $900,000 — 25 times the median net worth for renter households ($36,000).[18]

Historic systems of racist policies and practices have shaped and continue to shape access to resources and opportunities for communities of color. Real estate practices that denied homes to Black residents, along with disparities in educational attainment and employment add to a list of challenges that make home ownership and wealth accumulation a challenge for Black and brown families in King County.

Growing inequities shape the landscape of King County — mapping the conditions that have made low-income residents and communities of color vulnerable to chronic diseases, disruptions in the economy, and most recently — the impacts of the COVID-19 pandemic. The amount of wealth and disposable outcome that a family has after accounting for daily living expenses impacts that family's risk of financial instability, as well as their ability to sustain sudden disruptions in work or health that have been compounded during the pandemic. Similarly, people with underlying medical conditions — like heart disease, diabetes, and lung disease — are at higher risk for COVID-19 death. In King County, all of these conditions are more prevalent in communities of color, making them more vulnerable to the disease.

Description of Community

Continued

A CHANGING SOCIAL AND POLITICAL ENVIRONMENT: RACISM AS A PUBLIC HEALTH CRISIS

Recent events have prompted shifting social and political environments — locally and nationally. Communities across the county have been deeply impacted as people who live and work here react to COVID-19 and community mitigation measures, massive unemployment, a challenging housing market, and political unrest. A large and sustained movement for Black lives has taken the spotlight in Seattle following the murder of George Floyd in Minneapolis on May 25, 2020. The ongoing dialogue, demonstrations, and protests in Seattle and across King County have brought more attention to equity, social justice, anti-racism, and community empowerment in all sectors, including healthcare and public health.

On June 11, 2020, King County government declared racism a public health crisis, underscoring the importance of centering the voices and lived experiences of local communities most impacted by systemic racism and economic inequity in policy decisions.[19] Public Health – Seattle & King County is committed to helping to build stronger and appropriately resourced partnerships with community organizations and leaders to disrupt and dismantle racism. The presentation of data throughout this report illustrates how racism contributes to inequities in social determinants of health in King County. It serves as a foundation to inform hospitals, health systems, and community investments, resources, programs, and policies to dismantle structures that sustain inequities and improve the health of our community.

Description of Community

Continued

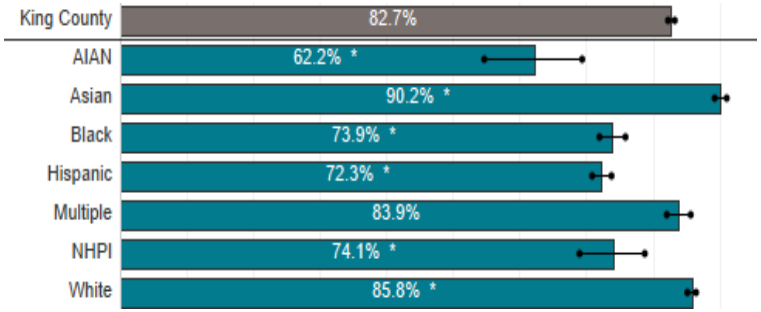
EDUCATIONAL ATTAINMENT

Educational attainment is an important determinant of health, as it is associated with income, employment, housing, and access to services. Averaging data from 2014–2018, close to half (48.6%) of King County adults do not have a **bachelor's degree**. There are disparities in educational attainment by race/ethnicity — Native Hawaiian/Pacific Islander (87.0%), American/Indian Alaska Native (85.1%), Hispanic (74.5%), and Black (73.2%) adults are at least 1.5 times as likely to be without a bachelor's degree compared to white (45.3%) adults.

Averaging data from 2014–2018, 29.3% of Hispanic residents have less than a **high school education,** compared to 7.0% county-wide and only 3.1% among white residents. Among South Region residents, 11.1% have less than a high school diploma — nearly double the rate in Seattle (5.4%) and the North Region (5.6%), and more than three times the rate in the East Region (3.5%).

During the 2018–2019 school year, 82.7% of students in King County **graduated from high school** within four years. However, Black, Hispanic, American Indian/Alaska Native, and Native Hawaiian/Pacific Islander students were significantly less likely to graduate from high school on time. The likelihood of graduating on time was even lower for English language learners, students experiencing homelessness, and students from migrant families. Fewer than 50% of students in foster care graduate on time. In the Tukwila School District, one in four students did not graduate on time.

High school graduation
King County (2018-2019)



Source: The Office of Superintendent of Public Instruction
* Significantly different from King County average

Description of Community

Continued

HOUSEHOLD INCOME

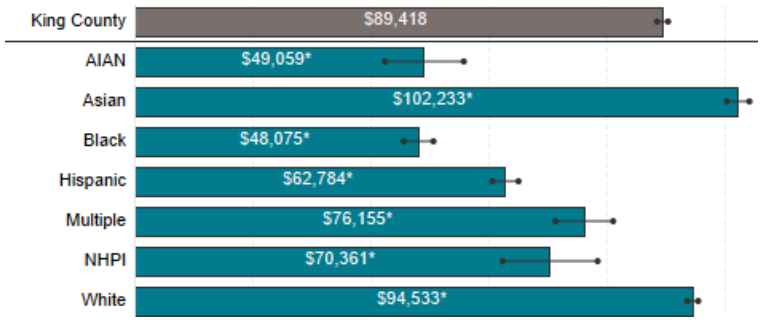
Income inequality affects a wide range of social and economic outcomes.[20] Median household income is closely tied to educational opportunities, employment, and health outcomes.

Averaging data from 2014–2018, the median household income for King County residents was $89,418. There are racial/ethnic gaps in household income, with Black households reporting significantly less than the average household, and Asian households reporting significantly more. The median income for Black households is $48,075, which is less than half the median income of Asian households ($102,233) and white households ($94,533).

Widening gaps in household income increase the advantages for those with higher median household incomes to access opportunities to thrive, including educational attainment, access to healthcare, and political power. It is predicted that the Black-white wealth gap will widen existing educational disparities during the coronavirus pandemic. This is especially concerning as families with fewer economic resources struggle to access the tools and resources that are needed to create home environments that support successful remote learning during pandemic-related school closures.[21]

Median household income

King County (average: 2014-2018)



Source: American Community Survey Public Use Microdata Sample (PUMS)
* Significantly different from King County average

Description of Community

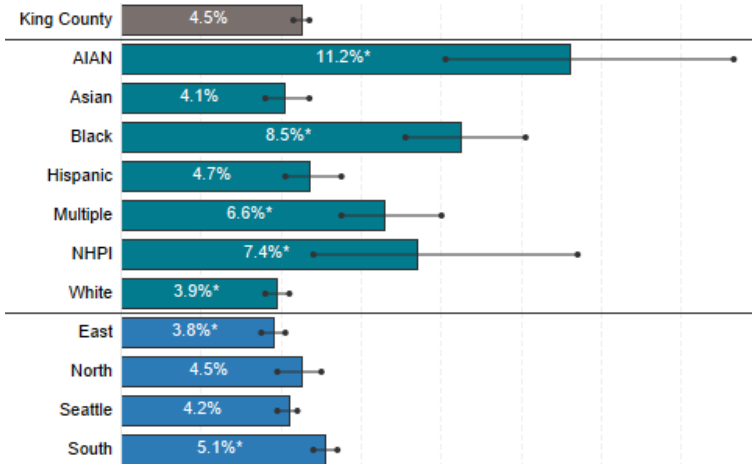
Continued

UNEMPLOYMENT

Mirroring the pattern for Washington state, the rate of unemployment in King County has been steadily declining from a peak of 9.4% in 2010, until 2020, when we experienced large increases in new unemployment claims per capita[ii] due to COVID-19. Roughly one in three workers (35.5%) in King County filed initial unemployment insurance (UI) claims with the Washington State Employment Security Department between March 1 and November 7, 2020, totaling 529,027 claims. As of November 7, initial claims filed per capita show that the industries with the highest percentage of claims were accommodation/food service, manufacturing, retail, construction, and healthcare and social assistance. Furthermore, Native Hawaiian/Pacific Islanders, Black/African American, and American Indian/Alaska Native workers had the highest percentage of claims per capita.

Averaging data from 2014–2018, the King County unemployment rate among residents age 16 and older is 4.5%. As with other indicators of economic health, glaring disparities exist by race and place. Unemployment among American Indian/Alaska Native residents (11.2%) is 2.5 times the county average. The unemployment rate is highest in the South Region (5.1%) and reaches up to 6.5% in Southeast Seattle and areas of Federal Way. Rates are lowest in the East Region (3.8%), where residents also have the lowest poverty rate and highest educational attainment compared to other county regions.

Unemployment rate (age 16+)
King County (average: 2014-2018)



Source: American Community Survey Public Use Microdata Sample (PUMS)
* Significantly different from King County average

[ii] *The unemployment claims due to COVID-19 reflect unemployment per capita.*

Description of Community

Continued

DISABILITY

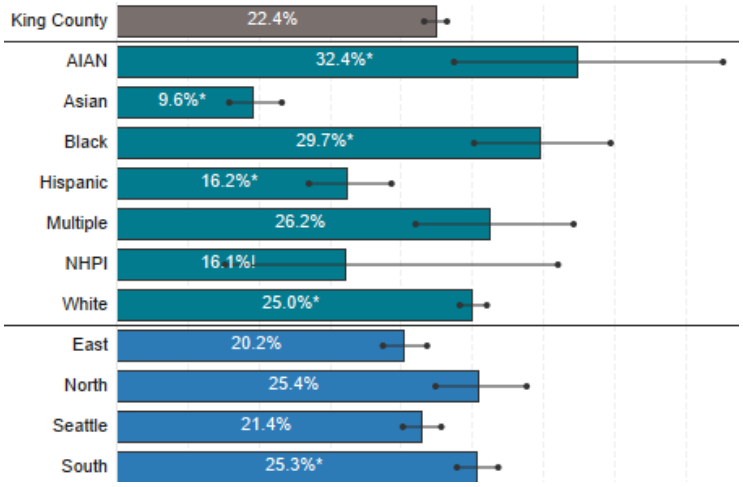
Averaging data from 2012–2016, the most recent years for which we have data, 22.4% of King County adults were limited in some way with activities because of physical, mental, or emotional conditions or have health conditions that require them to use special equipment, such as a cane, wheelchair, a special bed, or a special telephone. The rate of disability is significantly higher among adults who identify as LGB (29.5%). There are also significant differences for adults with disabilities among race, military service, and age groups. Thirty-four percent of North Highline residents reported a disability — the highest of all King County neighborhoods, followed by Vashon Island (32.5%).

While demographic characteristics of individuals with disabilities in King County are described here, it is important to review additional health and social indicators for individuals with disabilities. Therefore all American Community Survey (ACS) indicators[iii] available online have disability status included as a demographic variable.

[iii] *The American Community Survey (ACS) data source provides detailed demographic and population data such as education, housing, employment, and transportation. Generally, ACS indicators can be found online in the "Demographics" topic area.*

Disability (adults)

King County (average: 2012-2016)



Source: Behavioral Risk Factor Surveillance System
* Significantly different from King County average
! Interpret with caution: sample size is small, so estimate is imprecise

Description of Community

Continued

CHANGING DEMOGRAPHICS

Increasing racial and ethnic diversity among children is a continuing county-wide demographic trend. The population of children under age 18 is now 53% people of color. In 2018, 23.5% of King County residents and nearly 20% of Seattle residents were foreign born — a significant increase from 2016 in Seattle.

King County has a wide range of cultural and linguistic diversity. One in four King County residents live in a household where a language other than English is spoken. In 2019, Chinese, Spanish, and Vietnamese were the most commonly spoken languages outside of English across King County regions. Among the languages ranked 2nd, 3rd, and 4th across King County regions, Spanish; Chinese; Vietnamese; Hindi; Amharic, Somali, or other Afro-Asiatic languages; Telugu; Korean; and Urdu rise to the top.

Top 10 languages by region

King County (2019)

Rank	King County	East	North	Seattle	South
0	English Only	English Only	English Only	English Only	English Only
1	Spanish	Chinese	Spanish	Chinese	Spanish
2	Chinese	Spanish	Chinese	Spanish	Vietnamese
3	Vietnamese	Hindi	Korean	Amharic, Somali, or other Afro-Asiatic languages	Amharic, Somali, or other Afro-Asiatic languages
4	Amharic, Somali, or other Afro-Asiatic languages	Telugu	Urdu	Vietnamese	Chinese
5	Hindi	Russian	Tamil	Tagalog (inc. Filipino)	Tagalog (inc. Filipino)
6	Tagalog (incl. Filipino)	Japanese	Amharic, Somali, or other Afro-Asiatic languages	Korean	Punjabi
7	Korean	Malayalam, Kannada, or other Dravidian languages	Tagalog (incl. Filipino)	Japanese	Ukranian or other Slavic languages
8	Russian	Korean	Russian	Hindi	Korean
9	Japanese	Tamil	Other languages of Asia	French	Ilocano, Somoan, Hawaiian, or other Austronesian languages
10	French	Persian (incl. Farsi, Dari)	Japanese	Arabic	Russian

Source: American Community Survey Public Use Microdata Sample (PUMS)

Description of Community

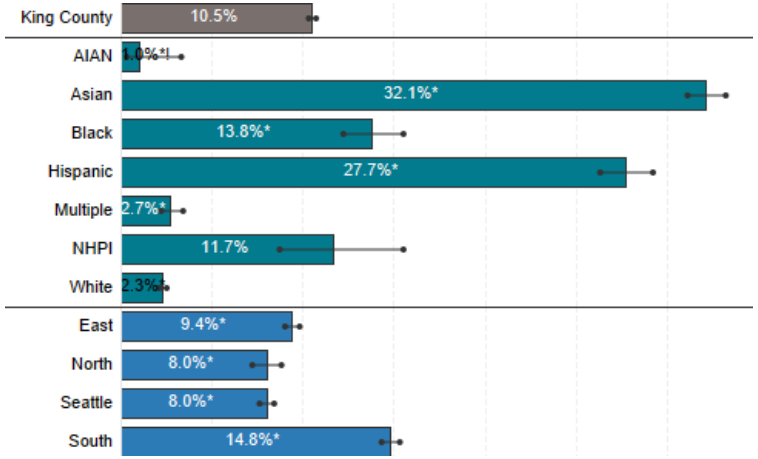
Continued

Averaging data from 2014–2018, 10.5% of King County residents over the age of five (including 40% of foreign-born residents) spoke English less than "very well." The percentage of Seattle residents reporting limited English proficiency has decreased from 11.8% in 2006 to 7.9% in 2018, while the King County rate hovered around 11% during that same period. The rate is higher in the South Region (14.8%) — limited English proficiency in SeaTac/Tukwila (25.5%) and Beacon Hill/Georgetown/South Park (27.1%) is more than twice the county average.

English language proficiency is directly associated with household income. More than 20% of residents with income less than $20,000 per year spoke English less than "very well" compared to 5.8% of people with an income of $150,000 or more. Language barriers also limit access to education, employment, and healthcare, presenting challenges for immigrant families to meet their basic needs.

Limited English proficiency (age 5+)

King County (average: 2014-2018)



Source: American Community Survey Public Use Microdata Sample (PUMS)
* Significantly different from King County average
! Interpret with caution: sample size is small, so estimate is imprecise

Description of Community

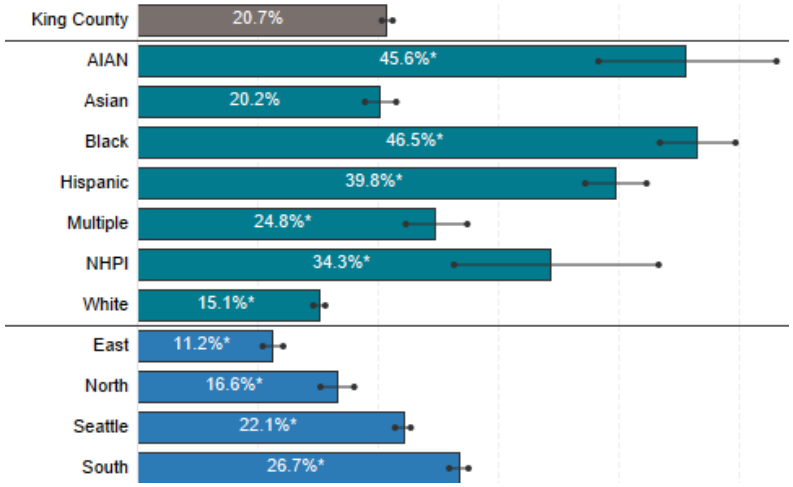
Continued

ECONOMIC INEQUITIES

Although poverty rates are declining in Seattle, King County, and Washington state, disparities persist by race, place, and disability. King County poverty[iv] rates are down from a 10-year peak of 25.4% in 2012. Averaging data from 2014–2018, one in five King County residents live in poverty or near poverty. More than 38% of young adults (18–24) and nearly half of Black and American Indian/Alaska Native residents lived below 200% of the federal poverty level (FPL). Black adults are more than 2.9 times as likely to be living in poverty or near poverty compared to white adults. The poverty rate among persons with disabilities is 1.8 times the county average. The South Region is disproportionately impacted, with two of the highest-poverty neighborhoods — SeaTac/Tukwila (35.7%) and Beacon Hill/Georgetown/South Park (36.5%).

Income <200% of Federal Poverty Level

King County (average: 2014-2018)



Source: American Community Survey Public Use Microdata Sample (PUMS)
* Significantly different from King County average

[iv] *Household income <200% of federal poverty level.*

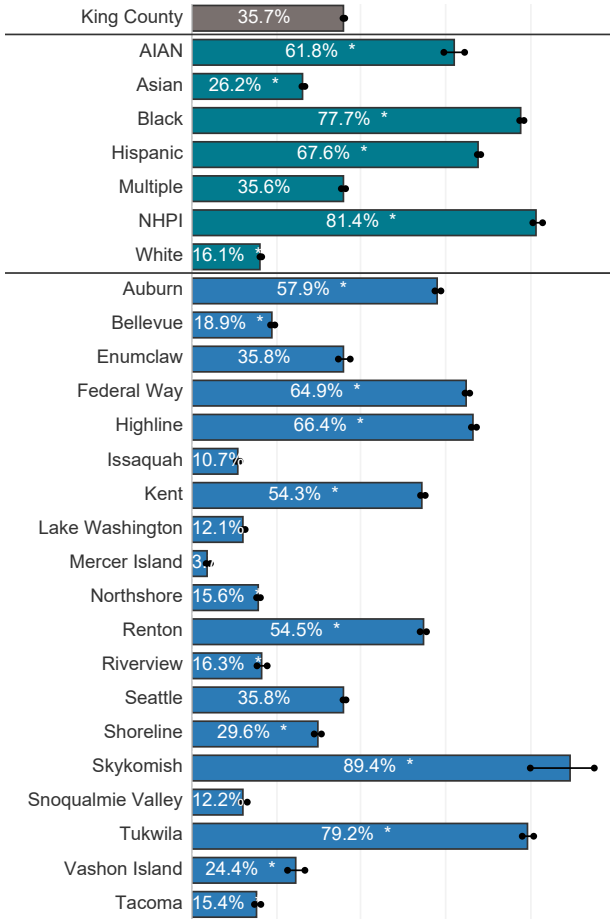
Description of Community

Continued

Eligibility for free and reduced-price school lunch is another sign of underlying economic inequities and varies widely across school districts. In King County (2017–2018 school year), 35.7% of students qualified for free and reduced price lunch. Compared to white students (16.1%), Native Hawaiian/Pacific Islander students are five times (81.4%), Black students are 4.8 times (77.7%), Hispanic students are 4.2 times (67.6%), and American Indian/Alaska Native students are 3.8 times (61.8%) as likely to qualify. The Tukwila school district has the second highest rate of students qualified for free and reduced-price lunch (79.2%).

Free and reduced price lunch

King County (2017-2018)



Source: The Office of Superintendent of Public Instruction
* Significantly different from King County average

Description of Community

Continued

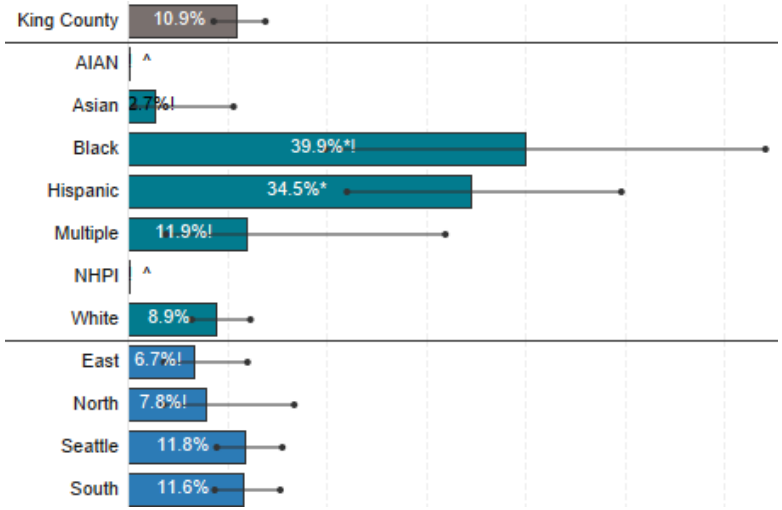
Disparities in food security reveal staggering racial inequities and signal serious vulnerabilities for communities of color to pandemic-related economic impacts. Food insecurity is defined as running out of food without enough money to purchase more. In 2018, 10.9% of King County adults bought food that sometimes/often didn't last and didn't have money to get more (last 12 months).

According to recent estimates, nearly 40% of Black adults are food insecure — more than any racial/ethnic group. Black adults are more than four times as likely to run out of food without money to purchase more than white adults. Uncertainty about food has increased among King County residents as a result of the staggering economic impacts of the COVID-19 pandemic. The gap between white and Black food-insecure households has increased fourfold over a five-year period — from 2013 (10.4% white, 17.3% Black) to 2018 (8.9% white, 39.9% Black).

Food insecurity among young adults (18–24) (19.3%) is nearly twice the county average. Adults who identify as LGB (22.4%) were 2.5 times as likely as heterosexual adults (8.8%) to report food insecurity. Southeast Kent reported the highest rate of food insecurity among all King County neighborhoods in 2018 (25.9%).

Food insecurity (adults)

King County (2018)



Source: Behavioral Risk Factor Surveillance System
* Significantly different from King County average
! Interpret with caution: sample size is small, so estimate is imprecise
^ Data suppressed if too few cases to protect confidentiality and/or report reliable rates

Description of Community

Continued

Following implementation of strategies to slow the spread of COVID-19, the number of local families experiencing food insecurity has increased throughout 2020. Enrollment in the Basic Food assistance program increased by 21.6% among King County households from January to June 2020 — an increase of 28,135 households — and food needs were the second most common reason for King County residents to call seeking assistance with social services in spring 2020.

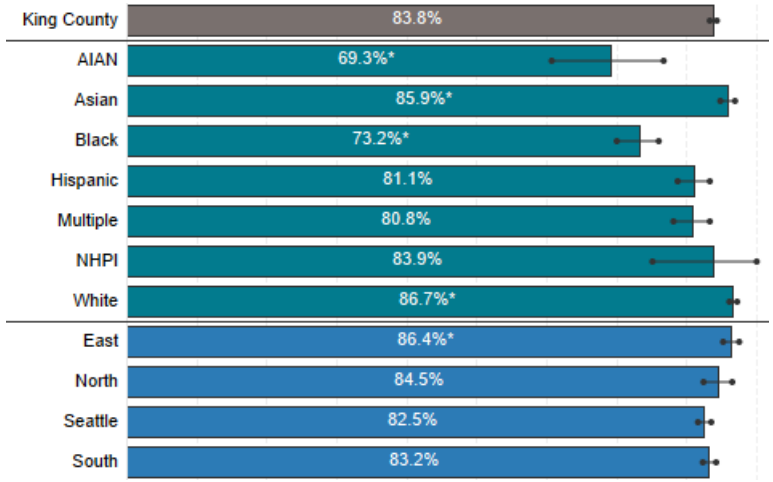
HOUSING AND TRANSPORTATION BARRIERS

With population and economic growth, King County has experienced escalating housing costs for renters and owners. Households with no severe housing cost burden are those paying less than 50% of household income for housing, including rent, mortgages, and housing owned free and clear (no mortgage).

Averaging data from 2014–2018, 83.8% of King County households paid less than 50% of their household income for housing. Compared to the average King County household, Asian and white households are significantly more likely to not experience a severe housing cost burden. There are persistent gender disparities in housing cost burden. Male residents (renters, owners with mortgages, and owners without mortgages) are significantly more likely than females to pay less than 50% of their income for housing costs. Increasing housing costs also affect affordability of other daily living expenses, such as food, transportation, and childcare.

Households that pay less than 50% of their income for housing costs

King County (average: 2014 - 2018)



Source: American Community Survey Public Use Microdata Sample (PUMS)
* Significantly different from King County average

Description of Community

Continued

Housing cost burden has been greatly impacted by the COVID-19 pandemic. As of September 8, 2020, weekly requests for housing-related assistance account for approximately 50% or more of calls to the 2-1-1 service hotline since April 2020. Increased housing needs are expected as families face evictions or loss of housing once local eviction moratoria and renter protections end.

While homelessness is an ongoing community concern, King County is housing more people every year. The 2019 Point-in-Time Count identified 11,199 individuals, youth, and members of families experiencing homelessness in Seattle/ King County — a decrease of 8% from 2018. Almost 70% of King County's homeless population lives in Seattle. Forty-seven percent of the homeless population was unsheltered, living on the street, or in parks, tents, vehicles, or other places not meant for human habitation — a decrease from 52% of the population in 2018. Compared to 2018, the number of unaccompanied youth and young adults experiencing homelessness decreased by 28%. The number of unaccompanied youths under the age of 18 decreased by 52%.

Compared to the overall population of Seattle/ King County, homelessness disproportionately impacts people and households of color. The homeless response system in King County includes a diverse set of programs and organizations that provide shelter, housing, and services to people experiencing homelessness. This includes emergency shelters, transitional housing, rapid re-housing (i.e., housing identification with case management and rental assistance), and permanent supportive housing programs. These programs/agencies are required to collect information about the people they serve in a central database, the King County Homeless Management Information System (HMIS). Reporting data from September 30, 2020, the King County HMIS Regional Homelessness dashboard shows that 10,301 King County households experienced homelessness and received services in the homeless response system. Most heads of these households identified as people of color.

While King County is 6% Black, 29% of households in the homeless response system identified as Black or African American. American Indian/ Alaska Native individuals make up just 1% of the King County population, but they make up 4% of the homeless response system. However, more than half of households who exited the homeless response system were households of color, and Black

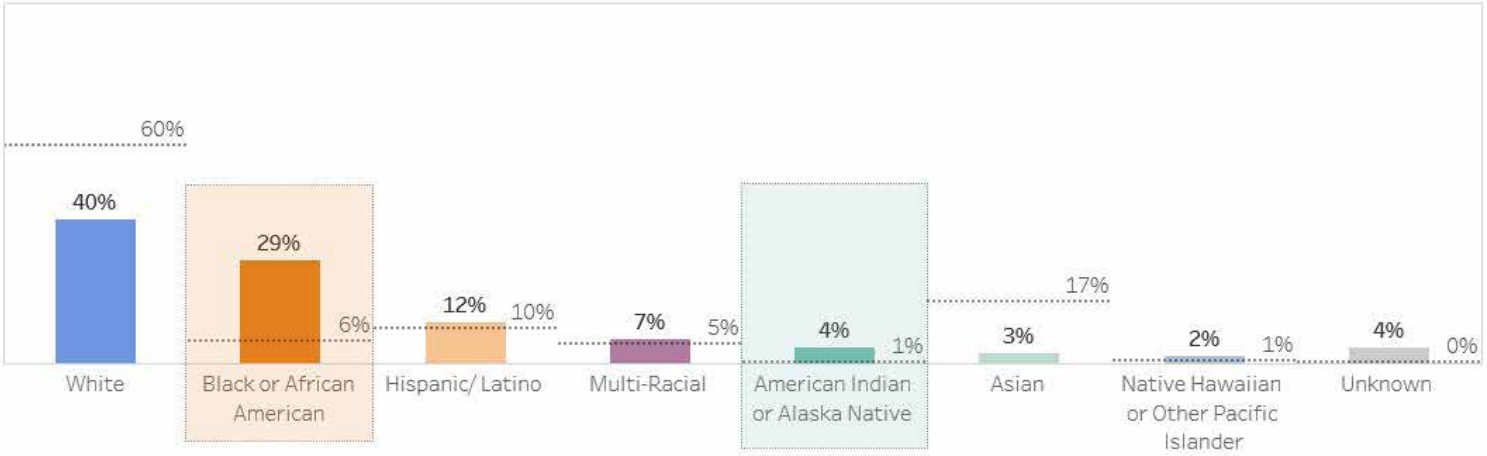
Description of Community

Continued

households were more likely to exit to permanent housing compared to other households by race/ethnicity. The 2020 Point-in-Time Count (January 2020)[v] report highlights similar racial/ethnic disparities in homelessness. It is anticipated that the COVID-19 pandemic will increase homelessness, so these figures may be significantly different in 2021. However, in light of the pandemic and due to safety concerns, the unsheltered count for the 2021 Point-in-Time Count will not occur as scheduled. King County received a waiver from the U.S. Department of Housing and Urban Development to cancel the 2021 unsheltered count due to the risks of gathering large numbers of volunteers and need for staff to focus on pandemic response efforts.

King County's Homeless Response System (10,301 total households)

King County (as of 9/30/2020)



[v] *Since the methodology and research team for the 2020 Point-in-Time count were different from the past three years, estimates are not directly comparable to previous years.*

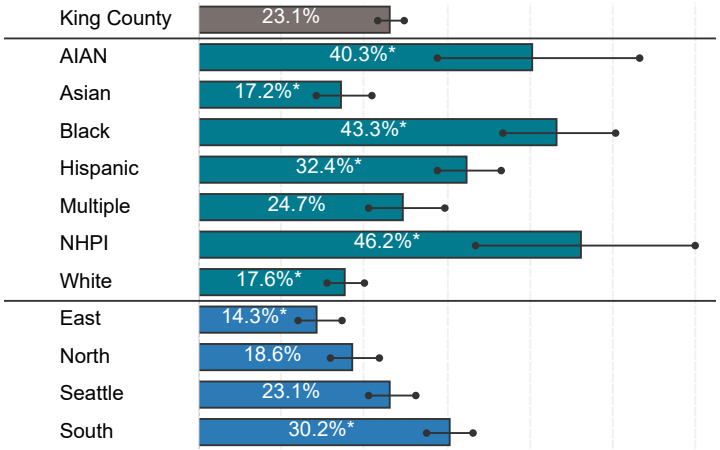
Description of Community

Continued

Access to affordable and reliable transportation is a basic need, especially for families with young children. Averaging data from 2017 and 2019, in King County, 23.1% of children lived in families that had found it difficult to afford transportation at least some of the time since the child was born. Apart from Asian residents, residents of color are more likely to report that they struggle to afford transportation compared to white residents. As people move further away from the city centers in search of affordable housing, transportation resources are even more important. In 2018, nearly 15% of King County residents reported commuting by public transit — an increasing trend in recent years. This is a significant concern when families are unable to access healthcare due to transportation issues. There are also growing implications for accessing employment during the COVID-19 pandemic, as many essential employees are unable to telecommute and may rely heavily on public transportation if they do not have a choice to use a private vehicle — potentially increasing their risk of exposure to the virus.

Families with children (ages 6 months - 5th grade) that found it difficult to afford transportation

King County (2017 & 2019)



Source: Best Starts for Kids Health Survey (BSKHS)
* Significantly different from King County average

Description of Community

Continued

RECURRING THEMES: INEQUITIES KEEP COMMUNITIES FROM THRIVING

Inequities by income, race, and place continue to shape the distribution of poor health and social outcomes in King County. Many of these inequities are driven by persistent systems, policies, and practices that are centered on racist or oppressive practices, which is made clear by the stark disparities and inequities across King County, especially when looking at indicators by race/ethnicity.

With few exceptions when viewing data over time, the health and well-being of communities of color have not improved significantly, and COVID-19 is likely to slow or even turn back progress if greater investments are not made to support communities and help them thrive. We also know that communities do not experience social and health factors in isolation. Rather, the cumulative effect of all these experiences is what impacts health and social outcomes. Furthermore, it is often the same communities that are impacted — underscoring the need for solutions that are culturally tailored and directed toward the places that are most affected.

Life Expectancy & Leading Causes of Death

Life expectancy is the culmination of all the health-promoting and debilitating factors that individuals face. As such, life expectancy and leading causes of death are key measures used to monitor progress in preventing disease and disability. Life expectancy in King County has been stable for the past decade, and generally higher than the national average. However, disparities in life expectancy and death rates by socioeconomic factors persist and have grown in some cases. Changes in causes of death and disability can help us understand trends in life expectancy.

Additional indicators available online include heart disease deaths, fair or poor health (adults), cancer deaths, and influenza/pneumonia deaths.

Public Health – Seattle & King County conducts investigations to help understand the circumstances and burden of deaths attributable to COVID-19. Death counts and trends are updated daily and available on the COVID-19 Outbreak Summary dashboard. Underlying health conditions such as diabetes and heart disease increase the risk of poor health outcomes due to COVID-19. As of September 1, 2020:

- The greatest burden of death is among those above 60 years old.
- Through September 1, more than eight out of 10 COVID-19 decedents had underlying medical conditions, such as heart disease, diabetes, chronic kidney disease, chronic lung disease, or immunosuppression.

Life expectancy among South Region residents has declined for the past 10 years.

- Although most COVID-19 deaths are among whites, the age-adjusted rate of death is highest among Native Hawaiian/Pacific Islanders (NHPI) and Hispanics. Among those under 60 years old, Hispanics make up less than 12% of the population but accounted for 42% of COVID-19 related deaths.

The data included in the rest of this section highlight the disproportionate deaths and vulnerabilities that many populations faced prior to COVID-19, which should be monitored closely to support populations that may be most impacted by COVID-19.

Life Expectancy & Leading Causes of Death

Continued

LIFE EXPECTANCY

Life expectancy is defined as the total number of years a newborn can expect to live given current death rates. Averaging data from 2014–2018 for King County, life expectancy at birth was 81.7 years and remained stable throughout this time period. In 2018, King County life expectancy exceeded the national average of 78.7 years and Washington state average of 80.2 years.[22] However, we still experience noteworthy differences in life expectancy by place and race/ethnicity in King County.

- The North Region (81.2 years) and the South Region (79.3 years) have significantly lower life expectancy compared to the King County average, whereas the East Region (83.9 years) and Seattle (83.4 years) both had significantly higher life expectancies than the North and South regions.

- Life expectancy among South Region residents has declined for the past 10 years. East Region (83.9 years) residents are expected to live 4.6 years longer than residents of the South Region.

- Residents of Mercer Island/Point Cities have a life expectancy of 86.7 years, while South Auburn residents have a life expectancy of 75.2 years — a difference of 11.5 years.

- Gender differences in life expectancy mirror national trends. Female residents (83.9 years) are expected to live on average 4.5 years longer than males (79.4 years). Nationally, females live on average five years longer than males.[23]

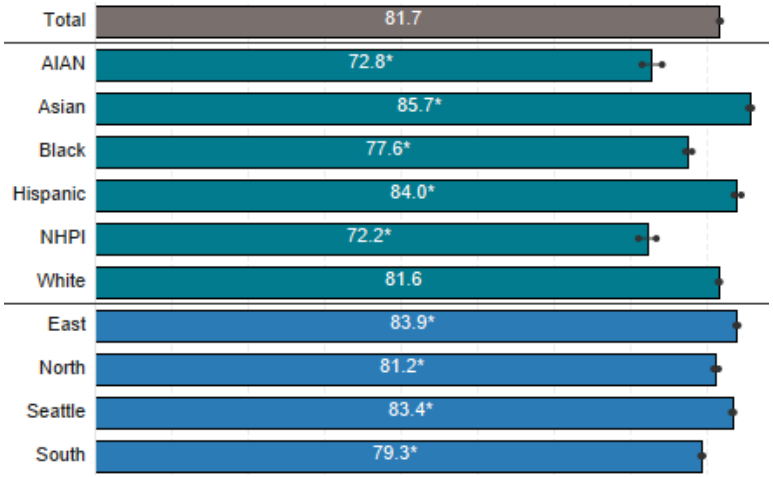
- Life expectancy is highest among Asian (85.7 years) and Hispanic residents (84.0 years).

- While Hispanic life expectancy is higher than the King County average, it has declined significantly from the 2011–2013 average of 86.7 years.

- Among Black residents (77.6 years), life expectancy is four years shorter than life expectancy

Life expectancy

King County (average: 2014 - 2018)



Source: WA State Department of Health, Death Certificate data
* Significantly different from King County average

Life Expectancy & Leading Causes of Death

Continued

of white residents (81.6 years). This gap is even greater by race and gender: life expectancy for a Black male is nine years less than for a white female (74.7 to 83.7 years, respectively).

- While estimates may be imprecise due to small population numbers, at 72.2 years, Native Hawaiian/ Pacific Islander residents have the lowest life expectancy of all racial/ethnic groups in King County. This is a decline of 5.6 years from the 2011–2013 average life expectancy of 77.8 years for this group.

- Residents living in low-poverty neighborhoods (83.8 years) live an average of 4.8 years longer than those in high-poverty neighborhoods (79.0 years).

LEADING CAUSES OF DEATH

Leading causes of death among King County residents vary by age and race/ethnicity. Averaging data from 2014–2018, heart disease and cancer remain the top two leading causes of death in King County overall. Heart disease was the leading cause of death for adults 65 years and older. While cancer was the leading cause of deaths for children 1–14 and adults 45–65, unintentional injury was the leading cause of death among teens (15–24) and young adults (25–44).

The five-year average rate and average annual counts for each cause of death are available online.

- Cancer and heart disease are the 1st and 2nd leading cause of death, respectively, for both males and females. Unintentional injuries were the 3rd leading cause of death among males, while Alzheimer's disease was 3rd among females.

- Among children age 1–14, the average all-cause death rate was 9.9 per 100,000. The top three leading causes of death among children were cancer (2.1 per 100,000), unintentional injuries (1.9 per 100,000), and congenital malformations (0.9 per 100,000).

- The death rate among men in King County is 1.4 times the rate among women. Gender differences are widened in certain age groups and causes of death.

Life Expectancy & Leading Causes of Death

Continued

In the 15–24 age group, males die at a rate three times that of females. In the same age group, the average death rate from unintentional injuries among males is nearly four times the rate among females.

- Suicide is the 8th leading cause of death overall, but 2nd in the 15–24 and 25–44 age groups. The male suicide rate is nearly four times the female rate in the 15–24 age group and nearly three times the female rate in the 25–44 age group.

- Males age 15–24 are nearly six times as likely as females of that age group to be killed by another person. In the 25–44 age group, the male homicide death rate is 3.2 times that of females.

- Alzheimer's disease remains the 3rd leading cause of death, affecting women more than men. Among adults older than 65, the rate of death from Alzheimer's among females was 1.8 times that of males.

- Heart disease death rates among men are 1.8 times those among women.

- While unintentional injury was the 4th leading cause of death overall, it was the leading cause of death among American Indian/Alaska Native residents. This has shifted from cancer as previously reported in the last CHNA (average 2011–2015), which is now the second leading cause of death for the American Indian/Alaska Native population.

- Among American Indian/Alaska Native residents, the rate of death from unintentional injury is 2.8 times the rate among Blacks, 3.5 times the rate among whites, and 6.6 times the rate among Asian residents.

- Diabetes is the 7th leading cause of death overall and the 3rd leading cause among Native Hawaiian/Pacific Islander residents.

Life Expectancy & Leading Causes of Death

Continued

Leading causes of death (ranked by the number of deaths)

King County (average: 2014 - 2018)

Cause category
- All causes
- Chronic disease
- Infectious disease
- Injury/violence
- Other

Rank	Total	AIAN	Asian	Black	Hispanic	NHPI	White
0	All causes 621.4 (12,958)	All causes 1,021.7 (112)	All causes 448.7 (1,146)	All causes 781.6 (785)	All causes 502.1 (360)	All causes 1,181.4 (88)	All causes 634.9 (10,231)
1	Cancer 140.6 (2,965)	Unintentional injuries 129.9 (18)	Cancer 111.3 (313)	Cancer 166.0 (172)	Cancer 105.7 (77)	Heart disease 259.1 (20)	Cancer 144.2 (2,320)
2	Heart disease 124.4 (2,593)	Cancer 155.1 (17)	Heart disease 79.2 (196)	Heart disease 154.8 (149)	Heart disease 95.7 (50)	Cancer 219.5 (19)	Heart disease 128.9 (2,128)
3	Alzheimer's disease 45.6 (924)	Heart disease 182.7 (16)	Stroke 33.8 (82)	Unintentional injuries 45.8 (59)	Unintentional injuries 33.7 (43)	Diabetes Mellitus 96.3 (7)	Alzheimer's disease 49.3 (822)
4	Unintentional injuries 34.9 (757)	Chronic liver disease 66.9 (9)	Alzheimer's disease 26.3 (56)	Diabetes Mellitus 47.3 (46)	Stroke 33.6 (17)	Stroke 109.4 (5)	Unintentional injuries 36.7 (557)
5	Stroke 31.6 (644)	Chronic lower resp. disease 42.0 (5)	Unintentional injuries 19.7 (55)	Stroke 43.7 (39)	Diabetes Mellitus 20.5 (14)	Unintentional injuries 25.8 (4)	Stroke 30.1 (490)
6	Chronic lower resp. disease 25.9 (523)	Stroke 59.7 (4)	Diabetes Mellitus 18.8 (47)	Chronic lower resp. disease 26.8 (27)	Chronic liver disease 12.2 (14) Suicide 6.6 (14)	Influenza/ pneumonia 21.8 (2)	Chronic lower resp. disease 28.4 (450)
7	Diabetes Mellitus 18.7 (389)	Diabetes Mellitus 31.2 (4)	Chronic lower resp. disease 11.1 (27)	Alzheimer's disease 34.6 (24)	--	Septicemia 26.9 (2)	Diabetes Mellitus 16.5 (265)
8	Suicide 12.1 (268)	Suicide 20.2 (3)	Suicide 7.3 (26)	Homicide 16.2 (23)	Alzheimer's disease 33.5 (12)	Essential (primary) hypertension 21.0 (2) Chronic lower resp. disease 42.9 (2)	Suicide 14.0 (203)
9	Chronic liver disease 9.6 (221)	Alzheimer's disease 41.2 (3)	Essential (primary) hypertension 8.8 (20)	Essential (primary) hypertension 19.2 (17)	Homicide 4.7 (11)	--	Chronic liver disease 10.2 (169)
10	Influenza/ pneumonia 9.9 (205)	Nephritis 14.4 (2)	Influenza/ pneumonia 8.4 (20)	Nephritis 12.6 (13)	Certain conditions orginating in the perinatal period 2.1 (7)	Suicide 8.4 (2)	Influenza/ pneumonia 10.0 (165)

Source: WA State Department of Health, Death Certificate data

Note: For each cause, the first number shown is the 5-year average rate per 100,000 and the number in parentheses is the average annual count for that cause over the 5-year period. For leading causes by age, the rates are age-specific. All other rates are age-adjusted. Multiple race data is not accurately reported on death certificates and is not recommended for analysis.

Life Expectancy & Leading Causes of Death

Continued

UNINTENTIONAL INJURY DEATHS

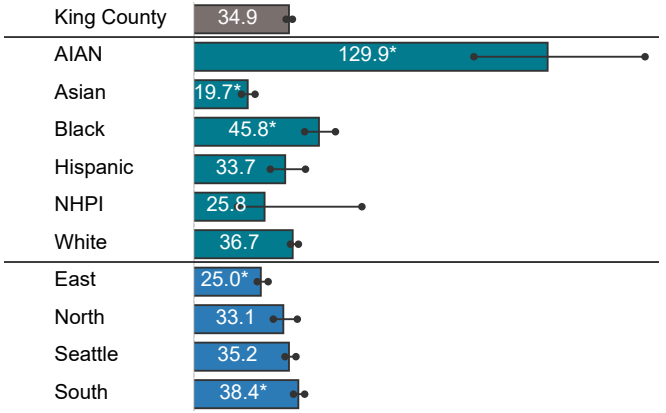
Unintentional injury deaths are tabulated separately from homicide, suicide, police/legal intervention, acts of war, or undetermined causes of death.[24] In King County, the leading causes of unintentional injury death (in order) are poisoning, falls, and motor-vehicle-traffic incidents.

Averaging data from 2014–2018, King County's annual rate of unintentional injury deaths was 34.9 per 100,000. This rate has increased over time from 32.5 per 100,000 (2013–2015 average) to 35.7 per 100,000 (2016–2018 average).

- The death rate from unintentional injury among American Indian/Alaska Native county residents (129.9 per 100,000) is 2.8 or more times the rate among other racial/ethnic groups.
- Adults in high-poverty neighborhoods (48.8 per 100,000) were more likely than those in medium- (32.8 per 100,000) or low-poverty neighborhoods (27.1 per 100,000) to die from unintentional injuries.
- For adults age 75 and older, the rate of death from unintentional injury (209.9 per 100,000) was six times the county average. The majority of unintentional injuries in this age group are due to falls (153.1 per 100,000).

Unintentional injury deaths

King County (average: 2014 - 2018)



Source: WA State Department of Health, Death Certificate data
* Significantly different from King County average

- Among King County neighborhoods, Downtown Seattle has the highest rate of unintentional injury death, at 77.1 per 100,000. The Federal Way neighborhood of Dash Point has the next highest rate at 53.2 per 100,000.

Chronic Illnesses

Chronic diseases are defined broadly as conditions that last one year or more and require ongoing medical attention or limit activities of daily living or both.[25] Chronic illnesses are among the leading causes of death, disability, and hospitalization in King County and contribute to significant economic costs for individuals and healthcare systems. Risk behaviors, such as tobacco and substance use, poor nutrition, and lack of physical activity — described in other sections of this report — increase the risk of developing chronic illness and are key areas for focused prevention and health promotion strategies.

Additional indicators available online include asthma prevalence (adults), chronic respiratory disease (adults), fair or poor health (adults), and stroke prevalence (adults).

Low-income adults are three times as likely as high-income adults to have diabetes.

ADULT HYPERTENSION

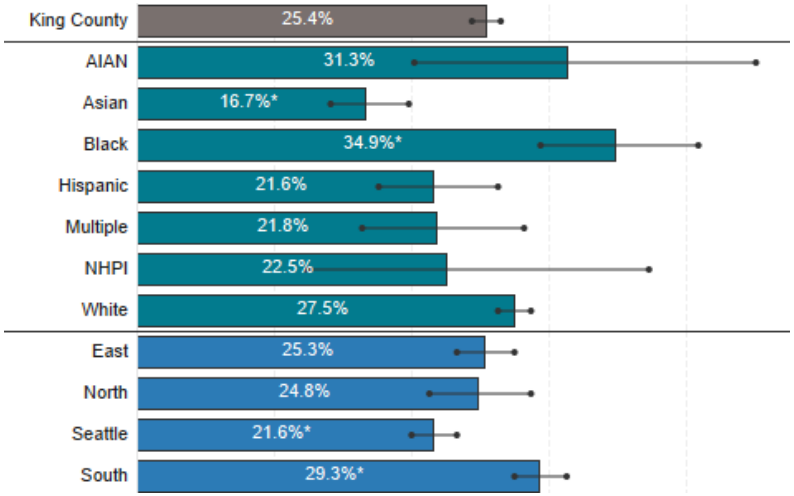
Averaging data from 2013, 2015, & 2017[i], 25.4% of King County adults were ever told by a doctor, nurse, or other health professional that they have high blood pressure.

- The prevalence of hypertension among Black residents (34.9%) was significantly higher than the King County average. Compared to other racial/ethnic groups, Asian adults had the lowest rate of hypertension (16.7%).
- The rate of hypertension among adults with a household income of $75,000+ was significantly lower than the King County average and all other income categories.
- The rate of high blood pressure among South Region adults was 29.3% — higher than the King County average. The city/neighborhood with the highest rate of adult hypertension was Auburn-South (37.8%), more than 2.5 times the rate of the city/neighborhood with the lowest rate — Northeast Seattle (14.6%).

[i] *Question asked every other year (BRFSS).*

Hypertension (adults)

King County (average: 2013, 2015 & 2017)



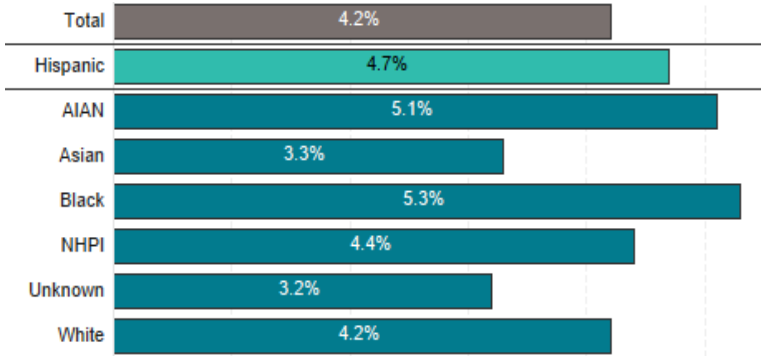
Source: Behavioral Risk Factor Surveillance System
* Significantly different from King County average

CHILDHOOD ASTHMA (MEDICAID)

In 2019, 4.2% of Medicaid-enrolled children[ii] (ages 0–17) had an asthma diagnosis.[iii]

- Asthma rates were highest among Black (5.3%) and American Indian/Alaska Native (5.1%) Medicaid-enrolled children.
- Auburn-North (5.3%) had the highest childhood asthma rate — nearly 2.5 times the rate of Vashon Island (2.2%), which had the lowest asthma rate among all King County cities/neighborhoods.

Asthma diagnosis (Medicaid children)
King County (2019)



Source: Medicaid claims data, WA State Health Care Authority (HCA)

[ii] This analysis includes Medicaid-enrolled children ages 0–17 who had seven or more cumulative months of Medicaid coverage in 2019.

[iii] Results from the analyses presented reflect the Medicaid beneficiary population receiving healthcare services. Therefore, these estimates are likely an underestimate of the true population rate, as we do not have information on individuals who do not seek healthcare.

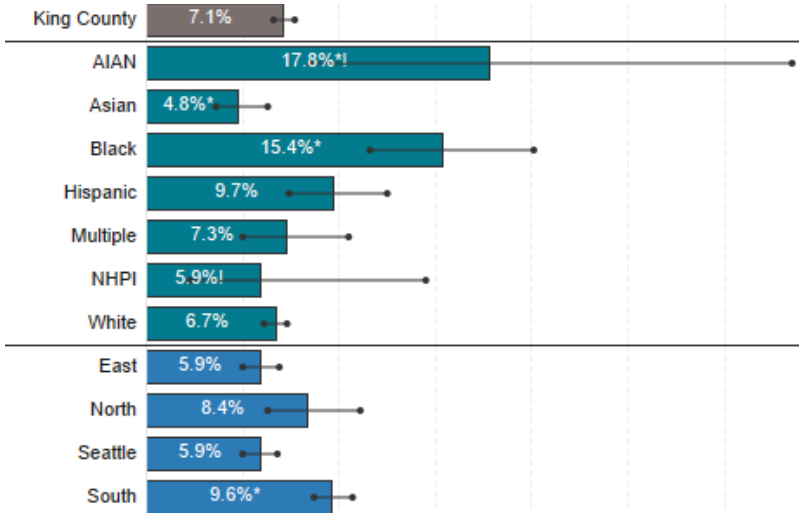
ADULT DIABETES

Averaging data from 2014–2018, 7.1% of King County adults reported having been told by a doctor, nurse, or other health professional that they have diabetes (excluding diabetes during pregnancy or pre-diabetes). This rate has not changed since 2009.

- Diabetes rates among young adults were low but increased with age. The diabetes rate among adults age 45–64 (10.3%) was more than four times the rate among adults age 25–44 (2.4%).
- In King County, the diabetes rate among military veterans (16.0%) was 2.5 times the rate among nonveterans (6.4%).
- The diabetes rate among adults over age 75 (18.9%) was more than 2.5 times the county average.
- Black adults (15.4%) were more than three times as likely as Asian adults (4.8%) to have diabetes.
- The likelihood of receiving a diabetes diagnosis decreased with higher household income.
- Adults with annual income lower than $15,000 (15.0%) were more than three times as likely as those with household income greater than $75,000 (4.4%) to have diabetes.

Diabetes prevalence (adults)

King County (average: 2014-2018)



Source: Behavioral Risk Factor Surveillance System
* Significantly different from King County average
! Interpret with caution: sample size is small, so estimate is imprecise

- South Region adults (9.6%) were more likely to have diabetes than adults in Seattle (5.9%) and East Region (5.9%).

Chronic Illnesses

Continued

LEADING CAUSES OF HOSPITALIZATION

Averaging data from 2016–2018 for the leading causes of hospitalization[iv] provides information about the impact of chronic disease and injuries on the inpatient healthcare delivery system in King County. At this time, we are able to look at data only from 2016 forward, as the diagnostic coding structure for healthcare claims data has changed, and the current guidance is that the two structures are not comparable. Since the transition occurred in the last quarter of 2015 and guidance on understanding the impact of the coding structure is not finalized, it is recommended that comparisons of data not be made before and after October 1, 2015. To focus this analysis on diseases and injuries that lead to hospitalization, this analysis excludes hospitalizations for normal pregnancy or delivery, normal childbirth, and injury sequelae.

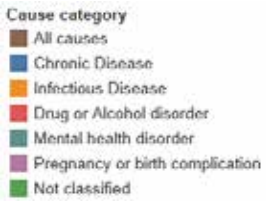
- The top three leading causes of hospitalization among adults, in order, were unintentional injury (560.2 per 100,000), septicemia (456.8 per 100,000), and osteoarthritis (294.2 per 100,000).
- While schizophrenia and other psychotic disorders (139.1 per 100,000) were the 6th leading cause of hospitalization overall, they were the 3rd leading cause among residents from high-poverty neighborhoods (490.1 per 100,000).
- Pregnancy and birth complications account for six of the top 10 leading causes of hospitalization among women.
- For children ages 1–14, the top three leading causes of hospitalization, in order, were asthma, unintentional injuries, and depressive disorders.
- Among adolescents and young adults (ages 15–24), the top three leading causes of hospitalization, in order, were depressive disorders, complications during childbirth, and schizophrenia and other psychotic disorders.

[iv] *Leading causes for hospital admission include both noninjury causes (e.g., diabetes) and injury causes (e.g., self-harm). Non-injury admits were identified using only the primary or first diagnosis code from categories defined by the Healthcare Cost and Utilization Project (HCUP) of the US Agency for Healthcare Research and Quality (AHRQ). Categories defined by the HCUP Clinical Classifications Software Refined (CCSR) version 2020-3 were used to map ICD–10-CM diagnosis codes. Injury admits were identified using all diagnosis codes, with injury intent (e.g., unintentional) and mechanism (e.g., fall) assigned using categories defined by the ICD–10-CM External Cause Matrix of the Centers for Disease Control and Prevention (CDC).*

Leading causes of hospitalizations (ranked by number of hospitalizations)

King County (average: 2016-2018)

Rank	Total	Female	Male
0	All causes 6,545.4 (145,188)	All causes 7,217.3 (84,149)	All causes 6,003.0 (61,038)
1	Unintentional injury 560.2 (12,032)	Unintentional injury 517.2 (6,158)	Unintentional injury 598.2 (5,874)
2	Septicemia 456.8 (10,018)	Septicemia 408.6 (4,832)	Septicemia 520.3 (5,187)
3	Osteoarthritis 294.2 (6,783)	Complications during childbirth 397.1 (4,695)	Osteoarthritis 254.6 (2,765)
4	Complications during childbirth 194.0 (4,695)	Osteoarthritis 328.2 (4,018)	Heart failure 259.1 (2,374)
5	Heart failure 214.7 (4,546)	Malposition, disproportion or other labor complications 233.1 (2,771)	Schizophrenia and other psychotic disorders 172.5 (2,005)
6	Schizophrenia and other psychotic disorders 139.1 (3,192)	Prolonged pregnancy 228.7 (2,755)	Acute myocardial infarction 171.7 (1,764)
7	Malposition, disproportion or other labor complications 113.8 (2,771)	Previous C-section 229.8 (2,667)	Stroke 140.9 (1,356)
8	Prolonged pregnancy 111.6 (2,755)	OB-related trauma to perineum and vulva 194.1 (2,320)	Alcohol-related disorders 113.1 (1,317)
9	Acute myocardial infarction 122.3 (2,717)	Heart failure 179.2 (2,172)	Skin and subcutaneous tissue infections 120.3 (1,297)
10	Previous C-section 112.1 (2,667)	Hypertension and hypertensive-related conditions complicating pregnancy, childbirth, and puerperium 165.0 (1,918)	Diabetes mellitus with complication 111.4 (1,208)



Source: Comprehensive Hospital Abstract Reporting System (CHARS)

Note: Under each cause, the first number shown is the 3-year average rate per 100,000 and the number in parenthesis is the average annual count from that cause over the 3-year period. For the leading causes by age, the rates are age-specific. All other rates are age-adjusted rates.

LEADING CAUSES OF CANCER INCIDENCE

Analysis of the leading causes of cancer ranks the 10 most common types of cancer based on the total number of new invasive cases during a five-year period. Cancer types that have less than 10 new cases during the five-year period were not included in the ranking. The analysis highlights disease burden as well as where to provide focused interventions if effective prevention measures are available. Averaging data from 2013–2017:

- The leading causes of cancer in King County were breast (female; 144.4 per 100,000) and prostate (male; 110.9 per 100,000).
- In Native Hawaiian/Pacific Islanders, female uterine cancer (88.5 per 100,000) took the second spot over prostate cancer (133.6 per 100,000), which was the 4th leading cause of cancer in this population.
- Among residents reporting multiple races, lung cancer (44.9 per 100,000) was the second most common cancer type.
- Cancer among children and young adults is relatively rare compared to adults. Leukemia was the most common cancer type in children age 1–14 (5.1 per 100,000). Among adolescents and young adults age 15–24, thyroid cancer was the leading type of cancer (5.7 per 100,000).
- Lung cancer was the most common type of cancer among adults over age 65 (278.8 per 100,000).

Most common cancer types (new cases)

King County (average: 2013-2017)

Rank	Total	Female	Male
1	Breast (Female) 144.4 (1,646)	Breast (Female) 144.4 (1,646)	Prostate (Male) 110.9 (1,156)
2	Prostate (Male) 110.9 (1,156)	Lung 43.7 (490)	Lung 53.4 (489)
3	Lung 47.9 (980)	Colorectal 31.1 (356)	Colorectal 41.1 (413)
4	Colorectal 35.8 (769)	Uterine (Female) 27.4 (328)	Skin Melanoma 37.0 (362)
5	Skin Melanoma 29.8 (642)	Skin Melanoma 24.5 (280)	Non-Hodgkin Lymphoma 26.7 (257)
6	Non-Hodgkin Lymphoma 21.0 (444)	Thyroid 19.4 (215)	Kidney 19.8 (198)
7	Uterine (Female) 27.4 (328)	Non-Hodgkin Lymphoma 16.4 (187)	Oral/Pharynx 18.1 (189)
8	Leukemia 15.1 (314)	Pancreas 11.4 (130)	Leukemia 19.8 (188)
9	Kidney 14.2 (307)	Leukemia 11.4 (126)	Urinary Bladder 17.9 (154)
10	Thyroid 13.5 (298)	Ovary (Female) 10.9 (123)	Liver 13.9 (153)

Source: Washington State Cancer Registry

Note: Cancers at the invasive stages only. Cancers at the in situ stage are excluded.

Under each cancer site, the first number shown is the 5-year average rate per 100,000 and the number in parentheses is the average annual count from that cause over the 5-year period. For the leading types by age, the rates are age-specific rates. All other rates are age-adjusted rates.

Medicaid profile

INTRODUCTION

HHC members chose to include this Medicaid profile in the CHNA report to describe the overall demographics of Medicaid beneficiaries in King County and to understand what is happening with emergency department (ED) use based on Medicaid claims. Using data from 2019, we reviewed leading causes of ED visits (defined as healthcare visits that include a revenue or procedure code for emergency services — urgent care visits are not included) by ranking the top 10 primary diagnoses for ED visits among different demographic categories and among individuals who had five or more visits to the ED without a visit to a primary care provider. These results can help inform quality improvement efforts within hospitals as well as highlight opportunities to support Medicaid beneficiaries in accessing care, resources, and programs.

Washington State Medicaid (i.e., Apple Health) covers a broad range of health services to address the diverse needs of beneficiaries in King County. For this profile, Medicaid beneficiaries are defined as individuals with seven or more months of Medicaid full medical benefit coverage, and less than five months of Medicare dual eligibility or third-party liability coverage in 2019. This definition accounts for some Medicaid enrollment changes throughout

Over half of adult King County Medicaid beneficiaries with five or more emergency department visits in 2019 had not visited a primary care provider that year.

Medicaid profile

Continued

the year while maximizing the inclusion of Medicaid claims to reflect patterns of healthcare utilization for those individuals.

DEMOGRAPHIC CHARACTERISTICS

MEDICAID OVERALL (ALL AGES)

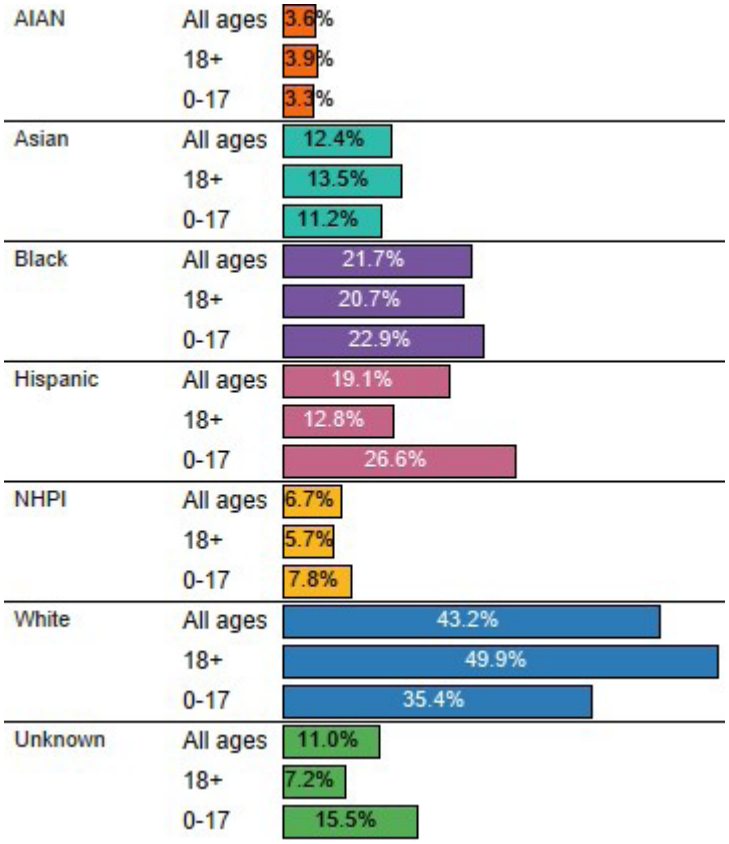
In 2019, there were 319,378 Medicaid beneficiaries with seven or more months of Medicaid full medical benefit coverage and less than five months of Medicare dual eligibility or third-party liability coverage in King County. This represents 64.7% of all Medicaid beneficiaries in King County and approximately 14% of King County's total population. Compared to the racial/ethnic makeup of King County overall, our defined King County Medicaid population is more diverse.

The representation of race/ethnicity among Medicaid beneficiaries was as follows:

- 43.2% white
- 21.7% Black
- 19.1% Hispanic
- 12.4% Asian
- 6.7% Native Hawaiian/Pacific Islander
- 3.6% American Indian/Alaska Native

Medicaid member demographics (Overall, adults, children)

King County (2019)



Source: Medicaid claims data, WA State Health Care Authority (HCA)

Medicaid profile

Continued

There are different Apple Health programs with different age limits and income eligibility. Generally, adult eligibility for Medicaid is age 19. The analysis by age in this report categorizes children as 0–17 and adults as 18 and over. Adults (ages 18+) represent 53.8% of Medicaid beneficiaries and children (ages 0–17) represent 46.2%. Most Medicaid beneficiaries (89.0%) chose English as their preferred language.

Neighborhoods in South King County had higher percentages of Medicaid beneficiaries in 2019. The five King County neighborhoods with the highest percentage of Medicaid beneficiaries were all in the South Region: Federal Way, Southeast Kent, SeaTac/Tukwila, North Auburn, and South Renton.

MEDICAID ADULTS (AGES 18+)

Roughly half of adult Medicaid beneficiaries were white (49.9%). Black adults (20.7%) represent the second highest percentage, followed by Asian adults (13.5%), Hispanic adults (12.8%), Native Hawaiian/Pacific Islander adults (5.7%) and American Indian/Alaska Native adults (3.9%).

MEDICAID CHILDREN (AGES 0-17)

Among children with Medicaid, children of color made up the majority of beneficiaries in this age bracket. The percentage of white Medicaid-enrolled children (35.4%) was lower than the percent of white Medicaid adults (49.9%). The percentages of Black (22.9%), Hispanic (26.6%), and Native Hawaiian/Pacific Islander children (7.8%) were all higher than the proportion of each race/ethnicity among adult Medicaid beneficiaries. Unknown race accounted for 15.5% of Medicaid-enrolled children — almost double compared to adults. Among children, 16.7% of beneficiaries listed Spanish as their (or their parent's/guardian's) preferred language, which was more than three times the rate of Spanish preference among adult beneficiaries.

LEADING CAUSES OF EMERGENCY DEPARTMENT (ED) VISITS BY NUMBER OF VISITS

Leading reasons for emergency department (ED) visits provide information to help tailor more effective programs to meet patient needs, address barriers in accessing healthcare services, and decrease potentially avoidable ED utilization. Visits to the ED represent a combination of true emergency needs, as well as visits that could be better addressed through primary care or other preventive services.

While this report focuses on the primary diagnosis listed on the health insurance claim for each ED visit, the accompanying online dashboards on CHI allows users to view all diagnoses reported for each ED visit

(e.g., up to a possible 12 diagnosis codes for each visit). This additional information often highlights underlying conditions that may contribute to the reasons for why individuals seek care at the ED.

This analysis of leading causes of ED visits ranks primary diagnosis by number of visits as opposed to number of people in order to present leading causes of ED visits based on what is most common. This analysis stratifies leading causes of ED visits by children, adults, and race/ethnicity. Further stratification by gender, age, or utilization rate would likely result in differing patterns.

LEADING CAUSES OF ED VISITS: *MEDICAID OVERALL (ALL AGES)*

In 2019, the top 10 leading causes of ED visits by number of visits for all Medicaid beneficiaries, adults, and children were:

Table 1. Top 10 leading causes of ED use (by primary diagnosis)

	Medicaid Overall (all ages)		Medicaid Adults (ages 18+)		Medicaid Children (ages 0-17)
1.	Respiratory infections	1.	Abdominal pain	1.	Respiratory infections
2.	Abdominal pain	2.	Pregnancy/childbirth complications	2.	Fever of unknown cause
3.	Pregnancy/childbirth complications	3.	Heart disease	3.	Ear conditions
4.	Heart disease	4.	Skin infections	4.	Abdominal pain
5.	Skin infections	5.	Respiratory infections	5.	Nausea and vomiting
6.	Sprain and strains	6.	Alcohol use disorders	6.	Open wounds
7.	Open wounds	7.	Sprain and strains	7.	Viral infection
8.	Minor injuries	8.	Urinary system disease	8.	Minor injuries
9.	Ear conditions	9.	Minor injuries	9.	Broken bones
10.	Urinary system disease	10.	Substance use disorders	10.	Sprains and strains

Source: Medicaid claims data, WA State Health Care Authority (HCA)

When we include all diagnoses (versus primary diagnosis only) listed on an ED visit's health insurance claim, substance use disorders (SUD) are the most frequently seen diagnosis for Medicaid beneficiaries overall. Though this finding does not mean that SUD is the primary reason for why these individuals use the ED, it does indicate that SUD is a common underlying condition among individuals who use the ED.

Medicaid profile

Continued

LEADING CAUSES OF ED VISITS *BY RACE/ETHNICITY: MEDICAID OVERALL (ALL AGES)*

The top three leading causes of ED visits by race/ethnicity for all Medicaid beneficiaries are reflected in the chart below.

- Among Asian, Black, Hispanic, Native Hawaiian/Pacific Islander and white Medicaid beneficiaries, respiratory infections were the leading cause of ED visits, largely driven by children. Among American Indian/Alaska Native Medicaid beneficiaries, alcohol use disorder was the leading cause of ED visits.

Top three leading causes of ED use *by race/ethnicity* (by primary diagnosis), *Medicaid Overall (all ages)*
King County (2019)

Cause of visit	Overall	AIAN	Asian	Black	Hispanic	NHPI	White
Respiratory infections	1	3	1	1	1	1	1
Abdominal pain	2	2	2	2	3	3	2
Pregnancy/childbirth complications	3		3	3	2	2	
Alcohol use disorders		1					
Skin infections							3

Source: Medicaid claims data, WA State Health Care Authority (HCA)

Historical and present-day experiences of American Indian/Alaska Native (AIAN) individuals may influence these results. The high number of alcohol use disorder-related ED visits may be reflective of community experiences and structural barriers that disproportionately impact this population. Furthermore, since we have ranked leading causes by the number of ED visits, a small number of male AIAN Medicaid adult beneficiaries who frequently visit the ED due to alcohol use disorder impact the results for the overall AIAN Medicaid population.

- Respiratory infections, abdominal pain, and pregnancy/childbirth complications were the top three causes of ED use, among Asian, Black, Native Hawaiian/Pacific Islander, and Hispanic Medicaid beneficiaries. Respiratory infections, abdominal pain, and skin infections were the leading causes of ED use for white beneficiaries. Among American Indian/Alaska Native beneficiaries, alcohol use disorder, abdominal pain, and respiratory infections were the top three causes of ED use.

Medicaid profile

Continued

LEADING CAUSES OF ED VISITS: *MEDICAID ADULTS (AGES 18+)*

The top 10 causes of ED use for adult Medicaid beneficiaries (ages 18+) were similar to the overall pattern of leading causes of ED use for all Medicaid beneficiaries as listed above — with the exception of open wounds and ear conditions for all beneficiaries, which are replaced with alcohol use disorder and substance use disorders for adult beneficiaries.

LEADING CAUSES OF ED VISITS *BY RACE/ETHNICITY: MEDICAID ADULTS (AGES 18+)*

The top three leading causes of ED visits by race/ethnicity for adult Medicaid beneficiaries (ages 18+) are reflected in the chart below.

Top three leading causes of ED use *by race/ethnicity* (by primary diagnosis), *Medicaid Adults (ages 18+)*
King County (2019)

Cause of visit	Overall	AIAN	Asian	Black	Hispanic	NHPI	White
Abdominal pain	1	2	2	2	2	2	1
Pregnancy/childbirth complications	2		1	1	1	1	
Heart disease	3	3	3	3	3		3
Alcohol use disorders		1					
Respiratory infections						3	
Skin infections							2

Source: Medicaid claims data, WA State Health Care Authority (HCA)

These racial and ethnic disparities in pregnancy/childbirth complications reflect national trends for communities of color. For example, Black women are more likely to experience pregnancy-related complications compared to white women.[26,27] Different patterns emerge when looking at results by race/ethnicity and gender, since these results reflect the large proportion of adult Medicaid beneficiaries who are women of childbearing age. See results described by gender and race/ethnicity below.

- Among adults and racial/ethnic groups, the overall leading cause of ED use was pregnancy/childbirth complication.
- For American Indian/Alaska Native adult beneficiaries, the leading cause of ED use was alcohol use disorder,

and for white adult Medicaid beneficiaries, the leading cause of ED use was abdominal pain.

- Heart disease was the third leading cause of ED visits for all races and ethnicities, with the exception of Native Hawaiian/Pacific Islander adults, among whom respiratory infections were the third leading cause and heart disease was the fourth leading cause.

LEADING CAUSES OF ED VISITS *BY GENDER AND RACE/ETHNICITY: MEDICAID ADULTS (AGES 18+)*

For adults (18+) by gender, patterns for leading causes of ED use vary.

Among males:

- Heart disease was the leading cause of ED visits in males. It ranks first among Asian, Black, and Native Hawaiian/Pacific Islander male Medicaid beneficiaries, 2nd among whites, and 3rd among American Indian/Alaska Native and Hispanic males.
- Skin infections were the 2nd leading cause of ED visits in males overall, but ranked among the top three only for white, Hispanic, Native Hawaiian/Pacific Islander, and American Indian/Alaska Native males.
- The 3rd leading cause of ED visits among males overall was alcohol use disorder. This was the 1st leading cause of ED visits for AIAN males, 2nd for Hispanic males, 3rd for white males, and 6th for Asian and Black males.
- While substance use disorders were the 5th leading cause of ED visits among males overall, they were the 4th leading cause among American Indian/Alaska Native males.
- Although schizophrenia and other psychotic disorders did not rank in the top 10 leading causes of ED visits for males overall, they were the 4th leading cause of ED use for Asian males.

Among females:

- Pregnancy/childbirth complications were the leading cause of ED visits for female Medicaid beneficiaries.
- Abdominal pain and heart disease are 2nd and 3rd.
- Respiratory infections were the 4th leading cause among females overall, but 3rd among Black, Hispanic, and Native Hawaiian/Pacific Islander female Medicaid beneficiaries.
- While alcohol use disorders were not listed in the top 10 leading causes of ED visits for females overall, they

were the 4th leading cause of ED visits for American Indian/Alaska Native females.

- Substance use disorders were not in the top 10 leading causes of ED visits for females overall or for any racial/ethnic group.
- Schizophrenia and other psychotic disorders were not in the top 10 leading causes of ED visits among females overall or for any race/ethnicity.

Top five leading causes of ED use *by race/ethnicity* (by primary diagnosis), *Medicaid Male Adults (ages 18+)*
King County (2019)

Cause of visit	Overall	AIAN	Asian	Black	Hispanic	NHPI	White
Heart disease	1	3	1	1	3	1	2
Skin infections	2	2		5	1	3	1
Alcohol use disorders	3	1			2		3
Abdominal pain	4	5	2	2	4	4	4
Substance use disorders	5	4			5	5	5
Respiratory infections			3	3		2	
Schizophrenia and other psychotic disorders			4				
Sprains and strains				4			
Open wounds			5				

Source: Medicaid claims data, WA State Health Care Authority (HCA)

Top five leading causes of ED use *by race/ethnicity* (by primary diagnosis), *Medicaid Female Adults (ages 18+)*
King County (2019)

Cause of visit	Overall	AIAN	Asian	Black	Hispanic	NHPI	White
Pregnancy/childbirth complications	1	2	1	1	1	1	1
Abdominal pain	2	1	2	2	2	2	2
Heart disease	3	3	3	4	4	4	3
Respiratory infections	4		4	3	3	3	5
Urinary system disease	5				5	5	
Alcohol use disorders		4					
Skin infections		5					4
Sprains and strains				5			
Headache			5				

Source: Medicaid claims data, WA State Health Care Authority (HCA)

Medicaid profile

Continued

LEADING CAUSES OF ED VISITS: *MEDICAID CHILDREN (AGES 0-17)*

The top 10 causes of ED use for children on Medicaid (ages 0–17) are listed in Table 1. These common childhood illnesses and symptoms are similar to national leading causes of pediatric ED visits.[28]

LEADING CAUSES OF ED VISITS *BY RACE/ ETHNICITY: MEDICAID CHILDREN (AGES 0-17)*

There were no obvious trends by race/ethnicity in the leading causes of ED visits among children. The leading cause of ED use in children of all races and ethnicities was respiratory infections. Fever of unknown origin was the second leading cause for all races and ethnicities, except for American Indian/ Alaska Native children, among whom fever was the third leading cause and open wounds were the second leading cause.

MEDICAID BENEFICIARIES WITH 5+ ED VISITS AND NO PCP VISITS

The emergency department (ED) is a critical healthcare setting for addressing medical emergencies and urgent care. While very few patients come to the ED frequently, those who do account for a disproportionately large share of overall visits and related costs. One study estimated that 4.5% to 8% of patients revisit the ED four or more times per year but account for 21% to 28% of all ED visits.[29] For many patients, the ED may be their only reliable source of healthcare. Patients may not have access to a primary care provider (PCP) or lack knowledge of where to seek appropriate care. A high rate of ED utilization may indicate inadequate access to care or poor coordination of care.[30]

We identified King County Medicaid beneficiaries with a high number of ED visits and no primary care visits (defined as healthcare visits that include a procedure or ICD-CM-10 code for primary care services, plus a provider taxonomy relevant to primary care) in 2019. For our analyses, we defined someone with a high number of ED visits as a Medicaid beneficiary with five or more ED visits in 2019.

Approximately 54% of all Medicaid beneficiaries in King County with five or more ED visits had no visits to a PCP in 2019. A majority (86%) of these individuals were adults (age 18+).

MEDICAID OVERALL (ALL AGES)

For all ages, among all races/ethnic groups, over half of Medicaid beneficiaries with a high number of ED visits did not have any visits to a PCP in 2019.

Medicaid profile

Continued

MEDICAID ADULTS (AGES 18+)

For adults (18+), among each race/ethnicity group, over half of Medicaid beneficiaries with a high number or ED visits did not have any PCP visits in 2019.

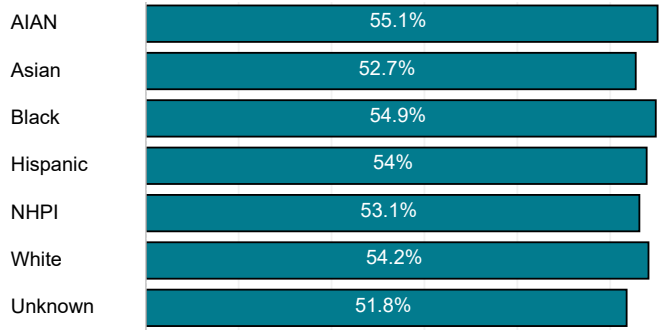
MEDICAID CHILDREN (AGES 0-17)

Given the small number of Medicaid-enrolled children with number of visits to the ED, we have excluded this analysis from the report. Most younger Medicaid child beneficiaries, regardless of number of visits to the ED, are engaged with their PCPs for vaccinations and well-child visits. Medicaid child beneficiaries who have visited the ED more than five times in the past year may be visiting the ED for management of chronic diseases, which may represent appropriate use of this acute care setting.

The ED is an important healthcare setting for quickly addressing medical emergencies. However, frequent visits to the ED and/or urgent care department can disrupt continuity of care and optimal health and place a heavy cost burden on patients, as well as the healthcare system. Individuals who do not have stable health coverage, or a regular source of primary care, are more likely to go to the ED for their care. Understanding the primary and underlying causes of ED visits, identifying barriers to accessing care, and

Among each race/ethnicity group, Medicaid adults with 5+ visits to the ED without any visits to a Primary Care Provider

King County (2019)



Source: Medicaid claims data, WA State Health Care Authority (HCA)

connecting patients to culturally competent primary care providers may assist in decreasing potentially avoidable ED visits. It is important to understand the factors that influence disparities by race/ethnicity to inform the development of tailored programs to improve healthcare experiences and health outcomes.

Medicaid profile

Continued

VISITS TO THE ED AND COVID-19

Early in the COVID-19 pandemic, public messaging advised individuals to avoid unnecessary healthcare use to reduce transmission of the virus and to ensure hospital and provider capacity for surges in COVID-19 cases. Early analyses suggest that ED use decreased nationally through June of 2020.[1] Respiratory infections were already the leading cause of ED visits before the COVID-19 pandemic in 2019. We anticipate COVID-19 symptoms will impact the leading cause of ED visits throughout the course of the pandemic.

To understand the impact that COVID-19 has had on ED visits in early 2020, we analyzed Medicaid claims from January 1 to April 30, 2020, and compared them to the same time period for 2019. Based on this analysis, we observed a decrease in overall ED visits with no significant difference in causes of ED use. The decrease in ED visits in early 2020 is likely resulting from the avoidance of ED use during the first couple of months of the COVID-19 pandemic, and consistent with national trends.

Access to Healthcare & Use of Preventive Services

Improving access to comprehensive quality healthcare services is a long-standing national public health goal. The ability to access health services in a timely matter is crucial to prevent, detect, and manage disease as well as to support overall quality of life. Health insurance coverage is a key component of entry to the healthcare system, and monitoring insurance coverage can indicate the degree to which the health needs of a community are met.

Healthcare coverage increased dramatically in King County following implementation of the Affordable Care Act (ACA). From 2010 to 2016, lack of health insurance dropped by more than 2/3 among young adults ages 18–24, as more young adults could remain on their parents' health insurance plans. With the initiation of the individual mandate in 2014, access to private insurance was expanded and more adults became eligible for Medicaid.

In December 2017, the individual mandate penalty was eliminated — effective in 2019. The Congressional Budget Office (CBO) estimated that eliminating the individual mandate penalty would cause 3–6 million individuals to lose insurance coverage between 2019 and 2021.[31,32] In the United States, early assessment of COVID-19's impact on health insurance showed that one in five adults who previously had health insurance coverage for either themselves, a spouse, or partner through their job reported that at least one of them had become uninsured in 2020.[33] The impacts of the pandemic and national policy changes on insurance enrollment and population health will require ongoing monitoring.

Additional indicators available online include adults without a usual primary care provider, adults who did not receive a flu vaccination in the past year, and youth who did not have a dental checkup in the past year.

Despite improvements in health insurance coverage since implementation of the Affordable Care Act in 2010, disparities in health insurance coverage persist and have worsened since 2014.

Access to Healthcare & Use of Preventive Services

Continued

INCOMPLETE VACCINE COVERAGE (AGE 19–35 MONTHS)

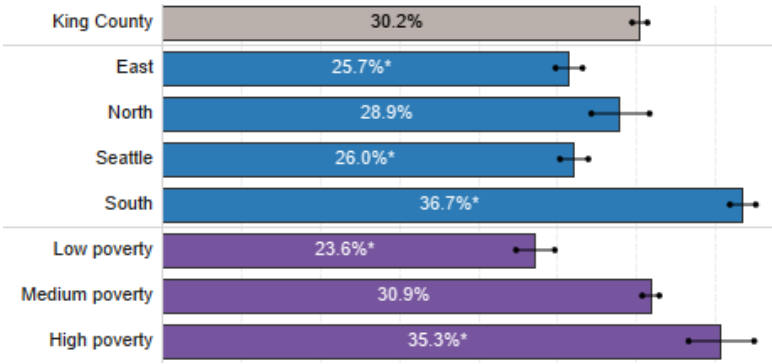
This indicator presents the percentage of children 19–35 months of age who have not completed the routine series of recommended vaccinations, referred to as the 4:3:1:3:3:1:4 series.[i] As of December 31, 2019, the rate of incomplete vaccination coverage for King County children age 19–35 months was 30.2%, which was an improvement on the previously reported rate of 33.4% in 2017. King County has not met the Healthy People 2020 objective of reducing incomplete vaccination coverage to 20% of children age 19–35 months.[34]

- In December 2019, the rate of incomplete vaccination in the South Region (36.7%) was significantly higher than all other King County regions.
- Incomplete vaccination rates were highest in high-poverty neighborhoods (35.3%). The two ZIP codes with the highest rates were 98057 (45.2%) and 98032 (44.9%), which includes Renton as well as the Des Moines/Kent area.

[i] *This routine series of vaccinations is defined as having four or more doses of diphtheria, tetanus, acellular pertussis (Dtap), 3 or more doses of polio vaccines, 1 measles containing vaccine, 3 or more doses of Haemophilus influenzae type b (Hib), 3 or more doses of hepatitis B (Hep B) vaccine, 1 or more doses of varicella vaccine, and 4 or more doses of pneumococcal conjugate vaccine (PCV).*

Incomplete vaccination coverage (age 19-35 months)

King County (2019)



Source: WA State Immunization Information System (Child Profile Health Promotion & Immunization Registry System)
* Significantly different from King County average

Analysis of vaccination rates as of June 30, 2020 showed a decrease in vaccination coverage compared to rates as of December 31, 2019, likely reflecting decreased access to and use of healthcare services during the COVID-19 pandemic. As of June 30, 2020, the King County rate of incomplete vaccination coverage had increased to 33.4%. Rates of incomplete vaccination increased among South Region families (40.7%) and families living in high-poverty neighborhoods (39.9%).

Access to Healthcare & Use of Preventive Services

Continued

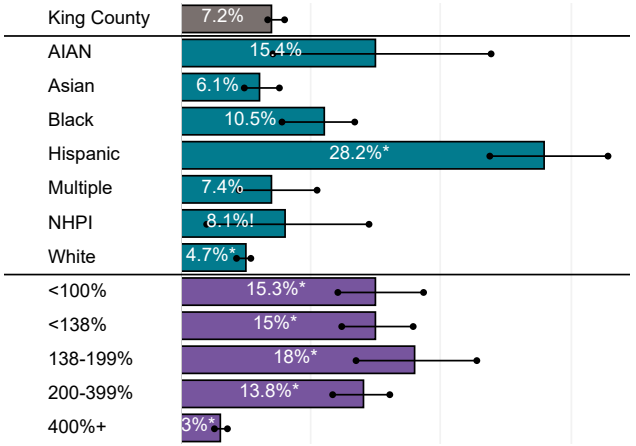
UNINSURED ADULTS

After ACA implementation, the rate of uninsured King County adults decreased significantly — from 16.4% in 2013 (prior to the ACA individual mandate)[ii] to 6.7% in 2016. Since 2016, the rate of uninsured King County residents has slightly risen, reaching 7.2% in 2019.

- Communities of color continue to be disproportionately uninsured — before and after implementation of the ACA. Racial/ethnic disparities in insurance coverage have increased since an initial narrowing of gaps in coverage in 2014.
- In 2019, Black adults (10.5%) were more than two times as likely to be uninsured compared to white adults (4.7%).
- Hispanic adults (28.2%) had the highest rate of uninsurance and were six times as likely as white adults (4.7%) to be without coverage.
- Burien residents (16.0%) and Tukwila residents (15.6%) were uninsured at rates more than twice the county average.
- Adults with household income below 100% of the federal poverty level (15.3%) were more than five times as likely as those in the highest-income households (3.0%) to be uninsured.

[ii]January 2014: ACA requires all Americans to have health insurance; more adults became eligible for Medicaid and tax rebates; private insurance available through the state's Health Benefit Exchange (Washington Healthplanfinder).

Uninsured adults
King County (2019)



Source: American Community Survey
* Significantly different from King County average
! Interpret with caution: sample size is small, so estimate is imprecise

Preliminary data modeling the impacts of COVID-19 on Washington state's health coverage estimate that the King County uninsurance rate reached its highest level in late May 2020 (19.4%), compared to 5.6% before COVID-19. While the uninsurance rate has slowly declined since its peak in May, it is important to continue to monitor for impacts to access to care — especially among populations with high rates of uninsurance prior to the pandemic, which are also the same populations hardest hit by the pandemic.[35]

Access to Healthcare & Use of Preventive Services

Continued

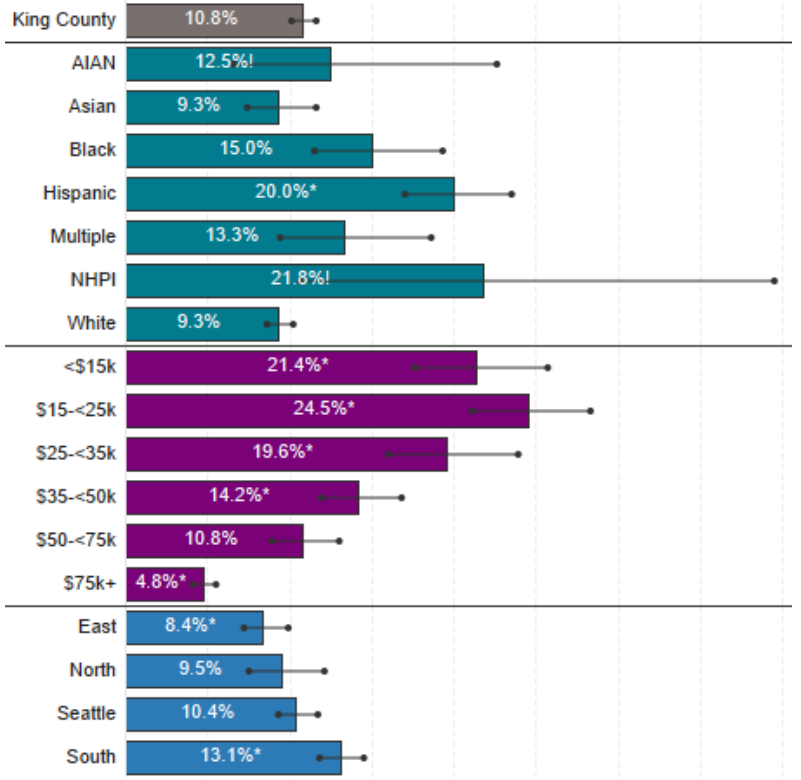
UNMET MEDICAL NEEDS

Individuals without health insurance are more likely to have unmet healthcare needs due to cost. As insurance coverage has improved, fewer King County adults report cost as a barrier to seeking needed medical care. Averaging data from 2014 to 2018, 10.8% of King County adults reported they needed to see a doctor in the past 12 months but could not due to cost — down from 15% during the period preceding ACA implementation (2011–2013 average).

- Among adults age 25–44, 13.1% reported unmet healthcare needs due to cost — higher than the King County average.
- Compared to Asian (9.3%) adults and white (9.3%) adults — the racial/ethnic groups with the lowest rates of uninsurance — Black (15.0%) adults were more than 1.5 times as likely and Hispanic (20.0%) adults were more than two times as likely to report unmet medical needs due to cost.
- Adults who identify as lesbian, gay, or bisexual (18.8%) were twice as likely to report unmet healthcare needs compared to adults who identify as heterosexual (9.5%).
- Adults with household income below $15,000 (21.4%) were more than four times as likely as those earning more than $75,000 (4.8%) to report unmet medical needs, though this income-based disparity has decreased over time.

Unmet medical needs due to cost (adults)

King County (average: 2014-2018)



Source: Behavioral Risk Factor Surveillance System
* Significantly different from King County average
! Interpret with caution: sample size is small, so estimate is imprecise

Access to Healthcare & Use of Preventive Services

Continued

COLORECTAL CANCER SCREENING

The U.S. Preventive Services Task Force (USPSTF) highlights strong evidence that colorectal cancer screening substantially reduces deaths from the disease among adults aged 50 to 75 years and that not enough adults in the United States are using this effective preventive intervention. The USPSTF recommends that adults be screened for colorectal cancer starting at age 50 and continuing until age 75 years.[36]

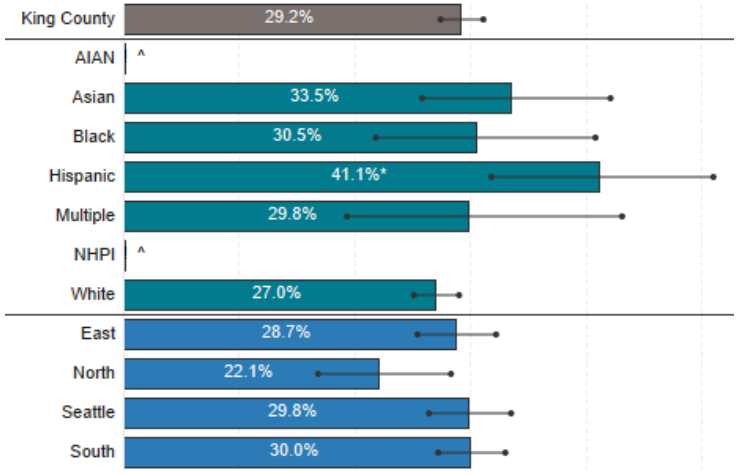
To assess adherence to colorectal cancer screening recommendations, the Behavioral Risk Factor Surveillance System (BRFSS) asks adults whether they have received a colorectal cancer screening. This indicator reports individuals age 50–75 who have received a fecal occult blood test (FOBT) within one year, flexible sigmoidoscopy within five years + FOBT within three years, or colonoscopy within 10 years. Averaging data from 2014–2016 and 2018,[iii] 29.2% of King County adults age 50–75 failed to meet these colorectal cancer screening recommendations — an improvement when looking at trends for the latest non-overlapping average years of 2011–2013, in which 32.5% did not meet screening recommendations.

- Colorectal cancer screening rates have been improving in King County since 2010. In 2018 — the most recent year for which we have data — 27.0% of adults age 50–75 had not met screening guidelines.

[iii] *Question was not asked in 2017.*

Colorectal cancer screening recommendation not met (adults 50-75)

King County (average: 2014, 2015, 2016, & 2018)



Source: Behavioral Risk Factor Surveillance System
* Significantly different from King County average
^ Data suppressed if too few cases to protect confidentiality and/or report reliable rates

- Among Hispanic residents, 41.1% did not meet screening guidelines — higher than the King County average. Cancer is the leading cause of death among Hispanic King County residents, with colorectal cancer as the third most common cancer type among this group.

- Adherence to screening guidelines increased with household income.

- Residents of the North Region in King County had the highest rate of adherence, with only 22.1% of adults 50–75 not meeting colorectal cancer screening guidelines.

Access to Healthcare & Use of Preventive Services

Continued

ADULT DENTAL VISITS

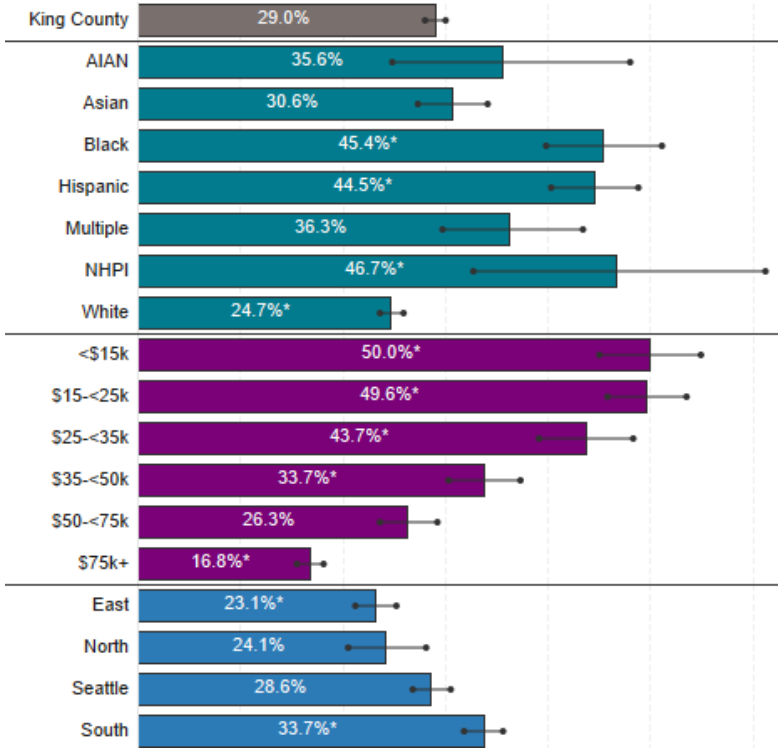
Averaging data from 2012 and 2014–2016[iv], 29.0% of King County adults reported they did not visit a dentist or dental clinic for any reason in the past year. This rate has been consistent for the past 10 years.

- Male residents (32.4%) were significantly more likely than female residents (25.6%) not to have visited a dentist or dental clinic in the past year.
- Half of adults with household income below $15,000 (50.0%) had not visited a dentist in the past year, reflecting long-standing income disparities for dental care.
- Native Hawaiian/Pacific Islander (46.7%), Black (45.4%), Hispanic (44.5%), and multiple race (36.3%) residents were significantly more likely not to have visited a dentist or dental clinic in the previous year compared to white residents (24.7%).
- Adults in South Region (33.7%) were most likely to report that they had not seen a dentist in the previous year compared to residents in other King County regions.

[iv]*Question was not asked in 2013.*

No dental checkup in last year (adults)

King County (average: 2012, 2014, 2015, & 2016)



Source: Behavioral Risk Factor Surveillance System
* Significantly different from King County average

Mental Health & Substance Use

Mental health includes our emotional, psychological, and social well-being. Protecting our mental health is important to protecting our physical health and quality of life. Mental illness, such as depression, can increase the risk for many types of physical health problems and chronic conditions, including stroke, type 2 diabetes, and heart disease.[37] Substance use may or may not be independent of mental health conditions and may be causal or exacerbate other quality of life indicators.[38]

Additional indicators available online include binge drinking (youth and adults), adolescents with an adult they can talk with, serious psychological distress (adults), and driving or riding in a car while high (youth).

High-income adults are nearly twice as likely to have the social and emotional support they need, compared to low-income adults.

Mental Health & Substance Use

Continued

ADULT FREQUENT MENTAL DISTRESS

Averaging data from 2014–2018, 10.8% of adults in King County had 14 or more days with poor mental health in the past 30 days.

- Frequent mental distress was most often reported among adults age 18–24 (16.8%). The percentage of adults reporting this indicator decreased with age.

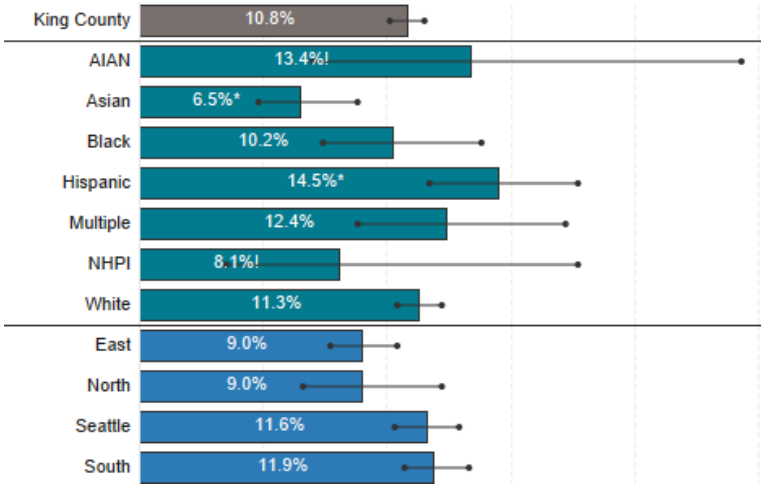
- The rate for adults with household income below $15,000 (26.9%) was almost 2.5 times the county average and four times the rate for adults with household income at or above $75,000 (7.1%). The prevalence of frequent mental distress decreases with each increasing income category.

- Frequent mental distress among Hispanic adults (14.5%) is significantly higher than the King County average.

- Adults who identified as lesbian, gay, or bisexual (LGB) (22.3%) were more than twice as likely as heterosexual adults (10.1%) to report frequent mental distress. The percent of adults reporting frequent mental distress has remained stable when looking at the overall county population, but LGB adults have seen a steady increase over the past several years, from 18.2% in 2012–2014 to 24.4% in 2016–2018.

Frequent mental distress (adults)

King County (average: 2014-2018)



Source: Behavioral Risk Factor Surveillance System
* Significantly different from King County average
! Interpret with caution: sample size is small, so estimate is imprecise

- South Region adults reported frequent mental distress at a rate of 11.9%.

- The highest rates across all cities/neighborhoods in King County included areas in the South Region, where 17.9% of adults in North Auburn and Federal Way – Dash Point/Woodmont reported frequent mental distress.

Mental Health & Substance Use

Continued

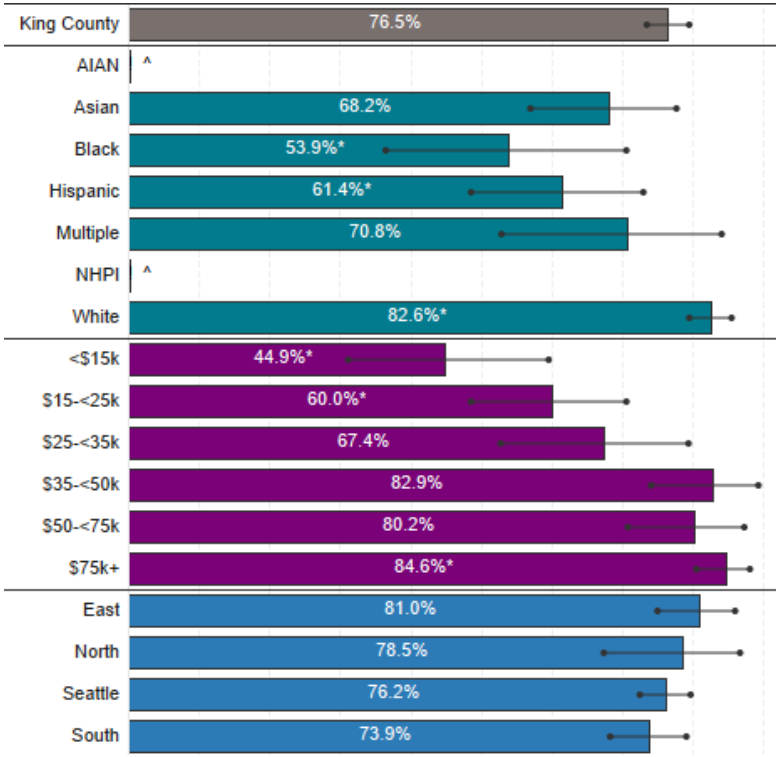
ADULT SOCIAL AND EMOTIONAL SUPPORT

Social and emotional support contribute to psychological health and well-being and are associated with healthy behaviors as well as self-rated health status. Averaging data from 2017–2018, in King County, 76.5% of adults always or usually get the social and emotional support they need.

- While there were no significant differences in this indicator by age, gender, or sexual orientation, differences by race/ethnicity and income are noteworthy.
- A majority of white residents (82.6%) report that they always or usually get the social and emotional support they need — significantly higher than Black (53.9%), Hispanic (61.4%), and Asian (68.2%) adults.
- Among adults with a household income of less than $15,000, 44.9% always or usually get the social and emotional support they need. This percentage is lower than the King County average and just over half the rate among residents with a household income of $75,000 or more (84.6%).

High social & emotional support (adults)

King County (average: 2017-2018)



Source: Behavioral Risk Factor Surveillance System
* Significantly different from King County average
! Interpret with caution: sample size is small, so estimate is imprecise
^ Data suppressed if too few cases to protect confidentiality and/or report reliable rates

Mental Health & Substance Use

Continued

TEEN DEPRESSION

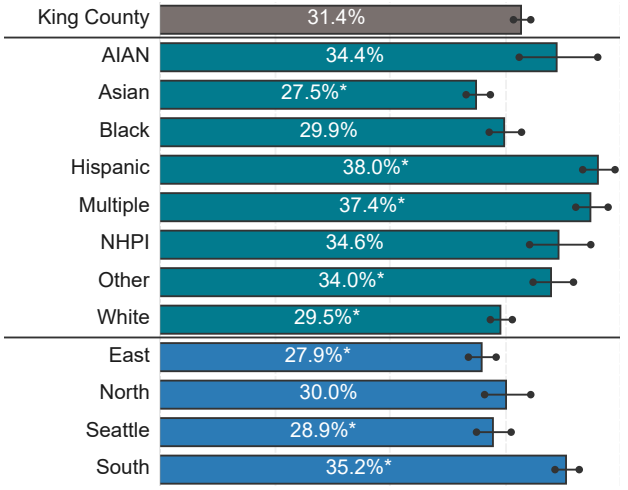
The prevalence of depression has been rising among King County youth for the past 10 years. This indicator reports whether students, during the past year, have felt so sad or hopeless for two weeks or more that they stopped doing some of their usual activities. Averaging data from 2016 and 2018, one in three (31.4%) King County 8th-, 10th-, and 12th-grade students experienced depressive feelings.

- The percentage of youth reporting depressive feelings increases significantly with each grade level from 25.7% of 8th-grade students to 35.6% of 12th-grade students reporting depressive feelings.

- Youth identifying as LGB+ (57.2%) were more than twice as likely to report depressive feelings compared to youth who identified themselves as heterosexual (26.4%).

- Hispanic (38.0%), Native Hawaiian/Pacific Islander (34.6%), American Indian/Alaska Native (34.4%), and multiple-race (37.4%) youth were more likely than Asian (27.5%), Black (29.9%), and white (29.5%) youth to report depressive feelings. However, differences exist among detailed Asian ethnic groups for youth — the depression rate exceeds the county average among Filipino students (36.5%) and is lower than average among Asian Indian students (23.2%).

Depression prevalence (8th, 10th, 12th grades)
King County (average: 2016 & 2018)



Source: Healthy Youth Survey
* Significantly different from King County average

- Youth in the South Region (35.2%) were more likely than youth in other King County regions to report depressive feelings.

Mental Health & Substance Use

Continued

ADULT SMOKING

Cigarette smoking continues to decline among King County adults. Averaging data from 2014–2018, 11.1% of King County adults reported that they currently smoked cigarettes every day or on some days — down from 13.9%, which was the average rate of current smoking for 2011–2013.

- Smoking among residents with household income less than $15,000 (24.4%) was almost four times the rate among higher-income households earning $75,000 or more (6.9%).

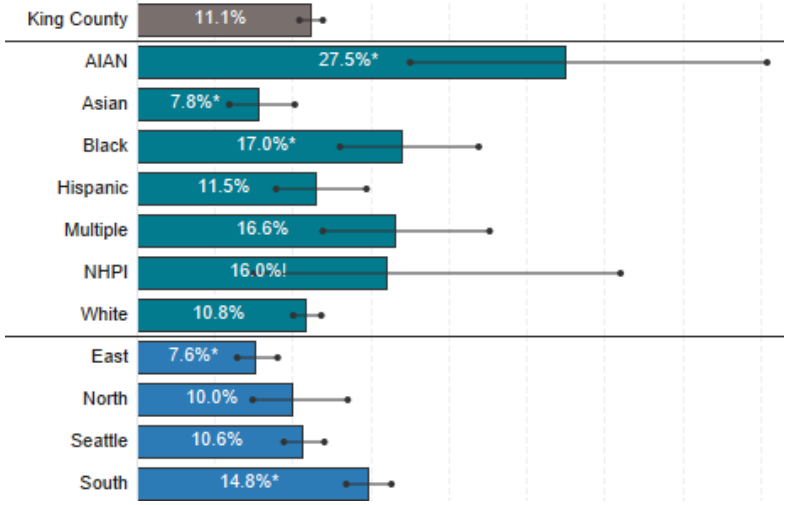
- Gender differences in cigarette smoking persist, with males (12.6%) more likely than females (9.6%) to smoke cigarettes.

- The rate of current smoking among adults identifying as LGB was 18.6% — higher than the county average and higher than the rate of smoking among adults identifying as heterosexual (10.6%).

- Though rates of cigarette smoking among American Indian/Alaska Native residents have been declining, 27.5% are current smokers — nearly 2.5 times the county average.

- Though declining in the South Region — from 18.6% (2009–2011) to 14.8% (2014–2018) — South Region adults are still significantly more likely to be current smokers than the average King County resident, and nearly twice as likely as adults in the East Region (7.6%).

Cigarette smoking (adults)
King County (average: 2014-2018)



Source: Behavioral Risk Factor Surveillance System
* Significantly different from King County average
! Interpret with caution: sample size is small, so estimate is imprecise

Mental Health & Substance Use

Continued

TEEN SUBSTANCE USE

E-CIG OR VAPE PEN USE

Electronic cigarettes, also called e-cigs or vape pens, are electronic devices that heat a liquid and produce an aerosol — a mix of small chemical particles that are inhaled. Most contain nicotine, which is highly addictive and can harm adolescent brain development.[39,40]

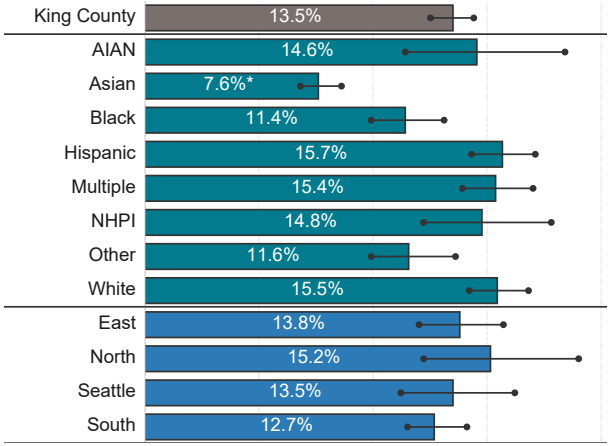
As rates of youth who report smoking cigarettes have continued to decline in King County, youth who report using e-cigarettes have continued to increase. This shift is especially concerning, since current e-cig use among youth (16.8%) is more than four times the reported rate of current cigarette smoking among youth in 2018 (4.2%). Considering this behavior change, this report has replaced the previously reported cigarette smoking indicator to focus on e-cigarettes use in youth.

This indicator reports on whether school-age youth in King County had used an electronic cigarette, also called e-cig or vape pen, on one or more days in the past 30 days[i]. Averaging data from 2016 and 2018, 13.5% of King County's 8th-, 10th-, and 12th-graders currently used e-cigs or vape pens.

[i]The definition of current cigarette, e-cigarette, or vape pen use is using one or more days in the past 30 days.

Current e-cigarette or vape pen use (8th, 10th, 12th grades)

King County (average: 2016&2018)



Source: Healthy Youth Survey
* Significantly different from King County average

- Among 12th-graders (20.6%), one in five were current e-cig users — more than 3 times the rate for 8th-graders (5.8%).
- Youth identifying as LGB+ were significantly more likely (21.0%) than youth identifying as heterosexual (13.4%) to report current e-cig use.
- E-cig use was lowest among Asian (7.6%), Black (11.4%), and students reporting "other" race/ethnicity (11.6%).

Mental Health & Substance Use

Continued

ALCOHOL, MARIJUANA, PAINKILLER, OR ANY ILLICIT DRUG USE

This indicator reports on 8th-, 10th-, and 12th-graders' high-risk substance use, including alcohol, marijuana, painkillers, or other illegal drugs (not including tobacco or vape pen use) in the past 30 days. When combining all high-risk substances, overall use among local public high school students has been declining for the past 10 years (though there are variations among individual substances, such as marijuana use among youth, described below). Averaging data from 2016 and 2018, 23.7% of King County youth attending public schools in the 8th, 10th, and 12th grades reported using high-risk substances, including alcohol, marijuana, painkillers, or other illegal drugs during the past 30 days.

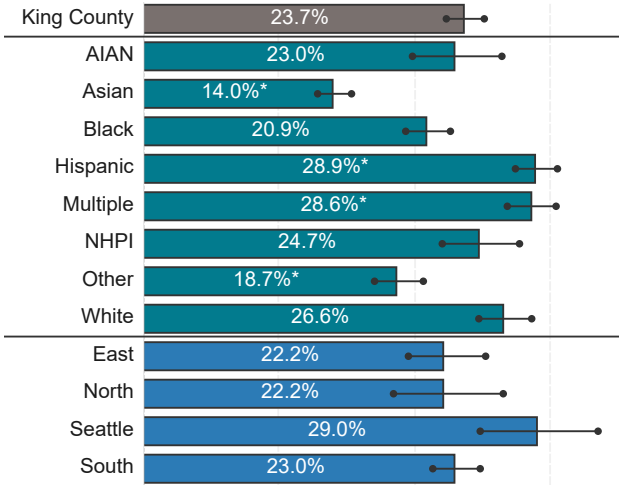
- Seattle students reported the highest rate of substance use (29.0%) compared to East (22.2%), North (22.2%), and South (23.0%) regions.

- The percentage of students reporting substance use increased 2.5 times between 8th (9.1%) and 10th (23.2%) grades and increased another 1.6 times between 10th and 12th (37.4%) grades.

- Hispanic (28.9%) and multiple-race (28.6%) youth were significantly more likely to report substance use compared to the King County average.

Alcohol, marijuana, painkiller or any illegal drug use in the past 30 days (8th, 10th, 12th grades)

King County (average: 2016&2018)



Source: Healthy Youth Survey
* Significantly different from King County average

- Among youth identifying as LGB+, 34.4% reported substance use — higher than youth identifying as heterosexual (23.5%) and higher than the overall King County average.

Mental Health & Substance Use

Continued

MARIJUANA USE

Averaging data from 2016 and 2018, when asked specifically about the use of marijuana or hashish, 15.0% of 8th-, 10th-, and 12th-graders reported using one or both in the past 30 days. When looking over time, while marijuana use among youth was declining since the peak in 2012 (17.9%) with a significantly lower rate in 2016 (14.8%), the most recent data from 2018 (15.2%) appear to be leveling previous declines.

- Seattle students (19.7%) reported the highest rate of marijuana or hashish use compared to the South (15.5%), North (14.2%), and East (11.9%) regions.

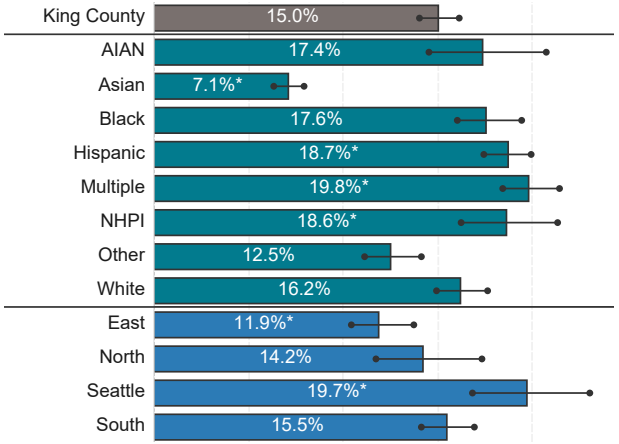
- The percentage of students reporting use of marijuana or hashish increased three times between 8th (4.8%) and 10th (14.8%) grades, and another 1.7 times between 10th and 12th (24.5%) grades.

- Students identifying as LGB+ (23.3%) were more than 1.5 times as likely as students who identified as heterosexual (14.4%) to report use of marijuana or hashish.

- Use of marijuana or hashish was highest among Native Hawaiian/Pacific Islander, Hispanic, and multiple-race students, and lowest among Asian (7.1%) students, though differences exist among detailed Asian ethnic groups — with Japanese (14.6%), Cambodian/Khmer (14.4%), and Filipino students (13.6%) reporting rates closer to the King County average.

Marijuana use (8th, 10th, 12th grades)

King County (average: 2016&2018)



Source: Healthy Youth Survey
* Significantly different from King County average

Mental Health & Substance Use

Continued

DRUG-INDUCED DEATHS

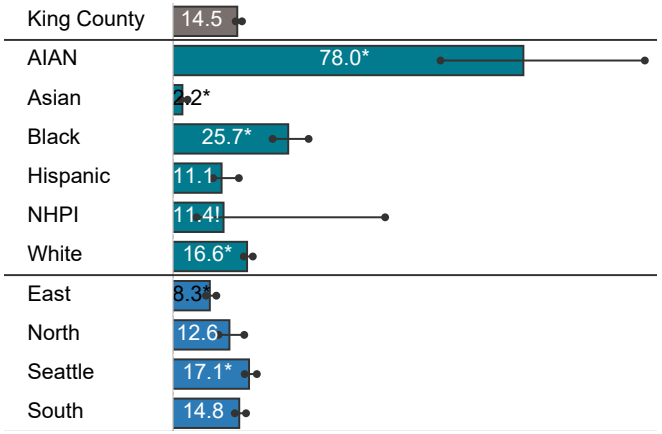
Drug-induced deaths include all deaths for which drugs are the underlying cause, including those attributable to acute poisoning by drugs (drug overdoses) and deaths from medical conditions resulting from chronic drug use. This includes death resulting from the use of illicit drugs, such as heroin and cocaine, as well as legal prescriptions and over-the-counter drugs (alcohol is not included).

The rate of drug-induced death in King County has slowly increased over the past 10 years, and opioid overdose deaths continue to be a major concern in King County. As of December 1, 2020, a review of characteristics of King County residents with a confirmed drug- or alcohol-caused death shows a sharp increase among residents <30 years old over the past five years — from 13% in 2015 to 24% in 2020. The number of confirmed overdose deaths involving methamphetamine have increased drastically in King County — from 88 deaths in 2015 to 209 deaths in 2019. Similarly, overdose deaths from fentanyl have skyrocketed — from three deaths in 2015 to 113 deaths in 2019. Fentanyl is a synthetic opioid that is 50-100 times more powerful than heroin.

The average drug-induced death rate of King County residents between 2014–2018 was 14.5 per 100,000 — significantly higher than 2011–2013, when the rate was 12.3 per 100,000.

Drug-induced deaths

King County (average: 2014-2018)



Source: WA State Department of Health, Death Certificate data
* Significantly different from King County average
! Interpret with caution: sample size is small, so estimate is imprecise

- Comparing King County neighborhoods, the average death rate from drugs is highest among people in Seattle – Downtown at 56.8 per 100,000. The next highest rate is Seattle – Beacon Hill/Georgetown/ South Park with 22.6 per 100,000.

- In King County, drug-induced deaths occurred most commonly between the ages of 45 and 64 (28.2 per 100,000). Victims were twice as likely to be male (19.3 per 100,000) as female (9.7 per 100,000) and were most likely to live in high-poverty neighborhoods (27.1 per 100,000) prior to their deaths.

Mental Health & Substance Use

Continued

- Drug-induced deaths for American Indian/Alaska Native residents were 78.0 per 100,000, which is more than five times the King County average.

- Drug-induced deaths were lowest among Asian residents (2.2 per 100,000).

Reviewing data from early 2020, overdose deaths were 44% higher in March 2020 compared to March 2019, and 72% higher in April 2020 compared to 2019. This increase was driven by fentanyl-involved overdoses.[41]

Mental Health & Substance Use

Continued

INJECTION DRUG USE BEHAVIOR

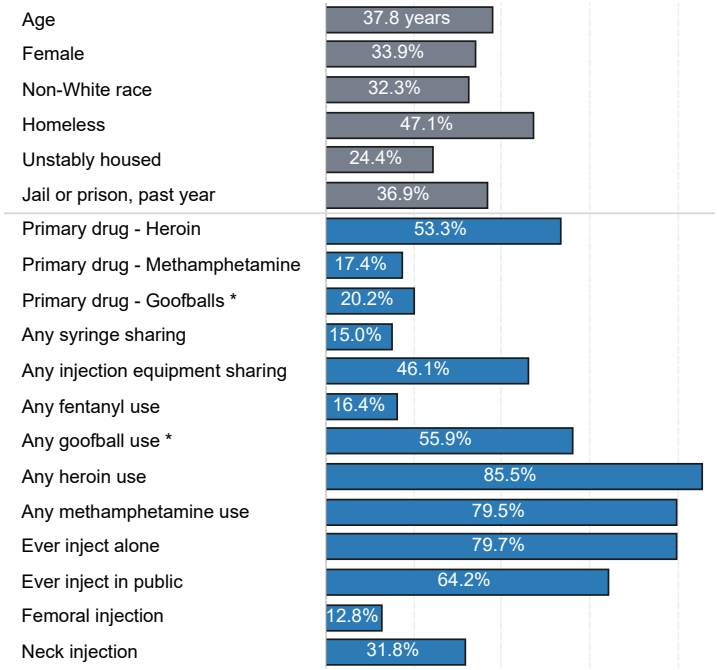
Public Health – Seattle & King County (PHSKC) conducts a biennial survey of syringe services program clients to monitor demographics, health, and behavior trends among people who inject drugs. In July 2019, PHSKC syringe services program staff surveyed 432 clients who visited a syringe services program site. Among these respondents:

- The mostly commonly reported primary drug used in the previous three months was heroin (53.3%), followed by methamphetamine and heroin mixed together, also known as "goofball" (20.2%), and methamphetamine (17.4%).
- One out of three surveyed syringe services program clients were actively in treatment for substance use.
- Nearly half (47.1%) of syringe services program clients were homeless.
- Most clients (85.5%) reported any heroin use in the past three months and 79.5% reported any methamphetamine use.
- A majority (79.7%) reported ever injecting drugs alone, and 64.2% reported ever injecting in public within the past three months.
- In 2018, there were close to 8 million syringes exchanged by the King County Needle Exchange Program.

Injection drug use behavior, reported by syringe services program survey respondents

(demographics & injection-related behaviors in the past 3 months)

King County (2019)



Source: King County Needle Exchange Survey, 2019
* Methamphetamine and heroin mixed together

Maternal & child health

The health and well-being of mothers, infants, and children are markers of overall community health. A mother's mental, physical, emotional, and socioeconomic well-being can affect pregnancy and birth outcomes as well as the health of their children into adulthood and subsequent generations. Improving birth outcomes, such as preterm birth and infant mortality, is among the nation's most pressing public health priorities. While King County does well compared to other parts of Washington state on many maternal and child health indicators, disparities in birth outcomes persist, particularly among Black, Hispanic, Native Hawaiian/Pacific Islander, and American Indian/Alaska Native populations. When comparing average three-year trend estimates with non-overlapping years from 2013–2015 to 2016–2018, the only indicator that has significantly[i] improved was the percentage of mothers who received early and adequate prenatal care from 71.5% to 72.8%.

Additional indicators available online include adolescent birth rate, breastfeeding initiation, and preterm birth rate.

In King County, infant mortality among Black mothers is more than 2.5 times the rate among white mothers. The disparity is even greater among American Indian/Alaska Native mothers, with an infant mortality rate four times the rate of white mothers.

[i]Significance is determined by non-overlapping confidence intervals.

Maternal & child health

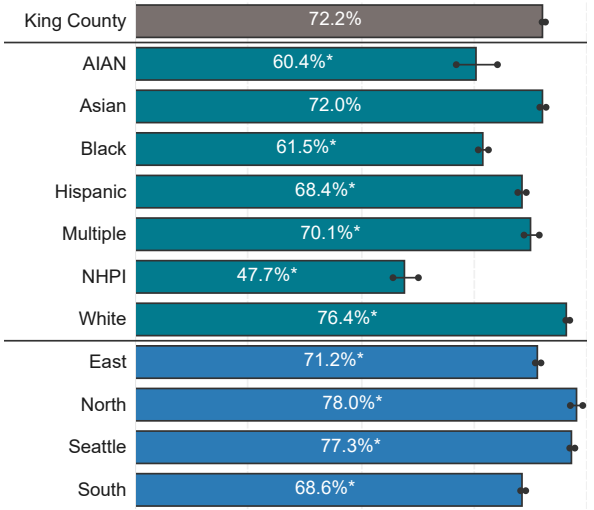
EARLY AND ADEQUATE PRENATAL CARE

Early and adequate prenatal care is important to increase the likelihood of a healthy pregnancy and birth. Ongoing prenatal care ensures that healthcare providers routinely assess the health of mother and baby to monitor fetal development and address potential problems and complications. This indicator analyzes mothers who initiated prenatal care in the first trimester and had at least 80% of the medically recommended number of prenatal visits.

Averaging data from 2014–2018, more than seven out of 10 expectant mothers (72.2%) in King County received early and adequate prenatal care. King County did not achieve the Healthy People 2020 objective that at least 83.2% of expectant mothers receive early and adequate prenatal care.[42] The updated Healthy People 2030 objective is that at least 80.5% of expectant mothers receive early and adequate prenatal care.[43]

- Native Hawaiian/Pacific Islander expectant mothers (47.7%) were significantly less likely to have early and adequate prenatal care compared to any other race/ethnicity. American Indian/Alaska Native (60.4%) and Black (61.5%) expectant mothers were the second and third less likely, respectively. White expectant mothers (76.4%) were most likely to have early and adequate prenatal care.

Early and adequate prenatal care
King County (average: 2014-2018)



Source: WA State Department of Health, Birth Certificate data
* Significantly different from King County average

- The likelihood of receiving early and adequate prenatal care increases with age. Young expectant mothers age 10–17 were least likely (48.4%) to have received prenatal care. Expectant mothers 18–24 years old had the second lowest percentage (60.8%).

- Disparities in early and adequate prenatal care exist by neighborhood poverty. Expectant mothers in high-poverty neighborhoods have the lowest likelihood (67.2%) of receiving early and adequate prenatal care.

LOW BIRTHWEIGHT

Low-birthweight babies are more likely to experience health complications and are at higher risk of infant mortality, respiratory disorders, and neurological problems. Low birthweight is defined as babies weighing less than 2500 grams or 5 pounds, 8 ounces at birth.

Averaging data from 2014–2018, 6.7% of babies in King County were low birthweight.

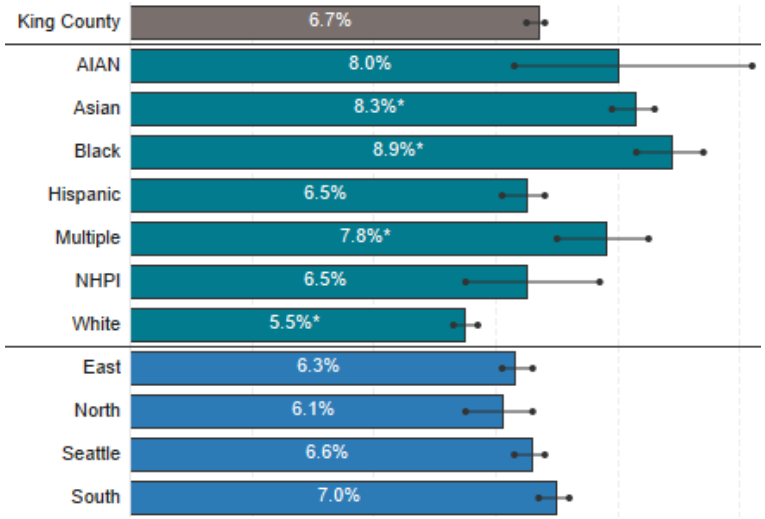
- Babies born to Black mothers (8.9%) were most likely to be low birthweight, followed by babies born to Asian mothers (8.3%). Both are significantly higher than the King County average.

- Mothers over 45 years old (13.8%) were more likely than any other demographic group to have low-birthweight babies, highlighting the risk that increasing age has on the likelihood of complications with birth outcomes.[ii]

- Mothers living in high-poverty neighborhoods (7.4%) were more likely than those in low-poverty neighborhoods (5.9%) to have low-birthweight babies

[ii]*This includes all infants, including multiples/higher-order births. Incidence of multiple births increases with age.*

Low birthweight (all births)
King County (average: 2014-2018)



Source: WA State Department of Health, Birth Certificate data
* Significantly different from King County average

Maternal & child health

INFANT MORTALITY

Infant mortality is defined as the death of an infant before their first birthday. Infant mortality rate is widely used as a measure of population health, as it is a general indicator of unmet need in a population and is associated with determinants of health, such as socioeconomic status, quality of medical care, nutrition, and education.

Averaging data from 2014–2018, 3.9 per 1,000 infants born to King County residents died within 365 days after birth. The King County rate is lower than the Washington state infant mortality rate of 4.7 infant deaths per 1,000 live births (2018)[44] and well below the Healthy People 2020 target of 6.0 per 1,000 live births.[45] Still, disparities persist by race/ethnicity, socioeconomic status, and neighborhood.

Averaging data from 2014–2018, 6.7% of babies in King County were low birthweight.

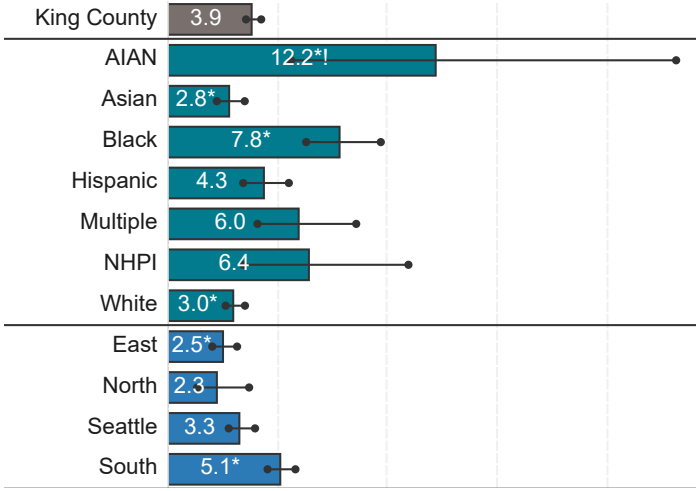
- Infants born to American Indian/Alaska Native mothers (12.2 per 1,000) die at rates more than four times the rate among Asian (2.8 per 1,000) or white mothers (3.0 per 1,000). Infants born to Black mothers (7.8 per 1,000) die at rates more than 2.5 times the rate of infants born to Asian or white mothers.

- Infant mortality in the South Region (5.1 per 1,000) is significantly higher than the county average, reaching as high as 8.3 per 1,000 in Federal Way – Dash Point/Woodmont — more than twice the county average and higher than any other King County neighborhood. Babies born in the South Region are twice as likely to die before their first birthday than babies born in the East Region.

- Infant mortality among mothers age 24 and younger is higher than the King County average.

Infant mortality

King County (average: 2014-2018)



Source: WA State Department of Health, Birth Certificate data
* Significantly different from King County average
! Interpret with caution: sample size is small, so estimate is imprecise

Physical Activity, Nutrition, & Weight

Consuming a nutrient-rich diet and getting regular exercise are key behaviors for maintaining a healthy weight as well as reducing the risk of chronic conditions, such as obesity, type 2 diabetes, heart disease, and stroke — all of which are associated with leading causes of death. Regular physical activity also provides additional benefits related to stress management and mental health among youth and adults. Disparities in these health behaviors are evident by race/ethnicity, economic status, and geographic location nationally as well as in King County.

Additional indicators available online include no breakfast today (youth), excessive screen time (youth), and sedentariness (adults).

Consumption of sugar-sweetened beverages is decreasing among youth in all King County regions and racial/ethnic groups.

Physical Activity, Nutrition, & Weight

Continued

ADULT PHYSICAL ACTIVITY

Averaging data from 2013, 2015, and 2017,[i] 24.2% of adults in King County met CDC recommendations for aerobic and strengthening exercise, defined as 150 minutes of moderate-intensity aerobic activity every week and muscle-strengthening activities on two or more days a week that work all major muscle groups. The percentage of King County adults meeting physical activity guidelines has gradually increased over the past 10 years.

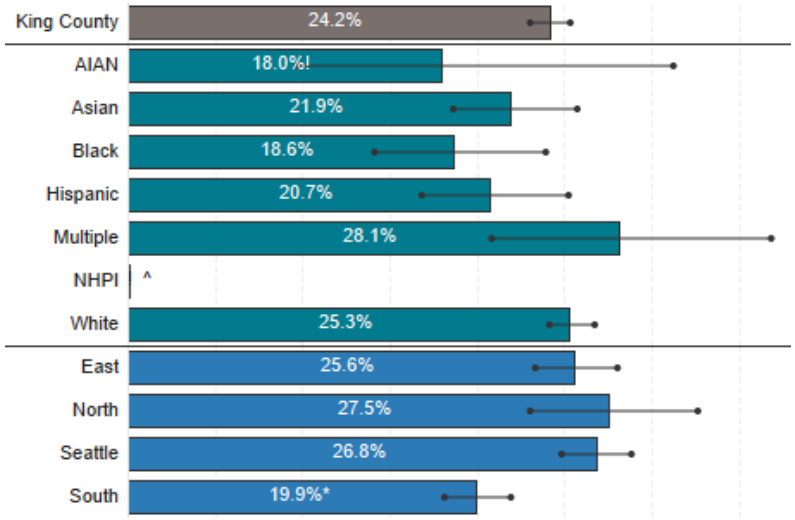
- Among adults, adherence to physical activity guidelines increases with income. Only 16.3% of adults with household income less than $15,000 met physical activity recommendations — lower than the King County average. Among higher-income families making more than $75,000, 26.4% of adults met physical activity recommendations.

- At 19.9%, South Region adults were significantly less likely to meet physical activity guidelines compared to other King County regions. Only 8.5% of South Auburn adults met physical activity recommendations.

[i]*Question not asked in 2014 or 2016.*

Physical activity (adults)

King County (average: 2013, 2015, & 2017)



Source: Behavioral Risk Factor Surveillance System
* Significantly different from King County average
! Interpret with caution: sample size is small, so estimate is imprecise
^ Data suppressed if too few cases to protect confidentiality and/or report reliable rates

Physical Activity, Nutrition, & Weight

Continued

ADULT OBESITY

Averaging data from 2014–2018, 21.5% of King County adults were obese, reporting a body mass index (BMI) greater than or equal to 30. Obesity rates among King County adults have been relatively stable for the past 10 years.

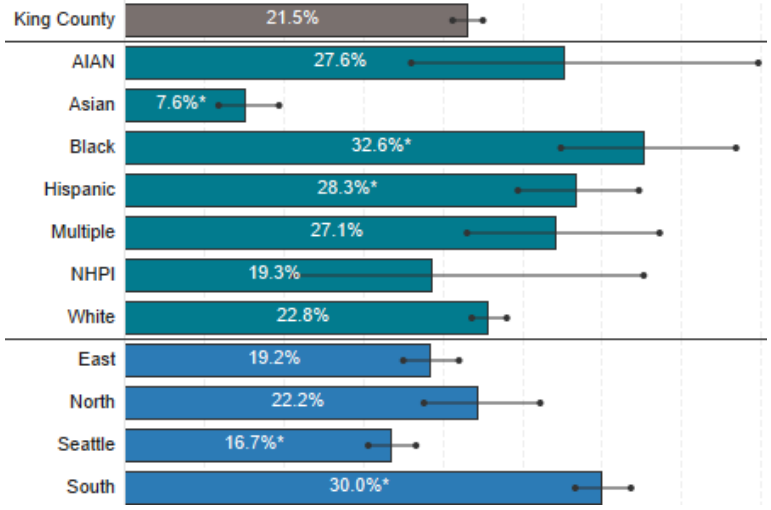
- Obesity prevalence among Black (32.6%) and Hispanic (28.3%) adults was significantly higher than the King County average and more than 3.5 times the rate among Asian (7.6%) residents.

- At 30.9%, obesity was most prevalent among residents with the lowest annual household income (less than $15,000), and least prevalent among those with annual household income greater than $75,000 (18.1%).

- Although the overall obesity rate in King County has been stable, obesity rates among American Indian/Alaska Native residents appear to be declining when comparing average three-year trend estimates from 2013–2015 (34.9%) to 2016–2018 (20.2%). This trend continues to build upon improvements in adult obesity rates going back to 2010–2012, when the average for AIAN residents was 55.4%.[ii] During this same period, among American Indian/Alaska Native residents, overweight but not obese rates appear to be increasing, signaling improvements in overall BMI.

Obese (adults)

King County (average: 2014-2018)



Source: Behavioral Risk Factor Surveillance System
* Significantly different from King County average

[ii] *Estimates may be imprecise due to small population numbers.*

Physical Activity, Nutrition, & Weight

Continued

YOUTH PHYSICAL ACTIVITY

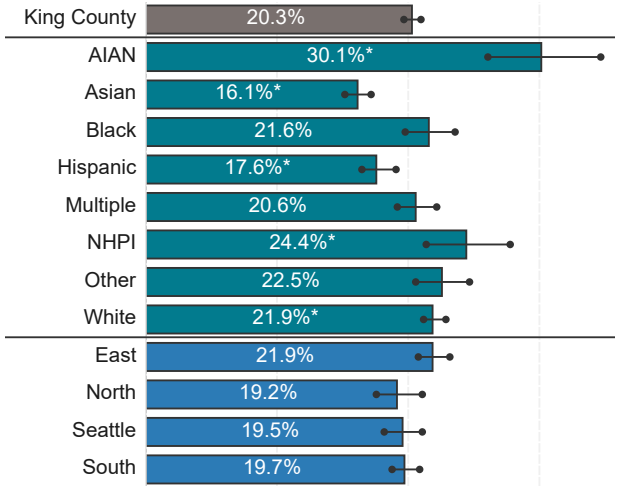
The physical activity guidelines issues by the U.S. Department of Health and Human Services recommend that children and adolescents should have 60 minutes or more of physical activity each day.[46]

Averaging data from 2016 and 2018, only one in five students (20.3%) in 8th, 10th, and 12th grades participated in physical activity for 60 minutes or more on seven of the previous seven days. Based on these data, King County did not meet the Healthy People 2020 objective of 31.6% of adolescents meeting federal physical activity guidelines.[47]

- As grade level increases, student participation in physical activity declines. By 12th grade, only 16.6% of students met recommendations compared to 25.4% of 8th graders.

- Males (25.7%) were more than 1.5 times as likely to meet physical activity guidelines as females (14.5%). At all grade levels, female students were significantly less likely than male students to meet physical activity recommendations; by 12th grade, only 10.9% of female students met recommendations.

Physical activity (8th, 10th, 12th grades)
King County (average: 2016 & 2018)



Source: Healthy Youth Survey
* Significantly different from King County average

- While health behaviors take time to improve, when viewing trends, it is evident that the percentage of students who meet physical activity recommendations has been declining recently for King County overall, including significantly for 8th and 12th graders, males, and South Region students.

Physical Activity, Nutrition, & Weight

Continued

YOUTH SUGAR-SWEETENED BEVERAGE CONSUMPTION

Regularly drinking sugar-sweetened beverages is associated with weight gain, tooth decay, and chronic health conditions, such as obesity, diabetes, and heart disease.[48] Consumption of sugar-sweetened beverages is decreasing among youth in all King County regions and racial/ethnic groups.

Averaging data from 2016 and 2018, 12.3% of King County students in 8th, 10th, and 12th grades consumed nondiet sodas or sugar-sweetened beverages daily — a continued decline from previous years (17.4% in 2014).

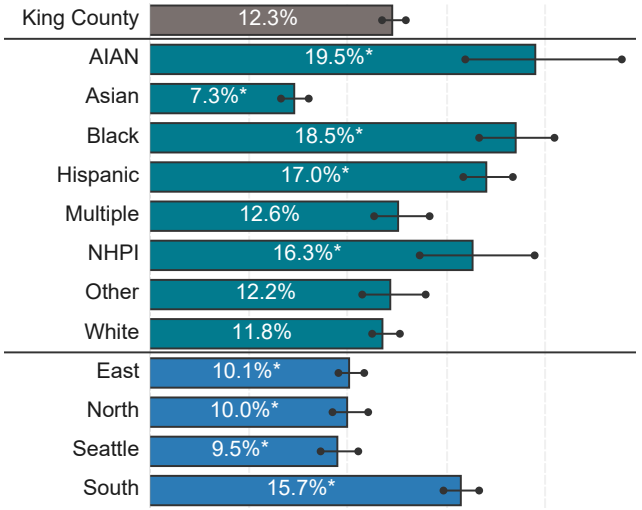
- Male students (15.1%) were more than 1.6 times as likely as female students (9.3%) to drink nondiet sodas or sugar-sweetened beverages daily.

- Daily consumption of sugar-sweetened beverages was lowest among Asian students (7.3%) compared to other racial/ethnic groups, though differences existed among detailed Asian ethnic groups — with Cambodian/Khmer (15.1%), Filipino (11.8%), and Japanese students (10.8%) reporting rates similar to the King County average.

- Despite a steady decline, South Region youth were still more than 1.5 times as likely as youth in other King County regions to drink sugar-sweetened beverages daily.

Drink soda or sugar-sweetened beverages daily (8th, 10th, 12th grades)

King County (average: 2016 & 2018)



Source: Healthy Youth Survey
* Significantly different from King County average

Physical Activity, Nutrition, & Weight

Continued

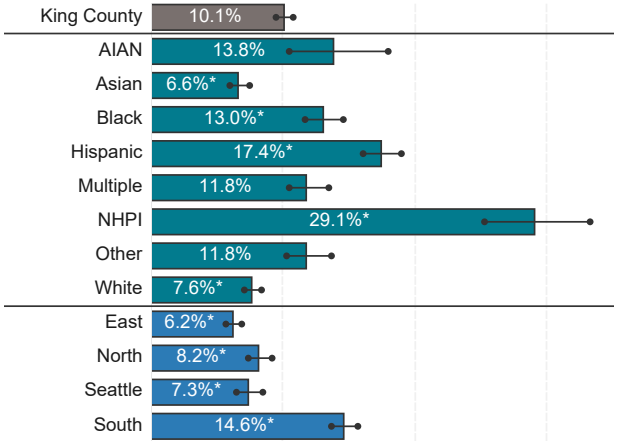
YOUTH OBESITY

Youth are considered obese if their body mass index (BMI) is in the top 5% for their age and gender. After a relative decline in 2012, student obesity rates have been increasing in King County.

Averaging data from 2016 and 2018, 10.1% of students attending King County public schools in 8th, 10th, and 12th grades were obese. King County youth obesity rates increased significantly between 2014 (8.8%) and 2018 (10.7%).

- Male students (12.4%) were more likely than female students (7.5%) to be obese.
- Youth obesity was highest among Native Hawaiian/Pacific Islander students (29.1%), at nearly three times the King County average.
- At all grade levels, students who identified as lesbian, gay, or bisexual (13.4%) were significantly more likely to be obese than heterosexual students (8.4%).
- Students in the South Region (14.6%) were most likely to be obese compared to all other regions. When compared to East Region students (6.2%), South Region students were more than twice as likely to be obese.

Obese (8th, 10th, 12th grades)
King County (average: 2016 & 2018)



Source: Healthy Youth Survey
* Significantly different from King County average

Violence & Injury Prevention

This section reports on hospitalizations and deaths related to suicide, firearm-related deaths, and hospitalizations from falls. While most of the data in this section were collected prior to 2020, it's important to note that during the COVID-19 pandemic, some patterns — especially around violence, suicide, and mental health — may be changing. Early numbers from 2020 suggest that firearm homicides may be on the rise around the county.[49] In addition, local officials have reported a sharp spike in domestic violence cases since the onset of COVID-19. In King County, 17 out of the 18 domestic violence homicide deaths reported through December 2020 occurred after the onset of the pandemic in March 2020. This is more than the number of domestic violence homicides reported in 2018 and 2019 combined. Six of those domestic violence homicide deaths in 2020 were committed by firearm.[i] While domestic violence has not been a standard indicator in the CHNA, these alarming trends underscore the importance of continued monitoring and focused support for mental health.

It is also important to emphasize that suicide is an ongoing concern among King County youth. The rate of suicidal ideation among youth (defined as having seriously considered attempting suicide within the past year) jumped from 16.7% in 2016 to 19.0% in 2018. During this same time, the rate of youth who had made a plan to attempt suicide within the past year also significantly increased from 14.1% in 2016 to 15.5% in 2018. Averaging data from 2016 and 2018, rates are alarmingly high among LGB+ youth for both suicidal ideation (42.1%) and suicide plan (35.0%).

Additional violence and injury prevention indicators available online include youth who felt safe at school, firearms stored in the home, youth who made a plan to attempt suicide, and adults (45+) who were recently injured in a fall.

The rate of firearm-related deaths in South Region has been rising for the past 10 years.

[i] *Personal communication – King County Prosecuting Attorney's Office, November 19, 2020.*

SELF-HARM AND ATTEMPTED SUICIDE HOSPITALIZATIONS

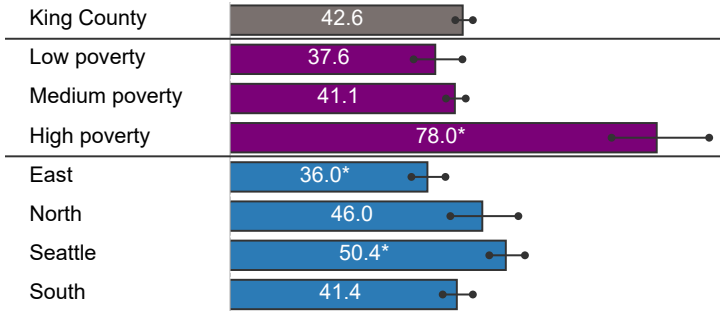
Averaging data from 2016–2018, the hospital admission rate for self-harm and attempted suicides[ii] was 42.6 per 100,000 residents in King County, which represents an average of 917 admissions each year. At this time, we are able to look at data only from 2016 forward, as the coding structure for healthcare claims data has changed, and the current guidance is that the two structures are not comparable. Since the transition occurred in the last quarter of 2015 and guidance on understanding the impact of the coding structure is not finalized, it is recommended that comparisons should not be made between data before and after October 1, 2015. This analysis excludes deaths and injury sequelae.

- Compared to other age groups, the rate of attempted suicide hospitalization was highest among young adults age 18–24 (77.0 per 100,000).
- Females (52.0 per 100,000) were significantly more likely than males (33.7 per 100,000) to be hospitalized for suicide.
- The hospital admission rate for self-harm and attempted suicides for people in the high-poverty group was 78.0 per 100,000 — higher than the King County average and more than two times the rate among the low-poverty group (37.6 per 100,000).
- The hospital admission rate for self-harm and attempted suicides in Seattle (50.4 per 100,000) was significantly higher than the King County average, and significantly lower in the East Region of the county (36.0 per 100,000).

[ii] *Excludes deaths and sequalae. Incudes subsequent encounters.*

Self-harm & attempted suicide hospitalizations

King County (average: 2016-2018)



Source: Comprehensive Hospital Abstract Reporting System (CHARS)
* Significantly different from King County average

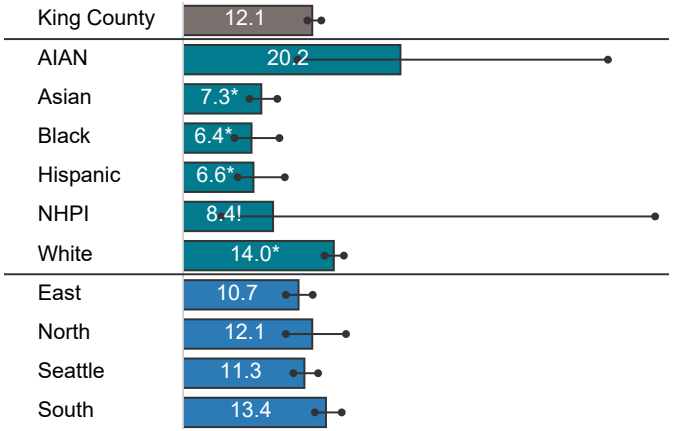
SUICIDE DEATHS

Averaging data from 2014–2018, the suicide death rate of King County residents of all ages was 12.1 per 100,000, which represents an average of 268 suicide deaths per year. For King County overall, this rate has not changed dramatically when comparing average three-year trend estimates from 2013–2015 to 2016–2018. The mental and behavioral health impact of COVID-19 is an important area to monitor. Recent data to assess the impact of COVID-19 indicate an increase in the percentage of adults who report feeling depressed, worried, and anxious from April through July 2020.

- The suicide death rate among children and adolescents (<18 years old) was 1.9 per 100,000.
- The rate for adults age 75+ was 20.0 per 100,000 — significantly higher than the King County average.
- Males (18.9 per 100,000) were 3.3 times as likely as females (5.8 per 100,000) to die from suicide.
- Suicide rates for Hispanic (6.6 per 100,000), Asian (7.3 per 100,000), and Black (6.4 per 100,000) populations were significantly lower than the county average of 12.1 per 100,000. The rate for white residents exceeded the county average at 14.0 per 100,000.
- The suicide rate among American Indians/Alaska Natives (AIAN) was 20.2 per 100,000 — the highest of all racial/ethnic groups, although due to small sample sizes, this estimate is imprecise and should be interpreted with caution.
- The death rate from suicide for people in Auburn – South was 22.3 per 100,000. This rate is higher than the King County average and the highest of all King County neighborhoods.

Suicide

King County (average: 2014-2018)



Source: WA State Department of Health, Death Certificate data
* Significantly different from King County average
! Interpret with caution: sample size is small, so estimate is imprecise

FIREARM-RELATED DEATHS

Averaging data from 2014–2018, the rate of firearm-related deaths (including unintentional death, suicide, and homicide by firearm) was 7.6 per 100,000 King County residents, which represents an average of 163 deaths per year. For King County overall, this rate appears to be increasing when comparing average three-year trend estimates from 2013–2015 to 2016–2018. For these same time periods, dramatic increases in firearm death rates are apparent for high-poverty neighborhoods, Native Hawaiian/Pacific Islanders, and the South Region of King County.

- Males (13.5 per 100,000) were more than seven times as likely to die due to firearms as females (1.9 per 100,000).

- Firearm-related deaths were more prevalent in high-poverty neighborhoods (10.3 per 100,000) compared to low-poverty neighborhoods (5.3 per 100,000).

- For young adults (age 18–24), the rate of firearm-related deaths (15.6 per 100,000) was two times the county average.

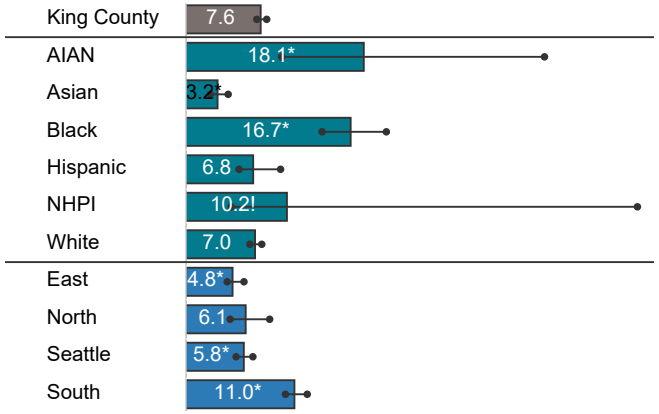
- Black residents (16.7 per 100,000) were 2.4 times, American Indian/Alaska Native residents (18.1 per 100,000) were 2.6 times, and Native Hawaiian/Pacific Islander residents (10.2 per 100,000) were 1.5 times as likely to die by firearm as white residents (7.0 per 100,000). Asian residents (3.2 per 100,000) were half as likely to die by firearms compared to white residents.

- The rate of firearm-related deaths in the South Region (11.0 per 100,000) remained higher than in the other regions and has been slowly rising for the past 10 years — significantly higher than the average firearm-related death rate in the South Region from 2009–2011 (7.8 per 100,000).

- The top three neighborhoods in King County with the highest firearm-related death rates were all in South Region — Kent-West (19.0 per 100,000), North Highline (16.7 per 100,000), and Auburn – North (15.3 per 100,000). Neighborhoods with the lowest rates of firearm-related deaths were Northeast Seattle (2.0 per 100,000), Sammamish (2.5 per 100,000), and Mercer Island/Point Cities (2.6 per 100,000).

Firearm-related deaths

King County (average: 2014-2018)



Source: WA State Department of Health, Death Certificate data
* Significantly different from King County average
! Interpret with caution: sample size is small, so estimate is imprecise

FALL HOSPITALIZATIONS

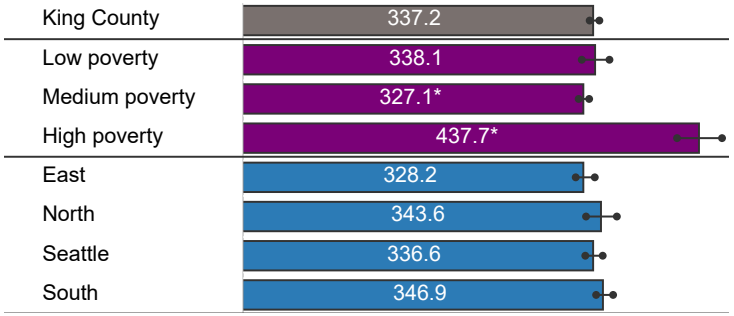
This indicator incudes unintentional nonfatal fall-related hospital admissions.[iii] Unintentional falls are a leading cause of death and injury, particularly for people over age 65. Having one serious fall doubles the chances to have another one fall.[50] Averaging data from 2016–2018, the admission rate for falls was 337.2 per 100,000 King County residents, which represents an average of 7,113 admissions per year. At this time, we are able to look at data only from 2016 forward, as the coding structure for healthcare claims data has changed, and the current guidance is that the two structures are not comparable. Since the transition occurred in the last quarter of 2015 and guidance is not finalized, it is recommended that comparisons should not be made between data before and after October 1, 2015.

- Fall hospitalizations rarely occur among children and young adults. The rate for adults age 65–74 was 789.3 per 100,000 — more than 12 times the rate among adults age 25–44 (65.0 per 100,000).
- Fall hospitalizations were most common among adults age 75 and older — 3,575.7 per 100,000 residents.

[iii]Fall-related deaths and hospitalizations due to sequelae from falls are excluded. Subsequent encounters are included.

Fall hospitalizations

King County (average: 2016-2018)



Source: Comprehensive Hospital Abstract Reporting System (CHARS)
* Significantly different from King County average

- Compared to females (341.4 per 100,000), males were less likely to be hospitalized for falls (325.5 per 100,000).
- The hospitalization rate from falls for people in the high-poverty group was 437.7 per 100,000 — higher than the King County average.

Determinants of Equity

RELATIONSHIPS BETWEEN RACE/ ETHNICITY AND HEALTH

Racial and ethnic disparities in health and social outcomes persist throughout the county. Similar to patterns shared in the previous CHNA, white and Asian populations in King County fare better than others across a number of health and social indicators. Since the aggregate "Asian" category masks disparities within, findings among detailed Asian ethnicities are presented when available. Current data do not permit us to disaggregate multigenerational African American communities from Somali, Ethiopian, and other emerging African communities within the Black race category, or to disaggregate among Hispanic groups. Comparisons between groups are meant to highlight inequities by race/ethnicity where they exist, and not to imply that any specific race/ethnicity is the standard to which others should be compared.

DETERMINANTS OF HEALTH BY RACE/ ETHNICITY

Access to care and use of preventive services

- In 2019, Hispanic adults had the highest rate of uninsurance and were six times as likely as white adults to be without coverage. Black adults were more than two times as likely to be **uninsured** compared to white adults.
- Compared to white and Asian adults (the racial/ethnic groups with the lowest rates of uninsurance), Black adults were more than 1.5 times as likely and Hispanic adults were more than two times as likely to report **unmet medical needs** due to cost.
- Hispanic adults are more likely not to have met **colorectal cancer screening** guidelines compared to the King County average. Cancer is the leading cause of death among the Hispanic community in King County, with colorectal cancer as the third most common cancer type in this group.
- Native Hawaiian/Pacific Islander, Black, Hispanic, and multiple-race residents were significantly more likely to have not **visited a dentist** or dental clinic in the previous year compared to white residents.

Maternal and child health

- Native Hawaiian/Pacific Islander expectant mothers were least likely to have **early and adequate prenatal care** compared to other racial/ethnic groups. White expectant mothers were most likely to have early and adequate prenatal care.
- Babies born to Black mothers were most likely to be **low birthweight,** followed by babies born to Asian mothers.

Determinants of Equity

Continued

Mental health and substance use

- Hispanic adults are more likely than the King County average to experience **frequent mental distress.**

- Eight out of 10 white residents report that they always or usually get the **social and emotional support** they need — significantly higher than Black, Hispanic, and Asian adults.

- Hispanic, Native Hawaiian/Pacific Islander, American Indian/Alaska Native, and multiple-race youth were more likely than Asian, Black, and white youth to report **depressive feelings**. However, among Asian ethnicities analyzed, the depression rate exceeds the county average among Filipino students but is lower than average among Asian Indian students.

- Cigarette **smoking** among American Indian/Alaska Native residents has been declining, though the rate of current smokers was still nearly 2.5 times the county average.

- Hispanic and multiple-race youth were significantly more likely to report **substance use** (including alcohol, marijuana, painkillers, or any illicit drug use) compared to the King County average. Use of **marijuana** was highest among Native Hawaiian/Pacific Islander, Hispanic, and multiple-race students, and lowest among Asian students, though differences exist among detailed Asian ethnic groups — with Japanese, Cambodian/Khmer, and Filipino students reporting higher rates that are closer to the King County average.

- **Drug-induced deaths** (all deaths for which drugs are the underlying cause) for American Indian/Alaska Native residents were more than five times the King County average. Drug-induced deaths were lowest among Asian residents.

Physical activity, nutrition, and weight

- Daily consumption of **sugar-sweetened beverages** was lowest among Asian students compared to other racial/ethnic groups, though differences existed among detailed Asian ethnic groups — with Cambodian/Khmer, Filipino, and Japanese students reporting higher rates that are similar to the King County average.

- **Obesity** prevalence among Black and Hispanic adults was significantly higher than the King County average and more than 3.5 times the rate among Asian residents. Youth obesity was highest among Native Hawaiian/Pacific Islander students, at nearly three times the King County average.

Determinants of Equity

Continued

HEALTH OUTCOMES BY RACE/ETHNICITY

Chronic illness

- The prevalence of **hypertension** among Black residents was significantly higher than the King County average. Compared to other racial/ethnic groups, Asian adults have the lowest rate of hypertension.

- **Asthma** rates are highest among Black and American Indian/Alaska Native Medicaid-enrolled children.

- Black adults were 3.2 times as likely as Asian adults to have **diabetes**.

Life expectancy and causes of death

- **Life expectancy** is highest among Asian (85.7 years) and Hispanic (84.0 years) residents. While Hispanic life expectancy is higher than the King County average, it has been declining in recent years. Life expectancy among Black residents (77.6 years) is four years shorter than life expectancy for white residents (81.6 years). While estimates may be imprecise due to small population numbers, at 72.2 years, Native Hawaiian/ Pacific Islander residents have the lowest life expectancy of all racial/ethnic groups in King County. This is a decline of 5.6 years from the 2011–2013 average life expectancy of 77.8 years for this group.

- The death rate from **unintentional injury** among American Indian/Alaska Native county residents (129.9 per 100,000) is 2.5 or more times the rate among other racial/ethnic groups.

RELATIONSHIPS BETWEEN INCOME AND HEALTH

Our review of health and social indicators reveals consistent income/poverty gradients in social determinants and health outcomes. Unless otherwise indicated, low-income is defined as households with an annual income of less than $15,000. High-income is defined as households with incomes above $75,000. Neighborhood poverty level is based on the proportion of households in a census tract in which annual household income falls below the federal poverty threshold. High-poverty neighborhoods are defined as those where 20% or more households are below the poverty threshold, medium poverty as 5% to 19% of households below the poverty threshold, and low poverty as less than 5% of households below the poverty threshold.

[ii] *The national poverty threshold for a family of four with two related children under 18 in 2018 was $25,465. https://www.census.gov/data/tables/time-series/demo/income-poverty/historical-poverty-thresholds.html*

Determinants of Equity

Continued

DETERMINANTS OF HEALTH BY INCOME AND POVERTY LEVEL

Access to care and use of preventive services

- Adults with a household income below 100% of the federal poverty level[ii] were more than five times as likely as those with a household income at 400% or more of the federal poverty level to be **uninsured**.

- Low-income adults (household income <$15,000) were more than four times as likely as high-income adults (household income $75,000+) to report **unmet medical needs.**

- Adherence to **colorectal cancer screening** guidelines increases with household income.

- Half of all low-income adults had not **visited a dentist** in the past year, reflecting long-standing income disparities for dental care.

- Incomplete **vaccination rates** for children (19–35 months) are highest in neighborhoods with a high proportion of households in poverty.

Maternal and child health

- Disparities in **early and adequate prenatal care** exist by neighborhood poverty. Expectant mothers living in neighborhoods with a high proportion of households in poverty have the lowest likelihood of receiving early and adequate prenatal care.

- Mothers living in neighborhoods with a high proportion of households in poverty were more likely than mothers living in neighborhoods with a low proportion of households in poverty to have **low birthweight** babies.

Mental health and substance use

- The rate of **frequent mental distress** among low-income adults was almost 2.5 times the county average and four times the rate for high-income adults. The prevalence of frequent mental distress decreases with each increasing income category.

- Less than half of low-income adults report that they always or usually get the **social and emotional support** they need. High-income adults were twice as likely to report that they have the social and emotional support they need.

- **Smoking** among low-income adults was almost four times the rate among high-income adults.

Determinants of Equity

Continued

Physical activity, nutrition, and weight

- Among adults, adherence to **physical activity** guidelines increases with income, though it is low overall for all groups. Adults from higher-income households are 1.5 times as likely as low-income adults to have met physical activity recommendations.

- **Obesity** was most prevalent among low-income adults, and least prevalent among high-income adults.

HEALTH OUTCOMES BY INCOME AND POVERTY LEVEL

Chronic illness

- Adults with an annual income lower than $55,000 were more than three times as likely as high-income adults to have **diabetes**.

- The rate of **hypertension** among high-income adults was significantly lower than the King County average and all other income categories.

Life expectancy and causes of death

- Residents in neighborhoods with a low proportion of households in poverty live nearly five years longer than those in neighborhoods with a high proportion of households in poverty.

- Adults living in neighborhoods with a high proportion of households in poverty were more likely than those living in neighborhoods with a medium- or low-proportion of households in poverty to die from **unintentional injuries.**

RELATIONSHIPS BETWEEN PLACE AND HEALTH

Recent analyses also found persistent (and increasing) disparities by geographic location, or place. This signals the high degree of geographic variability of community resources, such as access to healthy and affordable food, safe places to play, and distance to work, as well as availability of schools and healthcare systems throughout cities/neighborhoods and regions.

DETERMINANTS OF HEALTH BY LOCATION

Access to care and use of preventive services

- The percentage of children 19–35 months of age in the South Region with **incomplete vaccination coverage** (have not completed the routine series of recommended vaccinations) is higher than in all other King County regions.

- Rates of **uninsurance** in Burien and Tukwila are more than twice the county average.

Determinants of Equity

Continued

- Compared to other regions, residents of the North Region were most likely to have met **colorectal cancer screening** guidelines. South Region adults were most likely to report that they had ***not*** **seen a dentist** in the previous year.

Maternal and child health

- **Infant mortality** is highest in the South Region, where babies are twice as likely to die before their first birthday than babies born in the East Region.

Mental health and substance use

- Adults and youth in the South Region were more likely than residents in other regions to report **frequent mental distress** (adults) and **depressive feelings** (youth).

- South Region adults are significantly more likely to be current **smokers** than the average King County resident, and nearly twice as likely as adults in the East Region.

- Seattle students reported the highest rate of **substance use** compared to all other King County regions.

Physical activity, nutrition, and weight

- South Region adults are significantly less likely to meet **physical activity** guidelines compared to other King County regions.

- Youth in the South Region — compared to other county regions — are most likely to drink **sugar-sweetened beverages** daily and to be **obese**. The obesity rate among South Region students is twice the rate in the East Region.

HEALTH OUTCOMES BY LOCATION

Chronic illness

- Compared to the average King County resident, South Region adults are more likely to have **hypertension**. Among residents of South Auburn, hypertension was more than 2.5 times as prevalent as among Northeast Seattle residents. South Region adults are also more likely to have **diabetes** than adults in other King County regions.

- North Auburn has the highest **childhood asthma** rate for Medicaid-enrolled children of all King County neighborhoods — nearly 2.5 times the rate of Vashon Island (2.2%), where asthma rates were the lowest.

Life expectancy and causes of death

- The North and South regions have significantly lower **life expectancy** compared to the King County average, whereas the East Region and Seattle both had significantly higher life expectancies than the North and South regions. Life expectancy among South Region residents has declined for the past

10 years. East Region residents are expected to live nearly five years longer than residents of the South Region

- Among King County neighborhoods, Downtown Seattle has the highest rate of **unintentional injury death**, followed by the Federal Way neighborhood of Dash Point.

RELATIONSHIPS BETWEEN SEXUAL ORIENTATION, GENDER IDENTITY, AND HEALTH

The previous 2018/2019 CHNA report included a spotlight on LGBTQ+ youth and young adults to learn about barriers and opportunities for populations to access healthcare. As described in the LGBTQ Community Spotlight, the impacts of racism, ageism, poverty, and other forms of discrimination on health have overlapping effects for sexual and gender minorities.

In addition to disparities by race and place, we also see a relationship between sexual orientation and health in several adult and youth indicators. The way in which sexual orientation data is collected varies across surveys. In this report, adult indicators from the Behavioral Risk Factor Surveillance System (BRFSS) present sexual orientation as "LGB" (lesbian, gay, bisexual), whereas youth indicators from the Healthy Youth Survey (HYS) present sexual orientation as "LGB+" to reflect the category response that "something else fits better" in that survey. Comparisons between groups are meant to highlight inequities by sexual orientation where they exist, and not to imply that heterosexuality is the norm or a standard to which others should be compared. While information about sexual orientation is not available for all indicators, analyses of recent data show noteworthy disparities in some areas.

- Adults who identified as lesbian, gay, or bisexual (LGB) were more than twice as likely as heterosexual adults to report **frequent mental distress.** The percent of adults reporting frequent mental distress has remained stable when looking at the overall county population, but LGB adults have seen a steady increase over the past several years, from 18% in 2012–2014 to 24% in 2016–2018.

- LGB adults were twice as likely to report **unmet medical needs** and were more likely to be current **smokers** compared to adults who identify as heterosexual.

- Youth identifying as LGB+ were more likely to report current **substance, marijuana, and e-cigarette use** compared to youth identifying as heterosexual.

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Appendix A: Methods

IDENTIFICATION OF HEALTH NEEDS & SELECTION OF INDICATORS

For the 2021/2022 King County Community Health Needs Assessment (CHNA), a CHNA Advisory Committee (composed of five hospital/health system representatives from the King County Hospitals for a Healthier Community (HHC)) facilitated by Public Health – Seattle & King County (PHSKC) staff met over a series of months to develop a comprehensive plan for the report. In developing a plan, the CHNA Advisory Committee and PHSKC sought feedback from public health and hospital staff when considering how to describe and identify community health needs, discussing the selection criteria and indicators used to measure health needs, and determining standards for analyzing data, as well as presenting key findings. The CHNA Advisory Committee and PHSKC presented a recommendation and plan for the 2021/2022 CHNA report, which was approved by all members of HHC.

Committee members planned a succinct report focused on key indicators that relate to the hospitals' and communities' assets and resources to inform future collective strategies. Selected indicators focus on population-based preventive strategies and promote policy/systems/environmental change for maximum population health impact. The committee continues to recognize that partnerships between hospitals, community organizations, and communities are key to successful strategies to address common health needs.

The 2021/2022 CHNA report continues to build upon the population-based community health framework. To identify community concerns and assets, this report continues to consult and review a variety of existing community engagement reports from 2018–2019 to inform community identified priorities and overall themes. In addition to the required section of the report, HHC continues to focus on additional priorities, including access to care and use of preventive services, mental health and substance use, maternal and child health, physical activity, nutrition and weight, and violence and injury prevention. Furthermore, for the 2021/2022 CHNA report, a new section on COVID-19 was added as well as a Medicaid profile focusing on King County Medicaid demographics, top 10 causes of emergency department (ED) utilization, and high ED utilizers without a visit to a primary care provider in the last year. While hospitals and health systems reached consensus on a core set of topic areas, each hospital may also gather additional information specific to its service area.

Recognizing that the CHNA is not intended to provide comprehensive data for each specialized topic, indicators continue to be selected according to

Appendix A: Methods

Continued

the following criteria:

1. Availability of high-quality data that are population-based (where possible), measurable, accurate, reliable, and regularly updated. Data should focus on rates rather than counts.
2 Ability to make valid comparisons to a baseline or benchmark.
3. Prevention orientation with clear sense of direction for action by hospitals for individual, community, system, health service, or policy interventions that will lead to community health improvement.
4. Ability to measure progress of a condition or process that can be improved by intervention/ policy/system change, and there exists a capacity to affect change.
5. Ability to address health equity, particularly by age, gender, race/ethnicity, geography, socioeconomic status, although not all demographic breakdowns may be available for all indicators.
6. Alignment with local and national healthcare reform efforts, including the triple aim.

For the purpose of the 2021/2022 CHNA Report, eleven (11) indicators were removed for which timely and/or actionable data are not currently available in King County. Eighteen (18) new indicators were added to the CHNA to reflect emerging or more widely accepted community health needs, such as firearm-related deaths and e-cig or vape pen use. All removal and addition of indicators was conducted in a manner consistent with the aforementioned selection criteria.

The final set of indicators were analyzed, using appropriate statistical methods, by Public Health – Seattle & King County. Data were compiled from local, state, and national sources such as the U.S. Census Bureau, U.S. Centers for Disease Control and Prevention, Washington State Department of Health, and King County.

COMMUNITY ASSESSMENTS AND REPORTS

Recent reports, including broad community needs assessments, strategic plans, or reports on specific health needs were reviewed for context and relevant assets, resources, and opportunities. The following reports were reviewed:

Appendix A: Methods

Continued

#	Report Name	Organization
1	City of Burien Community Assessment Survey	City of Burien
2	City of SeaTac Human Services Needs Assessment	City of SeaTac
3	Puget Sound Educational Service District — Early Learning Programs Community Assessment 2018 / Supplement to the 2018 Community Needs Assessment	Puget Sound Educational Service District
4	South King County Mobility Coalition Food Access and Transportation Needs Assessment January 2019	Hopelink, South King County Mobility Coalition
5	And So We Press On: A Community View on African American Health in Washington State (2019 Research Report)	Byrd Barr Place
6	Affordable Housing Advisory Board 2018 Affordable Housing Update	Washington State Department of Commerce
7	Affordable Housing Update: 2019 Affordable Housing Update Pursuant to RCW 43.185B.040	Washington State Department of Commerce
8	Transportation Barriers and Needs for Immigrants and Refugees: An Exploratory Needs Assessment. June 2019.	UW Evans School of Public Policy and Governance Graduate Consulting Lab for Hopelink, King County Mobility Coalition
9	King County American Indian and Alaska Native Housing Needs Assessment	Seattle Indian Services Commission
10	King County Fare Structure Needs Assessment: KCMC Access to Work and School Committee. February 2018.	King County Mobility Coalition
11	Puget Sound Food Infrastructure Exploration	Ecotrust for Sustainable Communities Funders and the Bullitt Foundation
12	State of Play: Seattle-King County — Analysis and Recommendations	Aspen Institute Project Play
13	Seattle Rental Housing Study — Final Report (June 2018)	UW Center for Studies in Demography and Ecology
14	Snoqualmie Valley A Supportive Community for All: Community Needs Assessment	A Supportive Community for All
15	Community Input Summary: Puget Sound Taxpayers Accountability Account	Puget Sound Taxpayers Accountability Account
16	Chinatown International District Framework and Implementation Plan 2018 Status Report	City of Seattle
17	Youth update 2019 — City of Kent	City of Kent
18	City of Kirkland — 2018 Survey	City of Kirkland
19	Age Friendly Seattle Action Plan	City of Seattle
20	Sammamish Health and Human Services Needs Assessment	City of Sammamish
21	Seattle–King County Aging and Disability Area Plan Update 2018–19	Aging and Disability Services

Appendix A: Methods

Continued

22	Seattle Goodwill CAN	Seattle Goodwill
23	Solid Ground Community Report 2018	Solid Ground
24	SESE Family Engagement Survey Data	Southeast Seattle Education Coalition
25	Healthy Food Availability and Food Bank Network Report	City of Seattle
26	City of Seattle 2019 Annual Action Plan	City of Seattle
27	Area Plan 2020–2023 Seattle King County	City of Seattle
28	Fulfilling the Commitment to our Community: Needs Assessment for Urban Disabled and Elder Natives	Urban Indian Health Institute
29	Our Bodies, Our Stories	Urban Indian Health Institute
30	White Center CDA Annual Summit Strong Voices 2018 Report	White Center CDA
31	White Center 2019 Summit	White Center CDA
32	2019 Gender Affirming Healthcare Access Report	Ingersoll Gender Center
33	Celebrating the Power of Bilingualism	OneAmerica
34	Seattle's 2018–2022 Consolidated Plan for Housing and Community Development	City of Seattle
35	Lessons Learned from Community Engagement	SOAR
36	Consumer Voice Listening Project and Community Grants Program (2018)	HealthierHere
37	Consumer Voice Listening Project and Community Grants Program (2019)	HealthierHere
38	2019 Community Health Needs Assessment	Kaiser Foundation Health Plan of Washington
39	Community Health Needs Assessment 2018	Overlake Medical Center and Clinics
40	Community Health Needs Assessment 2018 Swedish Ballard	Swedish Ballard
41	Community Health Needs Assessment 2018 Swedish Edmonds	Swedish Edmonds
42	Community Health Needs Assessment 2018 Swedish (Seattle) Cherry Hill/ First Hill	Swedish (Seattle) Cherry Hill/First Hill
43	Community Health Needs Assessment 2018 Swedish Issaquah	Swedish Issaquah
44	Community Health Needs Assessment 2018 Swedish Cancer Institute	Swedish Cancer Institute
45	SCCA 2019 Community Health Needs Assessment (CHNA)	Seattle Cancer Care Alliance
46	Seattle Children's 2019 Community Health Assessment	Seattle Children's
47	Everything Is Medicine	Community Health Board Coalition
48	Report on Gun Violence Among Youth and Young Adults	Public Health – Seattle & King County

Appendix B: Report Definitions & Structure

REPORT DEFINITIONS AND STRUCTURE

For each indicator, this report includes:

- A description of the indicator
- Overall estimate for King County
- Multiple-year averaged estimates for select sub-populations (e.g. race/ethnicity and region) in either a bar chart or map
- Narrative interpretation that highlights important findings – typically of disparities (by race, place, income, gender, or sexual orientation) and trends

The Community Health Indicators (CHI) website includes additional data for each indicator included in this report as well as many other indicators. Additional indicators that are available online have been included at the beginning of each report topic section.

When available, CHI indicators include:

- King County estimate from the most recent year available, including rate and number of people affected (this estimate may differ from the multiple-year averaged estimates presented in the report). NOTE: For most analyses, data from multiple years are combined to improve the reliability of the estimates.
- A bar chart that shows multiple-year averaged estimates for all demographic breakdowns (e.g., age, gender, region, race/ethnicity, and income or neighborhood poverty level as a measure of socioeconomic status).
- A map of multiple-year averaged estimates by neighborhoods/cities, ZIP codes, or regions.
- A line chart of rolling-averaged estimates for King County and each region over time to show trends (please see definition of rolling averages below).
- More detail about each data point appears in a tool tip box when the pointer hovers over a bar or line on the chart.
- The following symbols are used in graphs throughout the report (*, ^, !):

  * Denotes values that are significantly different from the King County average

  ^ There are too few cases to protect confidentiality and/or report reliable rates

  ! While rates are presented, there are too few cases to meet a precision standard, and results should be interpreted with caution.

- To protect confidentiality, presentation of data follows various reliability and suppression guidelines per data sharing agreements.

Appendix B: Report Definitions & Structure

Continued

Confidence Interval (also known as error bar) is the range of values that includes the true value 95% of the time. If the confidence intervals of two groups do not overlap, the difference between groups is considered statistically significant (meaning that chance or random variation is unlikely to explain the difference).

Confidence intervals on the CHI website are turned off by default. Users may turn them on by clicking the appropriate radio button.

Crude, Age-Specific, and Age-Adjusted Rates

- Rates are usually expressed as the number of events per 100,000 population. When this applies to the total population (all ages), the rate is called the **crude rate.**

- Infant mortality, maternal smoking, and other maternal/child health measures are calculated with live births as the denominator and presented as a rate per 1,000 live births (infant mortality) or percent of births (preterm, low birth weight, etc.).

- When the rate applies to a specific age group (e.g., age 15–24), it is called the **age-specific rate.**

- The crude and age-specific rates present the actual magnitude of an event within a population or age group.

- When comparing rates between populations, it is useful to calculate a rate that is not affected by differences in the age composition of the populations. This is the **age-adjusted rate**. For example, if a neighborhood with a high proportion of older people also has a higher-than-average death rate, it will be difficult to determine if that neighborhood's death rate is higher than average for residents of all ages or if it simply reflects the higher death rate that naturally occurs among older people. The age-adjusted rate mathematically removes the effect of the population's age distribution on the indicator.

- Prevalence rates from the Behavioral Risk Factor Surveillance Survey (BRFSS) are expressed as a percentage of the adult population, usually ages 18+. Exceptions to the age range are noted. These rates are not age-adjusted.

- Prevalence rates from the Healthy Youth Survey (HYS) are for public school students in the specified grades and weighted to the population. HYS is asked only of students in grades 6 (abbreviated version), 8, 10, and 12 every other year.

Geographies: Whenever possible, indicators are reported for King County as a whole and for four regions within the county. If enough data are available for a valid analysis, they may also be reported by smaller geographic areas (cities,

Appendix B: Report Definitions & Structure

Continued

neighborhoods within large cities, and groups of smaller cities and unincorporated areas). Education data are reported by school district. For more detail, plus maps, see About King County Geographies or our geographic definitions page.

Cities/Neighborhoods (also known as Health Reporting Areas or HRAs): In 2011, new King County Health Reporting Areas (HRAs) were created to coincide with city boundaries in King County. These areas, recently renamed "Cities/Neighborhoods," are based on aggregations of US Census Bureau-defined blocks. Where possible, Cities/Neighborhoods correspond to cities and, for larger cities, to neighborhoods within cities, and delineate unincorporated areas of King County. These geographical designations were created to help cities and planners as they consider issues related to local health status or health policy. Cities/Neighborhoods are used whenever we have sufficient sample size to present the data. These are represented in the report as "city/neighborhood" data.

Federal Poverty Guidelines, issued by the Department of Health and Human Services, are a simplified version of the federal poverty thresholds. The guidelines are used to determine financial eligibility for various federal, state, and local assistance programs. For a family of four, the federal poverty guideline was $25,100 in 2018; in 2019 it was $25,750.

Neighborhood poverty levels are based on the proportion of people in a census tract in which their annual household income (as reported in the US Census Bureau's American Community Survey) falls below the federal poverty level.

- **High poverty:** 20% or more of the population in the neighborhood is below the federal poverty level. Using this criterion, 14.0% of the King County population lives in high-poverty neighborhoods.
- **Medium poverty:** 5% to 19% of the population is below the federal poverty level. Using this criterion, 62.7% of the King County population lives in medium-poverty neighborhoods.
- **Low poverty:** fewer than 5% of the population is below the federal poverty level. Using this criterion, 23.3% of the King County population lives in low-poverty neighborhoods.

This neighborhood-level characteristic is used where individual measures of income or poverty level are not available. The high-poverty area follows the definition of a Federal Poverty Area. The 5% limit for low-poverty areas was chosen to create a group markedly different from Federal Poverty Areas, and thus sensitive to differences in health outcomes that may be associated with socioeconomic differences, while maintaining enough tracts in each group for robust comparisons.

Appendix B: Report Definitions & Structure

Continued

For area-based measures of poverty, a census tract is considered a neighborhood. Data sources where census tract information is not available use ZIP codes to designate the neighborhood.

Race/Ethnicity and Discrimination: Race and ethnicity are markers for complex social, economic, and political factors that can influence community and individual health in important ways. Many communities of color have experienced social and economic discrimination and other forms of racism that can negatively affect the health and well-being of these communities. We continue to analyze and present data by race/ethnicity because we believe it is important to be aware of racial and ethnic group disparities in these indicators.

Race/Ethnicity Analysis in CHNA Report and CHI: The majority of indicators included in this report reflect race/ethnicity as mutually exclusive categories (where all race groups are mutually exclusive, and Hispanics are counted only once). In addition to mutually exclusive categories, where applicable on the Community Health Indicators website, there is an option for users to view race/ethnicity alone or in combination categories (where Hispanic is analyzed as an ethnicity and Hispanics are also counted in their preferred race group). NOTE: The Medicaid profile analysis uses mutually inclusive racial/ethnic groups to mirror the analyses included in various HealthierHere ACH dashboards, which present additional data for the King County Medicaid population.

Race/Ethnicity Terms: Federal standards mandate that race and ethnicity (Hispanic origin) are distinct concepts requiring two separate questions when collecting data from an individual. "Hispanic origin" is meant to capture the heritage, nationality group, lineage, or country of birth of an individual (or their parents) before arriving in the United States. Persons of Hispanic ethnicity can be of any race. 2010 Census terms: (One race) white, Black or African American, American Indian and Alaska Native, Asian, Native Hawaiian and Other Pacific Islander, Some Other Race; (Two or more races) Hispanic or Latino origin, white alone (not Hispanic or Latino). Persons of Hispanic ethnicity are also counted in their preferred race categories. Racial/ethnic groups are sometimes combined when sample sizes are too small for valid statistical comparisons of more discrete groups. For small groups (American Indian and Alaska Native, Native Hawaiian/Pacific Islander) in which a high proportion of King County residents are that race and one or more other races, the group "(race) alone or in combination" is sometimes used to include all who identify as that group.

Some surveys collect racial/ethnic information using only one question on race. These terms are:

Appendix B: Report Definitions & Structure

Continued

- **Terms:** Hispanic, white non-Hispanic, Black, American Indian/Alaska Native (AIAN), Asian, Native Hawaiian/Pacific Islander (NHPI), white, and Multiple Race (Multiple).

- Generally, the CHNA report uses the following race/ethnicity terms (when available): American Indian/Alaska Native (AIAN), Asian, Black, Hispanic, Multiple, Native Hawaiian/Pacific Islander (NHPI), and white.

Limitations of Race/Ethnicity Categories: When asked to identify their race/ethnicity in surveys, respondents are often offered a narrow range of options (see terms above); those broad categories are then used to make expansive race/ethnicity comparisons. The vast diversity within race/ethnicity categories does not allow us to distinguish among ethnic groups or nationalities within categories. Combining groups with wide linguistic, social, and cultural differences — such as African immigrants with Black Americans; Vietnamese, Korean, and East Indians in one Asian category; white Americans with eastern Europeans; or Brazilians with Mexicans — does not allow for a careful analysis of the potential disparities within groups, or the varied sociocultural influences on those disparities. In addition, some racial/ethnic samples in King County are too small to allow for informative comparisons or generalizations.

Rolling Averages: When the frequency of an event varies widely from year to year, or sample sizes are small, the yearly rates are aggregated into averages — often in three-year intervals — to smooth out the peaks and valleys of the yearly data in trend lines. For example, for events occurring from 2001 to 2015, rates may be graphed as three-year rolling averages: 2001–2003, 2002–2004…2011–2015. Adjacent data points will contain overlapping years of data.

Rounding Standards: Rates for all data sources are rounded to one decimal point (for example, 15.4%).

Statistical Significance: Differences between subpopulation groups and the overall county are examined for each indicator. Unless otherwise noted, all differences mentioned in the text are statistically significant (unlikely to have occurred by chance).

The potential to detect differences and relationships (termed the statistical power of the analysis) is dependent in part on the number of events and size of the population, or, for surveys, the number of respondents, or sample size. Differences that do not appear to be significant might reach significance with a large enough population or sample size.

Citation Request:

The data published in this Community Health Needs Assessment report and on the Community Health Indicators website may be reproduced without permission. Please use the following citation when reproducing:

"Retrieved (date) from Public Health – Seattle & King County, Community Health Indicators. www.kingcounty.gov/chi"

Appendix C: About Hospitals for a Healthier Community

ABOUT HOSPITALS FOR A HEALTHIER COMMUNITY

King County Hospitals for a Healthier Community (HHC) comprises 10 hospitals/health systems in King County and Public Health – Seattle & King County (PHSKC) with the fiscal administrative support of the Washington State Hospital Association (WSHA). This collaborative was formed in 2012 to identify the greatest needs and assets of the communities its members serve in order to develop coordinated plans to support the health and well-being of King County residents. One of the primary goals of HHC has been to collaborate on a joint community health needs assessment (CHNA) in order to avoid duplication of efforts, which, in turn, would help focus available resources on a community's most important health needs. HHC has collectively produced three CHNA reports: the 2015/2016 report, the 2018/2019 report, and this most recent 2021/2022 report.

PARTICIPATING HOSPITALS AND HEALTH SYSTEMS

EvergreenHealth

Kaiser Permanente

MultiCare Health System
Auburn Medical Center
Covington Medical Center

Navos

Overlake Medical Center & Clinics

Seattle Cancer Care Alliance

Seattle Children's

Swedish Health Services
Swedish Ballard Campus
Swedish Cherry Hill Campus
Swedish First Hill Campus
Swedish Issaquah Campus

UW Medicine
Harborview Medical Center
Northwest Hospital & Medical Center
UW Medical Center
Valley Medical Center

Virginia Mason Franciscan Health
St. Anne Hospital
St. Elizabeth Hospital
St. Francis Hospital
Virginia Mason Medical Center

Appendix D: 2019-2022 Evaluation of Impact

VIRGINIA MASON FRANCISCAN HEALTH VIRGINIA MASON MEDICAL CENTER

COMMUNITY ASSESSMENT

Virginia Mason Medical Center engaged in multiple activities to conduct its community health improvement planning process. These included conducting a Community Health Needs Assessment with community input, identifying collaborating community stakeholder organizations, describing anticipated impacts of program activities and measuring program indicators. This evaluation of impact outlines many of the programs that Virginia Mason Medical Center supported, either through financial or in-kind support, that addressed the health needs identified in the CHNA.

SIGNIFICANT HEALTH NEEDS

From 2019 through 2022, Virginia Mason Medical Center focused on the following priority health needs:

- Access to Care, Transportation, and Affordable/ Healthy Food
- Housing & Homelessness
- Firearm Violence Prevention

STRATEGY BY HEALTH NEED

The tables on the following pages present strategies and program activities the hospital delivered to help address significant health needs identified in the CHNA report.

They are organized by health need and include statements of the strategies' impact and any collaboration with other organizations in our community.

Appendix D: 2019-2022 Evaluation of Impact

Continued

HEALTH NEED: ACCESS TO CARE, TRANSPORTATION AND AFFORDABLE/ HEALTHY FOOD

BAILEY-BOUSHAY HOUSE

- Provided complex inpatient care through a 35 bed skilled nursing facility at Bailey-Boushay House for those living with HIV and other end of life complex diseases.
- Operated an 450+ outpatient program for those living with HIV, which includes medication support, access to basic needs, and psychiatric care.
- Provided chemical dependency support and outreach to those living with HIV.

COVID-19 VACCINATION

- Provided vaccinations to thousands of community members, in partnership with Amazon and other local organizations.
- Partnered with several organizations to provide vaccinations for vulnerable communities, including providing transportation and registration support.

CANCER PREVENTION, SCREENING AND CARE

- Increased compliance rates with HPV vaccination.
- Conducted a community education event on colon cancer prevention.
- Increased outreach and awareness around lung cancer screening.
- Expanded capacity for outpatient infusion.
- Developed a hereditary risk program.

PROJECT ACCESS NORTHWEST

- Virginia Mason Franciscan Health physicians provided donated care to Project Access patients.
- Provided financial support for the care coordination program.

EASTGATE PUBLIC HEALTH CENTER PARTNERSHIP

- Graduate Medical Education residents provided care to patients at the Eastgate Public Health Center in Bellevue.

FRESH BUCKS

- Provided financial support to the Fresh Bucks program, which provides vouchers to eligible residents. These vouches can be redeemed for fruits and vegetables at over 20 retailers in Seattle.

(continued next page)

Appendix D: 2019-2022 Evaluation of Impact

Continued

HEALTH NEED: ACCESS TO CARE, TRANSPORTATION AND AFFORDABLE/ HEALTHY FOOD

BLACK FARMERS COLLECTIVE

- Provided financial support to the Yes Farm, which is a two-acre agricultural farm in Seattle.

RESPITE CARE

- Provided financial assistance to Edward Thomas House medical respite program.

REFUGEES NORTHWEST

- Provided financial assistance to Refugees Northwest for their free bus ticket program.

FOOD IN MOTION

- Virginia Mason Medical Center provided surplus food to Food in Motion, a program of Operation Sack Lunch, which distributes food throughout the Seattle Area.

LEAD TESTING

- Partnered with King County Medical Society and Public Health - Seattle & King County to provide lead testing to youth.

FINANCIAL ASSISTANCE

- Continued to make access to financial assistance easy and accessible for all who qualify.

IMPACT

Adults without insurance in the City of Seattle stayed relatively flat, rising from 5.0% in 2016 to 5.3% in 2019. Adults who did not seek care due to cost in King County remained the same over the last few years, at 10.5%.

COLLABORATORS

Virginia Mason Medical Center collaborated with Project Access NW, Operation Sack Lunch, Edward Thomas House, Public Health - Seattle/King County and others to achieve our access to care goals.

Appendix D: 2019-2022 Evaluation of Impact

Continued

HEALTH NEED: HOUSING & HOMELESSNESS

BAILEY-BOUSHAY HOUSE

- Created an overnight shelter for the homeless population, which can accommodate up to 50 people per night.
- Provided housing stability project, which helped those experiencing homeless transition to permanent housing with ongoing support.
- Operated a rental assistance program that targets HIV+ people of color and women that houses 50 individuals and families previously homeless.

MARY'S PLACE

- Provide staff time to provide wellness education to residents at the Northshore Family Center.
- Donate supplies to shelter residents.

PLYMOUTH HOUSING

- Provided financial support for housing and stabilization programs.

SOLID GROUND

- Provided financial support for Solid Ground's housing programs.

LGBTQ ALLYSHIP

- Supported the "Let's Build! Housing, Community and Support" conference.

IMPACT

Virginia Mason Medical Center provided housing and housing support to hundreds of community members from 2019-2022.

COLLABORATORS

Virginia Mason Medical Center collaborated with the Bailey-Boushay House, Mary's Place, and community organizations to achieve these goals.

Appendix D: 2019-2022 Evaluation of Impact

Continued

HEALTH NEED: FIREARM VIOLENCE PREVENTION

SAFE FIREARM STORAGE GIVEAWAY EVENTS

- Provided space, staff, and financial support to bring a safe firearm storage event to the VM Regional Medical Center in Lynnwood in 2021.

ALLIANCE FOR GUN RESPONSIBILITY FOUNDATION

- Provided financial support for programs that promote safe firearm use.

IMPACT

Virginia Mason Medical Center provided 89 safe firearm storage devices to community members.

COLLABORATORS

Virginia Mason Medical Center collaborated with the WA Firearm Tragedy Prevention Network at Seattle Childrens and the Alliance for Gun Responsibility Foundation to achieve these goals.

Appendix E: VMMC Primary Service Area

VIRGINIA MASON MEDICAL CENTER PRIMARY SERVICE AREA

The primary service area represents 75 percent of inpatients served.

98101	98121	98942	98004	98105	98070	98011	98045
98110	98109	98027	98199	98058	98177	98056	98074
98104	98026	98208	98146	98188	98221	98223	98148
98902	98368	98001	98006	98422	98029	98531	98258
98908	98116	98115	98020	98502	98022	98028	98270
98926	98198	98903	98032	98043	98107	98321	98277
98382	98036	98103	98042	98059	98569	99301	98346
98003	98126	98037	98087	98391	98021	98002	98371
98023	98133	98102	98155	98030	98204	98072	98005
98122	99801	98106	98136	98033	98374	98951	
98362	98168	98584	98363	98108	98226	98053	
98118	98012	98178	98092	98501	98331	98075	
98144	98119	98370	98052	98512	98038	98229	
98040	98112	98125	98117	98550	98922	98532	
98901	98520	98034	98166	98031	98948	98577	